Chartered Insurance Institute

Standards. Professionalism. Trust.

Insurance underwriting process

IF3

2021 **STUDY TEXT**

Insurance underwriting process

IF3: 2021 Study text

RevisionMate

Available for the life of your enrolment, RevisionMate offers online services to support your studies and improve your chances of exam success. Availability of each service varies depending on the unit, but typically includes:

- **Printable PDF and ebook of the study text**.
- **Study planner** – build a routine and manage your time more effectively.
- **Student discussion forum** – share common queries and learn with your peers.
- **Quiz questions** – check understanding of the study text as you progress.
- **Examination guide** – practise your exam technique.

To explore the benefits for yourself, visit *www.revisionmate.com*

Please note: If you have received this study text as part of your update service, access to RevisionMate will only be available for the remainder of your enrolment.

Updates and amendments

As part of your enrolment, any changes to the exam or syllabus, and any updates to the content of this course, will be posted online so that you have access to the latest information. You will be notified via email when an update has been published. To view updates:

1. Visit *www.cii.co.uk/qualifications*
2. Select the appropriate qualification
3. Select your unit on the right hand side of the page

Under 'Unit updates', examination changes and the testing position are shown under 'Qualifications update'; study text updates are shown under 'Learning solutions update'.

Please ensure your email address is current to receive notifications.

© The Chartered Insurance Institute 2020

All rights reserved. Material included in this publication is copyright and may not be reproduced in whole or in part including photocopying or recording, for any purpose without the written permission of the copyright holder. Such written permission must also be obtained before any part of this publication is stored in a retrieval system of any nature. This publication is supplied for study by the original purchaser only and must not be sold, lent, hired or given to anyone else.

Every attempt has been made to ensure the accuracy of this publication. However, no liability can be accepted for any loss incurred in any way whatsoever by any person relying solely on the information contained within it. The publication has been produced solely for the purpose of examination and should not be taken as definitive of the legal position. Specific advice should always be obtained before undertaking any investments.

Print edition ISBN: 978 1 80002 011 5
Electronic edition ISBN: 978 1 80002 012 2
This edition published in 2020

The updater

Grace Maxted, LLB (Hons), ACII has worked in the London insurance market for 15 years. Her background is in claims adjusting, specialising in professional indemnity, directors' and officers', financial institutions, employers' liability and public and products liability insurance. Grace now trains for the CII modules from Certificate to Advanced Diploma levels and has also provided training in the Philippines and United Arab Emirates.

The CII would like to thank **Alasdair MacDonald, BA (Hons), ACII** and **Neil A Roff, B. Juris (U.P.E.), FIISA, ACII** for writing and updating previous editions of the study text.

We would also like to thank the following reviewers for their assistance with earlier editions:

Michael Poll, ACII Mike Cronin Nathan Brew Tony Pearson Andy Pilling.

Acknowledgement

The CII thanks the Financial Conduct Authority (FCA) and the Prudential Regulation Authority (PRA) for their kind permission to draw on material that is available from the FCA website: *www.fca.org.uk* (FCA Handbook: *www.handbook.fca.org.uk/handbook*) and the PRA Rulebook site: *www.prarulebook.co.uk* and to include extracts where appropriate. Where extracts appear, they do so without amendment. The FCA and PRA hold the copyright for all such material. Use of FCA or PRA material does not indicate any endorsement by the FCA or PRA of this publication, or the material or views contained within it.

While every effort has been made to trace the owners of copyright material, we regret that this may not have been possible in every instance and welcome any information that would enable us to do so.

Unless otherwise stated, the author has drawn material attributed to other sources from lectures, conferences, or private communications.

Typesetting, page make-up and editorial services CII Learning Solutions.

Printed and collated in Great Britain.

This paper has been manufactured using raw materials harvested from certified sources or controlled wood sources.

Using this study text

Welcome to the **IF3**: **Insurance underwriting process** study text which is designed to support the IF3 syllabus, a copy of which is included in the next section.

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

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

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

Activities: reinforces learning through practical exercises.

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

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

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

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

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

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

Refer to:

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

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

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

Think back to:

Think back to: highlights areas of assumed knowledge that you might find helpful to revisit. The sections referred to are available for you to view and download on RevisionMate.

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

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

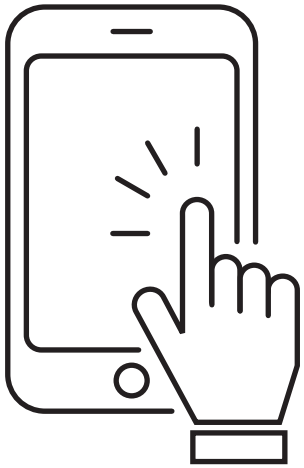
By referring back to the learning outcomes after you have completed your study of each chapter and attempting the end of chapter self-test questions, you will be able to assess your progress and identify any areas that you may need to revisit.

Not all features appear in every study text.

Note
Website references correct at the time of publication.

Revision just got a whole lot easier

RevisionMate is an online study support tool that helps you revise.



Key features can include:

- **Printable PDF and ebook of the study text**
- **Study planner* –** helps you build a routine and manage time effectively
- **Student discussion forum –** interact with your peers and share queries
- **Quiz questions –** check understanding of the study text as you progress
- **Examination guide –** useful hints, tips and a specimen paper with answers to help prepare you for the exam

*not available on RevisionMate app

Download the RevisionMate app from the Apple and Google Play app stores for use on iOS and Android devices.

Chartered Insurance Institute

Find out more
www.revisionmate.com

Examination syllabus

Chartered Insurance Institute

Insurance underwriting process

Objective

To provide knowledge and understanding of the role of underwriting including identification, assessment and acceptance of risk, rating and relevant financial factors.

Summary of learning outcomes		Number of questions in the examination*
1.	Understand the material circumstances relating to the insurance underwriting process.	5
2.	Understand underwriting procedures relating to the insurance underwriting process.	15
3.	Understand insurance policies in relation to the insurance underwriting process.	10
4.	Understand renewals and cancellation in relation to the insurance underwriting process.	3
5.	Understand personal insurances in relation to the insurance underwriting process.	3
6.	Understand commercial insurances in relation to the insurance underwriting process.	3
7.	Understand the main 'support' type insurance services available.	2
8.	Understand underwriting considerations in relation to the insurance underwriting process.	13
9.	Understand the principles and practices of pricing.	10
10.	Understand pricing factors within the context of the insurance underwriting process.	5
11.	Understand managing exposure within the context of the insurance underwriting process.	6

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

Important notes

- Method of assessment: 75 multiple choice questions (MCQs). 2 hours are allowed for this examination.
- This syllabus will be examined from 1 January 2021 until 31 December 2021.
- Candidates will be examined on the basis of English law and practice unless otherwise stated.
- Candidates should refer to the CII website for the latest information on changes to law and practice and when they will be examined:
  1. Visit *www.cii.co.uk/qualifications*
  2. Select the appropriate qualification
  3. Select your unit from the list provided
  4. Select qualification update on the right hand side of the page

Published October 2020
©2020 The Chartered Insurance Institute. All rights reserved.

1. Understand the material circumstances relating to the insurance underwriting process.

1.1 Explain why an underwriter needs to be aware of material circumstances in assessing a risk.

1.2 Explain the concept of the duty of fair presentation, to whom it applies and how the duty may be modified.

1.3 Define the words peril and hazard as used in the insurance industry and the relationship between them.

1.4 Explain the significance of moral and physical hazard for underwriters and how they are manifested.

1.5 Describe the methods used by underwriters to obtain material information.

2. Understand underwriting procedures relating to the insurance underwriting process.

2.1 Describe the general and specific questions asked of proposers.

2.2 Describe the procedure relating to quotations.

2.3 Explain the methods by which underwriters gather material information and their legal significance.

2.4 Describe the different ways in which premiums are calculated.

2.5 Explain the legal significance of procedures relating to the issue of cover notes, policies and certificates of insurance.

2.6 Describe the relevance of premium payment for valid cover.

2.7 Describe the methods used by insurers to collect premiums including instalment facilities.

2.8 Describe the features of Insurance Premium Tax.

3. Understand insurance policies in relation to the insurance underwriting process.

3.1 Describe the structure, functions and contents of a policy form.

3.2 Explain the meaning and significance of common policy exclusions.

3.3 Explain the meaning and significance of common conditions.

3.4 Explain how excesses, deductibles and franchises are used.

3.5 Explain the distinction between warranties, conditions and representations.

4. Understand renewals and cancellation in relation to the insurance underwriting process.

4.1 Describe the legal significance of procedures relating to renewals.

4.2 Explain how cancellation clauses operate.

5. Understand personal insurances in relation to the insurance underwriting process.

5.1 Describe the basic features and typical policy cover of motor insurance, health insurance, household insurance, travel insurance and extended warranties.

6. Understand commercial insurances in relation to the insurance underwriting process.

6.1 Describe the basic features and typical policy cover of property insurance, pecuniary insurance, cyber insurance and liability insurance.

7. Understand the main 'support' type insurance services available.

7.1 Describe the basic features of additional 'support' type insurance services available with specific reference to help lines, authorised repairers and suppliers, risk control/advice and uninsured loss recovery services.

8. Understand underwriting considerations in relation to the insurance underwriting process.

8.1 Describe the key underwriting criteria for motor insurance, health insurance and personal insurances.

8.2 Describe the key underwriting criteria for commercial property insurance, including fire and special perils, theft insurance, glass insurance and money insurance.

8.3 Describe the key underwriting criteria for pecuniary insurances, including legal expense insurance and business interruption insurance.

8.4 Describe the key underwriting criteria for liability insurance, including employers' liability, public liability, pollution liability, products liability and professional indemnity.

8.5 Describe the key underwriting criteria for extended warranties.

8.6 Describe the procedures commonly used to discourage individuals from making fraudulent claims.

8.7 Describe the procedures commonly used to detect fraudulent claims.

8.8 Explain the consequences of fraudulent claims for the insurer, their insureds and the fraudulent claimant.

8.9 Explain the effect on insurance of data protection legislation.

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

9. Understand the principles and practices of pricing.

9.1 Describe the sources, availability and types of data essential to the underwriting process.

9.2 Explain the importance of claims information on underwriting terms/premium rates.

Published October 2020
©2020 The Chartered Insurance Institute. All rights reserved.

9.3 Explain the nature of risk in terms of frequency and severity of claims.

9.4 Explain the significance of the claims loss ratio on premiums/acceptance of risk.

9.5 Explain the distinction between underwriting year, policy year, accounting year and calendar year.

10. Understand pricing factors within the context of the insurance underwriting process.

10.1 Define risk premium and its key features.

10.2 Describe the reporting factors of expenses, return on capital, investment income, tax and intermediary remuneration.

11. Understand managing exposure within the context of the insurance underwriting process.

11.1 Describe the basic factors influencing the market cycle.

11.2 Describe the principles of risk accumulation.

11.3 Describe the basic reinsurance considerations including the types of reinsurance.

Reading list

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

Note: The examination will test the syllabus alone.

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

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

CII study texts

Insurance underwriting process. London: CII. Study text IF3.

Books and eBooks

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

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

'Insurance intermediaries: underwriting agents' in Colinvaux's law of insurance. 11th ed. Prof. Robert Merkin. London: Sweet & Maxwell, 2016.

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

Pricing in general insurance. Pietro Parodi. CRC Press, 2015.*

Periodicals

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

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

Reference materials

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

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

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

Published October 2020
©2020 The Chartered Insurance Institute. All rights reserved.

Examination guide

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

Exam technique/study skills

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

Published October 2020
©2020 The Chartered Insurance Institute. All rights reserved.

IF3 syllabus quick-reference guide

Syllabus learning outcome		Study text chapter and section
1.	**Understand the material circumstances relating to the insurance underwriting process.**	
1.1	Explain why an underwriter needs to be aware of material circumstances in assessing a risk.	*1A*, *1B*
1.2	Explain the concept of the duty of fair presentation, to whom it applies and how the duty may be modified.	*1A*, *1C*, *1D*
1.3	Define the words peril and hazard as used in the insurance industry and the relationship between them.	*1E*
1.4	Explain the significance of moral and physical hazard for underwriters and how they are manifested.	*1E*
1.5	Describe the methods used by underwriters to obtain material information.	*1B*, *1F*
2.	**Understand underwriting procedures relating to the insurance underwriting process.**	
2.1	Describe the general and specific questions asked of proposers.	*1F*, *2B*
2.2	Describe the procedure relating to quotations.	*2A*
2.3	Explain the methods by which underwriters gather material information and their legal significance.	*2B*
2.4	Describe the different ways in which premiums are calculated.	*2C*
2.5	Explain the legal significance of procedures relating to the issue of cover notes, policies and certificates of insurance.	*2D*, *2E*
2.6	Describe the relevance of premium payment for valid cover.	*2F*
2.7	Describe the methods used by insurers to collect premiums including instalment facilities.	*2F*
2.8	Describe the features of Insurance Premium Tax.	*2F*
3.	**Understand insurance policies in relation to the insurance underwriting process.**	
3.1	Describe the structure, functions and contents of a policy form.	*3A*
3.2	Explain the meaning and significance of common policy exclusions.	*3B*, *3C*
3.3	Explain the meaning and significance of common conditions.	*3D*
3.4	Explain how excesses, deductibles and franchises are used.	*3E*
3.5	Explain the distinction between warranties, conditions and representations.	*3D*
4.	**Understand renewals and cancellation in relation to the insurance underwriting process.**	
4.1	Describe the legal significance of procedures relating to renewals.	*4A*
4.2	Explain how cancellation clauses operate.	*4B*
5.	**Understand personal insurances in relation to the insurance underwriting process.**	
5.1	Describe the basic features and typical policy cover of motor insurance, health insurance, household insurance, travel insurance and extended warranties.	*5A*, *5B*, *5C*, *5D*, *5E*
6.	**Understand commercial insurances in relation to the insurance underwriting process.**	
6.1	Describe the basic features and typical policy cover of property insurance, pecuniary insurance, cyber insurance and liability insurance.	*6A*, *6B*, *6C*, *6D*

Syllabus learning outcome		Study text chapter and section
7.	**Understand the main 'support' type insurance services available.**	
7.1	Describe the basic features of additional 'support' type insurance services available with specific reference to help lines, authorised repairers and suppliers, risk control/advice and uninsured loss recovery services.	*7A*, *7B*, *7C*, *7D*, *7E*, *7F*
8.	**Understand underwriting considerations in relation to the insurance underwriting process.**	
8.1	Describe the key underwriting criteria for motor insurance, health insurance and personal insurances.	*5A*, *5B*, *5C*, *5D*
8.2	Describe the key underwriting criteria for commercial property insurance, including fire and special perils, theft insurance, glass insurance and money insurance.	*6A*
8.3	Describe the key underwriting criteria for pecuniary insurances, including legal expense insurance and business interruption insurance.	*6B*
8.4	Describe the key underwriting criteria for liability insurance, including employers' liability, public liability, pollution liability, products liability and professional indemnity.	*6C*
8.5	Describe the key underwriting criteria for extended warranties.	*5E*
8.6	Describe the procedures commonly used to discourage individuals from making fraudulent claims.	*8C*
8.7	Describe the procedures commonly used to detect fraudulent claims.	*8C*
8.8	Explain the consequences of fraudulent claims for the insurer, their insureds and the fraudulent claimant.	*8C*
8.9	Explain the effect on insurance of data protection legislation.	*8D*, *8E*
8.10	Explain the importance of the fair treatment of customers and positive customer outcomes.	*4A*
9.	**Understand the principles and practices of pricing.**	
9.1	Describe the sources, availability and types of data essential to the underwriting process.	*8A*, *8B*, *9A*
9.2	Explain the importance of claims information on underwriting terms/premium rates.	*8B*, *9B*
9.3	Explain the nature of risk in terms of frequency and severity of claims.	*9C*
9.4	Explain the significance of the claims loss ratio on premiums/ acceptance of risk.	*9D*
9.5	Explain the distinction between underwriting year, policy year, accounting year and calendar year.	*9E*
10.	**Understand pricing factors within the context of the insurance underwriting process.**	
10.1	Define risk premium and its key features.	*10A*
10.2	Describe the reporting factors of expenses, return on capital, investment income, tax and intermediary remuneration.	*10B*, *10C*, *10D*, *10E*
11.	**Understand managing exposure within the context of the insurance underwriting process.**	
11.1	Describe the basic factors influencing the market cycle.	*11A*
11.2	Describe the principles of risk accumulation.	*11B*
11.3	Describe the basic reinsurance considerations including the types of reinsurance.	*11C*

Introduction

In the early days of marine insurance, the details of a ship or cargo to be insured would be described on a slip. This slip would be taken to Lloyd's of London and the person who was to carry the risk would read the details, then sign the slip under the details of the risk. In this way, the person carrying the risk became known as the underwriter.

The underwriting process is far more complicated nowadays but the term still applies.

Insurance is based on the concept of the common pool. Contributions, in the form of premiums from many policyholders, go into this pool out of which the losses of the few are met. In essence, the task of the underwriter is to manage this pool as effectively and profitably as possible. Thinking of the role of underwriting in this way we could say that it is the role of the underwriter to:

- assess the risk which people bring to the pool;
- decide whether or not to accept the risk, or how much to accept;
- determine the terms, conditions and scope of cover to be offered; and
- calculate a suitable, equitable premium.

In this course we shall be looking at the procedures involved in underwriting in a general sense, as well as examining the specific underwriting considerations applicable to the main classes of general insurance business.

Our course of study will encompass looking at the structure and content of policy wordings, premium payment, renewal and cancellation procedures as well as the main aspects of rating. The developments in related products and services will also be examined and we shall conclude by introducing the principles involved in managing an underwriting account.

Develop with drive

Membership helps push your potential to the next level.

Why membership matters:

- **Professional standards:** Our core beliefs of Standards, Professionalism and Trust – together with your designatory letters and our Code of Ethics – enhance your standing in an ever-changing world.
- **First class technical resources:** Stay ahead of the curve with the latest technical updates, market insights and learning.
- **Grow your professional network:** Meet like-minded professionals on our social media channels or at events and webinars delivered by our societies and local institutes.

We are here for you every step of the way, supporting you throughout your studies and your career.

Chartered Insurance Institute
Standards. Professionalism. Trust.

Find out more
www.cii.co.uk/membership

Contents

1 Material information

Contents	Syllabus learning outcomes
Introduction	
A Good faith	*1.1*, *1.2*
B Material information	*1.1*, *1.5*
C Presenting the risk	*1.2*
D Non-disclosure and misrepresentation	*1.2*
E Physical and moral hazards	*1.3*, *1.4*
F Obtaining material information	*1.5*, *2.1*
Key points	
Question answers	
Self-test questions	

Learning objectives

After studying this chapter, you should be able to:

- explain the concept of good faith;
- define material information and circumstances and give examples;
- explain the principles of the duty of fair presentation;
- explain the consequences of non-disclosure and misrepresentation;
- explain the parallels and differences between peril and hazard;
- explain moral and physical hazard and how they relate to the insurance underwriting process; and
- describe the methods used by underwriters to obtain material information.

Introduction

As mentioned in the course introduction, the role of an underwriter involves 'assessing the risk which people bring to the pool'. You may remember the concept of the common pool from your previous studies.

Part of this assessment involves reviewing the material information relating to the risk. The purpose of this chapter is to focus on the importance of material information in that assessment, the duty of disclosure, and to examine the significance of physical and moral hazard for underwriters. We shall also look at the ways in which underwriters obtain material information.

Key terms

This chapter features explanations of the following ideas:

Acceptance	Brokers	Consideration	Duty of disclosure
Fair presentation	Good faith	Material circumstances	Material information
Misrepresentation	Moral hazards	Non-disclosure	Offer
Perils	Physical hazards	Policy wording	Proposer

A Good faith

A contract is an agreement between two parties which is legally binding. However, not all agreements are legal contracts. For a contract to be legally binding, certain elements must be present. These include:

- an *offer*;
- *acceptance* of the offer;
- *consideration*, i.e. a benefit received by one party in return for a promise of the performance of an act by another party.

Elsewhere in your course of study you will learn that there are other important elements, such as an intention to create legal relations, which must also be present, but for the purposes of this course we are going to focus on these three aspects.

Using an insurance contract as an example we can appreciate more easily how they apply in practice.

Proposer provides information to insurers and requests a quote for motor insurance.	This is the presentation of the risk.
Insurers provide a quotation to the proposer.	This constitutes the offer.
Proposer accepts the quotation.	This constitutes acceptance.
Proposer pays the premium to insurers.	This constitutes consideration.
Insurers must also provide consideration to make the contract legally binding.	They promise to indemnify the proposer under the terms and conditions of the insurance contract in the event of a valid claim.

Most contracts are dealt with under a legal principle known by a Latin term, *caveat emptor*, or **buyer beware**. There are some statutes which also apply, giving protection to consumers against unfair practices.

Insurance contracts are different, as they are based on a promise to do something in the event that a certain set of circumstances occurs, in exchange for payment of the premium. But, because in the case of insurance, the promise is not tangible until a loss occurs, contracts are governed by a different legal principle, known as *good faith*. This was formerly known by the Latin term, *uberrima fides,* or utmost good faith.

Be aware
While the common law principle of utmost good faith still exists at the core of insurance contracts, the definition has been modified by recent legislation and is now referred to as good faith.

This principle imposes a duty which means that any party wanting to take out insurance (i.e. a *proposer*) must:

- provide all information asked for by the insurer; and in the case of:
  - **consumer contracts** ensure that all information provided in response to questions asked, or any additional information the proposer chooses to volunteer, is **full and accurate**; and
  - **non-consumer contracts** ensure that there has been **fair presentation** to the insurer, a 'reasonable search' has been carried out of the proposer's business, and that important information has been 'signposted' for insurers.

This information is viewed as material to the subject matter of the insurance and the insurer's acceptance of the risk. It can be information or material circumstances.

There are exceptions to this duty which will be discussed later.

It is important to flag that this position varies from that which existed prior to the implementation of the **Consumer Insurance (Disclosure and Representations) Act 2012**, and the **Insurance Act 2015**. Previously, a *proposer* was bound to disclose all information that a prudent insurer may wish to know. This proved difficult for the average consumer. We will talk about the changes implemented under each of these Acts and their impact on material information, disclosure and insurance contracts, later in this chapter.

Be aware
Your colleagues may still refer to this as 'utmost good faith'.

B Material information

The **Marine Insurance Act 1906** defines material fact, rather than material information or material circumstances, as follows:

> *Every circumstance is material which would influence the judgment of a prudent insurer in fixing the premium or determining whether to take the risk.*

This definition was debated for a number of years with many believing that it put insurers in a more advantageous position than proposers as they were able to determine what was material and what was not.

There was also concern that any issues with the information supplied were only usually identified in the event of a claim.

The Consumer Insurance (Disclosure and Representations) Act 2012 and Insurance Act 2015 addressed this imbalance for consumers and businesses respectively, and are discussed in more detail later in sections *Consumer Insurance (Disclosure and Representations) Act 2012* on page 1/5 and *Insurance Act 2015* on page 1/6.

The requirement to disclose material facts was changed by the Consumer Insurance (Disclosure and Representations) Act 2012. Consumers are only obliged to answer questions asked of them by insurers in the proposal form, but they must take care to answer those questions fully and accurately. They must also do this with any information they choose to volunteer to the insurer (i.e. that has not been requested by the insurer).

For non-consumers, the definition of what constitutes a **material circumstance** is now set out clearly in Section 7 of the Insurance Act 2015:

> … a circumstance or representation is material if it would influence the judgment of a prudent insurer in determining whether to take the risk and, if so, on what terms.

Examples of material circumstances include:

- special or unusual facts relating to the risk;
- any particular concerns which are leading to the request for insurance; and
- any facts that are specific to the class of business in question.

Reinforce
If a circumstance or representation would influence an insurer's decision to the take the risk, it is material.

At first, this does not sound very different to the Marine Insurance Act 1906. However, the new Act goes on to say under Section 7:

> … a material representation is substantially correct if the prudent insurer would not consider the difference between what was represented and what is actually correct to be material.

This is extremely important not only in distinguishing the existing position under the Marine Insurance Act 1906, but in setting the tone for the entire Act. An insurer's ability to rely on misrepresentation or non-disclosure is affected by whether any incorrect representation would make a difference to the insurer's decision to take the risk.

Be aware
Under the Insurance Act 2015, in contrast to the Marine Insurance Act 1906, insurers' ability to rely on misrepresentation or non-disclosure is affected by whether incorrect representations would affect their decision to take the risk, and the terms on which they might do so.

Apart from having no insurance, this would also invariably prejudice the proposer's ability to obtain insurance in the future, as most insurers ask whether previous policies have been avoided (i.e. nullified, said not to have existed, for example following deliberate, reckless or fraudulent non-disclosure and/or misrepresentation), as part of their general acceptance criteria.

This position allowed insurers to become passive and only respond when things went wrong, usually post-sale in the event of a claim. This type of outcome was even referenced by the Law Commission in its report leading to the Insurance Act 2015. It referred to it as 'underwriting at the claims stage'.

The Acts limit an insurer's ability to rely on any misrepresentation or non-disclosure, as well as limiting the remedies available to them. We will discuss these points later in *Non-disclosure and misrepresentation* on page 1/8.

Reinforce
The Insurance Act 2015 limits an insurer's ability to rely on any misrepresentation or non-disclosure. This means proposers are less vulnerable than under previous legislation.

It should be noted that there is some information that does not need to be disclosed, including:

- facts of law;
- facts of public knowledge;
- 'spent' convictions, as certain legislation does not allow them to be considered. It is worth thinking about this for private individuals/consumers compared to businesses where fines and penalties can have a different impact and may still require disclosure;
- facts that improve the risk;
- facts where the insurer has waived its rights to certain information;
- facts that a survey should have revealed;
- facts an insured did not know;
- facts covered by the policy terms; and

- facts that the insurer already knows, including those that its employee(s) know.

Most insurers encourage proposers to ask if they are uncertain whether something is material or not.

Disclosing material circumstances under the Insurance Act 2015
For non-consumer contracts in the absence of enquiry, the Insurance Act 2015 does not require the insured to disclose a material circumstance if:

- it diminishes the risk;
- the insurer knows it;
- the insurer ought to know it;
- the insurer is presumed to know it; or
- it is something as to which the insurer waives information.

At the time of writing, the Insurance Act 2015 has not been substantially tested in the courts, with only one case, ***Young v. Royal and Sun Alliance (2019)***, that considered whether the insurer had waived the insured's non-disclosure under the Act.

C Presenting the risk

We have already discussed the legislation revised from the Marine Insurance Act 1906, now we will discuss how the concept of disclosure varies for consumers and non-consumers (i.e. businesses, commercial entities).

C1 Consumer Insurance (Disclosure and Representations) Act 2012

As we have already discussed, the rules around disclosure have historically been rooted in the Marine Insurance Act 1906. This stated that the proposer must disclose all material facts, rather than material information or material circumstances, known to them prior to the inception of the contract. A fact was classed as 'material' if it could influence the judgment of a prudent insurer.

The core change under the Consumer Insurance (Disclosure and Representations) Act 2012 is to abolish the duty on **consumers** to volunteer material facts, material information or material circumstances. They are no longer required to consider what a prudent insurer would deem material; instead, they must answer all questions asked by the insurer fully and accurately. Any information that they do volunteer must also be full and accurate. Specifically, they must take reasonable care not to make a *misrepresentation* to the insurer as outlined in section 2 of the Act:

> It is the duty of the consumer to take reasonable care not to make a misrepresentation to the insurer.

Defining a consumer
A consumer can be defined as an individual who purchases an insurance policy primarily for their own private needs and not related to their profession, business or trade.

The Act also sets out how insurers must assess whether a consumer has taken reasonable care. They must consider:

- the type of insurance and the customer it is aimed at;
- any explanatory material produced/authorised by the insurer;
- the clarity of the insurer's questions;
- how clearly the insurer communicated the importance of answering their questions;
- how clearly the insurer communicated the consequences of failing to answer their questions; and
- whether an agent was acting for the consumer.

Crucially, the Act states that:

> A misrepresentation made dishonestly is always to be taken as showing lack of reasonable care.

Therefore, this does not protect consumers who intentionally deceive the insurer.

C2 Insurance Act 2015

The Insurance Act 2015 was born out of the same sentiment that resulted in the Consumer Insurance (Disclosure and Representations) Act 2012. The key difference being that the Insurance Act 2015 makes provisions for **non-consumers** (e.g. commercial risks and businesses). This also includes micro businesses (i.e. those with turnovers under €2m) which have recourse via the FOS. That said, aspects of the Act do also apply to consumers.

As with the Consumer Insurance (Disclosure and Representations) Act 2012, it is important to emphasise here that while the Insurance Act 2015 replaces the Marine Insurance Act 1906 for non-consumers, a large part of its intent is to simply clarify the provisions of that previous legislation.

The Act creates a duty on non-consumers to make a **fair presentation of the risk**, involving three key elements:

- The proposer must disclose every material circumstance it knows or ought to know. Failing this, the proposer must notify the insurer that it needs to make further enquiries about certain material circumstances.
- The proposer must ensure that its representation of the risk is clear and accessible. This relates to how the information is presented to insurers, rather than the content. It means including adequate signposting for material circumstances following a reasonable search of their business/risk. It also clearly sets out that vague information, or information lacking in full detail, will not be classed as clear and accessible.
- All material circumstances represented must be substantially correct and made in good faith. The latter is particularly important for any representations made about future events (i.e. the proposer must believe that they are accurate).

Reinforce

In summary, fair presentation must be clear and accessible, and take care not to (deliberately or otherwise) disclose limited information that could mislead.

Insurers must ask questions where appropriate, which are clear about the circumstances they are attempting to determine.

At first glance, this is not very different to the Consumer Insurance (Disclosure and Representations) Act 2012. In fact, the main difference is that non-consumers still need to disclose relevant information, even if the insurer does not ask for it. Consumer insurance contracts, on the other hand, are dependent on questions asked by insurers. The reason for this difference is, in part, because non-consumer contracts tend to be transacted via intermediaries, who are paid a fee or commission to provide advice and guidance to proposers on what insurers are likely to want to know about the risk being proposed.

This new duty of fair presentation is not actually that new in reality, and could be argued to be a simple update of the Marine Insurance Act 1906. While perceived to be less insurer-friendly, there is, in fact, a new duty on proposers not only to disclose information that is clear and accessible, but also to **signpost** material circumstances. This duty around how proposers present information to insurers did not exist prior to the Act.

Contracting out
It is possible for the parties to the insurance contract to agree that the provisions of the Insurance Act 2015 will not apply, and therefore that the **previous law on disclosures would apply**.

This means that in certain circumstances, parties are able to revert back to the position under the Marine Insurance Act 1906 discussed earlier.

The Insurance Act, however, puts a burden on insurers to be transparent when explaining the implications of this to proposers, and should they not do so, then any apparent contracting out within the documentation may have no legal effect. This is important as both the proposer and the insurer must agree to contract out; one cannot do so without the express agreement of the other. The Act anticipates different requirements based on the relative sophistication of the customer, and also recognises that if a broker is involved then they have a duty to alert their client to the potential disadvantages of these choices.

Question 1.1

Which of following legislation governs modern insurance contracts?

a. Insurance Act 2015 only. ☐

b. Consumer Insurance (Disclosure and Representations) Act 2012 and Insurance Act 2015. ☐

c. Marine Insurance Act 1906. ☐

d. In certain circumstances, all of the above. ☐

C3 Duration of the duty of fair presentation

The duty of fair presentation starts when negotiations begin and lasts throughout the life of any policy.

If an insured wishes to change a policy mid-term, such as amending the sum insured, description of the property, or the driving limitation under a motor policy, the duty is revived as if a new contract is formed.

Be aware
If the insured changes a policy mid-term, the duty of fair presentation is revived as if it is a new contract.

Insurers may, however, insert in their **policy wording** a continuing requirement to modify their rights under common law, thereby changing the duty on the proposer. This will be different for different classes of business and the following are some illustrations:

- **Commercial property insurance**. A policy condition requiring continuing disclosure of removal to another location, or circumstances that increase the risk of damage.
- **Motor and home insurance**. There is sometimes an onerous condition requiring continuing disclosure of all material changes for the duration of the policy, not only at the time of variations to the policy (i.e. a newly sustained conviction or an accident or loss). Under the new Act, insurers must not only make clear the continuing requirement to ensure that all questions answered are still accurate, but also make clear the consequence of failing to do so.
- **Public liability insurance**. By tightly defining 'the business' of the insured, the insured must notify any extension of activities. This may be coupled with a condition requiring ongoing disclosure.

C3A Pre-cover

The duty of fair presentation exists from the start of the quotation process. The duty would end if a quotation expired after its period of validity.

C3B Inception

The duty continues once cover is bound as a continuing duty of both parties under the contract of insurance.

Under the Consumer Insurance (Disclosure and Representations) Act 2012, insurers must draw the insured's attention to the answers they provided during quotation, ask them to confirm that they are still accurate, and explain the significance of non-disclosure and misrepresentation.

The same is true for non-consumers under the Insurance Act 2015.

C3C Mid-term

Between inception and any subsequent renewal negotiation, there would only be a duty of fair presentation if there was an alteration in risk. As a continuing duty, this is implied. However, most insurers expressly state this duty as a general condition of cover under their policies.

An example of this would be an increase in the sum a building is insured for. This might not increase the risk of a loss, but could impact its severity. For insurers needing to consider

accumulation and their capacity, it is important that this duty is observed throughout the life of the policy, and it is why they have conditions which not only control the requirement to make such disclosures, but also to protect them in the event that the disclosure is not made (e.g. average applying to a building).

Under the Consumer Insurance (Disclosure and Representations) Act 2012, insurers must draw the insured's attention to the answers they provided at the inception of the policy, ask them to confirm that they are still accurate, and explain the significance of non-disclosure and misrepresentation.

C3D Renewal

The duty of fair presentation exists at renewal. This is because the policy will normally be an annual contract (in the case of short-term business, e.g. non-life, general insurance), renewable every twelve months. In this scenario, it would be helpful for you to treat the policy as a new contract at each renewal, which it is in the eyes of the law.

Under the Consumer Insurance (Disclosure and Representations) Act 2012, insurers must draw the insured's attention to the answers they provided at the inception of the policy, ask them to confirm that they are still accurate, and explain the significance of non-disclosure and misrepresentation.

C3E Claims

This duty also exists in the event of a claim. Insurers may require information to be disclosed to them to assist in providing indemnity under the policy, and are reliant on the information being accurate. The most obvious example of this is when submitting costs in the event of a claim. The duty of fair presentation here is closely linked to the potential for exaggeration and fraud. Again, insurers set out the impact of an insured failing in this duty, most commonly through use of a claims condition in their policy wordings.

C4 Disclosure by an intermediary taking out insurance

Where an insurance contract is entered into on the instruction of one party by an agent or intermediary, they must disclose:

- all the facts communicated to them by the proposer; and
- any additional information which they are aware of.

The proposer must use due diligence to communicate all information to their intermediary. In effect, the duty on the intermediary is no different to the duty on the proposer. The difference created under the Insurance Act 2015 from previous legislation is that anything the intermediary knows is **imputed** back to the proposer.

D Non-disclosure and misrepresentation

A breach of the duty of fair presentation arises in one of two circumstances:

Non-disclosure
The proposer simply fails to tell the insurer something they know, and it is something that would have made the insurer either not enter the contract or do so on different terms.

Misrepresentation
This is where a statement is substantially false, relates to the subject matter of the proposal, and has induced the insurer to enter the contract.

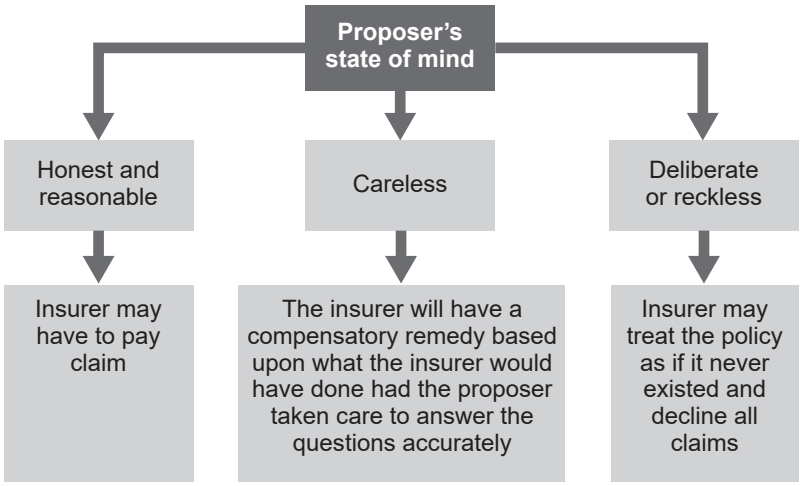
D1 Consumers and remedies

If the consumer took reasonable care (see above) not to breach their duty, the insurer has no remedy under the Consumer Insurance (Disclosure and Representations) Act 2012.

If the breach of duty did not induce the insurer to enter the contract of insurance, they have no remedy under the Consumer Insurance (Disclosure and Representations) Act 2012.

The breach is therefore 'qualifying' under the Act if the consumer did not take reasonable care, and if any breach led the insurer to enter the contract. In such cases the insurer would have the following remedies:

- If the breach was deliberate or reckless, the insurer could avoid the policy (it would be held to have never existed).
- If the breach was careless, the insurer could:
  - alter their terms and deal with the risk in the same way they would have done had there been no breach;
  - proportionately reduce the amount paid for a claim, if they would have charged a higher premium had there been no breach (similar to underinsurance and application of average, see *Average* on page 3/10).



Example 1.1

Consumer
John owns a car that he uses for purely personal reasons. He wants to take out a private motor insurance policy, which will provide comprehensive cover, and has applied for a quotation online.

As he is a consumer, the insurance contract he enters into is subject to the Consumer Insurance (Disclosure and Representations) Act 2012. This means that he must only answer questions (fully and accurately) asked by the insurer prior to the inception of the policy. He must also ensure that any information he chooses to volunteer is, again, full and accurate. However, the insurer cannot rely on John's failure to disclose any information for which he was not asked.

John purchases the policy. Following a claim for accidental damage to the vehicle, the insurer discovers that John failed to disclose that his wife, who is a named driver under the policy, has an unspent conviction for theft. Prior to the inception, the insurer only expressly questioned whether the proposer or any driver to be insured had any **motoring** convictions. Under the Act, the insurer must still consider whether the non-disclosure of the theft conviction is relevant to the loss. However, the insurer is not able to consider whether the non-disclosure was careless, deliberate or reckless, and it (the insurer) had failed to specifically query non-motoring convictions. Therefore, John was under no duty to disclose his wife's theft conviction.

As a result, the insurer would have to meet the cost of the claim in full.

Question 1.2

Joe bought a 'people carrier' vehicle to use as a taxi, but informed his insurers it was for private use only. The vehicle was subsequently stolen.

Can the insurer refuse liability for the theft claim? Give reasons for your answer.

D2 Non-consumers and remedies

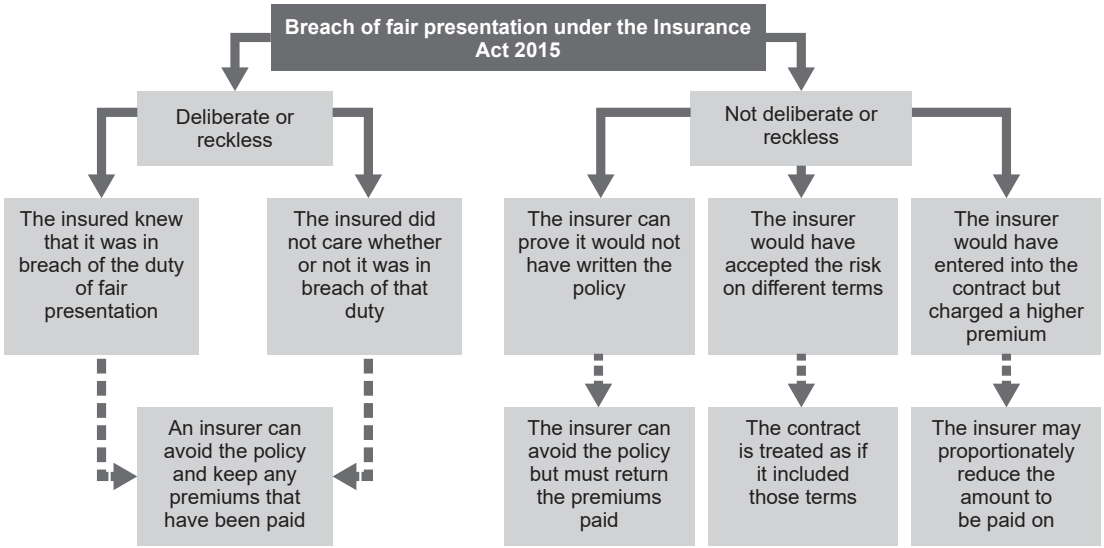
Under the Insurance Act 2015, insurers only have a remedy where:

- the insured has breached their duty of fair presentation;
- the insurer can show that the breach resulted in their entering into the contract, or entering it on terms they would not have done, had the duty of fair presentation been met by the insured.

This takes the provisions of the Marine Insurance Act 1906 and subsequent case law establishing that not only must there be a breach of duty, but that the breach must be material.

Providing these two criteria (above) are met, the insurer has a 'qualifying breach' under the Act and remedies as set out under the Act. The remedy available depends on whether any breach was deliberate or reckless, much in the same way that the Consumer Insurance (Disclosure and Representations) Act 2012 distinguishes between different types of breach.

- If the breach is deliberate or reckless, the insurer may void the policy and refuse claims. A breach can only be deliberate or reckless if the insured knew that it was in breach of its duty, or did not care whether it was in breach of that duty or not. While the burden of proof sits with the insurer, proving recklessness is something the Law Commission has said should be left to the courts.
- If the breach is neither deliberate nor reckless, the remedy depends on what the insurer would have done had the insured fulfilled their duty of fair presentation:
  - If the insurer would not have entered into the contract, they may void the policy and refuse all claims.
  - They may alter their terms and deal with the risk in the same way they would have done had there been no breach.
  - They may proportionately reduce the amount paid for a claim, if they would have charged a higher premium had there been no breach (similar to underinsurance and application of average, see *Average* on page 3/10). This has proved contentious in some segments of the market, particularly real estate. One large general insurer has come out with a different premium remedy, i.e. they will charge the additional premium that would have been payable had correct presentation been made in the first place, rather than proportionately reducing the claims cost.
- You should note though that the Act does not adopt the term 'careless', as used under the Consumer Insurance (Disclosure and Representations) Act 2012, it is left undefined.



It is important to remember that these remedies are the minimum an insurer has to adhere to for a non-consumer. They can choose to go further in opting not to pursue remedies for certain scenarios, and several insurers have opted to do so for various reasons, including perceived competitive advantage in attracting customers within specific segments of the market.

Example 1.2

Commercial customer
Smiths Limited, a shoe manufacturer, has applied to a local insurance intermediary for a quotation to insure its business and assets for material damage including theft. The insurer's question set asks about previous claims in the last five years.

As Smiths Limited is a commercial customer, the provisions of the Consumer Insurance (Disclosure and Representations) Act 2012 do not apply, instead the provisions of the Insurance Act 2015 are relevant. Specifically, the Act makes provision for fair presentation of material circumstances that must be clear and accessible.

Smiths Limited purchases the policy. Following a claim for malicious damage, the insurer discovers that Smiths Limited failed to disclose a previous incident involving theft from its premises for which it did not claim. Prior to the inception, the insurer had only asked about previous claims and not any previous incidents or losses that may have given rise to a claim. However, Smiths Limited still has a duty to volunteer all facts in a clear and accessible manner. They must ensure that they do not try to limit the information that they disclose, deliberately or otherwise. Although the insurer's question set only asks about previous claims, it would be clear that the insurer is concerned with previous incidents that would give rise to a claim under their policy with the proposer.

A previous incident involving a break-in to their premises is an indicator of a potential increased risk within the area in which the business is located. The insurer would need to be aware of this in order to consider whether increasing the premium or setting more restrictive terms is more appropriate.

As a result of Smiths Limited failing to volunteer information about this incident, it is likely that the insurer would need to decide whether it was induced into a contract that it would not have otherwise entered, or simply pay the claim. The insurer's remedies here would either be to adjust the terms or price to what they would have charged had they been made aware of the incident, or to reject the claim. They are unlikely to be able to avoid the policy entirely.

D3 Fraudulent breach of duty

If the non-disclosure or misrepresentation is fraudulent (also known as 'concealment'):

- the policy is voidable;
- the insurer can keep the premium and sue for damages;
- the insurer can ignore the breach of good faith, in which case the policy continues and the insurer would have to pay the claim.

E Physical and moral hazards

The insurance industry commonly uses the words 'hazard' and 'peril' in particular ways, with specific meanings. You may remember these concepts from your previous studies.The easiest way to define them is to view hazard in relation to peril:

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

For example, consider insuring a thatched cottage against fire. Fire would be the prime cause of the loss, but the thatched roof enables the fire to spread more quickly and cause more damage, if a fire occurs. Here, fire would be the peril, and the thatched roof, the hazard.

Hazard can be further broken down as follows:

- **Physical hazard**: this relates to the physical nature of the risk and includes any measurable dimension of the risk. Examples include:
  - motor insurance – age of driver, condition of vehicle etc.;
  - security protection at a shop – better security systems equals lower physical hazard;
  - personal accident and sickness – proposer's occupation (for insurance, a scaffolder would present a higher risk than a clerical worker); and
  - property construction – the higher the construction standard, the lower the physical hazard as the building will be more resistant to damage.
- **Moral hazard**: this arises from the attitude and conduct of people. It is usually the conduct of the insured. However, the conduct of the insured's employees and society as a whole, are also examples of moral hazard such as:
  - **carelessness** – a driver's lack of care can increase the chance of an accident happening, and its severity;
  - **dishonesty** – a person who has previously made fraudulent or exaggerated claims represents a greater moral hazard than one who hasn't; and
  - **social attitudes** which do not regard cheating insurers as immoral or illegal.

It is sometimes difficult to distinguish between physical and moral hazards, as one is often symptomatic of the other. Take, for example, poor factory management. This would be a moral hazard (attitude/behaviour), but may manifest itself as a poor physical hazard, e.g. unguarded machinery or not having a smoking policy.

Question 1.3

Which type of hazard causes insurers the greatest difficulty when quoting for a new risk: moral or physical? Why?

F Obtaining material information

The proposal form is the most common way for the underwriter to obtain information regarding the risk. There are, however, alternative ways of obtaining material information available to underwriters, their use depending on the class of business involved.

F1 Brokers

Brokers are used extensively in arranging commercial insurances, where their role may extend to preparing documentation for use by the underwriter in the assessment of a risk. This documentation can be extensive and may include a variety of information such as **risk registers** which would include individual exposures and claims experience, site inspection reports and preparation of health and safety reports.

Be aware
A risk register is a fact-finding tool that a broker would use when talking to clients.

Brokers also have their own **risk surveyors** and they will create reports, which could form part of the market submission or could be used by the brokers internally to gain a better understanding of the risk.

F2 Risk surveys

Risk surveys are often used to obtain information where the risk is large and/or complex such as in many commercial insurance risks.

It is the risk surveyor's role to act as the 'eyes and ears' of the underwriter and prepare a report for the underwriter covering a number of features including:

- a full description of the risk;
- an assessment of the level of risk; and
- a measure of the estimated maximum loss (EML), which is the maximum the surveyor believes will be the subject of a loss.

If appropriate, the report will also include a list of risk improvements the surveyor considers necessary.

F3 Supplementary questionnaires

These are used by some insurers when dealing with particular aspects of risk.

There are many areas where questionnaires can be used and examples include:

- money risks involving very high-value transactions;
- fire risks in respect of old or obsolete buildings;
- public liability risks involving for example, hairdressing, where the extent of the use of dyes and tints may require further investigation.

F4 Meeting with clients

This method is used most often in the case of commercial insurances.

F5 Call centres

Call centres are often used by insurers specialising in personal lines. These centres are considered to be very cost effective with computer systems that process documentation very quickly. To cut costs further many insurers have moved these operations offshore.

F6 Internet

Insurers are increasingly using underwriting platforms where proposers can provide material information online. These are sometimes referred to as 'quote and buy' platforms, where a quote can be completed entirely online. However, some systems will trigger a referral to underwriters.

Question 1.4
What type of business do you think is suited to call centre and internet-based solutions?

Key points

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

Good faith

- The common law principle of utmost good faith still exists at the core of insurance contracts, the definition has been modified by recent legislation and is now referred to as 'good faith'.

What are material information and material circumstances?

- Material information is something that has a bearing on the risk insured.
- A material circumstance is one that would influence an insurer's decision to take a risk and on what terms.
- From April 2013, and in the context of consumers, material information and circumstances are only those for which questions are asked by the insurer.

Duty of disclosure and fair presentation

- The core change under the Consumer Insurance (Disclosure and Representations) Act 2012 is to abolish the duty on consumers to volunteer material information.
- Fair presentation is a duty which exists for both parties to an insurance contract. It sets out that one party must inform the other of everything that is relevant to the insurance contract.
- The extent of the duty of fair presentation differs for consumers and non-consumers.
- Under common law, the duty of disclosure starts when negotiations begin and ends when the contract is formed (at its inception).

Consequences of non-disclosure and misrepresentation

- A breach of the duty of disclosure may arise in two circumstances: non-disclosure, where the proposer neglects to tell the insurer something, and misrepresentation, where a statement made to the insurer is substantially false.

Physical and moral hazard

- A peril can be defined as that which gives rise to a loss.
- A hazard can be defined as that which influences the operation of the peril.
- A physical hazard relates to the physical nature of the risk and includes any measurable dimension of the risk.
- A moral hazard arises from the attitude and conduct of people.

Obtaining material information

- Insurers use various methods to obtain material information, for example, proposal forms (the most common method) and risk surveys.

Question answers

1.1 d. In certain circumstances, all of the above.
The Consumer Insurance (Disclosure and Representations) Act 2012 is relevant for consumer contracts, the Insurance Act 2015 is relevant for commercial contracts, and the Marine Insurance Act 1906 can be relevant if both parties choose to contract out of the new legislation.

1.2 This would depend on whether the non-disclosure was fraudulent or not. If the non-disclosure was fraudulent (for instance, if Joe was attempting to get a cheaper premium), the policy would be voidable, and the insurer could sue for damages as well. If the insurer would not have accepted the 'taxi' risk in the first place, knowing the true nature of the risk, it is very likely that the insurer would reject the claim, and they would be entitled to do so.

However, the insurer can, at their discretion, pay the claim in full.

1.3 Moral hazard would generally be considered the more difficult aspect of quoting for a risk. Physical hazard is easily manifested, would be picked up quite easily by a standard survey, and there will be rating guidelines for the more common physical attributes of a risk.

Moral hazard, on the other hand, is not usually very evident, and relies on the character of the insured. To complicate matters, moral hazard often appears as a physical hazard (for instance, poor housekeeping could result in fire hazards being left lying around), and this could be concealed during a survey. There is no basis for rating such moral hazards and any premium adjustment would be random at best.

1.4 Call centres and the internet are only really suitable for risks where a rules-based solution can be provided. Examples include personal lines policies and very small commercial policies such as shops and offices.

Self-test questions

1. What are the three essential elements of a contract?
2. What information needs to be provided to insurers?
3. From an insurer's point of view, what is meant by material information and material circumstances?
4. Give four examples of types of facts that do not need to be disclosed.
5. What are the three key elements of a non-consumer proposer's duty to make a fair presentation of the risk?
6. What is misrepresentation?
7. Under common law, when does the duty of disclosure start and end?
8. Under what two broad circumstances may a breach of the duty of disclosure arise?
9. Explain the relationship between a peril and a hazard.
10. What are the most common methods by which an underwriter can obtain material information in respect of a risk?

You will find the answers at the back of the book

2 Underwriting procedures

Contents	Syllabus learning outcomes
Introduction	
A Quotations	*2.2*
B Proposal forms and declarations	*2.1*, *2.3*
C Premium calculation	*2.4*
D Policies, cover notes and certificates of insurance	*2.5*
E Contract certainty	*2.5*
F Premium payment	*2.6*, *2.7*, *2.8*
Key points	
Question answers	
Self-test questions	

Learning objectives

After studying this chapter, you should be able to:

- describe the procedures relating to, and significance of, quotations, proposals, policies, cover notes and certificates of insurance;
- apply the principles concerning the different ways in which premiums are calculated;
- describe the methods used to calculate premiums; and
- explain the features of insurance premium tax.

Introduction

We have now learnt how the duty of disclosure varies between consumers and non-consumers (i.e. businesses); fundamentally, however, the proposer is still required to provide all material information that an underwriter asks for and, in some instances, must make a fair presentation of their risk to underwriters. In all cases proposers must ensure that the information they supply is full and accurate. The underwriter, when in possession of all of the relevant information, will then assess the risk in terms of the information they have, decide whether to accept or reject the risk and, if they are to accept it, on what terms.

Simply put, then, underwriting can be viewed as the link between the proposal form and the policy that comes into existence. Not every proposal that is submitted to an insurer will be accepted. Some risks are particularly unattractive to insurers due to the likelihood of claims. Other proposed risks are simply immoral, e.g. a jewel thief insuring stolen goods. It is at the underwriting stage that decisions will be made.

In this chapter, we will be looking closely at the general procedures involved in this process.

Key terms

This chapter features explanations of the following ideas:

Certificates of insurance	Contract certainty	Cover notes	Insurance premium tax
New business declarations	Policies	Premium calculation	Premium payment
Proposal forms	Quotations	Statements of fact	Subjectivity

A Quotations

If you wanted to put new double-glazing into your home, you would most probably approach a number of companies in the window business before having it done. Each company would give you a ‘price’ for the work, as well as the benefits of their particular product. They would also identify any terms and conditions which applied to their quotation (for example, who is responsible for clearing the rubbish and redecorating after the windows have been fitted).

With personal lines insurance, an insurer must draw specific attention to any significant limitations and exclusions that apply to its contracts. This goes so far as drawing attention to terms which might vary from other competitors. Any individual or company wanting to take out insurance, would want to know the premium and the terms and conditions of the potential cover without actually being committed to the contract and accepting the terms and conditions. In insurance, terms and conditions are sometimes referred to as **subjectivities**. An example could relate to property insurance where cover may be provided 'subject to' a survey being carried out on the risk in question.

When this information is provided by an insurer, it is referred to as a **quotation**. Within the quotation pack there will be a number of documents including a covering letter, a document outlining the risk to be insured and a **statement of fact**. If requested the insurer will also be able to provide a copy of the policy wording.This enables the insured to make the best possible informed decision and ensures that the insurer has complied with contract certainty (discussed in *Contract certainty* on page 2/11).

This is a key duty of insurers and existing best practice requires insurers to ensure that their terms are clear, and the information on which the quotation is based is clear to the customer. For consumers, documentation goes as far as confirming all questions asked and answers provided. This existing best practice is touched upon in the **Consumer Rights Act 2015**.

A potential insured looking to purchase motor insurance, for example, may then approach a number of insurers who provide motor insurance and obtain a number of quotations, and look for the best terms and conditions available. The services of an insurance intermediary may be used to advise what is available.

Remember, an insurer who then supplies a quotation to a consumer does so according to the circumstances and material information, as requested by the insurer and as supplied by

the proposer. All the necessary information must be obtained in order to put forward a quotation to the proposer.

Question 2.1

Mrs Brown requires a household policy and phones General Insurance Co. for a quotation. The underwriter asks Mrs Brown a number of questions. This will enable the underwriter to decide whether to insure Mrs Brown, and if so, at what price and on what terms.

What questions do you think General Insurance Co. will ask Mrs Brown in order to provide a household policy quotation? Think of five.

A1 Quotation procedure

The procedures relating to quotations can be summarised as follows, although this list should not be viewed as exhaustive:

- The quotation will state for how long it is valid, usually a set number of days, e.g. 30 days.
- When the quotation is issued, **cover is not effective**, i.e. the insurer is not on risk and the proposer is not covered by the insurance. You will recall from the previous chapter, for a contract to come into existence there must be a valid *offer* and *acceptance*. The quotation can be viewed as the offer and a proposer would need to **accept** before the contract comes into existence.
- Unless the insurer has withdrawn the quotation, if the proposer accepts the quotation within the specified timescale, the insurer is legally bound to honour the quotation (on the terms quoted).
- However, if the circumstances upon which the quotation was based change, the insurer is **not** bound to maintain the quotation. Effectively, as the risk characteristics have altered, the quotation was for a different risk. An example would be if Sue in the activity above had an accident in the time in between quotation and acceptance, or changed to a more expensive or powerful car.
- During the number of days stipulated, the proposer has the option to accept or decline the quotation.
- When the period has expired and the proposer has not accepted the quotation, the quotation is no longer valid and the insurer is not bound to honour it. The insurer may, however, elect to do so after the expiry of the quotation.
- If no time is stipulated for the quotation to remain valid, the offer remains open for a **reasonable time**, as per the general rules for the interpretation of contracts. The insurer can withdraw the quotation at any time prior to acceptance by the proposer.

B Proposal forms and declarations

Consumers

Traditionally the **proposal form** has been the most common mechanism by which the underwriter receives information regarding the risk to be insured. It is completed by the proposer and submitted to the underwriter; it can be requested directly from the insurer or it may be provided by an intermediary. Proposal forms in their original format still exist for a number of classes of business but in some areas have been superseded by the use of the internet and call centres.

A proposal form may not be necessary at the point where an insurer provides a quotation. However, if a quotation is provided without a proposal form, it will normally be subject to the proposer completing one.

With most consumer insurances, insurers are expected to relay the answers to their questions provided by the proposer, both as part of the quotation provided, and post-sale after going on cover. They are also expected to repeat this information to the insured when mid-term adjustments are processed and renewals negotiated.

For consumers, proposal forms also contain a **declaration**. The declaration states that the information supplied by the proposer is true and correct to the best of the proposer's knowledge and belief, and must be signed by the proposer.

Telephone-based quotations and use of the internet
The internet has revolutionised the way insurers sell certain products, especially private motor and household insurance, with information obtained either by a 'direct' insurer or an intermediary entirely on the telephone. The material information is established by asking the questions that would feature on conventional proposal forms during a telephone conversation. If the risk meets the insurer's acceptance criteria, a quotation is provided. With telephone-based quotations, the questions asked must follow a set script. The answers are then captured by the insurer and repeated back to the proposer, as discussed above.

Insurance is also bought more and more via the internet, with the proposer answering questions posed on screen. It is important to remember here that both the **Consumer Insurance (Disclosure and Representations) Act 2012** and Consumer Rights Act 2015 deal with assumptive statements and tick boxes, particularly concerning e-trade and internet routes to market. This is important as both set out, if not expressly, the clear spirit of such contracts and the requirement to avoid assumptive answers. For example, most insurers have a general acceptance statement that deals with basic eligibility for an insurance quotation and cover; it talks about matters such as previous insolvency, convictions etc. Changes in the law mean that insurers cannot assume positive answers to these questions (e.g. no previous insolvency), but rather must clearly draw a consumer's attention to them, explain the consequences of providing false information, and capture the response the consumer provides.

Internet-based insurance products increasingly work to electronic systems and rule sets that do not require validation by underwriters for individual cases, unless the answer(s) provided in response to the insurer's question set raises a flag. In some instances, where the answer provided is not acceptable, the system will decline to quote entirely, rather than refer it for manual review by an underwriter. These internet-based products are usually part of home and motor insurance which can be transacted online or over the phone. They make obtaining insurance much quicker and, arguably in some cases, reduce insurer costs due to less reliance on underwriters and more on rule sets and questions, which are designed by central teams for use with the vast majority of policies they sell.

The speed of change in this area is fast and it is worth considering what the next revolution in the insurance industry might be. Established insurers need to lead with innovation, ever aware of the threat presented by the commoditising of personal lines insurance (direct, aggregators, affinity routes to market (e.g. Tesco, M&S)), but also of the next 'Facebook' that revolutionises the way we transact insurance. For example, Lemonade is an online insurer for home insurance in the USA, promising a quotation within 90 seconds and payment of claims within three minutes.

Commercial package risks
Some commercial insurances are suitable for the types of transaction seen in the personal lines market. These tend to be either for compulsory insurances or part of fixed packages where the cover is up to a limit, as one size fits all, rather than bespoke to the proposer's risk. They can be obtained via insurance intermediaries or from the insurer directly. They usually deal with packages for risks such as flats/small property owners/buy-to-let investors, shops, salons, offices, small contractors and commercial vehicles.

Some insurers have their products hosted by software houses allowing brokers to obtain multiple quotations for one risk by inputting the proposer and risk information once (rather than once on each insurer's website). However, functionality and availability vary across various software houses. Some only provide quotations, others are 'full cycle' and allow for mid-term adjustments and renewal transactions to be processed in full, including the issuing of a 'point of sale' electronic document.

A difference between the personal lines and commercial markets is the prevalence of personal lines insurance products available via aggregators. Aggregators exist in both spaces but not to the same extent.

Activity
Can you think of some well-known aggregators?

Larger commercial risks
Although proposal forms are used for most personal insurances (e.g. motor and household), they are often insufficient for many large and complex risks (e.g. industrial complexes, satellites) because of the information required. This is also true of small- and medium-sized commercial risks (e.g. shops and offices), which can also have more complex cover requirements:

- For small- and medium-sized commercial risks, presentations (often prepared for the proposer by their insurance intermediary) will be revised alongside online question sets and factfinders/questionnaires provided by the insurer.
- For large and complex commercial risks, presentations (prepared for the proposer by their insurance intermediary) are supplemented with insurer surveys, factfinders/questionnaires, and even face-to-face meetings with the proposer, insurance intermediary, and insurer.

Insurers may rely on a *subjectivity* (a condition of a quotation that must be met) as part of their quotation to proposers, but it is important that they are not used as ways of obtaining information the insurer should be asking for upfront. This goes back to the **Insurance Act 2015** and the overarching aim that both the proposer and insurer are clear about the information the insurance contract is based on, and the consequences if things go wrong, **before** entering into the contract.

Example 2.1

Following the Grenfell Tower tragedy in June 2017, there is a serious need for clarity between brokers and insurers to enable them to help guide customers more generally about the types of external panels and cladding available. For example, while an insurer could add a subjectivity to a quotation clarifying their understanding that a building has elements of composite insulation panels containing LPCB (loss prevention certification board-approved cores, e.g. Kingspan) after the proposer had confirmed this to them during the quotation process; they could not add a subjectivity to their quotation stating that it was based on there being **no** combustible composite insulation panels. This is because the subjectivity is ambiguous (in this context, everything is combustible if it gets hot enough), and because the insurer should be taking reasonable steps during quotation to ensure that this is not the case.

For businesses, proposal forms also include the aforementioned declaration and contain a **warning** (or **important note**). The warning concerns the material information and material circumstances which should be disclosed and points out the dangers if they are not disclosed. It also states that if the proposer is in any doubt whether information is material or not, it should be disclosed.

B1 Questions in the proposal form

These usually consist of **general** and **specific** questions.

B1A General questions

These are common to most general insurances and are usually as follows:

- proposer's name;
- proposer's correspondence address;
- proposer's occupation;
- period of insurance; and
- past insurance history: has the proposer been insured before? Have they had insurance declined? Loss record and claims experience?

B1B Specific questions

These questions are risk specific, i.e. they relate to the particular details of the risk to be insured, and help the underwriter to determine whether or not to accept the risk and on what terms:

- proposer's risk address, e.g. their locality and related risks such as flood, subsidence, or even theft, malicious damage, riot etc.;
- proposer's age, e.g. higher motor premiums for younger drivers;
- description of the subject matter to be insured, e.g. description of buildings in commercial property insurance;
- business details; and
- sum insured or limit of liability.

Be aware
Specific questions vary between insurers, risks and classes of business.

You should remember that general questions may also be specific questions for certain insurance products; for example, a proposer's occupation is also a specific question in most commercial insurances and will influence the premium they are charged.

Activity
Insurers are increasingly making use of the internet when it comes to attracting new customers and providing quotations. Visit the following websites and make a note of the questions asked by each insurer for motor and household insurance on their proposal forms. Is there much difference between the insurers? What about via aggregators?

Aviva: *www.aviva.co.uk/*.

Churchill: *www.churchill.com*.

Zurich: *www.zurich.co.uk*.

Compare the Market: *www.comparethemarket.com*.

Confused.com: *www.confused.com*.

MoneySuperMarket: *www.moneysupermarket.com*.

Question 2.2

To make sure that you are clear on what we have covered so far in this chapter, can you summarise the purpose of a proposal form?

C Premium calculation

A premium is the **amount paid to an insurer by the insured/proposer in consideration of the insurer agreeing to cover the risk**.

One of the tasks of the underwriter is to calculate a suitable, or fair (equitable) premium. A suitable premium is one that reflects the risk presented by the proposer. It is a fundamental principle of insurance that the premiums collected for similar risks proposed form a common pool.

The contribution of the insured (the premium) should reflect the amount of risk they present and the likelihood of taking money out of the pool in the event of a claim.

Example 2.2
If Sue in our previous example owns a small family car, rather than a fast sports car she is statistically less likely to incur accidental damage to the vehicle. Sue therefore brings a lower risk to the pool and should therefore pay less premium than a sports car owner.

Pricing is easier for insurers when they are dealing with a large number of similar exposures to risk, whether it is houses, cars, factories or ships. The **law of large numbers** enables an

insurer to determine a more accurate premium chargeable to the insured than would be the case if its experience were limited to a few risks. However, some insurers or markets (e.g. Lloyd's), cater for one-off demands for insurance where it can be extremely difficult to estimate a premium (e.g. a pianist's fingers or a footballer's legs).

Question 2.3

When it comes to the pooling of risks, the law of large numbers assists insurers make reliable:

a. Claims payment predictions. ☐

b. Investment return predictions. ☐

c. New business predictions. ☐

d. Premium income predictions. ☐

Premiums are usually arrived at by applying a **premium rate** to a **premium base**, with the rate reflecting the hazard associated with the insured, and the base being the measure of the exposure. In property-based insurance, this will normally be the value to the insured (replacement cost) or the limit of any payment. This could be reflected in the following formula:

sum insured × rate = premium

A scale of loadings and discounts may be applied to the above rate to reflect various inherent risk features. The rate is a figure set by the insurer based on the likelihood that a claim may have to be paid on the policy. A greater risk will be reflected in a higher rate, and vice versa. For example, a firework factory would be charged a higher rate for fire insurance than an office block. It contains more hazardous materials and presents a higher risk to the common pool. The rate could be a **rate per cent** or a **rate per mille**:

- Rate per cent is the price in pounds for each hundred pounds of exposure (e.g. a rate of 1.5 per cent means an insurer would charge £1.50 for every £100 of exposure).
- Rate per mille is the price in pounds for each thousand pounds of exposure (e.g. a rate of 2.5 per mille means an insurer would charge £2.50 for every £1,000 of exposure).

Question 2.4

If a house is valued at £120,000 and the insurer sets a rate of 0.6 per cent, what would the premium be?

a. £36. ☐

b. £72. ☐

c. £600. ☐

d. £720. ☐

In some classes of insurance there is no property to insure and an alternative exposure measure needs to be identified against which a rate can be applied. For example, in respect of employers' liability, the **wage roll** of the insured would be used; public and products liability policies often use **turnover**; professional indemnity insurance uses **fees earned**.

Be aware

While specific definitions vary, as a guide the exposure measures can be described as follows.

Wage roll: payments made to staff throughout the year.

Turnover: the amount taken by a business in a particular period.

Fees earned: represents the amount of revenue generated by a company for services within a particular time period, usually an accounting period.

Question 2.5

AB Tent Supplies has a turnover of £20m per year. General Insurance Co. offers products for liability insurance with an indemnity limit of up to £2m at a rate of 0.5 **per mille** on turnover. What would AB Tent Supplies premium be for £2m indemnity?

It can be seen in question 2.4 that although the increase in the limit of indemnity has increased by 150%, the premium only increased by 40%, because the premium is geared towards the measure of exposure (in this case turnover) and to a lesser degree towards the limit of indemnity. Remember; the **premium base/exposure** is the turnover, **not** the limit of indemnity.

C1 Adjustable premiums

In certain cases, the exposure measure is unknown at the start of the period of insurance, and all that can be provided is an estimate of what the exposure measure might be.

For example, with employer's liability insurance the insured can only estimate the total wage bill for the coming year. The rate is then applied to that figure, and at the end of the year, the insured submits a declaration showing the actual wages paid. The premium is then adjusted up or down depending on whether the actual wage bill was higher or lower than the estimate. The initial premium is referred to as a **deposit premium**.

It is important to note here that the provisions of the Consumer Rights Act 2015 (specifically, the prohibition of setting a price after a contract starts) do not apply, provided the insurer and insured are clear that premiums will be adjusted based on changes in exposure.

C2 Flat premium

In other cases, it is practice to charge a flat premium rather than apply a rate to a premium base; for example, motor insurance, where a premium is arrived at by consulting rating tables which take into account the hazard associated with, among other things, the individual insured and the insured's vehicle.

The factors that influence the premium are revealed in the proposal form. These factors are often held in a computer programme and a premium can be obtained by entering the appropriate factors. Hence the premium is automatically calculated on input of answers to a series of pre-programmed questions. Many intermediaries have a computerised system which provides quotes from various insurers according to the rating factors. The advantage of this method is the ease of update for insurers, the ability to provide a range of accurate quotations quickly and easily, and overall it reduces the possibility of manual calculation errors.

Other risks which may be flat rated include one off events. For example, an insured may attend an exhibition and request public liability insurance. For such exposures an insurer may charge a flat premium.

Example 2.3
Going back to our example of Sue wanting to insure her new car:

Mike has assessed the risk to the 'common pool' of insuring Sue and her car. He has decided he is willing to quote and provides Sue with a quotation of £500. The quotation is subject to the following terms:

- that only Sue will be allowed to drive; and
- she would be responsible for the first £250 of every claim.

Sue is now in a position to decide whether she wants to accept the quotation.

D Policies, cover notes and certificates of insurance

D1 Policies

The insured and the insurer need to be absolutely clear as to the terms and conditions agreed between them, and for this reason, a **policy** is issued. The policy contains all the details of the item/exposure insured, the operative perils, period of cover, exceptions, conditions, the premium and other relevant information. The policy is effectively **evidence of the contract**, and **not** the contract of insurance itself.

Think Back
The structure, form and content of an insurance policy is dealt with in *Structure, form and content* on page 3/2

The contract of insurance comes into effect once the insurer has accepted the insurance proposal, terms have been agreed and the premium has been paid or has been **agreed to be paid**. Therefore, the contract exists irrespective of the existence of an actual policy document. The policy is useful as proof in the event of a dispute over the terms agreed, but the absence of the policy document does not invalidate the contract.

D2 Cover notes

In practice, the production of the actual policy document may take some time, notwithstanding which, it may not be appropriate to issue a policy straight away for a number of other reasons. The following are examples of situations that may arise:

- An insurer has sufficient detail to accept a property risk but wishes a surveyor to visit the premises and provide a survey report of the risk and establish any necessary risk improvements that may be needed.
- An insurer may be awaiting the completion of a proposal form and is granting temporary cover until the form arrives.
- A new driver may need to be added to a motor policy. The insurer may want a declaration form completed regarding age, experience and insurance record. In the interim, a **cover note** is issued.

There may also be mid-term changes to policies where the insurer requires some extra information and defers the issue of policy amendment documents and/or endorsements until further information is forthcoming. In each case, there may be a need to provide interim evidence that cover is in force, and a cover note is prepared by the insurer and is issued to the insured. This is particularly so in the case of some changes to motor insurance policies (and some other compulsory insurances) where evidence of insurance is a legal requirement.

A cover note is essentially a document issued as evidence that insurance has been granted, pending the issue of a policy or policy amendment document and/or endorsements. It can be a completed printed form or letter confirming cover, or it can be produced electronically. It simply states that insurance is in force and provides brief details of the cover given. The cover note is **temporary** and is superseded once the policy and insurance certificate are issued.

The cover note will have the following features:

- commencement date (and time for motor insurance);
- a statement that the policy follows the normal terms and conditions of the insurer for that class of insurance;
- risk-specific information that identifies the property or liability that is covered;
- any special terms that apply; and
- expiry date of the cover.

Cover notes are particularly important for motor insurance, where there is a legal requirement to have a minimum level of insurance cover, and the cover note acts as evidence of that cover being in force. The **Road Traffic Act 1988** specifies what must be contained in a certificate of motor insurance, and as the cover note incorporates a temporary certificate as well, it must also contain all the information specified (see below). For motor risks, the time and date must never be backdated on a cover note as, under the Road Traffic Act 1988, this is illegal. Cover notes are still important, even with technological advancements and the Motor Insurance Database (MID), as there can be delays in uploading information about what an insurer is covering. For example, while insurers upload details onto the MID for their policyholders, this is usually done once a day overnight, resulting in a delay of up to 24 hours between purchase of cover and a policyholder's details appearing on the MID. Given the penalties for driving without insurance, the existence of cover notes is key even with the use of technology.

D3 Certificates of insurance

For compulsory insurances, it is a legal requirement that a **certificate of insurance** is issued to prove a policy is in force. It is evidence that a contract of insurance exists, and that the policyholder/insured complies with the law. It is issued by the insurer in the name of the insured.

The information to be shown on the certificate is laid down by the relevant statute which makes the certificate compulsory.

D3A Motor insurance

The Road Traffic Act 1988 directs that the following information must be contained in the certificate:

- registration mark of vehicle;
- name of policyholder;
- date of commencement of cover;
- expiry date;
- person or classes of persons entitled to drive;
- limitations as to use; and
- confirmation that cover complies with UK statutory requirements.

It does not show the scope of the policy cover (e.g. comprehensive, third party only etc.) and is usually sent electronically.

D3B Employers' liability insurance

It is compulsory for those who employ people to have insurance against costs they may be liable to pay in the event of the employee being injured during the course of their work.

In the case of employers' liability insurance, the certificate needs to carry the following information:

- Name of policyholder.
- Date of commencement of cover.
- Expiry date.
- Name of insurer.
- Authorised signature on behalf of insurer, i.e. usually a facsimile signature of chief executive.

- Level of cover, as the certificate must show that insurance cover is provided for at least the minimum level required by law. This is currently £5 million including costs, although in practice most insurers provide higher limits, usually double the minimum limit.
- A statement by the insurer declaring that the policy satisfies the relevant legal requirements.

Employers are no longer required to display the certificate at all their places of business. They used to be required to do so but an electronic certificate is now sufficient, provided it remains readily accessible to all employees.

E Contract certainty

The Association of British Insurers (ABI) in its summary guide states that 'Contract Certainty is achieved by the complete and final agreement of all terms between the insured and insurer by the time that they enter into the contract, with contract documentation provided promptly thereafter.'

The insurance industry is often called upon at very short notice to provide protection for business customers wishing to transfer risk. Insurers and insurance brokers have a history of rising to the challenge by providing protection quickly, often with limited information. In most situations this works very well and the insurance industry provides customers with clear protection and peace of mind.

However, there may be uncertainty, either on the part of the customer as to exactly what level of protection has been provided or on the part of the insurer, not knowing exactly what it is insuring.

Uncertainty may lead to disputes over what was agreed when the protection started. This may be very important if a customer needs to make a claim against the insurance contract and the terms of the contract are uncertain.

To help avoid disputes from uncertainty, the insurance industry has produced a code of good practice to help provide *contract certainty* before inception of the policy. The code is not compulsory, however most of the insurance industry has agreed to abide by the code. The code also has service standards for issuing insurance documents in a reasonable time.

The code does not stop the insurance industry reacting quickly to customers' urgent needs for protection. The code sees to it that there is a form of contract agreed when protection starts. There may be a need to agree changes to the exact terms of the contract when both parties have full knowledge. However, 'terms to be agreed' or similar references should not be used. While the Consumer Rights Act 2015 applies to consumers, its provisions are viewed largely as best practice by the FCA and as such insurers will be expected to continue to review their processes against requirements under the Act and subsequent legislation, as part of the FCA's thematic approach to regulation.

F Premium payment

As previously mentioned, the insurance contract comes into force once the insurer accepts the proposal and the premium has been paid. However, if the premium is not paid at the acceptance of the proposal, it is **implied** that the proposer promises to pay, and this promise is sufficient at law to support a valid contract (in line with the principle of 'consideration'). Here, we will consider the methods of collecting insurance premiums and the features of insurance premium tax.

F1 Methods of collecting premiums

The payment for an insurance policy is referred to as the premium. This is calculated and due at the start of the policy period. Most general insurance policies are renewable annually, i.e. twelve months after the cover started.

Payment will usually be:

- a single upfront payment (by cash, cheque or credit card);
- by credit; or
- in monthly instalments by direct debit.

F1A Credit

As stated in *Methods of collecting premiums* on page 2/11, the insurance premium will be due to be paid at the start of the policy period. If dealing direct with an insurer then an insured will need to ensure that they have either paid the amount in full or arranged payment via the insurer's instalment facility by the due date. If an insured has arranged their insurance via an intermediary however, then the intermediary may offer some alternative credit facilities as a customer service. The intermediary may accept payment by credit card, arrange finance with a finance house or arrange credit 'in-house'. A fee is usually charged because of the margin charged by credit companies for each transaction. The intermediary is likely to have a credit account facility with the insurer and will, having collected the monies from the insured, arrange for the premium (less commission the intermediary is due) to be paid to the insurer on their account.

Be aware
The process of providing credit is regulated by the FCA. The relevant specialist sourcebook is called the Consumer Credit Sourcebook (CONC) and sets out detailed obligations that must be complied with when carrying out credit-related activities. For further information, see: *www.handbook.fca.org.uk/handbook/CONC/*.

F1B Instalments

Most insurers will offer instalment payment. Insurers will usually charge a fee to reflect the loss of interest from the premium not being paid in full at the start of the policy, and the additional administrative charges incurred in collecting on a monthly basis. It may sometimes appear that there is no additional charge, but this will be reflected in the premium rates. Instalments can be paid by direct debit, whereby monthly amounts are collected automatically from the insured's bank account.

F2 Non-payment of premium

Most insurers will insist on payment of the first premium at the time the policy is taken out or by instalments. Cover is usually for twelve months from the start of the policy (except for some shorter period covers such as travel insurance for a single trip).

After twelve months the policy is said to be due for renewal, the renewal date being the anniversary of the day on which cover started.

Be aware
The majority of policies will expire at 00.01 or 23.59 to avoid any ambiguity over whether 12.00 means midday or midnight. They should also specify the applicable time zone, e.g. GMT for Greenwich Mean Time.

The premium for the renewal of the policy, the renewal premium, is advised by the insurer to the insured by way of a **renewal notice**.

Think Back
See chapter 4 for more on renewals and cancellation

In the event of non-payment of the premium the policy is not renewed and cover is lapsed.

F3 Insurance premium tax (IPT)

Insurance premium tax is levied on most general insurances where the risk is located in England, Wales, Scotland and Northern Ireland. The Channel Islands and Isle of Man, as well as the Republic of Ireland, are not subject to insurance premium tax but may have local levies which are payable.

The tax is payable by policyholders, but insurers are responsible for collecting the tax and accounting for it to HM Revenue and Customs. Two broad methods are provided in the relevant legislation for calculation of IPT, but most insurers calculate the tax as a percentage of the written premium.

The current rate of IPT is 12%. This is referred to as the standard rate.

A higher rate of 20% is applicable to travel insurance and engineering inspection service fees charged by some insurers, as well as some insurances sold alongside the purchase of vehicles and electrical appliances.

Reinsurance contracts, life assurance and certain marine policies are not subject to either the standard rate or higher rate of IPT.

Premiums for risks located outside the UK are also exempt, but they may be liable to similar taxes imposed by other countries.

Question 2.6

What would the amount of IPT be on a buildings policy that incepted on 1 January 2020, with a sum insured of £100,000 at a rate of 0.4%?

Key points

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

Quotations

- An insurer who supplies a quotation to a consumer does so according to the circumstances and material information, as requested by the insurer and as supplied by the proposer.

Proposal forms

- Traditionally the proposal form has been the most common mechanism by which the underwriter receives information regarding the risk to be insured.
- Although proposal forms are used for most personal insurances and the majority of small and medium-sized commercial risks, they are often insufficient for many large and complex risks.
- For consumers, proposal forms also contain a declaration.

Premium calculation

- A premium is the amount paid to an insurer in consideration of the insurer agreeing to cover the risk.
- Premiums are usually arrived at by applying a premium rate to a premium base, with the rate reflecting the hazard associated with the insured, and the base being the measure of the exposure.

Policies, cover notes and certificates of insurance

- The policy is effectively evidence of the contract – **not** the contract of insurance itself.
- For compulsory insurances, it is a legal requirement that a certificate is issued to prove a policy is in force.

Contract certainty

- The ABI states that 'Contract Certainty is achieved by the complete and final agreement of all terms between the insured and insurer by the time that they enter into the contract, with contract documentation provided promptly thereafter.'

Premium payment

- If the premium is not paid at the acceptance of the proposal, it is implied that the proposer promises to pay, and this promise is sufficient at law to support a valid contract.
- The rate of IPT is 12% for policies from 1 June 2017. Exceptions include travel insurance and engineering inspection service fees charged by insurers, where the rate charged is the same as that of VAT, currently 20%.

Question answers

2.1 Questions that General Insurance Co. would ask include:

- proposer's name and address;
- construction of the property;
- location of the property;
- area;
- occupation during the day;
- security.

2.2 A proposal form is used to gather as much information as possible to enable the underwriter to accurately assess the risk and decide on what further action to take.

2.3 a. Claims payment predictions.
This is because the insurer is providing cover against a large number of similar events.

2.4 d. £720.
£120,000 × 0.6% = £720.

2.5 It would be £10,000.

2.6 £48.00, i.e. £100,000 × 0.4% = £400; £400 × 12% IPT = £48.00.

Self-test questions

1. In terms of the offer and acceptance required to form a contract, how would you view an insurance quotation?
2. What is the purpose of the declaration found within a proposal form?
3. Distinguish between general and specific questions in a proposal form.
4. What is a premium?
5. Distinguish between a premium rate per cent and per mille.
6. What is a deposit premium?
7. What is a cover note?
8. What is insurance premium tax and at what rate is it charged?

You will find the answers at the back of the book

3
Insurance policies

Contents	Syllabus learning outcomes
Introduction	
A Structure, form and content	*3.1*
B Exclusions	*3.2*
C Conditions	*3.2*
D Warranties, conditions and representations	*3.3*, *3.5*
E Excesses, deductibles and franchises	*3.4*
Key points	
Question answers	
Self-test questions	

Learning objectives

After studying this chapter, you should be able to:

- describe the structure, function and content of an insurance policy;
- explain why there are certain common policy exceptions and conditions;
- differentiate between excesses, deductibles and franchises;
- explain how excesses, franchises and deductibles are applied; and
- differentiate between warranties, conditions and representations.

Introduction

In *Policies* on page 2/9, we learnt that the insurance policy is issued to formalise what the respective parties to the insurance contract have agreed. There are three things you should remember about the insurance policy:

- the policy will contain the details of the terms and conditions;
- generally speaking, the **parol evidence rule** applies, i.e. neither party can rely on any negotiations leading up to the contract, only on the contract itself; and
- the policy is only **evidence** of the contract and **not** the contract itself.

You can appreciate from these three points that it is a very important document.

In this chapter, we will examine the general layout and content of a typical insurance policy.

Key terms

This chapter features explanations of the following ideas:

Arbitration	Conditions	Contribution	Deductibles
Exceptions	Excesses	Franchises	Fraud
Operative clause	Policy schedule	Representations	Scheduled form
Subrogation	Terrorism	Warranties	

A Structure, form and content

A policy is generally issued in a **scheduled form**, i.e. the policy wording is pre-printed, often in a booklet, and a schedule is incorporated into the policy. The **policy schedule** contains all the variable information concerning the insured and details of the risks insured.

The schedule also usually signifies which sections of the policy are operative in relation to the pre-printed policy form.

Every insurer has its own form of policy for the various classes of business it offers, and these vary considerably in style and length. Style will usually be determined by company or corporate approaches to documentation. Some companies produce policies in A4 format; others bind them in plastic folders; others have smaller, booklet-type documents. The length of the document will be dictated more by the class of business.

Consider this…

Why do you think commercial combined policies are longer than personal accident policies?

A commercial combined policy, for example, provides cover for a number of sections such as property, business interruption, employers' liability and public liability, each of which will take up at least one page of the policy schedule whereas personal accident only relates to one coverage.

The ABI Statement of General Insurance Practice states that, in respect of policy documents, insurers must continue to develop more clearly worded proposal forms and policy documents. Most policies now strive to use clear, everyday language, and to define any words likely to be unfamiliar to the insured or capable of misrepresentation in any way.

The Consumer Insurance (Disclosure and Representations) Act 2012 further reinforces this need, as not only does it require that all questions are exact and clear enough for consumers to understand, but insurers are also expected to consider the clarity and accessibility of any explanatory material they produce. After all, it is important to consider such material when assessing whether proposers have taken reasonable care when providing information.

The **Insurance Act 2015** addresses the need to ensure that both the insured and insurer, as the two parties to the contract of insurance, are clear about policy terms and requirements, including remedies when things go wrong, **before** entering into the contract.

The **Consumer Rights Act 2015**, which came into force on 1 October 2015, also seeks to make policies clearer for consumers, particularly regarding their rights and the remedies available to them if things go wrong.

Consider this…

The most recent legislation seeks to ensure that insurance contracts are as clear and unambiguous as possible. This is important, as insurance is not a tangible product, but rather a promise to put something right when things go wrong. This is why it is essential that everyone understands what the contract does and does not provide for, as well as each party's obligations.

The general rule of interpreting an ambiguous contract term against the party that drew it up gives the insurer a real incentive to be clear in their intentions. This is known as ***contra proferentem***. Its effect is that insurers must be very careful in drawing up policy wordings.

Be aware

The legal rule *contra proferentem* is applied by courts when a policy wording is ambiguous.

Currently, the core terms of insurance contracts, such as exclusions, cannot be challenged on the grounds of fairness. This default position will remain unchanged under the Consumer Rights Act 2015. However, the Act also says that if a term of a contract is not transparent or prominent, it can be assessed for unfairness. Insurers, therefore need to make sure that the significant terms of insurance contracts with consumers are expressed in plain and intelligible language and have been adequately brought to the insured's attention. If a contract term is deemed unfair it will not be binding, although consumers are still within their rights to rely on a term if they wish to do so.

Here we shall be looking at the main components of a policy and you may find it useful to obtain a range of policy documents to compare the different approaches used.

Generally speaking, the basic structure of all general insurance policies will be the same, and will incorporate the following:

- heading;
- preamble;
- signature clause;
- operative clause;
- exceptions;
- conditions;
- policy schedule;
- information and facilities.

A1 Heading

Every policy will have a heading which includes the name of the insurer and in some cases, the address and company logo.

A2 Preamble

The preamble (also known as the **recital clause**) sets the scene for what follows in the policy by referring to the two parties, the insured and the insurer (although not by name), forming the contract in terms of which the insurer undertakes to indemnify the policyholder ('insured') in accordance with the cover detailed in the policy, in return for a price (the 'premium').

Think Back

Refer back to *Proposal forms and declarations* on page 2/3, for a brief explanation of the declaration

The preamble also states that the proposal form is part of the basis of the contract and will be incorporated within the policy. This effectively makes the proposal form part of the contract, even though it is not actually reproduced and printed within the policy for all insurance contracts. This has important implications in respect of the **declaration** signed by the insured on the proposal form.

It is important to note here that the proposal form is part of the basis of the insurance contract, but does not operate in any way with 'basis of contract' clauses, which are no longer permitted in law (see *Representations* on page 3/12).

A3 Signature

Below the preamble, or close to it, there will frequently be the pre-printed signature of an official from the company. This dates back to the times when policies were prepared by hand. It is not strictly necessary today and many policy documents omit a signature.

A4 Operative clause

The *operative clause*, also known as the **insuring clause**, is the most important section of the policy, and is where the actual cover provided is outlined. There may be just one clause outlining the cover or, as is more common, a number of such clauses (as with household or motor policies), each dealing with a different aspect of the insurance and often containing exceptions that are specific to each individual operative clause.

Each operative clause within the policy begins with words such as, 'The company will…' (in respect of insurance companies) or 'We, Underwriting Members…' (in respect of Lloyd's), and then stating exactly what the insurer or underwriter is promising to do, i.e. setting out the cover under the policy.

Example 3.1
An example of an operative clause may be as follows:

'To indemnify the insured against any claim(s) first made against the insured during the period of insurance in respect of any legal liability arising (including liability for claimants' costs) incurred in connection with the insured's business.'

A5 Exclusions

Think Back
The common policy exceptions are dealt with in *Exclusions* on page 3/6

All insurance policies contain some general exclusions which apply to the entire contract. These are in addition to specific exclusions that apply to different sections under a scheduled policy.

Be aware
You may hear the terms 'exceptions' and 'exclusions' used interchangeably. For practical purposes they mean the same thing.

A6 Conditions

Think Back
We shall look at conditions in more detail in *Conditions* on page 3/8

A **condition** is essentially a contractual term that the insured agrees to comply with during the period of cover.

Conditions are either **express** or **implied**.

Express conditions are always stated in the policy.

Implied conditions are implied by common law and practice and do not need to appear in the policy. Examples of these are:

- An insured must act as if uninsured and not use the insurance as an alternative to acting carefully. The insured may be required to advise the appropriate authorities, depending on the circumstances, e.g. police in the event of damage suffered during a riot, or a serious motor accident.
- The insured must take reasonable action to minimise a loss, e.g. attempt to extinguish a fire (but not if it endangers the insured).
- The insured must not hinder the insurers in their investigation of a claim.

In practice, these are often stated in the policy for clarification.

Reinforce
In addition, many fundamental principles of insurance are implied conditions. One of which you may remember from your previous studies is insurable interest, i.e. that the insured has an interest in the subject matter of insurance.

A7 Policy schedule

This is where the policy is made personal and specific to the insured, and is not a pre-printed, 'applicable to all' part. The variable parts of the policy are stated here, such as:

- insured's name;
- insured's address;
- policy period;
- premium;
- details of the subject matter;
- sum insured or limit of liability;
- policy number;
- reference to special exclusions, conditions or aspects of cover; and
- operative sections of the policy.

A8 Information and facilities

This may include any, or all, of the following:

- **Definitions**: insurers may define a single word or phrase to embrace the wider wording wherever the term is used. The definition will only apply if the word begins with a capital letter or it may be formatted in bold or italics within the policy.
- **Customer service standards statement**: for example, the response times that a policyholder can expect from the insurer.
- **Complaints procedure**: this may refer to a company's internal procedure and nominated person for complaints handling as a first port of call; if matters are not resolved satisfactorily, reference can be made to the Association of British Insurers and/or the Financial Ombudsman Services. Note that in the event of a complaint, all channels of dispute should be exhausted within the insurer concerned before reference to the Ombudsman; however, the Ombudsman asks firms to try and resolve complaints within **eight weeks** of the first complaint. If this time has already expired when the client contacts the Ombudsman, the Ombudsman will take the case.
- *Claims information*: this is particularly prevalent with motor insurance, where there may be a 'What to do?' section in the event of a motor accident (this should not be confused with formal policy conditions applicable in respect of claims). There may also be a Freephone claims service.

Enterprise Act 2016
The Government set out its plans for the Enterprise Bill in the Queen's Speech in May 2015.

It is aimed at promoting economic growth and supporting small businesses.

Part of the Act introduces a legal obligation on insurers to pay claims within a reasonable period of time. It furthers this obligation by allowing policyholders legal recourse to force claims to be paid promptly. It also provides for some limited compensation to be paid by insurers, but only where there has been an unreasonable delay in payment that causes the policyholder additional financial loss(es).

B Exclusions

Most general insurance policies will contain two types of exclusion:

- **General exclusions** – these apply to all sections of the policy and allow the insurer to deny cover under the policy, regardless of the section concerned.
- **Specific exclusions** – these apply to particular parts of the policy. For example, under a household contents policy there may be an exclusion relating to boats and their use. This clearly wouldn't be relevant to the buildings section.

Some general exclusions are common to all general insurance policies and are called **market exclusions**. The list below is not exhaustive.

Consider this…
Before moving on, think for a few minutes about the reasons why insurers insert specific and general exclusions in their policies. Try to imagine what sort of market exclusions would apply to general insurance.

B1 War and related perils

War is considered a **fundamental risk**. It is generally regarded as being the responsibility of the State: in the UK the Government would normally provide compensation for injury and damage occurring in the UK sustained during war conditions.

You should note that marine and aviation policies may be extended to include war risks.

Consider this…
What is a fundamental risk? Are all fundamental risks uninsurable?

A fundamental risk is one that applies to society generally and would normally be considered too serious to be insured by an insurance company. However, this is not always the case.

Certain fundamental risks can be insured against in appropriate circumstances. For example, earthquake damage would be considered a fundamental risk in certain parts of the USA (e.g. California), although earthquake is an insurable risk in the UK. This difference is due to the frequency and severity of earthquakes in the respective location. Insurers may seek to cap their exposure to this peril, and as such, earthquake cover may have its own sub-limit within the overall indemnity limit.

B2 Radioactive contamination and explosive nuclear assemblies

This is regarded as another form of fundamental risk. It falls into two categories:

- contamination as a result of a nuclear accident; and
- liability for nuclear installations.

Potential losses were seen as beyond the capacity of individual insurers and cover is instead provided by 'market pools' where insurers and reinsurers accept a share of the risk according to their underwriting capacity.

B3 Terrorism

Following major terrorist attacks in London in the early 1990s, commercial property insurers announced that they were no longer prepared to continue to regard such incidents as being covered under the normal fire and explosion perils.

The outcome was an agreement between insurers and the Government as follows:

- Insurers would continue to provide a very limited amount of cover in respect of *terrorism* damage from fire and explosion for industrial and commercial properties in Great Britain and the Government would be prepared, through **Pool Re**, a new company set up for the arrangement and owned by the most significant participants in the UK commercial property market, to provide a top-up cover which could be purchased via the insurers.
- The premium rates were decided by the Government.

This arrangement survived until shortly after the terrorist attack on the World Trade Center in New York on 11 September 2001.

This incident highlighted the fact that terrorist damage could be much greater than anything previously anticipated and that a catastrophic or very significant terrorist loss could occur. Further to this, that loss could potentially arise from an insured peril other than fire and explosion (i.e. aircraft) where the loss could still fall under the commercial insurance policy. This is because the arrangements at the time only dealt with the perceived terrorist threat of fire and explosion.

In July 2002 the insurance industry, via the ABI and the Government, announced a new arrangement. Under this new scheme, which became effective from January 2003, the following apply:

- All damage as a result of terrorist attacks is excluded by insurers' standard commercial property wordings for risks written in the UK.
- The choice is with the insured if they wish to purchase the additional cover. The main requirement is that if the insured purchases terrorism cover, they do so for all the effective sections covered by the policy. Additionally, terrorism cover must be purchased for all property locations covered by the policy although allowance may be made where the purchase of terrorism cover is a stipulation placed upon an insured by contract, e.g. where a term of a mortgage is that buildings are insured for terrorism.
- Cover was extended (where purchased) to a much wider 'all risks' type cover, including terrorism damage by biological contamination and nuclear contamination.
- The premium rates were no longer decided by Government, but by the individual insurers and Pool Re became a reinsurer of terrorism cover rather than an insurer as before.
- Each individual insurers' maximum liability is 'capped' for each terrorist event and per year. This cap is based on an insurer's market share.
- In Northern Ireland, due to civil commotion and terrorism, compensation is provided by the Government.

Be aware

These exclusions do not apply to private policyholders' cars, homes and property which are not covered by Pool Re, unless the individual is purchasing cover in connection with their business.

Some insurers are now able to offer this cover while some continue to exclude terrorism in its entirety, therefore leaving a potential gap in cover.

In April 2018, it introduced a limited write back of cyber cover under terrorism sections for its members and also indicated, following Government confirmation that it would amend the **Reinsurance (Acts of Terrorism) Act 1993**, it would shortly widen cover to include non-damage business interruption losses resulting from acts of terrorism, a 'gap' in cover identified following the Manchester Arena bombing and the London Bridge attack in 2017.

It is important to remember that the scope of the cover will follow the member's (insurer's) underlying policy wording. This is important as Pool Re deliberately acts to avoid influencing the market, and some insurers may opt not to widen their policies to provide such cover for non-damage business interruption as Pool Re is prepared to do so in the case of acts of terrorism.

Recent changes have been made to Pool Re to make terrorism cover more easily available and to decrease the cost of reinsurance for the cedant (the original insurer). The main changes are:

- The definition of an SME has been expanded to include businesses with assets up to £5m.
- There has also been a reduction in the business interruption rating.

B4 Pollution and/or contamination

This exclusion is standard in all property insurance as property policies cover property only, not the liability of the property owner. Damage to the insured's property is covered if the pollution or contamination itself results from any peril insured or if pollution/contamination causes an insured peril to occur.

Public liability policies are explicit about the fact that they intend to cover risks from an **unexpected, identifiable event**, not a gradually operating cause. Gradual pollution can be insured under an environmental impairment policy.

B5 Cyber risks

These risks are ever evolving but insurers offer specialist but limited buy-back cover for cyber risks, for a charge and with a restricted amount of liability in the event of a claim. More specialist insurers continue to offer buy-backs which are bespoke to individual business and may operate without limits, but these are less widely available and carry higher premiums.

Be aware
A buy-back is when you are charged an additional premium for something which is normally excluded.

As a result of Pool Re's changes to its own exclusions, many insurers have also updated their exclusions to include a definition of 'phishing'.

Question 3.1

Why do insurers have concerns about the impact of cyber risks?

B6 Marine policies

Standard to all property insurance policies, its effect is to exclude material damage cover for property also covered by a marine policy. If the marine policy cover is insufficient, however, the property policy will respond for the excess amount.

If the marine policy contains a corresponding clause, the insurers will contribute to the loss in the proportions agreed.

B7 Contractual liability

This excludes liability involved with claims arising from an agreement entered into by the insured and extends the insured's responsibilities beyond the common law position. The exclusion makes it clear that what is not covered is liability which exists only because of the agreement made. It is standard in all motor and liability policies.

B8 Sonic bangs

Standard to all property insurance policies, damage arising from pressure waves from aircraft or other aerial devices travelling at sonic or supersonic speeds is excluded.

C Conditions

As discussed earlier, conditions can be express or implied. The majority of conditions will be expressly written into the policy as they have to be adhered to by the insured. The main ones are as follows.

C1 Duties of the insured

This condition simply states that the insured must observe and fulfil all the terms of the policy.

C2 Alteration

This extends the duty of disclosure to a continuing duty, and requires the insured to notify the insurer of any changes that increase the risk.

C3 Action by the insured in the event of a claim

This varies from one class of insurance to another, but includes reference to how soon a claim needs to be notified and usually the method of notification.

C4 Fraud

This condition states that any benefit under the policy is forfeited if:

- the claim is in any way fraudulent (including artificially inflating a claim);
- any fraudulent means or devices are used to obtain any benefit under the policy;
- any destruction or damage is caused by the wilful act of the insured or anyone acting on the insured's behalf.

C5 Reasonable precautions

This formalises the insured's duty to take reasonable care and precautions to minimise the risk of loss or damage or of incurring liability; an insured should not treat insurance cover as an excuse for carelessness or inactivity.

While legislation does not preclude use of them, reasonable precaution conditions are not viewed positively by courts and can be held to be 'catch-alls'. As such, insurers are rarely able to rely on them in the event of a loss and there is a fair challenge to why they exist in the first place, particularly when they are implied conditions of cover.

C6 Contribution

This deals with the position of what happens if there are other policies in place covering the same loss, e.g. both landlord and tenant have policies in place covering the buildings.

Contribution is the right of an insurer to call upon other insurers similarly, but not necessarily equally, liable to the same insured in order to share the claims cost. The condition modifies the principle by limiting insurers' liability to their share of the loss when other policies also exist; therefore, the insured is obliged to claim proportionately from each insurer. For example a holidaymaker may take out a travel policy which covers personal possessions. Certain items such as camera equipment will usually also be covered under the all risks section of a household contents policy. If the camera was lost or stolen while on holiday, the policyholder would be covered under the two policies. The principle of indemnity is to place the insured in the same position they were in before the loss occurred. In this case the indemnity is to replace one camera. The insurers would then share the claim in agreed proportions.

There can also be non-contribution clauses, but these are outside the scope of this course.

C7 Subrogation

Subrogation is the right of the insurer to take over the insured's rights, following payment of a claim, in order to recover the payment (or part of it) from a third party wholly or partly responsible for the loss: simply put, the insurer can 'stand in the shoes' of the insured. For example, the insurer of Brian Jones' factory would indemnify Mr Jones in the event of fire damage at the premises. If the fire damage occurred as a result of the negligent actions of a neighbour – Bill Smith, the insurers may attempt to recover damages from Mr Smith. Any court action would be carried out in the name of the insured not the insurer, in this case ***Brian Jones v. Bill Smith***.

The subrogation condition modifies the common law position so that an insurer is able to exercise its subrogation rights **before** a payment is made.

C8 Average

This condition has the effect of reducing claims payments under property insurance policies in proportion to any underinsurance.

It can be expressed in the following equation:

$$\frac{\text{value insured under the policy}}{\text{value at risk}} \times \text{the loss}$$

Example 3.2
If the policyholder insured their buildings for £200,000, but they were valued at £250,000, and if then the policyholder suffered a £50,000 loss, they would only receive £40,000, i.e. £200,000 over £250,000 × £50,000.

This is normally calculated before the application of any excess, but individual insurers may vary their approach.

C9 Arbitration

This clause is intended to deal with **quantum** (amount) disputes in settlement of claims. Not all policies will contain this clause and some insurers rely on other methods to resolve these disputes, e.g. Financial Ombudsman Services.

C10 Cancellation

This will be dealt with in greater detail in *Cancellation* on page 4/4.

D Warranties, conditions and representations

D1 Warranties

Warranties are promises made by the insured relating to facts or performance concerning the risk. It is an undertaking by the insured that:

- something will or will not be done; or
- a certain fact exists or does not exist.

They may relate to past or present facts (i.e. a promise that something is so or was so) or may be a **continuing warranty**, in which the insured promises that a state of affairs will continue to exist or the insured will continue to do something.

Warranties are used to control the aspects of a risk which insurers believe are the most important or that they are particularly concerned about. As a result, they have the most significant impact on an insured or the subject matter if it is breached.

Examples of warranties:

- Property risk – there is a warranty that the premises must be protected by a fully operational sprinkler system.
- Marine risk – the vessel will not travel to certain parts of the world.

Warranties can be implied or express; express warranties are written and will be incorporated into the policy.

Question 3.2

Why does an insurer insert warranties into an insurance policy?

Consider this…
What happens if an insured does not comply with a warranty?

D1A Consumer contracts

The Consumer Insurance (Disclosure and Representations) Act 2012 amended the law in relation to consumer insurance contracts. One of the main impacts of the legislation was to

remove the ability of insurers to rely on basis of contract clauses to create warranties based on representations made by a consumer.

An insurer can still warrant that a consumer does or does not do something in relation to the subject matter being insured (e.g. fitting of an alarm to a motor vehicle), but their ability to rely on the breach of a warranty is restricted.

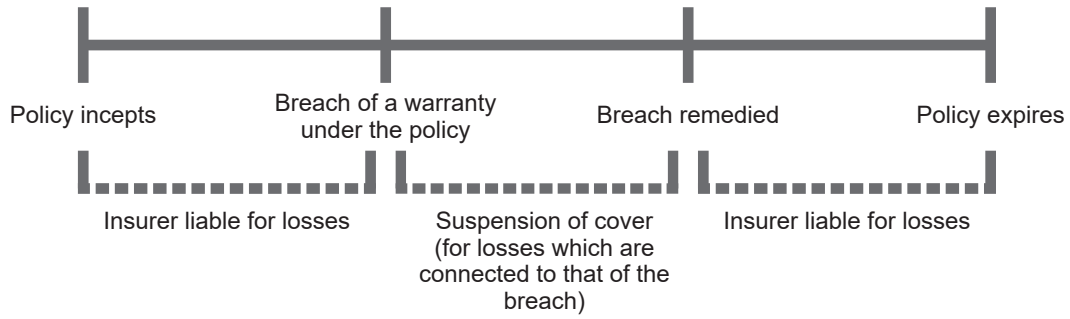
As with the position prior to the Act, they must give consideration to the materiality of any breach (i.e. the connection between the breach by the insured and the resulting loss).

D1B Non-consumer contracts

Under the Insurance Act 2015, a breach of warranty is suspensive. This means that it discharges the insurer from any liability under the policy from the date of the breach. However, being suspensive, if the insured repaired the breach at a later date, the insurer's liability would start again from the date the breach was repaired.

Be aware
Under insurance law, a suspensive condition is one where cover is suspended for as long as the insured fails to comply with the condition, but resumes if and when they start to comply with it again. Therefore, a breach of warranty under the Insurance Act 2015 can be said to be suspensive.

The insurer has the option of waiving any breach. This has the effect of ignoring the breach and continuing the insurance as if the breach had never occurred. However, should the insurer choose to waive the breach, they have no recourse to rely on it if they subsequently became aware of losses. They can though rely on a future breach should one occur.



Depending on the nature of the warranty and the breach, an insurer might be discharged from its liability from inception (*ab initio*). However, the insurer must consider whether the breach is material to a loss that has occurred, as well as whether reasonable attempts to comply with the warranty have been made.

Question 3.3

Give an example of an express warranty that an insurer may insert in a household policy and in a motor policy.

D2 Categories of conditions

Policy conditions are terms, which although they are not warranties, impose important obligations upon the insured.

The effect of a breach of condition is very serious and will vary depending on which of the following categories the condition falls in:

- conditions precedent to the contract;
- conditions subsequent to the contract;
- conditions precedent to liability (or to recovery).

Conditions precedent to the contract must be fulfilled **prior** to the formation of the contract itself. The implied conditions (e.g. insurable interest) fall into this category. Non-compliance raises doubts as to the entire contract's validity.

Conditions subsequent to the contract must be complied with once the contract is in force, e.g. notification of alteration of risk.

Conditions precedent to liability must be complied with for there to be a valid claim, i.e. the claims conditions saying that a claim should be notified promptly. If not complied with, **insurers may avoid liability for a particular loss, but need not repudiate the contract as a whole**.

As with warranties, under the Insurance Act 2015 a breach of condition is suspensive.

D3 Representations

Representations are written or oral statements made during the negotiations for a contract. Some may contain material information and others may not.

Historically, representations made by consumers and non-consumers could be converted into warranties in the policy by using a 'basis of contract' clause. This had the effect of allowing an insurer to discharge themselves of any liability in the event of a claim, regardless of whether the representation was material to the loss.

Such clauses have historically been viewed as 'catch-alls' and disapproved of in law. The reason for the disapproval is clear – such a method can effectively remove consideration from the insurer. The proposer provides consideration in the payment of the policy premium; the insurer, though, does not have to provide consideration by way of a warranty that, if breached, would allow them to retain the premium but repudiate a loss.

Section 6 of the Consumer Insurance (Disclosure and Representations) Act 2012 has abolished basis of contract clauses.

Section 9 of the Insurance Act 2015 has also abolished basis of contract clauses.

This is a much better position for insurers and for customers, as it ensures that both sides are aware of their rights and responsibilities **before** entering into the insurance contract. This is important as it should lead to fewer disputes.

Be aware

Such clauses may still appear in an insurer's policy wording for various reasons (e.g. they have not yet updated their wording in full following implementation of the Insurance Act 2015), but they **cannot** be relied on in law for consumer or non-consumer contracts, unless both the insurer and the insured have agreed to contract out of the Insurance Act 2015.

D4 Summary and comparison

Warranties	• Must be strictly and literally complied with. • Give the insurer the right to repudiate (reject) any claim where the breach relevant to the loss or damage. • Insurers must consider materiality of any breach. • Must be written into the policy, except where implied. • Following implementation of the Insurance Act 2015, breaches are now suspensive.
Conditions	• Some implied conditions are so fundamental that they affect the whole validity of the contract in the event of non-compliance. • Breach of a condition subsequent to the contract may allow the insurer to avoid cover under the policy. • Conditions precedent to liability give the insurer the right to repudiate a claim but not to repudiate the contract as a whole.
Representations	• Need to be made fully and accurately. • Do not normally appear in the policy. • Following the implementation of the Insurance Act 2015, defined legal recourses are available to the insurer in the event of false representations, depending on whether deliberate or reckless or neither deliberate nor reckless.

E Excesses, deductibles and franchises

E1 Excesses

An **excess** is the first amount of each and every claim for which the insured is responsible. Theoretically, the insured is their own insurer for the value of the excess. They may be:

- **compulsory**: imposed on the insured by the insurer; or
- **voluntary**: being accepted by the insured in return for a premium discount.

Excesses appear in most classes of general insurance.

In motor insurance, a **compulsory** excess may be imposed on a young or inexperienced driver for motor insurance, while an example of a **voluntary** excess is where an insurer offers a premium reduction if the insured accepts an excess of, say, £50, £75 or £100 in respect of accidental damage to the vehicle.

E2 Deductibles

A **deductible** is, essentially, a **very large excess**. This is increasingly prevalent with commercial insurances and could be found where, for example, a large industrial company accepts the risk for fire damage up to £50,000, and is essentially its own insurer for claims under this amount.

It should be noted that although there is a distinction in terms of size, in some sectors of the market place the terms ‘excess’ and ‘deductible’ are interchangeable.

E3 Franchises

A **franchise** is a **fixed amount** or **period** that acts as a threshold to determine whether claims are payable. Once the **amount** or **period** is exceeded, the claim is payable in **full**: nothing is deducted. If it is not exceeded, however, nothing is payable.

Franchises are not common, but are sometimes found in engineering business interruption insurances. Time franchises (e.g. seven days) are common with sickness cover under personal accident and sickness insurance policies.

For example, if a policyholder had a health insurance policy with a time franchise of seven days and was off work for six days none of the claim would be payable. But, if they were off for eight days, the whole claim would be payable for all eight days.

Question 3.4

Bob has a buildings policy with a sum insured of £50,000. If he has a claim for £1,500, how much would his insurers pay if he had an excess of £1,000 and a franchise of £2,000?

Question 3.5

How would your answers change in the above if the loss were £2,500?

Key points

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

Structure, form and content

- Insurance policies are issued in a scheduled form and a schedule is incorporated into the policy. The schedule contains all the variable information concerning the insured and details of the risks insured.
- Policies will incorporate the following: heading; preamble; signature and operative clauses; exclusions; conditions; policy schedule; information and facilities.

Exclusions

- Most policies will contain two types of exclusion: general exclusions and specific exclusions.
- Some general exclusions are common to all general insurance policies and are called market exclusions, e.g. war and related perils, terrorism.

Conditions

- Conditions include duties of the insured, action by the insured in the event of a claim, contribution and subrogation.

Warranties, conditions and representations

- A warranty is a promise made by the insured relating to facts or performance concerning a risk. It may be a continuing warranty.
- Warranties are usually express.
- Conditions fall into three groups: conditions precedent to the contract; conditions subsequent to the contract; conditions precedent to liability (or to recovery).
- Representations are written or oral statements made during the negotiations for a contract.

Excesses, deductibles and franchises

- An excess is the first amount of each and every claim for which the insured is responsible. They may be compulsory or voluntary.
- A deductible is a very large excess.
- A franchise is a fixed amount or period that acts as a threshold to determine whether claims are payable.

Question answers

3.1 Insurers are concerned about the accumulative effect cyber risks can have on their policyholders as a single event could impact upon a wide number of their policyholders. Also, policies have been developed over time and when written the consequences of cyber risks were not fully appreciated and insurers' pricing mechanism did not reflect the increased exposure. Until more is known about these risks insurers will remain cautious in their approach.

3.2 For a number of reasons, most important of which are to ensure some aspect of good housekeeping or management is observed, or certain more hazardous features of risk are not introduced without the insurer's knowledge.

3.3 For a household policy that a burglar alarm is fitted and always activated when the premises are unoccupied. For a motor policy that the vehicle on cover is kept in a garage at night.

3.4 With an excess of £1,000, he would pay £500. And, with a franchise of £2,000, he would pay £0.

3.5 If the loss were £2,500, the answer for the excess would be £1,500 (£2,500 less excess of £1,000). For the franchise it would be £2,500 (as the franchise of £2,000 is exceeded, the loss is paid in full).

Self-test questions

1. What are the main components of an insurance policy?
2. What is the purpose of the operative clause?
3. What is the difference between general exclusions and specific exclusions?
4. What policy conditions are common to most general insurance policies?
5. What is the difference between an excess, a franchise and a deductible?
6. What is a warranty in an insurance policy?
7. What three groups or categories can policy conditions be divided into?
8. What are the essential differences between a warranty and a representation?

You will find the answers at the back of the book

4

Renewals and cancellation

Contents	Syllabus learning outcomes
Introduction	
A Renewals	*4.1*, *8.10*
B Cancellation	*4.2*
Key points	
Question answers	
Self-test questions	

Learning objectives

After studying this chapter, you should be able to:

- explain the significance of procedures relating to renewals; and
- explain the meaning and significance of the cancellation clause.

Introduction

In chapter 3 we discussed insurance policies. In this chapter, we examine how they can be renewed and cancelled.

Key terms

This chapter features explanations of the following ideas:

Auto-renewal	Cancellation	Renewal notice	Statistics

A Renewals

As we now know from our brief mention in chapter 2, most general insurance policies are issued for a period of twelve months. Towards the end of that period they are said to be due for renewal. The anniversary date is, unsurprisingly, referred to as the renewal date.

The **renewal** date is an important date as it allows reconsideration of the insurance by both the insurer and policyholder. It allows the insurer to review the terms, conditions and premium for the risk, and then for the policyholder to decide whether they want to renew the insurance in the light of this. There is usually no obligation on either party to renew.

Although most general insurance policies are issued for a period of twelve months, insurers would, obviously, not be too happy if all their clients only stayed with them for twelve months and then switched insurers.

There will occasionally be a requirement for 'one-period' insurance. For instance, builders often take out short-term property policies known as **contract works or contractors' all risks cover** to cover buildings in the course of erection or new building work to existing buildings, e.g. extensions or loft conversions. The planned work may only be scheduled to last up to one year, therefore a short-period policy will be issued. Another example would be where a charity is set up to administer a short-term project or an event and wishes to insure its property and liability.

Consider this…
Why are insurers keen to encourage renewal of policies?

The reasons are twofold:

Statistics	If the client base remains stable, statistical information about the portfolio will be more accurate.
Cost	Policy renewal is a lot cheaper than acquiring new business: think of the marketing costs involved.

It is for these reasons that, although neither party is obliged to renew, insurers will take steps to secure renewal of the business for a further year.

Which leads to the question: how does the insurer go about trying to secure the business?

Insurers now rely on standard, automated procedures which involve sending a computer generated *renewal notice* to the insured before their contract expires.

For some insurances (for example, compulsory motor insurance), insurers may also automatically renew policies where customers have a direct debit arrangement in place (known as *auto-renewal*). They will advise new customers of this and argue that the benefit to the customer is to ensure continuous cover for a compulsory insurance. This is because it is not uncommon for policyholders to forget to renew. The FCA specifies that this process must be communicated clearly to the customer.

The insurer does not have to invite renewal, but if it wants to keep the business it is clearly in its interest to do so. The renewal notice will bring to the insured's attention that the period of insurance is coming to an end; it will also contain the renewal premium, and any proposed changes in the terms and conditions.

Technically, if the insured wishes to renew, they will send the premium to the insurer who will then send out confirmation of renewal (and, if appropriate, a new certificate of insurance). In practice, however, as most premiums are paid by instalments, the insured often needs do nothing further than allow the premium deduction to continue.

You may have encountered ICOBS in your previous studies. It also governs the area of renewals. **ICOBS rule 6.1.5R** reads:

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

Question 4.1

Think for a few moments about the insured's duties at renewal.

List what some of these might be.

Automatic and assumptive renewals have attracted scrutiny from the FCA, Government and the media in the past. The FCA is particularly concerned about outcomes for consumers and the risk that they may be treated unfairly. One area of focus is the difference between the pricing of new business, which often contains temporary incentives and discounts to win new customers, and renewals that may have such discounts removed, or may be the subject of increases to historic rating structures. As a result, an existing customer may end up paying more than they would had they applied for a new policy.

In April 2017, the FCA introduced new regulatory rules for transparency which affect personal insurances. These require insurers and intermediaries selling retail general insurance products to:

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

Be aware

The FCA's focus on the fair treatment of customers continues. In 2018, it announced a market study in conjunction with the Competition and Markets Authority (CMA) looking at how insurers charge home and motor customers for both new business and renewals, and promising to address any issues. The interim report of its findings can be found here: *www.fca.org.uk/publication/market-studies/ms18-1-2-interim-report.pdf*

Price discrimination, often referred to as differential or dual pricing, has been in the public's mind for a number of years thanks to consumer lobbying and pressure from the Citizens Advice Bureau, among others.

The term 'loyalty penalty' has been coined by several public figures to refer to the disadvantage suffered by some customers who do not shop around at renewal, or who are treated differently to new customers.

Consider this…

In addition to the FCA's focus on the fair treatment of customers, it is important to consider the general trend of moving protections further towards the consumer.

Ask yourself who is responsible for ensuring that a new consumer customer receives the most competitive price? The customer or the insurer?

Consider who is responsible for ensuring that consumer customers receive the most competitive price at the end of their existing contracts? Think about this also in the context of a mortgage, a mobile phone contract, home broadband or a fixed rate savings account. All of these have been considered by regulators, alongside household and motor insurance.

Under the **Consumer Insurance (Disclosure and Representations) Act 2012**, the insurer is required to take better care in ensuring that consumers are aware of the material information on which the contract is based. This is because most contracts are annual ones; renewal of a policy is actually entering into another contract between the insurer and the insured.

As a result, the insurer needs to remind the consumer of the questions and answers provided in the proposal form at the inception of the original policy. They already do this post-inception of the insurance contract, through statement of facts, which detail all questions asked by the insurer and all answers provided by the customer. However, at renewal insurers must now draw specific attention to these questions and answers and ensure that they are still accurate.

Another example of this scrutiny is the **Consumer Rights Act 2015**, which came into force from 1 October 2015. It affects insurance contracts and focuses on areas such as fair notice to customers and avoiding unfair contract terms. Insurers already work to much of this as best practice laid down by the FCA, but this legislation specifically requires the provision of **transparent** and **prominent** notices to customers, including renewal notices.

Positive customer outcomes
There should also be consideration of the ethical behaviours that surround delivering positive customer outcomes. Customers need to be confident that they are dealing with people and companies who are putting their interests first.

The CII Code of Ethics provides members of the insurance and personal finance profession with a framework in which to apply their role-specific technical knowledge in delivering positive consumer outcomes. Members are required to 'treat people fairly regardless of: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation'. Individuals should strive to adopt an inclusive 'whole customer approach' at every customer interaction point.

B Cancellation

The *cancellation* condition in an insurance policy defines how an insurance contract can be cancelled during its currency, generally by the insurer. The insurer usually has to send at least seven days' written notice of cancellation by recorded delivery to the insured's last known address. It is more common to see cancellation conditions requiring longer notice periods of up to 30 days, or restricting the circumstances in which insurers can cancel.

The insurer also undertakes to give a proportionate return of the premium for the unexpired period. This is, however, a rarely invoked right: insurers would not cancel mid-term simply because of a bad claims experience. An insurer's ability to invoke the cancellation condition is more tightly controlled under the Consumer Insurance (Disclosure and Representations) Act 2012 and the **Insurance Act 2015**.

Question 4.2

In what circumstances might an insurer invoke such a cancellation condition?

The **ICOBS 7.1.1R** gives consumers of a general insurance contract a 14-day period from the date of inception or renewal to cancel their policy; this is, in effect, a cooling off period (essentially, the customer has changed their mind about the policy). In order to be valid, notice of cancellation must be provided by the consumer before the relevant deadline. It must be on paper or another durable medium.

An insured may also have the right to cancel mid-term, but in this case, a **short-period premium** may be charged, giving a less than proportionate refund.

Consider this…

Why would an insurer want to charge short-period rates if a policyholder cancelled?

This is because much of the expense incurred in administrating insurance cover occurs at the start of the policy (checking proposal, giving quotations, setting up the policy, reconciling the premium etc.) and if the customer cancels within that first period costs to the insurer are

high. So they want to share a proportion of those costs with the customer, who could be said to have 'drained' some of the funds from the 'common pool' over and above what might be considered reasonable.

It should be noted that insurers do not always charge short-period premiums; it depends on circumstances. The return of premium is referred to as applying 'pro-rata'. The Consumer Rights Act 2015 introduces new protections for consumers around cancellation of contracts. While an insurer can still charge administration fees as part of cancellation, these cannot be disproportionately high.

The Consumer Rights Act 2015 also impacts policies which are sold as add-ons or as ancillary to the main product being purchased, meaning that if the primary policy is cancelled, the ancillary policy must also be cancelled at the same time. An example of this would be a consumer purchasing a private motor policy, and being cross-sold legal expenses or breakdown cover at the point of sale. Not only does the consumer have to actively affirm their purchase of the ancillary legal expenses policy (e.g. tick a check box rather than it being ticked assumptively), but the insurer must also cancel the legal expenses policy at the same time as any cancellation of the private motor policy.

In some instances, if the insured cancels the policy, no refund may be given. This is usually where there has been a claim during the current period of the policy (note, this cannot be done if there have been claims in a different period from the one being cancelled), as the insurer has provided consideration under the policy.

Be aware
If the insured cancels a commercial policy there are certain circumstances whereby changing insurer can present a gap in cover.

Key points

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

Renewals

- If insurers can keep their client base stable, statistics will be more accurate.
- Therefore, before a renewal date, a policyholder may be invited to renew by means of a renewal notice.

Cancellation

- Either party to the contract may cancel the contract mid-term, but there may be certain consequences.

Question answers

4.1 To provide details of any changes in the risk. In other words, the duty of disclosure is resurrected.

Examples of this could be that one of the drivers of a car had received a criminal conviction, or that some work had been done to underpin an adjoining house (in household insurance) to protect against subsidence.

4.2 The cancellation condition is typically brought into action when an insurer:

- discovers important material information that was not presented by the policyholder prior to completion of the contract, i.e. inaccurate or 'dressed up' claims experience, insured's criminal convictions, fraudulent activity etc.; or
- the survey report portrays the risk in a poor light increasing the insurer's exposures beyond acceptable levels; or
- the risk requirements indicated within the survey have not been completed within the timescale agreed.

Self-test questions

1. What is the purpose of a renewal notice?

2. If a policyholder cancelled their policy mid-term, why would an insurer often charge short-period rates for the period of cover?

You will find the answers at the back of the book

5

Insurance products: personal insurances

Contents	Syllabus learning outcomes
Introduction	
A Motor insurance	*5.1*, *8.1*
B Health insurance	*5.1*, *8.1*
C Household insurance	*5.1*, *8.1*
D Travel insurance	*5.1*, *8.1*
E Extended warranties	*5.1*, *8.5*
Key points	
Question answers	
Self-test questions	

Learning objectives

After studying this chapter, you should be able to:

- describe the basic features and typical policy cover of the insurance types detailed; and
- explain the underwriting approach and considerations for various classes of insurance.

Introduction

In chapters 1–4, we have been dealing with underwriting procedures on a general level. We shall now start to identify the particular cover and underwriting characteristics applicable to the main classes of general insurance. We begin in this chapter by examining the scope of typical policy cover in respect of the main types of personal insurance.

It may be useful to clarify at this point what we mean when we talk about personal insurances. We are referring to the various policy covers required by private individuals as consumers, as opposed to 'commercial' insurances which are insurances required by commercial entities such as companies and corporations. As we have already seen, the way that insurers deal with private individuals as consumers (retail customers) differs from the way that they deal with insurances purchased by commercial entities.

Commercial vehicle cover has been included under personal insurances as it makes sense to consider this at the same time as other motor insurances but it does belong more properly to the commercial insurances section.

Although we shall be looking at the **underwriting considerations** applicable to these classes in a later chapter it is important at this stage to consider how the cover provided by the various types of policy impact on the underwriting of those classes.

Key terms

This chapter features explanations of the following ideas:

'All risks' cover	Commercial vehicles	Comprehensive cover	Contents insurance
Exclusions	Extended warranties	Health insurance	Household insurance
Medical expenses	Motor insurance	Optional extensions	Personal accident benefits
Sickness cover	Third party only cover	Third party, fire and theft cover	Travel insurance

A Motor insurance

This is the most significant compulsory insurance in the UK: **it is illegal to drive or be in charge of a vehicle on a public road, as defined in the Road Traffic Act 1988, unless an insurance policy is in force in respect of legal liability for injury to others or damage to their property**.

In the **Road Traffic Act 1988**, 'road' (in relation to England and Wales) is defined as meaning:

> …any highway and any other road to which the public has access…

A1 Private motor insurance

There are four different levels of cover available. The lowest level is the narrowest form of cover, and extra areas of cover can be added for each level at an additional premium:

- Road Traffic Act (RTA) only;
- third party only;
- third party, fire and theft;
- comprehensive.

A1A Road Traffic Act only

Road Traffic Act only is the minimum cover required to comply with the Road Traffic Act 1988 and provides for unlimited indemnity in respect of bodily injury or death to third parties, a £1.2m limit for loss of or damage to third party property, claimants' costs and expenses, and emergency medical treatment and hospital charges arising out of the vehicle use.

Under the terms of the **European Union Third Directive** cars used in EU countries must provide a minimum cover of either:

- the minimum cover required in the country the vehicle is registered; or
- the minimum cover required in the country in which it is being used, whichever is the greater.

In practice there are very few RTA only policies issued.

Brexit

The UK voted to leave the European Union (EU) on 23 June 2016 and formally left the EU on 31 January 2020.

The UK is now in a transition period until 31 December 2020, although the COVID-19 pandemic may lead to an extension. Until the end of this period, the UK will continue to follow all of the EU's rules. The longer-term impact on the UK's overall regulatory framework will depend, in part, on the relationship agreed between the UK Government and the EU.

Please note: This is the position at the time of publication. Any changes that may affect CII syllabuses or exams will be announced as they arise.

A1B Third party only

Third party only provides, in addition to the above:

- a £20m limit in respect of third party property damage cover;
- indemnity to the insured's employer if the policy covers business use;
- indemnity for the liability of passengers; and
- legal costs to defend a claim.

Cover also provides the statutory cover while driving the specifically insured vehicle in any EU state.

A1C Third party, fire and theft

Third party, fire and theft includes, in addition to the above, the cost of repair or compensation of the insured if the vehicle is stolen, damaged during theft or attempted theft, and damage by fire, lightning or explosion.

A1D Comprehensive

Comprehensive is the widest possible protection and includes other accidental and malicious damage to the insured vehicle.

The cover is 'all risks', with exclusions. These exclusions include:

- wear and tear;
- depreciation, i.e. reduction in the value of the vehicle following an accident;
- loss of use, i.e. costs for alternative transport while the vehicle is off the road;
- mechanical and electrical failure;
- tyre damage from punctures or blow-outs (though note that any resultant damage would be covered).

There are also a number of extensions in cover that are included without additional cost.

These include:

- personal accident;
- medical expenses;
- personal effects; and
- usually a 'drive other vehicles' extension by the insured only, which is restricted to third party only cover or even Road Traffic Act only cover.

The cover under personal accident, medical expenses and personal effects is very limited and should not be likened to stand alone policies of the same nature. Typically, cover will automatically include the driving-other-cars extension but this is subject to other policy

restrictions (e.g. age of driver) and will usually only provide cover for the minimum that insurer offers (e.g. third party only).

It is important to make sure that you are very familiar with the difference between **third party, fire and theft** cover and **comprehensive** cover.

Question 5.1

Bill is driving his car along a straight road, he has a blow-out, his car veers out of control and he runs into the front wall of a house, doing serious damage to the car, the wall and injuring himself so badly he loses an arm. What cover would Bill have with RTA cover only, third party fire and theft, and a comprehensive policy with common extensions?

A1E Optional extensions

Optional extensions are typically available, usually for an additional premium (some may be automatically included), for example:

- breakage of glass (i.e. for a non-comprehensive policy);
- personal belongings and clothing (in addition to standard cover);
- provision of a courtesy car so while the policyholder's car is in for repair following an accident they are provided with a replacement vehicle, usually from the insurer's recommended repairer;
- extended personal accident benefits;
- foreign use cover beyond the minimum EU cover automatically provided;
- caravans and trailers;
- breakdown cover; and
- legal expenses.

This list is **not** exhaustive.

A1F Exclusions

There will be general and market *exclusions* in addition to the specific exclusions, such as contractual liability, war risks, use other than as specified, riot and civil commotion and sonic bangs.

It should be pointed out that cover is subject to the driver having a licence to drive the vehicle, or having had a licence and not being disqualified from holding one (which covers the situation where a licence has not been renewed by oversight, for example).

A2 Private motor cycle insurance

The policy format is the same as that used in private car insurance and the same levels of cover are available with the following small differences:

- there is no cover for theft of accessories or spare parts unless the cycle is also stolen;
- some policies do not provide indemnity to employers;
- there is usually no personal accident, medical expenses or personal effects cover.

Consider this…

Why would there be different restrictions on motor cycles?

There are extensions to cover available for additional premium, such as:

- cover for trailers; and
- riding other cycles extension.

Personal accident cover is available, though it tends to be restricted in scope.

The policy exclusions are essentially the same as those detailed in *Exclusions* on page 5/4.

A3 Commercial vehicles

Although we are dealing with this class of business as part of our consideration of 'motor' insurance, you should be aware that it is in fact a type of commercial insurance as opposed to a personal insurance.

The main types are:

- goods-carrying vehicles (from small vans to articulated lorries and those with a connected trailer);
- agricultural and forestry vehicles (e.g. tractors);
- passenger-carrying vehicles (e.g. hire cars, buses and coaches); and
- special construction vehicles or 'special types' (e.g. ambulances, cranes, forklift trucks, earth movers).

Like private car insurance, **commercial vehicle** insurance is concerned with insuring against damage to the vehicle, and liabilities to others arising out of the use of the vehicle.

It does not usually include damage to goods carried in the vehicle as this is covered by a goods in transit policy, although this is sometimes available for motor policies covering small vans issued to tradesmen.

There is usually a standard policy wording, which is then modified depending on the vehicle insured. The range of cover is the same as in private motor insurance; the cover, however, excludes the following:

- driving other cars extension;
- personal accident; and
- personal effects.

It also differs in respect of the use to which the vehicle is placed; there is, for example, a different rating for vehicles used for haulage (i.e. the carriage for reward of goods belonging to others), as distinct from carriage of own goods, and vehicles used for carrying dangerous substances are subject to special treatment.

The **third party liability** section provides unlimited indemnity for death or bodily injury to third parties, with a limit of, typically, between £1.2m and £5.0m for third party property damage, compared to the £20m limit for private cars. This enables the underwriter to limit the level of its liability on a case-by-case basis, depending on the nature of vehicle insured and goods carried.

There are also the following considerations:

- **Loading/unloading**: cover also applies here. An example would be dropping goods carried on the bonnet of a car parked near the vehicle while unloading.
- **Indemnity to driver**: usually anyone may drive on the insured's order/with their permission. The vehicle may be owned by a company, yet in the event of an accident a legal action or claim for damages may be brought against the driver, thus it is important that the policy covers both the company and the driver to avoid any potential gaps.
- **Indemnity to user**: the insured may allow others to use the vehicle for social, domestic or pleasure purposes. This allows drivers to take the vehicle home in the evening which is far more practical in many circumstances. It should also be noted that there can be a difference between 'driving' the vehicle and 'using' the vehicle. An example here would be an employed chauffeur. The chauffeur is clearly the driver, though they are being instructed by the employer, who would be the user. The detail and impact are outside the remit of this course, but it should be remembered that there can be a difference.
- **Indemnity to passengers**: indemnity for their acts of negligence is covered. For example, if a passenger opened the car door into the path of a passing cyclist, injuring them, the cyclist might bring a claim against the driver or the passenger, so again it is important both are covered.
- **Legal costs**.

There is a fairly extensive range of *optional extensions* available at an additional premium or some insurers may include some of these automatically. These include:

- medical expenses;
- windscreen cover; the cost of commercial vehicle windscreens can be very high indeed and there may be a limit on the policy. Think about the size of a windscreen on a large articulated lorry;
- loss of use (cover for costs of alternative arrangements while the vehicle is being repaired);
- increased third party property damage limit; this is especially relevant for large special type vehicles, such as earth movers and cranes which could potentially do a lot of damage as a result of their size and the nature of the work undertaken;
- personal belongings; this might be relevant for long-distance lorry drivers who spend several nights on the road and may carry reasonable values of personal effects which could be lost in the event of serious accident, fire or theft;
- indemnity to hirers; some companies often hire out commercial vehicles either on a regular or infrequent basis. This extension means that cover would extend to the person/company hiring the vehicle in the event of an accident or claim;
- sheets/ropes; this extends cover to include the large tarpaulins and ropes often used on large open-sided lorries. These can be quite valuable and expensive to replace (especially if they carry advertising and are printed), hence the ability to extend the policy to cover against loss.

Limitations are basically the same as private motor insurance.

Mention should also be made here of **fleet insurance**, which is a group of vehicles under single ownership, covered under one insurance. A minimum number of vehicles is required before insurers will consider rating vehicles as a fleet. The majority of insurers require ten or more vehicles to be covered before fleet rating is applied, though some will offer ‘mini-fleet’ policies for over five vehicles if the premium is high.

Generally, the cover available is similar to that under private motor policies; however, other covers are often included, for example:

- contingent third party insurance; for example, providing indemnity to a policyholder (which is an employer), where an employee is using their own vehicle on the employer’s business and their own insurance (which is intended to indemnify to the employer) proves to be inoperative;
- joint insured clause (i.e. two or more named insureds are treated as separate policyholders if one has a claim against the other);
- occasional business use; this is providing indemnity to an employee of a policyholder employer, where the employee is using their own vehicle on the employer’s business but it is known that their own policy does not cover business use. This is distinct from the contingent indemnity to the employer described above.
- roadside assistance;
- helplines, message handling and administration.

The purpose of fleet insurance is essentially twofold:

1. To enable rating to be carried out to take account of the individual experience of the particular policyholder.This requires a certain minimum number of vehicles to be practical, usually ten, although on larger fleets the statistical basis becomes more genuinely reflective of account performance. These can cover hundreds or thousands of vehicles.
2. To reduce administration for the policyholder and insurer by having a single multi-vehicle policy, the premium for which can be adjusted at agreed periods, instead of doing so at times of individual changes.

B Health insurance

People are exposed to many risks that may result in a reduction in their income or wealth. Income may be reduced by death, unemployment, accidental injury, sickness or disability. In addition, certain liabilities may increase, e.g. the costs of medical treatment. There is an obvious need to insure some or all of these risks, and this is the object of health insurance.

Health insurance can be broken down as follows:

- **Personal accident**, which provides payments in the event of accidental death or bodily injury.
- **Sickness**, which provides payment for disablement due to sickness.
- *Medical expenses*, which provides cover for individuals who seek medical treatment outside the NHS when they are ill.

A personal accident and sickness policy is a **benefit** policy, i.e. a contract to pay a sum of money in the event of a defined event occurring, whether or not the insured sustains a direct financial loss.

An operative time of cover is defined in the policy. For example, terms such as 'during the policyholder's usual occupation' or '24 hours'.

Personal accident and sickness policies can be **private**, i.e. taken out by the policyholder in respect of their own welfare, or **group**, where a number of persons are covered under one policy. Group policies are usually taken out by employers to protect against financial loss as a result of injury or illness to a member of staff.

Consider this…

What financial losses could an employer suffer as a result of injury or illness to an employee?

The list is not exhaustive but includes lost revenue through shortfalls in production, the cost of hiring in temporary staff, continuing salary to the injured/ill employee (over and above any standard statutory sick pay), the cost of private medical treatment for the employee (especially if the employee is a key member of staff with vital skills), recruitment and training costs, a lump sum payment to the family of any deceased employee or a nominal amount in respect of funeral expenses.

Personal accident and sickness policies can be purchased as stand alone policies, but are often 'add-ons' to travel, motor, household insurance or commercial combined insurance.

It should be noted that typical standard coverage is limited to those between the ages of 16 and 65 unless specifically noted as included by endorsement. However, this can vary and can range between 16 and 70 for accidents and between 16 and 60 for sickness.

The level of benefit is decided beforehand and is a fixed amount irrespective of whether it is to be paid weekly over a limited period of time and/or in a lump sum.

Be aware

It is important to remember that even though insurers now need to ask for all material information, rather than rely on the proposer to disclose it, they are still able to exclude pre-existing conditions from cover in respect of health insurances. They do not have to expressly exclude the conditions by listing them in the policy wording – it is enough for them to expressly state that pre-existing conditions are excluded unless agreed in writing by the insurer. This is a standard market exclusion; however, it is a significant exclusion, and therefore the insurer is required to draw specific attention to it in policy summaries and policy wordings.

B1 Personal accident benefits

The main benefit is a lump sum payable (**capital benefit**) in the event of:

- **Death**.
- **Loss of limbs, eyesight, speech, hearing** – the insured person must prove that the loss is permanent and total. Most insurers require that the loss occurs within an agreed period, i.e. 52 or 104 weeks from the date of the original injury. The lump sum payable is made in addition to any weekly benefit paid up to the time of the loss.
- **Permanent total disablement (PTD)** – permanent disability can be defined as a condition where recovery is not anticipated such as certain brain injuries or paralysis. As above, most insurers require that the PTD occurs within an agreed period, i.e. 52 or 104 weeks of the accident date.
- Permanent injuries that do not necessarily prevent the injured person returning to a relatively normal lifestyle, e.g. loss of digits, can be classed as **permanent partial disablement (PPD)**. Insurers utilise a pre-set scale of benefits known as the **continental scale** to calculate lump sum payments. For instance, the loss of one finger may generate a lump sum of 20% of the agreed lump sum for death and PTD.
- An injury that while serious is unlikely to result in PTD is classed as a **temporary total disablement (TTD)**. A weekly benefit is payable for each week of disability up to an agreed limit, usually 52 or 104 weeks. Most insurers incorporate a franchise before dealing with a claim, usually between 7, 14 or 21 days.
- An injury that results in an insured person being unable to perform a substantial part of their usual job is classed as **temporary partial disablement (TPD)**. These instances cater for those persons that while unable to perform their normal job can still perform some sort of role at work. The usual weekly benefits payable are reduced to an agreed percentage, e.g. 30%, to reflect the fact that the person can still perform certain tasks.

B2 Sickness cover

Illness or sickness cover is usually offered as an extension to the personal accident policy and provides weekly benefits for persons unable to perform any part of their normal job (i.e. TTD). A franchise is almost always applied.

So how does a franchise operate?

Most personal accident and sickness policies can be extended to include such covers as:

- Disappearance – in which the lump sum applicable for death is paid if an insured person disappears for longer than an agreed period, e.g. six months.
- Medical treatment to speed up the period of convalescence (recuperating).
- Hospital benefits to help pay for family travel costs etc. to hospitals, usually £25–£50 per 24-hour period of treatment.

Question 5.2

What is the difference between a benefit policy and a policy of indemnity?

There are standard exclusions under personal accident and sickness policies, for example:

- the insured being under the influence of, or being affected by, alcohol;
- self-inflicted injury or disease;
- childbirth, pregnancy, venereal disease or HIV;
- pre-existing illness or infirmity (unless notified to and cover agreed by the insurer); and
- accidents while participating in motor cycling, racing of any kind (except on foot), winter sports and mountaineering, although some of these can be 'bought back' by payment of an additional premium.

Question 5.3

Using what you have learnt in chapter 3 about franchises, what is the effect of the seven-day franchise commonly found with sickness cover?

B3 Medical expenses

This insurance provides cover for those who seek private medical treatment outside the NHS. This enables them to choose the hospital and consultant used and, in many cases, the timing of the treatment.

Typical in-patient cover includes:

- **hospital charges** incurred in surgery, theatre fees, consultations, nursing and after care costs;
- **specialists' fees** such as specialist consultations and surgeons' fees; and
- **additional costs**. such as ambulance fees.

Medical expenses cover is usually based on the level of benefits selected, and premiums tend to increase with the age of the policyholder.

Exclusions include:

- long-term residential care;
- pre-existing conditions (where treatment has been administered within five years prior to the date of cover commencing).

C Household insurance

Insurance for private houses and their contents is almost always provided by houseowners' or householders' comprehensive policies. These often combine protection for the house and its contents, and cover damage from fire and a large number of other perils which shall be dealt with in this section.

There is no such thing as a 'standard' *household insurance* policy, both cover and wordings vary. Here, we will look briefly at buildings and *contents insurance*.

C1 Buildings insurance

This includes not only the main structure but also garages, sheds, greenhouses, outbuildings, swimming pools, tennis courts, garden paths. Anything you would normally leave behind on moving from the house is part of the building, e.g. double glazing, fitted kitchens etc. The cover generally available is as follows:

- **Fire, lightning, explosion and earthquake**.
- **Riot, civil commotion, strikes, labour or political disturbances, malicious damage or vandalism**. Cover usually excludes loss or damage if the building is unoccupied for more than 30 or 60 days, malicious damage is usually subject to an excess.
- **Storm or flood**. Cover under this heading specifically excludes damage caused by frost, subsidence, ground heave or landslip and damage to fences or hedges, and is usually subject to an excess.
- **Falling trees or branches**. Walls, gates, fences or hedges will be excluded.
- **Escape of water**. This covers the bursting (for example, as a result of freezing) or overflowing of water tanks, apparatus or pipes, and includes any fixed domestic equipment. Cover excludes damage while the building is unfurnished or unoccupied for more than a certain period (30 or 60 days) and an excess is sometimes imposed, although this may be removed subject to an additional premium.
- **Escape of oil**. Damage caused by escape of oil from any fixed oil-fired heating system is covered and an unfurnished/unoccupied exclusion applies (30 or 60 days).
- **Theft or attempted theft**. Cover is usually excluded while the premises are left unfurnished or unoccupied for more than 30 or 60 days. There is no definition or other restriction on the use of the term 'theft', so that insurers cover theft as defined in the **Theft Act 1968**. The Act states that a person is guilty of theft if they dishonestly appropriate property belonging to another with the intention of permanently depriving the owner of it.
- **Impact**. Cover is in respect of impact or collision with aircraft or other aerial devices, or articles dropped therefrom, road vehicles, or animals. There may be an excess imposed

for the insured's or their family's vehicles or animals. Damage caused by pets is usually excluded.

- **Subsidence, ground heave or landslip**. Various exclusions will apply together with a large excess in the region of £1,000.
  - **Subsidence** refers to the downward movement of land on which buildings stand, usually because of changes in the ground's moisture.
  - **Ground heave** is when the ground swells and heaves after the moisture content of the soil increases.
  - **Landslip** is the falling away of land, for example, after prolonged heavy rain.
- **Breakage or collapse of television or radio receiving aerials, aerial fittings and masts**. This covers damage to the building caused by the collapse of the aerials, but not damage to the aerial itself which is usually covered under the contents section.
- **Accidental damage to drains, pipes, cables or underground pipes**. Covers accidental damage to water, oil, gas, sewage and drain pipes, underground telephone, television and electricity cables serving the building.
- **Accidental breakage of glass and sanitary fixtures**. Covers accidental breakage of fixed glass in windows, doors, fanlights and skylights or greenhouses, conservatories and verandas forming part of the building. It also covers accidental breakage of fixed wash basins, cisterns, baths and other sanitary fittings. The unfurnished/unoccupied exclusion applies.
- **Legal fees, architects' and surveyors' fees, cost of debris removal**. Covers **reasonable** legal fees and architects' and surveyors' fees necessarily incurred in the reinstatement of the building following loss or damage. The costs of demolition or shoring up the building and debris removal are also covered. Cover excludes any costs involved in preparing the insured's claim.
- **Loss of rent**. This provides cover in respect of ground rent (amounts payable by a leaseholder to the owner of the freehold) for a maximum period of two years and loss of rent for any part of the premises not occupied by the insured which has become uninhabitable. It also covers the reasonable cost of alternative but similar accommodation while the premises are uninhabitable as a result of an insured peril. A limit of 10%–15% of the buildings sum insured applies.
- **Accidental damage** Usually as an optional extension (this would include, for example, damage caused by putting your foot through the floor of the loft into the bedroom below, or damage caused during DIY such as putting a nail through a water pipe).

C2 Contents insurance

This generally means insurance for household goods and personal effects of every description, belonging to the insured or a family member living in the property. It includes cash and stamps (not part of a collection) up to £50–£100, and any fixtures and fittings belonging to the insured. The risks covered are essentially the same as for the buildings cover but with the following differences:

- theft, or attempted theft, of cash, currency, bank notes and stamps may be excluded; if it does not involve forcible and violent entry or exit;
- theft, or attempted theft, while the building is lent, let or sub-let in whole or in part may be excluded if it does not involve forcible and violent entry or exit;
- accidental damage cover: certain contents are excluded, e.g. clothing, money and stamps, plants.

There are usually limits on single articles of value (e.g. 5% of total sum insured) and a valuable limit (e.g. one-third of total sum insured). Valuable items, usually those in excess of £5,000, are generally specified under the policy.

The following extensions to cover are usually included automatically:

- **Temporary removal**. The policy is automatically extended to cover the contents while temporarily removed but remaining in the British Isles. However, the risk of storm and flood as regards property in transit or on the person is excluded. Theft is only covered:
  - at any bank, safe deposit or occupied private dwelling;
  - in any building where the insured or a family member is residing, or is employed or carries on business;
  - in the course of removal to or from any bank or safe deposit while in the insured's or the insured's family charge.
- **Clothing and personal goods of domestic employees**. Cash, currency notes, banknotes and stamps are excluded.
- **Accidental breakage of mirrors and glass or furniture**.
- **Loss of rent**. Cover is extended to include loss of rent and reasonable additional expenses incurred for alternative accommodation in the event of the premises becoming uninhabitable. Cover is usually limited to, say, 10%–20% of the contents sum insured.

Question 5.4

Why would certain risks (theft, malicious damage, escape of water/oil) be excluded if the property is left unoccupied?

Other extensions can be included for additional premium, e.g.:

- accidental damage to entertainment equipment;
- accidental damage while in the course of removal;
- cost of replacing door locks after theft of keys etc.

Typical exclusions may be as follows:

- property more specifically insured elsewhere;
- medals and coins, unless specifically insured;
- motor vehicles;
- livestock (other than horses).

All household policies also cover legal liability for accidental injury or accidental damage to material property, usually with a limit of at least £1m per claim (although increasingly insurers offer higher limits as standard) as part of the basic cover:

- Buildings: liability on owner and liability incurred under the **Defective Premises Act 1972** for faults in property formerly owned or occupied by the insured.
- Contents: liability incurred by the insured as occupier of the property, and at other premises used for temporary holiday accommodation. There will also be personal liability cover here for an insured while away from their premises.

Consider this…

What extensions in cover do you think can be added to a household policy?

C3 Optional extensions

The most common extensions apart from those already discussed in relation to the specific sections of buildings and contents are as follows:

C3A 'All risks'

Such cover is available for personal possessions regularly taken outside the property. Usually such cover is only available in conjunction with contents cover. Most insurers include a separate sum insured for unspecified and specified items.

Unspecified items

This covers items while away from the insured address. The definition of unspecified items may be very wide (for example, covering clothing, personal effects and valuables) or may be more restrictive (for example, some insurers may require a separate item for clothing).

Certain types of property are not insurable under this extension as:

- individual terms may need to be applied (for example, contact lenses);
- separate insurance is available (for example, motor vehicles); or
- insurers are not prepared to provide automatic cover (for example, documents).

The single article limit can vary from, say, between £100 and £1,000.

Specified items
Specified items are those which exceed the unspecified single article limit or those to which special terms apply. Examples are jewellery, furs and photographic equipment. The sum insured should represent the replacement value. Specific exclusions are:

- wear and tear etc.;
- insects or vermin;
- corrosion, rot, mildew, fungus or atmospheric conditions;
- any process of heating, dyeing, alteration or repair;
- scratching, denting, breakdown, faulty workmanship/materials;
- deeds, bonds, documents etc.

C3B Money and credit cards

The money extension provides a form of 'all risks' cover much wider than that included under the contents section. Cover relates to accidental loss of money. 'Money' usually covers cash, cheques, postal orders, bankers' drafts and postage stamps/certificates, premium bonds, lunch vouchers, gift vouchers, pre-loaded cash cards, phone cards and travel tickets. A limit of indemnity of between £200–£300 applies, with an excess often around £50. Specific exclusions may apply, including:

- shortages due to error/omission;
- losses not reported to the police within 24 hours.

The credit card extension provides cover in respect of financial loss following loss or theft of a card and its subsequent misuse. Credit cards usually include debit and cash cards as well as credit cards.

Some insurers offer additional services to the basic cover, such as emergency cash and a card registration scheme. A limit of liability, typically £500, applies.

Specific exclusions apply, including:

- unauthorised use of the credit card by one of the insured's household;
- breach of the issuer's terms and conditions.

C3C Bicycles

Cover is for pedal cycles and accessories on an 'all risks' basis. There may be a separate sum insured per cycle or, more usually, a limit per cycle of between £100 and £500 for all cycles owned by the insured or family members. An excess of, say, £25–£50 is typical.

Specific exclusions are as follows:

- loss or damage to parts or accessories;
- use for racing, pacemaking or trials;
- theft while unattended, unless secured.

C3D Freezer contents

Cover is in respect of deterioration of freezer contents due to a change in temperature or contamination as a result of accidental escape of refrigerant or refrigerant fumes. Some insurers set a limit of indemnity of, say, £1,000.

Examples of specific exclusions are as follows:

- fire, lightning or explosion damage (as such cover is provided by the basic policy);
- deliberate restriction of supply by the supplying authority;
- wilful or deliberate act of the insured, such as turning off the supply at the mains;
- damage after the freezer has reached, say, 15 years.

C3E Caravans

Most insurers provide cover under three sections:

- **Caravan and equipment**. Cover is in respect of 'all risks' of accidental loss of or damage to the caravan, its fixtures and fittings.
- **Clothing and personal effects**. This provides 'all risks' cover while the property is in the caravan, awning or towing vehicle.
- **Liability**. This covers legal liability for bodily injury or damage to property caused by or in connection with the caravan up to a limit of indemnity of, say, £1m.

Specific exclusions which may apply are as follows:

- the 'all risks' exclusions, such as wear and tear;
- theft while left unattended, unless closed and locked;
- hire or reward;
- business use;
- storm or flood damage to an awning.

C3F Small craft

Although definitions vary, small craft are defined as vessels not exceeding 23 feet (7 metres) overall and with design speeds not exceeding 17 knots (20mph). Cover is usually provided under four sections, namely:

- accidental loss or damage to craft, machinery and equipment;
- personal effects;
- salvage charges;
- liability to third parties and passengers: with a limit of indemnity of, say, £1m.

Cover may be excluded in respect of:

- use for hire or reward, or business purposes;
- liability for injury to employees;
- theft of outboard motors, gear and equipment, subject to security.

C3G Sports equipment

Cover is for accidental loss of or damage to sports equipment and specialist sports clothing owned by any member of the insured household. Cover usually applies anywhere in the British Isles and for a limited period (say, 60 days) worldwide in any one period of insurance.

Specific exclusions are as follows:

- motor vehicles, trailers, caravans, boats etc.;
- damage while the equipment is in use;
- living creatures;
- non-specialist sports clothing;
- pedal cycles;
- golf balls;
- camping equipment;
- equipment for certain hazardous pursuits: such as parachuting and mountaineering.

C3H Personal accident, hospital cash benefit and creditor insurance

Cover is available against the risk of personal accident and/or sickness, redundancy or unemployment for the insured and their family. Cover is also available against the inability to continue credit instalment payments in the event of redundancy or unemployment (limited to, say, 24 months, excluding the first month of any period).

C3I Domestic animals

Cover is available for horses, ponies, domestic cats and dogs. Please see below for a more detailed breakdown:

- **Horses and ponies**. Cover includes death from accident, sickness or disease, economic slaughter and loss by theft or straying. Cover may also include temporary incapacity, veterinary fees, saddles, bridles or other riding tack, third party liability, personal accident to the rider and accidental damage to the horsebox trailer.
- **Cats and dogs**. Cover includes veterinary fees, accidental death, death from illness, loss by theft, kennel fees while the owner is hospitalised, advertising and reward, third party liability and holiday cancellation following emergency surgery to the pet.

C3J Legal expenses

The legal expenses extension provides cover for the following costs:

- **Recovery costs**: for legal action taken to enforce the legal rights of the insured against third parties.
- **Civil defence costs**: for the defence of certain types of civil claims not covered by other forms of insurance.
- **Prosecution defence costs**: for the defence of certain criminal charges which may arise from unwitting acts of the insured.
- **Employment dispute costs**.

The limit of liability is usually up to £50,000 for incurred costs and expenses.

Specific exclusions are as follows:

- claims relating to events occurring outside the UK, the Channel Islands and the Isle of Man;
- appeals;
- costs and expenses not agreed by the insurer;
- claims arising out of the insured's business, deliberate or criminal act or omission, libel and slander, divorce or matrimonial matters and disputes between landlord and tenant.

It is important here to distinguish between legal expenses as a section of cover offered under most household insurance policies, and add-ons which are often cross-sold to customers at point of sale when obtaining cover for other classes of insurance (e.g. private motor).

C3K Flood Re

Across the UK one in six homes is considered to be at significant risk of flooding. In 2008, following extensive flooding across the UK in the summer of 2007, insurers subscribed to the **ABI Revised Statement of Principles on the Provision of Flood Insurance**, which was agreed with the Government.

This agreement was due to end in June 2013; however, it was extended until a new pool could be set up to cover the cost of flood insurance for homes.

Following the **Water Act 2014** and the **Flood Re Reinsurance (Scheme and Scheme Administrator Designation) Regulations 2015**, Flood Re was created as a non-profit fund, similar to Pool Re which was set up for terrorism following IRA bombings in the 1990s.

Flood Re is a reinsurance company owned and managed by insurers, funded by levies on member insurers. The total annual levy is £180 million and the individual insurer levy is based on the insurer's share of the home insurance market. The cost of this levy is passed on to home insurance policyholders with those at the highest risk of flood contributing the most. To ensure affordability, the individual cost that a high-risk policyholder will pay is based on the council tax band for their property, and the charges per council tax band are set out in legislation. The aim is to ensure that properties at significant risk of flood can still benefit from access to affordable flood cover without punitive excesses and/or barriers to indemnity.

Consider this…
Take a moment to think about the frequency of storm and flood events, even in the last five years.

Properties affected by such events will need affordable insurance cover, if not by the policyholder, then almost certainly as a contractual requirement of any mortgages or loans secured against them.

Flood Re only covers eligible residential properties, mainly homes. It will **not** cover:

- businesses (including SMEs); or
- properties built after 1 January 2009.

Flood Re has been set up to cover the vast majority of flood claims. If the pool is impacted by significant flood events, the Government will step in as insurer of last resort. As with Pool Re, the Government will only cover the cost initially; any monies paid will be recovered from the pool over future years. The scheme is due to run until 2039.

The restriction in the availability of Flood Re has seen some individuals in the market change residential lease agreements to make them eligible to access Flood Re via members. It has also led to several specialist insurers and managing general agents (MGAs) marketing policies specifically designed to cover the level of excess that can now be levied on proposers not eligible for Flood Re. These excesses are the level of risk customers retain themselves and can be tens or even hundreds of thousands of pounds. In some instances, they take the form of co-insurance, where the customer bears a proportion of any one loss as their excess, subject to a monetary minimum (e.g. 10% of any loss, or £10,000, whichever is the greater amount).

On the Web
You can view Flood Re's website at: *www.floodre.co.uk/industry/*.

D Travel insurance

Many people may require cover for personal accident, sickness and other related expenses during specific periods, sometimes when they are particularly at risk. A good example of this is when people go travelling. Insurers, therefore, often provide policies to compensate for these losses and specialist *travel insurance* policies have developed.

Consider this…
What risks can you think of associated with travelling?

Most travel policies cover the following:

- Personal accident benefits: usually £10,000–£25,000 for death, loss of eyes/limbs, or permanent total disablement. Hazardous activities are excluded but can be included at an additional premium.
- Medical and associated expenses: usually up to £1m.
- Loss of deposits, i.e. if the holiday is cancelled due to necessary and unavoidable holiday cancellation.
- Baggage, personal effects and money.
- Personal liability.
- Delayed baggage.
- Hospital cash benefits.
- Travel interruption.
- Travel delay.

In addition to the 'standard' cover, the following optional extensions are usually available:

- Failure of tour organiser.
- Lack of services or amenities.
- Loss of passport.
- Legal expenses.

There are general exclusions, such as pregnancy and childbirth, physical or mental disability, suicide, confiscated luggage and damage to fragile objects.

E Extended warranties

This insurance applies to buyers of mechanical and electrical goods. Normally, when you buy something like a new car or television, it comes with a warranty, which is a guarantee that provides for free repairs if the item needs repairing within a certain period of time. The insurance extends this period.

Example 5.1
You purchase a new washing machine, it is probable that the manufacturer will provide a guarantee (or warranty), which will usually last for twelve months. It is very likely that you will be offered an extended warranty policy at the time of purchase to extend this period for two, three, or even five years.

These policies, issued by insurers and some large authorised retailers, cover free repairs following electrical and mechanical defects.

Policies are also available to cover all of an insured's electrical products. There is usually a condition that the repairs must be carried out by the supplier. A typical sum insured is approximately £2,500.

The following exclusions apply to an extended warranty policy:

- Negligent handling and/or failure to comply with manufacturers' instructions.
- Risks normally covered by a household contents policy.
- War etc.
- Cost of repairs to bulbs, aerials, external wires, knobs, handles, driving belts, etc.

The same considerations under the Consumer Rights Act 2015 apply here, as those referenced in *Legal expenses* on page 5/14.

Key points

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

Motor insurance

- Private motor insurance is the most significant compulsory insurance in the UK.
- There are four different levels of cover available:
  - Road Traffic Act (RTA) only;
  - third party only;
  - third party, fire and theft;
  - comprehensive.
- Road Traffic Act only is the minimum cover required to comply with the Road Traffic Act 1988 and provides for unlimited indemnity in respect of bodily injury or death to third parties, a £1.2m limit for loss of or damage to third party property, claimants' costs and expenses, and emergency medical treatment and hospital charges arising out of the vehicle use.
- Comprehensive or fully comprehensive is the widest possible protection and includes other accidental and malicious damage to the insured vehicle.
- Cover is subject to the driver having a licence to drive the vehicle, or having had a licence and not being disqualified from holding one.
- The same levels of cover are available for private motor cycle insurance with some small differences:
  - no cover for theft of accessories or spare parts unless the cycle is also stolen;
  - the liability section generally only indemnifies the insured in respect of death and/or bodily injury to third parties, including pillion passengers;
  - no personal accident, medical expenses or personal effects cover.
- The commercial vehicles class of business is a type of commercial insurance as opposed to a personal insurance and includes:
  - goods-carrying vehicles;
  - carriage of passengers for hire and reward;
  - passenger-carrying vehicles;
  - agricultural and forestry vehicles;
  - vehicles of special construction or 'special types'.
- The cover provided does not include damage to goods carried in the vehicle as this is covered by a goods in transit policy.
- The range of cover is the same as in private motor insurance with variations in respect of the exclusion of certain benefits such as:
  - driving other cars extension;
  - personal accident;
  - personal effects cover.

Health insurance

- Health insurance can be broken down as follows:
  - Personal accident, which provides payments in the event of accidental death or bodily injury.
  - Sickness, which provides payment for disablement due to sickness.
  - Medical expenses, which provides cover for individuals who seek medical treatment outside the NHS when they are ill.
- A personal accident and sickness policy is a benefit policy and the benefit is a lump sum payable (capital benefit).
- Illness or sickness cover is usually offered as an extension to the personal accident policy and provides weekly benefits.

Key points

- Medical expenses cover is usually based on the level of benefits selected, and premiums tend to increase with the age of the policyholder.

Household insurance

- Household insurance for private houses and their contents and covers damage from fire and a large number of other perils.
- In addition to the main structure, buildings insurance includes garages, sheds, greenhouses, outbuildings, swimming pools, tennis courts, garden paths.
- Contents insurance generally means household goods and personal effects of every description, belonging to the insured or a family member living in the property.
- All household policies also cover legal liability for accidental injury or accidental damage to material property.
- There are several optional extensions available ranging from all risks cover for personal possessions regularly taken outside the property to caravans and pedal cycles.

Travel insurance

- Most travel policies provide a schedule of benefits ranging from personal accident benefits and medical expenses through to delayed baggage and travel delay. There are general exclusions, such as pregnancy and childbirth, physical or mental disability, suicide, confiscated luggage, damage to fragile objects.

Extended warranties

- Extended warranty insurance extends the period of guarantee that provides for free repairs that comes with the purchase of mechanical and electrical goods and the policy cover provides for free repairs following electrical and mechanical defects. There is usually a condition that the repairs must be carried out by the supplier.

Question answers

5.1 With RTA cover, he would be covered for damage to the wall (up to £1,200,000) and any emergency treatment fees he incurred as a result of being attended to after the accident. Note this would only be emergency fees and not medical costs.

With third party fire and theft cover, it would be as above and including third party property damage to the wall (up to £20,000,000).

With a comprehensive policy with common extensions, he would be insured for the damage to the car (excluding costs of the damage to the tyre, which is specifically excluded), the wall, any personal effects that were lost or damaged, treatment fees, some medical costs, and he would probably receive a payment under the personal accident section of the policy.

5.2 An indemnity policy places an insured in the same financial position after a loss as they were in before, i.e. a measurable financial loss must have occurred. A benefit policy pays a pre-defined benefit whether or not a financial loss actually occurred.

5.3 With a seven-day franchise, if an insured was sick for less than seven days, nothing would be payable under the policy, while once the seven days is exceeded, the claim would be paid in full, including the initial seven days.

5.4 Because these risks increase to a significant extent when premises are left unoccupied. Unoccupied premises are often prone to break-ins as they are an easier target, and damage caused by escaping water can become more severe as it would be undiscovered for a longer period. Because of this insurers exclude it, though arrangements can sometimes be made to 'buy back' the cover, usually subject to some restriction.

Self-test questions

1. What is the minimum motor insurance cover required to comply with the Road Traffic Act 1988, and what is the scope of this cover?

2. What exclusions apply to a comprehensive motor policy?

3. Under a motor cycle policy, when will there be cover for the theft of accessories or spare parts?

4. What is meant by saying that a personal accident and sickness policy is a benefit policy?

5. What basic cover is provided by private medical insurance?

6. How are 'buildings' defined in a typical household policy?

7. What are the basic sections of cover provided by travel insurance?

8. What optional extensions are usually available under a travel policy?

9. What standard policy cover is offered by an extended warranty insurance?

You will find the answers at the back of the book

6

Insurance products: commercial insurances

Contents	Syllabus learning outcomes
Introduction	
A Property insurance	*6.1*, *8.2*
B Pecuniary insurance	*6.1*, *8.3*
C Liability insurance	*6.1*, *8.4*
D Cyber insurance	*6.1*
Key points	
Question answers	
Self-test questions	

Learning objectives

After studying this chapter, you should be able to:

- describe the basic features and typical policy cover of the insurance types detailed; and
- explain the underwriting approach and considerations for various classes of insurance.

Introduction

So far we have looked at some of the common insurance products that are taken out by individuals. This chapter considers the kinds of insurances that a business would take out.

Key terms

This chapter features explanations of the following ideas:

'All risks' insurance	Material damage proviso	Special perils	Standard exclusions

A Property insurance

A1 Fire and special perils insurance

Fire insurance developed alongside the need for businesses to insure their assets. Initially the need for insurance was seen as very straightforward, to insure property against damage or destruction by fire.

Question 6.1

Why would a business want to take out insurance? List five things that they might want to insure.

The insurance market sees the 'Standard Fire Policy' (the ABI recommended wording) as the basis for its wordings although individual insurers have since issued their own plain English versions which provide standard fire cover, and then 'extra' perils (known as special perils or in some insurers' policies as specified contingencies) can be added. It is now common to issue policies covering **fire** and **special perils** as standard.

So what is **'standard' fire cover**? Standard fire cover is made up of three parts:

- fire (excluding explosion resulting from fire, earthquake or subterranean fire, and its own spontaneous fermentation or heating);
- lightning; and
- explosion (restricted to explosion of boilers or gas used for domestic purposes only).

Be aware

'Domestic' can still apply to industrial and commercial premises, as it relates to the use of the boiler. For example, heating the property or where gas is used in a canteen.

The special perils that may be included are as follows, each is preceded by 'damage caused to the property by' and can be added individually or in combinations. The usual practice nowadays is for all perils to be covered:

- Explosion. Namely those emanating from chemical reactions, producing suddenly expanding gases. Exclusions apply where damage is caused by the bursting of a boiler or other equipment that belongs to or is under the control of the policyholder where the internal pressure is due to steam only (these are items insurable under an engineering explosion policy).
- Aircraft (excluding sonic bang), i.e. an aircraft or aircraft parts falling through the roof of a building.
- Riot and civil commotion. The **Public Order Act 1986** defines a riot as a group of twelve or more people, gathered for and carrying out a common purpose with intent, and force if necessary, and in such a way as to alarm a person of reasonable firmness and courage. This will only usually cover riots in England, Scotland and Wales, as the Government has a separate scheme in place for Northern Ireland. Insurers apply a condition that riot claims are notified to insurers within an agreed period, normally seven days. This is because insurers can claim damages from the local police authority for damage incurred as a result of riot activity, and this needs to be lodged with the police within 42 days.

Following the riots in the UK in August 2011, the **Riot Compensation Act 2016** (which replaces the **Riot Damages Act 1886**) and the **Riot Compensation Regulations 2017**, which both came into force on 6 April 2017, limit what can be recovered from the police. The Act:

– applies a £1 million limit for any one claim;
– will not apply to any consequential loss;
– confirms the time period for bringing a claim against the police as 42 days;
– allows a further 90 days to submit full claims details;
– provides limited cover for motor vehicles and trailers; and
– permits replacement goods and property (with some exclusions) on a new-for-old basis.

Be aware
Most insurance policies do not limit what is covered in respect of riot or civil commotion, either under the material damage or business interruption sections, and provide cover up to the sum insured, set by the insured, subject to compliance with policy terms, conditions and exclusions (e.g. notification within a specified timescale). **Recovery by insurers and uninsured claimants from the police** is what is limited under the Act and Regulations.

- Malicious damage, i.e. vandalism.
- Earthquake. You will recall that in some countries ‘earthquake‘ is classed as a fundamental risk due to the frequency and severity of earthquake incidents. UK insurers are prepared to accept the risk of earthquake damage due to the minimal earthquake activity in this country. This is still the case despite several larger, albeit localised, earthquakes over the last few years, as the damage has been manageable and not excessive.
- Subterranean fire – otherwise known as underground fire. Particularly important if you live in an area with former mining activity.
- Spontaneous fermentation or heating.
- Storm and flood. These two perils are usually written together as quite often storm is the proximate cause of flood. An insurer is unlikely to offer flood in isolation and terms are applied to both perils to avoid ambiguity in respect of claims settlement. Property which is vulnerable to such losses is usually excluded, e.g. gates and fences, as are changes in the water table level.
- Escape of water (commonly referred to as ‘burst pipes’ cover). Some package policies may also make reference to escape of heating oil.
- Impact (including own vehicles).
- Sprinkler leakage – offered to companies with sprinkler fire protection in their premises provided the systems are maintained.
- Subsidence, ground heave and landslip (with special exclusions). Certain geographical locations in the UK are prone to subsidence-related damage due to the soil type in the area. Clay soils are also of particular concern, as is surrounding vegetation, and insurers will also be interested in local mining activity, both past and present. Although excluded under some insurers’ definitions of ‘special perils’, sinkholes may also be covered under some policies, as they are normally found under personal lines household policies. In fact, some insurers will pay for costs where there is no damage to property (yet), to avoid possible future damage if something like a sinkhole is left untouched.

A1A Standard exclusions

Certain causes of damage are excluded. Some of these are because they are regarded as fundamental risks (war, riot, radiation, pollution), and others because they are more properly insured under other types of commercial insurance policy (marine, consequential losses).

The main *exclusions* are as follows:

- War risks.
- Radioactive contamination/explosive nuclear assemblies.
- Terrorism – although a 'buy-back' will be available for political acts of terrorism, usually reinsured by member insurers with Pool Re. Some insurers do not exclude religious and ideological acts by deliberately omitting them from the terrorism definition; these are usually insurers offering capacity within the Lloyd's Market, which is not backed by Pool Re, and often carries individual location and policy annual aggregate limits. Most insurers' policies will respond to 'gap cover'; this is where a 'terrorist-type' incident occurs, but does not meet the definitions of terrorism under an insurer's policy. (This is sometimes referred to as 'lone wolf' cover.)
- Northern Ireland excluded perils.
- Pollution or contamination unless caused by an insured peril or it causes an insured peril to occur.
- Marine policies.
- 'More specifically insured' clauses. For example, a motor vehicle left in a building overnight that is lost to fire would usually be covered in its own right under a private car motor policy.
- 'Consequential loss' exclusion. For example, loss of profits or income following and consequent upon a loss proximately caused by an insured peril.
- Sonic bangs.
- Cyber risks which exclude damage resulting from risks such as computer viruses etc.

Although we have said that these insured and excluded perils are generally standard, you should be aware that the exact wording does differ slightly between the general company market and the Lloyd's Market.

A2 'All risks' insurance

While the standard fire policy lists what is and is not insured, demand arose for a policy which offered cover for accidental damage as well as the standard perils. **All risks** insurance developed in response to this, although the name 'all risks' is slightly misleading as it does not cover everything, it simply covers everything that is not specifically excluded.

It was realised generally that uncertainty of loss is not restricted to events brought about by fire and special perils, nor limited to events occurring on or about the insured's premises. The ABI has a recommended wording adding special perils to a basic fire policy and then adding the 'all risks' element, with its exclusions. Therefore, some exclusions can be restricted to only the extra 'accidental damage' cover, leaving the named perils intact.

In essence, all loss, destruction of or damage to the property insured is recoverable as long as it has occurred accidentally in respect of the insured, and the cause is not specifically excluded. There are no optional extensions: everything is covered, unless specifically excluded.

Exclusions can be divided into four groups:

- **Absolute exclusions**: war, pollution, contamination, consequential loss.
- **Gradually operating exclusions**: for example, corrosion/rust, wind/rain damage to property in the open.
- **Aspects of cover which can be written into the policy**: for example, money, glass, subsidence.
- **Property or risks more appropriate to another class of business**: for example, motor vehicles, aircraft.

A3 Theft insurance

While damage to property caused by fire was one of the earliest obvious causes of loss, other people stealing it, or damaging property while trying to steal it, followed close behind, so *theft insurance* developed in response to this need.

It is however very important to note that 'theft' has a very specific meaning in insurance terms and it is important to differentiate this from the strict legal definition.

The **Theft Act 1968** states that a person is guilty of theft if they:

> dishonestly appropriate property belonging to another with the intention of permanently depriving the other of it

Insurers include a phrase that it must include force and violence either in breaking in or out of the insured premises. Effectively, this means that a loss not involving a 'break in' would not usually be covered. For example, if a thief walks in to a building which has been left unlocked and steals something, it would not usually be insured. This removes cover for entry by a key, a trick or concealment on the premises while open, and leaving without forcible exit. If a key were obtained by threat or force, cover would usually apply.

Common extensions are as follows:

- breakage of glass (if not insured specifically elsewhere);
- replacement of locks, if the keys are lost/misplaced etc. – insurers would rather pay for an insured to replace the locks in the building than a large theft claim;
- temporary removal – covers theft damage while chattels (personal possessions) are being cleaned, restored, repaired etc. while temporarily away from the premises;
- index-linking (with premium adjustment at the end of the policy period); and
- extended or full theft, i.e. the 'forcible and violent entry' phrase is deleted – this is often requested when items of plant or stock are kept in the open overnight.

Question 6.2

What type of commercial risks can you think of that would require cover for full theft while kept in the open?

Exclusions are as follows:

- collusion, e.g. plotting and agreement between the thief and employee(s): this can be included, subject to underwriting and additional premium;
- fire and explosion;
- cash, bank notes etc. (this should be covered under a money policy); and
- livestock.

Cover for smaller risks is usually subject to compliance with an intruder alarm warranty and a minimum standard of security warranty.

Theft cover is usually priced using the theft estimated maximum loss (EML) as a rating factor, as more often than not a 100% loss is not expected. An EML is the amount (often expressed as a percentage of the sum insured) which is considered by the insurer to be an accurate reflection of the worst financial effect that the maximum foreseeable loss would have.

Consider this…

Why is the EML usually less than the sum insured in respect of theft?

Think about a large warehouse storing television and electrical equipment, all with a very high value. In practice, it would be very difficult, if not impossible, to steal everything so thieves would be selective in what they take. It would be very unlikely that all the contents would be lost at one time.

Reinforce

Remind yourself of how a first loss policy operates.

This is the sort of assumption you could make about a 'targeted' theft; another factor with an 'opportunist' theft is the lack of preparation and corresponding lack of time to coordinate what is and is not taken. In both examples, it is unlikely that all goods will be stolen.

You should note that underwriters generally apply different levels of rating for the type of goods at risk. For instance, thieves are fairly unlikely to steal office desks, paper, cleaning equipment and other general contents, especially if theft attractive 'target' items such as

office electrical equipment, computer equipment, wines, spirits, electrical stock, jewellery etc. are present. Underwriters would therefore tend to cover general contents at a reduced rate in comparison to 'target' goods.

A4 Glass insurance

Glass would usually be insured against damage caused by a fire or theft if a fire or theft policy were in place. However, some common causes of damage to glass (accidental damage) are excluded from these standard covers, so a business with large amounts of glass will often want cover for this. An example would be a high street shop as large plate glass windows can be extremely expensive.

The standard policy covers destruction or damage to all fixed glass, including windows, doors, fanlights, showcases, mirrored glass and glazed partitions, and usually includes an extension to provide for the cost of boarding up damaged glass until replacement can be effected. If damage happens overnight the costs of this can be quite high. Often the police will call a 24-hour glazier to board up windows to prevent further loss or damage.

Cover is 'all risks' but scratching or chipping is usually excluded. It may be extended, for additional premium, to include damage to storefront contents because of broken glazing, and damage to washbasins and sanitary fittings in hairdressing salons.

Damage by fire, lightning and explosion is generally excluded (these perils are covered under a standard fire policy). An excess, e.g. £50, is standard to avoid the small claims, although most insurers are now moving towards an excess of £250.

A5 Money

Think about how many businesses operate, especially retail shops. They sell goods for cash and often have large amounts of cash and cheques on the premises. Clearly there is a risk to this money, both while on the premises, and while in transit. As a result, many businesses will want to take out special insurance to protect against loss of money.

Insurers in their policy wording will refer to the negotiability of money, i.e. the ease with which it can be converted to cash.

Money, which is non-negotiable, is difficult to convert into a cash value and, therefore, insurers offer cover at a relatively high limit, e.g. crossed cheques. Limits of £250,000 or even £500,000 are not uncommon.

Negotiable items are readily convertible to their cash value, e.g. bank or currency notes. For these items the limits of liability are more modest and will depend upon locality and time, e.g. 'in safe', 'out of safe on the premises', 'in transit' and 'during or out of business hours'.

Question 6.3

Can you think of some other items which are non-negotiable and some which are negotiable?

In respect of negotiable items the following limits will be specified in the policy schedule:

- Any other money limit. This is the limit to money while in the premises when open for business and while in transit. In respect of money in transit insurers may stipulate an **escort warranty** where, depending upon the amount of money being carried, a specified number of able-bodied people may need to be present. Limits rarely exceed £10,000 and could be as low as £1,000 for smaller risks.
- Money in safe. Insurers will often require a security safe to be installed if the 'money' at risk exceeds certain limits. Safes are manufactured and tested to achieve a cash rating, i.e. an amount for which the safe is suitable to secure, this can range from £1,000 to £100,000 plus. It is often the job of the risk surveyor to determine whether a safe is required or assess whether an existing safe is suitable.
- In the insured's premises out of working hours. Up to, say, £250.
- The private residence of a director or employee. Nominal – up to £250.

A policy covers risks of loss or damage to or destruction of money on an all risks basis, and includes damage to safes or strong rooms caused by theft or attempted theft.

It can be extended to include:

- personal accident/assault; and
- credit cards (which are not covered by a standard money policy).

The principal specific exclusions are as follows.

Loss due to:

- error or omissions in accounting and book-keeping;
- dishonesty of an employee, not discovered within seven days;
- damage arising outside the UK, Isle of Man or the Channel Islands;
- a safe/strong room being opened by a key left on the premises while closed for business.

B Pecuniary insurance

So far we have dealt with losses that affect business by causing loss or damage to property belonging to the policyholder. But when running a business there are other financial losses that can be insured against. Because the loss here involves direct financial loss it is known as *pecuniary insurance*.

Consider this…
Bob owns a factory that makes furniture. He has a fire and theft policy covering the contents (machinery, stock, office materials, computers etc.) of his factory. One night there is a serious fire. Can you think what other losses Bob might incur?

In the event of serious damage he would be insured for the replacement costs of the contents. But his workforce will turn up for work the next day, and he will still be obliged to pay them for a certain period even though they can't work. He may have loans from the bank and will have to continue to pay interest. There may be a range of other financial obligations that he has to meet even though he cannot produce any more furniture and is, therefore, not selling anything and losing income.

This is the function of business interruption insurance (also sometimes known as BI or loss of profits insurance).

B1 Business interruption insurance

This covers the actual or potential loss of earnings and additional expenses incurred as a result of a material loss covered under property insurance.

Consider this…
Why would business interruption insurance be required?

It is important to note that property insurance only covers material loss following damage or destruction; however:

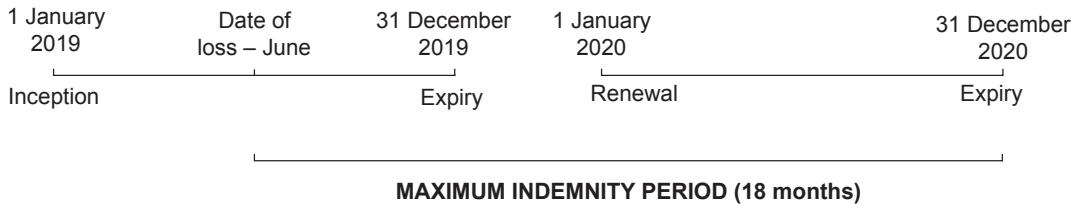
- earnings may reduce or cease following property damage;
- certain overheads will still need to be paid at their full level;
- there may be certain increases in costs incurred in order to keep the business operating.

These are covered by business interruption insurance (BI), as well as accountants' charges incurred in presenting the claim.

In assessing the need for business interruption insurance it is necessary to estimate the maximum time the income of the business could be affected as a result of damage caused by, for example, fire. This period is known as the **indemnity period**.

A maximum indemnity period is then chosen by the insured (this could be 12 months, or even 36 months). It is important that due consideration is given to this period, as it is not always obvious to see the ways in which a business could be affected as a result of a fire. The maximum indemnity period is the longest period over which the business interruption cover will support the business.

A maximum indemnity period may exceed the policy period, as below:



For example, take Bob's furniture factory. Although it may be possible to replace his machinery in a relatively short time (assuming they are not complicated machines with a long production time) and get back to production fairly quickly, what happens if Bob's main customer can't wait for him to get back in to business and has started ordering from an alternative supplier? It may take Bob time and some clever marketing to get that customer back. All this is a loss of income directly related to the fire, but it would only be insured if the indemnity period were sufficient to include that period of loss.

Cover will begin with the occurrence and end not later than the maximum indemnity period chosen. Cover is obviously restricted to the time the business was actually affected.

Policies are based on a sum insured representing the **gross profit** for the indemnity period chosen.

Gross profit is calculated as follows: turnover (with adjustment for opening stock and closing stock) less uninsured working expenses.

Gross profit

Gross profit = (Turnover + Closing stock) – (Opening stock + Uninsured working expenses).

Uninsured working expenses are those costs which vary in direct proportion to the level of turnover. These would include electricity, raw materials and such like.

The payroll element is usually insured in full, although a lower rate may be applied to this element.

The main items insured under a business interruption policy are:

- loss of gross profit;
- increased cost of working (ICOW) incurred in order to reduce the loss of gross profit following the insured event. Such costs should be 'economic' and be less than the amount of the gross profit saved.

From these will be deducted savings made during the indemnity period.

There will usually be a *material damage proviso*, requiring a property policy covering the physical damage for the incident, before the business interruption policy comes into operation. In practice, the two policies will usually be linked.

Consider this…

Why do you think insurers would insist on a material damage proviso?

Unless there is an insurance policy in force covering damage to the property there is a good possibility that this damage will not be repaired quickly and the interruption to the business will be longer. So any claim under the BI policy would be likely to be much higher.

The most common policies are business interruption arising from:

- **Fire and special perils**: the standard perils are extended to include non-domestic boilers. The special perils also contains six engineering special perils not covered by the material damage policy (although the material risk will need to be covered by an engineering policy because of the material damage warranty).
- **'All risks'**: insurers often issue a combined material damage and business interruption policy. As in property insurance this is not all risks, it covers any risk that is not specifically excluded.

- **Engineering**: the perils covered are usually either:
  - failure of the public utilities supply; or
  - sudden and unforeseen damage from any accidental cause not specifically excluded.

B1A Optional extensions

There are certain optional extensions. The cover will be the same, or sometimes a lesser range of perils, as at the insured premises. For example:

- **Specified suppliers**. Provides an indemnity to the insured if the supplier suffers a serious loss and cannot supply the insured's goods. Clearly, the insured will be unable to produce the finished item if the raw material is unavailable. This can expose the insurer to potentially heavy losses especially when the item supplied is specialist in its nature with no readily available alternative market. Insurers often require surveys of the supplier's premises if the exposure is particularly large. This can cause problems if the supplier is located in a foreign country.
- **Unspecified suppliers**. As above, however included under most business interruption wordings and providing a pre-set limit, i.e. 10% of the gross profit sum insured, for loss of profit as a result of a loss at a supplier's premises which has a subsequent negative effect on the insured's profits.
- **Specified customers**. Similar to above except the loss has to occur at a customer's premises, preventing them purchasing the insured's goods.
- **Transit**.
- **Prevention of access**. Customers being unable to access the insured's premises following damage to premises within the vicinity of their own could lead to loss of profits.
- **Public utilities**. Failure of gas, electricity or water to the insured's premises thereby affecting production and subsequent profit.
- **Notifiable disease/murder/suicide**. This extension provides for loss following the occurrence of one of these events and thereby prevents the insured from conducting their business activities at their premises. Increasingly insurers are being asked to include cover for other diseases which have become more high-profile (e.g. norovirus, ebola), even though some (e.g. norovirus) are not notifiable to local authorities. Such requests should be considered later in chapter 10 as potential additional costs to consider, should agreement be given to widen cover on a case-by-case basis.
- **Contract sites**. An insured may incur a loss if there is damage on a contract site where they are working.

B1B Increased cost of working

It is at this point that we need to address increased cost of working (ICOW) also known as **additional cost of working (ACOW)**.

Some companies would not necessarily experience large scale, if any, loss of profits if they suffered a serious fire or other loss at their premises. ICOW has been designed to provide that type of company with an amount of money to spend getting back on its feet as quickly as possible.

Example 6.1

If fire were to destroy an accountancy firm's office, the firm would lose its furniture, computer systems, records, stationery and other items. The insurer would appoint a loss adjuster whose function is to settle the claim on the insurer's behalf as quickly and economically as possible.

So how would the loss adjuster tackle the task? First, the company would need alternative accommodation which the loss adjuster would try to find. If there are suitable premises in the area this could take a few days. Provided the accountancy firm owns its building or is responsible for insuring it, the property insurance would reinstate the building (i.e. restore it to the state it was in before the fire), although this could take up to a year to complete.

Second, the loss adjuster would hire computers and office equipment for the temporary office. The insured might decide to tell customers about the move by advertising or holding an event at its new premises. The firm could be up and running again very quickly and would not have incurred a substantial loss of profits. The ICOW cover would provide for the costs of hiring alternative premises, office equipment and informing clients of the move.

A second scenario might involve a haulage contractor. A fire at its warehouse would destroy stock and any offices. However, the lorries, which earn the profits, would probably be out on the road or in the yard. The loss adjuster would simply need to hire a 'portacabin' office and find a temporary warehouse to hold stock pending the rebuild. The profits would not be unduly affected and ICOW would be an appropriate form of interruption cover.

A limited form of ICOW cover is provided under standard business interruption policies. Insurers are happy to pick up additional costs should the 'costs' incurred reduce the size of the overall profits claim. A good example would be a bakery which supplies bread to the main supermarkets. It would be in the insurer's financial interest to sub-contract the baking and packaging of bread to other bakeries, which may cost say, £500,000 up to the time of reinstatement and refurbishment etc. rather than cover the insured's loss of profits. After all, should they lose their supermarket contracts, the claim may run into millions.

The main difference between an ICOW extension under a loss of profits (business interruption) policy and a stand alone ICOW policy is that a stand alone policy covers uneconomic losses, i.e. the insured can allocate the money as they wish (within the terms of the policy of course) whereas under standard profits cover, the additional costs need to be economic, i.e. serve to reduce the size of the profits claim.

B2 Legal expenses insurance

These policies cover firms' or companies' costs arising out of the need to take action in the courts or to defend an action brought against the insured, as well as covering the cost of the insured's and their employees' time spent in court.

A standard policy consists of a selection of the following:

- **Employment disputes**: covers the costs of defending unfair dismissal or racial or sexual discrimination claims plus any awards made against the insured if unsuccessful.
- **Criminal prosecution defence cover**: covers the cost of defending an action against the insured, usually under health and safety legislation; fines are not covered (this would be against the public interest).
- **Property disputes cover**, e.g. with neighbours over planning applications.
- **Motor cover**, e.g. uninsured loss recovery, defending motor prosecution.
- **Patents, registered designs, copyright and trademarks cover**, e.g. defending claims against alleged breach of copyright.
- **Taxation proceedings**.

C Liability insurance

In law we all owe a duty to each other to ensure that our actions do not injure others or damage their property. This is known as the 'duty of care'.

In the event of a breach of the duty, a party can be liable to pay damages (compensation) to another who suffers loss or damage arising from **negligence** (lack of care). The most common example of this would be in a motor accident, where the person who is at fault is liable to pay for the repair to the other's car (usually paid for by insurers). Even if found not liable, a party may be liable for costs or expenses in taking legal action or advice. Covering such costs is the purpose of **liability insurance**. We will look at the various types in this section.

It is worth spending a little time on the concept of negligence here, as this drives liability and liability insurance. Without someone being in some way negligent there is not usually a legal liability to pay for injury or damage. In general terms negligence can be defined as:

> Doing something which the reasonable or prudent person would not do, or omitting to do something which a reasonable person guided by those considerations which ordinarily regulate the conduct of human affairs, would do.

If this happens and someone is injured, there may be a liability to pay damages to that person. Liability insurance provides cover for this possibility.

C1 Employers' liability insurance

The **Employers' Liability (Compulsory Insurance) Act 1969** required that every employer in Great Britain must be insured against liability for bodily injury or disease sustained by their employees arising out of and in the course of their employment, and that a **certificate of insurance** must be displayed at each place of business. The **Employers' Liability (Compulsory Insurance) Regulations 1998** extended these provisions in two important respects:

- the minimum limit required is £5m, although in practice insurers provide cover up to £10m in respect of any event including costs; an inner limit of a £5m limit of indemnity will apply if the insured is working offshore or in respect of events arising from terrorism;
- the certificate must be kept for 40 years.

The second of these provisions, together with the requirement to display a certificate at each place of business have been removed by the **Employers' Liability (Compulsory Insurance) Amendment Regulations 2008**, effective from 1 October 2008. A certificate in electronic format is acceptable provided it remains readily accessible to all employees.

While there is no 'standard' market wording for employers' liability (EL) insurance, most policies follow the same form, with wordings being broadly similar. Remember the policy provides coverage to the **insured**, the employer, against damages they are legally liable to pay to an employee. The most important provisions are as follows:

- Cover is for legal liability only, i.e. 'pure' accidents which are not the result of negligence are **not** covered. For example, if Bill is hit on the head by a hailstone while at work this would not be insured as it is not the result of his employer's actions or negligence. Nor would the policy cover a situation where the employer feels sorry for an employee as a result of an accident. There has to have been negligence (or breach of statutory duty) which has caused injury.

  Changes under the **Enterprise and Regulatory Reform Act 2013** remove the strict liability attached to employers; it is now a requirement for negligence to be proven when a claimant brings forth a claim. This has far-reaching implications, although its actual impact is yet to be tested. While the strict liability on employers has been removed, courts tend to avoid leaving claimants without a means of redress. Therefore, even if not compelled to in law, it is likely that courts will still award damages to claimants where negligence is not clear. This may lead to an increase in claims involving contributory negligence (i.e. a reduction in the damages to reflect a claimant's own negligence).
- Damages. Cover is to pay damages to the employee injured which will include loss of (and future loss of) earnings, pain and suffering. Cover includes **claimant's costs and expenses** in respect of costs in substantiating their claim, plus any award of cash and damages by the court.

- Definition of ‘employee’. This is ‘any person who is under a contract of service or apprenticeship with the insured’. [Definition taken from the Employers’ Liability (Compulsory Insurance) Act 1969.] This is usually extended to include, for example, self-employed persons (as long as they are wholly or mostly engaged by the employer), work experience students.
- ‘Arising out of and in the course of employment.’ This is usually the moment the employee passes through the ‘boundary gates’. Injuries to employees happening off the premises can also be ‘in the course of employment’ if the employee is engaged on work off site.
- Trade or business. This is usually extended to cover the insured’s ancillary activities which directly form a part of the business.
- Territorial limits. This is usually the UK, Isle of Man, the Channel Islands or while temporarily outside these territories.
- Period of insurance. Provided the injury or disease was caused during the period of insurance, the insured is liable even if the policy has expired. You may hear this referred to as 'losses occurring' which is discussed further in *Professional indemnity insurance* on page 6/14.

C1A Optional extensions

There are optional extensions, for example:

- Defence costs and expenses, i.e. those of the insured themselves. This relates to legal costs **not** following an accident, for example, where an insured is being prosecuted for a breach in Regulations. However, any fine resulting from such prosecution would not be covered and would be paid for by the insured themselves.
- Additional person(s) insured, i.e. any director, partner or employee of the insured in their personal capacity, for actions brought against them, for which the insured would be entitled to indemnity under the policy.
- Compensation for court attendance. Indemnity is provided to the insured up to a prescribed limit, e.g. £500 if an employee, director or partner has to attend a court session.
- Unsatisfied court judgments. If an employee successfully wins an award from a third party but settlement is not met by the third party, upon the insured’s request, payment for the amount of the damages or the settlement can be made to the employee provided that it is in connection with a work-related activity.

Cover may be limited by restricting the definition of ‘business’, excluding certain kinds of work, machines and/or processes, but as this is a compulsory class of insurance, the insurers cannot refuse to deal with a claim on these grounds, and merely obtains a right of recovery against their insured.

C2 Public liability insurance

Public liability insurance is ‘open’ in that it covers all legal liability that is not excluded. It provides an indemnity to the insured for legal liability to third parties for damages (including claimants’ costs and expenses) in respect of bodily injury, death, disease or illness, and for any loss of or damage to property which happens in connection with the business insured under the policy and occurring during the period of insurance.

Again, the critical point here is that there has to be legal liability, and therefore there must be negligence (or breach of statutory duty) in order for there to be a valid claim against the policy.

Question 6.4

Can you think of three examples where a claim could arise under a public liability insurance policy?

Mention should be made here of the following:

- **accident**: i.e. not a deliberate act or omission of the insured;
- **injury to persons**: i.e. there must be some form of physical or medical impairment;

- **loss of or damage to property**: there must be physical damage to material property (including loss or disappearance) though this excludes intangibles (e.g. copyrights) or indirect economic loss;
- **consequential loss**: e.g. for damage to a vehicle, the insured may be liable for the cost of a hire car while the third party's vehicle is being repaired – this would be covered; and
- **limit of indemnity**: usually, a limit per occurrence.

A number of exclusions apply such as:

- Injury to employees (this would be covered under an employers' liability policy); and
- Property belonging to the insured (covered under a property policy).

Think Back
Refer to *Product liability insurance* on page 6/13 for more on product liability

- Product liability.
- Contractual liability, i.e. agreements that the insured makes with third parties which are over and above the legal interpretation of 'legally liable'.

Example 6.2
Let's consider Bob and his furniture factory again. Andrew, one of Bob's main customers, sells Bob's products to trade customers at his wholesale warehouse. Andrew wants to increase sales and decides to hold a charity sports day at his premises to raise interest. Andrew proposes to Bob that he will treble his monthly order if Bob agrees to be liable for any injuries to Andrew's customers while competing in the events. This is a contractual agreement between Bob and Andrew, Bob would not be held liable in the eyes of the law for any injuries incurred unless of course Bob was involved and in some way negligent.

- Cost of rectifying defective work – insurers would not want to cover the cost of remedying poor workmanship. Any injury or damage to third parties incurred as a result of such workmanship would of course be covered.

Think Back
Refer to *Professional indemnity insurance* on page 6/14 for more on professional indemnity insurance

- Professional negligence.
- Deliberate acts, i.e. not 'accidents'.
- Motor vehicles.
- Vessels and craft.
- Lifts, elevators and boilers (covered by engineering policies).
- War risks.
- Radioactive contamination.

C3 Product liability insurance

The standard product liability insurance policy covers legal liability for bodily injury or property damage which arises out of goods or products manufactured, constructed, altered, repaired, serviced, treated, sold, supplied or distributed by the insured. Cover is not usually offered separately from the basic public liability policy, and is often sold in conjunction with the public liability (PL) policy as a combined PL/products cover.

Examples of product liability include:

- injury caused by faulty wiring on an electric kettle;
- injury caused by use of weak glass in a jar, causing it to smash too easily;
- damage to a car caused by a faulty brake part causing it to roll away while parked; and
- food poisoning caused by incorrectly processed food.

The points to remember about product liability insurance are:

- Cover is for consequential loss following actual injury or damage.
- Financial loss is not usually covered unless accompanied by bodily injury or loss of or damage to property.
- The basic cover is dependent on an element of accident.
- The injury or damage must occur during the period of insurance.
- A yearly aggregate limit of indemnity is usually specified.

You would expect to find the following exclusions in a product liability policy:

- Contractual liability.
- Damage to the actual good(s) supplied. Insurers are not looking to replace a damaged product, this is the manufacturer's problem.
- Faulty design or formula. Similarly insurers are not looking to make good any claims that the insured's products are faulty unless some injury or damage has occurred as a result.

C4 Pollution liability

Indemnity is provided to the insured in respect of pollution or contamination caused by a sudden identifiable, unintended and unexpected incident which takes place in entirety at a specific moment in time and place during any period of insurance.

All pollution or contamination arising out of one incident is treated as one claim. This is regardless of how many separate parties are affected or whether the damage spans more than one policy period.

The policy indemnity limit is in the aggregate during any one period of insurance. This cover does not always appear as a separate section in a policy.

C5 Professional indemnity insurance

This covers professional people's liability for injury, damage or financial loss to clients or the public as a result of breach of professional duty, or negligent acts, errors or omissions in their professional capacity. Most claims arise for financial loss.

An example might be an insurance broker giving advice on insurance coverage to a client on fire insurance for their factory, getting the business from the client and then simply forgetting to place that cover. If the factory burns down, the broker has clearly been negligent, the client has suffered loss as a result of this and the broker would be liable to pay damages. Professional indemnity cover is intended to provide insurance against the possibility of having to pay these damages (which in this case could be the value of the fire loss plus costs).

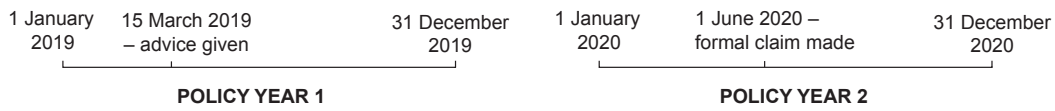
Consider this…
Try to think of some other examples of where a professional may give advice which leads to someone following that advice and then suffering some sort of loss.

Examples could include an architect designing a house incorrectly or a stockbroker recommending some shares in a disastrous company. The list could be endless.

With professional negligence, the courts may award damages for pure financial loss. This is particularly relevant in that usually the courts would not allow a claim if there is no injury or damage as well. An example of pure financial loss would be where a stockbroker negligently advised a client to buy weak shares: there must still be negligence, but the only loss is financial.

It is usual for the policies to offer cover on a **claims made** basis, i.e. the policy applies to claims made against the insured during the period of insurance rather than **losses occurring** during the policy period. This is why most professional indemnity policies will also contain a retroactive date.

Claims made versus losses occurring policy



Under a claims-made policy, the claim attaches to the year it is made, not when the advice was given.

Under a losses-occurring policy, the claim attaches to the year the accident happened rather than when the claim is made.

A retroactive date usually predates the inception of an insurance contract, which is normally an annual policy. Retroactive dates are normally applied from the first date you have held **uninterrupted** insurance. They are used by insurers to exclude claims relating to work which predates the retroactive date from which cover has been in place. It is important to note that you do not have to have held uninterrupted insurance with the same insurer, just that insurance has been in place. You should not be penalised for moving insurer, however, you may find that insurers are unable to provide retroactive dates from the date you have held uninterrupted insurance if, for example, you increase your limit of indemnity.

Dishonesty of the insured will usually be excluded.

C6 Directors' and officers' (D&O) insurance

D&O insurance cover protects directors against personal liability for financial loss suffered by third parties.

The **Companies Act 2006** codified certain responsibilities of directors and provided a statutory list of duties. Directors are to:

- Act within the company's constitution and properly exercise powers.
- Promote the success of the company for the benefit of its members.
- Exercise independent judgment.
- Exercise reasonable care, skill and diligence.
- Avoid conflicts of interest. Directors must authorise any individual director's conflict of interests. They may do so provided there is no conflict with the constitution of the company.
- Not accept benefits from third parties, unless this is unlikely to give rise to a conflict of interests.
- Declare an interest in any proposed transaction with the company. This must include the nature and extent of that interest.

Legislation states that unlike a company, liability is unlimited for individual directors.

Standard policy cover offered under a D&O policy has two elements:

- cover for directors and officers in their personal capacity when they are unable to claim an indemnity from the company; and
- cover to protect the company in circumstances where it is permitted to indemnify the directors or officers, such as in the repayment of legal defence costs.

C7 Errors and omissions (E&O) insurance

As a regulated business, intermediaries are required to hold professional indemnity insurance, specifically referred to as errors and omissions insurance. Insurance brokers owe a duty to their clients (and to insurers) when arranging insurances. They must carry out their client's instructions and give them proper advice. Any breach of this duty may impact their legal liability.

E&O claims occur where the broker has made a mistake that has caused their client to suffer a loss. This normally comes to light after the client has made a claim. The client is

indemnified by the insurance broker's E&O insurance policy. The main two reasons for claims being brought are:

- the policy wording does not say what the client expected; or
- the policy does not do what the broker said it would do.

The minimum limits and maximum level of policy excess are set according to the size of the intermediary.

C8 Medical malpractice insurance

People in the medical professions may be subject to claims on the grounds that they failed to use reasonable care. There is also the possibly of spurious claims when treatment or advice has been suitable. Patients may claim that they did not recover as satisfactorily or quickly as they had expected, implying that another form of treatment may have been more appropriate. This cover is for NHS trusts, doctors (including surgeons and consultants), nurses, dentists, pharmacists and 'alternative' practitioners.

Standard policy cover provides protection against damages and defence costs for any claims for bodily/personal injury or damage.

D Cyber insurance

Cyber insurance is still emerging both in terms of its availability and purpose. The ABI defines cyber insurance as covering ‘the losses relating to damage to, or loss of information from, IT systems and networks’.

This is an important and often overlooked protection for consumers and commercial customers. Think about your own home, internet access/connectivity is key, so much so that some now refer to it as a basic utility (like water, gas and electricity), and even as a human right. Think about the company you work for and your own role, could you do your job without IT? Think about this course, could you be assessed without IT?

Cyber insurance can relate to both damage of physical property (including the data on it), pecuniary loss following interruption, and liability to third parties in respect of loss of or damage to third party property or loss of third party data.

To understand this type of insurance, think about all the possible situations that could be indemnified in relation to IT and IT systems, which more traditional forms of insurance protection may not cover, such as:

- loss of data (e.g. electronic ledgers) or software;
- theft of money through electronic systems;
- loss of business following interruption to electronic systems;
- extortion by third parties who threaten to release sensitive data if they are not paid or specific demands are not met;
- reputational risk following loss of data, including customer data (there have been several well-publicised incidents involving retailers, banks and utility companies in the last few years);
- cost of paying damages (compensation) to third parties, such as customers, following the loss of personal data or interruption in access to systems;
- defence costs in the event of any action brought against a company following loss of customer data; and
- cost of paying damages arising from torts such as negligence or defamation or breach of privacy.

It would make sense to separate out such scenarios – you can think of them as first party (i.e. in relation to the proposer’s assets or finances) or third party (i.e. in relation to the proposer’s duty of care to third parties and their property).

Even with the high profile data breaches reported in the media, take up of these policies is mixed. Their availability also varies.

Some insurers are more specialist and offer comprehensive off-the-shelf products that have been built on more bespoke programmes for larger customers. Other insurers offer

enhancements to their basic products, with inner limits and restricted covers or restrictive conditions or exclusions.

The suitability of the product will be dictated by the business seeking the insurance. For example, retail banks and other organisations holding sensitive customer information, particularly consumer information, may need more protection than a metal working business, for example, with commercial customers only.

The availability of such products can be affected by the proposer – what existing protections do they have in place? For example, do they have adequate network security? Do they regularly back up their data to an external location and, if so, how frequently?

The need for this cover has even been recognised by Pool Re in the widening of its cover to members to include limited forms of protection against cyber events.

This is a new and emerging cover requirement for most businesses. Demand is not yet being seen in the consumer space, such as home insurance.

Activity
Think about the future and technological developments, such as driverless cars, could this create a cover need we have not yet thought of?

Key points

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

Property insurance

- Standard fire cover is made up of three parts:
  - fire (excluding explosion resulting from fire, earthquake or subterranean fire, and its own spontaneous fermentation or heating);
  - lightning;
  - explosion (restricted to explosion of boilers or gas used for domestic purposes only).
- Commercial property insurance policies now cover fire and special perils as standard.
- Certain causes of damage are excluded.
- 'Theft' has a very specific meaning in insurance terms and it is important to differentiate this from the strict legal definition: insurers include a phrase that it must include force and violence either in breaking in or out of the insured premises.

Pecuniary insurance

- Business interruption insurance covers the actual or potential loss of earnings and additional expenses incurred as a result of a material loss covered under property insurance.
- In assessing the need for business interruption insurance it is necessary to estimate the maximum time the income of the business could be affected as a result of damage.
- Policies are based on a sum insured representing the gross profit for the indemnity period chosen.
- The main items insured under a business interruption policy are:
  - loss of gross profit;
  - increased cost of working incurred in order to reduce the loss of gross profit following the insured event. Such costs should be 'economic' and be less than the amount of the gross profit saved.
- From these will be deducted savings made during the indemnity period.
- Legal expenses policies cover firms' or companies' costs arising out of the need to take action in the courts or to defend an action brought against the insured, as well as covering the cost of the insured's and their employees' time spent in court.

Liability insurance

- The Employers' Liability (Compulsory Insurance) Act 1969 requires that every employer in Great Britain must be insured against liability for bodily injury or disease sustained by their employees arising out of and in the course of their employment.
  - The minimum limit required is £5m although in practice insurers provide cover up to £10m in respect of any event including costs.
  - The policy provides coverage to the insured, the employer, against damages they are legally liable to pay to an employee.
- Public liability insurance provides an indemnity to the insured for legal liability to third parties for damages (including claimants' costs and expenses) in respect of bodily injury, death, disease or illness, and for any loss of or damage to property which happens in connection with the business insured under the policy and occurring during the period of insurance.
- For products liability, cover is for consequential loss following actual injury or damage. Financial loss is not usually covered unless accompanied by bodily injury or loss of or damage to property.
- Under a pollution liability insurance, indemnity is provided to the insured in respect of pollution or contamination caused by a sudden identifiable, unintended and unexpected incident which takes place in entirety at a specific moment in time and place during any period of insurance.

Key points

- Professional indemnity insurance covers professional people's liability for injury, damage or financial loss to clients or the public as a result of breach of professional duty, or negligent acts, errors or omissions in their professional capacity.
- Directors' and officers' insurance (D&O) protects directors against personal liability for financial loss suffered by third parties.
- Errors and omissions (E&O) insurance is a specialist form of professional indemnity cover. E&O claims occur where the broker has made a mistake that has caused their client to suffer a loss.
- Medical malpractice insurance provides protection for medical professionals against damages and defence costs for any bodily/personal injury claims.

Cyber insurance

- This is a new type of insurance protection that is arguably still emerging. The need for it has increased as more traditional policies have not been able to cater for the sorts of losses and damages that have increased with our reliance on IT.
- The cover needed can be wider and does not easily fit within existing descriptions of insurance.
- It is best to think about situations that could be indemnified under one of two categories: first party (i.e. in relation to the proposer's assets or finances) or third party (i.e. in relation to the proposer's duty of care to third parties and their property).
- The level of cover provided varies between insurer and is largely dictated by the level of protection adopted by a proposer.

Question answers

6.1 Because people invest in businesses in order to give them the assets to trade and make money. These assets have a value and without them the business cannot continue. So, much like individuals, businesses protect their assets by taking out insurance.

A business might want to insure its premises (the buildings), stock, machinery, business interruption, general office contents, motor vehicles. Other areas might be goods while in transit to customers, its liability to others if they are injured by its activities and against accidents to its employees.

6.2 The list is not exhaustive, however two obvious risks could be builders/timber merchants where materials are often stored in the yard area and garden centres where plants, timber buildings, statues etc. are often stored in the open overnight.

6.3 **Non-negotiable** items would include:

- crossed cheques (including crossed giro cheques and drafts but excluding pre-signed blank cheques);
- crossed bankers' drafts;
- crossed postal orders;
- crossed money orders;
- unused units in franking machines;
- National Savings Certificates;
- Premium Bonds;
- credit company sales vouchers;
- VAT purchase invoices.

Negotiable items would include:

- cash bank notes;
- currency notes;
- uncrossed cheques (including uncrossed giro cheques giro cash cheques and travellers' cheques but excluding pre-signed blank cheques),
- uncrossed bankers' drafts;
- uncrossed postal orders;
- uncrossed money orders;
- current postage and revenue stamps;
- National Insurance stamps (not fixed to cards);
- National Savings stamps;
- bills of exchange;
- luncheon vouchers;
- consumer redemption vouchers;
- Holiday with Pay stamps;
- gift tokens;
- trading stamps.

6.4 A sign hanging from an insured's premises may fall down and injure a passer-by; a customer could slip on a wet floor, hurting themselves; a loose roof tile could blow from the insured's building, damaging a vehicle parked on the street: the list is endless – any potential liability could have been named. The legal liability covers all forms, not just negligence but also nuisance, trespass and liability under statute.

Self-test questions

1. What are the three basic perils covered by 'standard' fire cover?
2. What four groups of exclusions apply to an 'all risks' fire insurance policy?
3. How do insurers limit the meaning of 'theft' as defined in the Theft Act 1968?
4. Name two optional extensions to a standard money policy.
5. What is the purpose of business interruption insurance?
6. What are the main sections contained within a commercial legal expenses policy?
7. What is the standard policy cover under a products liability insurance?
8. What is the standard policy cover under a professional indemnity insurance?
9. Is cyber insurance a first party or third party insurance, and what is the difference?

You will find the answers at the back of the book

Access your exam results, permits and records of achievement online

You can now access your exam permits, exam results and your records of achievement online at My CII. These documents will no longer be received by post as we are going paperless to give you better access at a time convenient for you, wherever you are.

My CII is a secure way to find all the information you need in one central place as well as being able to print copies whenever you need to. You will continue to receive your completion certificate by post.

We'd like to take this opportunity to wish you every success with your studies.

Visit My CII as soon as you're ready.

cii.co.uk

Chartered Insurance Institute

Standards. Professionalism. Trust.

7
Related services

Contents	Syllabus learning outcomes
Introduction	
A Helplines	*7.1*
B Authorised repairers and suppliers	*7.1*
C Risk control and advice	*7.1*
D Uninsured loss recovery services	*7.1*
E Legal expenses	*7.1*
F Claims management company	*7.1*
Key points	
Question answers	
Self-test questions	

Learning objectives

After studying this chapter, you should be able to:

- describe the main types of 'support'-type insurance services available, with specific reference to:
- helplines and their relevance;
- the use of authorised repairers;
- risk management; and
- the recovery of uninsured losses.

Introduction

Mr Smith has comprehensive motor insurance covering his vehicle. While stationary at a red light, Mr Smith's vehicle is hit in the rear by Mr Jones, who admits liability for the incident. Ordinarily, Mr Smith's insurers would have Mr Smith's vehicle repaired and Mr Smith would have to pay an amount on collecting up his vehicle (the policy excess).

This scenario raises certain issues/questions, for instance:

- How do Mr Smith's insurers arrange Mr Smith's repairs?
- Because Mr Smith's insurers have made a payment, Mr Smith's **no claims discount (NCD)** may be affected (it is, after all, a 'no **claims** discount', not a 'no **blame** discount'); what redress, if any, would Mr Smith have?
- Mr Smith had to pay his policy excess – how can he get this back?

These issues fall within the domain of **insurance-related services** and it is these, as well as other concepts such as risk management, that we shall be covering in this chapter. For clarity, this chapter will talk about value-added services as part of the main insurance contract, and not add-ons or other policies that are often sold with it (e.g. extended warranties, payment protection products).

Key terms

This chapter features explanations of the following ideas:

Authorised repairers and suppliers	Helplines	Risk analysis	Risk control
Risk identification	Risk surveyors	Uninsured loss recovery services	

A Helplines

Helplines or advice lines are mainly freephone numbers, often operating 24 hours a day, providing emergency assistance and expert advice to insurance policyholders.

Examples of where helplines may be used include:

- **Private motor insurance**: providing policyholders with 24-hour access to a call centre for assistance in the event of a vehicle breakdown. The insured will usually only pay for labour and parts for assistance provided, depending on the policy terms.
- *Household insurance*: providing legal advice and legal costs services, emergency services which provide immediate assistance in emergencies whether or not relating to claims, i.e. plumbers, roofers and glazing services.
- *Travel insurance*: most travel insurers provide cover for a medical emergency service. This is usually operated by a specialist company providing a 24-hour multi-lingual helpline facility. In an emergency, the company will advise or organise the necessary medical treatment or repatriation (getting the policyholder back home) facility.

There are many other types of helpline, and the above serves only to illustrate the facility.

It is important to note that following the implementation of the **Consumer Rights Act 2015**, use of premium rate phone numbers has been prohibited. Although the legislation does not apply to financial services, the FCA has confirmed that it is adopting a similar approach for insurers and other financial services providers with a requirement in its Handbook that customers should not pay more than a basic rate for telephone calls.

Example 7.1

Mr Smith might contact a helpline to discuss what he is able to do in connection with the losses he has incurred for which he is not insured under his own policy. As we will see, these might include his excess, out-of-pocket expenses and medical expenses.

B Authorised repairers and suppliers

Household insurers offer emergency and glazing services, providing policyholders with access to preferred/recommended contractors. Typically, the contractor, e.g. a glazier, would attend the callout and assuming it is a valid claim, submit their invoice directly to the insurers. Such contractors or suppliers are **authorised repairers**.

Authorised repairers are most commonly used in motor insurance. Private motor insurers have a panel of authorised or approved repairers and when a claim is reported, insurers will usually either provide policyholders with details of approved repairers in their area or directly instruct an approved repairer to collect the vehicle and carry out repairs etc.

Question 7.1

Can you think of the main benefits of a panel of approved repairers to private motor insurers and customers?

Other considerations are that tow-ins are usually arranged if a vehicle is not driveable as a result of an accident. High-tech equipment, e.g. digital video cameras, means that an 'insurance engineer' can inspect a vehicle without actually visiting the garage carrying out the repairs. Some approved repairers in higher-density areas have 'insurance engineers' based permanently at their premises.

C Risk control and advice

You will recall that we introduced the concept of risk control and advice (which we could call 'risk management') at the beginning of the course as part of the process of assessing the risk. Here we shall look at the concept in more depth.

Risk management could be described as the identification, analysis and economic control of those risks which can threaten the assets or earning capacity of an enterprise.

From this description, three steps can be identified in managing a risk:

- risk identification;
- risk analysis; and
- risk control.

Risk identification involves analysis of both the 'upside' and 'downside' of risk. The upside of risk relates to the failure to maximise opportunities while the 'downside' involves discovering what threats already exist and what potential threats exist in the future. As we know, the initial assessment of the risk by underwriters is often carried out by examining the proposal form and, if necessary, through a physical examination or **survey** to assist in identifying the existing and potential risks.

Risk analysis involves examining past data to evaluate the risk. For example, an insurer could look at the frequency and severity of fire claims at thatched properties to predict the number and average size of such claims in the future. Such analysis will help identify measures that could be taken to control the risk, such as lining the inside of a chimney with fire resistant material.

Risk control involves putting into action plans to reduce and even eliminate the risk.

The two main courses of action for insurers are:

- **Physical control measures (of the risk)**: e.g. requiring that approved locks are fitted to the doors of a private home to reduce the theft risk.
- **Financial control measures (of the potential loss)**: e.g. imposing an excess, arranging reinsurance.

The **risk surveyor** (sometimes called the loss control engineer) is the 'eyes and ears' of the insurer, identifying risks which the insured can either:

- eliminate, e.g. prohibiting smoking in workshops containing combustible materials; or
- control, e.g. storing combustible waste materials at least ten metres away from buildings to prevent the spread of malicious fires.

The risk surveyor should work closely with the underwriter in identifying the measures to control risk and ensuring the policy terms reflect these.

D Uninsured loss recovery services

Going back to Mr Smith at the beginning of the chapter, we will see that there are various uninsured losses that Mr Smith may want to recover (hence 'uninsured losses'). For example, if Mr Smith's insurer did not provide a courtesy car, Mr Smith may need to hire a vehicle. He may have suffered personal injury and require specific medical assistance.

Question 7.2

Can you think of any other uninsured losses that Mr Smith may have suffered?

There are various situations that arise in connection with motor insurance where the insured may have no cover but potentially has a legal right to recover losses from another person. This would occur where Mr Smith's own policy was only for third party, fire and theft, third party only, or Road Traffic Act only rather than comprehensive cover. In these cases, Mr Smith would, in effect, be 'uninsured' for his own damage.

Consider this…

Why would Mr Smith, in effect, be uninsured by his own insurers?

It is because the insurers will not pay for any damage repair to the insured vehicle as this is an exclusion under lower-level insurance, i.e. not comprehensive cover.

Many insurers adhere to the general principles that provide for a quick decision from insurers either admitting or denying liability for third party damage. If liable, they will arrange for the third party repairs (or payment of pre-accident value of vehicles if they are written off) and the provision of a replacement car at no cost to the innocent party.

It is important to note that increased insurance premiums due to loss of NCD are not recoverable as an uninsured loss. This is because where the insurer, having met the own damage claim, reduces the insured's NCD but subsequently makes a full recovery of its outlay, the insured will be reimbursed the increased premium due to the initial loss of NCD.

Some insurance intermediaries will provide assistance in respect of the recovery of uninsured losses, but practice varies.

Other organisations, such as accident management companies, may also offer additional services such as replacement vehicle services.

E Legal expenses

Claims can be pursued with the instruction of solicitors under a **legal expenses policy** that is usually purchased in conjunction with a motor policy. The wordings of these policies vary, but essentially they will provide an indemnity for legal expenses in pursuing an uninsured loss claim, where reasonable prospects of success exist. There will always be an indemnity limit, e.g. £50,000 or £100,000.

This legal expenses cover is not the same as that offered under most household insurance policies, where an add-on is cross-sold to customers at the point of sale. Add-ons are now subject to the Consumer Rights Act 2015. This sets out that any ancillary products and services offered at point of sale must be affirmed positively by the customer, rather than sold assumptively or without it being clear that a choice exists not to take the cover. The Act also sets out that such ancillary policies must be cancelled in the event that the main policy is cancelled.

F Claims management company

There are also specialist companies which will pursue claims for personal injury. Claims management companies act as intermediaries between claimants and the companies being claimed against. These can be on a 'no win, no fee' basis. The larger companies often advertise their services on television.

A claims management company would handle the whole claim through to settlement. If the claimant's case is won, then the company will take a fee, usually a percentage of the settlement or a flat lump sum, sometimes a combination of both. Fees can be in excess of 20% of the final payout and are regularly scrutinised.

There has been a recent clampdown in various types of claim, the most notable being that of whiplash claims, where claimants have been encouraged to exaggerate an injury to increase the overall settlement.

On the Web
For an overview of the whiplash reforms, see: *www.gov.uk/government/speeches/implementation-of-the-whiplash-reform-programme*.

Key points

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

Helplines

- Helplines are used to provide both information and assistance.

Authorised repairers and suppliers

- Approved repairers are often used to make the repair and recovery process more efficacious.

Risk control and advice

- Risk management could be described as the identification, analysis and economic control of those risks which can threaten the assets or earning capacity of an enterprise.
- The identification of a risk involves analysis of both the 'upside' and 'downside' of risk.
- Risk analysis involves examining past data to evaluate the risk.
- Risk control involves putting into action plans to reduce and even eliminate the risk.

Uninsured loss recovery services

- In the event of a claim, an insured may also suffer losses that are not covered by an insurance policy itself. To recover such losses, there are uninsured loss recovery services available, such as solicitors and specialised firms.

Legal expenses

- These policies provide an indemnity for legal expenses when pursuing an uninsured loss claim.

Claims management company

- These are specialist companies which pursue personal injury claims. They act as intermediaries between claimants and the companies being claimed against.

Question answers

7.1 Convenience: for both insurer and client.

Price: a price reduction on labour and parts is usually negotiated, benefiting the insurer in terms of the final cost of accidents and ultimately customers as cost savings can ultimately be passed on in terms of premium savings.

Competence: a sub-standard repairer would soon be removed from the panel. In addition, panel members often offer wider guarantees or services while the car is in for repair.

7.2 Other examples are loss of earnings, loss of amenities, loss of use, inconvenience. (This list is not exhaustive: there are many other examples.)

Self-test questions

1. Give an example of how a helpline may be used in respect of travel insurance.
2. With what type of insurance are approved repairers most commonly used?
3. How is risk management defined?
4. What are the two main components in controlling risk?
5. What is an 'uninsured loss'?

You will find the answers at the back of the book

8 Underwriting considerations

Contents	Syllabus learning outcomes
Introduction	
A Basic principles of underwriting	*9.1*
B Specific underwriting considerations	*9.1*, *9.2*
C Fraud: prevention, detection and consequences	*8.6*, *8.7*, *8.8*
D Equality Act 2010	*8.9*
E Data protection legislation	*8.9*
Key points	
Self-test questions	

Learning objectives

After studying this chapter, you should be able to:

- describe underwriting principles both generally and in connection with specific classes of business;
- identify the procedures used to prevent and detect fraudulent claims;
- explain the consequences of fraudulent claims on insurers, insureds and fraudulent claimants; and
- explain the effects of the Equality Act 2010 and data protection legislation on insurance.

Introduction

At the beginning of this course we discussed the nature of insurance as a 'common pool', with contributions of many people going into the pool and the losses of few being met from it.

We also acknowledged that, essentially, it is the underwriter's task to manage this pool effectively and profitably.

To recap then, the underwriter has to:

- assess the risk that a person brings to the pool;
- decide whether to accept the risk and if so, how much;
- determine the terms, conditions and scope of cover to be offered;
- calculate a suitable premium.

In this chapter, we will look firstly at the principles of underwriting in a general sense, before applying the principles to the particular types of insurance. We will also look at fraud, and its consequences on insurance and underwriting.

Key terms

This chapter features explanations of the following ideas:

Data protection	Fraud prevention and detection	Protected characteristics	Specific underwriting considerations

A Basic principles of underwriting

In relation to general (non-life) insurance, we can distinguish insurers' general approach to underwriting in respect of **personal** insurances and **commercial** insurances.

Underwriting personal insurances can be relatively straightforward. The proposal form is the main source of information and, if needed, an individual underwriter can request additional information from the proposer, taking care to ensure that any information requested, and then supplied, is relayed to the proposer in the post-quotation and post-sale policy documentation (e.g. within a statement of fact).

The **Consumer Insurance (Disclosure and Representations) Act 2012** shifts the duty of disclosure away from consumers. The consumer must only answer, fully and accurately, questions that the insurer asks of them. Despite fears of proposal forms becoming excessively long, customers have instead seen the questions on them become far more specific and detailed. For example, instead of just asking about previous claims, proposal forms ask about previous claims, as well as **losses or incidents that could have given rise to a claim**.

Under the **Insurance Act 2015**, commercial customers no longer have to consider what an underwriter might deem to be material but must give 'fair presentation' of their risk, having conducted a 'reasonable search' of their business and 'signposted' information for an insurer.

Be aware
The insured cannot 'data dump' (i.e. bombard the insurer with unnecessary and vast information) but has to present any information in a clear and accessible form.

The underwriting of commercial business insurances is generally more complicated as unlike personal lines business the risks are less homogeneous. Commercial insurances range from small shops and factories to large multi-national corporations with operations in many countries throughout the world. Risks can range from a few vehicles belonging to a company to aircraft and satellites. The degree of complexity of the underwriting required will obviously vary with the sheer size of the risk, but certain principles are still recognised.

The insurance underwriting process will always consist of an assessment of the following:

- The major underwriting factors affecting claims experience for the particular class of business. For example, woodworkers use potentially dangerous powered machinery; it is of no surprise therefore that the injury rate for employees in the woodworking industry is

more frequent and severe than injuries to office workers. Similarly, the frequency and severity of fire incidents in schools and colleges (mainly arson related) is higher than that presented by, say, hardware shops.

- The 'average' claim per member of the group.
- The proposer's characteristics in comparison with the 'average' member. For example, consider the extraction ducting over a deep fat frying range in a fast food restaurant. The risk having good cleaning procedures, i.e. weekly filter cleaning and a bi-monthly ducting clean through is less likely to suffer a duct-related fire than the risk that has a haphazard cleaning procedure or routine.

In essence, the underwriter is evaluating the hazard associated with the risk which is being proposed.

We will now go on to look at underwriting factors for particular classes of insurance in relation to what has been mentioned above.

B Specific underwriting considerations

Consider this…
Before moving on to each class of insurance, try and think of some examples of factors that would affect you, as an underwriter, in deciding whether to accept a risk and if so, on what terms. Also, think about why it would affect the underwriting process.

B1 Motor insurance

Many different factors are used in the motor insurance underwriting process, and several are equally relevant to private cars, motor cycles and commercial vehicles. Some of the key factors are:

- **Driver's age**. This is relevant because certain age groups are probably more susceptible to claims than others. For example, those in the 17–25 age group, which will include the less experienced driver and those lacking risk awareness (which could evidence a poor moral hazard), will expect to be charged more than those in the 40–50 age group who have more experience and probably drive more carefully.
- **Type and make of vehicle**. Expensive, rare or unusual vehicles will be more expensive and/or difficult to repair; powerful vehicles will be more difficult to control, especially in the hands of an inexperienced driver (this is a good example of how the different factors inter-relate). Commercial vehicles attract higher premiums due to their frequency and nature of use, value, size and type of cargo, resulting in an increased third party property damage or bodily injury risk.
- **Type of use**. A vehicle used for social purposes is inevitably going to spend less time on the road than a commercial vehicle. Also, within the categories of commercial use, some vehicles will be less susceptible to damage than others. Large haulage lorries that are part of a fleet present a different risk from a small van owned and operated by the same person.
- **Geographical area**. Some areas of the country have higher vehicle theft rates than others; where there are more vehicles on the road, there is more chance of an accident occurring.
- **Storage**. Where the vehicle is kept overnight or when it is not in use; obviously a garaged vehicle is less likely to be stolen than one left out on the road; it would also be less likely to be subject to malicious damage.
- **Driving record**. Previous claims history is important here; a poor claims history may be evidence of poor moral hazard, as would previous convictions.
- **Cover required and/or extensions requested**. The wider the cover the more risk is brought to the 'pool', so the underwriter should apply higher premiums and impose different terms.
- **Vehicle modifications**. Expensive stereo equipment or addition of attractive racing wheels increases the risk of theft.

B2 Health insurance

To recap on what we learnt in chapter 5 about health insurance, such insurance can be used to provide compensation in the event of death by accident, mitigate loss of income and pay for any expenses incurred if unable to work or finance the cost of private medical care. With this in mind it is easier to appreciate the range of underwriting factors that apply when assessing a health insurance risk:

- **Occupation**. This is a major rating factor for both personal accident and permanent health insurance (PHI). The general practice is to group occupations into four or five main classes, imposing premiums according to the level of accident or health risk involved. The classes will range from no or low accident/health risk (e.g. professional and administrative classes), to high or extra-hazardous risk (e.g. coal miners).
- **Age**. Generally the risk of illness increases with age, but in respect of accidents young people represent a higher risk as they are less aware of and take more risks in the workplace.
- **Family circumstances**. This will often include specific financial details for applications for PHI to ensure that benefits are not excessive.
- **Lifestyle and physical condition**. A person's lifestyle can have a significant effect on general health and longevity. For example, smoking is the primary cause of lung cancer and greatly affects the likelihood of heart disease. Obesity can also affect the heart and blood circulatory system.
- **Medical history**. This is particularly important for a PHI policy where the underwriter is accepting a greater potential liability than for, say, an accident only policy and close consideration needs to be given to the risk of a serious illness or accident leading to extended disability. In some circumstances a medical examination is required.

B3 Personal insurances

B3A Household insurance

Some of the most important factors in respect of the house (**the building**) itself are:

- **Construction**. Insurers are concerned here with what the house is made of. If it is not made of brick, stone or concrete, or not roofed with slates, tiles, metal or concrete, it would be an increased risk and therefore an additional premium would be charged, e.g. thatch roofed houses.
- **Location**. Some insurers have invested heavily into systems which allow for robust risk assessment of key risks such as storm, flood, subsidence, crime and arson relative to a specific post code. For those insurers who do not have the benefit of such systems local knowledge will be used or Government agency web sites, e.g. Environment Agency.

With respect to **contents**, insurers will be concerned with:

- **Area**. Some postcode districts represent higher theft risks.
- **Occupation during the day**. Sometimes discounts are provided if the property is occupied during the day or if the insured is a member of a neighbourhood watch scheme.
- **Security**. A minimum level of security may be expected and sometimes discounts may be given if an intruder alarm is fitted.

Type and level of cover is clearly relevant. Is cover just for buildings, or buildings and contents combined? Does cover apply only while at home, or is it required for contents/ belongings away from the home? Does cover include expensive jewellery? All this information will be the subject of questions on the proposal form.

B3B Travel insurance

All the following aspects would require special consideration:

- **Destination**. Medical expenses can be notoriously expensive in certain countries, e.g. USA.
- **Purpose and duration of travel**. Whether for a holiday or business etc.
- **Group policies**. This would involve situations where a whole group of people related or connected in some way could be involved in the same accident if travelling together.

- **Existence of pre-existing conditions**. Underwriters would want to establish if the insured was suffering from a condition that could result in a claim, e.g. heart disease, and may wish to exclude medical expenses cover in respect of the condition.

B4 Commercial property insurance

B4A Fire and special perils

The main factors are:

- **Use**. For example, is the building used as a garage, office etc. or is it a fireworks factory?
- **Types of goods stored on premises**. For example, bulk storage of combustible materials such as paper, cloth or highly flammable substances provide fuel to support a fire increasing the likelihood of extensive damage.
- **Construction and material**. Brick, steel frame, timber? In recent years risks which feature composite panels have been given a high profile. The food industry in particular has seen significant increases in premium especially where polystyrene has been used as an insulating material.
- **Safety features**. For example, fire alarms, fire walls, sprinkler systems.
- **Risk management features**. For example, housekeeping, control of contractors, audit and inspection and maintenance.
- **Number of floors and area**.
- **Method of heating and lighting**.
- **Location relative to perils**. For example, storm, flood, subsidence, theft and arson.

The rating factors for '**all risks**' insurance are essentially the same, but require deeper consideration of premium and terms as the cover is much wider.

B4B Theft insurance

Important considerations are:

- **Trade**. Some trades are naturally more vulnerable to theft than others. For example, a jeweller would be more vulnerable than a bookshop.
- **Geographical area**. Again, some areas are more susceptible to thieves.
- **Any moral hazard of owner**.
- **Nature and construction of the property**. With the most important consideration being its resistance to forced entry.
- **Theft precautions**. For example, intruder alarms, CCTV, security guards, security lighting etc.

B4C Glass insurance

The main considerations here would be the use of the building (in relation to the likelihood of glass being broken) and the geographical area. Vandalism is one of the main concerns when considering insuring large shop windows in town centres.

B4D Money insurance

In addition to knowing how much money is handled (cash, cheques) an insurer will want to know of precautions taken in storing and transporting money, whether there is a safe and/or strongroom and how employees are paid (if employees are paid in cash, obviously there is a great risk of a large amount of cash being on the premises). A business which handles a lot of cash (such as a shop) will be more at risk of a loss than one where most transactions are on account and money is transferred electronically via the bank network (such as an office).

B5 Pecuniary insurances

B5A Legal expenses insurance

Underwriting considerations will be directed firmly at establishing a proposer's susceptibility to actions through the courts. Possible questions would therefore be aimed at a proposer's employment criteria (and possibly the current breakdown of staff according to sex and/or race), views and actions in respect of health and safety legislation, and occupation (are they in a trade that can provoke ill feeling, e.g. planning, demolition contractors?).

B5B Business interruption insurance

Consider this…
Remind yourself of what is covered by business interruption insurance. Try and think what an insurer's main concern would be with a business interruption proposal.

Essentially, an insurer is concerned with how quickly a proposer can get their business up and running again after an incident/interruption features. For example,

- Could they operate from another premises?
- Is replacement machinery readily available?
- Are there any critical pieces of machinery or is there any interdependency between production lines and/or sites?
- Are there any seasonal features? The insured may be dependent upon key times of the year and damage at these times could have a significant impact on the business.
- External dependencies such as suppliers, customers and utilities.

As well as considering the above interruption features, the BI underwriter would also assess similar risks to the property underwriter. These are described as physical features.

B6 Liability insurance

Underwriting factors are different for the type of liability cover required:

- **Employers' liability**. Here, the principal consideration is the trade and occupation of the employee concerned, i.e. an insurer will obviously be concerned about the likelihood of an employee being injured or suffering from an industrial disease, and will want to assess the danger of their particular occupation (e.g. office worker versus scaffolder).
- **Public liability**. The major consideration here is the proposer's trade or business; because of the nature of the cover, if a proposer has little or no contact with the public at large, there would be little risk of liability to the public arising. Conversely, consider the situation where a large food retailer requires this insurance: they have high contact with the public and therefore represent a higher risk than, for example, a telesales office.
- **Pollution liability**. Risk assessment is heavily weighted towards trade, the materials used and whether there are adequate controls to prevent the escape of pollutants into the air or water. You will recall that the cover only operates from sudden identifiable events. Underwriters will want to know what chemicals are used and details of their storage arrangements and risk control measures such as bunding (containment of potentially hazardous materials).
- **Products liability**. As with public liability, the principal consideration is the proposer's trade or business. A drug manufacturer's potential exposure and risk would be, for example, greater than a business which manufactured socks. During the risk assessment process underwriters will specifically consider the final use of the product and its potential to cause bodily injury or damage to third party property. From a risk management perspective quality control systems would be of particular significance. Underwriters are also keen to know about any goods being exported to North America as the particularly litigious nature of society there results in a significant increase in the products liability exposure which the underwriter needs to consider and charge for.
- **Professional indemnity**. Underwriting considerations here will mainly be geared towards assessing the exact occupation, professional qualifications, experience and degree of moral hazard. The risk premium will be relative to the potential consequences of poor advice.

B7 Extended warranties

Extended warranty policies are usually sold at point of sale, so are not generally 'underwritten' as such. However, statistics would be produced by the insurer to assess the likelihood of a product breaking down over a period of time, and the premium would be set accordingly.

B8 Credit rating

Many insurers in both the personal lines and commercial insurance markets now consider a proposer's credit worthiness, both as part of their *acceptance* of a risk, and as a potential rating factor. This is not specific to one line or class of business, as across most lines a link has been detected (but not yet fully understood), between propensity to claim, claim frequency, average cost per claim and loss ratio, and credit rating.

C Fraud: prevention, detection and consequences

Insurance fraud can take many forms and the following are just a few examples:

- Inventing a loss event that never took place. For example, a burglary at home.
- Exaggerating the number of items stolen during an otherwise honestly reported break-in.
- Deliberately creating an insured event. For example, throwing paint on a carpet at home.
- Exaggerating the effects of an insured event. For example, claiming whiplash after a minor car accident where no injuries were received in order to claim compensation.

It is difficult to quantify insurance fraud because so much goes undetected. However, quantifying it by collecting data on the types and amounts of fraud is becoming increasingly important: many believe that quantifying the effects of fraud is the first step towards eliminating it.

Consider this…
What do you think are the consequences of fraud?

If a fraudulent claim is paid, its impact on various parties is far reaching:

- **The insurers**. The cost of fraud is enormous, and if individual insurers do not take it seriously, it will impact their bottom line (profit). Claim costs will rise, impacting on premiums and making them less competitive. They may even get a reputation as a soft touch, and may lead to genuine insureds avoiding them.
- **The insureds**. Even the genuine policyholders will be affected by the commensurate increase in premiums, not just the fraudsters.
- **Fraudulent claimants**. If they get away with it once, the temptation will be there to continue this practice in the future.

All insurers take measures to prevent, detect and combat fraud, but the insurance industry generally also has a number of bodies concerned with helping minimise its occurrence and maximise awareness of the problem and its negative effects.

Fraud prevention is dealt with mainly by the **Insurance Fraud Bureau** which was established to:

- coordinate industry-wide action (involving individual police forces, insurance companies and other agencies involved in fighting crime and fraud);
- actively run public education campaigns; and
- operate centres of expertise on fraudsters and their methods of operation.

New technology is used to detect fraud, including the use of a pooled claims database where insurers can share information from a variety of insurers and try to trap those repeated claimants by matching their new claims details against those already held.

These databases include the following:

- **Motor Insurance Anti-Fraud and Theft Register (MIAFTR)**. This contains details of all total loss and theft claims, and insurers can, therefore, check whether a total loss or theft of a vehicle is being claimed for more than once.
- **Motor Insurance Database (MID)**. This contains details of all registered vehicles in the UK, and the related insurance details, which assists the police in tackling motor vehicle crime.

- **Claims and Underwriting Exchange (CUE)**. This database contains information on incidents reported to insurers by personal insurance policyholders, which may or may not result in a claim. Subscribing members submit their data on individual claimants and check the true history of those individuals. Its aim is to eliminate multiple claims on parallel policies held by a single insured. The register has grown, and now covers domestic buildings, contents, motor and personal injury and illness policies.
- **Art Loss Register**. Founded through a collaboration between the insurance industry and the art world in response to increasing art theft, its operation relies on subscriptions from insurers. It has the objectives of:
  - increasing the recovery rate of stolen art and antiques;
  - deterring theft by making the resale of stolen articles more difficult.

The register is available to the insurance industry, the art trade, law enforcement and custom agencies, collectors and museums.

The majority of fraud is seen from a claims perspective but it is important to realise that fraud can also be committed when a proposer applies for a policy. This is known as **application fraud** by some insurers and is on the increase, with insurers seeking to combat this, particularly with the increasing use of aggregators (price comparison websites).

The Consumer Insurance (Disclosure and Representations) Act 2012 has had other indirect impacts on insurers. In addition to reviewing the questions they ask at the proposal stage, insurers are also looking at ways to obtain data from other sources (e.g. CUE), either to supplement information that they cannot obtain from the proposer, or to validate information which has already been provided.

The role of the claims handler
What can the individual claims handler do to combat fraud?

The claims handler plays a vital part in detecting fraud: methods of detection vary across the classes of business, but there are many common indicators. For example, claims handlers are trained to be cautious with claims:

- made soon after policy inception or renewal;
- where the insured has no documentation for lost items;
- where the insured has several similar claims for similar accidental loss or damage within a short space of time.

Other measures within the insurance industry have also had the effect of combating fraud while actually being implemented to enhance customer service and cut costs. For example:

- **Completing claim forms over the telephone**. Individuals often find it harder to lie directly, as opposed to merely filling in a form (the use of 'anti-fraud lie detectors' over the telephone has also been the subject of recent media coverage as the latest step in the fight to reduce fraud);
- **Claims settlement by replacement rather than cash**. If a fraudster claimed for a 'stolen' television to get cash, they would be frustrated by having to sell the replaced television to get the money. (The fraud would still be successful but this would, hopefully, act as a future deterrent).

D Equality Act 2010

The **Equality Act 2010** aims to harmonise and replace previous legislation (such as the **Disability Discrimination Act 1995** and **Sex Discrimination Act 1975**) and ensure consistency. The Equality Act covers the same groups that were protected by the old legislation – age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity. These are now called '*protected characteristics*'.

The Act extends some protections to characteristics that were not previously covered and also strengthens particular aspects of equality law.

The Act was introduced in 2010 but the implementation of some parts did not come into effect until 2011, 2012 and 2013.

The overall purpose of the Act is to tidy up and widen the laws already in place to prevent inequality and discrimination.

Table 8.1: Types of discrimination: definitions

Direct discrimination	This occurs when someone is treated less favourably than another person because of a protected characteristic they have or are thought to have (see perceptive discrimination below), or because they associate with someone who has a protected characteristic (see associative discrimination below).
Associative discrimination	This already applies to race, religion or belief and sexual orientation and has now been extended to cover age, disability, gender reassignment and sex. This is direct discrimination against someone because they associate with another person who possesses a protected characteristic.
Perceptive discrimination	This already applies to age, race, religion or belief and sexual orientation and has now been extended to cover disability, gender reassignment and sex. This is direct discrimination against an individual because others think they possess a particular protected characteristic. It applies even if the person does not actually possess that characteristic. The full guide provides an example of perceptive discrimination.
Indirect discrimination	This already applies to age, race, religion or belief, sex, sexual orientation and marriage and civil partnership and has now been extended to cover disability and gender reassignment. Indirect discrimination can occur when there is a condition, rule, policy or even practice in a company that applies to everyone but particularly disadvantages people who share a protected characteristic.

In deciding whether or not its practice is lawful the underwriter needs to consider if the practice affects, for example, disabled people (as defined) and, if so, whether it treats them less favourably than it treats non-disabled people, as a result of the disability in question. If it does, it must consider whether it does so with justification. There are a limited number of circumstances in which a service provider may treat disabled people less favourably. From an underwriting perspective, less favourable treatment is justified only if it is based on information that is relevant to the assessment of the risk. This includes actuarial or statistical data, medical research information and medical reports about the individual.

It is good practice for an insurer to have a documented underwriting philosophy which forms the basis of its practices and can be used to achieve competence of its staff through training.

In 2011, the European Court of Justice ruled that insurers can no longer use gender when rating for risks; as a result, insurers have been forced to remove any gender-related rating from their products. This ruling from the ***Test-Achats*** case came into force at the end of 2012. It has had an impact on motor insurance for consumers, with most insurers moving rates for female drivers (historically identified as 'better' drivers) in line with rates for male drivers.

E Data protection legislation

Who does the GDPR apply to? The GDPR applies to 'controllers' and 'processors'. The definitions are broadly the same as under the now superseded Data Protection Act 1998 (DPA 1998) – i.e. the controller says how and why personal data is processed and the processor acts on the controller's behalf.

The GDPR places specific legal obligations on processors; for example, firms are required to maintain records of personal data and processing activities. A firm has significantly more legal liability if it is responsible for a breach. These obligations for processors are a new requirement under the GDPR.

Controllers are not relieved of their obligations where a processor is involved – the GDPR places further obligations on controllers to ensure their contracts with processors comply with the GDPR.

What information does the GDPR apply to? The GDPR applies to personal data. However, the GDPR's definition is more detailed, reflecting changes in technology and in the way in which information is collected. It makes it clear that information such as an online identifier – e.g. an IP address – can be personal data.

The GDPR applies to both automated personal data and to manual filing systems where personal data is accessible according to specific criteria. This is wider than the DPA 1998's definition and could include chronologically ordered sets of manual records containing personal data. Personal data that has been anonymised – e.g. key-coded – can fall within the scope of the GDPR depending on how difficult it is to attribute the pseudonym to a particular individual.

Sensitive personal data: The GDPR refers to sensitive personal data as 'special categories of personal data'. These categories include:

- race;
- ethnic origin;
- politics;
- religion;
- trade union membership;
- genetics;
- biometrics (where used for ID purposes);
- health;
- sex life; or
- sexual orientation.

Principles: Under the GDPR, the data protection principles set out the main responsibilities for organisations. They are similar to those in the DPA 1998 with added detail. The most significant addition is an accountability principle: the GDPR requires firms to show how they comply with the principles – for example by documenting the decisions they take about a processing activity.

Data Protection Principles

All personal data should be:

1. processed lawfully, fairly and in a transparent manner in relation to individuals;
2. collected for specified, explicit and legitimate purposes and not further processed in a manner that is incompatible with those purposes;
3. adequate, relevant and limited to what is necessary in relation to the purposes for which they are processed;
4. accurate and, where necessary, kept up-to-date;
5. kept in a form which permits identification of data subjects for no longer than is necessary for the purposes for which the personal data is processed; and
6. processed in a manner that ensures appropriate security of the personal data, including protection against unauthorised or unlawful processing and against accidental loss, destruction or damage, using appropriate technical or organisational measures.

Lawful processing: For processing to be lawful under the GDPR, firms need to identify a lawful basis before they can process personal data and document it. This is significant because this lawful basis has an effect on an individual's rights: where a firm relies on someone's consent, the individual generally has stronger rights, for example to have their data deleted.

Consent: Consent under the GDPR must be a freely given, specific, informed and unambiguous indication of the individual's wishes. There must be some form of positive opt-in – consent cannot be inferred from silence, pre-ticked boxes or inactivity, and firms need to make it simple for people to withdraw consent. Consent must also be separate from other terms and conditions and be verifiable.

Firms can rely on other lawful bases apart from consent – for example, where processing is necessary for the purposes of an organisation's or a third party's legitimate interests. Firms were not required to automatically refresh all existing DPA consents in preparation for the GDPR, but if they rely on individuals' consent to process their data, they must make sure it meets the GDPR standard. If not, firms must either alter the consent mechanisms and seek fresh GDPR-compliant consent or find an alternative to consent.

Rights: The GDPR created some new rights for individuals and strengthens some of those that existed under the DPA. These are:

- The right to be informed.
- The right of access.
- The right to rectification.
- The right to erasure.
- The right to restrict processing.
- The right to data portability.
- The right to object.
- Rights in relation to automated decision making and profiling.

Data subject access request (DSAR): Under the GDPR, individuals have the right to access their personal data. In a financial services firm, this would mean providing all the records the firm holds on a particular client such as notes summarising conversations, any recorded conversations and completed documentation.

Individuals can exercise this right by submitting a DSAR to the organisation concerned, which can be made verbally or in writing. The organisation generally has one month to respond to a DSAR, although it can take an additional two months in certain circumstances. If the organisation fails to respond, the individual must complain to the organisation in the first instance. If they remain dissatisfied after that, they can make a complaint to the Information Commissioner's Office. The first copy of an individual's personal data should be provided free, although charges are permitted for additional copies if the organisation feels such a request is unfounded or excessive. Where this is the case, they can ask for a reasonable fee to cover administrative costs.

Accountability and governance: Accountability and transparency are more significant under the GDPR. Firms are expected to have in place comprehensive but proportionate governance measures. Good practice tools such as privacy impact assessments and privacy by design are now legally required in certain circumstances. Practically, this is likely to have meant more policies and procedures for some organisations, although many will already have good governance measures in place.

Breach notification: The GDPR places a duty on all organisations to report certain types of data breach to the relevant supervisory authority, and in some cases to the individuals affected.

Transfers of personal data to third countries or international organisations: The GDPR imposes restrictions on the transfer of personal data outside the European Union, to third countries or international organisations, in order to ensure that the level of protection of individuals afforded by the GDPR is not undermined.

Key points

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

Basic principles of underwriting

- The insurance underwriting process consists of an assessment of the following:
  - The major underwriting factors affecting claims experience for the particular class of business.
  - The 'average' claim per member of the group.
  - The proposer's characteristics in comparison with the 'average' member.
- In essence, the underwriter is evaluating the hazard associated with the risk which is being proposed.

Specific underwriting considerations

- The underwriting of commercial business insurances is generally more complicated as unlike personal lines business the risks are less homogenous.
- An underwriter will consider different underwriting factors depending upon the class of business.

Fraud: prevention, detection and consequences

- Insurance fraud is a significant problem for the insurance industry and can take many forms including:
  - inventing a loss event that never took place;
  - deliberately creating an insured event; and
  - exaggerating the effects of an insured event.
- The claims handler plays a vital part in detecting fraud; methods of detection vary across the different classes of business.
- The insurance industry has a number of bodies concerned with helping minimise the occurrence of fraud and maximise awareness of the problem and its negative effects.

Equality Act 2010

- Under the Equality Act 2010 it is unlawful to discriminate unfairly against disabled people in the provision of insurance. Underwriters may apply less favourable treatment to disabled persons only if it is based upon information that is relevant to the assessment of the risk.

Data Protection Act 2018

- The Data Protection Act 2018 is designed to regulate the systems for holding and processing data relating to any living person who can be identified from the data held, in line with the General Data Protection Regulations (GDPR).
- All public bodies and businesses (insurers included) handling such data must comply with principles of good information handling.

Self-test questions

1. What is the principal task of the underwriter?
2. Give five underwriting factors in respect of motor insurance for an individual.
3. What is the main rating factor in respect of health insurance?
4. What are the main underwriting factors in respect of household buildings insurance?
5. What will be an underwriter's principal concern when considering a proposal for business interruption insurance?
6. What is the fundamental purpose of the Insurance Fraud Bureau?
7. What will be the effect of fraud on genuine policyholders?
8. What is meant by sensitive personal data under the Data Protection Act 2018?

You will find the answers at the back of the book

Learning support is close to hand

Need a little support with your studies?

Revision aids are available for selected units, with exclusive discounts for members.

Our range of revision aids includes:

- **Key facts booklets –** pocket sized summaries of your study text, great for use while on the move
- **E-learn tutorials –** interactive online study programmes with questions to help you gauge your progress
- **Knowledge Checker –** an online tool to test your understanding of the study text, testing by individual chapter, random questions or full tests covering the breadth of the study text

Download the RevisionMate app from the Apple and Google Play app stores for use on iOS and Android devices.

Chartered Insurance Institute

Find out more
www.cii.co.uk/qualifications
or call **Customer Service**
on +44 (0)20 8989 8464

9
Establishing the price: rating factors

Contents	Syllabus learning outcomes
Introduction	
A Data required	*9.1*
B Importance of claims information	*9.2*
C Frequency and severity of claims	*9.3*
D Claims loss ratios	*9.4*
E Account performance and monitoring	*9.5*
Key points	
Question answers	
Self-test questions	

Learning objectives

After studying this chapter, you should be able to:

- describe the types of operational data needed by senior management to implement underwriting policy;
- explain the significance of claims information on underwriting terms and premium rates;
- explain the relationship between frequency and severity as components of risk;
- explain claims loss ratios and their impact on premiums and acceptance of risk; and
- explain and compare the different types of monitoring and accounting periods used.

Introduction

The insurance market is affected by an extremely wide variety of factors. These factors can be within the control of insurers such as their targeted products and markets, competitive performance etc. There are, however, many factors that are outside of insurers' control such as poor weather, natural disasters etc. As well as meeting the needs of customers and claimants, insurers also need to satisfy the demands of shareholders and other interested bodies such as regulators, monitoring agencies and the Government.

The financial demands on an insurance company are clearly vast and as in all business ventures insurers need to make profits to meet these demands.

To enable an insurer to make the required profits, extensive planning is required and the most appropriate method of planning is via the use of data or management information (MI). MI assists companies in analysing trends and forecasting the future by manipulating the data they have access to.

MI should flow in a loop back to the decision maker who then analyses the detail in respect of various aspects of business activity in order to develop plans and strategies.

In this chapter we shall focus on the type of data required in order to make decisions about insurance underwriting processes – in particular rating and pricing. You will gain an insight in to the role claims data plays in this process, in addition to how claims loss ratios and different types of monitoring periods are used in the decision-making process.

Key terms

This chapter features explanations of the following ideas:

Accounting year	Calendar year	Claims information	Claims loss ratios
Earned loss ratio	Frequency	Operational data	Outstanding loss ratio
Policy year	Severity	Underwriting year	

A Data required

Insurers, like all large companies, make decisions at different levels and therefore require different types and amounts of information. We can break down the levels of decision as follows: board level decisions, managers' decisions and operational decisions.

We can see the different levels as an 'information pyramid'.

Figure 9.1: Figure 9.1

- **Board level**: here, directors are concerned with group performance/profitability, the control of 'downside risk' (e.g. through catastrophe reinsurance) and broad strategy implementation.
- **Managers**: they will be responsible for different divisions within the business, e.g., sales, underwriting, personnel, and therefore require information that is specific to their area of responsibility. For instance, a property underwriting manager would be particularly interested in weather-related data and details of large claims; whereas a sales manager/ director would be interested in new business activity and renewal retention levels.
- **Operational level**: the issues will surround the implementation on a day-to-day basis of the underwriting practices and procedures established by the management team. So, data will focus on customer service levels, accuracy of claims handling and settlement, documentation and credit control.

We will now have a look at the type of information required at each level; this is a broad breakdown and serves to illustrate the focus needed at each level.

A1 Board level reporting

Issues concerned at this level are:

- **growth**: gross and net (i.e. how is the premium growing, both in total and net of reinsurance?);
- **loss ratios**: gross and net (i.e. what is the relationship of claims to premium income?);
- **underwriting margin/profit**;
- **business mix**: by class, distribution channels, geographically;
- **exposure accumulations** (i.e. is there an exposure to a particular loss by virtue of writing too much business in a particular class or area?);
- **competitive positioning**: how the company measures up to competitors;
- **return on capital**: profit expressed as percentage of capital;
- **solvency**: relationship between the capital and exposure to risk, usually expressed in terms of premium income.

A2 Reporting to underwriting managers

Reporting will generally be monthly. The key consideration is trends over time and this data will often be presented geographically. Issues concern:

- growth by product;
- retention rates (i.e. how much business is being kept and not lost to a competitor?);
- new business flow analysis;
- lapse flow analysis, i.e. lost business;
- loss ratios;
- claims trends: frequency and severity; average cost per claim;
- underlying claims;
- large losses; frequency and severity;
- weather-related losses; frequency and severity;
- reserve consistency;
- rate changes and increase in end price to customer (e.g. rate, indexation);
- commission rate (to intermediaries);
- expense ratios (i.e. what is the total level of costs compared to premium?);
- exposure accumulations; and
- market share and competitor activity.

A3 Operational data

This level requires monthly, and often weekly, reporting, for instance by intermediary, policy class or by underwriter. Specific information provided includes:

- loss ratio claims statistics: frequency/severity/large losses/claims movements;
- new business;
- retention;
- rate increases;
- credit control;
- compliance with contract certainty standards.

Example 9.1
An insurer will need to extract the data for the above from their various IT platforms. Not many insurers (if any) will have the information all in one platform and departments are created to provide the necessary reporting mechanisms.

B Importance of claims information

Claims are the principal 'cost of production' for an insurer and the accurate analysis of past claims histories (and flowing from this, forecasting the future cost of claims) is crucial to the profitability of an insurer's underwriting account.

We mentioned briefly in *Reporting to underwriting managers* on page 9/3 that the identification of trends is a key consideration for the underwriting manager when making decisions regarding underwriting terms and premiums.

Analysing *claims information* in various ways provides the underwriting manager with the information needed to ensure that predictions can be made about the future loss pattern and, in turn, the premium needed to cover the anticipated future claims costs.

There are many different ways that this analysis can be done and much of the detail of claims analysis techniques is outside the scope of this course. However, the significance of claims information on underwriting terms and premium rates can be appreciated through an understanding of the range of questions the underwriter will be asking when reviewing the claims data.

Consider this…
What type of management information will an underwriter be interested in and what questions will they be asking when they review the claims data?

When analysing claims data underwriters will consider:

- Looking at each year chronologically, is the experience improving or deteriorating?
- Is the number of claims each year increasing or decreasing (considering large versus attritional (volume))?
- Is the average cost of claims each year increasing or decreasing (considering large versus attritional (volume))?
- What are the causes of the claims?
- Are there any large claims that are distorting the pattern?
- Are individual claims reserves accurate, given the nature of the claim?
- What is the position regarding underlying claims?
- How are the claims recorded:
  - year of notification; or
  - underwriting year?

Whatever form the analysis of past claims information takes, it is only a part, albeit an important part, of the wider activity of assessing risk premium. In the next chapter we shall take a closer look at the various aspects relating to claims information as well as the other factors that play a role in the calculation of risk premium.

Before we consider further the relationship between claims and premium calculation, we need to understand the nature of risk and, in particular, the significance of the frequency and severity of claims.

B1 Personal injury discount rate

When claimants involved in life-changing injuries accept lump-sum payments from insurers, the amount they receive is adjusted based on the rate of return (interest) they can reasonably be expected to achieve by investing the lump sum. This adjustment is made by courts and linked to the rates of return on low-risk investments, such as index-linked gilts.

From 20 March 2017, all new and outstanding claims were subject to a discount rate of –0.75%. This is, in effect, a loading to reflect the fact that investment returns had not been keeping pace with inflation, which resulted in a reduction in the value of the lump-sum payment awarded in real terms.

The change of rate was significant for insurers, as it applied to both existing claims that were outstanding, as well as to new claims. This means that its impact is retrospective in many cases. For the sake of clarity, though, it did not apply to historic claims that had already been settled, as most insurers' policy wordings contained a provision which stated that claims were paid in full and final settlement.

In September 2017, following insurer feedback, the then Lord Chancellor confirmed that a review of the discount rate would take place, recognising that the type of investments claimants make may not be 'very low' risk portfolios, but rather 'low' risk portfolios. It also stated that the rate would be reviewed every three years by an independent expert panel chaired by the Government Actuary.

The last significant discussion took place on 19 March 2019, when the Government advised it was starting a review of the discount rate and whether it should be changed from –0.75%. It has since been set at –0.25% with effect from 5 August 2019. While an improvement, this is still effectively a load and will impact some insurers who have stated they have been reserving on the assumption of a nil rate. There will continue to be regular reviews, which insurers will undoubtedly seek to use to amend the discount rate further.

Reinforce
The personal injury discount rate was changed to –0.25% with effect from 5 August 2019.

The specifics of the personal injury discount rate are discussed in more detail in other units, but it is important to mention it here as an example of the type of event now and in the future that can significantly affect an insurer's claims reserving and, consequently, their pricing for customers. Coupled with increasing levies and changes to IPT, it not only impacts the price that is paid by the customer, but it could also lead to some lines of business hardening.

C Frequency and severity of claims

Risk is usually assessed in terms of:

- *Frequency*: how often will it happen?
- *Severity*: when it does happen, how serious will it be?

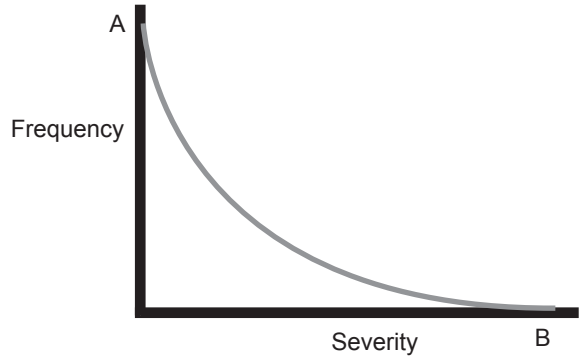
Factors relating to both frequency and severity must be taken into account in our assessment of risk, and this relationship varies from one risk to another.

Example 9.2

Imagine a house on a river, which is prone to overflowing its banks. This involves risk. It is uncertain **whether** the river will overflow, and if it does, **when** it will happen. Imagine, then, a second house 100 yards away, atop a slight hill: here, there is a lesser risk of flooding.

Our view on the level of risk may change if we consider the potential **amount** of damage. If the first house was worth £20,000 and the second house £200,000, we might amend our view as to which is the greater risk in view of the higher potential severity of loss. Therefore, insurers must take into account the factors of both frequency and severity in their assessment of risk.

Figure 9.2: Relationship between frequency and severity



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

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

High frequency and low severity
In these instances, there will be a large number of small losses and relatively few large losses. Depending on the type of insurance, often a suitable excess can accommodate these small losses.

Examples include theft of mobile phones or motor windscreen claims. Research into industrial incidents has shown a similar pattern.

Such losses are relatively predictable and may be referred to as the 'underlying claims cost' and should approximately be in direct proportion to the number of exposure units insured. A prudent underwriter should be able to predict these loss levels up to a certain degree of tolerance. For example, on a property account you might expect between 20% and 25% of the total premium to be exposed to underlying claims costs, i.e. excluding weather and large losses which have a degree of volatility attached to them.

Low frequency and high severity
Here, the situation is the reverse: there will be fewer incidents, but when they do occur the result will be far more serious.

Good examples of this type of risk profile are accidents involving oil-carrying sea vessels, e.g. the Deepwater Horizon oil spill in the Gulf of Mexico in 2010. Technological advances can help to reduce the frequency of accidents.

Think Back

See *Reinsurance* on page 11/4, for more on reinsurance

These losses are far less predictable compared to the underlying losses referred to above. As a result, insurers will take out reinsurance to protect themselves against such volatility.

Reinsurance will apply to:

- specific large losses; or
- an accumulation of exposures which create a large loss for the insurer following a single event; or
- the effects of an accumulation of events over a specific period.

As part of this process insurers will monitor accumulation.

Consider this…
Can you think of any perils/scenarios that could give rise to an accumulation of risk for a property insurer?

You may have thought about a number of things including:

- fire (which can spread between premises);
- insuring a number of insureds occupying the same premises;
- insuring both the landlord and the tenant of the same premises;
- storm and flood (which can affect a number of properties in the same area).

D Claims loss ratios

At this point we can now start to consider the relationship between claims and premium and, in particular, the **claims loss ratio**.

A claims loss ratio is the ratio of claims to premiums, and is calculated by dividing the amount of claims incurred by the amount of premium received, i.e.:

$$\text{Claims ratio} = \frac{\text{claim incurred}}{\text{premium}} \times 100$$

Example 9.3
If company A's motor account had a premium income of £100,000, and claims of £103,000, the claims ratio would be:

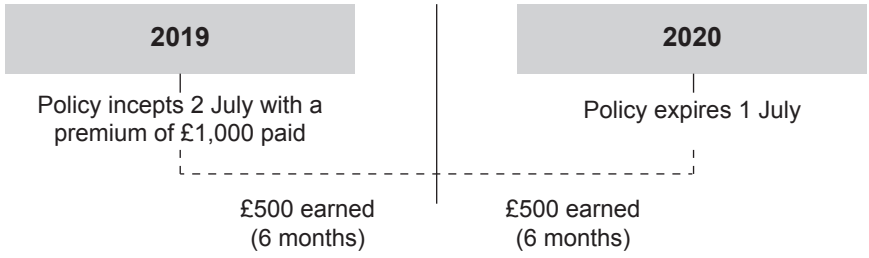
$$\frac{103{,}000}{100{,}000} \times 100 = 103\%$$

Claims ratios are very useful indicators of how an account is running, and in this section we will look at the main variations used in the analysis of data.

D1 Earned loss ratio (ELR)

Here we introduce the concept of earned premium. If an insurer begins cover on the 1 July and its financial year runs from 1 January until 31 December, then it will only have earned 50% of the premium in the financial year in which the premium is entered onto the accounts (or is 'booked').

An *earned loss ratio* can then be calculated by comparison of the claims for the period up until 31 December with the premium earned as above.



Earned loss ratios may be adjusted at account level to reflect reinsurance spend and IBNR (incurred but not reported) claims. The latter deals with the need to reserve for claims which

have not yet come to light, but nevertheless may possibly occur. Emerging risks provide an example of this in respect of liability.

Consider this…
There is rarely a shortage of stories in the media about the potential consequences for our health and welfare of lifestyle choices, social trends, legislative, technological and environmental developments. What do you think might constitute an emerging risk that insurers need to prepare for?

There are a whole range of issues that you might have thought of that would be considered as emerging risks, including:

- toxic mould;
- electro-magnetic forces;
- stress;
- passive smoking;
- environmental/climate change;
- NHS reform (recovery of costs); and
- asbestosis (developments in legislation).

When measuring ELR at policy level or broker level, IBNR and reinsurance are not taken into account.

IBNR claims are considered to be a funding issue at account level and are considered only when analysing the 'bigger picture' and the future prosperity of the account.

The concern at policy level and broker level is to consider the relative profitability of the individual policy or broker relative to other brokers and policies and achievement of a target ELR which is acceptable. This target ELR will reflect that there is still a need to make additional allowances for IBNR at account level.

D2 Outstanding loss ratio (OLR)

This loss ratio is extracted directly from the computer system or claims files. These figures represent claims that have been reported to insurers but not yet settled. This ratio does not recognise the fact that 100% of the premium has not yet been earned, instead claims are compared against 'booked' premium and as such are of fairly limited value.

E Account performance and monitoring

Armed with all this information regarding claims and premiums, managers must also make decisions about periods over which this information should be monitored.

The main types of monitoring period are:

- *policy year*;
- *underwriting year*;
- *calendar year*; and
- *accounting year*.

Each has its own area of use and value. To compare and contrast the different approaches, we shall use the following data.

Table 9.1:

	Policy details		Claims details	
	Policy period	**Premium (£)**	**Date of loss**	**Value (£)**
Policy A	01/07/15–30/06/16	1,000	01/12/2016	100
	01/07/16–30/06/17	1,500	01/03/2017	250
	01/07/17–30/06/18	2,000		
Policy B	10/04/14–09/04/15	5,000	01/07/2014	1,000
	10/04/15–09/04/16	4,000	01/02/2015	2,500
	10/04/16–09/04/17	5,000	01/05/2016	10,000
	10/04/17–09/04/18	4,500	28/06/2017	3,000

E1 Policy year

Policy year tracking is suitable for addressing the performance of individual policies. Generally, each twelve-month period would constitute a separate policy 'year'.

Using the figures in table 9.1, the data for Policy A would be presented as follows:

Table 9.2:

Period	**Premium**	**Claims**	
		Number	**Value**
Year 1: 01/07/2015–30/06/2016	1,000	0	0
Year 2: 01/07/2016–30/06/2017	1,500	2	350
Year 3: 01/07/2017–30/06/2018	2,000	0	0
Totals	4,500	2	350

Consider this…
Do you consider the claims experience for this policy to be acceptable?

From the above example you will see that £4,500 has been booked and a total of £350 in claims has been incurred. This means that the outstanding loss ratio is 7.8%, which would be considered as a good return for the insurer.

Question 9.1

If the data above was extracted on 30 April 2018 what would the ELR be?

E2 Underwriting year

This type of monitoring period is used at account level, with individual policy data being grouped into 'underwriting years' based on the year in which the policy incepts (or renews).

Assuming policy periods are twelve months long, two years will elapse between the start of the underwriting year and the last date of cover of the last policy to be attached to that year. However, those risks will have been subject to the particular underwriting and pricing philosophy in use during the underwriting year. The monitoring period thereby focuses on both claims trends and also the impact of decision-making as it develops with time.

In studying table 9.3, compiled from the example data, it can be seen that underwriting year data is simply the sum of policy year data, allocating policies on the basis of the first year of the policy period.

Table 9.3:

Underwriting year	Number of policies	Premium	Number of claims	Claims value	Loss ratio
01/01/2014–31/12/2014	1	5,000	2	3,500	70.0%
01/01/2015–31/12/2015	2	5,000	0	0	0.0%
01/01/2016–31/12/2016	2	6,500	3	10,350	159.2%
01/01/2017–31/12/2017	2	6,500	1	3,000	46.2%
Totals (Four year)		**23,000**	**6**	**16,850**	**73.3%**
Totals (Three year)		**18,000**	**4**	**13,350**	**74.2%**
Totals (Two year)		**13,000**	**4**	**13,350**	**102.7%**

E3 Calendar year

With this type of monitoring, claims and premiums from individual policies are allocated to a calendar year.

Claims are allocated to the relevant year on the basis of the date of loss.

Using the data from table 9.1, the claims would be presented as follows:

Table 9.4:

Calendar year	Number of claims	Claims value
2014	1	1,000
2015	1	2,500
2016	2	10,100
2017	2	3,250
2018	0	0
Totals	6	16,850

Premiums are allocated according to that portion of the policy premium that is earned during the relevant calendar year.

Example 9.4

For example, if a policy ran from 1 July 2016 to 30 June 2017, and the premium was £1,000, only half (£500) the premium would have been 'earned' in 2016, because only half the policy year is in 2016, the other half being in 2017.

E4 Accounting year

This is similar to the calendar year approach, but with the following modifications:

- The period will depend on the financial year, e.g. 1 October to 30 September, rather than 1 January to 31 December.
- Prospective premium and claims developments from the accounting year end have to be estimated.

Because estimates are incorporated, trends are harder to detect; therefore, this information should only be used to support decision-making as a last resort.

Key points

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

Data required

- Data is required throughout an insurance company. This includes board, management and operational level.

Importance of claims information

- Claims are the principal 'cost of production' for an insurer and the accurate analysis of past claims histories is crucial to the profitability of an insurer's underwriting account.

Frequency and severity of claims

- Insurers are concerned with both the frequency and severity of claims.

Claims loss ratios

- The earned loss ratio (ELR) provides the most accurate measure of performance at policy level.

Account performance and monitoring

- Performance will be monitored at account level on a regular basis.

Question answers

9.1 To calculate the ELR we need to consider what premium has been earned.

- In Years 1 and 2 the full premium has been earned, i.e. £2,500.
- In Year 3 only 10 months has been earned so 10/12ths of £2,000 is used, i.e. £1,666.
- Total earned premium is therefore £4,166.
- ELR is therefore as follows:

$$\frac{£350}{£4,166} = 8.40\%$$

Self-test questions

1. What are the three levels of the 'information pyramid' in a typical insurance company?

2. What issues are considered at board level?

3. What issues are considered at underwriting managers' level?

4. What is the relationship between the frequency and severity of risk?

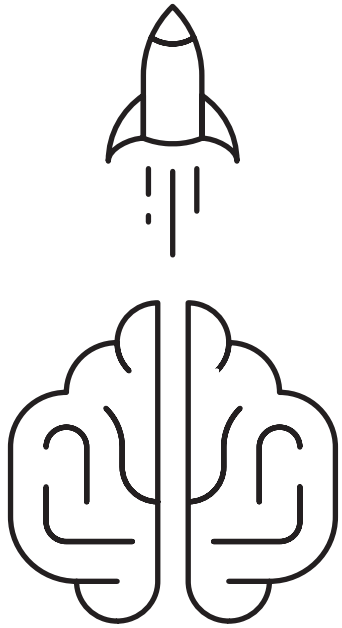
5. If company A had premium income of £75,000 and claims of £100,000, what would the claims loss ratio be on these figures?

6. What is the difference between a policy year and an underwriting year?

7. What is the difference between a calendar year and an accounting year as monitoring periods?

You will find the answers at the back of the book

Supporting your research



From reports and articles that can be referenced in coursework assignments and dissertations, to ebooks, statistics, and specialist librarians just an email away, knowledge services' resources provide a wealth of information.

Join today at **www.cii.co.uk/join** and access all of the following:

- **eLibrary –** thousands of eBooks, journals, and reports available to download or read online
- **Research assistance –** knowledge services staff help you locate resources, search specialist databases, and access print articles and book chapters
- **Reports and statistics –** on market trends and analysis with supporting statistics

Chartered Insurance Institute

Find out more
www.cii.co.uk/knowledge

10

Establishing the price: pricing factors

Contents	Syllabus learning outcomes
Introduction	
A Risk premium	*10.1*
B Expenses	*10.2*
C Return on capital employed (ROCE)	*10.2*
D Investment income	*10.2*
E Premium taxes	*10.2*
Key points	
Question answers	
Self-test questions	

Learning objectives

After studying this chapter, you should be able to:

- identify and explain the underlying factors that should be considered in assessing a risk premium;
- describe the effect of expense costs on premium rates;
- identify the concept of the return on capital employed (ROCE); and
- explain the importance of providing for taxation in establishing price.

Introduction

In this chapter, we consider how risk premiums are assessed and the expenses that affect premium rates. We go on to explore the concept of return on capital employed (ROCE), the role of investment income, and premium taxes.

Key terms

This chapter features explanations of the following ideas:

Catastrophe claims	Claims inflation	Claims run-off	Commission
Expenses	Exposure	Financial Services Compensation Scheme	Fraud
Frequency	IBNR claims	Insurance premium tax	Investment income
Large claims	Latent claims	Motor Insurer's Bureau (MIB)	Premium taxes
Reinsurance cost	Return on capital employed (ROCE)	Risk premium	Severity

A Risk premium

Risk premium can be defined as:

> the expected ultimate cost in claims of the risk being accepted, including an allowance for the degree of uncertainty attaching to the claims cost (whether in the estimating process or through the nature of the claims themselves).

It can be further defined as representing the amount of money required today to fund claims, i.e. the time value of the money is taken into account.

In other words it is the premium required to cover the total cost of claims, recognising that in some cases these may take some considerable time to settle. An example would be an employers' liability claim for an industrial disease. It could take several years to identify the existence and impact of the disease and then several more years to settle the claim. By the time settlement is made inflation and other external factors such as changes in legislation could mean that the real cost of settlement is much higher than would have been the case had the claim been settled in the policy year.

Consider this…
Can you think of some industrial diseases which may take many years after the event for the symptoms to be identified?

We will look briefly at the key features of risk premium, and some of the issues surrounding its calculation.

A1 Frequency

The expected number of claims should be forecast accurately; it should also account for anticipated changes in the environment, the portfolio of risks and the individual risks.

Each distinctive type of claim should be projected separately.

You would expect a higher frequency on a motor account than on a fire account, simply because motor accidents are more common than fire and special perils claims.

A2 Severity

Likewise, the average cost of different types of claim should be assessed. The average cost of a fire claim would tend to be higher than a motor accident. An allowance should always be made for catastrophes (these would include windstorm and flooding in the UK and earthquakes and hurricanes elsewhere in the world).

A3 Large claims

An underwriter needs to consider, in respect of any class of business, how many *large claims* they can expect and how much they need to allow for these claims.

Large claims play a disproportionate role in pricing and profitability, with smaller insurers being particularly disadvantaged as their portfolio is less likely to be able to absorb such losses.

Large claims, specifically those involving liability to third parties, are increasingly impacting future ratings. In recent years, the use of periodic payment orders (PPOs) has increased for serious personal injury claims. PPOs can add significant costs to claims settlements, as they are designed to make structured payments to claimants for life, and to avoid the need for the State to fund care costs once settlements have been spent by claimants. Owing to the need for structured payments, there is an increased cost incurred through administration, and in better predicted lifespans of claimants.

More recently, with changes made to the personal injury discount rate in March 2017, insurers have seen the impact on both **existing** and new claims, with reserves on some large personal injury claims increasing by more than 100% to allow for the lack of any future investment income, which might previously have been achieved by claimants on large payments. The revised rate of –0.25% (August 2019), while an improvement, falls below the Ministry of Justice's proposed rate of between 0.0% and 1.0%.

A4 Reinsurance cost

Think Back
Reinsurance on page 11/4 explains basic reinsurance considerations

In order to protect the company from catastrophic single or combined losses (e.g. a flood in the UK for a household insurer) insurers often buy reinsurance protection. The variety of types of covers available is outside the scope of this course, but it is important to understand that these costs must be factored in to the pricing of the product costs (the premium).

This cost will vary by class and company. The more significant it is, the more important it is that the underwriter allocates its cost equitably to avoid creating a competitive pricing disadvantage.

A5 Claims run-off

Claims data should be adjusted to allow for the **provisional** nature of case estimates. Underwriters should be aware of the source of such data, the purpose for which it was intended, and how it was reached.

An underwriter will see risks being re-reserved once more information relative to a claim becomes available. Sometimes claims may be re-opened although you should note that in respect of liability claims insurers will use precautionary reserves even if the insurer has declined liability for an incident. This is because an insurer has a regulatory obligation to identify its potential liabilities and needs to ensure that adequate reserves are in place. The insurer may decline liability for an incident but could still end up losing the legal argument and having to pay the claim.

Such claims movements are referred to as **run-off** and could produce a surplus or a claims deficit.

A6 IBNR (incurred but not reported) claims

This is a factor that underwriters must consider carefully in establishing pricing.

Example 10.1

At the end of a year when all the numbers are totalled, underwriters look at them and base all pricing decisions on the figures recorded on 31 December. But this only deals with a certain percentage of claims. Think about the last few weeks in December. People are busy, post is slow, people often take extended Christmas holidays. This all impacts on the reporting of claims, in other words, many claims events may have occurred which are not recorded in insurers' books. These are referred to as incurred but not reported (IBNR). It is important that such claims are accounted for when assessing the total claims for that underwriting year, otherwise the numbers on which pricing is based are inadequate.

Another example is Hurricane Dorian that struck the Bahamas in 2019. Insurers would be aware if they had exposure in the affected region but there would be a delay in residents returning to their homes, assessing the damage and reporting it to insurers.

Depending on the class of business and the age of claims, this aspect can be significant and it is prudent for an insurer to create precautionary reserves for these eventualities.

A7 Catastrophe claims

Catastrophe claims differ from large claims in the sense that they reflect the accumulation of a large number of claims, all arising from a common event such as a hurricane.

The underwriter needs to estimate both their frequency and severity, and manage their exposures and buy optimal levels of reinsurance cover.

A8 Latent claims

For liability classes, latent claims are an extreme form of IBNR as, in some instances, there may be more than 50 years between the cause and the claim.

For instance, asbestos-related diseases such as mesothelioma have been given a high profile with many insurers in the UK and the USA having to create reserves now for incidents which occurred over 40 years ago. Another form of latent claim is that of abuse, with claims not being brought for many years. In addition, insurers are becoming increasingly aware of new or emerging risks such as stress, toxic mould and EMF (the technology associated with mobile phones).

These types of claims are referred to as 'long tail' claims. In other words while the business has been written many years ago, the claims can still come in many years afterwards. Such claims are now presenting the insurance industry generally with serious issues.

Question 10.1

Which lines of business are more likely to be affected by latent claims?

A9 Claims inflation

Claims inflation, especially in respect of personal injury claims, often exceeds generic inflation due to changes in legislation, some of which are retrospective. Recent changes in legislation include NHS recoveries and changes in the discount rates on the Ogden personal injury discount rate tables discussed in earlier chapters. To take account of inflation the premium needs to be adjusted to reflect any devaluation of the funds available to pay claims when they arise.

A10 Exposure

Claims data is historical and, therefore, should be adjusted to reflect today's **exposure** rather than that when the claims arose. This may require consideration regarding change in the amount of the exposure and/or changes to the inherent risks relative to the risk presented. For example, working practices in an industry may have changed such that certain types of claim which were previously common to that industry may now be unlikely due to changes in working practices.

Example 10.2
Consider a metal working or plastics manufacturing risk. Traditionally these risks have presented insurers with a significant 'manual handling' risk. However, following technological advances, a number of these machines are now automated and controlled by computer (CNC controlled). As a result, the manual handling risk has reduced substantially.

In such circumstances it would not be appropriate to price the risk based upon historical claims statistics as this is based on a different risk profile and would not reflect the improvement in the risk.

A11 Fraud

Several insurers now have dedicated anti-fraud teams, particularly for retail and small and medium enterprises (SME) insurances, which are becoming increasingly commoditised and traded via e-trade routes (i.e. insurers' websites, software house systems, aggregators online).

A key issue facing insurers is the increasing prevalence of fraud; both claims fraud (crash for cash), and application fraud (misrepresenting information online to obtain a price, or changing answers several times to sense check and obtain the best price).

Insurers are allowing for this cost in their pricing, typically by expressing the increase cost as a deterioration to their loss ratio. For example, if an insurer writes to a 55% developed loss ratio via intermediaries, they may increase this loss ratio significantly (for example, by over 10%) to reflect the increased claims cost of transacting business via an electronic route online.

A12 Legal Aid, Sentencing and Punishment of Offenders Act (LASPO) 2012

Following the implementation of LASPO in 2013, several insurers anticipated improvements in claims costs, owing to changes to the way claims are notified and settled. These anticipated improvements were translated into rate reductions, particularly for casualty and motor business, where some insurers reduced rates by up to 15%. This improvement has not been realised by insurers; while there was improvement in loss ratios, particularly in motor insurance, following implementation of LASPO, these have not continued over the long term. It is generally accepted that the legislation continues to have an impact, but that more still needs to be done to protect against undue costs as a result of spurious or exaggerated claims, and claims farming.

Be aware
Claims farming is when a company or a person encourages another to make a claim.

B Expenses

We have dealt in *Risk premium* on page 10/2 with risk premium, i.e. the amount of money required to fund a claim.

There are also other factors that need to be taken into consideration, such as the cost of running an insurance business, and this needs to be recovered through the 'price' charged. The total of these costs, together with any commission paid, also needs to be considered. This is essentially an accounting function, and underwriting skills would add little or nothing.

Consider this…
What expenses do you think are incurred in running an insurance business?

Examples of expenses include:

- staff costs;
- premises;
- electricity and other utilities;
- computers and machinery;
- marketing and advertising; and
- commission paid to agents and brokers.

We will now look at some of these in a little more detail.

B1 Fixed expenses

There will always be a cost associated with processing a particular product; this cost does not increase with the size of the risk.

As an example, the accounting entries, record-keeping, policy issue and certificate production for a given product are likely to be much the same for a £1,000 risk as for a £100,000 risk.

Therefore, a fixed amount should be allocated per policy.

B2 Variable expenses

Conversely, there are expenses that vary according to the size, complexity and nature of each risk. For example, larger risks tend to be more complex, require more mid-term changes and are likely to require a higher level of service from surveys and risk management, while others require more bespoke solutions tailored to the needs of individual proposers.

The price, therefore, needs to take into account the amount of such variable costs for each product line. Examples of variable costs could be grouped under the following headings:

- underwriting;
- commission;
- claims handling.

B2A Underwriting

Services such as policy alterations, risk management, disaster recovery planning, help lines etc., provided to policyholders are independent of the existence or volume of claims.

B2B Commission

Commission is the amount (normally a percentage) paid to the agent, intermediary or broker who introduces the business to the insurer (and is paid for subsequent periods of insurance). This may vary from 7.5% on a motor fleet up to 25% or more on some classes of commercial credit insurance.

This can vary by product or case by case and may be negotiated.

If there are special intermediary remuneration schemes (e.g. incentives for volume of business, profit, or a combination), the underwriter needs to model the impact into the pricing framework.

Commission can take other forms (e.g. work transfer). In a work transfer arrangement, the insurer pays the intermediary a percentage of the premium charged in exchange for taking on more work (e.g. issuing documentation, acting as the underwriter under the terms of a delegated authority). Such payments are more common with particular classes of insurance and segments (e.g. real estate). Insurers must allow for this increased cost across their distribution channels. For example, within the Real Estate market, it is common for commissions and work transfer payments to total between 40-50%, compared to a typical commercial, combined policy where they total between 20-25%. This puts more pressure on the loss ratio an insurer needs to write to, in order to achieve their target **combined operating ratio** (COR) (discussed later in *Investment income* on page 10/7).

B2C Claims handling

This cost varies according to the number and complexity of claims. There should therefore be:

- a charge per claim; and
- a charge reflecting the differences in the volume of work required for more involved cases.

These charges, again, vary by product and claim type.

In summary, while underwriters can add little to the specific process of cost allocation, they should ensure that the model by which expenses are allocated bears a close resemblance to the actual day-to-day realities of what takes up everyone's time.

B2D Other expenses

Insurers sometimes incur other costs for the policies they sell. Usually, the following tools can help deliver the insurer's target combined operating ratio (COR) if they are used correctly:

- Risk management funds: in the real estate market, these funds are offered to a customer towards the agreed costs in maintaining or protecting the asset(s).
- Low claims rebates: some insurers offer to pay back a portion of the premium to incentivise more positive risk management.

C Return on capital employed (ROCE)

The *return on capital employed (ROCE)* is a key financial concept. The 'risk capital requirement', calculated by actuaries, is the proportion of total account premiums which must be kept as free reserves to ensure that an insurer can meet its claims obligations.

As the return (that is, **profit**) is measured as a proportion of the capital employed (ROCE), classes of insurance with a higher degree of volatility must be capable of generating higher profits if they are to justify the shareholders taking that risk.

It is helpful to think about the need for return on capital in relation to other investment opportunities. If you had money to invest you could get 3% simply by putting it in the bank. This would carry virtually no risk. Higher risk investments might carry a greater return (but there is a greater risk of loss too).

So, if an investor decides to invest in a company there has to be a return on that investment which is higher than would have been secured from, for example, a bank. This is the return on capital.

D Investment income

With general insurance, there has historically been unease at allowing for investment income in pricing. This section will deal briefly with the relevant general principles.

Consider this…
Why are insurers able to earn significant amounts from investment income?

Insurers are able to earn *investment income* by virtue of the substantial amounts of capital and reserves they control. They are required by law to maintain certain levels of reserves based on the total premium income they receive. This is to pay for future claims.

They are allowed to invest this income. The income received from this investment process is another 'earning stream' for the business.

There is some debate about whether this income should be relied on by insurers as it is not their core business, and as the markets can fluctuate, it cannot be relied upon. However, when investment returns are high, there is a temptation to rely on this, and to cut the basic profit margin calculation. In effect, rates become more competitive to secure more business and premium, which can then be invested and the profits are made on these investments. In theory this is fine, but when investment returns are cut, the rating structure needs to be robust enough to continue to produce a return on capital, or insurers lose money.

The 'underwriting result' is the business result without investment income. It consists of the combination of the loss ratio, the commission ratio and the expense ratio. This is referred to as the **combined operating ratio (COR)** and is a common measure of the financial health of general insurers. While this figure is a percentage, the underwriting result is an actual profit or loss value.

It is this relationship between profit and the yield from the underwriting result plus investment income that tends to produce the cyclical nature of insurance. This causes swings between hard markets (when rates and premiums are higher) and soft markets (when they tend to be lower to attract more business on which to secure investment returns). The market will turn from soft to hard when the returns for insurers are inadequate and capital – as a consequence – is withdrawn. Once the insurance market peaks capital re-enters the market and in accordance with supply and demand theory rates drop and the market becomes soft. We shall look at this in more detail in the next chapter.

D1 Income only, or capital gains too?

Insurers tend to balance their portfolio between two broad classes of investment:

- interest-bearing investments; and
- investments whose value can be expected to grow at least in line with the economy (equities).

The latter have generally generated a higher rate of return over the medium to long term, but are more volatile in the short to medium term, hence the balance.

If the contributions of capital gains were ignored, returns would be understated, and the insurer's products may become overpriced and uncompetitive.

As we saw above, the counterside of this is that if these returns are relied on the products may become very competitive, which may be good, but can cause difficulties if the investment returns diminish.

The ABI Statement of Recommended Practice requires the full amount of capital movements to be shown in the profit and loss account.

D2 Actual or expected rates of return?

If capital gains are included, the investment returns are likely to be volatile. Even the income-only element is likely to move with the economic cycle. Current yields only reflect historical rates.

Therefore, a detached assessment should be made of the rates expected to be available over the lifetime of the contract.

E Premium taxes

In the UK, these come in a variety of forms ranging from 'pure' taxation (e.g. insurance premium tax) expressed as a fixed percentage of premium, to quasi-taxation such as the levies raised by:

- the Financial Services Compensation Scheme (FSCS);
- the Motor Insurer's Bureau (MIB); and
- Mesothelioma Act 2014 levy.

E1 Financial Services Compensation Scheme (FSCS)

The FSCS levies a surcharge based on a percentage of gross direct premium to fund claims by policyholders whose insurer has become insolvent. The demands on the FSCS are difficult to forecast and, therefore, the amount of the levy cannot easily be assessed.

In effect, therefore, if a policy is priced incorrectly, it may be the shareholders and not the policyholders who fund the levy.

E2 Motor Insurers' Bureau (MIB)

In the UK, this is the insurer of last resort for property damage or injury by an uninsured or untraced driver. There is an annual levy, dependent on claims experience. The rate for individual insurers depends on their mix of business, with higher rates for non-comprehensive private motor and fleet business than for comprehensive private motor.

Underwriters will therefore need to incorporate the MIB levy in pricing, at a level that they will need to forecast.

E3 Mesothelioma Act 2014

Mesothelioma is a cancer of the lining of the lungs and other organs following exposure to asbestos or materials containing it. It takes a long time to manifest itself, on average anywhere from 15 to 20 years after exposure.

From March 2014, a levy has been charged on all premiums for employers' liability cover. This levy funds the Diffuse Mesothelioma Payment Scheme, which allows those suffering from mesothelioma-related illnesses, but unable to trace their employers, to obtain financial support. In the sixth year of the scheme, the total levy charged for 2019/20 was £33.3 million.

The scheme initially provided compensation to individual claimants based on 80% of the average of civil claims, but was increased on 10 February 2015 to 100% of the average of civil claims under the Diffuse Mesothelioma Payment Scheme (Amendment) Regulations 2015.

Key points

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

Risk premium

- Insurers will price the risk to ensure that both the risk premium and their expenses are covered.
- The risk premium is made up of funding for the following: frequency and severity of claims, large claims, reinsurance, claims run-off, IBNR claims, catastrophe claims, latent claims, claims inflation and should reflect the current exposure.

Expenses

- Expenses can be fixed or variable.
- Variable expenses include underwriting costs, commission and claims handling.

Return on capital employed (ROCE)

- An insurer needs to provide a return on capital for its investors. In view of the associated risk of investing in an insurance company it is necessary to provide a higher return compared to a conventional bank account.

Investment income

- Insurers make significant returns following investment of income in their possession. These returns should not be relied upon however.

Premium taxes

- Insurance attracts IPT at a rate of 12% subject to some exceptions.

Question answers

10.1 Liability claims are likely to cause the main concern because there is usually a significant gap between the occurrence of the incident and the extent of the injury or damage. Most emerging risks are having an impact on the liability lines of business too. This is unlike property claims where the cost of damage is known within a relatively short time.

Self-test questions

1. What is the risk premium?
2. What is the difference between IBNR and run-off claims?
3. Why is claims inflation a problem for insurers in fixing the price of insurance?
4. What is the difference between fixed and variable expenses?
5. What is ROCE?
6. What is the purpose of the levy charged by the Financial Services Compensation Scheme?

You will find the answers at the back of the book

11
Managing exposure

Contents	Syllabus learning outcomes
Introduction	
A Market cycle	*11.1*
B Risk accumulation	*11.2*
C Reinsurance	*11.3*
Key points	
Question answers	
Self-test questions	

Learning objectives

After studying this chapter, you should be able to:

- describe the basic factors influencing the market cycle;
- describe the principles of the accumulation of risk; and
- describe the basic considerations applicable in the purchasing of reinsurance.

Introduction

Underwriters have an important role in assessing the risks proposed. This assessment must include both qualitative aspects (i.e. the specifics of the risk proposed such as whether it is a firework factory or an office block) and quantitative aspects (i.e. how substantial the risk is). They must ensure that the **exposures** (i.e. sums insured or policy limits representing a potential claim) brought to the **pool** are rated against desired company standards. The account underwriter or manager is responsible for the wider implications of exposure control.

This final chapter will deal briefly with the problems of the market cycle and risk accumulation, how they can arise, and also with the principles of reinsurance, one of the steps that can be taken to manage exposure.

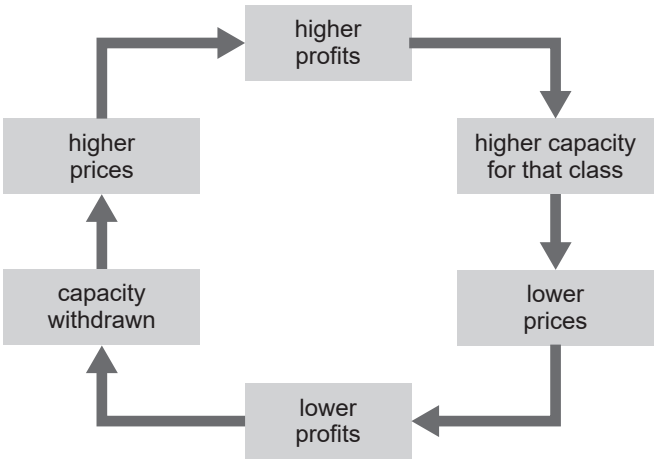
Key terms

This chapter features explanations of the following ideas:

Excess of loss	Hard market	Liability risks	Non-proportional reinsurance
Proportional reinsurance	Reinsurance	Single events	Single risks
Soft market	Stop loss insurance	Surplus	

A Market cycle

The classic insurance cycle can be illustrated as follows:



It goes without saying that if an insurer experiences higher profits in a particular class of business, it and its reinsurers will want to increase investment in that class to accept more business with a view to generating greater profits. Market-wide capacity therefore increases, but premium rates are reduced as insurers try to maintain market share and underwrite more new business risks. Unfortunately claims costs rise as a result of claims inflation and this, plus a reduced premium rate, affects underwriting profits. The result is a reduction in returns for investors and eventually, the withdrawal of capacity which causes premiums to rise (supply versus demand). Once insurers are seen to be making good returns again, capital re-enters the market, rates fall and the cycle is repeated.

This is known as the insurance cycle. During times when rates are reducing the market is said to be **softening**, but when rates are increasing the market is said to be **hardening**.

Question 11.1

Do rates in the market for different lines of business go ‘hard’ and ‘soft’ at the same time?

It is very difficult to identify the length of the market cycle. There is no reason why the cycle cannot be longer or shorter depending on economic factors, changes in the law and other

external influences. For example, following the terrorist attack on the World Trade Center (9/11) in 2001, reinsurance costs increased and capacity reduced.

From a risk perspective cycles can be **shortened** in several ways such as, but not exclusively, by:

- Amendments to legislation can result in new liabilities arising for different classes of accident, injury or loss where none existed previously.
- More onerous legislation can extend liabilities during the currency of policies, which were not envisaged and not funded for in premium levels.
- Weather-related incidents. For example, the floods due to Storms Ciara and Dennis in early 2020.
- Major disasters such as hurricanes or acts of terrorism. Following the events of '9/11', the worldwide insurance market turned instantaneously.

There may be economic issues which drive the market cycle too. Insurers are major investors in the financial markets and therefore the impact of their returns from such activities can have an effect on their own profitability. If returns are not forthcoming there is greater emphasis on their underwriting result which may drive a requirement to apply increased rates.

B Risk accumulation

Insurers must always be aware of loss exposures arising from:

- *single risks*;
- *single events*.

B1 Single risks

The action will vary depending upon whether the business written is property or liability.

B1A Property and business interruption risks

Taking a fire risk as an example, calculating the maximum exposure for any one risk is not simply a case of adding the sums insured at a single location, but involves assessing the **estimated maximum loss (EML)** which is likely to occur. (N.B. This is also sometimes referred to as the maximum probable loss (MPL), although some insurers using MPL also do so as a more conservative assessment using different rules on which to base the maximum loss.)

Be aware
Some insurers may refer to a probable maximum loss (PML), i.e. the maximum loss that an insurer would be expected to incur on a policy.

Example 11.1
A policyholder insures two factories, each valued at £1m but located 50 metres apart. A fire in one of the factories is unlikely to spread to the other. Therefore while the total value at risk may be £2m, the EML is only £1m.

The EML must be accurate to have any purpose: it will have important reinsurance (and commensurate premium) implications. Once the EML has been calculated, an underwriting decision must be taken on the desirability of accepting the risk within the gross account. This is influenced by the extent to which this risk, when added to other accumulations at that risk, will aggregate to produce too high an exposure from a single risk.

The risk surveyor plays a critical role in helping identify the estimated maximum loss and effective communication with the underwriter is vital in ensuring that all aspects of the risk in question are understood. In the example above it would be vital for the underwriter to know that while the factories were 50 metres apart one was immediately downhill from the other and the factories were connected by an underground conveyor belt system (through which a fire might spread).

If the EML is greater than the insurer's acceptability limits it has two options. Firstly it could purchase reinsurance so that it can write 100% of the risk or, alternatively, it could take a proportion of the risk and co-insurance would need to be arranged. Co-insurance is the sharing of a risk between two or more insurers.

B1B Liability risks

The handling of liability business is slightly different as cover is based on a limit of liability rather than a sum insured and an EML. In the liability market it is common to encounter layering of limits of liability.

Example 11.2
An insurer may be presented with a risk relating to the manufacture of a certain product. It feels that it can only accept a limit of liability of £2m, but the proposer requires a £5m limit of liability. In these circumstances the proposer would arrange additional protection between £2m and £5m with another insurer, i.e. they will purchase excess of loss insurance for £3m in excess of £2m.

B2 Single events

The threat of catastrophe is a phenomenon that insurers have to accept as part of their business. Many individual losses can result from one catastrophic event affecting a large number of policies, e.g. a windstorm on the south coast could affect household, commercial, fire, motor, marine and aviation policies. Here, insurers have to acknowledge such possibilities and seek the financial stability that catastrophe reinsurance protection can offer.

C Reinsurance

What is reinsurance?
Reinsurance is an extension of the fundamental concept of insurance, that is, the sharing of risk: it is an insurance organised by an insurer against claims incurred under contracts of insurance written by that insurer. In essence, an insurer insures the risk again.

Why do underwriters seek reinsurance?
There are a number of reasons (although the following list is not definitive), including:

- protection of the account against a single large event, e.g. earthquake;
- protection of the account against a large claim on a single item, i.e. an art museum;
- protection of company capital;
- protection against fluctuating claims costs from year to year;
- operational capacity, i.e. insurer X may only be able to insure fire risks up to £1m and prearranged reinsurance facilities in excess of this can ensure an acceptable level of services is provided to customers;
- entering a new market, e.g. a life company starting a marine or aviation portfolio;
- building up the account;
- minimising loss impact on income generated;
- underwriters' peace of mind; and
- sharing heavy/hazardous risks.

Ultimately, insurers want to keep as much premium as possible at the same time as reinsuring as much risk as they can. No underwriter will want to part with very profitable business. However, buying some protection against unexpected events may be desirable, indeed it is a crucial part of managing the overall account and exposures.

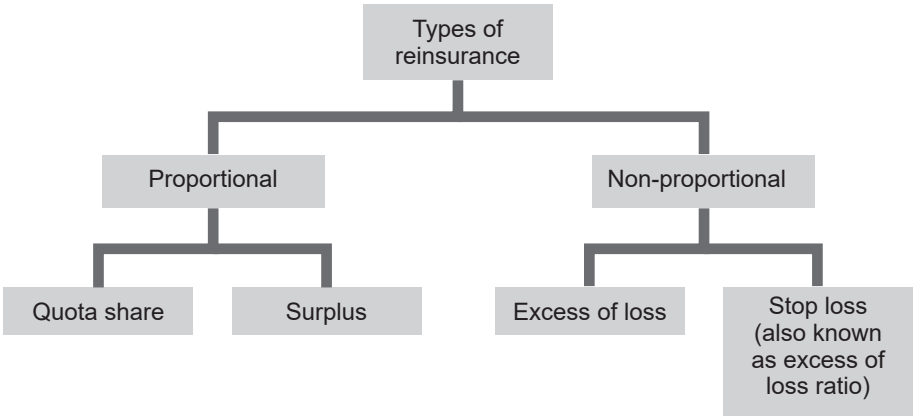
The underwriter should always bear in mind that they are legally bound to pay for losses arising **before** seeking their indemnity through reinsurers. This can place an obvious strain on resources.

C1 Types of reinsurance

Essentially, there are two main types of reinsurance:

- **proportional**; and
- **non-proportional**.

These can then be further sub-divided as follows:



C1A Proportional reinsurance

Here, the reinsurer accepts an agreed share of the risk to be ceded (put forward for reinsurance), and pays any loss incurred on the same basis.

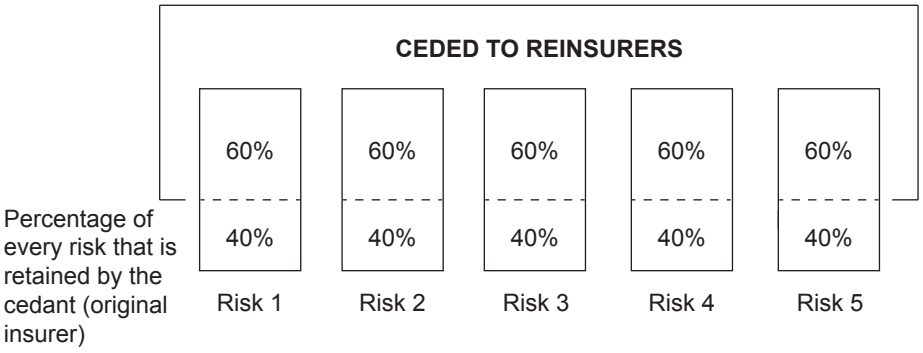
Proportional reinsurance can be divided into quota share and *surplus*.

Quota share

With quota share reinsurance, an agreed proportion of all insurances written by an insurer will fall within the treaty. For example, if an insurer has a treaty covering 60% of its motor portfolio, the reinsurer would accept liability for 60% of every policy written (even if the insurer could actually retain certain policies within its own acceptance limits).

The big advantage of this type of reinsurance is that it is very easy to administer: the reinsurer accepts its proportion as soon as the business is written. It has the obvious disadvantage, however, that the insurer must pay the reinsurer premiums for risks that it could retain for its own account.

This form of reinsurance is principally utilised by new insurance companies, or where an existing company is embarking on a new class of insurance.



Surplus

With this form of reinsurance, the insurer only reinsures those risks where the sum insured exceeds its own retention limit. The insurer will purchase additional lines equal to the line it is able to write, known as the 'maximum retained line'.

Example 11.3

An insurer is permitted to write a maximum line of £100,000 (their maximum retained line). If it decides it wants to write a maximum of £600,000 for a particular risk, it may wish to arrange a five line surplus treaty with reinsurers to provide five lines equal to the insurer's maximum line (i.e. 5 x £100,000 = £500,000).

Policy	Sum insured	Amount retained	Amount reinsured	% reinsured	Balance
1	£100,000	£100,000	–	–	–
2	£300,000	£100,000	£200,000	66.67%	–
3	£500,000	£100,000	£400,000	80.00%	–
4	£600,000	£100,000	£500,000	83.33%	–
5	£700,000	£100,000	£500,000	71.43%	£100,000

C1B Non-proportional reinsurance

With these types of reinsurance, a reinsurer agrees to contribute to losses exceeding a specified figure for a premium negotiated with the insurer.

Non-proportional reinsurance can be divided into **excess of loss** and **stop loss** (also known as excess of loss ratio).

Excess of loss
This could be written on a:

- per risk basis;
- per event basis.

Example 11.4

On a per risk basis, if an insurer enters in to a contract with a reinsurer where the reinsurer's liability under an excess of loss reinsurance is for £100,000 in excess of £50,000, this could be illustrated as follows:

Loss	Amount	Insurer's liability	Reinsurer's liability	Balance
1	£25,000	£25,000	–	–
2	£75,000	£50,000	£25,000	–
3	£125,000	£50,000	£75,000	–
4	£200,000	£50,000	£100,000	£50,000

This type of reinsurance is often arranged in **layers**, for example:

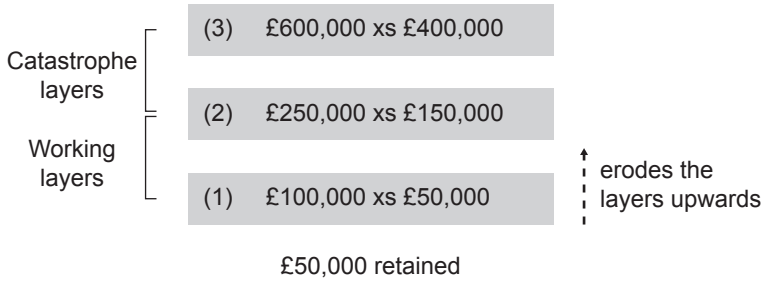
Layer 1: £100,000 in excess of £50,000

Layer 2: £250,000 in excess of £150,000

Layer 3: £600,000 in excess of £400,000

In this example, if the insurer did not have any further layers, it would be responsible for the balance of £50,000 in loss 4.

On a per event basis, the reinsurer's liability is based on the total losses incurred by the insurer due to the occurrence of one event. For example, an earthquake may affect more than one class of insurance (motor, property) and several insured risks may sustain loss.



Stop loss (excess of loss ratio)
With this type of reinsurance, the insurer is primarily concerned with protecting its loss ratio. If, for example, an insurer wanted to prevent its maximum loss ratio from exceeding 80%, it could obtain reinsurance for claims in excess of this figure.

Reinsurers would usually limit their maximum liability and would also generally insist that an insurer shares in any reinsured loss. Otherwise the insurer would basically be guaranteeing that it would not suffer an underwriting loss.

Table 11.1: Summary of reinsurance terminology

To cede	The act of sharing the risk with reinsurers.
Cedant	Another word for the original insurer who is passing the risk to reinsurers.
Facultative reinsurance	Reinsurance purchased for an individual risk, generally because it would not fit within any other part of the reinsurance already available. Will only respond to claims arising out of that one risk.
Proportional reinsurance	Reinsurance where the premium and claims are shared between insurer and reinsurer in pre-agreed proportions, such as 30%. In the simplest form of contract there will be no financial limitations, the reference will only be made to proportions but in more complex contracts there will be limits expressed in financial terms relating to the size of the risks that can be shared with the reinsurers. Quota share and surplus treaty reinsurance are examples of this type.
Retrocedant	A reinsurer obtaining reinsurance for itself.
Retrocession	A cession where the entity ceding is already a reinsurer.
Retrocessionaire	A reinsurer accepting reinsurance from an entity that is itself a reinsurer.
Treaty reinsurance	Reinsurance that can be purchased to cover a wider portfolio of risks, either a class of business or even an insurer's whole book of busines

Key points

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

Market cycle

- The insurance industry is exposed to a market cycle where rates can be seen to be hard or soft depending upon the status of the market. It is driven by available capital in the market which in turn is driven by investment returns and underwriting results. The market cycle can vary by line of business.

Risk accumulation

- Insurers need to monitor their exposures against losses from a single risk or a single event.
- In respect of a single property risk they will monitor their accumulations and calculate an EML. If the EML exceeds company thresholds for acceptance reinsurance or co-insurance shall be sought if they wish to write the business.
- Catastrophe events can affect a number of risks on different accounts. Therefore, insurers will purchase catastrophe reinsurance to ensure that adequate protection of the account is provided.

Reinsurance

- Reinsurance comes in various forms. It can be proportional, e.g. quota share or surplus, or non-proportional, e.g. excess of loss or stop loss.

Question answers

11.1 From experience different lines of business change their status at various times. Invariably in the commercial market motor premiums lead the cycle followed by the other casualty lines such as employers' and public liability and then, finally, the property lines of cover.

Self-test questions

1. What factors can shorten the market cycle?

2. With regard to risk accumulation, what are the two areas of potential loss exposure that insurers must consider?

3. What is an EML?

4. What step might direct insurers take to minimise their potential aggregation of risk exposures in their fire account?

You will find the answers at the back of the book

Chapter 1 self-test answers

1 The essential elements of a contract are:

- offer;
- acceptance; and
- consideration.

2 Consumers only need to respond to questions asked by the insurer on the proposal form. Non-consumers must disclose all material circumstances. In both cases the information must be full and accurate.

3 A material fact or circumstance is a fact which would influence an underwriter in deciding whether to accept a risk or not, and if accepted, on what terms.

4 Facts that do not need to be disclosed include:

- facts of law;
- facts of public knowledge;
- 'spent' convictions;
- facts that improve the risk;
- facts where the insurer has waived its rights to certain information;
- facts that a survey should have revealed;
- facts an insured did not know;
- facts covered by the policy terms; and
- facts that the insurer already knows, including those that its employee(s) know.

5 The proposer must:

- disclose every material circumstance it knows and ought to know, or must notify the insurer that it needs to make further enquiries;
- ensure that its representation of the risk is clear and accessible; and
- ensure that all material circumstances represented are substantially correct and made in good faith.

6 Misrepresentation is a false statement relating to the subject matter of a proposal and which leads an insurer to enter into a contract.

7 Under common law, the duty of disclosure begins when negotiations begin and ends when the policy starts. The duty would only be revived at renewal.

8 A breach of the duty of disclosure may arise by either:

- misrepresentation; or
- non-disclosure.

9 A peril is what gives rise to a loss, while hazard actually influences the peril itself.

10 The various sources from which an underwriter will obtain material information, depending on the class of business and details of the risk are as follows:

- the proposal form;
- brokers;
- risk surveys;
- supplementary questionnaires;
- meeting with clients;
- call centres; and
- the internet.

Chapter 2 self-test answers

1 A quotation can be viewed as an offer by the insurer, and for a contract to come into force, there must be an acceptance by the proposer. This acceptance must be within any timescales as specified by the insurer.

2 The declaration states that the information supplied in the proposal form is true and correct to the best of the proposer's knowledge and belief. It must be signed by the proposer.

3 General questions are usually common to most general insurances and consist of items such as name, address and period of insurance. Specific questions are risk specific, that is they relate to the particular details of the risk to be insured, e.g. description of the insured subject matter, proposer's age.

4 A premium is the amount an insured pays to the insurer for the insurer to accept the risk. It is the insured's consideration in respect of the insurance contract.

5 A premium is usually arrived at by applying a premium rate to a premium base. A rate per cent is a price in pounds for each one hundred pounds of exposure, while a rate per mille is the price for each one thousand pounds.

6 If a premium base is unknown at the start of an insurance period, this can be estimated and a premium charged on this estimated figure. At the end of the period, the premium will be adjusted up or down accordingly. The initial premium paid is known as a deposit premium.

7 A cover note is a document issued as evidence that insurance is in force, pending the issue of the policy.

8 Insurance premium tax is payable on most insurance premiums to HM Revenue and Customs (although collected by insurers). The rate is currently 12%, which took effect from 1 June 2017. This is for all policies except travel insurance and some engineering insurances which have a rate of 20%.

Chapter 3 self-test answers

1 An insurance policy will generally consist of the following:

- heading;
- preamble;
- signature clause;
- operative clause;
- exclusions;
- conditions;
- policy schedule; and
- information and facilities.

2 The operative clause outlines the actual cover provided by the policy. It is, therefore, essentially the most important section of the policy.

3 General exclusions apply to all sections of the policy, while specific exclusions only apply to particular parts of the policy.

4 The common policy conditions are as follows:

- the insured must observe and fulfil all the terms of the policy;
- the duty of disclosure is a continuing duty (i.e. it amends the common law position);
- duties of the insured in the event of a claim;
- fraudulent claims condition;
- mitigation clause;
- contribution;
- subrogation;
- average;
- arbitration; and
- cancellation.

5 An excess is the first amount of each and every claim for which an insured is responsible. A deductible is, in essence, a very large excess. A franchise is a fixed amount (or time period) acting as a threshold to determine whether a claim is payable. If this threshold is exceeded, the claim is paid in full; if not, nothing is payable.

6 A warranty in an insurance contract is a promise made by the insured relating to facts or performances concerning the risk; it is an undertaking by the insured that something will/will not be done, or that a certain fact does/does not exist.

7 Conditions in an insurance policy can be divided into the following three groups:

- conditions precedent to the contract;
- conditions subsequent to the contract;
- conditions precedent to liability.

8 Warranties must be strictly and literally complied with, are written into the policy (unless implied) and give the insurer the right to repudiate any breach relevant to a loss/damage. A representation is not normally in the policy, need only be substantially correct and allows repudiation of a claim only if a breach is material.

Chapter 4 self-test answers

1 A renewal notice informs the insured that their insurance contract is about to come to an end and invites them to renew the policy. The renewal notice contains the renewal premium and any proposed changes in the terms and conditions.

2 The administration rates incurred in setting up the policy are high and the policyholder would be considered to have cost the common pool more than average and is, therefore, often charged more than simple pro-rated charges.

Chapter 5 self-test answers

1 The minimum cover required is Road Traffic Act only. This covers unlimited indemnity in respect of bodily injury or death to third parties, loss of or damage to third party property (with a limit of £1,200,000), claimants' costs and expenses, and emergency medical treatment and hospital charges arising out of the vehicle use.

2 Although other exclusions may apply, the most common will be:

- wear and tear;
- tyre damage from blow-outs or punctures;
- mechanical and electrical failure;
- depreciation;
- loss of use.

3 A motor cycle policy only covers the theft of accessories or spare parts if the motor cycle itself is also stolen.

4 A benefit policy means that the policy is a contract to pay a certain sum of money in the event of a defined event occurring. There does not need to be a direct financial loss.

5 Private medical insurance provides cover for individuals seeking medical treatment outside the National Health Service, giving an individual the choice of specialists, consultants, hospitals and also the timing of the treatment.

6 'Buildings' are the main structure of the private dwelling and includes garages, sheds, greenhouses and other outbuildings. It also includes swimming pools and tennis courts. Anything you would normally leave behind when you move would be considered part of the building.

7 The basic sections of a travel insurance policy are as follows:

- personal accident benefits;
- medical and associated benefits;
- travel delay;
- travel interruption;
- baggage, personal effects and money;
- delayed baggage;
- hospital cash benefits;
- loss of deposits;
- personal liability;
- cancellation.

8 The following optional extensions are usually available in addition to the 'standard' cover:

- the failure of the tour organiser;
- lack of services or amenities;
- loss of passport;
- legal expenses.

9 Extended warranty cover is in respect of repairs following electrical and mechanical defects, for a period of up to five years from purchase. Policies are available to cover all electrical products in an insured's house, and a typical limit is around £2,500.

Chapter 6 self-test answers

1 'Standard' fire cover is made up of:

- fire;
- lightning; and
- explosion.

2 The four groups of exclusions are as follows:

- absolute exclusions;
- gradually operating exclusions;
- aspects of cover which can be written into the policy (for additional premium); and
- property or risks more suitable to cover under another type of policy.

3 Insurers include a phrase that the theft must 'involve entry to or exit from the premises by forcible and violent means'.

4 The standard money policy may be extended to include:

- personal accident/assault; and
- credit cards.

5 Business interruption insurance covers the actual or potential loss of earnings and additional expenses incurred as a result of a material loss covered under a property insurance.

6 The main sections are:

- employment disputes cover;
- criminal prosecution defence cover;
- property disputes cover;
- motor cover;
- patents, registered designs, copyright and trademarks cover; and
- taxation proceedings.

7 The standard policy covers legal liability for bodily injury or property damage arising out of goods or products that an insured has manufactured, constructed, altered, repaired, serviced, treated, sold, supplied or distributed.

8 Professional indemnity insurance covers professional persons' liability for injury, damage or financial loss to clients or the public as a result of breach of professional duty, or negligent acts, errors or omissions in their professional capacity.

9 Cover for cyber losses may be required for both first party and third party covers. The cover a customer receives will depend on the product offered by the insurance they choose. An insurer may cover first party losses only, third party losses only and associated costs (e.g. defence costs, costs of public relations), or both under one or multiple products.

First party losses relate to the proposer's assets or finances. Third party losses relate to the proposer's duty of care to third parties and their property.

Chapter 7 self-test answers

1 The most common use of a helpline in travel insurance is in respect of emergency medical service. A policyholder is usually provided with a card containing a 24-hour helpline number that they would use and the company would then arrange treatment or repatriation, as appropriate.

2 Approved repairers are most commonly used in motor insurance. Most insurers have a countrywide network of such repairers.

3 Risk management can be defined as the identification, analysis and economic control of those risks which can threaten the assets or earning capacity of an enterprise.

4 The two main components of risk control are:

- physical control measures of the risk; and
- financial control measures of the potential loss.

5 An uninsured loss is any loss that is not covered by insurance and can range from a simple policy excess to extensive personal injury.

Chapter 8 self-test answers

1 The underwriter's task is to manage the common pool (of funds) effectively by assessing risk, deciding whether to accept the risk and deciding upon the terms and conditions of acceptance, and calculating a suitable premium.

2 Many different factors are used in rating motor insurance, and different insurers will consider different factors to be more important than others. Examples are:

- driver's age;
- type and make of car;
- use of vehicle;
- geographical area;
- where the vehicle is kept overnight;
- driving history;
- modifications to vehicle; and
- cover and extensions.

3 The main rating factor for health insurance is occupation.

4 The most important rating factors for buildings insurance are use, construction and location.

5 With business interruption insurance, an underwriter's principal concern will be how quickly a proposer can get their business up and running again after an incident.

6 The Insurance Fraud Bureau's main purpose is to co-ordinate industry-wide action (general and life offices, police forces and other agencies) in fighting crime and fraud.

7 Genuine policyholders would be affected by fraud by seeing a marked increase in premiums.

8 Sensitive personal data pertains to any data that falls into one of several special categories of personal data, including race, genetics and biometrics.

Chapter 9 self-test answers

1 The three levels are:

- Board.
- Underwriting managers.
- Operational level.

2 Issues considered at board level include:

- growth of the company;
- loss ratios;
- underwriting margins;
- mix of business;
- accumulations;
- competitive standing;
- capital returns;
- solvency.

3 Issues concerning underwriting management include growth by product, retention rates, loss ratios, claims trends, new business flow, underlying claims, large losses, weather-related losses, market share, accumulations, rate changes and commissions.

4 The frequency of risk pertains to how often a risk happens, while severity of risk is concerned with when it does happen, how serious it is.

5 The claims loss ratio would be:

$$133.33\% \left(\frac{100{,}000}{75{,}000} \times \frac{100}{1} \right)$$

6 A policy year refers to the actual period of insurance covered by a particular policy, i.e. inception date to end date. An underwriting year refers to the year in which a policy incepts, i.e. if the start date of a policy is 1 July 2018, the underwriting year is 2018 (01/01/18–31/12/18).

7 With calendar year monitoring, a claim is allocated to an actual calendar year (1 January to 31 December) on the basis of the date of loss, i.e. if the date of loss was in 2018, it is allocated to the 2018 calendar year. An accounting year will be twelve months long, but will mirror the insurer's accounting year which is not necessarily 1 January to 31 December of any year.

Chapter 10 self-test answers

1 The risk premium can be defined as 'the expected ultimate cost in claims of the risk being accepted, including an allowance for the degree of uncertainty attaching to the claims cost (whether in the estimating process or through the nature of the claims themselves)'. Essentially, it is the amount of money required to fund claims.

2 IBNR claims are 'incurred but not reported', i.e. the claim has happened, but the insurer has not been notified. Run-off claims involve claims which have been reported to the insurer, but following progression of the claim through to negotiation the claims reserve changes.

3 The value of the money set aside to settle claims will have reduced in real terms. Underwriters should check Government indices and economic forecasts.

4 Fixed costs are generally the costs associated with processing a particular product, irrespective of risk size. On the other hand, many other product expenses vary with size, complexity and nature of risk (e.g. risk surveys); these are variable costs.

5 This is 'return on capital employed', that is, the profit made on the capital invested.

6 To fund claims by policyholders whose insurer has become insolvent.

Chapter 11 self-test answers

1 A market cycle can be shortened by:

- Amendments to legislation, which can result in new or extended liabilities.
- Changes in underwriting policy.
- Weather-related incidents.
- Major disasters, such as hurricane or terrorism.

2 The two areas are:

- Single risks.
- Single events.

3 EML is 'Estimated Maximum Loss'. It is an amount expressed in a percentage form reflecting the worst financial effect that a loss could have. It could be 100% of the sum insured, but is normally less.

4 They could arrange adequate reinsurance cover.

Cases

Legislation

Index

T

U

V

W

Chartered Insurance Institute
42–48 High Road, South Woodford,
London E18 2JP

tel: +44 (0)20 8989 8464

customer.serv@cii.co.uk
www.cii.co.uk

Chartered Insurance Institute
@CIIGroup

© Chartered Insurance Institute 2020

Ref: IF3TB1

FSC www.fsc.org
MIX
Paper from responsible sources
FSC® C023114