INSURANCE INSURANCE GENERAL MATTERS CONCERNING ALL TYPES OF INSURANCE I. GENERAL MATTERS CONCERNING ALL TYPES OF INSURANCE Why is insurance so important to society? Life has its unexpected moments. Sometimes these moments are good. Sometimes they bring times of challenge, like illness or accident or damage to your home when a typhoon hits, or even the premature death of a love one. The unexpected also means life is unpredictable and we have to think of the future, like how can we finance our retirement. Society has found a way coping with the unexpected. It's called insurance. Insurance doesn't stop the unexpected from happening, but it can make things a bit more bearable when it does. Insurance can also help us face the future with confidence. Although it's not glamourous, insurance provides society with a foundation of resilience. That's why insurance is so vital and has been around for thousands of years, almost as long as humanity itself. Insurance is provided by insurance companies. They provide insurance through the thousands of contracts they enter into every day. Like any industry, insurance has its own form of jargon, but it's easy to understand if you take a minute: Insurance jargon is easy to understand The contract which an insurance company enters into to provide insurance is called an insurance policy. It sets out all the terms and conditions on which the insurance is provided. A person who buys insurance by entering into an insurance policy with the insurance company, is called a policyholder. Under the terms and conditions of an insurance policy, the policyholder agrees to pay the insurance company a price called a premium. In return or the payment of premium, the insurance company commits to pay the policyholder if a specified event or accident stated in the insurance policy happens during a set period of time in the future called the policy period. The commitment by the insurance company to pay if the specified event or accident happens during the policy period, is called insurance coverage. The policyholder who has purchased the insurance policy is said to be protected or covered for the specified events or accidents in the insurance policy. The protection or coverage are also sometimes termed as the insurance benefits under the insurance policy. The policyholder in purchasing an insurance policy is also said to have transferred the risk of the specified event or accident, to the insurance company. When the specified event or accident happens, to obtain payment from the insurance company, the policyholder makes a claim under the insurance policy. In order for a claim to be covered under the insurance policy, the claim must arise from the specified event or accident in the insurance policy and not fall within any of the exclusions stated in the insurance policy. Exclusions denote situations which are not covered under the insurance policy. The insurance policy often sets a cap on the maximum amount the insurance company has to pay the policyholder, called the policy limit. Sometimes the insurance policy also specifies an amount of loss which the policyholder has to bear himself if specified event or accident happens, before he can claim under the insurance policy. This is called the excess or deductible. A person can buy an insurance policy through one of the distribution channels which an insurance company uses to offer insurance policies. Licensed insurance brokers are one these distributions channels. A person looking to buy insurance can appoint a licensed insurance broker obtain advice and to approach numerous insurance companies to find the most suitable insurance policy to meet the person's needs. A person can also approach an insurance company through one of the company's appointed licensed insurance agents (appointed by a licensed insurance company to sell its insurance policies). A person can also approach an insurance company directly and apply for insurance through, for example, the internet platform provided by the insurance company. Indeed, as technology progresses, a number of new technology based alternative distribution channels are being used by insurance companies to offer insurance policies (also known as Insurtech). The basic legal issues you need to know about an insurance policy Despite all this jargon (and despite the technology being used), an insurance policy is just the same as any other contract. It is entered into by "offer" and "acceptance", supported by consideration in the form of the premium paid by the policyholder and the insurance company's commitment to provide cover for the specified event or accident, and intent to create contractual relations. However, there are certain additional legal characteristics which apply to insurance policies that do not apply to other contracts. These are as follows: An insurance policy must protect

against uncertainty An insurance policy can only protect against the happening of an uncertain event. For example, an accident policy protects against loss arising from an accident; medical and critical illness insurance policies protect a policyholder for the costs of getting ill or sick or having to go to hospital; motor insurance protects against the loss arising from a car accident. All of these events may or may not happen and are therefore uncertain. With regards to life insurance, sad though may be, it is certain that we will all die one day. However, it is uncertain when we will die. Life insurance cannot stop you from dying but it can protect your loved ones (i.e. your beneficiaries) for the loss of your financial support, in the uncertainty of you dying too soon. An annuity policy – being a type of life insurance policy – also protects a policyholder for the extra costs of living longer than expected (again, an uncertainty) and, in this way, provides crucial retirement protection. The fact that insurance policies cover uncertain events means that there is a wide variety of different types of insurance policies offered by insurance companies. Insurance policies can cover you for risk of death, accident, illness, the cost of going to hospital, damage or loss or theft to your household possessions, damage to your car or property, the risk of incurring liability to third parties, your flight getting cancelled and other related risks when you go on holiday. Insurance policies also support the risks of entire industries (like marine insurance which supports the maritime industry, or aviation insurance which supports associated with the aviation industry). There are insurance policies to cover risks associated with doing business or trade (like employee's compensation and public liability insurance, professional indemnity insurance, directors and officers insurance, and trade credit insurance). Further as society achieves progress through innovation, so new risks emerge and insurance adapts to cover these new risks. Hence, we now see the emergence of cyber insurance policies and specific coverages which you can buy for your Smartphone and other gadgets. An insurance policy is based on utmost good faith and the duty of disclosure Unlike most other types of contracts, an insurance policy is a contract based on the duty of utmost good faith. The duty of utmost good faith applies to all insurance policies. The most important aspect of the duty of utmost good faith is the duty of disclosure which a person looking to buy an insurance policy (i.e. a prospective policyholder) has. The duty of disclosure means that a person looking to buy an insurance policy from an insurance company, must disclose all material facts about the risk which the person is looking to insure. The law imposes this duty of disclosure because the person looking to buy insurance has all the relevant information in relation to the risk he is looking to insure, whereas the insurer has none. For example, a person looking for life insurance knows what illnesses he has had in the past, whether he has any ongoing medical issues, what his lifestyle is like and what information was in his last health check-up. All of this is highly relevant to the risk he is looking to insure (i.e. the risk of him dying sooner than expected). The insurance company knows none of this information and needs the person to disclose it to the company, so the risk can be assessed, the amount of premium estimated and a decision made as to whether or not enter into the insurance policy. As such, the law requires the person seeking insurance to be honest and make full disclosure to the insurance company of all pertinent information in relation to the risk so that the insurance company is fully informed before deciding to enter into the insurance policy. Failing to disclose such information has serious consequences. It will entitle the insurance company to "avoid" the insurance policy. This means the insurance company, on discovering the non-disclosure by the policyholder, can simply pay back the premium and act as if the insurance policy never existed (denying insurance coverage to the policyholder). It is, therefore, imperative that a person disclose all pertinent information in relation to the risk when buying insurance. A person buying an insurance policy must have an insurable interest In order to buy an insurance policy to cover a risk, the person buying the insurance should have an interest in the risk to be insured. This called an "insurable interest". A person has an insurable interest in the risk to be insured, if the harm or damage to the item being insured (whether it is the person's life or property) would cause that person to suffer loss. In the case of a life insurance policy, a person who buys insurance on his life, has an obvious insurable interest (in that he has an interest in not dying – the loss

of his life being the risk insured). If a person wishes to purchase the insurance to cover another person's life, the purchaser will have an insurable interest provided the relationship between the purchaser and the insured person is one whereby the purchaser will suffer either emotional loss or financial loss if the insured person dies. An insurable interest based on emotional loss certainly arises from a relationship of marriage. Further, (by reason of section 64A of the Insurance Ordinance (Cap. 41)) a parent of a minor or a guardian of a ward under 18 years of age are deemed to have an interest in the life of the minor or ward (and therefore the parent or guardian can purchase insurance on the life of the minor or ward). An insurable interest based on financial loss, could arise by reason of a debt owed (as the person who is owed the debt has an interest in the life of the person owing the debt). A company may have an insurable interest in the life of a key employee. A person may have an insurable interest in the life of any person on whom they are financially dependent. In the case of most property insurance, the risk being insured is the risk of damage to a physical object (an apartment, or a car, or a ship, for example). The person buying the insurance must have an interest in the physical object being insured i.e. the person must stand to lose if the physical object is damaged. For example, if a car is stolen, the car owner would suffer a loss (and therefore has an insurable interest in the car). The principle of indemnity (whereby certain types of insurance policies only indemnify a person for loss caused – see below) is linked to this as the person can only suffer loss from damage to the property, if he has an interest in the property. One of the reasons the law requires a person to have an "insurable interest", is to prevent insurance being used by a person to gamble on the lives of other people with whom they have no relationship whatsoever. The requirement for "insurable interest" also prevents what is known as moral hazard. By requiring a person to have an insurable interest in the risk insured (for example a property), it removes any incentive for a person to act immorally by deliberately damaging the property (or recklessly not safeguarding the property) in order to bring about a claim under the insurance policy. Insurance policies and the principle of indemnity Many (but not all) insurance policies are based on the principle of indemnity. This means that the insurance company indemnifies the policyholder for the loss caused to the policyholder as a result of the specified event or uncertainty (up to the amount of the policy limit). For example, a motor insurance policy will indemnify a car owner for the costs of having to repair his car (i.e. his loss) if it is damaged. In other words, the insurance company only pays a claim if (and to the extent) the policyholder has suffered loss from the specified event or uncertainty in the policy. There are however exceptions of this, namely insurance policies which are "contingency" insurance policies. A contingency insurance policy is one whereby a set amount (as stated in the insurance policy) is paid out to the policyholder by the insurance company on the happening of the specified event or uncertainty. A life insurance policy is a type of contingency policy in that it specifies a set amount which aims to reflect the value placed on the life of the policyholder. It is that set amount which is paid by the insurance company in the event of the policyholder's death during the policy period. This is so even if the actual loss to policyholder's dependents in financial terms resulting from his death, is different from the set amount which is paid. 1. THE INSURED PERSONS OR POLICYHOLDERS MIGHT SOMETIMES FAIL TO DISCLOSE ALL THEIR PERSONAL INFORMATION TO THE INSURANCE COMPANY. WILL SUCH A NON-DISCLOSURE LEAD TO THE REJECTION OF CLAIMS? WHAT IMPORTANT FACTS MUST BE DISCLOSED? 1. THE INSURED PERSONS OR POLICYHOLDERS MIGHT SOMETIMES FAIL TO DISCLOSE ALL THEIR PERSONAL INFORMATION TO THE INSURANCE COMPANY. WILL SUCH A NON-DISCLOSURE LEAD TO THE REJECTION OF CLAIMS? WHAT IMPORTANT FACTS MUST BE DISCLOSED? The duty of good faith which applies to all insurance policies, means that the person buying the insurance policy must disclose all material facts (including personal information) in relation to the risk. This disclosure must be made to the insurance company from which the person is seeking to buy an insurance policy to cover the risk. Note, not all kinds of information are required to be disclosed. The person looking to buy insurance policy is only required to disclose information that is "material" to the risk. Information is "material" to the risk if it is information which is relevant

and important for the insurance company to take into account when assessing the risk to decide whether or not to insure the risk and to determine the amount of premium to charge for the insurance policy. For example, if the information would cause the insurance company to set a higher premium than would be the case if the information is not disclosed, then the information is material and should be disclosed. Furthermore, the duty on the person seeking insurance is not just to disclose material facts about the risk which he actually knows, but to disclose material facts which he could reasonably be expected to know and disclose. On receiving the relevant information the insurance company will make an assessment of the risk. Based on that assessment, the insurance company sets the terms and conditions and the rate of premium to offer to the person looking to buy. This process is called underwriting the proposed insurance coverage. A material non-disclosure occurs when the policyholder conceals or fails to disclose to the insurance company material facts that are relevant to the risk for which insurance is being sought. If there is a material non-disclosure, the insurance company will be able to avoid the insurance policy (i.e. when there is a claim, get out of having to pay the claim by handing back the premium and acting as if the insurance policy never existed). As such a material non-disclosure has serious consequences. For example, a claim under a medical insurance policy may be rejected (and the policy avoided) if the policyholder did not disclose (prior to buying the insurance policy) that the insured person has a heart condition, as had the insurance company known that fact, it would have charged a higher premium. Given the serious consequence a material non-disclosure can bring about, it vital that A person answers all the questions in the insurer’ s application form as fully and as honestly as possible. It is vital a person think carefully before giving an answer. If a person has any uncertainty as to whether or not to disclose a particular piece of information to the insurance company, it is recommended that he err on the side of caution and disclose it. 2. FURTHER TO THE QUESTION ABOVE, IF A PIECE OF NON-DISCLOSED INFORMATION IS NOT RELATED TO A PARTICULAR CLAIM, CAN THE INSURANCE COMPANY STILL REJECT SUCH CLAIM? 2. FURTHER TO THE QUESTION ABOVE, IF A PIECE OF NON-DISCLOSED INFORMATION IS NOT RELATED TO A PARTICULAR CLAIM (E.G. I SUBMIT A CLAIM DUE TO AN INJURY FROM PLAYING FOOTBALL, BUT I HAD NOT PREVIOUSLY MENTIONED MY SMOKING HABIT), CAN THE INSURANCE COMPANY STILL REJECT SUCH CLAIM? As indicated in the answer to Question 1, the question is whether the information is material (i.e. relevant) to the risk for which insurance is being sought. A medical insurance policy provides coverage for the medical costs when the person is ill or injured and needs to incur medical costs. If a person smokes that increases the risk of getting ill, so it is highly relevant (i.e. material) for an insurance company’ s assessment of the risk of providing the person medical insurance. Indeed, it is likely the insurance company will charge a higher premium for the medical insurance policy if the policyholder is a smoker. So if this fact is not disclosed, and the person later makes a claim under the insurance policy for medical costs arising from a football accident, the insurance company can reject the claim, avoid the policy and hand back the premium, even though the football accident has nothing to do with the person being a smoker. This may seem unfair. That, however, is the result of an insurance policy being based on the principle of utmost good faith and the duty of disclosure. If the non-disclosed information is vital enough to have affected the underwriting decision of the insurance company, it may be legitimate for the company to decline a claim (and avoid the insurance policy) even though the non-disclosed information is not related to the current disease or injury. The disputes settled by the Insurance Complaints Bureau indicate that drinking and smoking habits are an important factor in the assessment of the risks in life or health insurance by insurance companies. As such, factors such as this (i.e. drinking or smoking habits) should be disclosed to the insurance company when buying these types of insurance policies. Again, we would reiterate that it is imperative that when filling in an application for an insurance policy, a person answer the questions as fully and carefully as possible. If the person thinks of a fact which he is unsure whether it is material, it is better to be cautious and draw it to the insurance company’ s attention. 3. WHAT ARE THE USUAL "EXCLUSION CLAUSES" IN AN INSURANCE POLICY? 3. WHAT ARE THE USUAL "EXCLUSION CLAUSES" IN AN INSURANCE POLICY?

There are "exclusion" clauses in most insurance policies. If a situation stated in an exclusion clause applies, a loss arising from that situation would not be covered under the insurance policy even if the loss results from the specified events or uncertainties which the insurance policy is supposed to protect against. Exclusion clauses operate to carve out certain situations from the insurance coverage under an insurance policy. Exclusion clauses are put in insurance policies usually because of the following two reasons. Firstly, sometimes the magnitude of the risk associated with the situation referenced in the exclusion clause is so significant and unpredictable, that the insurance company simply cannot provide insurance coverage for it. Secondly, the situation is covered under another type of insurance policy and therefore the exclusion prevents overlap in coverage between the two different types of insurance policies. There are different types of exclusions for different types of insurance policies. An exclusion clause may apply generally in respect of the whole insurance policy, or may only apply to specific sections of the insurance policy. In certain circumstances, an exclusion clause may be limited or removed by the policyholder paying an additional premium to the insurance company. The following are some examples of exclusions in respect of certain types of insurance policies. Life insurance: the insured person commits suicide within the first two years after the insurance policy is issued; certain activities considered to be dangerous such as flying other than with a regular scheduled airline, hang-gliding, motor-car racing , scuba- diving or skydiving ; exclusions arising from death during war. Medical and hospitalization insurance: self-inflicted injury or suicide; pregnancy and childbirth; existing illness or disease prior to the insurance being effected; AIDS or AIDS Related Complex; intoxication by alcohol, narcotics or drugs not prescribed by a registered medical practitioner; and injury, sickness or accident sustained or medical treatment received outside of Hong Kong. Property insurance: war; acts of terrorism; flooding; pressure waves caused by aircraft or other aerial devices travelling at super-sonic speeds; radiation from nuclear fuel or combustion of nuclear fuel; asbestos pollution or contamination; and fines, penalty, punitive or exemplary expense. Motor vehicle insurance: modified vehicle; where reasonable care was not taken to protect the vehicle; operation of the vehicle not within the law; use of the vehicle other than for the declared or specified purpose; driving while under the influence of alcohol, narcotics or illegal drugs; unlicensed driver; excess load; unlawful purpose; and unsafe condition of the vehicle. (Note: The above are examples only. You should carefully check all the actual exclusion clauses written in your particular insurance policies.) 4. I PAID THE PREMIUM ONE WEEK LATE (OR ONE MONTH LATE). IS MY POLICY STILL VALID? WILL THE INSURANCE COMPANY DENY MY CLAIM IF AN ACCIDENT HAPPENED IMMEDIATELY BEFORE MY PREMIUM PAYMENT? 4. I PAID THE PREMIUM ONE WEEK LATE (OR ONE MONTH LATE). IS MY POLICY STILL VALID? WILL THE INSURANCE COMPANY DENY MY CLAIM IF AN ACCIDENT HAPPENED IMMEDIATELY BEFORE MY PREMIUM PAYMENT? Often insurance companies would include a "grace period" clause in their insurance policies. A "grace period" provides for a grace of, say, 30 or 31 calendar days (depending on the terms actually written in the insurance policy) to pay an overdue premium. The policy remains in force during the grace period. Thus, if a claim were made within the grace period, the insurance company is liable to pay the claim but the company has the right to deduct the amount of the overdue premium from the proceeds of the payment of the claim. Note, however, that particularly in some commercial insurance policies, insurance companies may include a premium warranty clause, whereby the premium must be paid by certain date and if it is not paid by that date, then the coverage is void. It is therefore important for you to check your insurance policy, to understand the terms which apply to payment of premium. 5. THE INSURANCE COMPANY HAS DELAYED PROCESSING MY CLAIM. CAN I CLAIM INTEREST DUE TO SUCH A DELAY? 5. THE INSURANCE COMPANY HAS DELAYED PROCESSING MY CLAIM. CAN I CLAIM INTEREST DUE TO SUCH A DELAY? If there is an express term in the insurance policy providing for payment of interest by the insurance company for having delayed the payment of a claim, a contractual right would exist for payment of interest in the event of delay, provided that the policyholder has not himself breached any terms in the insurance policy. However, it is very rare for insurance policies to include such a clause. That stated, if it can be shown that there was an undue/improper delay on the

part of the insurance company, a complaint can either be lodged with The Insurance Complaints Bureau (the "ICB") to seek to recover interest for the delay. If the claim falls within the Terms of Reference for the ICB, therefore, this is a potential avenue to be able to claim interest. 6. I HAVE TAKEN OUT SEVERAL INSURANCE POLICIES COVERING THE SAME RISK (E.G. HOSPITAL CONFINEMENT OR HOUSEHOLD DAMAGE). CAN I CLAIM FOR THE SUM INSURED UNDER ALL POLICIES OR JUST THE ACTUAL EXPENSES/LOSSES ONLY? IS THE CLAIM FOR THE DEATH BENEFIT UNDER LIFE INSURANCE SUBJECT TO DIFFERENT RULES? 6. I HAVE TAKEN OUT SEVERAL INSURANCE POLICIES COVERING THE SAME RISK (E.G. HOSPITAL CONFINEMENT OR HOUSEHOLD DAMAGE). CAN I CLAIM FOR THE SUM INSURED UNDER ALL POLICIES OR JUST THE ACTUAL EXPENSES/LOSSES ONLY? IS THE CLAIM FOR THE DEATH BENEFIT UNDER LIFE INSURANCE SUBJECT TO DIFFERENT RULES? An insured person is not prevented by the law from purchasing any number of insurance policies covering the same item/person for the same risk. However, for insurance policies which are based in the indemnity principle, there is normally an "other insurance" clause in the insurance policy to address these situations so as to avoid the policyholder seeking to recover more than his loss. The “other insurance” clause will set out the liability of the insurance company where the policyholder has also purchased "other insurance" to cover the same risk. The “other insurance” clause often provides for one of three results: The most harsh “other insurance” clause provides that the insurance company will have no liability on the insured item/person in which the insured person has purchased other insurance (leaving all loss to be recovered from the other insurance policy). The “other insurance” clause may provide that the insurance company will only be liable for the loss in excess of the cover for the risk provided by the other insurance policy (also known as an “excess” provision). The “other insurance” clause may provide that the insurance company will only pay a pro-rata portion of the loss, with the other insurance policy. The above are the types of “other insurance” clause commonly seen in medical, personal injury and property insurance policies (which are usually based on the indemnity principle). “Other insurance” provisions aim to prevent the policyholder from obtaining unfair enrichment under the Common Law. In other words, the total amount of the claims payable under the "primary insurance" (the subject policy) together with the "other insurance" (the other policies) should not exceed the fair value of the repair or replacement of the insured item (i.e. the fact that the policyholder has multiple insurance policies should not enable him to recover more than his total loss or expenses incurred). Accordingly, a policyholder can claim under all of his insurance policies. Depending on their terms, however, the claims may be adjusted according to the express provisions under the "other insurance" clauses in each of the policies. Example : You have taken out two medical insurance policies in which the sum insured for medical expenses is $10,000 for each policy (aggregate sum insured is $20,000). If your medical bill is $15,000, you can only obtain $10,000 from one of the policies and get $5,000 from the other one. (You cannot obtain $10,000 from one insurance policy and another $10,000 from the other insurance policy, because this would be more than your medical bill of $15,000). The position as regards life insurance policy is different (as this is contingency insurance). Here, if there is nothing untoward (e.g. fraud or misrepresentation), the insurance company will be liable to pay in full regardless of there being other policies under which claims could also be made. 7. I HAVE TAKEN OUT SEVERAL INSURANCE POLICIES COVERING THE SAME RISK (E.G. HOSPITAL CONFINEMENT OR HOUSEHOLD DAMAGE). CAN I CLAIM FOR THE SUM INSURED UNDER ALL POLICIES OR JUST THE ACTUAL EXPENSES/LOSSES ONLY? 7. I HAVE TAKEN OUT SEVERAL INSURANCE POLICIES COVERING THE SAME RISK (E.G. HOSPITAL CONFINEMENT OR HOUSEHOLD DAMAGE). CAN I CLAIM FOR THE SUM INSURED UNDER ALL POLICIES OR JUST THE ACTUAL EXPENSES/LOSSES ONLY? An insured person is not prevented by the law from purchasing any number of insurance policies covering the same item/person for the same risk. However, there is normally an "other insurance" clause in the insurance policy that requires disclosure by the insured person of all the other insurance taken out. The "other insurance" must cover the same risk, the insurance coverage is additional, and the relevant policies are valid and subsisting. Typically, the clause may set out the liability of the insurance company where the insured person has also purchased "other insurance", which could be categorised as follows : The "escape" provision whereby the

insurance company will have no liability on the insured item/person in which the insured person has purchased other insurance; The "excess" provision whereby the insurance company will be liable for the amount of the excess insurance over and above the "other insurance" only; and, The "pro-rata" provision whereby the insurance company's liability will be limited to a proportion of the loss. The above is the position as regards medical, personal injury and property insurance. The provisions above intend to prevent the insured person from unfair enrichment under the Common Law. In other words, the total amount of the claims payable under the "primary insurance" (the subject policy) together with the "other insurance" (the other policies) should not exceed the fair value of the repair or replacement of the insured item (i.e. the total loss or all the expenses incurred). Accordingly, you may claim under all of the policies. Depending on the terms of all your policies, your claims may be adjusted according to the express provisions under the "other insurance" clause in the way that the total payment will not exceed fair compensation for your loss. Example: You have taken out two medical insurance policies in which the sum insured for medical expenses is $10,000 for each policy (aggregate sum insured is $20,000). If your medical bill is $15,000, you can only obtain $10,000 from one of the policies and get $5,000 from the other one. The position as regards life insurance policy is different. See question 15 of A. Life insurance (including retirement products) above. 1. THERE ARE TWO TYPES OF INSURANCE INTERMEDIARY, NAMELY "INSURANCE AGENT" AND "INSURANCE BROKER". WHAT ARE THE DIFFERENCES IN THEIR ROLES/FUNCTIONS AND QUALIFICATIONS? ARE THEY REQUIRED TO BE REGISTERED BEFORE PERFORMING THEIR WORK? 1. THERE ARE TWO TYPES OF INSURANCE INTERMEDIARY, NAMELY "INSURANCE AGENT" AND "INSURANCE BROKER". WHAT ARE THE DIFFERENCES IN THEIR ROLES/FUNCTIONS AND QUALIFICATIONS? ARE THEY REQUIRED TO BE REGISTERED BEFORE PERFORMING THEIR WORK? Most people have their insurance matters dealt with through an insurance agent or broker. Acting on behalf of the general public, insurance agents and brokers advise and arrange the purchasing of insurance. They also prepare reports, keep records and in the event of a loss, help the policy holders to submit and settle a claim. Insurance agents There are two types of insurance agents: independent agents and employed agents. Independent agents are self-employed and represent insurance companies and earn a commission on the policies that they help to write. In Hong Kong, independent agents are restricted to representing no more than four insurance companies. No more than two of them can be life insurance companies. On the other hand, there are employed agents who work exclusively for one insurance company. In addition to being paid a basic salary, they also earn commission on the business that they bring in. Insurance agents are required to be licensed and supervised by the Insurance Authority in accordance with the Insurance Ordinance (for more details, see question 2). To check the identity of an insurance agent, you may visit the Register of Licensed Insurance Intermediaries maintained by the Insurance Authority. To be licensed, insurance agents are required to pass the Insurance Intermediaries Qualifying Examination conducted by the Vocational Training Council, unless they are exempt. To ensure professional standards, they are also required to attend continuing professional development programmes as a condition for the renewal of their licence. Insurance brokers An insurance broker exclusively represents the insured person (but not the insurance company). On behalf of the insured person, the broker searches insurance companies for the best available coverage suitable to the needs of the insured person. Usually, this type of insurance relates to commercial activities, the coverage is specialised, and the insurance is for a large amount. A broker might be a company or a person, working on a commission basis. An insurance broker must be licensed by the Insurance Authority in accordance with the Insurance Ordinance. A broker which is a company must meet the minimum requirements set out in the Insurance (Financial and Other Requirements for Licensed Insurance Broker Companies) Rules (Cap. 41L), the most important of which are: having a minimum capital and a minimum net asset value; having professional indemnity insurance; and, keeping proper books and accounts and separate accounts for each client. Also, the responsible officer of a broker company is also subject to several minimum requirements to ensure professionalism of insurance brokerage (for more details, see question 2). In addition, the technical representatives of a broking company, have passed the qualifying examination, unless exempted, in order

to be licensed and be required to attend professional development programmes. For more details, see question 2. Lastly, a person or company is not permitted to act as an agent and a broker at the same time. 5. I AM NOT SATISFIED WITH THE COMPENSATION AND THE CONDUCT OF MY AGENT/INSURANCE COMPANY. SHALL I SETTLE THE DISPUTE IN COURT, OR APPROACH OTHER ORGANIZATIONS? DO THE COURTS OR OTHER ORGANIZATIONS IMPOSE A LIMIT ON THE AMOUNT OF ANY CLAIM IN EACH CASE? 5. I AM NOT SATISFIED WITH THE COMPENSATION AND THE CONDUCT OF MY AGENT/INSURANCE COMPANY. SHALL I SETTLE THE DISPUTE IN COURT, OR APPROACH OTHER ORGANIZATIONS? DO THE COURTS OR OTHER ORGANIZATIONS IMPOSE A LIMIT ON THE AMOUNT OF ANY CLAIM IN EACH CASE? Under the Code of Conduct for Insurers (Part IV: Management of Insurance Agents, Paragraph 35), an insurance company is required to have internal procedures for handling complaints against its agents. Therefore, you should file the complaint against your agent with your insurance company first. If you are not satisfied with the way on how your insurance company handled your complaint against the agent, you should then file your complaint with the Insurance Authority. As regards the complaint against your insurance company, you should also file the complaint with the company first. The Code of Conduct for Insurers (Part VII: Inquiries, Complaints and Disputes, Paragraph 48) requires insurance companies to have procedures in place to handle and attempt to resolve complaints by policyholders. If you are not satisfied with the way on how your insurance company handled your complaint, you should then file your complaint with the Insurance Authority. If appropriate, you could, at the same time, file a complaint with the Insurance Complaints Bureau (“ICB”). This body is set up specifically to handle insurance complaints in an expedient and less costly way. Generally speaking, the ICB can handle a complaint against an insurance company if it is of a monetary nature and the amount of money involved does not exceed HK$1,000,000. Beware that you should file the complaint with the ICB within 6 months from the day of notification by the insurance company of its final decision against which you want to complain. In relation to court proceedings, you may go to the following courts: The Small Claims Tribunal : for claims of $75,000 or less (to get more information about how to prepare for the trial, please click here); The District Court: for claims that exceed $75,000 but do not exceed $3,000,000; The Court of First Instance of the High Court, which has unlimited jurisdiction. Taking your claim to any of the above courts should always be the last resort. You are recommended to seek legal advice before doing so. 6. MY AGENT MADE SOME FALSE STATEMENTS WHICH INDUCED ME TO BUY INSURANCE FROM HIM. CAN I TERMINATE THE POLICY AND ASK FOR A REFUND OF THE PREMIUMS? 6. MY AGENT MADE SOME FALSE STATEMENTS WHICH INDUCED ME TO BUY INSURANCE FROM HIM. CAN I TERMINATE THE POLICY AND ASK FOR A REFUND OF THE PREMIUMS? An insurance agent shall not, with the aim of concluding the deal with you, make any inaccurate or misleading statements about his/her insurance company or the policies issued by the company. As the agents’ employers, the insurance companies are also vicariously liable for the acts of their agents. Furthermore, under the Code of Conduct for Insurers (Part IV: Management of Insurance Agents, Paragraph 34), insurers should not exclude or limit their liability for the actions of their agents acting in the course of their agency. Previously, we discussed the legal principle of the parties having to deal in utmost good faith. In the example in question, the insurance company through its agent has acted in bad faith. This fact gives you the right to avoid the policy (i.e. you can cancel the policy and ask for a refund of the premiums that you have paid). 7. MY AGENT ASKS ME TO PAY HIM CASH SO THAT HE CAN PAY MY PREMIUMS PROMPTLY ON BEHALF OF ME. IS HE ALLOWED TO HANDLE PREMIUM PAYMENTS IN THIS WAY? 7. MY AGENT ASKS ME TO PAY HIM CASH SO THAT HE CAN PAY MY PREMIUMS PROMPTLY ON BEHALF OF ME. IS HE ALLOWED TO HANDLE PREMIUM PAYMENTS IN THIS WAY? There are clear requirements under the Code of Conduct for Licensed Insurance Agents issued by the Insurance Authority in relation to how an insurance agent should handle client’s premium. The agent must have the authority to receive and handle the premiums on behalf of the insurance company and to handle those premiums in strict conformity with the requirements, controls and timing set out by the insurance company. Also, your agent has to avoid mixing your money with his personal funds and maintain proper records of premiums received. Regarding payment of premiums by way of cash, your agent is allowed to handle cash payments, if it is not reasonably feasible for the agent to accept

payment by any other means; and the insurance company authorizes the agent to receive cash payment, and the payment is received and handled within the limits of such authority. To be on the safe side, you should check the rules and satisfy yourself that your agent will act accordingly. 1. WHAT IS MEANT BY A "COOLING-OFF PERIOD"? IF I HAVE JUST PURCHASED A LIFE INSURANCE POLICY BUT HAVE SECOND THOUGHTS A FEW DAYS LATER, CAN I CANCEL THIS POLICY? 1. WHAT IS MEANT BY A "COOLING-OFF PERIOD"? IF I HAVE JUST PURCHASED A LIFE INSURANCE POLICY BUT HAVE SECOND THOUGHTS A FEW DAYS LATER, CAN I CANCEL THIS POLICY? In Hong Kong, for the protection of consumers' interests, a person purchasing a long-term insurance policy (mostly life insurance) is given a cooling-off period to review the terms and conditions of the policy within a reasonable period of time after the purchase. If the insurance purchaser wants to withdraw within the cooling-off period, he/she has the right to cancel the insurance policy and obtain a full refund of the insurance premium, subject to the market value adjustment (if applicable). The cooling-off period is 21 calendar days after the delivery of the policy or issue of a Cooling-off Notice (see below) to the policyholder or the policyholder's representative, whichever is the earlier. The Cooling-off Notice should inform the policyholder of the availability of the policy and the expiry date of the Cooling-off Period. The Cooling-off Notice should remind the policyholder that he/she has the right to re-consider his/her decision to purchase the life insurance product and to obtain a refund of premium paid if the policy is cancelled within the Cooling-off Period. The Cooling-off Notice should also remind the policyholder to contact the Customer Service Department of the insurer directly (service hotline number should be provided) if he/she does not receive the policy contract within 9 calendar days from the issue date of the Notice. In all cases, insurance agents are bound to inform their clients about the "cooling-off period" and the right to cancel within that period. 2. MY INSURANCE AGENT ASKED ME TO TRANSFER MY EXISTING LIFE POLICY TO ANOTHER INSURANCE COMPANY. ARE THERE ANY POTENTIAL LOSSES ARISING FROM SUCH A TRANSFER? 2. MY INSURANCE AGENT ASKED ME TO TRANSFER MY EXISTING LIFE POLICY TO ANOTHER INSURANCE COMPANY. ARE THERE ANY POTENTIAL LOSSES ARISING FROM SUCH A TRANSFER? Prior to switching your life insurance policy to another insurance company, you should be careful that your agent is not making inaccurate or misleading statements or comparisons to persuade you to switch. This is not uncommon as your agent could earn a commission from your switching to another insurance company (where the agent is also switching to a new insurance company). There are two primary matters you must carefully consider. Firstly, in connection with your application for the new insurance, you will be required to answer questions about your health, occupation and lifestyle. If the new insurance company rejects your application because of any of the updated information disclosed in the course of answering questions, you will be required to inform your existing insurance company of the rejection and the reason(s) under the "change of circumstances" clause (if any) in your existing policy. This may lead to your existing insurance company canceling your policy or requiring you to pay a higher premium. Secondly, bear in mind that the new policy may contain different provisions and that the "contestable period"under the new policy may start afresh. The worst case is the possibility of a claim being rejected under the new policy which would otherwise have been paid under the existing policy. In order to protect consumers against the above risks, there is a requirement for them to complete the Customer Protection Declaration Form (the "CPD Form", which can be downloaded from the website of the Hong Kong Federation of Insurers for reference). Where there is a switching or replacement of a policy, the insurance agent must declare on the CPD Form that he/she has fully explained the risks that would be involved to the client. The client must also declare that he/she understands the risks concerned . In this case, the cooling-off period is 14 days from the date a copy of the CPD Form is delivered to the existing insurance company by the new insurance company. In summary, make sure that your insurance agent is not making inaccurate or misleading statements or comparisons to persuade you to switch. Any additional genuine and legitimate benefit available under the new policy may make it worth switching, but you must be clear of the potential risks and what could be done to manage these risks. Last revision date: 26 February, 2020 5. WHAT IS MEANT BY A "CONTESTABLE PERIOD" IN RELATION TO LIFE INSURANCE? 5. WHAT IS MEANT

BY A "CONTESTABLE PERIOD" IN RELATION TO LIFE INSURANCE? A "contestable period" is a contractual provision that is often found in a life insurance policy. The contestable period usually covers a period of one or two years from the effective date the insurance policy, depending on the terms actually written on the policy. Through this provision, the insurance company has the right to contest (to dispute) the validity of the insurance policy and to refuse to pay the death benefit if the insured person dies within the contestable period. The most common reasons are suicide or misrepresentation of the health of the insured person. Within the contestable period, the insurance company has the opportunity to investigate whether or not a vital misrepresentation has been made. However, after the expiration of the contestable period, the beneficiary of the insurance policy is protected against the contesting of the insurance company (i.e. the policy becomes "incontestable"). In other words, the insurance company will be obligated to pay the death benefit once the contestable period has expired, except where there is fraud (e.g. submitting fake documents during the insurance application or claim process). Please note that the "contestable period" provision may not apply to supplementary benefits, such as payment of medical or hospital confinement expenses. In addition, life policies can be without any "contestable period" clause at all. 6. WHAT IS THE EFFECT OF A "SUICIDE CLAUSE" IN A LIFE INSURANCE POLICY? 6. WHAT IS THE EFFECT OF A "SUICIDE CLAUSE" IN A LIFE INSURANCE POLICY? Under the "contestable period" clause, which is usually in force for one or two years, the insurance company can deny the claim where the insured person has committed suicide. 7. CAN THE INSURANCE COMPANY DENY MY CLAIMS MADE UNDER THE INSURANCE POLICY BECAUSE OF THE NON-DISCLOSURE OF HEALTH PROBLEM AND THAT THE DOCTOR FAILED TO DIAGNOSE DURING THE MEDICAL CHECK-UP PRIOR TO MY INSURANCE APPLICATION? 7. THE INSURANCE COMPANY APPOINTED A DOCTOR FOR MY MEDICAL CHECK-UP BEFORE APPROVING MY INSURANCE APPLICATION. THAT DOCTOR FAILED TO DISCOVER A HEALTH PROBLEM THAT I DID NOT DISCLOSE. CAN THE INSURANCE COMPANY USE THIS NON-DISCLOSURE TO DENY ANY CLAIMS I MAY SUBSEQUENTLY MAKE UNDER THE INSURANCE POLICY? Under the principle of utmost good faith, the insured person or the policyholder has the duty to disclose all the information relating to the purchase of insurance to the insurance company. Consequently, irrespective of there having been a medical examination conducted by a doctor appointed by the insurance company who failed to diagnose the health problem, that insurance company may still deny your claim. This is particularly so if your non-disclosure is important, and has affected the assessment of your risk profile by the insurance company. 8. WHAT ARE THE DIFFERENCES BETWEEN A "REVOCABLE BENEFICIARY" AND AN "IRREVOCABLE BENEFICIARY"? UNDER WHAT CIRCUMSTANCES CAN I CHANGE AN IRREVOCABLE BENEFICIARY IN MY LIFE INSURANCE POLICY? 8. WHAT ARE THE DIFFERENCES BETWEEN A "REVOCABLE BENEFICIARY" AND AN "IRREVOCABLE BENEFICIARY"? UNDER WHAT CIRCUMSTANCES CAN I CHANGE AN IRREVOCABLE BENEFICIARY IN MY LIFE INSURANCE POLICY? A beneficiary in a life insurance policy is the person(s) who will receive the money (death benefit) from the insurance company upon the death of the insured person. There is a "Beneficiary Designation" section in life policies in which the policyholder names the party or parties as the beneficiary or beneficiaries who will receive the proceeds of the death benefit. A revocable beneficiary designation gives the policyholder the right to change the beneficiary without the consent of the named beneficiary. An irrevocable beneficiary designation does not give the above right. That is to say, the consent of the named beneficiary must be obtained before the policyholder can change the beneficiary. According to the subject question, the policyholder can only change the beneficiary if the named irrevocable beneficiary shown on the policy consents to the proposed change. 9. MY SON IS NOW 15 YEARS OLD. CAN I NAME HIM AS THE BENEFICIARY IN MY LIFE INSURANCE POLICY? WOULD HE BE ENTITLED TO RECEIVE ALL THE PROCEEDS IF I DIE BEFORE HE REACHES THE AGE OF MAJORITY (I.E. THE AGE OF 18)? 9. MY SON IS NOW 15 YEARS OLD. CAN I NAME HIM AS THE BENEFICIARY IN MY LIFE INSURANCE POLICY? WOULD HE BE ENTITLED TO RECEIVE ALL THE PROCEEDS IF I DIE BEFORE HE REACHES THE AGE OF MAJORITY (I.E. THE AGE OF 18)? Yes, you can name your son (who is a minor) as the beneficiary of your life policy. You should arrange to name a guardian and/or trustee to receive and manage the proceeds on his behalf until he reaches the age of majority after which he can inherit all the proceeds directly. 11. WILL MEDICAL REPORTS ISSUED BY TRADITIONAL CHINESE MEDICAL PRACTITIONERS

BE ACCEPTED BY AN INSURANCE COMPANY WHEN PROCESSING CLAIMS? 11. WILL MEDICAL REPORTS ISSUED BY TRADITIONAL CHINESE MEDICAL PRACTITIONERS BE ACCEPTED BY AN INSURANCE COMPANY WHEN PROCESSING CLAIMS? There is usually a standard provision in an insurance policy that medical reports are those issued by a registered medical practitioner of western medicine. Thus, unless the policy specifically admits medical reports issued by registered Chinese medical practitioners, such reports will not normally be accepted for the purpose of claims. 10. THE INSURED PERSON HAS DISAPPEARED FOR SEVERAL YEARS. CAN THE BENEFICIARY SUBMIT A CLAIM FOR THE DEATH BENEFIT UNDER THE RELEVANT LIFE INSURANCE POLICY? 10. THE INSURED PERSON HAS DISAPPEARED FOR SEVERAL YEARS. CAN THE BENEFICIARY SUBMIT A CLAIM FOR THE DEATH BENEFIT UNDER THE RELEVANT LIFE INSURANCE POLICY? Firstly, if the beneficiary is in a legal position to do so (e.g. he/she is the spouse, parent or child of the insured person), that beneficiary must obtain a court declaration that the insured person is legally dead. At Common Law, a person is considered legally dead if that person has disappeared for 7 years or more, unless there is any evidence to the contrary. Once the court issues a declaration that the insured person is legally dead, the beneficiary can submit a claim to the insurance company for the death benefit. Regarding the details on how to apply for a court declaration, please consult a solicitor. 12. I TOOK OUT AN INSURANCE POLICY IN HONG KONG BUT I WAS INJURED IN A FOREIGN COUNTRY. WILL THIS AFFECT MY CLAIM? 12. I TOOK OUT AN INSURANCE POLICY IN HONG KONG BUT I WAS INJURED IN A FOREIGN COUNTRY. WILL THIS AFFECT MY CLAIM? That would depend on the coverage of your insurance policy as set out in the terms and conditions of the policy. If the coverage includes events happened in a foreign country, then your claim for the injury suffered overseas will be admitted. 13. CAN A PERSON UNDER 18 YEARS OF AGE PURCHASE A LIFE INSURANCE POLICY? 13. CAN A PERSON UNDER 18 YEARS OF AGE PURCHASE A LIFE INSURANCE POLICY? The rule under the law is that a minor (a person under the majority age of 18), usually cannot make contracts. An exception to this rule is that if the contractual goods or services are considered as "necessaries" for the minor, such contract is legally binding (please refer to the topic of Consumer Complaints). If the insurance contract is beneficial to the minor, the contract may be upheld by the Court. In practice, when a minor submits an application for buying life insurance, the insurance company may first assess the income of that minor (i.e. whether or not he/she can pay the premiums). You should also note that a minor can be named as the "beneficiary" in a life insurance policy (please refer to the relevant question and answer). 14. IF MY INSURANCE POLICY HAS LAPSED AND I TRY TO "REINSTATE" MY POLICY BY PAYING THE PREMIUMS AGAIN, CAN I SUBMIT ANY CLAIMS TO THE INSURANCE COMPANY AT THIS STAGE? 14. IF MY INSURANCE POLICY HAS LAPSED AND I TRY TO "REINSTATE" MY POLICY BY PAYING THE PREMIUMS AGAIN, CAN I SUBMIT ANY CLAIMS TO THE INSURANCE COMPANY AT THIS STAGE? Normally, there is a "reinstatement" clause by which a life insurance policy that has lapsed (usually due to non-payment of premiums) can be reinstated. The policy can be brought back into force again even though the policy was no longer in force. It will usually be less expensive to reinstate a policy than to purchase a new one. The premium for a new policy would likely be more expensive due to the fact that the insured person is older. Therefore, the person's risk profile would likely fall into a higher premium category. The "reinstatement" clause usually permits the policyholder to reinstate the policy , provided that certain conditions are met with, for example: The insured person shows to the insurance company evidence of insurability (e.g. a satisfactory medical report). This condition is usually waived for lapses of less than two months; All the overdue premiums plus any interest payable are all paid up-to-date; Any policy loan (derived from the cash value of the policy) taken out must be either repaid or reinstated; The policy has not been surrendered to the insurance company in return for cash; and, The period lapsed must not be more than three years. During the time in which the reinstatement of the policy is being processed, any claim submitted would be held pending the approval of the reinstatement application by the insurance company. 13. I HAVE TAKEN OUT SEVERAL INSURANCE POLICIES COVERING THE SAME RISK (E.G. HOSPITAL CONFINEMENT OR HOUSEHOLD DAMAGE). CAN I CLAIM FOR THE SUM INSURED UNDER ALL POLICIES OR JUST THE ACTUAL EXPENSES/LOSSES ONLY? IS THE CLAIM FOR THE DEATH BENEFIT UNDER LI 13. I HAVE TAKEN OUT SEVERAL INSURANCE POLICIES COVERING THE SAME RISK (E.G. HOSPITAL

CONFINEMENT OR HOUSEHOLD DAMAGE). CAN I CLAIM FOR THE SUM INSURED UNDER ALL POLICIES OR JUST THE ACTUAL EXPENSES/LOSSES ONLY? IS THE CLAIM FOR THE DEATH BENEFIT UNDER LIFE INSURANCE SUBJECT TO DIFFERENT RULES? An insured person is not prevented by the law from purchasing any number of insurance policies covering the same item/person for the same risk. However, there is normally an "other insurance" clause in the insurance policy that requires disclosure by the insured person of all the other insurance taken out. The "other insurance" must cover the same risk, the insurance coverage is additional, and the relevant policies are valid and subsisting. Typically, the clause may set out the liability of the insurance company where the insured person has also purchased "other insurance", which could be categorised as follows : The "escape" provision whereby the insurance company will have no liability on the insured item/person in which the insured person has purchased other insurance; The "excess" provision whereby the insurance company will be liable for the amount of the excess insurance over and above the "other insurance" only; and, The "pro-rata" provision whereby the insurance company's liability will be limited to a proportion of the loss. The above is the position as regards medical, personal injury and property insurance . The provisions above intend to prevent the insured person from unfair enrichment under the Common Law. In other words, the total amount of the claims payable under the "primary insurance" (the subject policy) together with the "other insurance" (the other policies) should not exceed the fair value of the repair or replacement of the insured item (i.e. the total loss or all the expenses incurred). Accordingly, you may claim under all of the policies. Depending on the terms of all your policies, your claims may be adjusted according to the express provisions under the "other insurance" clause in the way that the total payment will not exceed fair compensation for your loss. Example: You have taken out two medical insurance policies in which the sum insured for medical expenses is $10,000 for each policy (aggregate sum insured is $20,000). If your medical bill is $15,000, you can only obtain $10,000 from one of the policies and get $5,000 from the other one. The position as regards life insurance policy is different. Here, if there is nothing untoward (e.g. fraud or misrepresentation), the insurance company will be liable to pay in full regardless of there being other policies under which claims could also be made. Last revision date: 26 February, 2020 C. ACCIDENT OR PERSONAL INJURY INSURANCE C. ACCIDENT OR PERSONAL INJURY INSURANCE Accidents do happen all the time and may result in personal injury or even death. An accident insurance policy gives protection (such as reimbursement of medical expenses) should the policyholder suffer accidental death or bodily injury. 1. WHAT IS THE GENERAL MEANING OF "ACCIDENTAL INJURY"? IF I WAS INJURED BUT DID NOT HAVE A VISIBLE BRUISE OR WOUND, CAN I STILL SUBMIT A CLAIM FOR SUCH AN INJURY? 1. WHAT IS THE GENERAL MEANING OF "ACCIDENTAL INJURY"? IF I WAS INJURED BUT DID NOT HAVE A VISIBLE BRUISE OR WOUND, CAN I STILL SUBMIT A CLAIM FOR SUCH AN INJURY? An accidental injury is a mishap that is unusual, fortuitous, unexpected or unforeseen resulting in damage or injury to the body. The admission of a claim is based on medical certification by a licensed medical practitioner. Therefore, if your doctor, who is qualified, has certified that you have sustained an accidental injury, then regardless of whether or not there is a visible mark of your injury, your insurance company is bound to admit your claim based on the medical certificate. 2. WHAT ARE THE GENERAL MEANINGS OF "PERMANENT DISABILITY" AND "TEMPORARY DISABILITY"? I RECEIVED A LUMP SUM FROM AN INSURANCE COMPANY DUE TO A PERMANENT DISABILITY BUT SURPRISINGLY RECOVERED TWO YEARS LATER. CAN THE INSURANCE COMPANY ASK ME TO REFUND PART OF ITS PREVIOUS PAYMENT? 2. WHAT ARE THE GENERAL MEANINGS OF "PERMANENT DISABILITY" AND "TEMPORARY DISABILITY"? I RECEIVED A LUMP SUM FROM AN INSURANCE COMPANY DUE TO A PERMANENT DISABILITY BUT SURPRISINGLY RECOVERED TWO YEARS LATER. CAN THE INSURANCE COMPANY ASK ME TO REFUND PART OF ITS PREVIOUS PAYMENT? A disability, in the context of injuries, refers to the inability to carry on with one's normal activities and occupation as a result of sickness or accident. "Permanent disability" is a disability that the insured person will not recover from. "Temporary disability" is one that the insured person will recover from. A medical certificate must be submitted together with the claim as evidence of the insured person's condition of disability. Payment of the benefit for permanent disability may be made at one time in one lump sum or over a period of time by

a series of payments. In the above question, you have received a lump sum. Unless the payment was conditional in which you are required to refund the payment if you recover partially or wholly in future, then the insurance company cannot ask for a refund. In usual cases, the standard terms in an insurance policy would not have a condition requiring refund where a lump sum is payable. By contrast, where the benefit is payable by installments, there could be a condition that the insured person provides proof to the insurance company from time to time of his/her continuous permanent disability. It depends on the specific terms of the policy in question. 3. I SELDOM PARTICIPATE IN RISKY OR DANGEROUS SPORTS/ACTIVITIES (E.G. WATER SKIING), BUT I WAS INJURED ON ONE OCCASION WHILE PLAYING SUCH A SPORT. IS SUCH AN INJURY CONSIDERED AS AN "ACCIDENT" OR "SELF-INFLICTED" OR A "NEGLIGENT" EVENT? 3. I SELDOM PARTICIPATE IN RISKY OR DANGEROUS SPORTS/ACTIVITIES (E.G. WATER SKIING), BUT I WAS INJURED ON ONE OCCASION WHILE PLAYING SUCH A SPORT. IS SUCH AN INJURY CONSIDERED AS AN "ACCIDENT" OR "SELF-INFLICTED" OR A "NEGLIGENT" EVENT? WILL IT AFFECT MY CLAIM FOR MEDICAL OR ACCIDENT INSURANCE? As discussed under the subject of "exclusion" clause, the main issue is whether or not the particular sports that you have participated in is an excluded coverage. If yes, the insurance company will not pay. If no, you can submit a claim which will likely be admitted. 4. IF I HAVE RECEIVED COMPENSATION FROM PERSONAL INJURY LITIGATION AGAINST THE WRONGDOER, WILL IT BE USED TO SET OFF PART OF MY CLAIM FROM MY INSURANCE POLICY? 4. IF I HAVE RECEIVED COMPENSATION FROM PERSONAL INJURY LITIGATION AGAINST THE WRONGDOER, WILL IT BE USED TO SET OFF PART OF MY CLAIM FROM MY INSURANCE POLICY? There should be a "subrogation" clause which is also a standard term in an insurance policy. Under this clause, if your insurance company has already paid your claim, your rights and remedies are "subrogated". In simple words, the insurance company is placed in your position and takes over all of your rights and claims against the defaulting party. Note that your insurance company can only exercise the right of subrogation if it has admitted and paid your claim under your insurance policy. According to the facts in the above question, you have in effect exercised your rights and have already obtained compensation from the wrongdoer. In this case, the compensation may be offset against the liability of your insurance company under the policy it has issued to you. Example : You have obtained $20,000 as compensation from the defaulting party via personal injury proceedings. However, your insurance company should pay you $40,000 according to your insurance policy. Since you have already received $20,000 from the wrongdoer, you will only get $20,000 from the insurance company. The principle of subrogation is to prevent the insured persons from making a profit out of their insurance policies. For details about personal injury litigation, please go to another topic - Personal Injuries. D. INSURANCE AGAINST DAMAGE OR LOSS OF PROPERTY D. INSURANCE AGAINST DAMAGE OR LOSS OF PROPERTY Loss of or damage to household contents such as furniture, decoration, electrical appliances and personal valuables can be insured. A typical example of such kind of insurance is a "Householder's Comprehensive" insurance policy which may provide cover in one package for loss of or damage to the contents of a dwelling caused by fire, lightning, explosion, burst water pipes, theft, typhoon and windstorm, and flood; loss of or damage to servants' property; costs of alternative accommodation during the period in which the household is being repaired after a misfortune that is insured against; liability to the public; and personal accident benefits for the policyholder. Q&A; 1. IF MY HOME AND THE FURNITURE INSIDE ARE DAMAGED, WILL THE INSURANCE COMPANY COMPENSATE ME FOR THE FULL VALUE OF MY PROPERTY? WILL THE INSURANCE COMPANY MAKE A PROFESSIONAL VALUATION OR ESTIMATION BEFORE EFFECTING PAYMENT? 1. IF MY HOME AND THE FURNITURE INSIDE ARE DAMAGED, WILL THE INSURANCE COMPANY COMPENSATE ME FOR THE FULL VALUE OF MY PROPERTY? WILL THE INSURANCE COMPANY MAKE A PROFESSIONAL VALUATION OR ESTIMATION BEFORE EFFECTING PAYMENT? Unless the claim is for a small amount, in which case the insurance company will fix the amount of compensation itself, the insurance company will usually appoint a surveyor to assess and confirm the damage and determine the fair compensation. In both cases, the amount of compensation will likely be less than the original purchase price. The ordinary wear and tear factor, and the deprecation, will normally be included in the calculation of the compensation. However, where the insured property is a valuable article, the value of the property and the amount of compensation can be agreed

beforehand. In the event of loss or total damage, the insurance company is liable to pay the agreed amount. In the example of a painting or an antique, the insurance company may appoint an expert to determine the fair value of the painting/antique before agreeing to the insured amount. 2. I AM AN OWNER OF A FLAT INSIDE A BUILDING THAT HAS COVERAGE FOR THIRD PARTY LIABILITY. CAN I ESCAPE FROM ALL LIABILITY IF VISITORS OR OCCUPIERS WERE INJURED IN AN ACCIDENT INSIDE THE BUILDING? 2. I AM AN OWNER OF A FLAT INSIDE A BUILDING THAT HAS COVERAGE FOR THIRD PARTY LIABILITY. CAN I ESCAPE FROM ALL LIABILITY IF VISITORS OR OCCUPIERS WERE INJURED IN AN ACCIDENT INSIDE THE BUILDING? If the insurance of the third party's risk only covers the common areas of the building, the insurance company will only pay if the accident happened in these areas (but not inside your flat). You will have to purchase your own occupiers' liability insurance for coverage of your own flat in respect of injuries to visitors in your flat. Most home-owner's insurance includes this cover. 1. WHEN AN ACCIDENT HAPPENS, WHAT SHOULD A DRIVER DO OR NOT TO DO? IN CASE THE DRIVER IS BEING SUED BY THE VICTIMS, SHOULD THE DRIVER APPOINT A LAWYER FOR DEFENCE BEFORE INFORMING THE INSURANCE COMPANY? 1. WHEN AN ACCIDENT HAPPENS, WHAT SHOULD A DRIVER DO OR NOT TO DO? IN CASE THE DRIVER IS BEING SUED BY THE VICTIMS, SHOULD THE DRIVER APPOINT A LAWYER FOR DEFENCE BEFORE INFORMING THE INSURANCE COMPANY? The driver should immediately report the accident to the Police so that the traffic accident can be officially recorded. The official record might be needed as evidence in any subsequent insurance claims and legal proceedings. To avoid the coverage being affected, the driver should generally avoid settling or agreeing to any matter on his/her own with any of the other parties involved without the prior consent of the insurer, in particular where there are injuries to any third party. As soon as practicable after the accident, the driver should notify the car owner (if he or she is not the car owner) and the insurer. The notification to the insurer (which is generally required to be made in writing) should be made within the time specified at the relevant motor insurance policy to avoid any potential breach of policy condition. The driver should also keep the insurer informed of the case progress (e.g. the date of taking police statement, the laying of information or charge sheet, the date of court hearing etc.) and seek the insurer's directions on how to proceed with the matter. For any prosecution against the car owner or the driver, the insurer may, in some cases, take over the defence of the proceedings and instruct its own legal adviser in assessing the merits of defence. 3. I AM THE REGISTERED OWNER BUT NOT THE "REAL OWNER" OF A CAR ("REAL OWNER" IS THE PERSON WHO ACTUALLY PAID FOR THE CAR). CAN I OBTAIN INSURANCE COVERAGE IN RESPECT OF THE CAR? 3. I AM THE REGISTERED OWNER BUT NOT THE "REAL OWNER" OF A CAR ("REAL OWNER" IS THE PERSON WHO ACTUALLY PAID FOR THE CAR). CAN I OBTAIN INSURANCE COVERAGE IN RESPECT OF THE CAR? WILL IT MAKE A DIFFERENCE IF I AM THE "REAL OWNER" BUT NOT THE REGISTERED OWNER? As described in the first part of the question, you are the registered owner (i.e. the legal owner) but not the "real" or "beneficial" owner of the car. As the registered owner, you still have an insurable interest in the car. Irrespective of the ownership position between you and the real / beneficial owner, you are liable for all the risks as between you and all other parties in case a traffic accident occurs. Therefore, you can and should purchase motor insurance for your car. Regarding the second part of the question, if you can show evidence of your beneficial ownership (e.g. you have paid all or part of the purchase price for the car), you may also purchase the motor insurance for the car. 2. SHOULD THE DRIVER ARRANGE TO REPAIR THE CAR IMMEDIATELY AFTER A TRAFFIC ACCIDENT? IS THE DRIVER REQUIRED TO OBTAIN PRIOR APPROVAL FROM THE INSURANCE COMPANY FOR THE COSTS OF ANY REPAIR? 2. SHOULD THE DRIVER ARRANGE TO REPAIR THE CAR IMMEDIATELY AFTER A TRAFFIC ACCIDENT? IS THE DRIVER REQUIRED TO OBTAIN PRIOR APPROVAL FROM THE INSURANCE COMPANY FOR THE COSTS OF ANY REPAIR? If the car is insured by the loss and damage cover, the driver should not arrange to repair the car by himself or herself without consulting the insurer first. If the car is damaged in a traffic accident, the driver should immediately contact his/her insurer so that the insurer can instruct its own surveyor or adjustor to assess the extent of the damage, the repairs need to be done, as well as the costs to be involved. Where towing fees are covered under a motor insurance policy, your insurer may sometimes instruct you to engage towing service provider(s) designated by it if such service is required. Subject to the directions

given by the insurer on repair based on the findings of its own surveyor, the car owner can either claim for the reasonable repair costs or have the repairs carried out at the agreed sum. Upon paying your repair costs and any other relevant expenses / losses (e.g. towing fees, expenses incurred for renting substituted car), generally speaking your insurer is entitled under the terms of the motor policy to commence recovery action against the wrongdoer (if any) on your behalf by its subrogation rights (i.e. the right to subrogate your claim for property damage and loss against the wrongdoer upon providing indemnity to you under the policy). You may be required to provide reasonable assistance to the insurer for initiating and conducting the recovery claim. You are however entitled to include your uninsured loss (e.g. excess or any expenses not covered under the policy) in the recovery claim. 4. I AM A CAR OWNER. AM I BOUND TO PURCHASE THIRD PARTY LIABILITY INSURANCE FOR MY CAR UNDER THE LAW? WHAT ARE THE CONSEQUENCES IF I FAIL TO DO SO? 4. I AM A CAR OWNER. AM I BOUND TO PURCHASE THIRD PARTY LIABILITY INSURANCE FOR MY CAR UNDER THE LAW? WHAT ARE THE CONSEQUENCES IF I FAIL TO DO SO? Section 4 of the Motor Vehicles Insurance (Third Party Risks) Ordinance (Cap. 272) requires all users (including a car owner and all permitted users or drivers) to have third party insurance covering the relevant motor vehicle. A car owner should arrange motor insurance for your car. Any person who fails to purchase motor insurance for your car is liable for a fine of up to HK$10,000 and to an imprisonment of 12 months. The person convicted of the offence may also face a disqualification from driving for a period of between 12 months and 3 years. In addition, you and the permitted driver(s) would have to bear the civil liability of bodily injury or death caused to any third party by any accident arising out of the use of your car without insurance cover. The potential amount of compensation payable by yourself or the driver could be substantial which may adversely affect your financial status or even results in your bankruptcy or insolvency. G. EMPLOYEES' COMPENSATION G. EMPLOYEES' COMPENSATION Employers are liable to pay compensation for injuries that are sustained by their employees as a result of accidents that arise out of and in the course of their employment. They may also be liable for occupational diseases suffered by their employees. For more information regarding employees' compensation matters, please go to another topic - Employment Disputes. 1. DOES HONG KONG LAW REQUIRE ALL EMPLOYERS TO TAKE OUT INSURANCE FOR THEIR EMPLOYEES? IS THERE A STATUTORY MINIMUM AMOUNT FOR THE SUM INSURED? 1. DOES HONG KONG LAW REQUIRE ALL EMPLOYERS TO TAKE OUT INSURANCE FOR THEIR EMPLOYEES? IS THERE A STATUTORY MINIMUM AMOUNT FOR THE SUM INSURED? Under the Employees' Compensation Ordinance (Cap. 282), employers are required to take out employees' compensation insurance. According to section 40 and schedule 4 of this Ordinance, the minimum amount of insurance coverage is: Where the number of workers in a company does not exceed 200, $100 million per event; Where the number of workers in a company is more than 200, $200 million per event; In the case of a principal contractor undertaking construction work, $200 million per event; and, In the case of a group of companies, $200 million per event. 16. WHO ARE REQUIRED TO JOIN THE MPF SCHEMES (OR OTHER RECOGNIZED OCCUPATIONAL RETIREMENT SCHEMES) UNDER THE LAW? ARE SELF-EMPLOYED PERSONS OR CASUAL WORKERS (WHO ARE NOT EMPLOYED UNDER CONTRACTS OF EMPLOYMENT) ALSO REQUIRED TO JOIN THESE SCHEMES? 16. WHO ARE REQUIRED TO JOIN THE MPF SCHEMES (OR OTHER RECOGNIZED OCCUPATIONAL RETIREMENT SCHEMES) UNDER THE LAW? ARE SELF-EMPLOYED PERSONS OR CASUAL WORKERS (WHO ARE NOT EMPLOYED UNDER CONTRACTS OF EMPLOYMENT) ALSO REQUIRED TO JOIN THESE SCHEMES? Unless exempted for specific cases, the Mandatory Provident Fund Schemes Ordinance (Cap. 485 of the Laws of Hong Kong) requires all employers to arrange for their employees, including casual workers, to join a MPF scheme or a recognized occupational retirement scheme. However, casual workers who work for less than 60 days are not included in the requirement. Self-employed persons are also required to join a registered scheme. 17. WHAT ARE THE STATUTORY AMOUNTS OR PERCENTAGES OF INCOME FOR MANDATORY CONTRIBUTIONS UNDER MPF SCHEMES? 17. WHAT ARE THE STATUTORY AMOUNTS OR PERCENTAGES OF INCOME FOR MANDATORY CONTRIBUTIONS UNDER MPF SCHEMES? In the case of employees, the mandatory contribution to be made respectively by the employees and their employer is a sum equal to 5 percent of the employee's monthly wage. For the calculation of mandatory contribution, the monthly wage is subject to a maximum amount of $25,000 per month.

However, an employee whose monthly wage is less than $6,500 is not required to make the mandatory contribution. For self-employed persons, the mandatory contribution is 5 percent of the person's monthly earnings (subject to a maximum level of income of $25,000 per month or $300,000 per year). Similar to the case of employees, a self-employed person whose monthly income is less than $6,500 is not required to make mandatory contributions. In the case of casual workers who are members of an industry scheme, the authority publishes the required percentage of contribution. Please also note that these casual employees are not required to make mandatory contributions if their daily income is less than $250. In addition to the mandatory contributions, employees or self-employed persons can also make voluntary contributions to their MPF schemes. For guidelines regarding voluntary contributions, you should check with your scheme providers. E. PROFESSIONAL LIABILITY INSURANCE E. PROFESSIONAL LIABILITY INSURANCE Will professional liability insurance (e.g. for doctors or lawyers) cover all claims resulting from professional negligence? Are there any guidelines for defining "negligence" in such cases? Nowadays, anyone who gives another person advice and/or services that require skills according to the standards of a recognized discipline or expertise might be regarded as a professional. In Hong Kong, the law requires members of certain professions to have professional indemnity insurance. For example, as we have discussed in the answer to Question 1 in Part II, the law requires insurance brokers to have this type of insurance. Under professional indemnity insurance, typical coverage includes: breach of statutory duty and/or common law duty; unintentional defamation and infringement of patent, copyright and trademark; loss or damage to documents; criminal or malicious acts by employees and principal of the insured person/company. The typical exclusions (items that are not covered) include: criminal or deliberated wrongful acts of the insured professional; claims or circumstances known prior to the policy taking effect; any matters arising from or as a result of insolvency, bankruptcy or liquidation; acts of war or terrorism; and, any matters outside of the specified jurisdiction or territory. Professional negligence may arise from an act or continuing conduct of a professional which fails to meet the standards of the required care and skill, and results in provable damage to his or her client. However, negligence does not include the exercise of professional judgment even where the results are detrimental to his or her client. HOW CAN I GET AN INSURANCE POLICY? II. HOW CAN I GET AN INSURANCE POLICY? Traditionally, potential policy holders acquire insurance policies through and with the help of an insurance intermediary. The first part below is devoted to an overview of such a traditional way to obtain an insurance policy with particular focus on the new regulatory regime on insurance intermediaries. With the advent of 21st Century, technologies permeate our daily lives and radically transform our ways of living and interacting with the world. The insurance sector is no exception to this irreversible current. Insurance technology, also known as “Insurtech”, through employment and utilization of the Internet and the latest technologies, unleashes the potentials to rethink how insurance would work in our society, from selling insurance policies to provision of after sales services. The second part below offers a glimpse into Insurtech and how does it help to enhance the quality of services provided by the insurance sector. A. INSURANCE INTERMEDIARIES A. INSURANCE INTERMEDIARIES Introduction On 23 September 2019, the Insurance Authority (IA) took over the regulatory functions of the three Self-Regulatory Organisations, namely the Insurance Agents Registration Board, established under the Hong Kong Federation of Insurers, the Hong Kong Confederation of Insurance Brokers and the Professional Insurance Brokers Association, to directly regulate insurance intermediaries (including insurance agents and insurance brokers) in Hong Kong, as empowered by the Insurance Ordinance (Cap. 41) (“Ordinance”). Q&A; ON INSURANCE INTERMEDIARIES 2. WHAT ARE THE REQUIREMENTS FOR AN INDIVIDUAL TO BE A LICENSED INSURANCE INTERMEDIARY OR RESPONSIBLE OFFICER OF LICENSED INSURANCE AGENCIES OR INSURANCE BROKER COMPANIES UNDER THE NEW REGIME? 2. WHAT ARE THE REQUIREMENTS FOR AN INDIVIDUAL TO BE A LICENSED INSURANCE INTERMEDIARY OR RESPONSIBLE OFFICER OF LICENSED INSURANCE AGENCIES OR INSURANCE BROKER COMPANIES UNDER THE NEW REGIME? Under the new regulatory regime, any person who carries on a regulated activity must possess a valid licence under the Insurance Ordinance, unless exempted. The Insurance Authority

considers various key criteria in determining whether an applicant is a fit and proper person, including the academic qualifications, professional qualifications and working experience of the applicant; the reputation, character, reliability and integrity of the applicant and the applicant's financial status or solvency. An applicant must be fit and proper in order to be licensed, and this requirement is ongoing. The Guideline on "Fit and Proper" Criteria for Licensed Insurance Intermediaries under the Insurance Ordinance, issued by the IA, sets out the relevant licensing requirements under the new regime. The licensing requirements under the new regime are more stringent than the previous self-regulatory regime which is aimed to enhance the standards of professionalism and conduct of insurance intermediaries: Original Requirements New Requirements Minimum academic requirements Individual licensees F.5 graduate Level 2 or above in five subjects (including Chinese or English, and Mathematics) in the Hong Kong Diploma of Secondary Education Examination (HKDSE) Responsible officers of licensed insurance agencies or insurance broker companies Bachelor's degree Continuing Professional Development (CPD) training Minimum CPD hours 10 hours 15 hours New training courses - At least 3 CPD hours related to ethics or regulations 3. ARE LICENSED INSURANCE INTERMEDIARIES REQUIRED TO COMPLY WITH ANY PRINCIPLES OF PROFESSIONAL CONDUCT? 3. ARE LICENSED INSURANCE INTERMEDIARIES REQUIRED TO COMPLY WITH ANY PRINCIPLES OF PROFESSIONAL CONDUCT? Yes. Licensed intermediaries play an important role in the Hong Kong insurance industry and serve as a vital conduit between the public and the insurance sector. The IA issued the Code of Conduct for Licensed Insurance Agents and Code of Conduct for Licensed Insurance Brokers (collectively, Code of Conduct) which sets out fundamental principles of professional conduct which are expected of licensed intermediaries. The aim of the Code of Conduct is to promulgate principles and related standards and practices with which licensed insurance intermediaries are ordinarily expected to comply in carrying on regulated activities. The Code of Conduct sets out eight general principles, namely: the requirement to act honestly, ethically and with integrity; act in the best interest of clients and treating clients fairly; exercise care, skill and diligence; possess appropriate levels of professional knowledge and experience; disclose accurate and adequate information to clients; ensure the suitability of the regulated advice; avoid conflicts of interests; and have sufficient safeguards in place to protect client assets. 4. WHAT POWERS DO THE INSURANCE AUTHORITY HAVE TO ENSURE INSURANCE INTERMEDIARIES' COMPLIANCE WITH THE STATUTORY REQUIREMENT AND TO DEAL WITH INSURANCE INTERMEDIARIES' MISCONDUCT? 4. WHAT POWERS DO THE INSURANCE AUTHORITY HAVE TO ENSURE INSURANCE INTERMEDIARIES' COMPLIANCE WITH THE STATUTORY REQUIREMENT AND TO DEAL WITH INSURANCE INTERMEDIARIES' MISCONDUCT? First of all, the Insurance Authority has the power to conduct inspections for the purpose of ascertaining whether a licensed insurance intermediary complies with the Insurance Ordinance. The scope of IA's inspection powers is wide ranging enabling the IA to: Enter into any business premises of the licensed insurance intermediary; Inspect and make copies of records; Make enquiries of the intermediary or a person who has information relating to the licensed insurance intermediary. Also, if the Insurance Authority believes that an insurance intermediary has contravened the Insurance Ordinance, or has conducted regulated activity in a way involving fraud, misconduct or otherwise prejudicial to the interest of policy holders (or potential policy holders), it can investigate into the matter. To facilitate the investigation, the Insurance Authority has a broad range of powers at its disposal. It can require any person who is relevant to the investigation or is reasonably believed to have possession of information or documents relevant to the investigation to: Produce a record or document; Give an explanation or further particulars in respect of a document Attend before the investigator and answer questions; Answer in writing questions raised by the investigator; and Give assistance to the investigator [1] If, after an investigation, the Insurance Authority found that a person is guilty of misconduct or is not a fit and proper person to be licensed, the IA can: Revoke or suspend the licence; Prohibit the person from applying to be licensed for a period of until the occurrence of an event that the IA specifies; Reprimand the person publicly or privately; and Fine the person to an amount which is the greater of $10 million or 3 times the amount of the profit gained or loss avoided by the person as a

result of the misconduct. In relation to the imposition of pecuniary penalty, the IA has issued a Guideline setting out the considerations IA would take into account when exercising its power to impose a pecuniary penalty. [1] Sections 64ZZH(6) & (7) of the Ordinance B. INSURTECH AND VIRTUAL INSURER B. INSURTECH AND VIRTUAL INSURER 1. WHAT IS INSURTECH? 1. WHAT IS INSURTECH? Generally, Insurtech is a generic term referring to the innovative deployment and application of technology to enhance the quality of insurance services provided by insurance companies or insurance intermediaries to policy holders or customers, and to make buying insurance and handling insurance-related matters more convenient. Some examples of Insurtech are:- Buying and selling of insurance policies through digital channel (the insurance company specializing in this way of selling insurance policies is also known as “virtual insurer”) the use of Internet and mobile phone application for handling matters in relation to insurance such as submission of insurance claims; use of wearable health trackers to collect health data for the purpose of medical health insurance; monitoring device in motor cars to track behavior of the driver for underwriting, renewal or claims handling of motor insurance; leveraging on cashless payment methods to make premium and insurance claims payment faster and more convenient. If you want to find more about the latest development of Insurtech in Hong Kong, you can visit the Insurance Authority’s website at: https://www.ia.org.hk/en/aboutus/insurtech_corner.html. 2. WHAT ARE THE POTENTIAL BENEFITS OF OBTAINING AN INSURANCE POLICY FROM A VIRTUAL INSURER? 2. WHAT ARE THE POTENTIAL BENEFITS OF OBTAINING AN INSURANCE POLICY FROM A VIRTUAL INSURER? One of the most obvious benefits reaped by obtaining an insurance policy from a virtual insurer is to save premiums. Theoretically, without involving any insurance intermediary in the selling process, no commission needs to be paid by the customer. Also, buying insurance through a virtual insurer can make the whole selling process more convenient. With Internet and an electronic device such as computer and mobile phones, customers can learn about and buy insurance policies at anytime and anywhere. 3. WHAT SHOULD I BE AWARE OF WHEN I CONSIDER OBTAINING AN INSURANCE POLICY FROM A VIRTUAL INSURER, OR TO USE INSURTECH TO DEAL WITH INSURANCE-RELATED MATTER? 3. WHAT SHOULD I BE AWARE OF WHEN I CONSIDER OBTAINING AN INSURANCE POLICY FROM A VIRTUAL INSURER, OR TO USE INSURTECH TO DEAL WITH INSURANCE-RELATED MATTER? Even though utilization of technology in the insurance sector brings tremendous benefits, you should be careful of the following: As a rule of thumb, insurance products with simple features are suitable for buying and selling via a virtual insurer; On the other hand, if the insurance product of which you are considering is complex or involves a substantial and long-term commitment (e.g. a product with a long premium payment period, or with advanced features such as different payout options), you may want to purchase such products via an insurance intermediary who can explain the details of the insurance policy to you and assist you in handling matters in relation to the insurance policy. Typically, if you choose to buy insurance policies from a virtual insurer, no insurance intermediary would explain the features of the insurance product and give you advice on whether such insurance product is suitable for you having regard to your financial conditions and insurance needs. Hence you should make sure that you have read through and understand the terms and conditions of the insurance policy, including the insurance coverage and the existence of exclusion clauses. You should also be aware of the risks associated with the insurance policy, e.g. the surrender charge which can cause substantial loss if you fail to pay premiums on time. If you do not understand any part of the policy, you should consult representatives from the virtual insurer, or consider obtaining an advice from an insurance intermediary. Moreover, cybersecurity is a major concern for virtual insurers and other application of Insurtech with heavy reliance on the Internet. To this end, the Insurance Authority has a Guideline on Cybersecurity and all insurance companies, including virtual insurers, must comply with at all times. You should also strive to protect yourself against cyber risks when obtaining insurance policies via Internet or using online services provided by insurance company, e.g. to use private network connection and keep your passwords strictly confidential. Also, the use of technology in our modern society causes a grave concern on privacy and personal data, and Insurtech has no escape from it. In Hong Kong, all personal data collected by insurance companies

are under the protection of the Personal Data (Privacy) Ordinance (Cap. 486). You should pay attention to how your personal data collected by insurance company is handled, for instance you should read carefully the Personal Information Collection Statement (“PICS”) which would list out for what purpose(s) can the insurance company use your personal data. When using a mobile application developed by an insurance company, you should check the privacy settings and what permissions are granted to this application. COMMON TYPES OF INSURANCE III. COMMON TYPES OF INSURANCE A. LIFE INSURANCE (INCLUDING RETIREMENT PRODUCTS) A. LIFE INSURANCE (INCLUDING RETIREMENT PRODUCTS) Life insurance typically provides a cash sum on the death of an individual (i.e. the insured person) or on him/her becoming incapacitated in consequence of an injury or sickness. Some of the major types of life insurance are summarized as follows: Term Life A "Term Life" policy pays a lump sum (also called "death benefit") only upon the death of the policyholder/the insured person. It does not provide any dividends or savings, but pure protection against death. Term policies are of a fixed duration, for example 10 or 20 years. If no claim is made, the policy will expire at the end of the term. Whole Life A "Whole Life" policy pays a lump sum upon the death of the policyholder/the insured person or at the termination of the policy. It usually covers a longer and unfixed duration (usually up to age of 100 of the policyholder/the insured person) as long as the premiums are paid. Premiums for a whole life policy are usually fixed based on the age of the insured person when the policy is issued and they do not increase as time passes. Unlike a term life policy which may expire without paying out, a whole life policy would always pay out eventually. Hence, the premiums for a whole life policy are typically much higher than those of a term life policy. Some whole life polices (known as “participating policies” or “with-profits policies”) provide dividends to policyholders, for the insurance company will share its excess profits with the policyholders. Premiums for such participating policies are typically higher than those of non-participating policies Endowment An "Endowment" policy pays out a lump sum after a specific term (usually 5, 10 or 20 years) or if earlier, upon the death of the policy holder / the insured person. It is designed to provide the policyholder savings for future living, as well as a life insurance protection. Annuity An annuity is typically used for retirement planning which helps policyholders accumulate savings for getting a steady income after retirement or over a long term in future. A policyholder pays premiums to an insurance company, who in turn provides the policyholder with a regular payment for a period specified in the contract after a designated period of time or when the policyholder reaches a certain age. Qualifying Deferred Annuity Policy A deferred annuity is one type of annuities. The policyholder pays premiums regularly over a period of time (i.e. the accumulation phase), in return he will receive regular income for a period of time in future (i.e. the annuitization phase). To promote voluntary retirement savings, the Government of Hong Kong in 2019 introduced tax reliefs in respect to certain deferred annuities that are certified by the Insurance Authority as Qualifying Deferred Annuity Policies (QDAP). The policyholder (as taxpayer) of a QDAP can claim for potential tax deductions on premiums paid up to HKD60,000 per tax assessment year. Investment-linked assurance schemes An investment-linked assurance scheme (ILAS) is a life insurance policy issued by an insurance company which provides the policyholder with life insurance cover plus investment options (usually funds). Its policy value is determined by reference to the performance of the “underlying or reference funds”. While the policyholders have the ownership of the life insurance policy, the underlying assets (normally the underlying or reference funds) are owned by the insurance company. Mandatory Providential Fund Schemes (“MPF”) Following the implementation of the MPF (an employment-based retirement protection system) on 1 December 2000 , both employers and employees should know more about their rights and obligations relating to MPF schemes. For more information regarding MPF matters, please visit the website of the Mandatory Provident Fund Schemes Authority. 2. WHAT DO I NEED TO CONSIDER IF I AM THINKING WHETHER TO REPLACE AN EXISTING INSURANCE POLICY WITH A NEW INSURANCE POLICY? FROM WHOM MAY I SEEK ADVICE? 2. WHAT DO I NEED TO CONSIDER IF I AM THINKING WHETHER TO REPLACE AN EXISTING INSURANCE POLICY WITH A NEW INSURANCE POLICY? FROM WHOM MAY I SEEK ADVICE? Prior to switching your life insurance policy to another insurance company, you

should be careful that your agent is not making inaccurate or misleading statements or comparisons to persuade you to switch. This is not uncommon as your agent could earn a commission from your switching to another insurance company (where the agent is also switching to a new insurance company). Replacing an existing life insurance policy with a new insurance policy may bring certain risks and consequences which you need to consider carefully: Financial implications Life insurance policies usually last for a long period of time. If you surrender your existing life insurance policy, particularly during the early years of the policy period, you will usually suffer loss; The cash value that you may receive from surrendering your existing life insurance policy may be less than your total premium paid; You may be subject to withdrawal or surrender charges; In purchasing a new life insurance policy, a substantial part of the initial premium may be used to pay for policy administration and insurance intermediaries costs; You may have to pay higher premium under the new life insurance policy in view of the difference in age and changes of health and other conditions; and You may lose the financial benefit accumulated over the years (e.g. loyalty bonus or dividends) under the existing life insurance policy. Insurability implications: If you purchase a new life insurance policy to replace an existing life insurance policy, some benefits, which are the policy features of the existing life insurance policy, may not be covered under the new life insurance policy due to changes in age, health conditions and occupation, etc.; and Riders / supplementary benefits under your existing life insurance policy may not be available under the new life insurance policy. Claims eligibility implications: Benefits under the existing life insurance policy will no longer be payable to you if you surrender the policy or allow it to lapse; and You may need to start a new waiting period in respect of certain benefits (e.g. medical, critical illness, suicide or incontestability) under the terms and conditions of the new life insurance policy. In Hong Kong, to protect life insurance policy holders' interest, subject to some exceptions, licensed insurance intermediaries are generally required to advise customers who are considering to replace an existing life insurance policy with a new policy whether the arrangement is in their best interests taking account of any reduction in the total cash value or sum insured under the existing policy, and any other adverse consequences. In order to protect consumers against the above risks, there is a requirement for them to complete the Important Facts Statement - Policy Replacement (the "IFS-PR", which can be found as Appendix B in the Guideline on Long Term Insurance Policy Replacement issued by the Insurance Authority). Where there is a switching or replacement of a policy, the insurance agent must declare on the IFS-PR that he/she has fully explained the risks that would be involved to the client. The client must also declare that he/she understands the risks concerned. In summary, make sure that your insurance agent is not making inaccurate or misleading statements or comparisons to persuade you to switch. Any additional genuine and legitimate benefit available under the new policy may make it worth switching, but you must be clear of the potential risks and what could be done to manage these risks. 3. HOW CAN I FIND OUT ABOUT THE BENEFIT ILLUSTRATION OF A LIFE INSURANCE POLICY PRIOR TO PURCHASING IT? 3. HOW CAN I FIND OUT ABOUT THE BENEFIT ILLUSTRATION OF A LIFE INSURANCE POLICY PRIOR TO PURCHASING IT? For most life insurance policies, insurance companies are required to provide benefit illustrations to the customers at the point-of-sale according to the following requirements: An authorized insurer should prepare an inforce re-projection illustration based on the current policy option chosen by the policy holder (e.g. withdrawal, premium offset, top-up, etc.), and the updated actuarial assumptions and the authorized insurer's current view of the market outlook. The re-projection should start from the policy year in which the re-projection is performed, taking into account the policy's updated inforce policy status (e.g. attained age, current sum assured, etc.). Relevant warnings of associated risks and explanatory notes should be suitably modified and presented. For some particular product types (e.g. ILAS, participating, universal life (non-linked) and non-participating policies), authorized insurers are required to provide further information to the customers according to additional requirements applicable to the specific product types. 4. WHY DO I NEED TO PROVIDE THE INFORMATION FOR COMPLETING THE FORM FOR FINANCIAL NEEDS ANALYSIS PRIOR TO PURCHASING LIFE INSURANCE

POLICY? 4. WHY DO I NEED TO PROVIDE THE INFORMATION FOR COMPLETING THE FORM FOR FINANCIAL NEEDS ANALYSIS PRIOR TO PURCHASING LIFE INSURANCE POLICY? Life insurance policies are generally long term in nature and may lock up the liquidity of customers. It is therefore important for authorized insurers and licensed insurance intermediaries to ensure that a proper assessment of a customer's circumstances including his/her needs, financial condition, ability and willingness to pay premiums, etc., is undertaken before any recommendation is made in respect of a suitable life insurance policy for the customer, and that the recommendation is based on such financial needs analysis ("FNA"). An authorized insurer or a licensed insurance intermediary is required to collect relevant and sufficient information from a customer to conduct the FNA before making recommendation in respect of certain types of life insurance policies. If a customer refuses to disclose information during the FNA process, the licensed insurance intermediary would be unable to comply with the FNA requirements, and consequently the licensed insurance intermediary could not recommend any insurance product to the customer. 15. I HAVE TAKEN OUT SEVERAL LIFE INSURANCE POLICIES COVERING THE SAME RISK (ON THE LIFE OF THE SAME PERSON), CAN I CLAIM FOR THE DEATH BENEFIT UNDER ALL LIFE INSURANCE POLICIES? 15. I HAVE TAKEN OUT SEVERAL LIFE INSURANCE POLICIES COVERING THE SAME RISK (ON THE LIFE OF THE SAME PERSON), CAN I CLAIM FOR THE DEATH BENEFIT UNDER ALL LIFE INSURANCE POLICIES? For life insurance policies the position is that if there is nothing untoward (e.g. fraud or misrepresentation), the insurance company will be liable to pay in full regardless of there being other policies under which claims could also be made. This position is in contradistinction with the case when a same risk under medical, personal injury and property insurance is covered by more than one insurance policy. For more details on this, please see question 7 of B. Medical Insurance. 18. I HAVE ALREADY JOINED A MPF SCHEME. DO I STILL NEED TO CONSIDER OTHER RETIREMENT PLANS, E.G. LIFE INSURANCE AND OTHER INVESTMENT TOOLS? 18. I HAVE ALREADY JOINED A MPF SCHEME. DO I STILL NEED TO CONSIDER OTHER RETIREMENT PLANS, E.G. LIFE INSURANCE AND OTHER INVESTMENT TOOLS? As the average life expectancy for Hong Kong people grows longer, retirement period can potentially last for many years. The monthly living expenses and medical fees during retirement, together with inflation cost, could be a substantive burden for a typical retiree. MPF is an employment-based retirement protection system of which employees and employers make regular mandatory contributions at 5% respectively of the employee's relevant income, subject to the minimum and maximum relevant income levels. To enjoy a secure retirement life, you may need to consider additional retirement planning to meet your retirement needs. In order to diversify the financial sources after your retirement, you may consider different saving, insurance and investment tools which offer alternative means for financial protection, money management and bequest tools, involving different risk exposure, to tailor the plan to serve your retirement needs and risk appetite. B. MEDICAL INSURANCE B. MEDICAL INSURANCE What is Medical/Health insurance? Medical/health insurance is a type of insurance coverage that indemnifies the insured person for the cost incurred for surgeries, hospital care, dental services and other types of health care services. Depending on the terms of the particular insurance policy, the insurers may reimburse the insured person upon receiving a claim, or the insurers may pay the healthcare provider directly after the insured person has already received the medical services. Different types of medical/health insurance It is important for consumers to understand basic concepts when shopping around for the most suitable medical/health insurance product that meets their needs. Below are explanations of the common terminologies used on the market to describe different types of medical/health insurance: Hospital cash insurance refers to policies that provide payment for income replacement or for reducing the burden of hospital expenses during the duration of the insured person's hospitalization. This payment may be calculated on a daily basis and is usually non-accountable (i.e. the hospital cash may be used on anything not necessarily related to hospital expenses). Personal accident insurance refers to policies that provide lump-sum payment upon the insured person suffering certain personal accidents, injuries, or death. Payment is usually contingent upon the "trigger" event, i.e. the occurrence of the "accident" as defined by the particular policy, and may cover reimbursements of medical cost. Most personal accident

insurances are able to provide a single indemnity to the insured if he/she suffers permanent disablement or accidental death which would help cover the daily living expenses of the insured and his/her family. Critical illness protection insurance refers to policies that provide lump-sum payment upon the insured person falling ill to certain catastrophic illnesses or medical emergencies. Payment is not dependent upon incurred medical costs but is triggered by the occurrence of the specific illness covered under the policy. Coverage depends on the definition of critical illness and varies between products. Q&A; ON MEDICAL INSURANCE 1. WHAT IS THE DIFFERENCE BETWEEN GROUP AND INDIVIDUAL MEDICAL/HEALTH INSURANCE? 1. WHAT IS THE DIFFERENCE BETWEEN GROUP AND INDIVIDUAL MEDICAL/HEALTH INSURANCE? Group medical/health insurance is a common type of employment benefits offered by employers to employees, with employers paying for the premium in order to provide medical/health insurance coverage for their employees. In general, group medical/health insurance provides coverage to eligible employees within the group regardless of the pre-existing health conditions of the employees, but the coverage ceases upon the employment’s termination. By contrast, applications for individual medical/health insurance often require applicants to declare pre-existing health conditions, so that insurers may decide whether to accept an application and, if accepted, the scope of the insurance coverage to be provided (e.g. whether to exclude a particular pre-existing condition from cover). 2. WHAT IS THE VOLUNTARY HEALTH INSURANCE SCHEME? 2. WHAT IS THE VOLUNTARY HEALTH INSURANCE SCHEME? In 2019, the Hong Kong Special Administrative Region Government launched the policy initiative known as “Voluntary Health Insurance Scheme” (“VHIS”), under which participating insurance companies offer hospital insurance indemnity plans that are certified by the Food and Health Bureau (“Certified Plans”). The objective of the VHIS scheme is to enhance the protection level of hospital insurance products, provide the public with an additional choice of using private healthcare services through hospital insurance, and relieve the pressure on the public healthcare system in the long run. An insurance policy becomes a “VHIS Policy” when it is in whole or in part issued under a Certified Plan. The premiums paid for a VHIS Policy is eligible for the tax deduction under the Inland Revenue Ordinance (Cap. 112). If a VHIS Policy provides both Certified Plan coverage and other insurance protection, only the premiums in relation to the Certified Plan are eligible for the tax deduction. 3. WHAT IS THE MINIMUM INSURANCE COVERAGE OFFERED BY CERTIFIED PLANS? 3. WHAT IS THE MINIMUM INSURANCE COVERAGE OFFERED BY CERTIFIED PLANS? All Certified Plans must meet the following conditions or offer the following coverage:[1] Guaranteed renewal up to 100 years of age (without re-underwriting) No "lifetime benefit limit" 21-day cooling off period Premium transparency Coverage extended to: Unknown pre-existing conditions (will be partially covered in 2nd year (25%) and 3rd year (50%) after policy inception and fully covered (100%) afterwards) Treatment of congenital conditions which have manifested or been diagnosed since the age of 8 will be covered Day case procedures such as endoscopy conducted in day centres will be covered Prescribed diagnostic imaging tests such as Computed Tomography (CT scan), Magnetic Resonance Imaging (MRI scan) and Positron Emission Tomography (PET scan) conducted during hospital stay or in an outpatient setting will be covered, subject to 30% coinsurance Prescribed non-surgical cancer treatments such as radiotherapy, chemotherapy and targeted therapy will be covered Psychiatric inpatient treatments in local hospitals will be covered up to the limit of HK$30,000 per policy year There are two types of Certified Plans: Standard Plan which is fixed in product design and adheres to the minimum complying requirements of VHIS, and Flexi Plan which must provide basic protection equivalent to Standard Plan coverage plus a flexible top-up protection to suit market needs subject to certain rules set out by the Food and Health Bureau.[2] [1] https://www.vhis.gov.hk/en/about_us/scheme.html [2] https://www.vhis.gov.hk/en/consumer_corner/list-plans.html 4. HOW DO I KNOW WHETHER AN INSURANCE POLICY IS A VHIS POLICY? 4. HOW DO I KNOW WHETHER AN INSURANCE POLICY IS A VHIS POLICY? Upon successful certification, each Certified Plan is assigned a unique certification number that can be found on this website and the website of the insurance companies concerned.[1] For ease of identification, the pages relevant to the Certified Plan in each VHIS Policy have a footer stating that “the content on this page is part

of the Terms and Benefits of Certified Plan ()”.[2] For further information, please refer to the following links: List of Standard Plans: https://www.vhis.gov.hk/en/consumer_corner/standard-plan.html List of Flexi Plans: https://www.vhis.gov.hk/en/consumer_corner/flexi-plan.html Search Certified Plans: https://www.vhis.gov.hk/en/consumer_corner/plan-search.html [1] https://www.vhis.gov.hk/en/consumer_corner/list-plans.html [2] https://www.vhis.gov.hk/en/about_us/scheme.html 5. WHAT IS THE IMPACT OF A “SUICIDE CLAUSE” ON MEDICAL/HEALTH INSURANCE IF THE POLICYHOLDER HAS TRIED TO COMMIT SUICIDE, BUT ONLY INJURED HIMSELF? 5. WHAT IS THE IMPACT OF A “SUICIDE CLAUSE” ON MEDICAL/HEALTH INSURANCE IF THE POLICYHOLDER HAS TRIED TO COMMIT SUICIDE, BUT ONLY INJURED HIMSELF? In the case of medical/health insurance, as discussed under the subject of the "exclusion" clause, suicide and self-inflicted injury are excluded from the coverage. Therefore, where the insured person has committed suicide or has injured himself in the course of attempting to commit suicide, a claim for insurance under the policy would not be accepted. 6. WILL MEDICAL REPORTS ISSUED BY TRADITIONAL CHINESE MEDICAL PRACTITIONERS BE ACCEPTED BY AN INSURANCE COMPANY WHEN PROCESSING CLAIMS? 6. WILL MEDICAL REPORTS ISSUED BY TRADITIONAL CHINESE MEDICAL PRACTITIONERS BE ACCEPTED BY AN INSURANCE COMPANY WHEN PROCESSING CLAIMS? There is usually a standard provision in an insurance policy that medical reports are those issued by a registered medical practitioner of western medicine. Thus, unless the policy specifically admits medical reports issued by registered Chinese medical practitioners, such reports will not normally be accepted for the purpose of claims. F. MOTOR INSURANCE F. MOTOR INSURANCE A. Overview Motor insurance is designed to provide cover for loss or damage to your motor vehicle and that of third parties, and bodily injury or death of third parties. The scope of cover under a motor insurance policy varies, e.g. it may insure you against your costs of repairing / replacing your car following an accident or it may insure against your liability to pay compensation to an injured person following a traffic accident. Insurance coverage varies according to the terms and conditions of an insurance policy. The major types of motor insurance are summarized as follows: 1. Third party liabilities Third party liability covers you against liabilities of property damage claims and/or personal injury claims by third parties. Under the Motor Vehicles Insurance (Third Party Risks) Ordinance (Cap. 272) (“MVIO”), it is compulsory to take out a motor insurance policy with an authorized insurer covering the liability for bodily injury or death of any third party arising out of the use of your motor vehicle on a road. Please see section C “Compulsory Motor Insurance” below for further details. 2. Damage or loss to your own motor vehicle This type of insurance covers loss or damage to your own motor vehicle resulting from a traffic accident, fire, theft or other damage or loss howsoever caused. The insurance policy usually provides for an excess clause which sets out the initial amount of the claim that you need to pay before you are indemnified by the insurer under the policy. 3. Comprehensive cover This is a composite cover which protect you against both liabilities of property damage claims and/or personal injury claims by third parties and damage or loss of your own motor vehicle. Generally speaking, premium for a comprehensive cover is higher than a mere third party liability cover or damage or loss to own motor vehicle. Different types of motor insurance are offered by insurers. You should choose the type of insurance that meets your needs. B. Common coverage issues Insurance policies typically contain contractual provisions such as conditions and exclusions. An insurance condition is an obligation on the insured to act in a particular way upon which the validity of the policy or of any claim may depend. An exclusion provision eliminates an insurer’s liability in certain circumstances by specifying the loss or damage that is not covered by a policy. Therefore, it is important that you carefully review your policy wording before purchase and comply with all conditions set forth in your policy. 1. Limitation as to use of motor vehicle A ‘limit as to use’ clause is commonly found in a motor insurance policy. The clause usually states insurance coverage under the policy is operative only when the motor vehicle is used for certain purposes, for example, social, domestic and pleasure purposes or for the insured’s business or profession. In these circumstances, the policy will not operate when the motor vehicle is used for other

purposes (e.g. for hire or reward or racing). Therefore, it is important that the use of the motor vehicle is in accordance with its permitted use in order to be eligible for claiming your loss or damage under the policy. 2. Authorized driver In general, motor insurance policies cover the liability of the car owner and the driver(s) authorized or permitted by the owner to use the car. Hence, where the driver takes the car without authorization (e.g. by theft), the motor insurance policy would not cover the liability arising from the use or driving of the car by the unauthorized driver. Further, no indemnity would be provided for the liability arising out of the use or driving of a car by any person not holding a valid driving licence. Your driving history such as past claims history and traffic conviction records is one of the important matters for an insurer to evaluate risks and decide whether to accept the risks, set premium or other terms of the policy, for example, an excess clause for young and unexperienced driver (e.g. driver of age below 25 or holding a driving licence for less than 2 years). 3. Other conditions It is a common condition in a motor insurance policy for the insured person to report to the insurer incident leading to the loss or damage within a specified period of time. If the car owner or the driver is prosecuted for an offence arising out of the use of the car, the car owner or the driver should report to the insurer the impending prosecution and also the progress of the case, and pass all relevant documents (e.g. summons, charge sheet, etc.) to the insurer in a timely manner and in accordance with the policy terms and conditions. Late reporting or failure to forward all relevant documents may be relied upon by the insurer as a ground to reject your claims. 4. Exclusions Like all other insurance policies, motor insurance policies contain exclusion clauses which exclude or exempt the insurer from paying your claims in certain circumstances. You should read through all the exclusions before you purchase a motor insurance policy so as to avoid your future claim from being denied. Below is a list of common exclusions of a motor insurance policy: the car is used outside a specified territory / jurisdiction; the owner or the driver fails to comply with the limitation as to use clause; the car is used by an unauthorized driver; the use of the car is by a driver under the influence of alcohol or drugs; liability arises from war, nuclear disasters, strike, riot, civil commotion, terrorism or any other specified incident; and the use of the car fails to comply with any laws or regulations relating to the carriage of dangerous goods. C. Compulsory Motor Insurance 1. Motor Vehicles Insurance (Third Party Risks) Ordinance (“MVIO”) The scheme for compulsory motor insurance is prescribed under the MVIO. Section 4(1) of the MVIO obliges any person using (and any person permitting others to use) a motor vehicle on a road must be covered by an in-force motor insurance policy in relation to the use in respect of third party risks in compliance with the statutory requirements. The effect is to require all drivers to be protected by insurance against any potential third party (e.g. passengers, pedestrians, other car users etc.) of bodily injury or death in Hong Kong. The scope of compulsory cover does not extend to the liability in respect of death or bodily injury arising out of and in the course of a person’s employment insured by other policy (e.g. risk insured under any statutory employees’ compensation insurance policy) or any contractual liability. The minimum amount of liability arising out of one event to be covered by a statutory motor insurance policy is prescribed under section 27 of the Motor Vehicles Insurance (Third Party Risks) Regulations (Cap. 272A) to be HK$100 million. 2. Consequence of failing to take out a compulsory motor insurance Section 4(2) of the MVIO criminalizes any person (including the car owner or the driver) for using or permitting other in using a motor vehicle on a road without the required compulsory insurance. The maximum penalty of contravening section 4(2) is a fine up to HK$10,000 and imprisonment for 12 months. Further, a person convicted of this offence would be disqualified from holding or obtaining a driving licence for such a period as the court may determine being not less than 12 months nor more than 3 years from the date of conviction. 3. Effect of compulsory motor insurance against exclusions / breach of policy condition In general, if the circumstances of the incident giving rise to liability falls within the scope of an exclusion or the insured has committed a breach of any policy condition under a policy, the insurer is not obliged to provide any indemnity to the insured or is entitled to repudiate policy liability against the

insured for breach of policy condition. Having said that, section 10(1) of the MVIO provides that, in respect of the liability statutorily required to be covered under the MVIO (i.e. third party liability of bodily injury or death), the insurer of a compulsory motor insurance is generally liable to pay compensation to the injured person or deceased for liability arising out of the use of the insured motor vehicle notwithstanding the policy can be or had been cancelled or avoided. The purpose of section 10(1) of the MVIO intends to offer a general protection to the victims (or the dependents of the victims) of traffic accidents a direct right against the insurers under the relevant compulsory motor insurance policies for seeking compensation and damages subject to certain procedural requirements under section 10(2). The direct recourse against the insurer exists regardless of whether the insurer is entitled to repudiate policy liability against the car owner or the driver because of the operation of any exclusion or any breach of policy condition. The insurer is nevertheless at liberty to seek contribution or indemnity against the default car owners or drivers pursuant to the provisions under the policy or other cause of action (if any). For the avoidance of doubt, section 9(1) of the MVIO further provides that any policy condition providing no liability shall arise under a compulsory motor insurance policy shall be of no effect in connection with the claims under section 6(1)(b), i.e. the claim in respect of the third party liability of bodily injury or death arising out of the use of the insured motor vehicle on a road. 4. Effect of compulsory motor insurance against non-disclosure or misrepresentation of material facts Although third parties' direct right to seek compensation or damages against the insurer would not be affected by cancellation or avoidance of the motor insurance policy, such right may in certain circumstances cease. Under section 10(3) of the MVIO, an insurer may disclaim such right by obtaining a declaration that, apart from any provision contained in the relevant motor insurance policy, the insurer is entitled to avoid it on the ground that it was obtained by non-disclosure of a material fact, or by a representation of fact which was false in some material particular. The insurer must commence proceedings to obtain the declaration before or within 3 months after the third party's action for compensation in respect of the liability of bodily injury or death. The insurer must also give notice to the relevant third party(ies) before or within 7 days after the commencement of the action initiated by the relevant third party(ies) specifying the non-disclosure or false representation. Section 10(5) of the MVIO defines "material" as to the fact or information of such a nature as to influence the judgment of a prudent insurer in determining whether he will take the risk, and if so, at what premium and on what conditions. D. Motor Insurers' Bureau of Hong Kong The protection under the statutory compulsory motor insurance regime does not cover the following three situations: (i) the driver fails to take out any compulsory motor insurance policy in contravention with the MVIO, (ii) the liability of bodily injury or death is caused by an untraced driver, and (iii) the inability to pay compensation by the car owner and the driver coupled with the insolvency of the insurer concerned. In order to remedy the above situations, the Motor Insurers' Bureau of Hong Kong ("MIBHK") was established in 1980 to administer a non-statutory compensation scheme. All authorized insurers writing motor vehicle third party risks insurance are required by the Insurance Authority to become a member of MIBHK. The finance of MIBHK is generally supported by the levy and contribution made by the insurer members charged on its motor policy premium. Under this non-statutory scheme, MIBHK has undertaken to provide indemnity to the third party victims of uninsured drivers for liability subject of compulsory insurance under the MVIO, or compensation on an ex gratia and discretionary basis for untraced driver cases. Insolvency fund is also maintained by MIBHK to avoid victims of traffic accidents left not compensated due to insolvency of the insurer concerned. Given the locality of the scheme, the victim (or the dependent of the victim) should note that the judgment for liability of bodily injury or death must be obtained at first instance (or on appeal) in a court of competent jurisdiction in Hong Kong, but not any court in other jurisdiction. E. Purchasing a suitable motor insurance Apart from the level of premium, a car owner should also consider the nature and scope of coverage, the intended use of the vehicle, the amount of excess, the potential discount of "no claim bonus" (i.e. the rebate or

discount of premium for no record of claim at subsequent renewal), and the jurisdictional / territorial issue where the vehicle is intended to be driven. The opening of Hong Kong-Zhuhai-Macao Bridge (“HZM Bridge”) since 2019 illustrates a jurisdictional / territorial issue for motor insurance. The HZM Bridge is a cross-boundary connection between Hong Kong, the Mainland and Macao and the three jurisdictions are governed by different laws and have different statutory motor insurance requirements. Vehicles from Hong Kong using the HZM Bridge are required to comply with the laws of all these jurisdictions. You may refer to the Frequently-asked Questions on HZM Bridge and the leaflet titled “Tips for Buying Insurance” available at the Insurance Authority’s website for the details and tips to consider in purchasing suitable motor insurance policy(ies) for your car. 5. DO I NEED TO DISCLOSE THE TRAFFIC ACCIDENT(S) I HAVE PREVIOUSLY BEEN INVOLVED AS A DRIVER WHEN I APPLY FOR MOTOR INSURANCE? WILL I BE CHARGED OF A HIGHER PREMIUM IF I DISCLOSE I HAVE RECENTLY BEEN CONVICTED OF ANY TRAFFIC OFFENCE SUCH AS ILLEGAL PARKING? 5. DO I NEED TO DISCLOSE THE TRAFFIC ACCIDENT(S) I HAVE PREVIOUSLY BEEN INVOLVED AS A DRIVER WHEN I APPLY FOR MOTOR INSURANCE? WILL I BE CHARGED OF A HIGHER PREMIUM IF I DISCLOSE I HAVE RECENTLY BEEN CONVICTED OF ANY TRAFFIC OFFENCE SUCH AS ILLEGAL PARKING? You should refer to the full wording of the questions asked or the information requested in the motor insurance application form. In general, insurers would pose questions relating to your personal particulars (e.g. age and driving experience), your car’s particulars (e.g. model, engine number, chassis number, etc.) and the driver’s previous driving history (e.g. whether you have been involved in any traffic accident or been convicted of any traffic offence within a specified period of time). You should make full and frank disclosure in answering those questions and providing the requested information in the application form. The actual scope of disclosure (for example, what kind of traffic offence conviction is required to be disclosed) is subject to the relevant wording in the application form. If you have omitted to provide any required particulars or (innocently or otherwise) provided false particulars in answering the questions stated in the application form, your insurer may apply for a declaration to avoid your motor insurance policy based on non-disclosure or misrepresentation of facts if such particulars are material, i.e. the particulars are of such nature as to influence the judgment of a prudent insurer in determining whether the insurer will take the risk, and if so, at what premium and on what conditions. Regarding the amount of premium, it is generally calculated in accordance with a set of data including your age, occupation, driving experience and records, the type of motor insurance policy being applied for, the model and valuation of your vehicle, as well as your past claim history and traffic conviction records (different insurers may have different formula of calculation). However, you should note that in most of the cases, the amount of premium potentially saved by withholding / misrepresenting material particulars would be outweighed by the potential adverse impact of the avoidance of your motor insurance subsequently by your insurer (which results in you being personally liable for paying compensation to the any third party claim). Hence, if you are in doubt as to whether certain particulars need to be disclosed, it would be prudent to disclose it to the insurer. H. TRAVEL INSURANCE H. TRAVEL INSURANCE A. Overview Travel insurance is designed to cover unforeseen losses incurred while travelling. Subject to the coverage of a travel insurance policy, a policy usually covers flight delays, trip cancellation, loss of money and possessions, accidental death, medical expenses, lost/damaged luggage and third party liabilities, etc.) which are aimed to meet travellers’ needs. Certain policies also provide ancillary services (e.g. evacuation services) to handle emergency needs during the trip. Premium varies depending on the scope of cover and amount of indemnity. In general, you may purchase travel insurance to cover yourself and your travel companion. B. Common insurance covers Generally speaking travel insurance comprises different forms of insurance cover: 1. Death and disablement A common form of protection a travel insurance policy provides is an indemnity (usually at a fixed sum) for the unfortunate event of death or disablement of travellers. Regarding the claim of disablement, the indemnity is usually confined to permanent disablement and that the prescribed amount of indemnity is set for each and every prescribed forms of disablement. 2. Medical expenses This form of

protection generally covers two main items: (i) bodily injuries sustained during your trip and (ii) sickness/disease contracted during your trip. The form of indemnity varies across travel insurance policies. Common forms of protection are reimbursement of medical expenses for medical treatment (in-patient or out-patient, or both) in respect of your injury sustained during your trip, and payment of cash allowance benefit which is generally restricted to hospitalisation during your trip. Subject to the terms and conditions of the policy, travel insurance may also provide emergency assistance services to travellers for serious medical conditions. Some travel policies provide 24-hour worldwide telephone medical advice services and emergency evacuation and repatriation services. These ancillary services are usually provided by contractors engaged by the insurers. Travellers should check the terms and conditions of the policy carefully and understand the scope of services and consider whether any additional charges may be involved (e.g. fees for international telephone calls or upgrade of air ticket class for repatriation). 3. Personal liabilities This cover provides protection against your potential legal liability for bodily injury to third parties, or loss or damage to properties of third parties as a result of your negligence. Reasonable legal costs and expenses are also covered, subject to the limit of indemnity. 4. Loss, damage or stolen luggage Travel insurance not only provides indemnity to you for luggage lost or damaged (whether by an accident or theft) during your trip, but may also extend the cover of your household contents lost as a result of burglary when you are absent from your residence for travel. Luggage and certain electronic devices (e.g. laptops and mobile phones) may be specifically named in the policy to be subject to different limits of indemnity and conditions for indemnity. 5. Flights delay and trip cancellation or curtailment Subject to the terms and conditions of the policy, allowance or compensation may be payable to you for flights delay, trip cancellation or curtailment. This cover is often subject to certain specific conditions. For example, allowance or compensation is only payable if the flight delay exceeds a specified number of hours. Trip cancellation or curtailment may only become eligible for claim as a result of bodily injury or sickness of serious nature. Certain travel insurance policies may extend coverage to provide indemnity for trip curtailment or trip cancellation due to serious bodily injury or sickness of the insured person’s immediate family member(s). 6. Loss of money, possessions and travel documents Coverage in travel insurance always provides for loss of money, other possessions and travel documents arising from theft, robbery or burglary during the trip. 7. Special covers Hiring a car for travel is very popular nowadays. Some travel insurance policies provide cover for liability arising out of the use of a hired car. Another example of special cover is hole-in-one insurance for golf competition or event. This is a type of prize-indemnification coverage to eliminate your potential expenses (e.g. offering any special gifts to the players in the same golf course if you are extremely lucky to score a hole-in-one). C. Matters for attention when choosing travel insurance When choosing travel insurance, consider what financial loss or other matters you want protection against and find out whether a particular insurance plan is suitable and sufficient for your needs. While premium for travel insurance is cheaper than most of other types of insurance (e.g. medical insurance), it is still important that you understand what is covered and what is not covered. 1. Coverage and territorial issue You should choose a suitable travel insurance plan taking into account your travel destination(s) and the duration of your journey. In doing so, you should always consider whether a specific travel insurance plan provides the protection you want and pay close attention to the exclusions (where there may be common and also different exclusions applicable to each cover). For example, if you are planning to engage in certain adventure activities or extreme sports, such as skydiving, mountain climbing, hot air balloon and bungee jumping, please note that some travel insurance policies do exclude coverage for accidents arising out of these activates or sports. If you want protection against accidents arising out of any of these activities or sports, you do need to make sure the travel insurance plan you purchase would provide such protection or the activities or sports you are planning to engage in are covered with an optional rider. It would be prudent to consult your insurer or a licensed insurance intermediary before your purchase. As travel insurance is designed to cover unforeseen

events while travelling, losses or expenses incurred as a result of a pre-existing condition (e.g. your pre-existing health condition) would be excluded. For the same reason, suicide would be excluded for cover too. 2. Premium, excess and limit of indemnity While travel insurance policies can always be purchased at a relatively low premium, it possibly consists of a higher amount of excess (i.e. the initial amount of the claim that is borne by you) or a lower limit of indemnity. It would be prudent to review the policy terms holistically to ensure the insurance plan meets your needs. 3. Emergency assistance services You should have a copy of the policy and the contact details of your insurer's 24-hour emergency service hotline number with you while travelling so that you can contact your insurer when necessary. 4. Claims handling process While making a claim is unlikely to be at the top of your mind at the time you purchase travel insurance, you should review the policy and consider what documentation you need in case you need to make a claim. For example, if you make a claim for loss of personal money or other possessions, you are usually required to file a police report obtained in the location where the loss is identified. If you make a claim for damage to baggage or flight delay, you are usually required to submit a certificate issued by the relevant airport or air carrier in support of your claim. If you make a claim for medical expenses reimbursement, you would be required to submit receipts together with signed medical reports indicating diagnosis and date of attendance. Many insurers require originals of receipts and other relevant documents in order to process a claim. Therefore, you should always ensure that you bring back originals of receipts and other relevant documents from your trip and retain a copy of them after your claim is submitted to the insurer. It is also important that you are aware of the timing of making a claim so that your claim is not denied for late notification or submission. FAQS ON TRAVEL INSURANCE 1. I HAVE ALREADY PURCHASED MY AIR TICKET AND TRAVEL INSURANCE FOR MY NEXT TRIP. HOWEVER, IT APPEARS THERE IS POLITICAL INSTABILITY IN THE COUNTRY I AM GOING TO VISIT. WHAT SHOULD I DO? 1. I HAVE ALREADY PURCHASED MY AIR TICKET AND TRAVEL INSURANCE FOR MY NEXT TRIP. HOWEVER, IT APPEARS THERE IS POLITICAL INSTABILITY IN THE COUNTRY I AM GOING TO VISIT. WHAT SHOULD I DO? Apart from your personal safety concern, you should note that there are two aspects of travel insurance that may be relevant to your travel plan. The aspect is a common exclusion that loss arising from a direct or indirect consequence of war, invasion, act of foreign enemies, civil war, rebellion, revolution, riot, performing duties as a member of armed forces or other law enforcing agencies would be excluded for cover. The other aspect relates to trip cancellation or curtailment cover. Generally speaking, trip cancellation cover entitles you to claim back wasted expenses which are not recoverable from any other party (e.g. non-refundable air ticket fare) if your trip is cancelled as a direct result of an insured risk. Similar, there may as well be trip curtailment cover in your policy. Generally speaking, cover for curtailment entitles you to claim back a pro-rata refund of any pre-paid accommodation, car hire or holiday excursions you will no longer be able to use following your return home. Under some policies, curtailment will also cover reasonable travel expenses you have had to pay on your return journey unless travel has been arranged for you by your travel insurer. You should review your policy and consider whether it is appropriate for you to proceed with your trip. Contact your insurer and ask about scope of coverage in your policy, especially if you are planning not to proceed with your travel plan. 2. I HAVE SIGNED UP A LOCAL TOUR AND SHALL PARTICIPATE IN A HOT-AIR BALLOON ACTIVITY FOR MY COMING TRIP. WHAT SHOULD I PAY ATTENTION TO WHEN BUYING MY TRAVEL INSURANCE? 2. I HAVE SIGNED UP A LOCAL TOUR AND SHALL PARTICIPATE IN A HOT-AIR BALLOON ACTIVITY FOR MY COMING TRIP. WHAT SHOULD I PAY ATTENTION TO WHEN BUYING MY TRAVEL INSURANCE? You should make sure that adventures activities such as hot-air ballooning is covered under the travel insurance plan you are going to purchase. Some travel insurance plans do exclude coverage for injuries sustained during these activities. Depending on your planned activities, you may want, or need, to supplement your travel insurance plan with a rider. The purpose is to provide you with coverage for injuries sustained during activities that would otherwise be excluded on your travel insurance plan. 3. I AM A FREQUENT TRAVELLER AS I LIKE TO VISIT DIFFERENT COUNTRIES TO APPRECIATE THE BEAUTY OF NATURE AND MOUNTAIN SCENE. ARE THERE ANY TIPS FOR ME IN BUYING

TRAVEL INSURANCE? 3. I AM A FREQUENT TRAVELLER AS I LIKE TO VISIT DIFFERENT COUNTRIES TO APPRECIATE THE BEAUTY OF NATURE AND MOUNTAIN SCENE. ARE THERE ANY TIPS FOR ME IN BUYING TRAVEL INSURANCE? In addition to the matters as discussed in Section C above, the following matters may be relevant to you. Firstly, you can choose between a single-trip policy and an annual policy depending on your travel frequency. If you travel with sufficient frequency, buying an annual travel insurance policy may help you to save money and also the trouble from purchasing a new travel insurance each time before travelling. Secondly, you should review the territory(ies) covered by your travel insurance. While some policies provide worldwide cover, other policies may limit its cover to certain countries (e.g. Asian countries or European countries) at varying premiums. Even if you have purchased an annual policy, you should also check whether the country(ies) you are going to visit is within the covered territories of your annual policy each time before you travel. The third issue is the activities you are going to planning to do covered or not covered under your insurance plan. Some examples of high risk activities and extreme sports are paragliding and kitesurfing, rock climbing, mountain biking, skydiving, trekking, surfing, skiing and snowboarding. The cover for these activities. When in doubt, you should always contact your insurer to clarify the coverage issue. 4. I AM TRAVELLING TO A CITY AT EARLY MORNING OF THE DAY AND WILL RETURN BEFORE MIDNIGHT. DO I STILL NEED TO BUY ANY TRAVEL INSURANCE FOR SUCH A SHORT TRIP? 4. I AM TRAVELLING TO A CITY AT EARLY MORNING OF THE DAY AND WILL RETURN BEFORE MIDNIGHT. DO I STILL NEED TO BUY ANY TRAVEL INSURANCE FOR SUCH A SHORT TRIP? CAN I JUST BUY THE ONE OFFERED BY AIRLINE COMPANIES AT THE TIME WHEN I PURCHASE MY AIR TICKET ONLINE? Given the relatively low level of premium and the potential adverse consequence of being uncovered by insurance, it would probably be in your interest to have your trip covered by travel insurance, regardless of its duration. Some airline companies and travel agencies are licensed insurance agencies and they do offer to their customers their principal insurers' travel insurance plans. You may choose to purchase through them an insurance plan that meet your needs. Please note that the policy is a contract of insurance between the travel insurer and you. Your purchase decision should not be lightly made without an understanding of the terms and conditions of the travel insurance plan. Further, when you purchase air tickets online, you should check whether any add-on insurance service has been opted-in or not (i.e. whether the box to purchase has already been pre-checked for you) to avoid paying for a policy that you are not intended to buy.