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Neelesh Garg

MD & CEO, TATA AIG General Insurance

IBAI

Volume 2.0 || Issue 8 || November 2022

THIS ISSUE

FROM THE PRESIDENT'S DESK

THOUGHTS FROM SENIOR INSURANCE LEADERS

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MD & CEO,
TATA AIG GENERAL INSURANCE

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Hari Radhakrishnan

LEGAL CORNER

We are not supercars, we are Lamborghini !

Lamborghini !!! What do we think when we hear about the name of this car. First thing what comes one's mind is aspiration, power, speed and many synonyms

Is it possible to drive a Lamborghini or a Ferrari or any other Supercars in India? But what is more important is to choose which roads you can take them along to. Choosing a road with a hump can be a task to drive through. The roads which you wish to roam around must be properly examined, or the person owning the car will end up damaging the car, which will eventually cost a lot.

I think we have a similar situation in Insurance as we move in the new era where acceleration is required, and the necessary impetus has been provided by the Regulator. The question is do we have potential to absorb so many changes and quickly adjust to the situation considering the risk involved in the business and mind you any wrong advice will harm the customer.

The proposed changes of completely free market where there will no brokerage structure, free product pricing, free policy wordings are wishful thinking.

This looks like a perfect situation for Brokers whose job is to understand the risk, device suitable Insurance coverage after understanding the clients risk taking capability, create competition to get him the best price, placement and finally claim Servicing.

Although, free pricing would be definitely in the interest of the consumer to inculcate better risk management practices, allowing certain risk to be retained, higher deductible to reduce the frequency etc. but simultaneously moving to free wordings may create chaos as we may have different wordings by each insurer plus brokers and we may end up 20-30 versions of policy wordings for each line of business. In spite of 50 years of erstwhile tariff wordings we are still struggling with interpretations for so many clauses. Eg. Departmental Clause, Market Value Clause(stocks), Designation of Property clause, lighting, etc. We have still not been able to figure out a common platform for the Insurers to agree on the same. We have numerous litigations in the courts due to difference of opinion/interpretation by Insurers/Surveyors. If the wordings become free, how will we protect the policyholder against such market changes.

Do we have Grievance Redressal Mechanism at the Regulators office to control the Insurer and provide justice to the Customers, or else most of the disproportionate claims will go to court and we all know the pace of the decisions at the court and layer of courts before the customer gets justice.

I feel all the stakeholders need to rethink before taking such a bold and disruptive step which can go either way and create a permanent trust deficit. Get the foundation right before we launch our rockets

The first 6 month saw a good jump in the GI figures as compared to the last 6 months of F.Y. 21-22, the Industry netted a premium of 1,25,195 crores a jump of 15.31%.

At IBAI our priority continues to be advocating for members interest and concerns as we concentrate on evolving issues facing our Clients, Profession and Industry.

We want every member to contribute towards the growth of our fraternity by involving themselves at this crossroads.

In addition to our involvement in various committees formed by the regulator we are also engaged in discussions with the various government department and stakeholders.

These frequent opportunities to participate in consultation are very welcome. We trust it continues and our voice is not only heard but also acted on.

While we work hard, make sure we enjoy the ride too, may be bumpy for a start but remember it's the supercar.

Sumit Bohra
President IBAI

EXCLUSIVE INTERVIEW

THOUGHTS FROM SENIOR INSURANCE LEADERS

NEELESH GARG

MD & CEO
TATA AIG GENERAL INSURANCE

In an exclusive interview with IBAI, Mr.Neelesh Garg, TATA AIG General insurance. shares his candid responses to a range of questions posed to him.

Insurance penetration seems to be the buzzword. The IRDAI, while providing various enablers for the industry, has set ambitious premium growth targets for the next five years. How confident are you about the insurance industry achieving this scorching pace of growth?

Insurance penetration in India registered a growth of 11.7% in the last two years—increasing from 3.7% to 4.2%. So, there is certainly a lot of potential to mine in terms of numbers. The level of insurance density in India has also recorded consistent growth in the last couple of years and even in the face of pandemic, the insurance industry displayed remarkable resilience. There is, therefore, a lot of scope for growth and ample reasons for optimism.

Our philosophy, at Tata, always has been to set ambitious targets first and then design strategies to achieve those targets. The Government, as well as the IRDAI, are taking multiple initiatives across the spectrum to increase the penetration of insurance. Some of these initiatives indeed hold the key: Protecting the interest of the policy holder; Claims processing with speed; Digital initiatives to drive business and for outreach. We are aligned with IRDAI's vision and are taking a lot of similar initiatives to ensure that we will achieve the ambitious target.

Which lines of business, you opine, would lead the enhanced penetration drive?

There are approximately 7 Cr MSME in India. Out of these approximately 70 lakhs are buying insurance. This shows that it is grossly underpenetrated segment. Many digitalization initiatives such as growth in number of GST registrations, Udyam registrations and one district product one product (ODOP) have successfully demonstrated scaling up of exports through MSME. All these MSMEs are part of banking system which makes them addressable market for insurance.

Even the health insurance in India is at a low level. 30 percent of our population is still not covered financially for health. It comes to around 40 crore individuals in absolute numbers that is a matter of grave concern given that India is trying to achieve Universal Health Coverage. Moreover, those who are insured are not insured sufficiently. Underinsurance is therefore a major concern that needs to be addressed.

Apart from targeting these segments, the insurance players collectively need to enhance their reach and distribution capabilities to bring the underserved sections of the society into the fold—low-income population, vulnerable sections, calamity-prone regions etc. To further the cause of financial inclusion through insurance, IRDAI has advised insurance companies to adopt districts for spreading insurance literacy and for coverage of families based on their insurance needs. In due course of time, such measures will certainly bear positive results.

The formula seems to be – Lower expenses will lead to lower premiums for the client. Lower premiums will pave the way for greater penetration. Do you anticipate premium rates falling in any line of business leading to more people buying the product?

There is a scope for improving productivity & reducing inefficiency & passing the benefit to the customers. However, a just throwaway price will not lead to higher penetration; it might have the opposite effect. Insurance penetration will increase when clients avail of the benefits of risk transfer for which a combination of factors such as risk awareness, knowledge of insurance solutions, sound advice on the right insurance solution for the right risk, track record of prompt & fair settlement of claims, clients & insurers partnership for risk improvement etc. will play a vital role.

Are you happy with the product mix between Corporate and Retail at Tata AIG? Any big changes contemplated in this mix, keeping in mind the numbers to be achieved by 2027? Specifically, will Tata AIG look at crop insurance and health insurance schemes of the Government as areas to be in? Or on the corporate side, any innovative offerings?

Tata AIG has always maintained a fine balance between corporate and retail. We have gained considerable market share in both the segments and even in future our endeavour shall be to drive both simultaneously. We are trying to focus on the SME segment especially because it is under insured and has latent needs that need to be addressed. Tata AIG has always been at the forefront of initiatives launched by the government, and it is our mission to serve the society. In our bid for continuous innovation, we keep revisiting and filing new products or upgrading the existing ones. We recently upgraded our bestselling D&O and GPA products and forayed into the aviation business. We have also launched a sandbox product for SME clients.

Surety Bonds – Is it a good space for the insurers to be in under the current circumstances? Will Tata AIG try to be a leader in this segment or adopt a ‘wait and watch’ approach?

I think it is a great initiative, we are looking forward for the opportunities this segment will provide. We are working with the regulator very closely on this new segment.

Your views on the mushrooming ‘healthcare products’ whose backbone is still the hospitalisation insurance, from a number of operators who are neither insurers nor insurance distributors though they display a few characteristics of both?

Health insurance, especially after the Covid induced pandemic, is going through a big transformation. A large number of companies have forayed into this segment using different methods to reach out to the market. The customers have a lot of options today. I am sure the regulator will take the right steps keeping in mind the best interests of the customers. We are very confident about our offerings in the health segment. We are diligently working towards the health business with an intention to reach to the larger public with full compliance. We want to expand health insurance from secondary/tertiary to primary which will also include OPD & wellness initiatives. For example, we have a product that covers expenses incurred on in-patient treatment taken under Ayurveda, Unani, Siddha and Homeopathy.

What are the technology initiatives undertaken recently at Tata AIG? No doubt, technology is a MUST today and is a great business enabler but do you believe that ‘standalone’ technology can be a Sales channel by itself?

While technology is a key business enabler, the role played by intermediaries is equally important. Intermediaries serve as the critical link between insurance companies and the end consumers. As players with broad knowledge of the insurance marketplace, including products and prices intermediaries also play many roles in the functioning of insurance markets.

With the help of multiple disruptive tech initiatives, we have been able to scale up our policies fivefold from 2018 to 2022. Our system uptime has improved, and our issuance time has been cut by more than half.

Our products are fuelled by technology – right from designing, to selling, to servicing, all the way to claims settlement. To cite an example, we have an app called NETRA powered by high-resolution live video streaming and image capture capabilities for conducting remote digital inspections. Today, Tata AIG has virtual offices catering to the periphery. They are manned by tech-powered workforce to conduct business without having to travel hundreds of kilometres physically. Our channel partners play a very critical role in helping us increase insurance penetration along with technology enhancement.

Even after nearly 50 years since nationalisation and 21 years after opening up, there is still a lack of trust between insurers and insureds. Insureds always have the feeling that getting a claim approved is the most difficult task in the world. No doubt, every insurer has the statistics to show that the number of claims settled exceed 85-90% of the claims lodged. Essentially the dissatisfaction and doubt stems from the whole process of claim settlement. What has Tata AIG done to change the narrative or make the whole claims process a pleasant experience for the policyholders?

There are perceptions and there are facts. Perceptions might be suggesting lack of trust but the facts are otherwise. The claims ratios are published by the regulator. We at Tata AIG believe that Trust is at the core of the Tata Group and Tata AIG. Our customer ratings have always helped us to be ahead of the curve. One of the reasons for the false perception is mis-selling. Therefore, our endeavour has always been to educate customers/channel partners well. We also regularly seek feedback to improve our services. We have an in- house training team of UW professionals who regularly conduct sessions to ensure proper guidance. At Tata AIG, we proudly say that we ask a lot of questions at the time of underwriting to ensure that we don't do underwriting at the time of claims. We have created an Express Claims Unit to settle claims that are less than 50K in less than 7 working days. As it amounts to a significant percentage of the overall claims value, it makes a lot of difference. We have heavily invested in technology to change the customer experience of the entire claims process and settle claims swiftly.

Do you see a lot of fraudulent claims of late? Has this in any way changed the approach to claims such as looking at each claim with a jaundiced eye and acting accordingly? How have you strengthened the Fraud Control systems?

Fraudulent claims has been a reality for long in Insurance Claims, worldwide, but may be the difference is we have now started talking more about frauds in India and taking more visible actions. Yes, during and post the pandemic, we do find an increase in frauds in Health claims. However, this has not changed our approach - Tata AIG has always believed in just and fair settlement of Claims and continue to do so. At the same time we also continue to strengthen measures to curb frauds since every fraud claim paid is at the cost of genuine customers. While Tata AIG was the first Insurance Company to establish a Special Investigation Unit in Claims way back in 2002, we have also now moved to more sophisticated systems for identification of fraud through the life cycle of a claim , with the help of ML and AI. This also ensures that the genuine claims are turned around quickly while more detailed reviews are done for claims with red flags.

With a common limit of 30% on GDPI being allowed by the IRDAI towards EoM coupled with the necessity to allow discounts if a customer approaches the insurer directly, has created a lot of unease/apprehensions in the minds of distributors. How do you address these apprehensions that their renewals will be protected?

At Tata AIG we work very closely with the distributors. We strongly believe that the distributors add a lot of value to our customers. We have always worked with them closely and we will continue with the same approach in future as well. Be it in policy structuring and proper guidance on coverage; in claim servicing & delivery or even managing expectations.

As one of the top general insurers in the country, Tata AIG does source business through multiple distribution channels? Inter-channel conflicts are bound to crop up. What is the mechanism you have in place for smoothening out these irritants?

We have been maintaining a fair policy for our renewals as well as for new businesses for the last 21 years. We do not differentiate between any channel partners at all and this approach has always been acknowledged by our partners at various forums. In fact, our policy is emulated by many of our peers and it has come to become an industry standard in itself. We shall continue to follow the same.

What are your expectations from brokers in terms of shouldering additional responsibilities on your behalf (apart from bringing in premium), be it in the claims process, risk management activities or generally educating the public on insurance awareness and nuances?

I think the brokers' fraternity is doing an excellent job in increasing penetration and ensuring sufficient insurance for the clients. Brokers can also ensure creating a talent pool in the industry. They can work along with the clients to ensure implementation of preventive risk management. Brokers can try to move the physical work to digital mode as much as possible, as it will lead to substantial savings on expenses and help in further increasing the reach in smaller towns.

What has been Tata AIG's role in creating insurance awareness and education especially after the IRDAI Chairman put forth 'insurance awareness creation' as a major agenda item at the Bima Manthan?

Insurance is a complex financial product and existing and prospective policyholders must be empowered with the knowledge of assessing risk coverage needs and for choosing insurance products suitable to meet those needs. Tata AIG is completely in line with IRDAI's agenda of creating awareness about insurance - making people aware of the concept of insurance, kinds of insurance policies, risks covered, benefits offered, exclusions, and conditions etc. We have been consistently launching ad campaigns, conducting webinars/seminars and also running various educations series with our business partners.

Do you think there is severe shortage of good insurance talent in the industry? How do you attract and retain the best talent and what will be your suggestions for promoting better quality insurance education?

Insurance is a fast-growing industry and need for high quality talent is only set to grow in future. Our industry always recruits talent from the best institutions including all spheres like finance, actuarial, medical, IT etc. Now with technology changing the whole insurance paradigm, even the skill set required will gradually change. New capabilities revolving around data science and advanced analytics will have to be integrated. It also necessitates upskilling and reskilling of the present talent pool. Having said that, it is a job which also demands critical thinking, creativity and social intelligence in equal measures.

Tata AIG has been recognized as a Great Place to Work in India by GPTW Institute. One of the key enablers for this achievement has been our people practices which are attuned to the changing needs of our employees – a case in point being our Reward and Recognition policy - TagiSmiles. Through this policy, the Company intends to promote and reward actions and behaviours at workplace that are in line with our vision and values. The program rewards employees for their corporate citizenship. This provides a mutually beneficial platform for paving the way to our collective success.

Finally, your views on some of the exciting changes which may come about in the Indian insurance industry a) Micro-insurance companies & State-level insurers. b) Indian reinsurance companies c) Captives d) Premium financing companies e) Managing General Agents (MGAs).

India is a large and growing market with a huge scope for increasing insurance penetration. As the industry matures, with due development in regulation, many of these forms will find their place in Indian market.

IBAI thanks for your valuable time and views and also wishing a grand success to the the entire TATA AIG General Insurance team on behalf the all Insurance brokers

GRADUAL LOSS EXCLUSION

THE TROJAN HORSE

Hari Radhakrishnan

Regional Director,
First Policy Insurance Brokers

Typically, property insurance policies have an exclusion for loss or damage due to gradual deterioration, deformation or distortion, more so when machinery breakdown is also covered. Further, the insuring clause will require the loss, damage or destruction to be physical and accidental.

What is the import of the above insuring clause and the exclusion?

Any loss or damage has two attributes: causation and occurrence. The time lag between causation and occurrence is latency.

T (occurrence) - T (causation) = T (latency)

In property insurance policies, the latency has to be minimal for the loss to qualify as accidental. If there is too much of time lag where the occurrence of loss follows days or weeks or months after the causation or the event that triggered the loss, then the loss can be considered as a gradual occurrence. It doesn't meet the requirement of an accidental occurrence or a fortuity, insurable under the policy.

However, this is where it gets a bit murky as to how much of a latency is an acceptable threshold for a loss to be considered as accidental.

Take the case of an explosion. It doesn't happen all of a sudden. There is a build up of pressure over time and when the space cannot hold it any more, it gives way and an explosion happens. There is latency.

Similarly, there is a breakage of a connecting shaft between an alternator and engine. Upon microscopic examination of the broken shaft, it is found that the grain structure depicts a flaw that has developed over time. There is latency.

Though in both the case of explosion as well as breakage, there is latency, the former would be usually be paid but the latter declined. There is an inconsistent application of mind when it comes to the gradual loss exclusion.

So what's the solution?

To me, latency alone should not be the deciding factor for gradual loss exclusion. The key question to be asked is what was the insured's position with regard to the latency.

Was the insured privy or ought to have been privy to the latency? Could he have prevented the loss by taking measures to alter or change the circumstance of latency?

If the answer to both the questions are in the affirmative, then the loss is not accidental, but gradual. Else, it is accidental and the claim ought to be paid. Latency should not be held against the insured when he is not in a position to detect and/or prevent it. If one does, that results in commercially unsound outcomes.

I think none of the property insurance policies that I have come across give any clarity as to how latency would be handled. This can result in unfavourable situations for the insured, where unscrupulous loss adjusters or insurers do Trojan Horsing of claims by introduction of latency and the gradual loss exclusion.

Traps in PROFESSIONAL INDEMNITY INSURANCE

Hari Radhakrishnan
Regional Director,
First Policy Insurance Brokers

This article is for the benefit of all concerned, particularly customers and brokers, who deal with professional indemnity policies for construction projects.

Usually, the project professional indemnity policies have a bad workmanship exclusion. This is because the objective of a professional indemnity policy is to cover wrongful acts in the discharge of professional services by an insured. Workmanship such as physical construction and manual labour is not something related to the rendering of a professional service. These are in the form of business or trade risks and covering them under a professional indemnity insurance, would tantamount to a work execution guarantee, which is not the objective of the insurance coverage granted.

Types of bad workmanship exclusions:
There can be two types of such exclusions

- total bad workmanship exclusion and
- limited workmanship exclusions.

The language can typically be as under:

Total bad workmanship exclusion: "This policy will not indemnify the Insured in respect of any cost to repair or replace faulty workmanship in any construction, erection, fabrication, installation, assembly or manufacturing process performed or provided by an Insured, including materials, parts or equipment furnished in connection therewith.'

Limited bad workmanship exclusion: "The Company will not cover the Insured for any Loss, Defence Costs or any other amounts insured under this Policy which arise out of or are in any way connected with any construction, assembly, installation or maintenance unless it results directly from an act, error or omission of the Insured in the provision of Professional Services."

Limited bad workmanship exclusion is decidedly better than the full bad workmanship exclusion.

To give an example, pouring concrete comes under workmanship and providing advice or specification as to how such pouring needs to be done becomes professional service. The former cannot be covered, but the latter can be.

With a full bad workmanship exclusion, the damage due to bad pouring of concrete would be excluded, regardless of whether it was done as per design specification or not.

However, with a limited bad workmanship exclusion, the damage would be covered if the design which provided for the pouring was defective, but execution was done as per specifications.

What is the problem with the bad workmanship exclusions?

The bad workmanship exclusion pre-supposes that there is a fine distinction between "hard" and "soft" parts of a construction project, so that the professional indemnity insurance cover can be limited to the latter alone.

Unfortunately, this is wishful thinking. The demarcation lines are often blurred.

Besides actual construction or execution, any construction project consists of the following:

- Feasibility studies
- Analysis
- Project Design
- Quantity surveys
- Drafting
- Technical calculations
- Specifications
- Supervisory activities such as project management, construction management and time flow management.

Now, it is easy to say that all of the above soft parts of the project would be professional services and all the hard stuff of actual construction is workmanship.

So anything the folks at the site do is all workmanship. But in the real world of construction, they can be intermingled.

Assuming there is a tunnel boring project and there is some unexpected geology experienced. The site engineers choose to make some modification to the design specification and address the situation on hand, rather than having the matter run upstairs for a revision in the design approved.

In such a situation, if there is a trigger for a claim, then would it come under the professional service or bad workmanship?

One view is that design choices left to the good sense of the site personnel shall also be professional service in which case the claim becomes payable. But in case the insurer doesn't agree with this and holds that design constitutes the document approved by the central design office for the project, the claim becomes untenable.

Conclusion:

Professional indemnity policies, particularly those covering construction projects, need a careful analysis of the activities involved and the respective ownership of such activities. There has to be a clear matching of various construction related activities with what constitutes professional service and what does not. If this is not done, there can be disputes and disappointments at the time of claim. Further, the customers must understand and brokers must explain to them, the extent of professional indemnity insurance coverage available under the policy, so that uninsured risks are not assumed to be insured while executing projects.

RESPONSIBLE MSME INSURANCE

Micro, small and medium enterprises (MSMEs) make up the vast majority of companies that generate high levels of employment and also create wealth in the country. In this age of start-ups, they will again multiply faster because all start-ups mostly begin as SMEs. This means that Intermediaries with customer focus (customer-facing) must go that extra mile, to convert static and even stale insurance products to suit their needs. It is well known that entrepreneurs themselves are unfamiliar with insurance. They need to be made aware that insurance is the only answer to unforeseen risks across their fragile value chain, both vertically and horizontally, meaning not only for their hard risks, but also loss of revenue risks, credit risks, and protection of their families and their employees.

It is necessary for intermediaries to specialise in this area. First, it is necessary to understand the nature of these organisations. Many of them are run as individual micro-entrepreneurs who do the business by themselves. Quite a few of them are informal and may not even be registered as legal entities. Others are small family businesses, and no formal contractual relations may exist between employees. The rest may be more formal, with a few formal employees, but still operate with low margins and cash, rendering them face many risks, that will destroy them if not hand-held by the right insurance covers.

Resilience is important for MSMEs

Insurance can be made the key instrument to make MSMEs more resilient and sustainable. The Casualty Actuarial Society of USA found that SME risks can be divided into four categories.

- Hazard risks are risks arising from the assets (fire, riot, flood etc.) and includes also risks to persons who need accident, life and health insurance. Insurance can play a key role in this category of risks.

- Financial risks include risks include cash flow, inflation, credit related issues etc. Insurance has some role to play here, such as in credit-linked insurance, Business Interruption covers and so on.
- Operational risks and strategic risks are often external, and relate to matters such as competition, obsolescence and poor management capability. In this area insurance cannot cover most of them. However, liability risks can arise and there has to be an insurance ring-fencing them to cover their increasing liability risks.

Hazard insurance need to be tailor made for SMEs by converting fire insurance into a multi-risk property insurance with needed add-ons. It may include riot/political violence insurance, loss of money insurance including business funds kept at home. Coverage can be comprehensive, but this can make the product/s unaffordable, or it can be a limited cover across several types of risks. Limited covers can be also tailored so as to offer no questions asked claim settlement as to quantum of loss, similar to what is seen in parametric insurance.

It is also important to note that insurer sales force cannot be very effective to spend time and use their expertise to explain complex products and options to small businesses owners, who may in turn easily be put off by complexity and too many options.It is thus better for independent intermediaries like Brokers to develop a set of "missionary" sales force to promote SME insurances.

This sales team, even as they build up their dialogue and learning with the SME sector, can help to fine tune products and keep the attractiveness of insurance relevant and inviting. Insurers also find it efficient to adapt products to suit a distribution channel or large segments of clients, rather than for individual customers.

The Society of Insurance Broking and the Chartered Insurance Institute (CII), has a publication titled "The importance of 'trust' in the SME insurance sector". It speaks of the vital 'trust factor' where an insured cannot see value in insurance until they have a claim. A claim not paid or underpaid, will spread the bad news fast in their circles, and set back by miles the marketing efforts made. All insurance solutions offered should be transparent, efficient and simple to understand. In this segment insureds should not be sacrificed on technicalities and formalities, when a claim arises. All processes should be simplified using apps and IT tools.

Building Blocks of Trust

Some of the building blocks identified in the above publication are:

1. Protection – real and effective
2. Price – perceived value for money
3. Ease of taking a protection that has a fit to the segment
4. The insured having a say in the claim settlement
5. Speeding indemnity in claims to match the cash need of the insured
6. Certainty that the insurer will look after their customers
7. Loyalty and Respect for the customer

Everyone in the insurance sector need to reflect on supporting the protection and promotion of SMEs, for which their organisations must develop a changed mindset and ally with each other, as the opportunities in this sector are enormous. It also can be seen as a public duty to promote them as they generate employment and wealth among the common people.



A Fire Loss can setback the Country's Progress

There is considerable happiness about Vedanta and Foxconn investing in the country's first-ever semiconductor plant. Semiconductor is described as the new 'oil' of our fast-moving digital economy. Vedanta Chairman said (Business Line 15.09.2022) that he sees them as the brain of our electronics. On the same day Economic Times had an article titled "When India Lost Its Chips'. It said that the Government realised that semiconductors had the potential to be the foundation for a new revolution. So, in 1984, Government of India founded the Semi-conductor Complex Ltd. (SCL). It was to design and manufacture leading edge circuits and electronics. The company could progress from 5-micron process technology to 0.8-micron in the late 1980s. Reaching world level standard was
expected shortly.

All these hopes were dashed in 1989 when a devastating fire broke out at SCL. The cause of the fire was unknown. It took 8 years and further huge investment before production re-started. But by this time companies like Samsung and others captured critical market share in the world.

It is reported that the semiconductor manufacturing industry uses several types of specialized equipment; all of which are highly sensitive and cost millions of dollars. The equipment include: Electronic testing equipment, Computerized process monitors, clean rooms, Lasers, X-ray machines and so on. They also use potentially highly hazardous materials, including chemicals used in the manufacturing process such as solvents, acids, caustics etc.

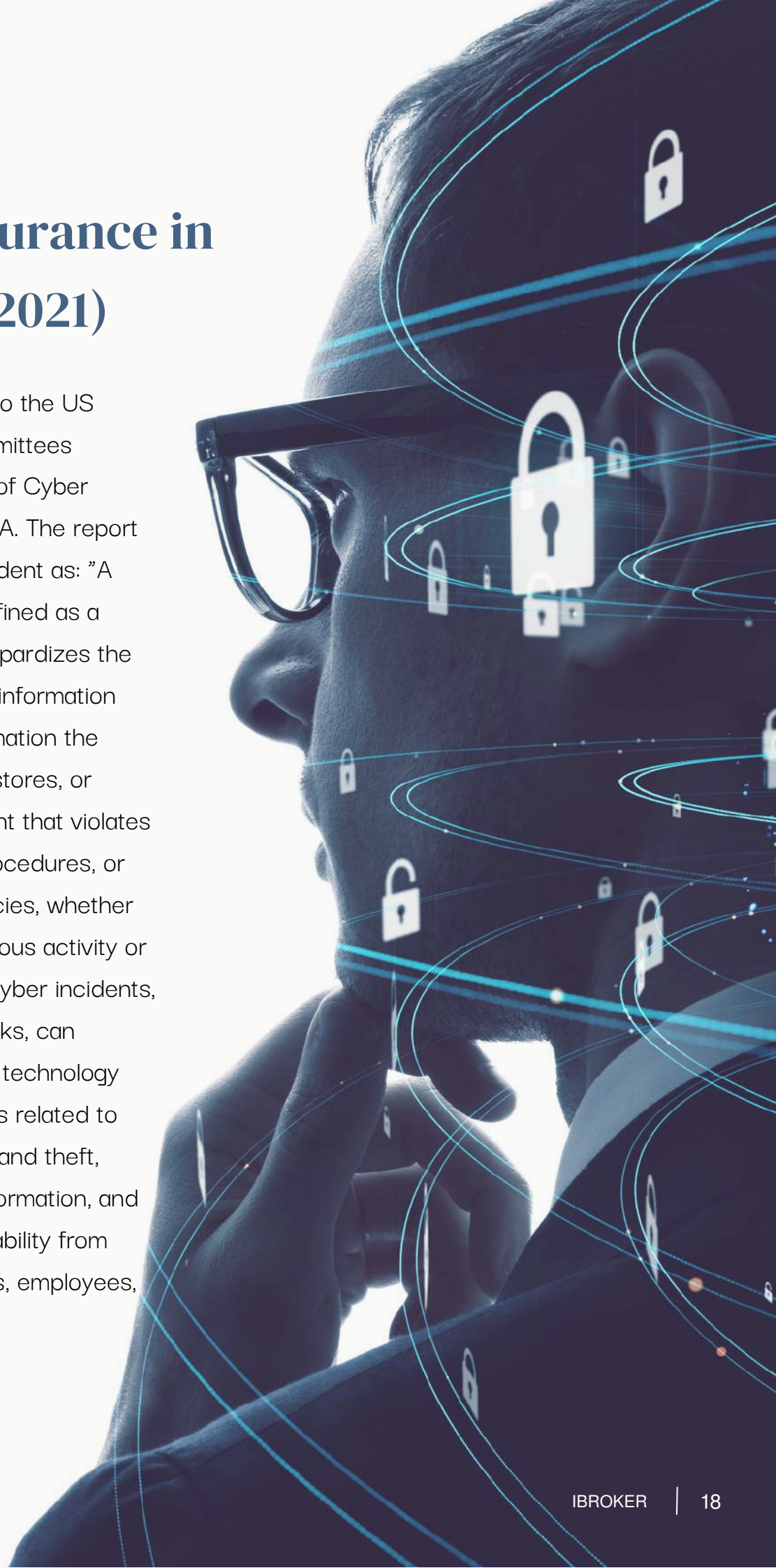
These types of material can offer a significant potential for fire exposure as also additional loss potential from water and smoke damage common in semiconductor industry. These ignition sources and toxic materials and the fact that the stocks and equipment are high-valued, and requiring a cleanroom environment makes the semi-conductor factories face substantial property loss potential. A fire or smoke loss that happens in the clean room can destroy all of the stocks present and will require extensive cleaning, in addition destroy the state-of-the-art processing equipment.

It was seen that even a small fire could potentially result in a large, expensive property damage, extra expense and/or business interruption loss. As a result, the management, insurers, loss prevention experts have to focus on managing these exposures effectively, because these factories are extremely sensitive to a wide variety of perils, such as fire, water, heat, smoke, dust, and arcing.

Thus, a fire made India lose almost 40 years in the semiconductor race and all industries in India had to face acute chip shortage, including banks who could not issue debit cards. All this happened because of a fire. Hence, this is a timely reminder to all professionals in insurance, regarding the importance of risk management, loss prevention approaches and fashioning rapid post-loss solutions to get back to production. Delay in these activities will make the concerned high-tech unit obsolete. This makes the job of Brokers (customer-facing intermediaries) and forward-looking insurers work in tandem with industries like the semi-conductor industry and the government to risk-proof such new ventures in the high-tech era in line with the vision that India will be the Tech Capital not only in software but in hardware as well.

Cyber Insurance in the USA (2021)

A May 2021 report to the US Congressional Committees disclosed the state of Cyber Insurance in the USA. The report defined a cyber incident as: ”A cyber incident is defined as a cyber event that jeopardizes the cybersecurity of an information system or the information the system processes, stores, or transmits; or an event that violates security policies, procedures, or acceptable use policies, whether resulting from malicious activity or not.“ It stated that cyber incidents, including cyberattacks, can damage information technology assets, create losses related to business disruption and theft, release sensitive information, and expose entities to liability from customers, suppliers, employees, and shareholders.



Cyber Risk Significant

The study found that malicious cyber activity created significant risk to the businesses and critical infrastructure of the US as also to the government, which caused costs that ran into billions of US dollars each year. Threat from cyber criminals was rising and becoming pervasive and the report emphasised the need for a stable cyber insurance market. Insurers offer businesses and other entities, cyber insurance to protect against first-party (policyholder) and third-party losses (policyholder's clients or customers). Cyber insurance is made available by standalone policies or as a part of a package policy that provides various kinds of coverage. The Report stated that according to Marsh McLennan, its clients are taking up cyber insurance more and more and it went from 26% in 2016 to 47% in 2020. However, being the leader in insurance Broking their rate may be more than the rate for the market as a whole. The report found that along with increasing demand, the premium rates were also rising. Even as more insurers were offering covers, insurers were putting in more restrictive policy terms and coverage limits.

The report stated that according to S&P Market Intelligence and the National Commission of Insurance Commissioners (NAIC), the number of cyber insurance policies in force in the US increased by about 60 percent in 2016–2019, from about 2.2 million policies to more than 3.6 million policies. The amount of total direct written premiums increased by about 50 percent during this period, from $2.1 billion to $3.1 billion. It was seen that the factors that vary the extent of premium include the size of a company, its industry, and the extent to which it has strong cyber controls.

The Report noted that intermediaries are finding that insurers have been tightening policy terms and conditions for cyber specific policies. They also have been adding exclusions to traditional lines of coverage and package policies with cyber endorsements to avoid any ambiguity that coverages would overlap with cyber policies. These restrictions seek to eliminate coverage of "silent" cyber risks that could damage multiple businesses and result in insurers accumulating significant unforeseen losses that could pose a risk to their solvency.

One challenge facing the cyber insurance industry was the limited availability of historical loss and cyber event data. Insurers use historical loss data to quantify risk and set premium rates for insurance products. However, according to reports historical data on cyber losses are very limited, incomplete, or of poor quality. A 2020 report by the International Association of Insurance Supervisors (IAIS) noted that incomplete or inaccurate historical data on cyber incidents decreases the reliability of actuarial models, leading to increases in uncertainty around loss estimates. Without access to such data, some industry participants and researchers are concerned that current prices for cyber policies may not accurately reflect risk. According to NAIC, if a product is priced too low, an insurer may not have the solvency to pay claims, which could lead to insolvency. On the other hand, if the cover is priced too high, few businesses and consumers might be able to afford the coverage.

No Common Terminology in Cyber Insurance

Further the Report noted that the terms commonly used in cyber policies are not consistently defined. A report by the Congressional Research Service found a lack of consensus on what defines a cyberattack. A report by the Geneva Association noted that neither "cyber war" nor "cyberterrorism" has a common definition in the insurance market. It also noted that no global consensus exists on the exact behaviour or criteria that define a cyber event as either terrorism or warfare. Finally, representatives from the Council of Insurance Agents and Brokers informed that insurers may define ransomware attacks in different ways. NAIC warned that inconsistent policy language, which includes the definition of key policy terms, might present challenges for the insurance industry. It was explained that if the industry does not use consistent definitions for key policy terms, it will not be clear which perils are covered and which are excluded. In addition, this ambiguity can result in misunderstandings and litigation between insurers and policyholders. According to the Geneva Association, common terminology could lead to a more sustainable cyber market in which insurers could make informed choices about the levels of coverage and policyholders could understand better their insurance protection.

Cyber Disasters are the Biggest Loss Makers Now

According to the Geneva Association, the annual global economic cost of cyber incidents may be almost twice the average annual amount of natural disaster losses. Even more importantly a recent study by Deloitte found existing cyber exposures continue to change and new ones arise. It noted that even as insurers collect more data and hone predictive models based on prior cyber threats, the underlying exposure keeps changing. This makes it difficult to create a reliable predictive model when it is not clear what new objective, strategy, or technique cyber threat actors may deploy.

(Source: United States Government Accountability Office, Report to Congressional Committees: May 2021 CYBER INSURANCE Insurers and Policyholders Face Challenges in an Evolving Market GAO21477)

Expanding and Evolving Business Interruption (BI) Coverage

Business Interruption (BI) insurance is a coverage that intends to protect the business of the insured. Interruption in business activities means an insured is unable to do business owing certain underlying losses which are traditionally insured. The benefit of the BI policy comes from choosing the right indemnity period. If for example fire policy is considered, BI indemnity period can include the estimated time required to rebuild the premises, replace the plant, machinery and stock and regain custom lost during the period during which trading is affected. This would include practical aspects such as the time taken to demolish and clear the site and organise rebuilding including competitive tendering and possibly complete redesign where necessary. It is also possible that the time taken to obtain replacement machinery, may have a long lead time, also becomes an important consideration.

The cover is for a maximum sum insured representing the Insured's Gross Profit and the increase in the Insured's cost of working for the anticipated period that production will be interrupted following damage. There are many nuances in all these which are not easy to understand and hence no one, whether insurers or intermediaries or even customers are showing the necessary interest in taking a BI policy. However, in these days of plentiful capital, business interruption insurance has become the critical insurance for the survival of the business. It is high time that this business is made a mainstream insurance in India.

Many new applications for BI risks have been developed such as:

Traditional BI	Trade Disruption	Terrorism
Cyber Loss BI	Pandemics	Environmental
Cyber Network Interruption	Product Liability and Recall	Others such a Political Risk
Supply Chain Disruption	Product Contamination	

In Prudential LMI Commercial v. Colleton Enterprises, Inc., 976 F.2d 727 (4 th Cir. 1992), U.S. Court of Appeals for the Fourth Circuit held that "Generally, business interruption insurance "is designed to do for the insured in the event of business interruption caused by [an insured peril], just what the business itself would have done if no interruption had occurred ….". For proving the claim, the court held that: "In order to establish coverage for lost profits or lost earnings under business interruption coverage provisions, the insured must establish that: (1) the peril insured against occurred, (2) the peril caused damage to the business facility insured, (3) the damage resulted in a partial or complete interruption of business; and (4) the business suffered a loss of earnings or profits as a direct result of the business interruption."

However, insurers have gone further and now there are important extensions such as:

1. Ingress/egress – No or restricted access to a business can cause loss of income even when the business facility itself does not have physical damage. For example, if a flood or landslide blocks all roads leading to the site of the insured, it may be impossible for employees and/or customers to reach the premises.
2. Civil authority - restricted access can result from orders of a civil authority. An example is loss of business income during a curfew imposed by a city or state in response to civil commotion.
3. Public Utilities coverage indemnifies the Insured against loss or damage at the premises of electricity generating stations, transmission networks, gas suppliers, water purification plants, pumping stations and pipelines of an authority employed by law to supply water, gas or electricity for public consumption, all of which results in an interruption of such at the premises of the Insured.

Other Type of Policies

Construction policies often include a type of Business Interruption insurance called Advance Loss of Profits (ALOP) or Delay in Start-Up (DSU) coverage. This cover provides indemnity to the Insured in respect of loss of profits due to the contract works being delayed as a result of a loss insured under the terms of the works section of a Contractors All Risks or Erection All Risks policy. Usually, it is only the principal and financiers who can be insured under this type of coverage. It also differs in as much as the period of indemnity starts with the provisional hand over date at the end of the construction or period (known as the date of practical completion) and not the date of any loss under the material damage policy. However, the business risk of the entrepreneur and any contractual penalties cannot be insured under an ALOP or DSU policy.

Contingent Business Interruption (CBI) is increasingly in demand which protects a business should a situation arise where suppliers or customers are affected by insured losses, which can be an extension to cover loss of turnover or income due to loss or damage at the premises of customers and suppliers.

More specialised CBI insurance are sometimes offered for instance to railways facing loss, if stations are unable to operate as a result of a rail disaster. Airlines can take BI if for instance a specific holiday destination is not open because the resorts there suffered cyclone damage. Thus, Business Interruption coverage has many benefits which can save customers from sinking when a loss takes place and there is need to popularize this protection urgently.

INSURANCE TERMS COMPARISON

1. All Risks vs. Named Perils

In an all-risk policy any fortuitous loss is covered, if the same is not specifically excluded in the policy. In all risk policies the duty of the insured is less onerous. The House of Lords in the case British & Foreign Marine Insurance Co. v. Gaunt,1921, House of Lords, held that the plaintiff was not required to prove the exact mechanism by which the loss occurred: "We are, of course, to give effect to the rule that the plaintiff must establish his case, that he must show that the loss comes within the terms of his policies; but where all risks are covered by the policy and not merely risks of a specified class or classes, the plaintiff discharges his special onus when he has proved that the loss was caused by some event covered by the general expression, and he is not bound to go further and prove the exact nature of the accident or casualty which, in fact, occasioned his loss."

Named perils policies cover only the events named in the policy. For example, a named perils policy that only covers a fire loss will not pay if the loss is caused by a flood. In named perils policies, the duty of the insured is more onerous as the claimant has to prove the loss as being a peril covered in the policy clearly.

2. Scheduled Coverage vs. Blanket Coverage

Blanket coverage offers a certain amount of coverage, a limit, for a class of property, but with a sub-limit per item.

Thus, in home insurance the blanket coverage offers a limit of Rs. 1,00,000 for valuables, but then there might be a sub-limit of Rs. 20,000 for covering specifically jewellery and watches.

Scheduled coverage indicates that the insured is more organised and so an insurer can offer a more nuanced protection. Thus, to ensure jewellery on a scheduled basis, the insured will need to provide the insurer with a list of the jewellery, the insured wants to insure and where necessary an acceptable valuation certificate of the items. In valued items such as ornaments, in case of an unforeseen loss as covered, the insured will be reimbursed for the value agreed as given in the policy.

3. Replacement Cost vs. Actual Cash Value

The term "replacement cost" means the cost to replace the property with other property of comparable material and quality used for the same purpose.

The term "actual cash value" is not as easily defined. In India the term used is "market value," which is the amount a buyer would pay a seller if neither were under undue time constraints. The usual definition is: the cost to replace with new property of like kind and quality, less depreciation. Thus, simply put the only difference between replacement cost and actual cash value is a deduction for depreciation. However, both are based on the cost today to replace the damaged property with new property.

4. Earth Movement vs. Earthquake

Earth Movement means any natural or man-made earth movement, including but not limited to earthquake, landslides, subsidence or volcanic eruption regardless of any other cause or event contributing concurrently or in any other sequence of loss.

An earthquake is the shaking of the surface of the Earth resulting from a sudden release of energy in the Earth's lithosphere that creates seismic waves. Earthquakes can range in intensity, from those that are so weak that they cannot be felt, to those violent enough to propel objects and people into the air and wreak destruction across entire cities.

5. Latent Defect v. Wear & Tear

In the case Schon v. James, 1947, the Court of Appeal of Louisiana noted the difference between a situation in which there is a hidden defect in the material of which the piece of machinery is constructed and that in which the defect is caused by wear and tear alone. "A latent defect is a hidden defect and generally involves the material out of which the thing is constructed. If the grit, which counsel claims is the reason for the loosening of the lock nut and the cause of the accident, got into the axle bearings, it must have been because of wear and tear rather than an inherent defect in the materials composing the bearings."

Latent defect means a defect not manifest, but hidden or concealed and not visible or apparent; a defect hidden from knowledge as well as from sight, and specifically a defect which reasonable inspection will not reveal. Glens Falls Ins. Co. v. Long, 195 Va. 177, 77 S.E.2d 457 (1953).

6. Theft v Larceny

In the US case Raff v. Farm Bureau Ins. Co., 181 Neb. 444, 149 N.W.2d 52, the court said: "In popular usage, the word ` theft' is another name for ` larceny.' As a general rule, however, the term as used in an insurance policy is not necessarily synonymous with larceny, but may have a much broader and more inclusive meaning. It could cover pilferage, swindling, embezzlement, conversion, and other unlawful appropriations as well as larceny."

It is usual that policies exclude in "theft" covers, anything relating to mysterious disappearance, inventory shortage, wrongful conversion, or embezzlement.

7. Exception v Limitation

In the case Barrie Toepfer Earthmoving and Land Management Pty Ltd v CGU Insurance Ltd [2016] NSWCA 67, the Supreme Court of New South Wales (AU) stated: "[49] In Wallaby Grip, the High Court recognised the distinction between an exception and a limitation as to the amount payable under an indemnity, but said that in each case the onus is on the insurer (at [35]): "The difference between the two is that an exception may prevent an insurer's liability from arising, whereas a limitation of the kind here in question operates after the obligation to indemnify has arisen and upon the amount payable pursuant to it. It limits the extent of the insurer's liability. What they have in common is the purpose of limiting an insurer's liability, where the circumstances necessary for it have otherwise been shown to exist. In each case the insurer should bear the onus of proving the limitation."

Claims: What the Insured must understand about allegations of Fraud

Insurers are very concerned about frauds. Courts are event more concerned, because insurance is about utmost good faith. Hence in insurance, various penalties can be imposed for fraud. These penalties can include refusal to pay the entire claim, including the genuine part of the loss, and in addition, recover payments already made relating to that claim, terminate the policy even ab initio and retain the premium. Fraud claims also punishes the rights of an innocent joint insured.

Courts state that fraud can be penalised in many ways. In the case Manifest Shipping Ltd. v. Uni-Polaris Insurance Co. Ltd – the 'Star Sea', the House of Lords, (UK, 2001), the court listed three grounds: (i) the principle reflected in s.17 of the Marine Insurance Act 1906, leading to avoidance ab initio (from the beginning); (ii) general contractual principles, including repudiation; and (iii) a special rule relating to fraudulent insurance claims. Lord Hobhouse explained the special rule relating to fraudulent claims:

The Fraudulent Claims special rule (Principle)

"The insured who has made a fraudulent claim may not recover the claim which could have been honestly made". The logic behind the principle – "is simple. The insured must not be allowed to think: if the fraud is successful, then I will gain; if it unsuccessful, I will lose nothing." His speech was duly endorsed by the other Judges on the Bench.

It is also necessary that the fraud must be material. Materiality has been put in different ways in different cases: (a) "sufficiently serious to justify stigmatising it as a breach of [the insured's] duty of good faith so as to avoid the policy". (Millett LJ in Galloway v GRE [1999] 1 Lloyd's Rep 209); (b) fraudulent "to a substantial extent" (Orakpo v Barclays Insurance Services [1995]). Courts have endorsed in this regard Colinvaux's Law of Insurance 9th Ed at 9.024: "A claim can only be fraudulent if the assured is dishonest or at the very least culpably reckless. Mere negligence on the part of the assured will not suffice."

In this regard courts have wrestled with the fraudulent devices e.g., a lie which does not affect the outcome of the claim. What if it is merely a "reckless untruth", as found in the case Versloot Dredging BV v HDI Gerling Industrie Versicherung AG & ors; [2016] UKSC. The lower court found the repudiation of the claim which it ordered, a disproportionately harsh sanction. The Supreme Court, examined the matter and stated: ""... I would be strongly attracted to a materiality test which permitted the court to look at whether it was just and proportionate to deprive the assured of his substantive rights, taking into account all the circumstances of the case."

The court stated that "the amount payable under an insurance contract – (is) a right which accrues at the time of loss

..." What pained the court was that "the harshness of the result is most apparent when, as here, the Court has, in the end, determined that the claim is otherwise valid". The court saw that the so-called fraud was merely a "collateral lie told in advancing the claim", but the claim remained as really genuine because the insured made no effort to get any additional amount by way of fraud.

Generally innocent exaggeration is found in claims because it is known that insurers will survey and assess the claim. In Orakpo v Barclays Insurance Services [1995] LRLR 443, the court stated that: "In cases where nothing is misrepresented or concealed, and the loss adjuster is in as good a position to form a view of the validity of the claims of the insured, there would be a legitimate reason that the insured was merely putting forward a starting figure for negotiation."

It has been found that many allegations of fraud against the insured fall flat in a court of law. Insurers usually appoint investigators of poor quality who often collect what the court would think are unproven allegations as those who made the statements would not come forward to testify, nor is the investigator held to proof by the insurer.

Therefore, it would be better for the insurance sector if insurers take fraud more seriously, in that they should pursue only cases where is there is clear evidence of fraud and then pursue it logically and win the case. In all other cases, they cannot go by allegations of even the Fire Brigade or Forensic Reports as these have been found to be false when the matter comes before the court. The Supreme Court in the case Canara Bank v. UII Co. Ltd. 2020, condemned the investigator who provided the forensic report that was found to be wrong. Fraud is important, but indemnifying innocent customers is equally important.

Insurance is Hard for the Insured: Intermediary Role has to be Broadened

An insurance policy or contract is termed an "aleatory" contract, meaning that it is a contract where a fortuitous/uncertain event determines the parties' rights and obligations. The insured has to perform first, that is pay the premium and get the cover. The insurer only promises to perform an act if a fortuitous loss occurs. This aleatory nature of insurance contracts gives the insurer a great deal of leverage. The insured may be given a less than best product and worse in case the claim is denied or paid meagrely, the insured has few remedies. Thus, in case of a loss, the insured will be under financial loss which may lead even to liquidation

.

In the case E.I. du Pont de Nemours & Co. v. Pressman, 679 A.2d 436, 447(Del. 1996), Delaware Supreme Court stated: "Insurance is different. Once an insured files a claim, the insurer has a strong incentive to conserve its financial resources balanced against the effect on its reputation of a "hard-ball" approach.

Insurance contracts are also unique in another respect. Unlike other contracts, the insured has no ability to "cover" if the insurer refuses without justification to pay a claim. Insurance contracts are like many other contracts in that one party (the insured) renders performance first (by paying premiums) and then awaits the counter-performance in the event of a claim. Insurance is different, however, if the insurer breaches by refusing to render the counter-performance. In a typical contract, the non-breaching party can replace the performance of the breaching party by paying the then-prevailing market price for the counter-performance. With insurance this is simply not possible. This feature of insurance contracts distinguishes them from other contracts and justifies the availability of punitive damages for breach in limited circumstances."

Further, insurance policies are not tangible products that can be inspected prior to sale and remain the same over time. Insurance policies are promises, written in words that are often seen as difficult and which can be subject to multiple interpretations or have meanings established through custom and practice, familiar to insurers and not to the policyholder. At the point of sale, it is difficult to evaluate the nature of the promises made. As said, an insured cannot "kick the tires" of an insurance policy.

The language used in the policy is a point that gets condemned. The Kentucky Court of Appeals in the case, Universal Underwriters Ins. Co. v. Travelers Ins. Co., 451 S.W.2d 616, 622-23 (Ky.Ct.App. 1970 described the frustration engendered by the convoluted language employed in standardized insurance policies: "Ambiguity and incomprehensibility seem to be the favourite tools of the insurance trade in drafting policies. Most are a virtually impenetrable thicket of incomprehensible verbosity. . . . The miracle of it all is that the English language can be subjected to such abuse and still remain an instrument of communication. But, until such time as courts generally weary of the task we have just experienced and strike down the entire practice, we feel that we must run with the pack and attempt to construe that which may well be impossible of construction."

When a claim arises, most disputes are settled by negotiations with surveyor or insurer and is not taken to court or Tribunal in the first instance. If an insured asks for more than what was lost, then allegations of fraud and exaggeration gets raised. If the insured, mistakenly asked less, any revision of estimate can be arbitrarily rejected.

The Madras High Court in the case Hefc Ergo General Insurance Co Ltd vs M/S Rohini Movie Park Rukmini on 19 April, 2019 stated: 42. It is to be noted that at the time of entering Insurance Policy Agreement dated 05.06.2015, the parties had equal bargaining power. The insurer has decided to opt for Reinstatement Value Policy and the Insurer accepted the same and had collected the premium under the Reinstatement Value Policy. After the damage and loss occurred due to flood on 02.12.2015, the insured has lost his bargaining power."

Finally, an amount is offered on a 'take it or forego basis with a full and final discharge voucher. Filing a court case on this basis is a like a chance game. If the insured has not been corresponding and keeping records of the claim made and the minutes of the negotiations and also sending protest letters immediately after being forced to sign the discharge voucher, the chance of a court passing the full claim is under a cloud.

All the above indicate that Intermediaries, especially independent intermediaries, need to understand customer helplessness and empower them, rather than merely sell a cover and leave the insured to an unfortunate fate in the event of a claim or any other dispute with the insurer.

The Looming presence of Negligence

The looming presence of liability risks on organisations and individuals is increasing. It is well known that we are living in an age of accountability, responsibility and transparency. Punishment is to be expected if persons are not accountable or if there are lapses in responsibility. In corporate and governing institutions, transparency has become all too important and the slightest transgressions are magnified and beamed all over the world. It is also possible that what was intended to be hidden violating transparency can have a 'long tail' but justice will catch up. It is very sad to see how many titans in the corporate and governance world since the Satyam Collapse have fallen. Globally also well-known liability disasters have been repeatedly blown up.

Negligence which is often the starting point of liability is not so easy to determine unless scrutinised by courts.

For example, in the case P (A Child) v Royal London Mutual Insurance Society Ltd [2006] EWCA Civ 421, the court examined the allegation of the insurer that the cause of accident was a wilful and malicious act deliberately done. The court said that "Most acts, including negligent acts, are deliberate and intentional." The court gave an example: "If I light a bonfire in my garden which gets out of control and burns down my neighbour's house would I be covered by this policy? On the insurer's construction I would not because I had started the fire deliberately; on the judge's construction I would be covered because I had not intended to burn down my neighbour's house. But if I was reckless in the sense that I have explained, cover would be excluded and rightly so. My act could properly be characterised as wilful."

Negligence has become a widening subject today and authors categorise negligence into 5 parts: (1) duty, (2) breach, (3) cause in fact, (4) proximate cause, and (5) harm.

Duty is the obligation one person has to another. It acts as a discipline to compel people to behave in a responsible manner. Negligence was initially defined in terms of a breach of the duty of care. It was said that every negligence claim must pass through the "duty portal". The breach of duty brings in accountability and courts will fasten liability on the person who caused the injury. If no duty was breached the person who received the injury will have to bear their own losses.

Breach, can be an act or omission. It is implied that there exists a standard of care to avoid causing harm to others. If anyone acts carelessly or in a rash and negligent manner, the duty gets breached. In trying to assess the care that is required, the law tries to look at how a reasonable prudent person would behave in that specific situation so that no unjust punishment is given. By doing this the court hopes to find an objective standard against which to measure the conduct of the accused. This duty of care works differently for different persons. Hence directors of companies, and professionals such as doctors, auditors and similar persons trained in skills are expected to have a higher standard of care in their respective fields and roles.

Cause in Fact – before negligence is fastened on the accused, the plaintiff has to establish that there was a relationship between the negligence of the accused and the harm that the victim suffered. This is the central element in negligence matters. People meet with all types of losses or harm in their daily lives, and while many of them arise from the negligence of other persons, such harm can arise from the victim's own negligence or just bad luck. Very often, in such situations the 'but for" test is required to prove that the harm was caused by the negligence of the accused person.

Thus, if a driver is driving the vehicle carefully and a pedestrian carelessly walking on the road is hit; if it can be proved that the driver was not negligent in any manner, there is no liability.

Proximate Cause – the courts examine closely whether as per logic, fairness and practicality, the alleged wrongdoer ought to be held legally accountable for the plaintiff's(victim's) harm, if it is seen as "remote" from the defendant's breach. Proximate cause is traditionally referred to as "legal cause" (in an effort to distinguish it from factual cause). Courts try to find out proximate cause according to the fairness facts unique to every case. The concept of "foreseeability" is the cornerstone of proximate cause test. If the consequence was unforeseeable as per reasonable standards, there is no liability.

Harm - is the damage that a person suffers as a result of a defendant's breach of duty. Requiring a defendant to compensate the plaintiff for harm negligently caused by the defendant is the underlying, restitutionary (and deterrent) objective of the negligence cause of action. The law requires a negligent tortfeasor to restore what the plaintiff had lost as a proximate result of the defendant's wrong.

Liability is an ever-expanding field and any unfortunate action of any person or organisation can cause third-party loss and hence liability insurance has to grow rapidly to protect unfortunate third parties and empower everyone at risk of causing harm by their activity or behaviour.

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