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BHARGAV DASGUPTA

IBAI

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THIS ISSUE

FROM THE PRESIDENT'S DESK

THOUGHTS FROM SENIOR INSURANCE LEADERS

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President's Message

Year of Change Ahead.

Happy New Year !

As we embark on this new journey together, let us approach it with hope and optimism, ready to tackle the challenges ahead and work towards a better future for our industry. Coming financial year will be exciting as well as challenging after all the planned reforms coming into effect, but I'm confident we'll be resilient as ever and make it through the decade.

Providing customers with more choice, wording, and pricing options is always the key to orderly market growth, and finally we are on the right track.

A million-dollar question looms over me every day: how and when will this all play out. Insurance is a complex subject that involves a number of stakeholders, ranging from the customer to the intermediary to the insurer to the reinsurer, and unless the full circle is covered, the objective cannot be achieved.

I am sure we all don't want the bloodbath of 2009, that was a low for the whole industry and most the Insurers sunk in that era by depleting their reserves. We need De-tariffing, not insane pricing and unwarranted discounts which is unsustainable.

De-tariffing is not about lower pricing, it is about freedom of choice. In terms of rates, I do not know if they will increase or decrease after April 1, 2023, but we will be able to provide customers with more choices in terms of higher deductibles for better retention and self-insurance, a choice of indemnity period, a choice of perils, a first loss limit, et al. Depending on the customer's risk appetite, and risk management practices, we can help choose the coverage and help insure/place his assets accordingly.

I think we all need to move in the era of understanding the requirements of the customer rather than selling them what is available in the market. Innovation is the key and who better than us as intermediaries know the pulse of the market. The best way to increase penetration is to collaborate, think, devise, and create market-friendly products.

We request the members to come forward with their suggestions and contribute towards the betterment of the industry.

Cyber Jaagrookta is launched in IBAI website is the first of the 12-part series, complimentary to all IBAI members. As per regulators requirement you are supposed to run the program for the whole year for your employees to create cyber safety hygiene and awareness.

In closing my sincere thanks to all our IBAI members for your openness and the continued support you have provided our association again this year. It has been great to speak to so many of you throughout 2022 to keep us informed and help guide our responses and the representation we make.

Sumit Bohra
President IBAI

Thoughts from senior insurance leaders

EXCLUSIVE

Bhargav Dasgupta

Exclusive interview with

Bhargav Dasgupta

MD & CEO,
ICICI Lombard general Insurance

Insurance penetration' is the buzzword. The IRDAI while providing various enablers for the industry has set ambitious premium growth targets for the next 5 years. How confident are you about the insurance industry achieving this scorching pace of growth without compromising profitability?

India is poised to become a US$5 trillion economy by 2025 and the sixth-largest insurance market in the world over the next decade. This in itself augurs well for the industry's growth. In this context, the recent announcements by the regulator will help in encouraging capital flows into the industry, along with new product innovations and expanding distribution. IRDAI's vision 2047 provides a perfect opportunity to the insurance industry to demonstrate its commitment towards the vision and ensure proliferation of insurance in every nook and corner of the country. The intent is to cater to the changing dynamics of the insurance landscape and promote healthy & sustainable development with innovative products suitable to the needs of customers. Whether we do it profitably or not is really up to the industry players. In fact, if we do not ensure profitable growth, there won't be enough capital to invest in distribution, new products, technology upgradation, etc that is critical for sustained growth.

As a leading player in the Indian non-life industry, what are your thoughts on ways to ensure that a 'win-win' situation prevails for all stakeholders viz. – the customer, the intermediary & the insurer & industry growth is in an organised manner?

The recent slew of reforms has been path breaking in many ways. The vision of the regulator to ensure 'Insurance for All' is truly inspirational and these reforms will go a long way in achieving that objective. They pave the way for a 'win-win' scenario for all stakeholders involved in the ecosystem and the industry at large.

With 'Use and File', customers can now avail of wider spread of innovative solutions and have access to customised risk cover products. While for both channel partner and insurer, this has allowed for more agility in launching products and a higher play of innovation, customisation and a wider bouquet of services.

With customer eKYC, insurers would have a better understanding of their customers with greater contactibility and ensure higher retention levels as well as a seamless and faster claim process. For insurers too, the risks of fraudulent claims could be countered, as it will greatly improve the accuracy of risk management and better pricing for genuine customers, which is again a win for all.

With proposed 'dematerialisation of insurance policies', akin to securities, it will help streamline access, support, as well as expedite claims by collating all information of all insurance policies of an individual – life, health, travel, motor and group at one single place.

The improved ease of doing business through principle based regulations, encouragement to private equity investors and expanding partnership options for corporate agents and IMFs is conducive for industry growth at large. This will free up distribution models for and aid the intermediaries as well as access to multiple touch points for customers.
Even the recent move of allotting states to each insurer as the lead in the region will enable higher penetration and advocacy for insurance adoption, whilst working collaboratively with all stakeholders.

Apart from bringing in premiums, what are the other services which you opine can be entrusted to brokers and which would take the workload off insurers?

A big part of a broker's job is not just to get in the premiums or sell the policies but also to help customers select the right policy that will benefit them. The pre-work goes into establishing what covers those customers' needs and educate customers on various options available in the market and suggest the best product after analysing the customer's wants and needs. The broker should also help the customers through the claims process and ensure that claims are processed on time and without hassle.

As a 'technology-oriented' company, we are keen to know new technology initiatives taken by ICICI Lombard to create a better customer experience. Do you believe that technology used purely for sales can be a successful channel in itself?

Our approach is to be available to our customers anywhere, anytime and through whichever channel they prefer. We do not believe that digital is the only way to sell or service, but we are big believers in omnichannel and phygital. We have developed multiple technology initiatives for our physical distribution channels across retail and commercial line of business. Over 97% of our policies are issued digitally. We have used technology across the customer touch point including lead management, policy issuance, engagement, endorsements, claims and renewals. We provide multiple channels, including Nysa- our web platforms and Myra- our email bot and multiple APIs to book policies, as well as to endorse and service clients digitally using chat bots, virtual IVRs and NLP based voice bots. This has led to not just a reduction in the processing time for clients, distributors and for us, but has improved the overall customer experience. Few brokers have integrated with our APIs for booking policies and process endorsements. This has enabled them to design their own journeys and process transactions from their own eco system without any manual intervention. Technology enables our partners and customers to complete a transaction at any time and through the channel of their choice. Technology is not just transforming our sales related processes but the entire spectrum of our customer led journeys.

Even after nearly 50 years since nationalisation & 21 years after the 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 ICICI Lombard done differently to make the whole claims process a pleasant experience for the policyholders? How do you think IBAI can help in fostering greater trust & comfort in the minds of customers' vis-à-vis insurers?

Lack of trust was a major issue in the past; not as deep-rooted now. However, even today, we see issues regarding mis-selling or uninformed buying of insurance policies, ignorance about policy coverages and/or limitations, lack of awareness about claim documents required to substantiate the claim, etc which creates friction between customers and insurers leading to negative experience for all stakeholders. Further, there are instances wherein we at ICICI Lombard have aligned with the spirit rather than the letter of the policy, but that may not be a common practice across the sector.

For instance, in Property line of business, most policies require the customers to reinstate the damaged asset/property either by way of repair or by way of replacement. Post completion of reinstatement, such claims are settled mostly in reimbursement mode. Customers being ignorant of the policy mandates applicable on them, find this process cumbersome and time-consuming. Often customers incorrectly interpret this as delaying tactics at end of the insurers. Herein the role of the intermediaries and us in educating customers becomes crucial.

IBAI on their part should ensure sustained efforts of the broker fraternity to educate the customers about their policies, the coverages, terms and conditions and claim settlement process. An aware customer will be able to better understand the policy, which will ensure an eco-system of trust and comfort amongst the stakeholders.

At ICICI Lombard, we place great emphasis on faster settlement of claims and hassle-free experience for our customers. With the singular focus of reducing the turnaround time in such claims, we recently launched a 100% digital solution to settle the frequency of claims within 10 days to ease the cash flow issues of the retailers, small-scale traders and businesspersons of MSME sector. This ramp up in the service level was made possible through the adoption of digital survey, reduction of documentation; One Time Password (OTP) based consent, penny drop & digital Know Your Customer (KYC). For severity claims, the focus is on the early confirmation of admissibility, which sometimes involve up-front, transparent discussions with the customer. Post confirmation of admissibility, the focus shifts to making timely on account/interim payments to assist with the liquidity of the customers.

Even as we talk of creating greater 'trust' among the stakeholders, 'fraud management' needs to be looked at closely too. Do you see a rise in the number of fraudulent claims? Any new steps taken on fraud management?

Post Covid, with the challenges in the ecosystem, various elements in the society are coming under financial stress and there is a pressure to exploit vulnerabilities/ and or identify opportunities to gain undue advantage either singularly or in collusion with entities.
We are aware that opportunistic frauds are a real menace, to the insurance industry. Taking into account these fraud risks, we have built in processes and mechanism to mitigate fraud risks as follows -

1. ICICI Lombard fraud mitigation team has invested into various machine-learning models, past 4 to 5 years and now we are reaping good results from them.
2. Our fraud investigation team and investigating agency brings in market intelligence. These are converted into smart triggers and shared with the claims and U/W teams for effective triggering of claims in real time.
3. On detection of fraud, various punitive measures including lodging Police complaints, filing FIR, reporting to various regulating body like Medical Council, RTO, FDA etc is initiated.

What are the new initiatives planned for creating 'customer awareness' about insurance? Do you feel that awareness programs could be more successful if done jointly at the industry level, say- by the General Insurance Council?

The coming years are driven by the reforms, the burgeoning ecosystem of digital health, emergence of digital intermediaries across the entire customer lifecycle, increased insurance awareness, and participation from 'Bharat' and SME sector adoption of insurance will accelerate across segments. The council has initiated some steps in promoting joint customer awareness plans, which will give customers better choices, help deepen the industry's reach and address the penetration gap. No doubt, more needs to be done.

ICICI Lombard has multiple channels of distribution. When channel conflicts do arise, what is the robust mechanism you have to ensure that every channel gets a fair deal?

We follow an omnichannel approach of distribution to cater to our diverse segments of customers. These include physical (Banca, Agency, Broker, telecalling led) or digital (website, mobile app, whatsapp, email etc) or phygital channels of distribution. From a sourcing point of view, we deploy technology and have clear Chinese walls to ensure the credit of originating point of sourcing the policy and the attribution of the same is mapped to the right channel. This ensures there is no friction or conflict between multiple modes. With over 21 years of our legacy in this business, we have built long lasting deep relationships with offline and traditional models of distribution and over time, we have only bolstered the relationship..

What the Future holds?

Swami Bimananda musings

Balasundaram R

Swami Bimananda was in deep meditation.
I bowed respectfully before him and after a minute asked in a low voice – 'Swamiji, what is the future of the non-life insurance industry in India?

Complete silence for a while, before Swamiji slowly opened his eyes. I waited with bated breath, eager to hang on to every word he uttered.

'Vats', he began softly ..... ' I see a lot of confusion, distrust, blame-games, pain, you understand? Dark clouds & headwinds everywhere.' He paused for a moment and in a firm, loud voice said 'This too shall pass. The sun will shine brightly through the dark clouds after a while and tail-winds will push the industry forward to great, new heights'.

A bit comforted but still unsure, I shot my second question bravely –' Swamiji, with the new directive from the Regulator, that there will be no cap on commissions and insurers can decide on the same, as a broker will my earnings reduce? This is my biggest fear.'

Fear is your biggest enemy, answered Swami Bimananda. 'You will not earn less than what you earn and not earn more than what you deserve. The more people you serve faithfully, more will your earnings be'.

'I do not fully understand, Swamiji', I said. His only reply was a beatific smile.

So, I switched to my next question – ' Swamiji, with no IIB-based rates in Property insurance, will there be a steep drop in premiums'?

Swamiji closed his eyes for a moment and then started talking – 'Insurers & brokers have to search for the 'soul' of the insurance industry ....i.e. Underwriting. Serious 'soul-searching' is to be done. Once this purity of the soul is achieved, there will be no rash decisions on pricing. It will be your duty too, to effectively convey this to clients so that they understand the soul-searching process and try to improve themselves from within. All beings on this planet, be they insurers, insureds, reinsurers, brokers, they are all my children & I have to take care of all of them, none of them should wither off'.

'Swamiji, one more question – How will the freedom in policy wordings & policy structuring play out?'. Swamiji replied ' Vats, that will be the next level of enlightenment to which you mortals should reach. Right now, none of you is ready for the same. Inner-development & soul-searching should continue. With purity comes clarity and with clarity comes happiness.

'Swamiji', I began. He cut me short – 'You ask too many questions. Ask these questions to yourself, think of all the beings in the world, the insurance industry, keep improving yourself every day and you will get the answers yourself'. With that, Swami Bimananda raised his right hand in blessing and went back to his meditation.

Spotlight

JEETU, THE INSURANCE DOYEN

Hari Radhakrishnan

Jitendranath Nayer or Jeetu, as we all fondly call him, is a stalwart of the Indian insurance industry. He is so well known in the industry for his technical acumen and sharp intellect, that I would not attempt to make an introduction about him to you. It is such a great pleasure for me to write about him and my association with him in various capacities; as a former colleague in the two insurance companies that we worked together; as my former boss; as my partner in insurance broking and as a friend, philosopher and guide.

Jitendranath Nayer

My association with Jeetu traces back to my time at Oriental Insurance. He joined Oriental as a direct recruit officer in 1978. He had an illustrious career in Bombay as divisional manager handling large corporate accounts and later on as Manager at the Bombay Regional Office No 1 (BRO-1), which was a tied regional office handling corporate accounts. BRO-1 used to be the premier regional office of the company generating the biggest premium amongst the regions. He was fully supportive of his subordinates and an expert in fields like marine cargo and hull.

As a young direct recruit officer in the 1990's, I looked up to seniors like Jeetu for inspiration. He was an exemplar of professionalism and gentlemanly conduct in a nationalized insurance sector. While the image of the public sector insurers at that time of economic liberalization in the Indian market was not favorable, Jeetu set an example of operating in a fashion unlike that of someone in a government run company. He set high standards of excellence in performance, which cannot be beaten even by leading private sector professionals of today.

When the insurance industry was opened for private sector participation, Jeetu was amongst the first, whose talent was recognised. The loss of the public sector became the gain of the private sector. He was hired by Bajaj Allianz to helm their underwriting and sales function for the western zone. Jeetu later on joined Chola MS as head of commercial business and later on left Chola to join RSA, which was his last stint with an insurance company.

Jeetu was never fully content with working for insurance companies. He found the operations of the insurers too straight jacketed to his liking and felt it curbed innovation. Broking held out a lot of promise for him. He took a gamble and founded Amicus Insurance Broking Services in 2008 along with his like minded former colleagues from Oriental, Sobha Sah and S. Balakrishnan.

As is his wont, Jeetu set high professional standards in Amicus as well. He emphasized on absolute compliance to regulations without accepting any over-riding commissions or inducements, which was a norm then as it is today. He also preferred to work on exclusive mandates and frowned on multiple mandates. Amicus had to be content with a slower growth trajectory as a consequence, but for Jeetu that was an acceptable price to pay, for his adherence to his principles.

In running Amicus, Jeetu was a stickler for frugality. He never did any flashy events or incur unnecessary expenditure. He used to tell me that whether business will come to Amicus or not, from a quote slip that we float is not within our control. But how much we can spend is.

I joined Jeetu on his broking journey later after finishing my career with other organisations. Amicus was like a second home to all of us rather than a workplace. Jeetu was always chilled out and one could pick a quarrel with him on any technical or other matter without fear of being judged. He took everything in his stride.

In his broking role, he was steadfast in putting the customer interest at the core while doing placement of policies. He used to do incisive analysis of policy wordings and coverage offered, ferreting out critical but disguised coverage gaps or challenges. He is a man who is deeply concerned with the market not focussing enough, on customer concerns in the transaction of insurance. He always says that as brokers, we need to foreground customer concerns before the regulators and insurers, instead of our bread and butter issues of brokerage earnings, so that our voice gets heard.

While Amicus had blossomed and made a name for itself as a highly professional broker, tragedy struck us with Jeetu being diagnosed with cancer. Due to demands of the intensive treatment he had to undergo, he could not continue actively running the business. This prompted him to engage with prospective buyers for an M&A which was finally concluded with the merger of Amicus with First Policy Insurance Brokers.

I owe my career in the insurance industry to Jeetu in a substantial measure. He was instrumental in my joining Chola under him, from Oriental Insurance in the wake of liberalization of the industry. I have tremendously learned from Jeetu due to our long association with him. He is my "go to" person, if I run into any technical matter relating to insurance. Even though I get sometimes acknowledged for my own technical knowledge, I must say I am just a matriculate, whereas Jeetu is the real PhD of insurance.

Moving from customer protection to customer promotion

Customers are the key to creating markets. Customers provide the revenues and profits to those companies that focus on customer requirements. However, despite the obvious logic of this, organisational focus often shifts away from consumer interests, in the short-term rush for results. With increasing regulations, companies focus on a narrow vision of compliances, and not on the more promising aspect of customer creation and promotion. Client protection concepts including 'treating customers fairly' (TCF) are emerging as new paradigms of customer welfare. In the milieu that today's economy is increasingly a risk economy, insurance has become a compelling requirement.

Insurance manages risk by the pooling of random (insurable) risks, using the law of large diversifiable numbers. Insurers are also using innovative concepts, tools and technologies to look at risks traditionally considered difficult to insure or uninsurable. Insurers need to push the boundaries of uninsurability, because risks needs are changing.

The Insurance Industry needs to keep an eye on how to take forward the universalisation of insurance. There is a case for communities, social groups and governmental agencies to advocate and promote protection schemes for those at the bottom of the pyramid. For the burgeoning middle class there has to be more personalised marketing for covers that effectively deal with their risks at the higher economic level. There should be no 'missing middle or bottom'. The bottom line is that the promise to pay has to be a certitude that empowers the policyholder when a covered loss takes place..

Risk being what it is, the product space will need a hundred flowers to bloom, and innovations need to surround customers to eliminate various hassles, paperwork and delays. Technology, on-line information and comparisons, cut - through and straight-through management of processes, brand and service reputations, quality of people and their service readiness, ethics and cost saving techniques for the customer are all essential, to give real value to the risk solutions people desperately seek.

Marketing and Intermediary activity

Each part of the risk value chain needs to managed strategically to get customers enrol for risk protection products. In the distribution space, there has to be differentiation between information and advice. Emphasis should be given on communicating in multiple formats, times and occasions, using plain language and vernacular idiom and where relevant even explanatory pictures. Relationship based interaction is the key as creating trust and confidence is necessary because insurance is for the long term. In the risk business only the conviction of the long term works for the customer. The randomness of risk makes losses strike haphazardly across time and place, and people need to be motivated and pushed to buy again and again. The value that is to be sold is not claims but protection. Risks pauperise consumers in disaster times because they do not have deep pockets which insurers, however, have. If insurance convictions can spread among the population, risk taking and mastery of risks can make countries rise up the development ladder faster.

Underwriting

Differentiating between different risks on the basis of a comprehensive risk assessment is the core of insurance. To be able to differentiate between the risks submitted to them, insurers must have access to objective and relevant statistical data at the time of underwriting. In insurance, the applicants will always know more than the insurer, no matter how careful the underwriting. The complexity of financial products should ensure that insurance products are converted into simple propositions, such as spelling out the type of product, whether indemnity/ reinstatement/ replacement or repair/ or a benefit only. Price must be explained against the benefit package to show its reasonableness, and the periodicity of payment should add to the affordability factor.

Renewal of Polcies

Renewals are of essence to get the products working effectively from birth to death or across the lifecycle of any risk. It is well known that an old client is a gold client as the risk of over-consumption (moral hazard/adverse selection) keeps falling as a claim-free renewal history lengthens. Managing a break-free insurance is an onerous task for any insured and insurers should serve to remind and assist the securing of continuous protection through cost reduced formats such as email and sms. Effective protection upgrades should be ensured whether through wider/deeper/more effective covers, the price discount entitlement should be passed on for claim free renewals or downward revision in prices, and updating of risk profile should be asked for and meticulously recorded in the contract.

Claims

Claims are the moments of truth that certify the effectiveness of protection. The indemnity should be assured, correct and timely. Many techniques and processes are in vogue, but it should be relevant to the special characteristics of the product sold and the nature of the consumer. Sophisticated insurances and customers and large size claims would need complex proofs and elaborate investigations and assessments. However, as size and sophistication reduce the onerous processes of claim settlement should be reduced and paperwork and formalities should be minimal, well explained and easy to submit. There should be contract certitude as well as assured time for settlement subject to insured's cooperation in proving the loss and providing the insurer the necessary documents.

Finally, there is an increasing responsibility for insurers to offer fair and respectful treatment to customers. Safeguards should be put in place against corrupt and non-transparent practices, as well as against abusive or aggressive behaviour by the employee/intermediary including loss assessors. Special care is needed to safeguard the interests of marginal customers, as such customers are often first timers, inhibited, overawed and new to formalities. Customers' right to make complaints, how they can make complaints, the time frame and method of resolution and the manner of making appeals or for going to ombudsman, consumer courts etc. should be made part of the service package.

DEDUCTIBLES IN INSURANCE

Deductible in insurance is a provision by which the insurer will pay losses in a policy when the loss amount is in excess of specified amount or percentage. It is intended to eliminate small 'attritional' losses. It also hopes to motivate the insured to reduce frequency losses. The use of deductibles when chosen voluntarily can reduce premiums.

The size of the deductible varies on a number of factors such as:

1. .The nature of the perils
2. The patterns of the frequency and severity of the losses
3. The financial capability of the insured to bear such losses – capability of self-insurance.
4. The cost-benefit to insurer and insured in claim handling costs
5. The need to give the insured a stake in loss prevention
6. It can reduce premium load as the deductible moves up
7. Only when certain limits of deductibles are accepted only certain covers can be underwritten

Thus, deductible help the insurer achieve certain insurance based objectives such as:

- Reduce moral hazard and encourage loss control. This makes giving insurance more attractive to the insurer and reduces premium for the insured.
- Reduced losses and loss adjustment costs. The administrative load on the insurer is higher in percentage terms when claims are small and the demands of time, effort and paperwork can be onerous for both parties. Hence attritional claims are normally excluded by the use of deductibles.
- Reduced premium cost – the expense load falls dramatically as also a percentage of the loss. The additional loss prevention efforts also get translated into lower rates.
- It encourages loss reduction, a win-win-win for insurer, insured and society.

Deductibles can be of two types:

- A per event deductible – this applies to each item, each location, each occurrence, each claim. Deductibles can be in terms of amount, percentage of loss or sum insured or time periods.

- Aggregate deductibles – It is set in a period of time, say one year. Once the deductible is crossed all claims are payable in full.

Deductibles can also be categorised as under:

- Straight deductible – a specified amount is deducted from the claim and if the limit of deductible is not reached the claim is not payable.

- Deductible on per claim basis or per occurrence basis – Each claim made is separately deducted in a per-claim basis deductible, whereas it is deducted only once across all claims in an occurrence basis deductible, regardless of the actual number of claims involved.

- Percentage deductible – This can be on the basis of the sum insured, the value of the insured property, or the amount of loss. Each approach has its own logic in motivating the right kind of insurance approach by the insured. In the case of deductible on the basis of sum insured, the insured is incentivized to make sure that the insurance is on the full value of the property. This is especially important when the underinsurance clause is absent or not effective to be a selection against the insurer.. Deductibles can be on the amount of loss as against the amount of insurance. This is to encourage the insured to loss minimise once a loss has occurred.

- Disappearing deductible – this is a means to combine the franchise-deductible concept. However, this method of deductible is now rarely used because it is felt that insureds must share in the loss sustained as part of the need to lessen losses due to lack of constant improvement in risk minimisation.

BURGLARY INSURANCE

Burglary Policy is one of the earliest insurances. It complements fire insurance on contents and is generally paired with fire insurance. The policy covers the risks of burglary, housebreaking and hold up. It is interesting to note that the crime "burglary" is not defined by Indian Penal Code. It is therefore necessary for the insurers to give a comprehensive definition of the term burglary in the policy. Before understanding the said definition, it is necessary to understand various other theft related crimes:

Theft: Indian Penal Code in Section 378 defines theft as follows: "whoever intending to take dishonestly any movable property out of the possession of any person without the consent of that person or of any person having for that purpose authority, moves that property in order to such taking is said to commit theft."

Housebreaking: This term is defined by IPC under Sec.445. The gist of it is: A person is said to commit housebreaking who commits house trespass if he effects his entrance into the house (or any part of it), or if being in the house (or any part of it) for the purpose of committing an offence, or having committed an offence therein he quits the house, such entrance or exit being made by use of force in one of the six ways as described in the Indian Penal Code.

Robbery: As per Sec. 390 of the IPC, the term robbery means: "If in order to the commission of or in committing of the theft or in carrying away property obtained by theft, the offender, for that end, voluntarily causes (or attempts to cause) to any person death or hurt or wrongful restraint or fear of instant death or hurt or wrongful restraint or fear of instant death or hurt or wrongful restraint". It is to be noted that this is an aggravated form of theft.

Dacoity: Section 391 of the Indian Penal Code states dacoity as "where five or more persons conjointly commit or attempt to commit a robbery or are present and aid such commission or attempt, every one of them is said to commit dacoity"

Hold-up: This term is not defined in most policies but means stealing of money from a building/person/vehicle by using violence or by threatening to use violence, usually by outsiders and not the staff.

SCOPE OF COVER:
The policy covers loss of or damage to the insured property on account of:

i. Burglary: The term is defined in the policy as follows:

1. Theft of property from the premises following upon felonious entry of the said premises by violent and forcible means.
2. Theft by a person in the premises who subsequently breaks out by violent and forcible means provided there shall be visible marks made upon the premises at the place of such entry or exit by tools, explosives, electricity or chemicals. Use of force may be against property and person.

ii. Housebreaking. As defined earlier.
iii. Hold-up As defined earlier.

Add-on covers:
On payment of extra premium, the policy can be extended to cover Riot & Strike risks. Another add-on covers sometimes granted as a special case by insurers is to include the risk of theft without forcible entry or exit known as larceny.

Property covered:
The main type of property covered is of course the moveable property in the premises such as stock of different varieties and other portable items. However, items like furniture and fixtures can also be covered because of their susceptibility to theft as well as damage during attempts of theft.What is more, even the damage caused by burglars to the premises containing the insured property is also covered (within the overall sum insured on contents) if the Insured is responsible for making good the loss.

Two classes of contents deserve special mention here: Jewellery and Cash. In respect of jewellery shops, there is a separate policy specifically designed for the trade, known as Jewellers Block Insurance Policy. Cash can be covered under Burglary policy along with other stock of the Insured provided

1. A separate sum insured for cash is mentioned,
2. Cash is secured in locked safe,
3. A complete and up-to-date record of cash is kept secure but outside the safe containing cash, and
4. The key clause is made applicable. The essence of the key clause is that claims for theft of cash from safe by using the original or duplicate key belonging to the Insured are admissible only if the key is obtained by violence, threat or force.

Exclusions

- Underwriters do not want to cover losses due to "in house" or insider acts. The exclusion states that no claim is admissible in which any member of the Insured's household or employee is involved as principal or accessory.
- The spirit of the policy is to cover losses involving forcible and felonious entry or exit. Therefore, the policy does not cover theft by any other person who is lawfully on the premises. (Note that the policy in certain cases can be extended, on payment of additional premium, to cover "theft and larceny" without involving forcible entry to or exit from the premises.)
- Losses which can be insured under a fire, motor or plate glass insurance policy are excluded. (Note, however, that the risk of riot and strike can be covered as an add-on peril).
- Inventory losses, which mean losses which get discovered only at the time of routine stock taking.
- Certain property by default is not covered unless it is specifically stated in the policy, such as deeds, bonds, securities, cash, stamps, etc.

- War and nuclear exclusions.
- Depreciation, wear and tear, consequential losses.

Policy conditions:

The major conditions are as under which also include claims procedure.

1. The policy provides cover for losses caused by criminal acts. Hence an important condition provides that in the event of a loss the Insured has to give immediate notice to both the insurer as well as the police. The insured is further to take all possible steps to apprehend the guilty person/s and to recover the property lost. The insurer, if deemed necessary, will require the Insured to take steps for the prosecution and conviction of the guilty person and recovery of the stolen property from him. The insurer bears the expenses on this account.
2. Reasonable Care: The insured is required to take all reasonable steps to safeguard the property and to secure the doors, windows, and all other openings.
3. Alteration of risk: Any material alteration of the risk must be conveyed to the insurer and be registered in their records
4. Average: This is the condition of under insurance. Each item of the schedule of the policy is separately subject to average. This is a full value insurance cover.
5. The usual conditions of contribution, subrogation and arbitration.
6. One important condition allows the insurer to provide indemnification by way of reinstatement, replacement or repairs of the property or pay by cash.
7. Like fire policy, the sum insured stands reduced by the amount of claim paid and can be reinstated on payment of pro rata additional premium.

Note: In respect of burglary insurance on dwellings and residences, the policy is more liberal and includes the risk of theft without forcible entry or exit.

Can Debris Removal Costs that Pile-up in a Claim Destroy an Insured?

Climate change losses such as cyclone and floods are getting common. If a cyclone tears through an area and it can cause roofs of houses and factories to fly off. Debris of all kinds can be blown anywhere and everywhere. Initially, an insured may be relieved and even complacent that there is adequate property damage insurance in respect of storm, tempest, flood and inundation. Then to their horror it may be seen that the storm and flood has created a havoc of debris far beyond what was imagined. Debris can affect own premises and get blown or carried by flow across an entire area around to the neighbouring properties/ public places. Similarly, others debris can come into the insured premises. Further complicating matters can be fact that chemicals and oils used in making various products could have leaked outside, contaminating the ground and water supply. Mud and slush can come into the premises in great quantities which can bury the up to a level the compound and stop operations. Water channels can get blocked by mud, rivers or rivulets can change course, and make viability for certain operations impossible and so on.

Again, the loss of the insured can be part of a national calamity and the insured, the broker, the insurer and the surveyor would have a very hard time coping with the disaster in its many dimensions. Debris removal costs and possible liability claim issues will begin to loom apart from the loss to assets and loss of earnings etc. The first issue is that when calculating losses, debris removal and clean up are additional costs to repairs and reinstatement. Today the cost of cleaning up and disposing of debris has increased substantially and environmental laws impose progressively stricter and more costly rules relating to disposal of debris, particularly of hazardous materials.

Coming back to coverage, does the SF&SP allow such coverage? For this the terms, conditions and exclusions of the policy show the following:

- In the Standard Fire & Special Perils Policy there is the General Exclusion no. 8, which disallows claim for removal of debris, beyond 1% of the claim amount. Here the limitations are tight as this is a traditional named peril policy and very much unlike an All-Risk Policy like IAR, where anything not specifically excluded can be held to be covered.

- The relevant clause for natural perils is: VI Storm, Cyclone, Typhoon, Tempest, Hurricane, Tornado, Flood and Inundation. Loss, destruction or damage directly caused by Storm, Cyclone, Typhoon, Tempest, Hurricane, Tornado, Flood or Inundation excluding those resulting from earthquake, Volcanic eruption or other convulsions of nature. The critical words are loss, destruction or damage directly caused. Hence there has to be loss to the underlying covered property, machinery or stock.

- Apparently, the policy terms covers only internal debris directly caused by the peril to the insured property. Assuming for instance, that there is great influx of mud and slush from outside, the claim for the cost of removal of silt can be substantial. Assuming that external debris affects a plant, the indemnity payable can only be marginal (only as exception to exclusion no.8 of the policy), only 1% cover for debris removal, which can be extended on payment of additional premium but subject to a further limit of only 10% of the sum insured. The limit of 10% again indicates that the benefit is intended to be marginal.

- If there is basic coverage, still the role of sum insured needs to be considered when looking at coverage and claim assessment. The sum insured in an SF&SP policy is traditionally applicable to the assets covered. No provision is there for coverage of costs. If there is loss or damage to the covered items then the applicable sum insured can be used to pay for costs directly required to repair or reinstate the item as part of the sum insured applicable.

  This aspect is clear when we consider that whatever we have to pay, it cannot go above the sum insured.

  This is also relevant in the context of the wording in the policy at the end of the coverage section: PROVIDED that the liability of the Company shall in no case exceed in respect of each item of the sum expressed in the said Schedule to be insured thereon or in the whole the total Sum Insured hereby or such other sum or sums as may be substituted therefor by memorandum hereon or attached hereto signed by or on behalf of the Company.

- The fact that removal of debris is an exception to an exclusion indicates that such costs are basically intended to be excluded in the original vision of the policy. In today's context when costs of a loss need to be covered, insurers may have to provide add-ons to the policy to negate the effect of this exclusion. However, adds on can leave ignorant insureds in the lurch and hence the removal of debris costs should be made in the main policy along with cost of debris removal of the insured from the neighbouring property as also debris from outside.

- In 2013 there was a meeting of the Seniors of the insurance industry to discuss Uttarakhand floods, where silt had entered and blocked many power plants and also the water channels leading to the plants and huge costs were required to be incurred. It was decided by them that any such costs within the insured property would be covered to make the plant come back to normalcy, subject to availability of sum insured. Other indirect losses due to occurrences such as change of river course were held to be not covered. However, no analysis of the intent of the traditional policy was discussed. This new view of covering debris removal costs is an innovation to meet the needs of climatic disasters, but unfortunately this interpretation is still kept not yet mainstreamed. It needs to be made part of the policy.

Other special debris removal problems that may require attention can include:

(1) Molten material—the escape of molten material (metal, glass, plastic, etc.) can produce large loss. If the cause is an insured peril, there is debris removal coverage, but the cost may well exceed the debris removal limit unless the exposure has been recognized and additional debris removal coverage purchased.

(2) Toxic or radioactive contamination—can involve severe and expensive debris clean-up and disposal problems. Toxic materials can be found even in shops and godowns as well.

(3) Clean-up costs of smoke from a fire or fine particles from a flood, or in the water used to extinguish fire can be astonishingly high.

(4) "Third party" claims—injury to others or damage to their property—as well as workers compensation claims from pollution are also major exposures for any insured involved with hazardous or toxic materials, but are outside the scope of the policy and insureds must be advised to take suitable cover for these and related losses.

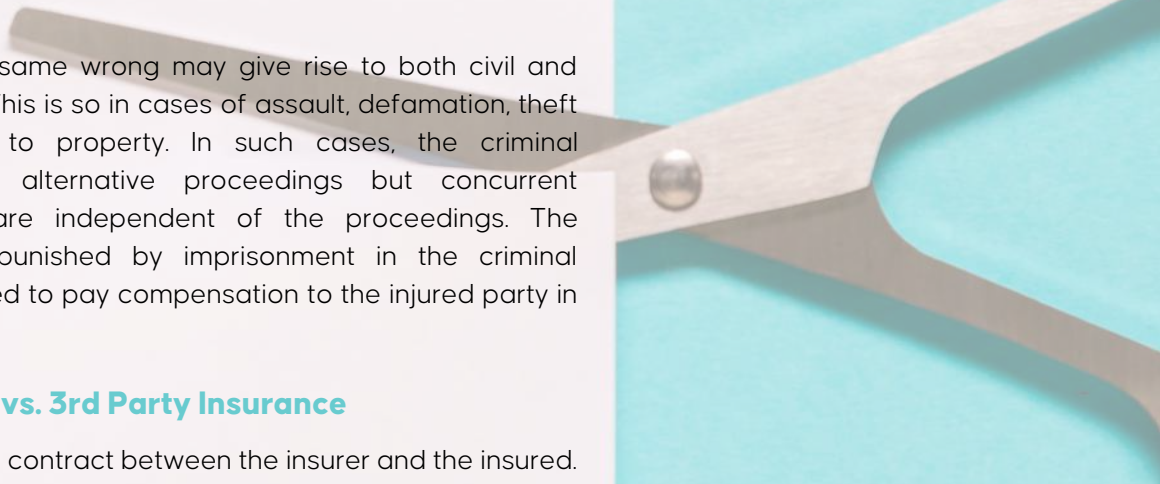
Thus, there may be a need for complete overhaul of the SF&SP policy to modernise it for the needs of managing debris losses against all types of possible losses. Insurers and Brokers can initiate actions to be proactive in this area.

Liability Insurance – Snippets on Various Aspects

Civil vs. Criminal Liability

The main difference between civil and criminal liability lies in the procedure. There are in general four points of distinction between the two:

1. Crime is a wrong against society but a civil wrong is a wrong against a private entity or entities.
2. The remedy against a crime in punishment but the remedy against the civil wrongs is damages.
3. A third difference between the two is that of the procedure. The proceedings in case of a civil wrong are called civil proceedings and criminal and civil proceedings takes place in two different sets of courts.
4. The liability in a crime is measured by the intention of the wrongdoer; but in a civil wrong the liability is measured by the wrongful act and the liability depends upon the act and not upon the intention.



It is possible that the same wrong may give rise to both civil and criminal proceedings. This is so in cases of assault, defamation, theft and malicious injury to property. In such cases, the criminal proceeding are not alternative proceedings but concurrent proceedings. Those are independent of the proceedings. The wrongdoer may be punished by imprisonment in the criminal proceeding and ordered to pay compensation to the injured party in the civil proceedings.

1st Party Insurance vs. 3rd Party Insurance

An insurance policy is a contract between the insurer and the insured. A 'first party' is the party who is insured under an insurance policy and is often referred to as the policyholder or the insured. If an insured makes a claim directly against his/her own insurance company (the 'insurer') in terms of the insurance policy, such claim is referred to as a 'first party claim'.

Some common examples of a first party claim are:

- A factory suffers damage as a result of a fire and the insurer refuses to cover all or part of the loss.
- A person suffers an accident or illness and there is a policy covering both contingencies, and a claim can be lodged with the insurer.

A 'third party' is someone who is not a party to the contractual insurance relationship between the insurer and insured. If a third party makes a claim for a loss caused by the insured against that person or the property of that person, against an insured, that insured will file this claim with the insurer concerned to defend and indemnify him/her under the terms of the insurance policy. The insurer will refer to this as a 'third party claim'.

Some common examples of a third-party claim are:

- A customer slips and falls in an office or hospital - duly insured by an insurer
- A neighbour's property is damaged by a flood which was caused by an act or omission of the insured
- An individual is seriously injured following a car accident caused by an insured

Certain insurance policies will only provide coverage for first party claims, for instance: health insurance, fire insurance and life insurance. However, most home insurance policies and automobile insurance policies contain provisions for both first party and third-party claims. Cyber policies also have both type of covers.

Since the relationship between the insurer and insured is a contractual one, the document which forms the basis for any first party claim is the insurance policy itself.

Court: Primary & Excess as also "other insurance" Liability Insurance

This may be explained from taking a quote from a US Court case. In the case Fireman's Fund v. Structural Systems Technology Inc, in United States District Court, D. Nebraska (2006), the court stated as follows citing many other cases:

"Primary insurance coverage is provided when, under the terms of the policy, liability attaches immediately upon the happening of an occurrence that gives rise to liability, as opposed to excess or secondary coverage,

which attaches only after a predetermined amount of primary coverage has been exhausted. Midwest Neurosurgery, P.C. v. State Farm Ins. Cos., 673 N.W.2d 228, 235 (Neb.Ct.App.), aff'd, 686 N.W.2d 572 (Neb. 2004). True excess and umbrella policies "require the existence of a primary policy as a condition of coverage" and their express purpose is to protect the insured in the event of a catastrophic loss in which liability exceeds the available primary coverage. National Sur. Corp. v. Ranger Ins. Co., 260 F.3d 881, 885 (8th Cir. 2001) (emphasis in original).

Insurance policies often contain "other insurance" clauses, which purport to reduce the insuring company's liability when there is other insurance to cover the same loss. See In re Popkin Stern, 340 F.3d 709, 716 (8th Cir. 2003). When two policies provide coverage for the same incident, the question of which policy provides primary coverage is a legal question determined by examination of the language of the policies at issue. United States Fid. Guar. Ins. Co. v. Commercial Union Midwest Ins. Co., 430 F.3d 929, 933 (8th Cir. 2005). Other insurance clauses fall into three categories: (1) pro rata clauses which provide that the insurer will pay its pro rata share of the loss, usually in the proportion which the limits of its policy bear to the aggregate limits of all valid and collectible insurance; (2) excess clauses which provide that the insurer's liability shall be only the amount by which the loss exceeds the coverage of all other valid and collectible insurance, up to the limits of the excess policy; and (3) escape clauses which provide that the policy affords no coverage at all when there is other valid and collectible insurance. In re Popkin Stern, 340 F.3d at 716."

Claim v. Loss

The words 'claim' and 'loss' can have different meanings in liability insurance. Both will be used in respect of liability cover to describe a claim against the Insured and a claim by the Insured against the policy loss suffered by the claimant. The word Claim with a capital C will usually mean claim against the Insured but this is not always so and therefore it is important to find out what is meant by claim / Claim according to the policy definition.

The word "Loss" will also be used to describe the loss suffered by the Insured in respect of property damage, fraud, fidelity etc. It is important to ensure that these phrases are correctly expressed consistently, throughout the policy wording because they do sometimes get used inappropriately, by accident and this can lead to misunderstandings and disagreements in the event of a claim. It is also seen that in endorsements to a policy, words may be used inconsistently with the original term or meaning in the policy

THE FUSS ABOUT CAUSATION

> There are all sorts of technical and hyper-technical discussions going on about proximate cause. It is well known that the doctrine of proximate cause is one of the principles of insurance. In insurance law 'causa proxima et non remota spectatur' means the immediate and not the remote cause. An insurer has to find out the immediate and not the remote cause is to find the trigger for the peril for paying the claim.

This is the theory. In practice people find it difficult to arrive at consistent results. Author, Kenneth Vinson states that "In tort law's darkest corner lurks the concept of proximate cause. Causation's mystifying riddles constitute the last refuge of muddy thinkers. ... When lawyers and judges toss causation rhetoric into briefs and opinions, the resulting babel smothers common sense and further corrupts legal English." Proximate cause was defined in the case of Pawsey v Scottish Union & National Insurance Company (1908) as: the active and efficient cause that sets in motion a train of events which brings about a result, without the intervention of any force started and working actively from a new and independent source."

It is seen that insurers/ surveyors/investigators/ forensic labs/ lawyers are seen to throw their opinions in a haphazard way without understanding what is proximate cause and creating confusion for others. When looking at loss/ failures, such as a fire or flood, it is necessary to look at the efficient cause, which is most often the proximate cause. There can be underlying causes that may be more difficult to see, but they may or may not contribute to the actual loss causation. However, they may need to be studied by risk managers for the purpose of systemic improvement to prevent the recurrence of similar types of problems in future. Some of these causes are called root causes. Root Cause Analysis identifies the root causes...what, how and why the catastrophe occurred.

Unfortunately, confusion often exists about causes because there can be actual or alleged causes all across from proximate cause down to root causes. There are possible ways to try to determine them.

Definitions (NASA, NPR 8621.1A, App. A)
·Proximate Cause. Event(s) that occurred, including any condition(s)that existed immediately before the undesired outcome, directly resulted in its occurrence and, if eliminated or modified, would have prevented the undesired outcome. Also known as the direct cause or causes.

- ·Root Cause. One of multiple factors (events, conditions, or organizational factors) that contributed to or created the proximate cause and subsequent undesired outcome and, if eliminated or modified, would have prevented the undesired outcome.

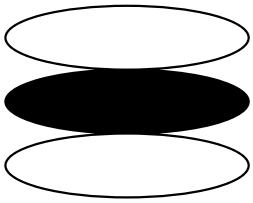
When a loss occurs, there will often be a series of events leading up to the incident and so it is sometimes difficult to determine the nearest efficient or proximate cause. Everything depends upon the circumstances and the facts of the case. It is important to note that the Courts interpret and decide the proximate cause in each case after examining the facts.

In property insurance the need is to find the closest efficient cause and stops there. In liability cases the need of proximate cause is to find out who is to blame so as to fasten liability. In property insurance, normal negligence is considered as a hazard and only when clear evidence emerges that there was gross negligence or misconduct, the matter gets examined further.

If one or more perils operated and one or more of these perils are covered by the Policy, the resultant loss or damage will be covered. In some countries the principle of concurrent causation has come into vogue by which if there is coverage of one peril say storm, but another peril (e.g. flood) is excluded then claim for storm part of the damage is payable. This can generate a conflict, the insurer who covered flood will try to put all the losses on the insurer who covered storm and vice versa – wind vs. water cases. There are also problems of other types if there are multiple covered causes, different deductibles may apply to the various perils concerned. All concerned need to make a decision as to under which peril the claim will be considered (and therefore which deductible will apply). Insurers also will need to find the repercussions of the decision taken as that may affect reinsurers and/or insurers who have covered the risk under parallel policies. Like UK, Indian law also states that if there are two proximate causes, one of which covers the loss and the other peril is an exclusion, then the loss is not payable.

It is important to note that across countries, courts hold that the cause of the loss has to be determined by common sense principles. In the case Acciona Infrastructure Canada Inc. v. Allianz Global Risks US Insurance Company 2014 BCSC 1568, the Supreme Court of British Columbia stated: "In all classes of insurance - marine, fire, accident, casualty - the rule is that the proximate cause alone can be considered. "Direct loss" does not restrict insurance to damage done on the premises. The word "direct", in qualifying "result", does not imply that there can be no step between the cause and the consequence. The cause of the loss has to be determined by common sense principles and by ascertaining what in substance is the cause." The UK Supreme Court in the case Global Process Systems Inc and another (Respondents) v Syarikat Takaful Malaysia Berhad (Appellant) (2011) stated that: "The matter that this is not the test for proximate cause, but that proximate cause is one that which is proximate in efficiency. However, what that means cannot be more clearly stated than in the UK case Bingham LJ put it in T M Noten BV v Harding [1990] Lloyd's Rep 283, 286-287 which ruled that: "Unchallenged and unchallengeable authority shows that this is a question to be answered applying the common sense of a business or seafaring man." The principle that common sense is the basis of understanding principles such as that of proximate cause is repeated across many court rulings.

FAQS ON INSURANCE CLAIMS



1.The insurer is forcing us to sign a full and final discharge voucher and will not allow us to submit a protest for paying us less, as we feel that the indemnity offered is short of what is right. Can we give a full and final discharge and then go for arbitration?

Courts are holding that unless coercion or undue influence is proved – full and final discharge given by an insured cannot be challenged by the insured. The Supreme Court of India in the case New India Ass. Co. Ltd vs Genus Power Inf. Ltd (2014) stated: "9. In our considered view, the plea raised by the respondent is bereft of any details and particulars, and cannot be anything but a bald assertion. Given the fact that there was no protest or demur raised around the time or soon after the letter of subrogation was signed, that the notice dated 31.03.2011 itself was nearly after three weeks and that the financial condition of the respondent was not so precarious that it was left with no alternative but to accept the terms as suggested, we are of the firm view that the discharge in the present case and signing of letter of subrogation were not because of exercise of any undue influence. Such discharge and signing of letter of subrogation was voluntary and free from any coercion or undue influence. In the circumstances, we hold that execution of the letter of subrogation, there was full and final settlement of the claim. Since our answer to the question, whether there was really accord and satisfaction, is in the affirmative, in our view no arbitrable dispute existed so as to exercise power under section 11 of the Act. The High Court was not therefore justified in exercising power under Section 11 of the Act."

The insured has to file protest immediately after the discharge is signed and payment received and in the protest the fact of undue influence and bad faith of the insurer in paying less than what should have been paid, should be clearly recorded with details. If the insurer does not respond, reminders may be sent, to reinforce the record of bad service by the insurer.

2.The insurer has refused to pay our storm claim stating that there was no severe cyclonic storm as claimed by us. Relying upon the Beaufort wind force scale, the insurer insisted that the velocity of the wind has been reported to be only at 32 km per hour and therefore, there was neither Storm nor Hurricane.

In the case M/S.Opg Energy (P) Ltd vs The New India Assurance Company ...(2018), the Madras High Court stated: "To interpret the Policy of Insurance in the way suggested by the Insurance Company in the case on hand would amount to nullifying the very contract of the Insurance. If the Insurance Company is allowed to rely upon the Beaufort scale measurements and deny the claim, the very object of the contract of Insurance would be nullified. As seen from the definition of the word Storm in the New Webster's Dictionary as well as Ramanatha Aiyar's Advanced Law Lexicon, it is clear that the word Storm used is more general in nature and it cannot be confined only to the occurrence of wind with a speed of above 88 kms per hour.

(para15) In United India Insurance Co. Ltd., v. Kiran Combas and Spinners reported in 2007 (1) SCC 368, the Hon'ble Supreme had pointed out that adopting a Hyper Technical meaning to the terms of the Policy with a view to defeat any purpose of the contract of the Insurance cannot be allowed by the Courts."

3.The surveyor appointed by the insurer is highly prejudiced and is likely to provide a report that is highly inaccurate and/or wrong. Can we appoint our own surveyor?

The Surveyor's Regulation states in Sec. 13 (1) "(j) surveying and assessing the loss on behalf of insurer or insured;". This indicates that an insured also may appoint a surveyor and a surveyor can accept the work on behalf of an insured. The Supreme Court of India in the case Sumit Kumar Saha vs Reliance General Insurance (2019) stated in para 17: "The surveyor appointed by the insured was right in deducting 10% and in arriving at the figure of Rs.41,90,940/-. The other issue which weighed with the surveyor appointed by the Insurance Company regarding deduction of salvage value was rightly answered by the National Commission and as such does not require any elaboration."

4.Our claim is being delayed and threatened to be repudiated on the ground that there was negligence on our part, and in view of this, as per the insurer, the claim merits repudiation. What is the position?

The U.S. Court of Appeals for the Fifth Circuit - 117 F.2d 794 (5th Cir. 1941) in the case Federal Ins. Co. et al. v. Tamiami Trail Tours, Inc., et al. stated: "An overwhelming percentage of all insurable losses sustained because of fire can be directly traced to some act or acts of negligence. Were it not for the errant human element, the hazards insured against would be greatly diminished. It is in full appreciation of these conditions that the property owner seeks insurance, and it is after painstaking analysis of them that the insurer fixes his premiums and issues the policies. It is in recognition of this practice that the law requires the insurer to assume the risk of the negligence of the insured and permits recovery by an insured whose negligence proximately caused the loss. In the absence of fraud or gross negligence on the part of the insured, his negligence is no defense against his recovery."

In a Marine matter the US Phœnix Insurance v. Erie & Western Transportation Co. 117 U.S. 312 (1886) 6 S. Ct. 750, stated: "No rule of law or of public policy is violated by allowing a common carrier, like any other person having either the general property or a peculiar interest in goods, to have them insured against the usual perils, and to recover for any loss from such perils, though occasioned by the negligence of his own servants.

By obtaining insurance, he does not diminish his own responsibility to the owners of the goods, but rather increases his means of meeting that responsibility. If it were true that a ship owner, obtaining insurance by general description upon his ship and the goods carried by her, could, in case of the loss of both ship and goods, by perils insured against, and through the negligence of the master and crew, recover of the insurers for the loss of the ship only, and not for the loss of the goods, some trace of the distinction would be found in the books. But the learning and research of counsel have failed to furnish any such precedent."

The Supreme Court of India has the final word. In the case Canara Bank vs M/S United India Insurance Co. Ltd (2020), the SC stated: "16. In any event, neither in the report of M/s. Truth Labs nor in the other reports by the insurance company is there anything to show that the insured had set the cold store on fire. Whether the fire took place by a short circuit or any other reason, as long as insured is not the person who caused the fire, the insurance company cannot escape its liability in terms of the insurance policy. We reject the contention of the insurance company that the fire was ignited by the use of kerosene and hence it is not liable." By this the SC says that arson or attempt at arson as per exclusion is not payable.

INVENTORY LOSS EXCLUSION IN INSURANCE POLICIES

It may be noted that in many insurance policies especially 'all-risk' policies there can be an inventory loss exclusion clause.

The purpose of 'Inventory Loss Exclusion' clause as per courts was "to protect insurers from errors that may be inherent in a business's self-created inventory records (for example, as a result of negligence or improper bookkeeping)." It accomplished that purpose by prohibiting recovery "on proof of inventory loss alone." (American Fire & Cas. Co. v. Burchfield, 232 So.2d 606, 609 (Ala. 1970). However, courts note that the language does not bar the introduction of inventory computation evidence, but it will be only for the purpose of proving the amount of the loss.

The Court of Appeals of Tennessee noted in the case HCA Inc v. American Protection Insurance Co., (2005) that as an exception to coverage, inventory exclusion clauses have been in general use in the insurance industry for half a century. Very often insureds use the inventory shortage, when discovered, owing to physical verification of stock or accounting practices and attribute the same to employee dishonesty. The US courts had to discuss the above exclusion often:

1. Danal Jewelry Co. v. Fireman's Fund Insurance Co., 107 R.I. 33, 264 A.2d 320 (1970). In this case, the Supreme Court of Rhode Island affirmed the trial court finding that Plaintiff had failed to prove that he had sustained a loss due to employee dishonesty. The court noted a conflict of opinion in reported cases as to whether or not the clause was free from ambiguity, noting that the majority rule appeared to be that the clause was indeed unambiguous. Under the majority rule the inventory computations were not admissible in evidence.

A minority of decisions have held the clause to be ambiguous and that such inventory computations were admissible as corroborative evidence of an otherwise established loss. The court then held that the Plaintiff's proof failed the test under either rule and affirmed the judgment of the trial court.

2. Paramount Paper Products Co. v. Aetna Casualty & Surety Co., 182 Neb. 828, 157 N.W.2d 763 (1968). In this case, the trial court sustained Defendant's (insurer's) motion to dismiss the case at the close of Plaintiff's evidence. On appeal the Supreme Court of Nebraska affirmed acknowledging that some evidence of loss existed independently of inventory calculations. The court stated, however, that "in the present case, Plaintiff had knowledge of only two thefts by employees and the merchandise lost as a result of these thefts was all recovered. Consequently, Plaintiff has failed to prove by either direct or circumstantial evidence any loss whatsoever by reason of employee dishonesty. It has simply shown that such dishonesty had existed, and, by inference, it seeks to attribute its entire loss revealed by an inventory computation to employee dishonesty."

3. Dunlop Tire & Rubber Corp. v. Fidelity & Deposit Company of Maryland, 479 F.2d 1243 (2nd Cir.1973). In this case, the trial court dismissed the case on the grounds that Dunlop had failed to prove that the loss was sustained by reason of fraudulent or dishonest acts of Dunlop employees. The court of appeals affirmed the finding that no independent evidence of loss separate and apart from inventory computations existed.

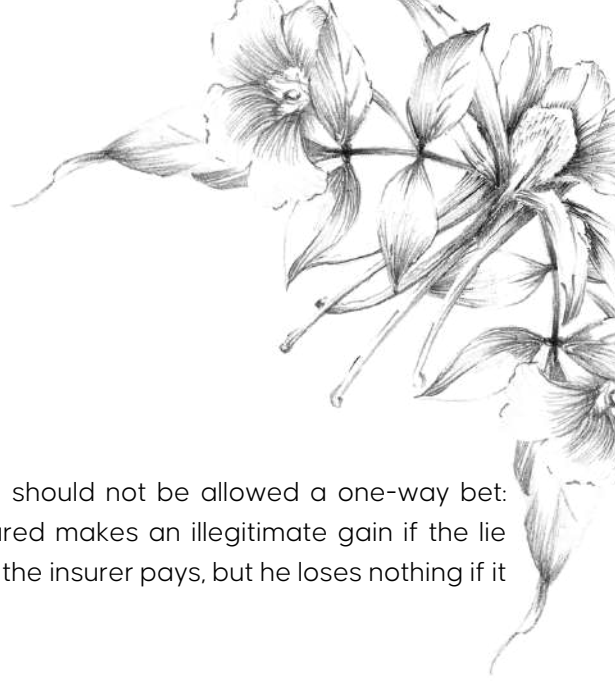
The court observed: "The standard inventory exclusion clause has been the subject of considerable adjudication. In the typical case, the insured has evidence, other than inventory computations, of the factual existence of a loss due to employee dishonesty. The insured, however, does not have independent evidence indicating the full extent of the claimed loss. The courts are divided as to whether under such circumstances, inventory computations may be introduced to prove the full amount of the loss."

Teviro Casuals, Inc. v. American Home Assurance, 81 A.D.2d 814, 439 N.Y.S.2d 145 (1981). In this case a jury trial resulted in a verdict for the plaintiff in the amount of $15,209. Proof by the plaintiff independent of inventory computations reveals that one employee had been convicted of stealing clothing valued at $20. The appellate court reversed and dismissed holding "even under the line of cases permitting inventory computations to prove the full amount of the loss where there is evidence of a loss due to employee dishonesty, which is apparently the majority view, we doubt that such limited evidence of employee dishonesty is legally sufficient under the exclusion clause to permit the use of an inventory computation to establish (1) that there was a loss of thousands of garments and (2) that the loss was attributable to employee dishonesty."

5. Ace Wire & Cable Co. v. Aetna Casualty & Surety Co., 60 N.Y.2d 390, 469 N.Y.S.2d 655, 457 N.E.2d 761 (1983). In this case the Supreme Court, Queens County, granted summary judgment to the defendant under the "inventory computation" exclusion clause of the policy. The appellate division reversed. The Court of Appeals of New York held that, while "some independent evidence" of loss due to employee theft was required before inventory records could be used in corroboration of the loss, such independent evidence actually existed in the plaintiff's proof, and the grant of summary judgment was improper. The court's description of the exclusionary language is enlightening.

Inventory shortage losses are attributed often to employee dishonesty, including fidelity guarantee insurance and/or various sections of the crime insurance policy. It is clear that shortage discovered at the time of stock taking or accounts auding, cannot be attributed to loss under any insurance policy.

REFLECTIONS ON INSURANCE CLAIMS



In the case Versloot Dredging BV and another v HDI Gerling Industrie Versicherung AG and others, [2016] UKSC, the Supreme Court of UK gave important insights into insurance claims.

When an insured makes a claim under his insurance policy, the insured has to be clear that the claim has to be within the cover provided by the policy. Further, the loss has to occur without the involvement or complicity on the part of the insured and that it is not exaggerated as to amount, with a view to take advantage of the loss. In addition, there should not be any breach of any specific warranty in the policy. Such a claim is good in law and would succeed.

The court emphasised the principle that the starting point in law is that it is not a precondition of the insurer's liability that a claim should have been made on them. The insured's right to indemnity arises as soon as the loss is suffered. In this context, a fraud is a forfeiture. Where a claim has been fraudulently exaggerated, the insured's dishonesty is calculated to get him something to which he is not entitled. The courts cannot cut a claim that is affected by fraud or illegality into its legal and illegal parts as per public policy. Hence a fraud claim is not payable, even for the part which has not been affected by the fraud.

However, the situation is different where the insured is trying to obtain no more than what the law would regard as his real entitlement and the lie (untruth) that may have been made, is irrelevant both to the claim as such or to the amount of the claim. In this case the lie is dishonest, but the claim is not. The court noted that the fraudulent claim rule is peculiar to contracts of insurance, because of the traditional concern with the informational asymmetry in policy contractual relationship, and any hiding of material information makes insurers vulnerable and insurance as a public good get destroyed.

The insured should not be allowed a one-way bet: that an insured makes an illegitimate gain if the lie passes and the insurer pays, but he loses nothing if it does not.

The court distinguished between an insurer's assessment of a claim (claim settlement) and that it is quite different in character when the insurer makes assessment of a risk at the underwriting stage. In deciding whether to accept the risk and on what terms, the insurer has a complete discretion. No court will interfere in an underwriters' underwriting judgement. This is because there are no legal standards by which the underwriter's decision can be assessed. It is a pure question of judgment, which the hypothetical prudent insurer may make for good reasons or bad in his own commercial interest. Hence the critical importance of the impact of non-disclosure by an insured on his thought processes.

However, when deciding whether to accept a claim under an existing contract, the insurer's position is very different. He has no discretion, because he is already bound... Ultimately, his assessment is simply an attempt to predict what a court would decide. The court was of the view that the rule of repudiation of fraudulent claims rule cannot be applied to a lie which are not relevant to the correctness of the claim and such claims should be recoverable. Such an action by an insurer would be disproportionately harsh to the insured, because it does not serve any legitimate commercial interest of the insurer that they can justify. It leads naturally to the harsh and anomalous consequences which a court cannot allow.

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