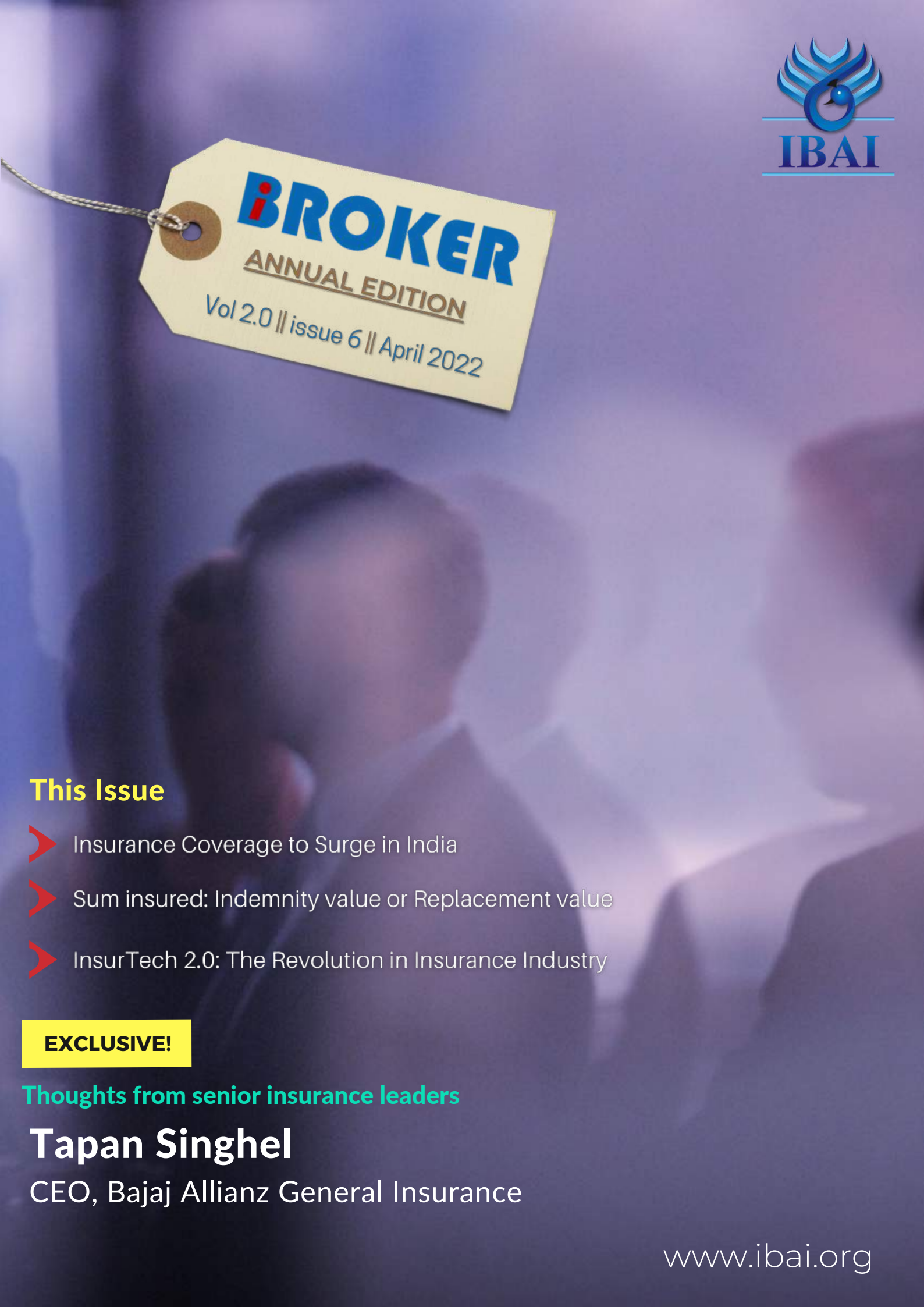


## This Issue

- Insurance Coverage to Surge in India
- Sum insured: Indemnity value or Replacement value
- InsurTech 2.0: The Revolution in Insurance Industry

**EXCLUSIVE!**

**Thoughts from senior insurance leaders**

# Tapan Singhel

CEO, Bajaj Allianz General Insurance

www.ibai.org

# MEET THE MAN WITH A GRIT TO MAKE INDIA INSURED.

**Debasish Panda**

IRDAI Chairman

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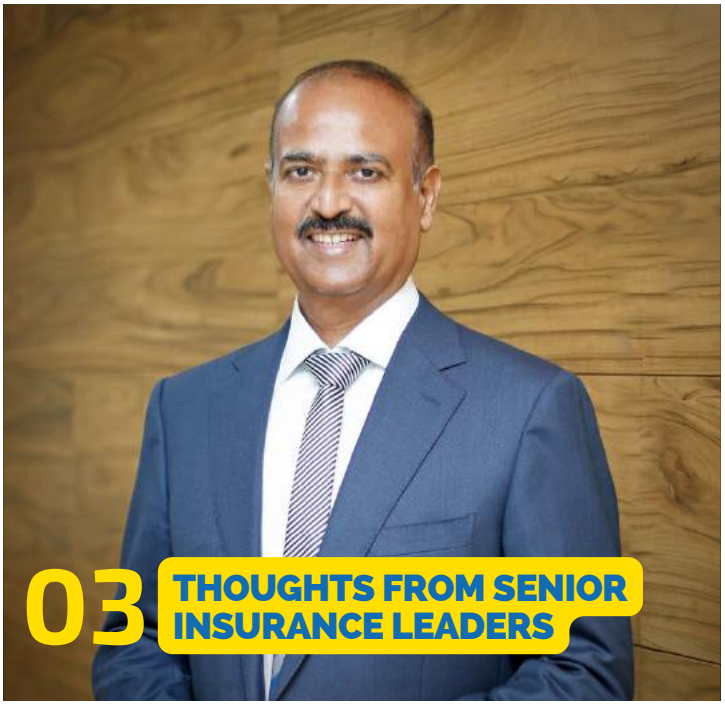
IBROKER

# THIS ANUAL EDITION





PRESIDENT'S MESSAGE

# THE MORE THINGS CHANGE...

This happened in 1990s. It was a Saturday.

Teachers were meeting the parents to share their report cards. The 90s dad wrapped up the meeting with the son's teacher and on his way home, stopped at a medical store to order a few medications. On his way out, he noticed a jar of 5 star chocolate. He asked for one. The store owner was also a fellow parent. He asked him, rather innocently, "Is this because your son did well in school?"
The dad thought for a moment and answered, "This is because he will do well in the future."

His son was within ear shot. Many of us need to hear but don't. His son was at the right place and the right time.

That 90's dad knew something about the Harvard study from the 1950s, Dr. Curt Richter placed rats in a pool of water to test how long they could tread water. On average they'd give up and sink after 15 minutes.

But right before they gave up due to exhaustion, the researchers would pluck them out, dry them off, let them rest for a few minutes — and put them back in for a second round.

In this second try — how long do you think they lasted? Remember — they had just swam until failure only a few short minutes ago... How long do you think?

Another 20 minutes? 7 minutes? No! 60 hours! That's not an error. That's right! 60 hours of swimming.

The conclusion drawn was that since the rats believed that they would eventually be rescued, they could push their bodies way past what they previously thought impossible.
There is an important lesson here, replace the rats with the insurance intermediaries. We have got a second chance with the new regulator in place.
The real challenge for our business is keeping with the change and being resilient. Despite being a sector generally acknowledged as being slow to change, insurance must face up to disruption and changing regulatory environment.

Customer outcomes are a key driver for competition these days and government is keen to regulate where the customer is concerned.

Finally, the much-awaited suspense is over and we had the Chairman of IRDAI Shri Debashish Panda take charge at the Regulators office on 14th March 2022.

He appears to be a man on a mission and would change the age-old traditional practice and lethargy in the system. His goal is very clear and needs maximum penetration through out the country and is ready to take the necessary steps and help us in achieving our dreams.

We were immediately gifted with the perpetual license promise as soon as we had a word with him during our short meeting. We will interact with him in the coming weeks and put across our challenges and plans to take the industry to the next level (remember the rat story above)

I think if we have the right regulatory atmosphere, the Brokers need to make the most of it by spreading their wings and investing in building their organisation.

The year end GI figures for F.Y. 21-22 have been decent although the momentum should pickup with the capex cycle starting and gaining speed in the upcoming year. The overall growth was pegged at 11.03% over the corresponding year with SAHI company delivering the growth of 32.53% and which I feel will continue to grow at the same rate with the awareness and need.

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.

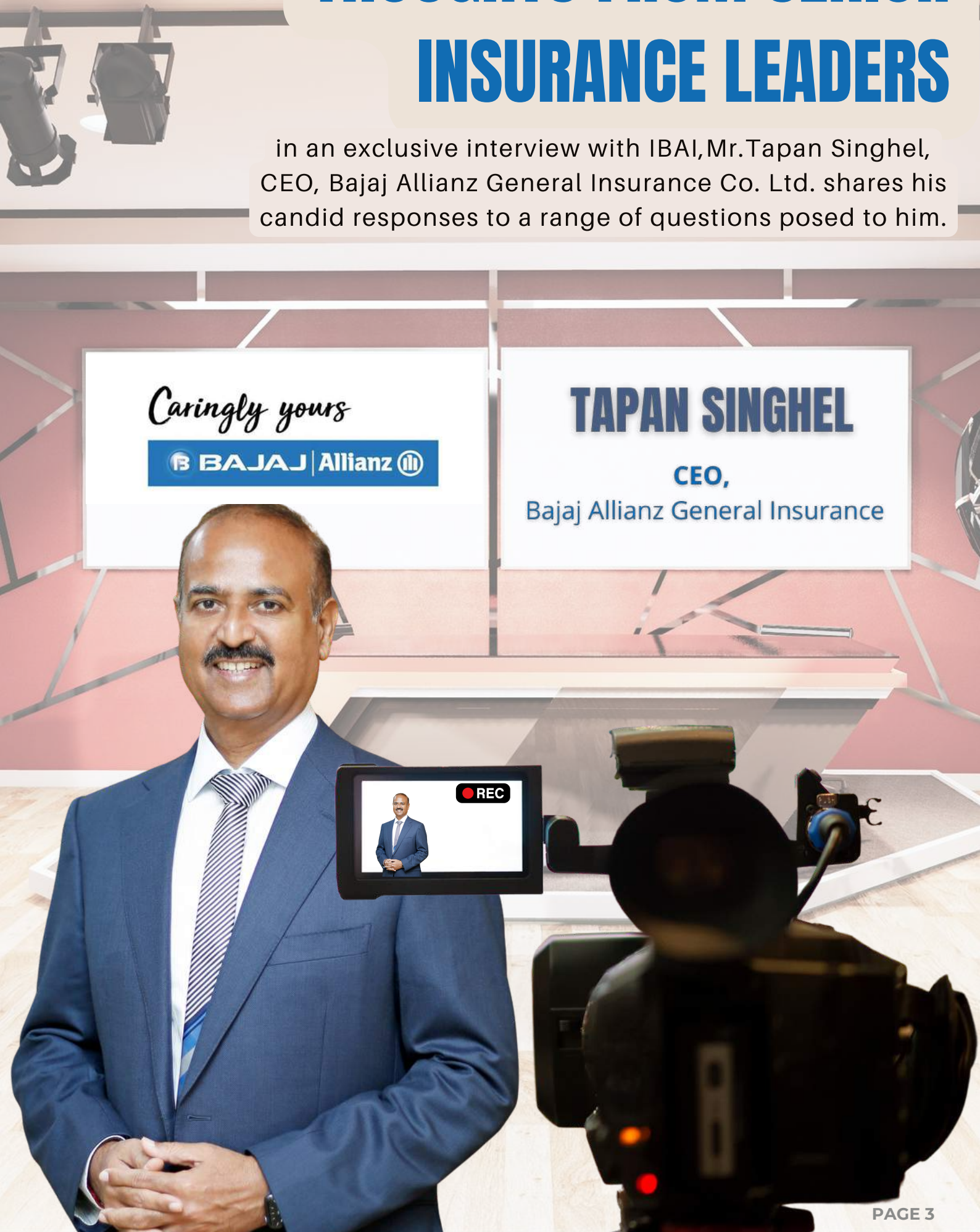
We will be soon launching the
1. New IBAI Website
2. LMS Module for broker qualified person, POSP & MISP
3. Unified platform for Retail Health which will be accessible to all the broker members for quote comparison.

To achieve success, team effort is required. IBAI is up for the challenge and the initials indications are that the regulator is open to a joint approach. We look forward to making it happen

**Sumit Bohra**
President IBAI

# THOUGHTS FROM SENIOR INSURANCE LEADERS

in an exclusive interview with IBAI,Mr.Tapan Singhel, CEO, Bajaj Allianz General Insurance Co. Ltd. shares his candid responses to a range of questions posed to him.



Apart from being a successful CEO who has helmed Bajaj Allianz for a while now, you are a great social media influencer with over 675,000 followers on Linkedin. Your podcast 'Caringly Yours' or 'Tea and Tales' are eagerly looked forward to by viewers. Is this a carefully cultivated approach to aid business or do you have a genuine liking for talking to people and exchanging notes?

I believe that one can learn and imbibe many lessons from others. When I first started using social media, the intent was to be approachable to my customers; as the CEO of a customer-centric organization, I felt I should be easily accessible to my customers, and social media offers that easy access. However, soon I realized that it is an excellent platform to share the life lessons which I have learned, share stories of interesting people that I have met. I thought it is a great medium to share my learnings with the public at large. I have been through various experiences, various phases of life, have met some remarkable people, and all this has shaped me as a person; I wanted to share those insights with a larger public.

As a salesperson, I know that some of the best conversations happen over a cup of tea. I thought, why not hold discussions with some noteworthy, inspiring people, learn from their stories and experiences, that is how 'Tea and Tales' started.

'Caringly Yours' is our attempt to bring back the element of 'Care' in a society which is gradually moving away from its core values and our brand also revolves around the theme of 'Care'. This is our attempt to bring out the concept of care in its truest sense in the format of experiences and stories shared through podcasts.

People may not have time to watch the videos that we share, but a podcast is a convenient medium; people can listen to it on the go.
We keep utilizing various social media platforms to interact with people, and share lessons in the hope that it helps them navigate their journey of life.

Now coming to business, Motor, Health & Agriculture insurance have been the main growth-drivers for the non-life insurance industry in the last few years. In a Covid-ravaged world, which line of business in your opinion will trigger the next phase of growth in the non-life insurance industry in India?

I think health insurance will continue to be one of the drivers of growth for the insurance sector. The pandemic has yet again emphasized the need of having comprehensive health insurance. With the increase in NAT CAT events across the country, the need for property insurance, particularly home insurance is also going to pick up.

*Cont...*

Another line of business that is going to witness a steep rise is liability insurance, with the unprecedented increase of cyber-attacks and the increasing dependency on the virtual world, products like cyber-liability insurance are going to shift from the realm of niche products to mainstream products. Also, liability will play a major role as the predominant element of products in other lines of businesses too, one example that comes to mind is self-driven cars where the vehicle will be navigated through programs or robots, the claims will trigger liability insurance rather than own damage. So liability is going to become a very crucial LOB in near future.

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Profitability of all insurers have been badly hit due to Covid claims and with the pandemic showing signs of weakening (if there be a third wave, it is expected to be less damaging) , claims from deferred hospitalisation treatment for non-Covid claims seem to have picked up. Do you see the tide turning and improved profitability in the second half of this fiscal, though we are already in the last quarter?

Yes, the pandemic had a role to play in increased health claims but irrespective of the pandemic or the market situations, the philosophy of the business matters the most. The organizations that practice prudence in underwriting, operational efficiency, and monitor their costs judiciously, are the companies that will make a profit out of their core business. Bajaj Allianz General Insurance has been one such organization. There might be cyclic up, and downs, which is part of the business but overall business philosophy should not change, companies should generate profits from their core operations and not rely solely on investment incomes. Many organizations believe they can acquire a major market share by burning cash. If you look at the insurance industry, only prudent players, who underwrite risks with caution and have offered best-in-class services to their customers have managed to thrive. I believe this philosophy always works, irrespective of the external factors.

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Bajaj Allianz has done very well since its inception on all parameters be it the mix of retail & corporate business, channel mix and even the flexibility in terms of structure of offices, no doubt, but how do you attract the new generation of insureds be it in retail or on the corporate side who are tech-savvy and look at organisations which are nimble-footed, technologically advanced and who are willing to work as Risk management partners, rather than mere carriers of risk?

We have always believed that customers want solutions, not products. Our products are designed to address the pain points of our customers, be it introducing the country's first individual cyber insurance policy in the wake of rising cyber threats, or brining the first-ever pet dog insurance in the country to help our customers take care of their furry friends. Recently we introduced Health Prime Riders, which offers a holistic health solution to our customers. We have always been at the helm to offer unique solutions; our products are easy to understand and easy to buy. When you offer solutions that add value, the challenge to attract customers minimizes.

One more crucial factor that has helped us attract new-age customers is a strong digital presence. Collaboration with fin-tech and e-commerce players has also helped. Youngsters buy products from these platforms, being present in this space and offering them relevant sachet products is a good entry point to get these customers on board.

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As a corollary, do you think the Property insurance rates introduced by GIC Re with a one-fit solution for all risks in a class, actually acts as a big disincentive for Risk management. Better managed risks do not get better terms and disillusions clients who focus on risk management. What are your thoughts in this regard so that clients spend time and money on risk improvements?

Before 2007, there were fixed rates for properties irrespective of the risk management measures taken by clients; there were fixed discounts for certain risk management measures. However, there was a standardization based on the industry this lasted till the de-tariffing happened. De-tariffing should have led to product innovation, a rise of new risk management tools, but instead, it led to a price war with discounting going to 99%; obviously, someone had to step in to stop this blood bath. We always maintained that we must charge the right price for the risk and not just play on price, but somehow price became the only point of discussion. But fixed IIB rates is not the long-term solution; I have always believed that the free market should decide the rates. From the perspective of maintaining a decent balance sheet, this is good. However, from the perspective of a free market this is something that requires a re-evaluation.

Since prices are more or less defined, now the onus is on the insurer to provide the best risk-management solutions to the clients. The differentiator will be hyper speed of claims settlement, best risk management solutions right from pre-inspection to risk assessment to providing post-assessment reports. Insurers and brokers have to offer risk consultancy, valuable inputs over and above insurance.

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 a mammoth task in itself. 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 is Bajaj Allianz doing to make the whole process of claim management a better experience for the clients? How do you keep raising the bar as client expectation soar?

Payment of claims is the moment of truth for the customer, a policy is nothing but a promise. I think the distrust towards the insurance industry is a result of a few bad or negative experiences getting highlighted and the positive experiences not getting highlighted at all. It is the job of the insurers to pay claims, and the industry is doing this very well. On average, the industry has a combined ratio of 115-120%, is paying huge claims, the numbers prove that the industry pays claims. But the industry does not speak about it, to the extent it should.

We at BAGIC aim to be the best claims-paying company in the country, with this in mind we came up with initiatives like Motor On the Spot settlement (MOTS), where claims up to a certain amount get settled in minutes. We were the first to start the concept of cashless settlement in health insurance, and now it has become an industry standard.

Claims can also be registered and processed through our Caringly Yours app, which is an all-in-one mobile app where customers can do an end to end management of their policies. We also integrated our AI-enabled chatbot, BOING on WhatsApp, which facilitates customers to register claims without waiting in the IVR queue. Reimbursement claims too can be settled through soft copies, which can be uploaded on mobile apps, to start the claims process by the time hard copies are couriered. We are heavily using new-age technologies and digitalization to bring down the claim settlement TAT from hours to minutes, as a result of these technologically driven initiatives, our claims settlement TAT and grievance ratio is amongst the lowest in the industry and our NPS is amongst the highest in the industry.

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

Yes, up until a few years ago, there was some shortage of talent in the industry, but gradually the gap is filling up. Many universities and colleges have introduced courses on core-insurance subjects.

Today, many talented youngsters are joining the industry, many of whom have studied insurance and risk management at the academic level. Institutes like III are contributing to the talent that is coming into the industry.

*Cont...*

Attracting good talent has always been complex, more so in today's time when there is no dearth of options for the candidates. Today's youth look for agility in jobs; they are digital natives who look for virtual comfort and enjoy working in collaboration, they prefer to work in gigs, and the insurance industry can offer all this. The industry has opportunities for people from diverse academic backgrounds, be it engineers, doctors, marketing professionals, data enthusiasts, you name it. The industry holds unimaginable potential, and it is going to become one of the biggest employers that the country has been.

Today, the insurance industry is heading for exciting times; the institutes imparting insurance education must work in close association with insurance companies, understand the market requirements and keep updating their course curriculum. We, at BAGIC, tie-up with the select institutes, to offer modules and short courses to ensure that students are market-ready when they enter the industry.

IBAI

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?

Brokers are one of the most powerful distribution channels in the industry, licensed by the regulator. Their expertise lies in insurance and risk management; they help clients to map their risks, find appropriate solutions to cover the risk exposures thus helping clients protect their balance sheets.

Brokers are engaged by the clients to support their insurance solutions programs, help them customize their insurance covers, help design the policies with relevant covers, and much more. Brokers are not only the best advisors of their clients, but they also play a significant role in ensuring the economic well-being and security of society at large. Thus the expectations are that they should serve the customers very well, right from risk management to assisting in claims settlement, right from providing effective insurance solutions to bringing best international practices in India.

*IBAI thanks for your valuable time and views and also wishing a wonderful financial year to the entire Bajaj Allianz General Insurance team on behalf the all Insurance brokers*

# INSURANCE COVERAGE TO SURGE IN INDIA

What should be the ultimate size of insurance in the Indian economy. One cannot look at a prophet- like prediction, but one can easily read the figures of the leading insurance country in the world – the USA – and make our own extrapolative projections.

The 2021 Insurance Fact Book published by the Insurance Information Institute of USA gives figures relating to 2019. The net premium written in the US totalled US$ 1.32 trillion of which 48.4% was Property & Casualty (P/C) and Life and Accident (L/A) was 51.6%. The P/C 637.7 billion US$. (One dollar is around Rs. 75.00 and one billion is 1000 million or 100 crores). In 2019 there were 5965 insurance companies in the US which included 2496 P/C companies, 837 L/A companies, 952 Health insurers etc. Insurance companies contributed almost US$ 630 billion or 2.9% to the US GDP as per US Bureau of Economic Analysis. The premium taxes paid in 2019 was $23.6 billion or $ 72 for every person in the USA. The US insurance industry employed 2.8 million people of which 1.6 million for insurers and 1.2 for brokers, insurance agencies and other insurance related companies.

The above statistics indicate the place of insurance in society. Insurance Protection business has thus to surge in India at a rapid pace to grow the economy and reach global levels. As per the 2021 Insurance Fact Book, India does not figure in the top ten countries in insurance rankings. The honour belongs to USA, PR China, Japan, UK, France, Germany, South Korea, Italy, Canada and Taiwan, in that order.

Insurance offers far too many benefits to the economy which is yet to be properly understood by insurers and insurance intermediaries. Insurance not only indemnifies and protects, it seriously studies loss exposures and works on reducing them in the economy. Insurance acts as contingent capital, and hence when losses come down and/or losses are indemnified in full, the risk of doing businesses falls and this is important in economies when entrepreneurship is the key to development.

It protects everyone in the economic value chain – owners, financiers, employees, the public (third parties), as also investors, who can sue for errors and omissions of managements. It supports social welfare when it enforces employee protection and third-party insurance across activities and actions of organisations and persons (errors and omissions), covers the health disasters of companies and families etc.

The recent initiatives by policy makers in India have given a big boost in insurance. It began with a massive insurance push in agriculture insurance. Apart from the sudden growth of premium, the portfolio is seeing the infusion of technology and other inputs to make the cover an empowerment tool for the cultivator and the agriculture economy. More recently, the thrust has been in the health risk area. Health risks have been ballooning and 'out of pocket' payments for health disasters are all too common. Too many families were being reduced to a state pf perennial poverty by health disasters. Almost all the poor in India (approx. 500 million of them) was intended to be covered by the Central or State Government schemes. Hence the talk now is that while the rich and the poor has been covered, there is now a huge missing middle in health insurance.

The inclusion of compulsory insurance for protection of the title to the land by the property buyer in the RERA Act was welcomed, coupled with 'housing for all' being promised. Again, Sec. 83 of the new Consumer Protection Bill 2018 states that "A product liability action may be brought by a complainant against a product manufacturer or a product service provider or a product seller, as the case may be, for any harm caused to him on account of a defective product." Such lability protecting legislations will keep growing so that negligence, errors and omissions and other actions that are injurious to the public as third parties are made available to hasten orderly economic growth and public protection.

**Role of the Intermediaries in promoting a surge in insurance**

Insurers can be the value multipliers in the insurance sector. There is a need to make intermediaries visible and tangible before the uninsured population. It is well known that it is the policyholders who pay commissions through insurers. This realisation should empower intermediaries in offering in full the life-cycle value of insurance especially to the retail policyholder. There are many values that only the intermediary can offer to both parties in an insurance contract, i.e., the insured and the insurer.

| VALUE | CUSTOMER | INSURER |
|---|---|---|
| **Create a win-win in insurance** | Give the best insurance fit to the customer | Give an insurable (good) customer to the insurer |
| **Give the needed motivational push to the customer/insurer** | Customers may not enjoy buying insurance – give the consumer the motivational push to buy | Be the first line underwriter to insurer. Make the customer desirable to the insurer |
| **Reducing costs for insured and insurer** | Lower the search costs of the customer | Reduce the 'total' risk cost for the insurer |
| **Offer the best buy for the customer/ help the insurer to right price the risk** | Understand customer need and fit the product as best buy for the customer. | Help to price risk more accurately in the true spirit of risk-based insurance |
| **Reduce the uncertainty costs for the customer and insurer** | Reduce the complexity of products. Hand-hold the customer across the product cycle. | Reduce the frictional costs of insurance, provide comfort to both parties |
| **Smoothen procedural hassles, reduce risks** | Help customer to cross all procedural hassles when taking insurance. | Disclose the behavioural aspects of the insured's risk, |
| **Exemplary claim handling** | Handhold the customer to speed assessment and settlement. | Help insurer to speed settlement, adhering to proper indemnity principles |
| **Cross-sell and upsell products to the customer** | Widen and deepen relationships and benefits of insuring | Improve the 'book' of the insurer |
| **Make the product 'live' for the customer** | Provide transparency and use for the products purchased. | Help to carry out feedback & research inputs for the insurer |
| **Add relational value to customer** | Shield the customer against the actuarial and bureaucratic mind-set of the insurer | Help the competitiveness of the insurer by life-time tie with the customer |
| **Take the customer up the protection value chain** | Help the customer to evolve with the changes regarding better products and prices | Ensure the life time revenue and profits from the relationship |

*Intermediaries now have the role to bring the magic wand to the insurance sector to make it grow and flourish. There is a debate as whether insurance penetration brings development to a country or whether development comes first and insurance growth comes as a result of that. Intermediaries should bet on the first proposition – "we will make the country a developed one by providing protection and reducing risks in the economy in the shortest time".*

# WHAT IS CYBER INSURANCE

## & HOW IT CAN AFFECT YOUR ENTERPRISES

**Gurunathan V,**
Director and CEO,
TVS Insurance Broking Limited.

As Enterprises, Government and Public rely more on digitalisation, cyber security is very pivotal and critical for all organisations and individuals to function nowadays.

Cybercrime has been rising over the past 12 to 18 months, affecting businesses of all nature and sizes where the reliability on data network is the basis of operations. Cybersecurity also occupies the prime position in a company's major governance concern, with the data as the most valuable one, for the investors and other stakeholders, with pandemic bringing in a wave of innovations and disruptions in the markets. As more companies have shifted to work from home, the database breaches and hacking attacks have led to loss of businesses across industries. Nowadays, even the best of system with security may still be breached through cyberattacks. Sources say that almost 26000 Indian websites have been hacked in a 10 month period ended October. The attackers may compromise computer systems in different parts of the world with hidden identities.

Though cybersecurity is unique to every business, most of them have some common trails. Weak Passwords, being the common cause for many attacks, unprotected passwords and passwords not changed regularly are very vulnerable for attacks. Different types of malwares contribute to the biggest breaches, due to the out-of-date antivirus software. Working in unsecured environments, like a common Wi-Fi network, usage of private emails and the USB drives can be vulnerable points of attacks for breaches, if used in Organisation networks. It is purely in the hands of the Organisation to take the right steps to prevent and counteract potential threats. Organisations should train employees to have strong password, following proper protocols of passwords and also should ensure the firewalls are secured to resist any malware attacks by installing regular software updates, periodically. This is why, a VPN is being insisted in organisations to make the hacking difficult.

It is very bewildering to know what can happen by an attack viz., by using the network systems and the internet, the individual's or any corporate identity can be stolen.

There can be Internal Threats through employee negligence and employee ignorance and External Threats through former employees, competitors, hackers who steal corporate data and money through email spoofing and fishing, by asking for ransom and terror attacks through IT systems. Obviously, these will trigger the Reputational damage, Financial Loss, Lawsuits with Litigations, Regulatory investigations, above all Loss of Clients and thereby Revenue. Ransomware attacks continue to evolve in the market with the last 8 to 10 months seeing the highest numbers with threats to expose sensitive data. For eg., World's leading popular social platform suffered a data breach whereby millions of profiles were sold on the dark web, containing email addresses, names, IDs, dates of birth, and phone numbers. In another incident, a largest foreign bank by assets was hacked and targeted in ATM fraud in a foreign territory. The bank suffered a financial loss from withdrawals. Insurers add Crime policy also to cover any employee collusions. Ransom attackers can expose the employees' HR files or clients' vulnerable data.

There are Cyber Insurance solutions available in the market which protect against losses caused by cyberattacks including first party, third party losses and cyber extortions. First Party covers the Electronic Theft loss, Electronic Communication Loss, Electronic Threat loss, E Vandalism loss, Business Interruption (income loss due to fraudulent access causing impairment of operations), etc., Third party loss covers Disclosure liability (any customer claim due to system security failures resulting in unauthorised access), Content liability (for alleged copy right or infringement), Reputational Liability, Conduit Liability, etc., Expenses cover provides a gamut of Privacy Notification Expenses, Crisis expenses, Reward expenses, etc., Few insurers even provide cover for proactive forensic services for any threat situation, if there is a likely one.

Company should understand why the organisation needs Cyber insurance solution, instead of just getting a cyber insurance cover. Cyber insurance help cover legal expenses, in a situation of damages due to cyberattack. Cyber insurance should be part of the Company's overall business continuity strategy, because this helps the company to quickly recover post an incident as the company need not pay hefty business interruption services. Ability to identify whether an attack has occurred and to quickly shield are few underwriting principles of the insurers.

Insurers make a thorough meticulous due diligence through proposal forms, interactions, network diagrams and the cyber strategies of the company before providing a Cyber insurance cover. Insurers, as part of their study, check the processes of MFA (Multifactor Authentication), tested backups, how networks are monitored and logged in and the users whether employees and / or vendors.

**Gurunathan V**

Buying a cyber insurance is not enough, but the company should ensure strict protocols, teach and train the employees on the digital hygiene. Proactive risk management strategies viz., using Complex Strong passwords which cannot be easily guessed, not writing passwords in papers or giving it to colleagues or friends, updating passwords, Multi Factor Authentication, proper Firewall use, Physical Security controls like implementing access controls over servers and routers, preventing remote employees from using unsecured devises for sensitive business and asking them to work in VPN, Regular Software Updates, Administrative access to only few important employees can be good examples of good digital behaviour. These are important underwriting points to provide cyber insurance by the insurers.

Due to the heavy ransomware exposures, the insurers provide the cover only to companies depending on the sector, profile and digital behaviour of the company. Insurers look for Turnover of the company, Individual IT devices, any personal identifiable information, any system or network outsourcing and if so regular system audits, IT Security, Policies on Information Governance and Compliance, any Encryption protection usage, Malware and Patch Management, Application and Network Security, Access Control, Security Awareness to provide a cover.

Thanks to work from home situations, insurers have brought out products for individuals too at reasonable premium levels, apart from the Business Enterprises solutions. While the cost of the cover for Companies may be obtained at approximately around 4 to 5% of the limit applied for, Retail Cyber products come with the individual cover and with add ons like with family or also with protection of digital assets from malware with limits of liability ranging from 50000 to 1 Cr., at prices ranging from Rs. 1500 to Rs. 15000 with different range of limits of liability. This can be very useful in the event of any retail cyber breach. Many insurers are coming up with attractive premium levels. The exclusions can be any deliberate fraudulent or wilful violation, patents, unlawfully collected data, unsolicited correspondences, to name a few.

Insurance cover is always to ensure good risk management and prevention of loss challenges. Said that, a clear written incidence planning and testing drills are crucial to minimise the attacks. A capsuled cyber insurance and the maturity of the company both are important because companies using best of practices with impeccable technical solutions and systems may still be vulnerable in these modern-day cyber environments.


Taking cover from
cyberattacks
Insurers have come up with products for both individuals and business enterprises at attractive premium rates

Author's article was published by The Hindu on 11th April 2022

# In Need for Simpler Policy Wordings & Interpretations

Courts are not happy when policies run long and the exclusions which are at some distant place in the policy erase the coverage given earlier.

In the case The Financial Conduct Authority v Arch Insurance (UK) Ltd and others [2021] UKSC 1 the UK SC stated: "In any event, the overriding question is how the words of the contract would be understood by a reasonable person. In the case of an insurance policy of the present kind, sold principally to SMEs, the person to whom the document should be taken to be addressed is not a pedantic lawyer who will subject the entire policy wording to a minute textual analysis (cf Jumbo King Ltd v Faithful Properties Ltd (1999) 2 HKCFAR 279, para 59). It is an ordinary policyholder who, on entering into the contract, is taken to have read through the policy conscientiously in order to understand what cover they were getting.

The notion that such a policyholder who is presumed to have reached p 93 of the RSA policy wording would understand the general exclusion of contamination or pollution and kindred risks on that page to be removing a substantial part of the cover for business interruption loss that was ostensibly conferred on p 38 is as unreasonable as it is unrealistic."

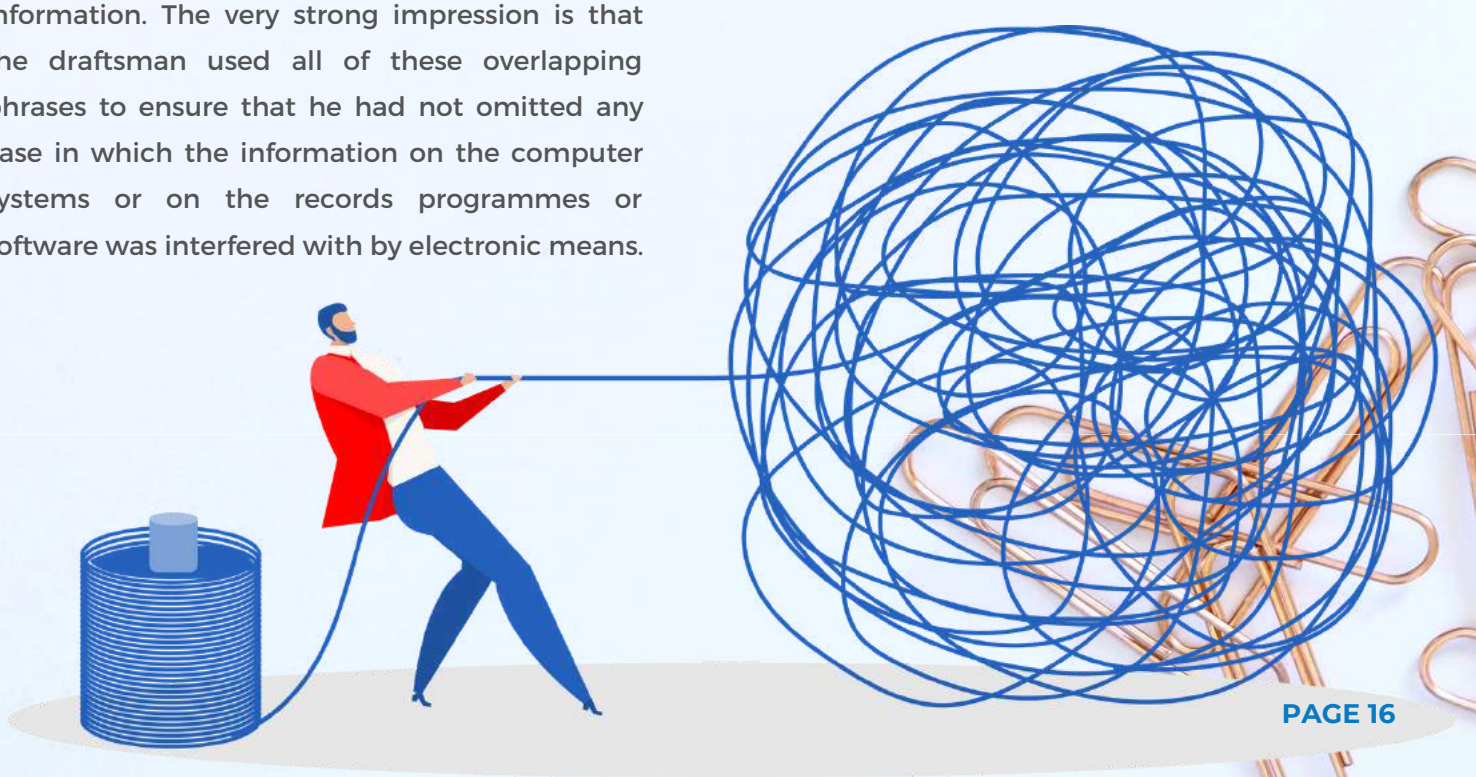
In the case Champion Internat'l Corp. v. Continental Cas. Co., 400 F. Supp. 978 (S.D.N.Y. 1975), US District Court for the Southern District of New York stated: "Insurance companies could prepare policies in clear, simple and precise language which would inform insureds of the limits of their coverage. Insurance companies could avoid the risk of ambiguity if they use short and precise words and short and simple sentences to express their intent clearly. In spite of continued admonitions of the courts to get rid of such language, insurance companies continue to issue such policies using insurance jargon and verbose and meaningless generalities, all of which result in ambiguities."

In the case Steven v. Fidelity & Casualty Co., 58 Cal.2d 862 (1962) SC California (USA), the court observed: “It is a matter almost of common knowledge that a very small percentage of policy-holders are actually cognizant of the provisions of their policies and many of them are ignorant of the names of the companies issuing the said policies. The policies are prepared by the experts of the companies, they are highly technical in their phraseology, they are complicated and voluminous--the one before us covering thirteen pages of the transcript--and in their numerous conditions and stipulations furnishing what sometimes may be veritable traps for the unwary." (P. 230.)”

**Insurer – Linguistic Overkill**

In the case Tektrol Ltd v International Insurance Company of Hanover Ltd & Anor [2005] EWCA Civ 845 the England and Wales Court of Appeal (Civil Division) commented on this as follows: 15. “I consider that that attributes to the draftsman too precise a use of language. There are already redundancies or potential redundancies in the clause: in particular, one would be hard pressed to provide a definition of the two terms that clearly distinguished "distortion" of computer information from "corruption" of computer information. The very strong impression is that the draftsman used all of these overlapping phrases to ensure that he had not omitted any case in which the information on the computer systems or on the records programmes or software was interfered with by electronic means.

The technique used in this clause appears very clearly to be that which has been identified by Lord Hoffmann in two cases that he heard respectively as a puisne judge and when sitting in this court. Speaking of the drafting technique in leases he said in Tea Trade Properties Ltd v CIN Properties Ltd [1990] 1 EGLR 155: "The draftsmen traditionally employ linguistic overkill and try to obliterate the conceptual target by using a number of phrases expressing more or less the same idea." And in the context of insurance he said of an agreement between Lloyd's names and underwriters in Arbuthnott v Fagan [1995] CLC 1396: "In a document like this, however, little weight should be given to an argument based on redundancy. It is a common consequence of a determination to make sure that one has obliterated the conceptual target. The draftsman wanted to leave no loophole for counter-attack.....It is no justification for construing the language so as to apply to a situation which, on a fair reading of the general purpose of the clause was not within the target area."



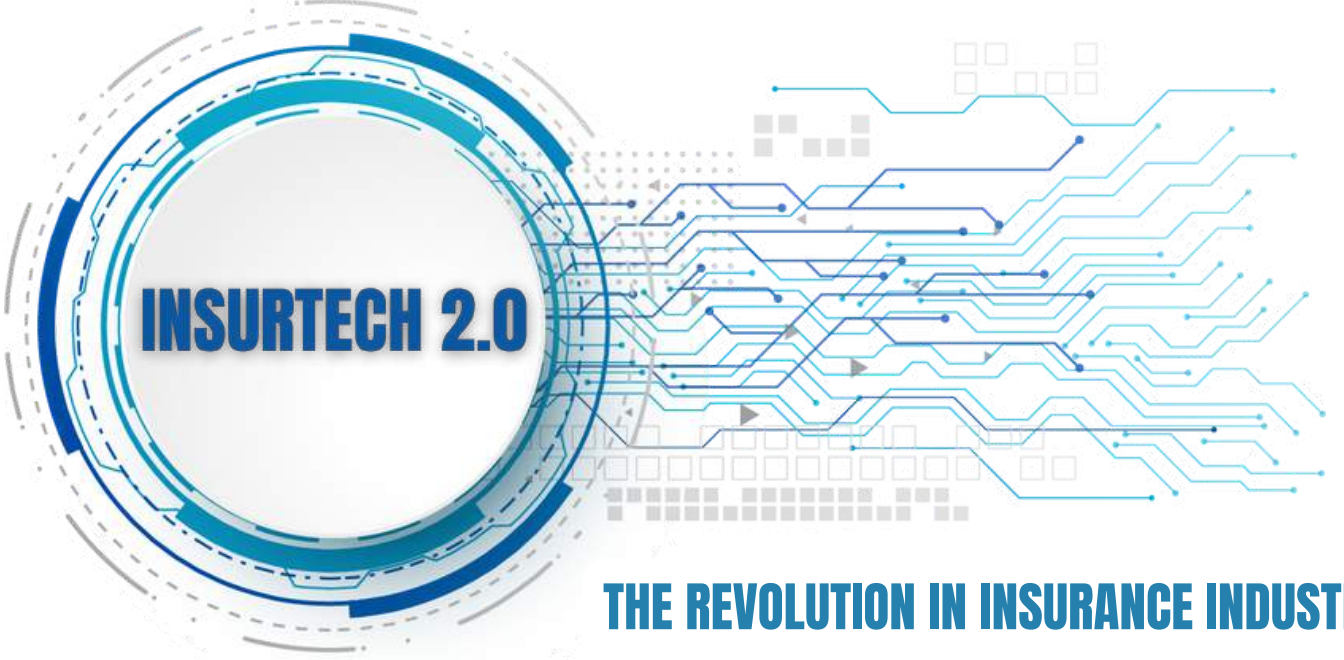
## Understanding Policy Terms when a Claim Occurs

Courts are clear that layman's understanding of terms unless they are technical and defined in the policy. For example, the concept of fortuity is well explained in the case Standard Structural Steel v. Bethlehem Steel Corp., 597 F. Supp. 164 (D. Conn. 1984) by the United States District Court, D. Connecticut. It stated that "A fortuitous event is one which occurs accidentally, as a layman, and not a technician or scientist would understand that term.... It is an event "which happens by chance ..., unexpectedly or without known cause, [one which is] undesigned [,]" or unplanned... An event which is certain to take place or is inevitable cannot be fortuitous, but a court must exercise restraint in its determination of whether an event was inevitable...It must also gauge inevitability by standing in the shoes of the parties at the time the contract of insurance was made."

Washington Supreme Court, in the case McDonald v. State Farm Fire & Cas. Co., 119 Wn.2d 724, 837 P.2d 1000 (1992) stated: "Insurance policy language must be interpreted in accord with the way it would be understood by the average person".

The UKSC in the case Global Process Systems Inc and another (Respondents) v Syarikat Takaful Malaysia Berhad (Appellant), [2011] UKSC 5 was equally clear: "19. Although there were some authorities before the Marine Insurance Act 1906 that appeared to proceed upon the basis that the relevant cause was that closest in time to the loss, it is now well settled that this is not the test for proximate cause: Leyland Shipping Co Ltd v Norwich Union Fire Insurance Society Ltd [1918] AC 350. The proximate cause is that which is proximate in efficiency; and, as Bingham LJ put it in T M Noten BV v Harding [1990] Lloyd's Rep 283, 286-287: "Unchallenged and unchallengeable authority shows that this is a question to be answered applying the common sense of a business or seafaring man."

The Supreme Court of India also in the case United India Insurance Co. Ltd vs M/s Harchand Rai Chandan Lal (2004) stated: "But before parting with the case we would like to observe that the terms of the policy as laid down by the Insurance Company should be suitably amended by the Insurance Company so as to make it more viable and facilitate the claimants to make their claim."




# THE REVOLUTION IN INSURANCE INDUSTRY

Over the last few years, the wave of digitisation has reshaped the entire business canvas. Today, almost every player in the market is trying to make a mark of its own by leveraging emerging technologies. The Covid-19 pandemic has further propelled the pace of this transition by making digitisation the ultimate solution for business operation and customer outreach

A reflection of this technological shift has also been observed in the insurance domain. Be it legacy insurance companies or new-age insurance startups like us, every organisation is modernising its core technology in an effort to become more efficient as well as effective.

One of the most notable global technological trends in the InsurTech space has undoubtedly been artificial intelligence (AI). Today, AI has re-engineered predictive analytics and modelling of customer behaviour.

It has enabled InsurTechs to build a model that allows for higher-quality touchpoints with customers. As per a GlobalData forecast, AI platform revenues within insurance are expected to grow to a staggering USD 3.4 billion by 2024.

Besides AI, our industry is also adopting wearable technology to monitor the physical activity of its customers via mobile applications in a bid to mitigate risks by accurately assessing relevant data. This global trend is also parallelly adding volumes to various dimensions of the healthcare sector.

**InsurTech - A Potential Game Changer for the Industry**

InsurTechs are being viewed as a potential game-changer and emerging leader of the ongoing FinTech revolution. According to a Swiss Re report, the global insurance premium values are expected to transcend from the current USD 5 trillion to USD 7 trillion by the end of the year 2022.

Be it digitally-enabled insurance selling processes, use of algorithms for right customer profiling, adoption of Natural Language Processing (NLP) based chat modules for faster customer assistance or integration of machine learning with conventional underwriting methods, InsurTech startups have overhauled the entire insurance territory.

**Ankit Kumar Agrawal,**
CEO,
Girnar Insurance Brokers Pvt Ltd.

A lot of success of InsurTechs can be attributed to the fact that today we live in a 'Phygital' Era wherein technology helps us combine the interpersonal touch of insurance consultancy with the latest technologies to make insurance buying a cakewalk for older as well as newer generations.

In this dual setup, customers get to enjoy the best of both worlds - personalised advice and face-to-face interactions with insurance agents which strengthen their belief that they are spending their money wisely as well as with all the comforts of digital processes such as easy policy comparison and documentation.

**InsurTech Enhancing the Customer Experience**

Insurance products have often been subject to the prejudice of being complex in nature. However, with InsurTechs in the field, insurance products have become simpler for customers, which has, in turn, enriched their pre as well as post insurance buying experience.

Infact, it won't be wrong to say that after the emergence of InsurTechs, the customer expectations from our industry have completely changed. Today, the customer is not forced to go through lengthy paperwork or does not find themselves being overwhelmed with technical jargons as with digitisation, every process and detail is available online; things have become simpler and more accessible than before. I can say that this has been possible as we have struck the four most critical aspects of customer satisfaction correctly, that are simplicity, speed, transparency, and quality.

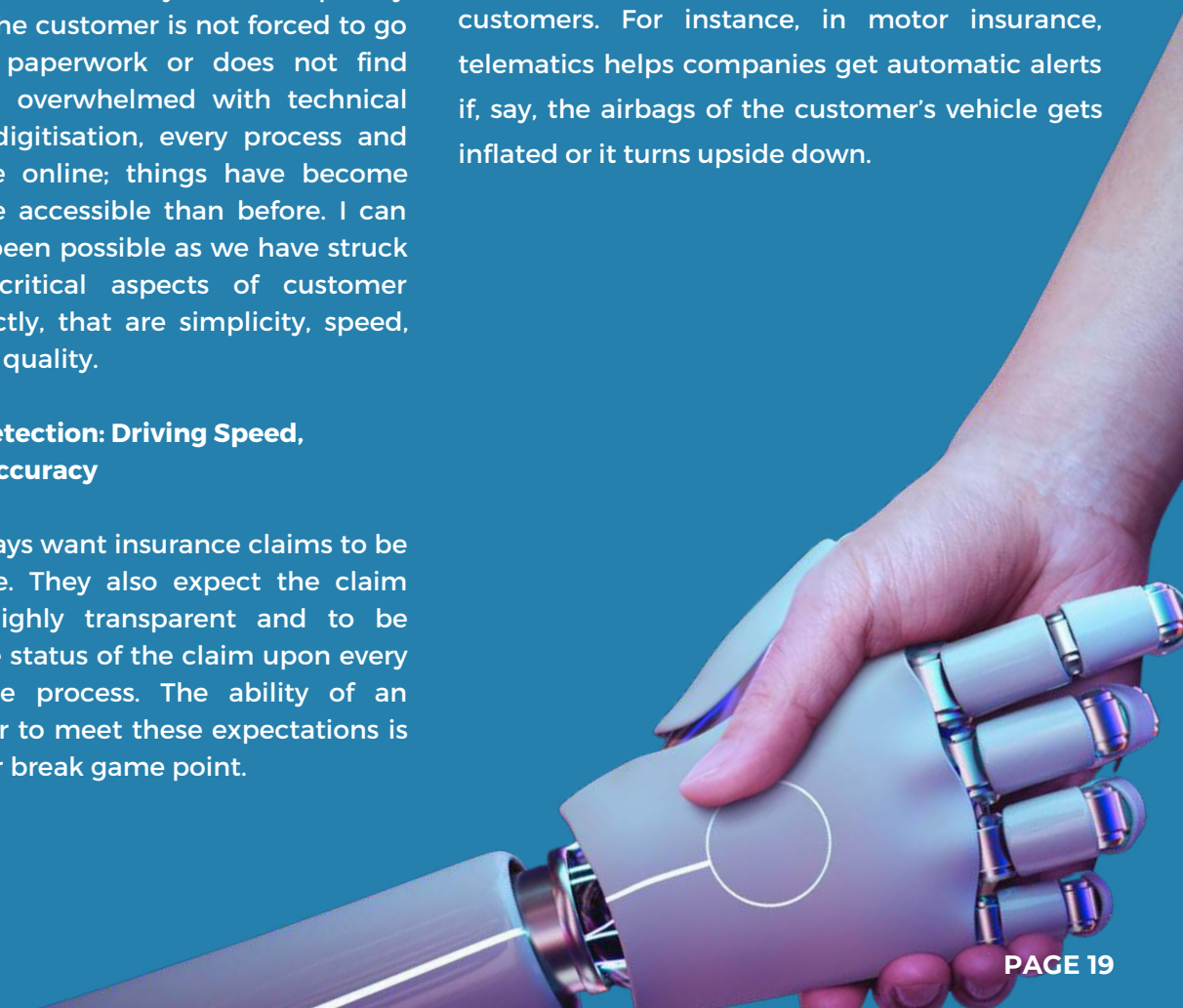
**Claims & Fraud Detection: Driving Speed, Transparency & Accuracy**

Policyholders always want insurance claims to be easy and intuitive. They also expect the claim process to be highly transparent and to be notified about the status of the claim upon every movement in the process. The ability of an insurance provider to meet these expectations is the entire make or break game point.

And one of the major challenges in this regard is the possibility of a claim being a fraudulent one. And previously, the detection of these fraud claims was highly dependent on insurance agents who relied on intuitions to a large extent due to the limited availability of data with them.

But today, detection of fraudulent claims and their accuracy is being taken care of by technologies like Machine Learning which detects the genuineness of a claim by comparing it with previously registered fraudulent claims. These ML models identify common parameters of fraud claims and flag suspicious claims, enhancing fraud detection and accelerating their processing time. According to a Mckinsey report, the automation of the claims journey itself can reduce businesses' process costs by as much as 30% and frauds by 4%.

Another significant tech in this regard is IoT (Internet of Things) which helps players like us to get notified about any damage incurred by the customers. For instance, in motor insurance, telematics helps companies get automatic alerts if, say, the airbags of the customer's vehicle gets inflated or it turns upside down.



**InsurTech Disrupting the Traditional Value Chain?**

InsurTechs have certainly disrupted the traditional value chain of the insurance industry. The upcoming technologies and their implementation in our day-to-day processes have shifted the business orientation from a linear process to a dynamic one, which is highly driven by data and consumer behaviour.

The new value chain proposition of the insurance space is dominated by the evolving habits and needs of the customers which continuously push us to enhance our offerings, unlike before when the concentration was on providing a protection solution.

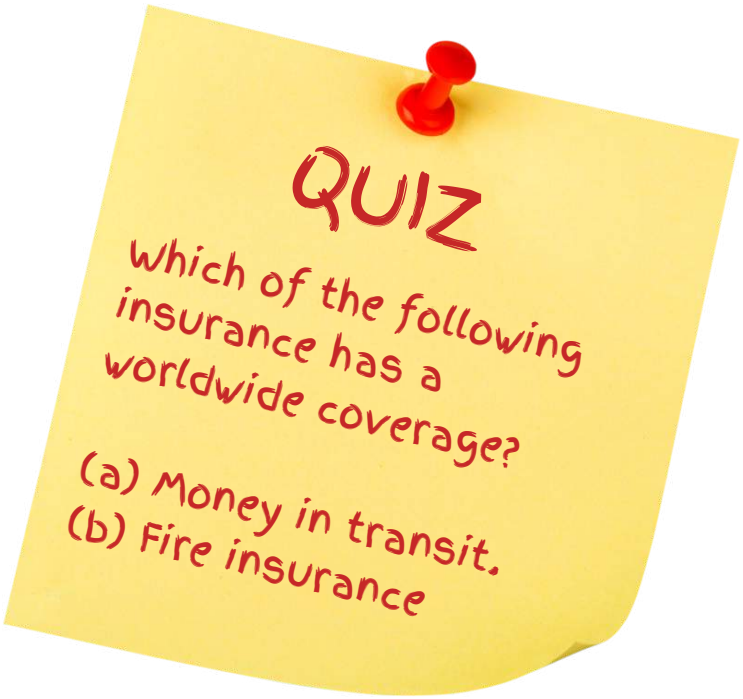
I believe this shift to a prevention and prediction model will help insurance providers to expand the lifecycle of their customer interactions and strategise their products and services.

**Innovative Strategy Towards Protecting Millions of Happy Customers**

InsurTechs are continuously adopting innovative strategies to keep customers protected against the risk of cyber-attacks and data leakages. For this, our industry is now extensively relying on virtual solutions for daily business operations. We are also making use of preemptive incident-response platforms to shorten their response time against cyber attacks and to provide immediate solutions with no or minimal loss.

Internally also, InsurTechs are making use of cloud infrastructure security to determine security posture, model standard cyber policies, detect misconfigurations, and protect their data against attacks and insider threats.

All-in-all, InsurTechs are paving the way for a brighter future for insurance, not only in India but all over the world. In the times to come, we can expect the insurance penetration rate to pump up across regions, along with the level of accuracy and efficiency in business operations and convenience and awareness among insurance buyers.




Ms Sneha Shah, Whole-time Director and Business Head of Unison Insurance Brokers, got featured in the cover story of Women Entrepreneur India Magazine.

The article gives insights into Indian Insurance & Broking industry and how the tech space shapes the industry in more prominent dimensions. It also talks about how the industry has evolved over the years and how today's youth consider insurance as the first choice of career.

**Sneha Shah**
Whole-time Director and Business Head of Unison Insurance Brokers

Scan or click the QR Code to access the article

# TAILORMADE HEALTH INSURANCE POLICIES

## Health Insurance has many models

Health insurance is now considered essential and hence there is a need to universalise health insurance. It is a public good having personal, community and social importance. Where free government universal insurance is not possible, there is a steady movement towards commercial insurance (private health insurance) because there are limitations in what governments and employers can provide. Insurance has the core competence to look at risks very critically to bring in insurability to health disaster losses. The challenge is to convert sickness insurance into 'good health' insurance, where ideally the insurance function should motivate insureds to look after their health and fitness, through preventive and promotive risk management tools.

## Let a hundred flowers bloom

One of the important values in private health insurance is the ability to give choices and options for health coverage to groups and communities. There are affordability, availability and cost control issues in health insurance and hence there is a felt need for coverages that can be tailored to specific group requirements of customers.

This tallies well with the concept in insurance that voluntary insurance is a conviction-based insurance unlike compulsory insurance where insurance is seen as a burden and there is no proper risk management component.

## Ideal conditions for Insurability

Before considering the complexities of tailor-made health insurance policies it is important to keep in mind the conditions of insurability. The standard conditions are as follows.

- Determinable and measurable loss – It must be possible to determine clearly when a loss has occurred and the magnitude of the loss.
- Large number of roughly homogeneous, independent exposure units – so that the statistical law of large numbers can provide an accurate prediction of expected future losses.
- Only accidental and unintentional losses are to be considered as insurance covers fortuity, but in health insurance once a person enters, the group will bear the expense of continued morbidity.

- Insurability is not possible if there is a risk of systemic or catastrophic losses, i.e. positively correlated across exposure units, in such a manner that the statistical law of large numbers does not hold.
- There must be a calculable chance of loss – This is to develop premium rates, for which the insurer must be able to estimate accurately both expected frequency and severity of loss.
- Economically feasible premium must be possible so that potential purchasers find the premium affordable.

### Group Insurance for tailor-made policies

Tailor made policies are possible in their ideal form in large groups. In small groups the chance for major changes from standard policies are difficult. Therefore, for large groups tailor made policies are now quite common and hence the subject needs a great amount of analysis and skills on the part of the insurer (risk carrier), the broker (the cost-benefit package initiator) and the TPA (service provider). Therefore, all the four parties which include the group organiser also need to think deeply and craft a win-win policy coverage framework that is sustainable for all. The policy should be based on a standard policy for a group so that all the standard wordings need not be crafted once again and important clauses are not thereby innocently omitted which will have important implications at the time of disputes before any legal forum.

In addition, the IRDAI guidelines on group insurance should be complied with in tailor-made group insurances. Insurance for groups cannot be on ad hoc basis, but there should be clear groups existing for purposes other than insurance.

There should be a clear administration point and they will act on behalf of the group as an administration point but the beneficiaries only will get the benefit of group discount (except in employer-employee groups in case employer pays the premium) as also the claim benefits Ideally in such insurances the claim payment should be on cashless basis so far as the beneficiary is concerned, as out of pocket payments are considered iniquitous and inappropriate when consumers have an insurance contract to empower and entitle them to benefits as covered.

In a group insurance many factors are analysed such as:

- Classes of employees
- Plan of insurance
- Age distribution
- Eligibility (waiting period)
- Sex distribution
- Benefit structure
- Dependent distribution
- Cost sharing
- Earning distribution
- Administration facilities
- Location of the group distribution
- Previous coverage and experience

## Components of an insurance scheme

In all health insurance schemes – various inter-related functions are involved

- Policy design and pricing the coverage
- Premium collection
- Purchasing of medical care (negotiation with hospitals)
- Services including claim payments
- Renewal and renewal terms

## Policy Design

### Group membership

The group organiser must ideally collect the desirables of the insurance cover from the group members. Normally all group insurance will also be family insurance. To avoid adverse selection, it is desirable that all members of the family and group are included. However, when the pricing issues come up there could be exclusions of very senior citizens and persons with incurable disabilities or diseases at the initial stage of enrolment which could otherwise will drain the resources of the group, as the pricing will be on experience and exposure basis. Other forms of lessening of risk may also be considered such as covering only persons in the working age and students on compulsory basis and all others on optional basis as their premium may be steep. Groups have to take a long-term view to their health risks and sustainability as per their economic capability to pay premiums and control or reduce health risks. It is not in the interest of groups to play with insurers or intermediaries to make a short-term gain as these could tarnish the image of the group over the long term and also remove the motivation of their members of lessen their health risks and increase their real welfare, which is the real purpose of managing health risks insurance.

### Benefit Determination

The benefit determination should ideally start from a regular standard policy and what the group does not require should be removed and the pricing thereof should be reduced. Thereafter the add-ons that the group requires should be considered one by one. The insurance benefit could be given on each person basis or on a family floater basis. There could be benefits through a top up insurance amount on named disease basis per family and further this could be an excess of loss basis on group floater basis. If the disease cover is for specific critical diseases there could be a reinstatement facility in exceptional disaster cases for this floater sum insured at the group level on a negotiated premium, keeping the prospect of continued treatment for those already benefitting or those who are likely to need the benefit. Ultimately premium rates will have to be adjusted to pay for all covered losses, given in whatever manner and hence facilitations and other methods to reduce premium costs will have to be matched by risk reducing measures or the rates will go up disproportionately, and even be unaffordable.

The benefit enumeration starts with surgical covers, and then goes on to hospitalisation covers, and thereafter it may consider named outpatient treatments and procedures. In rare cases, groups who can afford also may seek to have OP visits including routine treatments. It is to be noted that OP cover is to be used as a risk management measure or as part of managed care. Even then this part of the cover is to be priced at close to 100% of the benefit as everyone will use the OP cover to the fullest extent. The rate could be reduced only if the main cover is highly profitable and can subsidise the OP cover without prejudice to the profitability of the policy.

## Premium basis and collection methodology

The premium consideration on groups depends on the risk factors such as the age and morbidity or disease profile of the group. One of the best methods of understanding risks of groups is to examine their earlier medical cost (claim experience). Usually, health insurance being a frequency loss (with limited severity risk) experience is the best form understanding the risk. Based on the experience over the last 3 to 5 years the future exposures need to be evaluated including the aging risk of everyone, the inflation risk and so on, which then may be added to the experience ratio. New benefits should be also priced appropriately looking at the frequency and severity factors.

The rating of the policy can be on individual or family risk basis, or on community risk basis. Community rating is done by which the entire group is charged the same premium irrespective of risk factors. This helps to subsidise those at higher risk as a measure of solidarity by those having lower risk and is sometimes considered desirable as morbidity is not always self-induced. Here the solidarity concept ensures that the transfer happens not only between the healthy and sick but also from the young to the old. However, such community rate also can be detrimental, if it prejudices the motivation of members to control risk, and this could induce moral hazard in such a fashion that those with less risk and moral hazard are likely to exit the group as the premium charge they carry will be actuarially unfair.

The premium charged may be collected upfront annually or even monthly as allowed in the insurance rules, but when collected on monthly basis the interest factor lost to the group should be loaded on to the premium.

## Group discount

- The first part of group discount would be on the basis of reduction of administration costs. A group policy can remove from the insurer the need to issue individual policies but issue a master policy. Even then the discount for this would be only between 5 to 15% depending on the group size.
- The next discounts are technical discounts based on how much the group is willing to reduce risks vis-a vis the standard policy. These can be pre-claim or underwriting risk reduction discounts and post claim cost reduction discounts.
- Underwriting risk reduction discounts include risk factors such as age, morbidity profile, previous treatment cost experience, those with chronic conditions and so on. The general and easy method is to calculate previous claim/cost experience and load for inflation since health insurance is a frequency risk.
- Claim cost reduction is easier to assess, by selecting only hospitals within low-cost bands. This is the healthcare purchasing function, which is the most important aspect of tailor-made health insurance as the group should work with the insurer and TPA to limit hospital charges, by proactively selecting affordable hospitals and pharmacies for normal diseases and in case of need for specialised treatments there should be referral to super-specialties. Choosing the right hospital and ensuring low-cost but effective treatment can lower premiums substantially and/or the sum insureds of all beneficiaries could be raised much higher.
- The insurer could negotiate for more managed care methods to control costs, such as preventive health checkups, health improvement activities and sensitization, the

adoption of referral for admission to hospital, getting a second opinion for surgeries, care and case management for those admitted in hospitals, rigourous utilisation review and so on

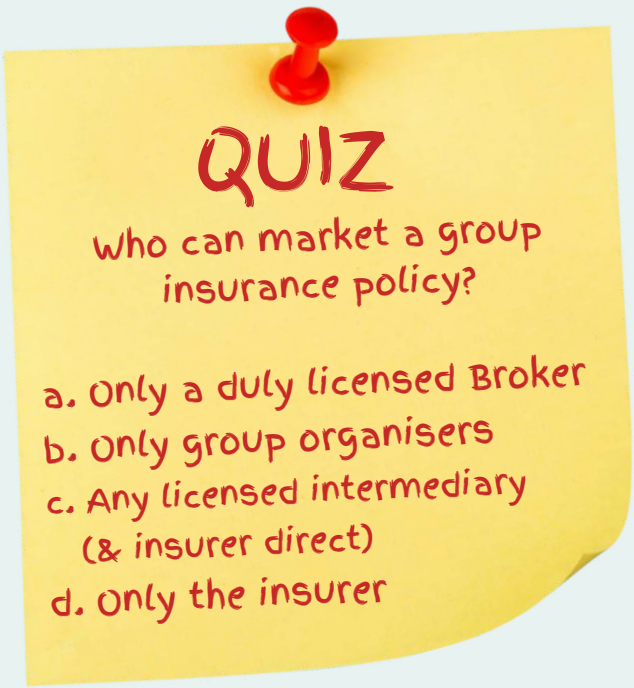
- The group should make all efforts to prevent adverse selection and moral hazard by the all including hospitals, and strict action is to be taken against fraud and abuse.
- Finally, there should be an "as if" clause in the policy not only for the benefit of the insurer, but also to load the user members against higher claim ratio. The 'as if' clause works on the principle of loading or discount based on the actual claim ratio. Since there is a chance that the insured may change insurers the 'as if' clause will not work if there is no enfoceable MOU agreeing to a minimum 3- or 5-year policy time frame.

The rating of the policy can be on individual or family risk basis, or on community risk basis. Community rating is done by which the entire group is charged the same premium irrespective of risk factors. This helps to subsidise those at higher risk as a measure of solidarity by those having lower risk and is sometimes considered desirable as morbidity is not always self-induced. Here the solidarity concept ensures that the transfer happens not only between the healthy and sick but also from the young to the old. However, such community rate also can be detrimental, if it prejudices the motivation of members to control risk, and this could induce moral hazard in such a fashion that those with less risk and moral hazard are likely to exit the group as the premium charge they carry will be actuarially unfair.

The premium charged may be collected upfront annually or even monthly as allowed in the insurance rules, but when collected on monthly basis the interest factor lost to the group should be loaded on to the premium.

### The Role of the TPA

The role of the TPA should be clearly discussed and agreed between all the parties and the TPA should be paid an appropriate fee based on the services rendered.



The TPA should provide services that can reduce morbidity and claims in collaboration with in-house doctors and with the hospitals concerned. They should generate clear statistics that should of use to both the insurer and the insured to study the contours of the insurance service so that the behaviour of usage and costs can be traced and controlled to the extent possible. They should focus on the following in the interest of optimization of care:

- Eliminating coverage for unnecessary medical services,
- Improving cost effectiveness, coordination with providers, and the statistical data base,
- Broadening coverage where appropriate
- Use of managed care techniques such as obtaining second opinions, gatekeeping, concurrent care review, and case review
- Ensuring that the hospitality component of the care is minimised and the curative part of the care is maximised.
- Discussing the escalation of costs beyond projected costs on review which should be frequent.
- Analysis of the morbidity patterns and costs across various age groups and other parameters as may be required, and also across hospitals, if there are many and minimise costs.
- Suggesting better coverage packages based on experience and data analytics.

### Benefit change

When it is not possible to raise rates, benefit changes may have to be considered, based on claims experience, so that premium costs are kept low or moderate. There are many alternatives to rate increases. These include:

1. Reduction of Benefits
    a. By an increase in waiting period
    b. Through an increase in deductible
    c. By fixing sub limits / fixed limits
2. There could be addition of managed care features to reduce cost / utilization
3. Changes could be made in policy provisions e.g. exclusion of non – life threatening surgeries involving large amounts such as hip replacement,
4. Along with rate increase the insurer could offer new benefits to mitigate the burden of premium hike; e.g. where people claim only for diagnostic purpose as inpatient add such a benefit but limit the number of diagnostics allowed in an outpatient mode.
5. Premium stabilization reserve can be maintained to reduce the deficit, if the policies are renewed with the same insurer over a long period.
6. Claims education and control program is necessary for all members.

### Claim Ratio Issues

There is a general expectation from groups that the claim ratio must be close to the premium paid. Worldwide it is seen that a claim ratio of 80-85% of the premium is paid out as claims and only the balance is to be used for expenses, commission and profits. With infusion of technology costs could be compressed and services enhanced.

### Conclusion

There is a need for insurers and intermediaries to make a compelling case for groups to consider group and tailor-made insurance-based schemes to manage their healthcare and health costs.

# DOES NEGLIGENCE OR INEVITABLE ACCIDENT, MAKE AN ACCIDENT LESS ACCIDENTAL?

In the Canadian SC case Canadian Indemnity Co. v. Walkem Machinery and Equipment Ltd., [1976] 1 S.C.R. 309, a crane on a self-unloading barge, made for carrying logs, collapsed. The barge with the crane was provided to the plaintiff by the defendants in an inadequate state of repair and it was found that the defendants had known that the vessel was not in a proper state of repair but had returned it to the plaintiffs in that state without warning. The court found that Canadian Indemnity was liable to indemnify Walkem Machinery and Equipment Ltd. under the Comprehensive Business Liability Policy that applied to the loss and indicated that a loss may be accidental even if it may have been avoided by greater care:

The Canadian SC stated: "One must avoid the danger of construing that term as if it were equivalent to "inevitable accident." That a mishap might have been avoided by the exercise of greater care and diligence does not automatically take it out of the range of accident. Expressed another way, "negligence" and "accident" as here used are not mutually exclusive terms. They may co-exist."

In another Canadian SC case Martin v. American International Assurance Life Co., 2003 SCC 16 the insured, a doctor who was addicted to opiate medications, died from a drug overdose. The SC found that the doctor did not expect to die but simply made a miscalculation concerning how much Demerol his body could tolerate. The court explained that an event is not an accident if it is bound to happen in the ordinary course of events, but that an event does not become not an accident simply because it could have been avoided by taking more care, or because it occurred in the course of dangerous activity.

It follows that death is not non-accidental merely because the insured could have prevented death by taking greater care, or that a mishap was reasonably foreseeable in the sense used in tort law. Nor does a death that is unintended become "non-accidental" merely because that person was engaged in a dangerous or risky activity. As this Court emphasized in Canadian Indemnity, supra, at p. 316, the jurisprudence assigns a generous meaning to "accidental", in the absence of language to the contrary in the insurance policy. The pivotal question is whether the insured expected to die.

The court stated in para 12: "Almost all accidents have some deliberate actions among their immediate causes. To insist that these actions, too, must be accidental would result in the insured rarely, if ever, obtaining coverage. Consequently, this cannot be the meaning of the phrase "accidental means" in the policy. Insurance policies must be interpreted in a way that gives effect to the reasonable expectations of the parties: Reid Crowther & Partners Ltd. v. Simcoe & Erie General Insurance Co., [1993] 1 S.C.R. 252, at p. 269. A policy that seldom applied to what reasonable people would consider an accidental death would violate this principle."

Indian Supreme Court has adopted the line taken above. In the case National Insurance Co. Ltd vs Swaran Singh & Ors (2004), the SC said: "An accident is not susceptible to a very precise definition. The popular and ordinary sense of the word was "an unlooked-for mishap or an untoward event which is not expected or designed". In R. Vs. Morris [(1972) 1 W.L.R. 228], the Court of Appeal defined the word as an "unintended occurrence which has an adverse physical result".

Our Supreme Court continued: "The Supreme Court of Canada in Pickford & Black Ltd. vs. Candian General Insurance Co. [(1976) 2 Lloyd's Rep. 108], stated the law thus : "The meaning to be attached to the word "accident" as employed in the body of an insurance policy was thoroughly explored by Mr. Justice Pigeon in the reasons for judgment which he delivered on behalf of the majority of this

Court in The Canadian Indemnity Co. v. Walkem Machinery & Equipment Ltd., (1975). In the course of these reasons at p. 5 he adopted the views expressed by Mr. Justice Freedman, in a dissenting opinion in the Court of Appeal of Manitoba in Marshall Wells of Canada Ltd. v. Winnipeg Supply and Fuel, R. Litz & Sons Co. v. Candian General Insurance Co., (1964) 49 W.W.R. 644 at p. 665 where that learned Judge said: "With respect, I am of the view that what occurred here was an accident. One must avoid the danger of construing that term as if it were equivalent to "inevitable accident." That a mishap might have been avoided by the exercise of greater care and diligence does not automatically take it out of the range of accident. Expressed another way, "negligence" and "accident" as here used are not mutually exclusive terms. They may co-exist."

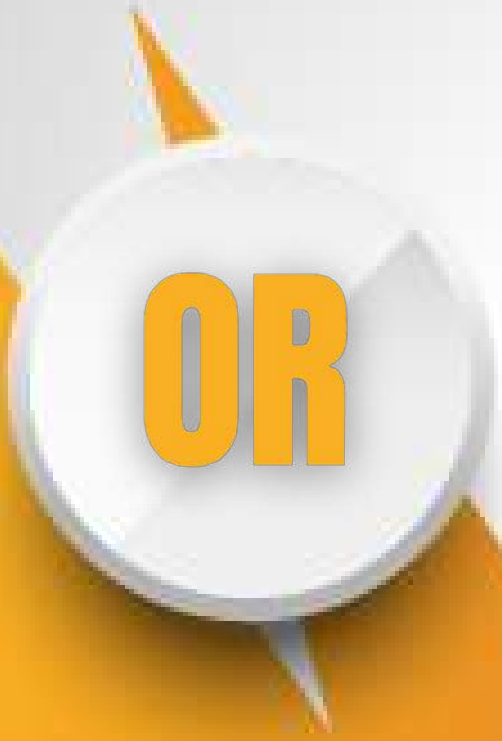
Our SC further continued: "After expressing the view that even an occurrence which is the result of a calculated risk or of a dangerous operation may come within the meaning of the word "accident", Mr. Justice Pigeon went on to say at p. 6 : "While it is true that the word "accident" is sometimes used to describe unanticipated or unavoidable occurrences, no dictionary need be cited to show that in everyday use, the word is applied as Halsbury says...to any unlooked for mishap or occurrence...this is the proper test..."

Further , "In Halsbury's Laws of England, Fourth Edition Reissue, it is stated: "An injury caused by the willful or even criminal act of a third person, provided the assured is not a party or privy to it, is to be regarded as accidental for the purposes of the policy, since from the assured's point of view it is not expected or designed. In Colinvaux's Law of Insurance (6th Edition) page 304, the following illustration is given : "If a man walks and stumbles, thus spraining his ankle, the injury is accidental for while he intends to walk he does not intend to stumble. In Hamlyn v. Crown Accidental Insurance the assured's injury was due to stooping forward to pick up a marble dropped by a child as it rolled from him. He stood with his legs together, separated his knees, leaned forward and made a grab at the marble, and in doing so wrenched his knee. The injury was held by the Court of Appeal to be accidental, on the ground that the assured did not intend to get into such a position that he might wrench his knee."

Finally on the issue of negligence our SC stated: "At para 17-13 of the said treatise, it is stated: "Accident includes negligence It makes no difference that the accident was caused by the negligence of the assured (as opposed to his intentional act). Thus, there is an accident where the assured crosses a railway line without exercising due care and is knocked down by an approaching train. In fact, one of the commonest causes of accidents is negligence, and an accident policy applies, excepted perils apart, whether the injury is caused by the negligent act of the assured himself or of a third party."

# SUM INSURED

## INDEMNITY VALUE




## REPLACEMENT VALUE

Assessing what should be the correct value for insuring a building or its contents can be a perplexing question for many. If there is underinsurance one not only gets penalised for the under insured amount, but it may seriously and unexpectedly (for many) deprive a considerable part of the claim when a partial loss occurs. Over insurance is also not beneficial; the insured has to pay more premium.

There is two ways in which property insurance value or sum insured can be calculated:

Market Value (MV) Cover is the value of the item at the time of the loss. Payment of the indemnity value is designed to put the insured in the same financial position as immediately before the loss occurred. This therefore takes into account the issue deprecation. So, if a property was built 10 years ago but costing today Rs. 10 lakhs, assuming a straight-line deprecation of 1%, after 10 years the depreciated value of the property will be Rs. 9 lakhs. This will be the indemnity value.

It may be seen that one has to take today's reconstruction cost and on that calculate the depreciation.

Replacement Cost or Replacement Value (RV)
The term replacement cost or replacement value refers to the amount that one would have to pay, at the present time to replace any one of its assets. Replacement cost is not market value but is instead the cost to replace an item or structure at its pre-loss condition. Using the same example as MV cover, assuming
Rs.10 lakhs as the cost of construction today, the sum insured should be Rs. 10 lakhs.

How Do I Calculate the MV? - Depending on make of the building (wood, concrete or mixed) a set deprecation percentage is used normally to depreciate the cost of the building until its insurance period. Surveyors may refer to RBI index or other

How Do I Calculate the RV? Depending on make of the building (wood, concrete or mixed) the full cost of replacement of the same type and quality is determined. It can be best done by a registered Valuer, once in a while.

*In today's context, no insured merely wants money, but want their building or property back duly reinstated. So, RV cover is by far, the more secure option. Whilst the cost of carrying out the valuation and paying higher premium may bring some extra associated costs, it will lessen the financial burden at the time of claim.*

# INDEMNITY VALUE VS REPLACEMENT VALUE

# The Pros and Cons of Market Value (MV) and Reinstatement Value (RIV) at the time of Claim

## Market Value

In market value policies the insured has no need to spend money(reinstate). The claim is assessed by the surveyor and settled by the insurer, without any proof any reinstatement.

The insured only needs to intimate the claim immediately and provide the estimate of loss.
The insurer may pay on account claim but there is no obligation to reinstate.

When the surveyor comes it is necessary to extend cooperation to prove the claim.
It is the obligation of the insurer to prove that an exclusion applies and the claim is not payable

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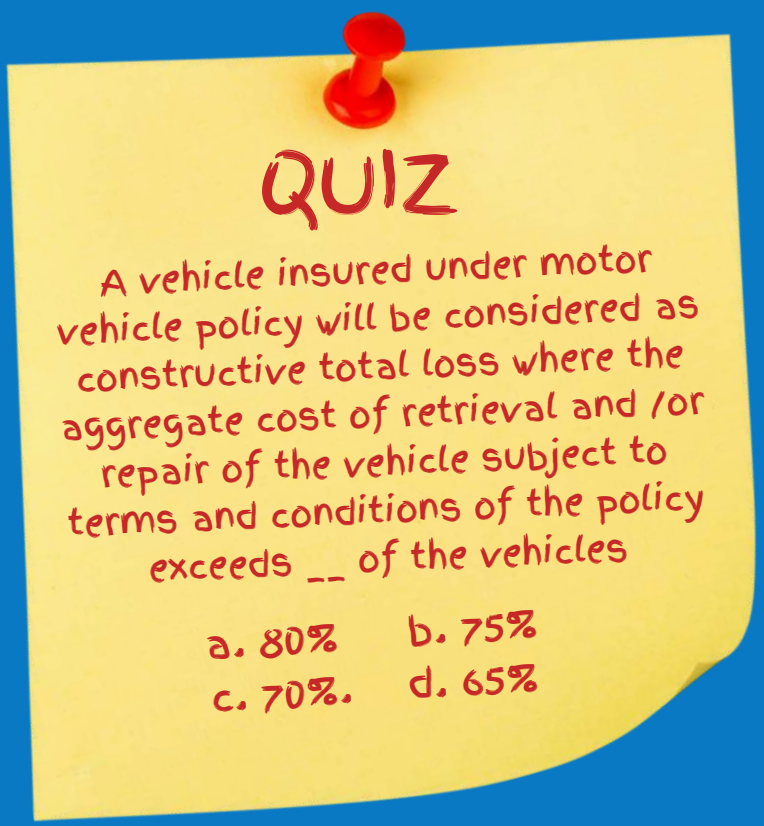



## Reinstatement Value

In RIV policies the insured has obligation to reinstate (spend money), otherwise the claim will be paid on market value only.

The decision to reinstate must be formally intimated to the insurer at the earliest.

It is a moral obligation of the insurer to pay either an on-account payment or the market value of the claim at the earliest – so that the insured has cash to carry out the reinstatement.

The Delhi High Court in the case M/S. Anantraj Agencies Pvt. Ltd. vs National Insurance Co. Ltd. (2016) quoted the UK case Western Trading Ltd. v Great Lakes Reinsurance (UK) Plc ([2015] "The requirement on the assured to reinstate cannot be read to arise until the insurer has confirmed that it will indemnify."

Insurers need to pay as per market value to provide necessary funds to begin rebuilding, and subsequently while in carrying out the construction, obtain additional amounts up to the replacement value already incurred

Madras High Court in the case Hefc Ergo General Insurance Co Ltd vs M/S Rohini Movie Park Rukmini on 19 April, 2019: "There is no clause, which gives unilateral discretion to the insurance company to change the same into Market Value Basis."

# THE TRUE NATURE OF MCE/BUILDERS POLICY AS PER COURTS

## Features of Project Insurance

- It is often a multi-peril policy
- Its function is to provide to the owner the promise that the contractors will have the funds to rebuild in case of loss
- Contractors get protection against the crippling cost of starting afresh in such an event, the whole without resort to litigation in case of negligence by anyone connected with the construction
- It is a “blanket” wrap-up policy covering the entire project
- It covers each and every consultant, contractor, and subcontractor
- All the Parties involved in the Project have Insurable Interest to get the Benefits of the Policy
- Each sub-contractor engaged under a building or engineering contract is entitled to insure the entire contract works for their full value
- The purpose of builders’ risk policies in particular is to offer broad coverage, which benefits both insureds and insurers
- Builders’ risk construction policies are the norm, if not a requirement, on construction sites

The first major case relating to this line of business was pronounced by the Supreme Court of Canada in the case: Commonwealth Construction Co. Ltd. v. Imperial Oil Ltd. et al., [1978] 1 S.C.R. 317. A general contractor, Wellman-Lord, entered into a contract with Imperial Oil Ltd. for the construction of a fertiliser plant, and a subcontractor, Commonwealth, was charged with the installation of process piping. In the course of that installation a fire took place, which was admittedly the responsibility of Commonwealth. In the Judgement the SC noted: "As already noted, the multi-peril policy under consideration is called in the contract between Imperial and Wellman-Lord a course of construction insurance. In England, it is usually called a "Contractors' all risks insurance" and in the United States, it is referred to as "Builders' risk policy". Whatever its label, its function is to provide to the owner the promise that the contractors will have the funds to rebuild in case of loss and to the contractors the protection against the crippling cost of starting afresh in such an event, the whole without resort to litigation in case of negligence by anyone connected with the construction, a risk accepted by the insurers at the outset. This purpose recognizes the importance of keeping to a minimum the difficulties that are bound to be created by the large number of participants in a major construction project, the complexity of which needs no demonstration. It also recognizes the realities of industrial life."

This was reiteraterated in 2015 the Court of Appeal, Alberta in the case: Ledcor Construction Limited v Northbridge Indemnity Insurance Company, 2015 ABCA 121: "[37] Thirdly, it must be recalled that the insurance policy in question is a "blanket"wrap-up policy covering the entire project. It covers each and every consultant, contractor, and subcontractor. This form of policy undoubtedly reduces the overall insurance costs of the project because it reduces overlaps in coverage." ....[38] Fourthly, in the context of a multi-year, blanket wrap up insurance policy designed to cover (i) all actors and activities on the site, during (ii) the entire course of construction of the EPCOR Tower as a single "Project", it does not make any difference:

(a) that there was any temporal gap between the installation of the windows and the window washing that damaged them. This was a multi-year insurance policy for the entire project, not an annual renewable policy....

(b) that Ledcor was retained as a "construction manager", rather than as a "general contractor". It does not matter that Bristol Cleaning was retained directly by the owner, rather than by a general contractor.The scheme of the insurance policy is that all activities on the site are to be covered by one policy.There is nothing in the policy wording to suggest that coverage varies depending on the contractual relationships of the parties; the coverage depends on the type of"damage".

All the Parties involved in the Project have Insurable Interest to get the Benefits of the Policy In UK, the England and Wales Court of Appeal (Civil Division) in the case Deepak Fertilisers & Petrochemical Corporation v Davy McKee (London) Ltd & Anor [1998] EWCA Civ 1753 (1998) examined the issue and stated: "63. Thus, the question to be determined is whether Davy would have had an insurable interest in the plant itself. In the absence of such interest no question could arise of Davy insuring the plant or Deepak doing so on Davy's behalf. In our judgment, the answer to this issue is not complex. Davy may well have had an insurable interest in the plant whilst it was under construction and commissioning.

In MacGillivray on 'Insurance Law' (9th Edition) at 1-150 it is stated:

"Where a contractor undertakes work and his right to payment is dependent upon the completion of the work, he has an insurable interest in the subject matter of the contract whether it be in his possession or not, because the destruction of the subject matter would prevent him from earning his remuneration under the contract. He has an insurable interest up to the value of the work done and materials expended, and on his expected profits if specifically insured...

This was reiteraterated in 2015 the Court of Appeal, Alberta in the case: Ledcor Construction Limited v Northbridge Indemnity Insurance Company, 2015 ABCA 121: "[37] Thirdly, it must be recalled that the insurance policy in question is a 1-151 Sub-Contractors. It has been held in cases concerned with the right of an insurer to sue an insured sub-contractor in the name of co-assured, that each sub-contractor engaged under a building or engineering contract is entitled to insure the entire contract works for their full value, and to claim on the policy for damage to a part of the works which is neither his property nor at his risk."

**Court purpose of Builders Policies**

The Canadian Supreme Court in the case Ledcor Construction Ltd. v. Northbridge Indemnity Insurance Co. 2016 SCC 37, further clarified: "[66] Therefore, in my view, the purpose behind builders' risk policies is crucial in determining the parties' reasonable expectations as to the meaning of the Exclusion Clause. In a nutshell, the purpose of these polices is to provide broad coverage for construction projects, which are singularly susceptible to accidents and errors. This broad coverage — in exchange for relatively high premiums — provides certainty, stability, and peace of mind. It ensures construction projects do not grind to a halt because of disputes and potential litigation about liability for replacement or repair amongst the various contractors involved. In my view, the purpose of broad coverage in the construction context is furthered by an interpretation of the Exclusion Clause that excludes from coverage only the cost of redoing the faulty work itself — in this case, the cost of recleaning the windows."

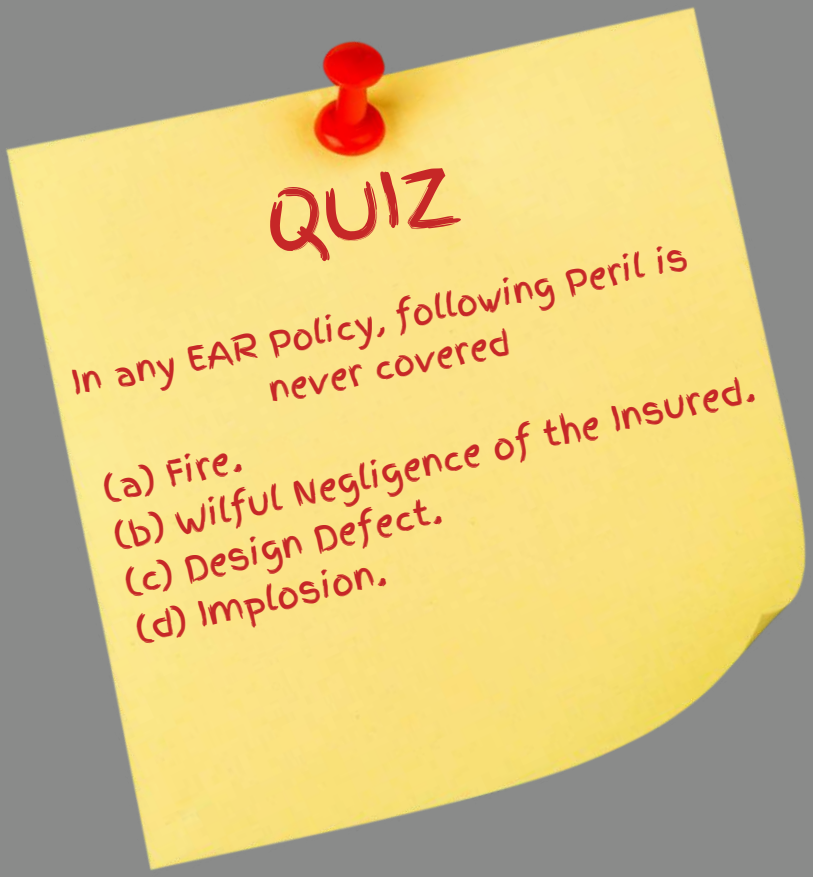
**All Risk Coverage**

The Canadian SC continued: "[67] "The raison d'être of insurance is coverage": D. Boivin, Insurance Law (2nd ed. 2015), at p. 288. The purpose of builders' risk policies in particular is to offer broad coverage, which benefits both insureds and insurers: "Urbanization and industrialization in the past 100 years have made the concept of an insurance policy covering all conceivable risks advantageous to both insureds and their insurers. The insured benefits from the extensive nature and scope of the coverage, and insurers benefit from the economies of managing and marketing a policy which, in terms of its scope, has certainty. For these reasons, the "all risk policy," which creates a special type of coverage extending to many risks not customarily covered under other types of insurance policies, is attractive to both the insurance industry and consumers.

Although such policies are said to insure against all risks, this description is not entirely accurate. As a general rule, insurance offers protection only for fortuitous contingent risk: Progressive Homes, at para. 45. Moreover, builders' risk policies contain various exclusions, meaning indemnity is precluded in many circumstances of fortuitous loss: Dolden, at pp. 342-44. Despite these qualifiers, builders' risk construction policies are the norm, if not a requirement, on construction sites in Canada. In purchasing these policies, "contractors believe indemnity will be available in the event of an accident or damage on the construction site arising as a result of a party's carelessness or negligent acts", which are the most common source of loss on construction sites: Dolden, at pp. 345-46.

And, in selling these policies, insurers are prepared to insure risks relating to problems caused by faulty . . . workmanship, but they are not prepared to insure the quality of . . . the workmanship in a construction project per se. The argument is that the contractor is responsible for doing [its] job right and the insurance company is not there to provide compensation for inadequate performance by a contractor of the very work the contractor agreed to perform.

Consequently, an interpretation of the Exclusion Clause that precludes from coverage any and all damage resulting from a contractor's faulty workmanship merely because the damage results to that part of the project on which the contractor was working would, in my view, undermine the purpose behind builders' risk policies. It would essentially deprive insureds of the coverage for which they contracted."



# Liability Insurance

## 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:

1. A factory suffers damage as a result of a fire and the insurer refuses to cover all or part of the loss.
2. 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**

The whole matter 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.

**Duty to Defend v. Duty to Indemnify**

1. Duty to Defend

If there is any legal or factual basis that could be developed at trial, which would obligate the insurer to pay under the policy, the insured is entitled to a defense. Many States in the US favour an expansive view of an insurer's duty to defend; and any ambiguity in policy language will be construed in favour of the insured. Generally, in the US, the insurer's obligation to defend suits against its insured is broader than its liability for damage claims.

The insurer's duty to defend suits brought against its insured is determined by the allegations of the injured plaintiff's petition, with the insurer being obligated to furnish a defense unless the petition unambiguously excludes coverage.

Generally, the allegations in the claim petition are liberally interpreted in determining whether they set forth grounds which bring the claim within the scope of the insurer's duty to defend the suit brought against its insured. Courts in the US have spoken in the matter definitively:

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2. Duty to Indemnify

In contrast to the duty to defend, the duty to indemnify is narrower: while the duty to defend depends only on the allegations made against the insured, the duty to indemnify depends upon the facts established at trial and the theory under which judgment is actually entered in the case.

Court Views on the Duty to Defence

In the case Seaboard Sur. Co. v. Gillette Co. in the Court of Appeals of the State of New York (1984) stated:

Where an insurance policy includes the insurer's promise to defend the insured against specified claims as well as to indemnify for actual liability, the insurer's duty to furnish a defense is broader than its obligation to indemnify. The duty to defend arises whenever the allegations in a complaint against the insured fall within the scope of the risks undertaken by the insurer, regardless of how false or groundless those allegations might be. The duty is not contingent on the insurer's ultimate duty to indemnify should the insured be found liable, nor is it material that the complaint against the insured asserts additional claims which fall outside the policy's general coverage or within its exclusory provisions. Rather, the duty of the insurer to defend the insured rests solely on whether the complaint alleges any facts or grounds which bring the action within the protection purchased. Though policy coverage is often denominated as "liability insurance", where the insurer has made promises to defend "it is clear that [the coverage] is, in fact, `litigation insurance' as well." As such, "[s]o long as the claims [asserted against the insured] may rationally be said to fall within policy coverage, whatever may later prove to be the limits of the insurer's responsibility to pay, there is no doubt that it is obligated to defend." (Schwamb v Fireman's Ins. Co., supra, at p 949.)

# WHAT COURTS SAY ABOUT EXCLUSION CLAUSES

In the case National Insurance Co. Ltd. v. Ishar Das Madan Lal (2007), the Supreme Court noted that where there is an exclusionary clause in an Insurance Policy, burden lies on the insurer to establish that the exclusion is attracted. The SC stated: "However, there may be an express clause excluding the applicability of insurance cover. Wherever such exclusionary clause is contained in a policy, it would be for the insurer to show that the case falls within the purview thereof. In a case of ambiguity, it is trite, the contract of insurance shall be construed in favour of the insured.

In the case New India Assurance Company Limited v. Rajeshwar Sharma and Others (2019) the SC went into great detail. "15 The position of the common law with respect to the interpretation of exclusionary clauses in insurance policies is no different. In Cornish v Accident Insurance Co Ltd, Queen's Division Bench, 1889, the Court of Appeal emphasized the duty of the insurer to except their liability in clear and unambiguous terms. The Court of Appeal held that: "... in a case of real doubt, the policy ought to be construed most strongly against the insurers; they frame the policy and insert the exceptions. But this principle ought only to be applied for the purpose of removing a doubt, not for the purpose of creating a doubt, or magnifying an ambiguity, when the circumstances of the case raise no real difficulty." According to The Law Relating to Accidental Insurance, the position is elucidated below:

"The object of the exceptions is to define with greater precision the scope of the policy by making clear what is intended to be excluded and contrasting it with what is intended to be included.

Since exceptions are inserted in the policy mainly for the purpose of exempting the insurers from liability for a loss which, but for the exception, would be covered by the policy, they are construed against the insurers with the utmost strictness and it is the duty of the insurers to except their liability in clear and unambiguous terms. The onus of proving that the loss falls within an exception lies upon the insurers, unless by proving the language of the exception the assured

is expressly required to prove that, in the circumstances, the exception does not apply." In 2016, the UK Supreme Court dealt with the interpretation of an exclusion clause in a solicitors' professional indemnity insurance policy in Impact Funding Solutions Ltd v Barrington Support Services Ltd [2016] UKSC 57.

Dealing with the construction of insurance exclusions, Lord Toulson JSC in the case above observed thus: "The fact that a provision in a contract is expressed as an exception does not necessarily mean that it should be approached with a pre-disposition to construe it narrowly. Like any other provision in a contract, words of exception or exemption must be read in the context of the contract as a whole and with due regard for its purpose.

As a matter of general principle, it is well established that if one party, otherwise liable, wishes to exclude or limit his liability to the other party, he must do so in clear words; and that the contract should be given the meaning it would convey to a reasonable person having all the background knowledge 5 Supreme Court as per Lord Toulson JSC (with whom Lord Mance, Lord Sumption and Lord Hodge JJSC agreed) [2016] UKSC 57 which is reasonably available to the person or class of persons to whom the document is addressed... This applies not only where the words of exception remove a remedy for breach, but where they seek to prevent a liability from arising by removing, through a subsidiary provision, part of the benefit which it appears to have been the purpose of the contract to provide. The vice of a clause of that kind is that it can have a propensity to mislead, unless its language is sufficiently plain. All that said, words of exception may be simply a way of delineating the scope of the primary obligation." The principles for construing insurance exclusions as laid down in Impact Funding Solutions Ltd v Barrington Support Services Ltd (above) were relied upon by the England and Wales High Court (Commercial Court) in the case of Crowden and Crowden v QBE Insurance (Europe) Ltd [2017] EWHC 2597 (Comm).

While dealing with the question of construction of insurance exclusions, Judge Peter MacDonald Eggers QC in Crowden and Crowden v QBE Insurance observed:

the Court must adopt an approach to the interpretation of insurance exclusions which is sensitive to their purpose and place in the insurance contract. The Court should not adopt principles of construction which are appropriate to exemption clauses - i.e. provisions which are designed to relieve a party otherwise liable for breach of contract or in tort of that liability - to the interpretation of insurance exclusions, because insurance exclusions are designed to define the scope of cover which the insurance policy is intended to afford. To this end, the Court should not automatically apply a contra proferentem approach to construction. That said, there may be occasions, where there is a genuine ambiguity in the meaning of the provision, and the effect of one of those constructions is to exclude all or most of the insurance cover which was intended to be provided. In that event, the Court would be entitled to opt for the narrower construction..."

**Conclusions:**

1. Where there is an exclusionary clause in an Insurance Policy, burden lies on the insurer to establish that the exclusion is attracted.
2. The object of the exceptions is to define with greater precision the scope of the policy by making clear what is intended to be excluded and contrasting it with what is intended to be included.
3. Exceptions are construed against the insurers with the utmost strictness and it is the duty of the insurers to except their liability in clear and unambiguous terms.
4. All said, words of exception may be simply a way of delineating the scope of the primary obligation.
5. The Court must adopt an approach to the interpretation of insurance exclusions which is sensitive to their purpose and place in the insurance contract.

# BURGLARY INSURANCE CHECK-LIST

Burglary/ Housebreaking is usually defined in policies as: “the unforeseen and unauthorized entry to or exit from the insured premises by aggressive and detectable means with the intent to steal contents therefrom.” The Traditional wording is: “Burglary or Housebreaking (theft following upon an actual forcible and violent entry of or exit from the premises by the person or persons committing such theft) or Hold-up”.

In such a situation, insurers will be happy to obtain from intermediaries a checklist of the physical hazards – this is also useful as additional service to the insured, to obtain better outcomes in case of a claim, especially when the goods at risk are prone to burglary.

## Checklist for the Physical Hazard

- Attractiveness of the material for theft risk
- Local crime situation
- Possibility of transporting goods easily
- Ease of selling stolen goods
- Premises – strong, protected windows and other openings
- Illumination – well lit, good visibility by people around
- Enclosure, gates, etc.
- Position of risk within building - Adjacent rooms used by whom
- Unsecured adjacent rooms, cellars, attic rooms, etc.

## Physical security components

- Walls, ceilings, floors
- Roof, roof cover, roof windows, roof structures; light domes
- Doors - Door leaf, door frame, Lock, hinges and bolts,
- Glass – extensiveness and vulnerability
- Illumination inside, outside
- Windows, shop windows, display cabinets
- Use, maintenance of existing security components and alarms, including cctvs
- Emergency exists and hatches, other openings and weak points (e.g. ventilation openings)

## Burglar / hold – up alarm systems

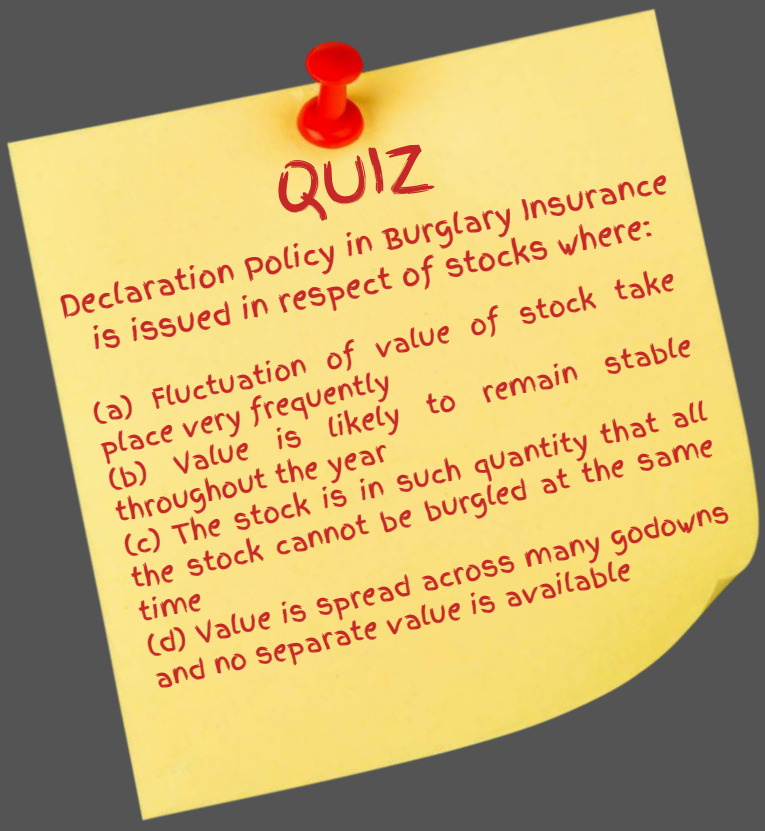
- Acknowledged alarm system installed
- Maintenance contract
- Emergency power supply
- Protection against sabotage
- Type of surveillance - Open spaces
- Television, camera surveillances - Outer spaces, interior rooms
- Direct transmission to the police or to a private guarding / security company

## Organizational measures

- Access authorization, Security of keys
- Rules regarding presence / absence - Guarding
- Illumination inside, outside
- Proper accounting of goods and their values
- Use, maintenance and functional testing of existing security components and alarms

## Measures for the protection of particular valuables

- Degree of exposure
- Nature of valuables
- Place of storage within building
- Type of room, container
- High – security room (structure of walls, ceilings, floor, locks and closing mechanisms)
- Safe (acknowledged make and design, security rating, weight) Strong room (security rating)



# NON-STANDARD OR COMPROMISED CLAIMS

## PRINCIPLES AS PER COURTS

PSU insurers in their Claim Manuals since long had guided: “It is clarified that where the breach of policy condition or warranty are neither the cause of loss nor have contributed to the extent of loss, the claim can be treated as Standard Claim.” Generally, insureds believe that claims must be paid in full or be repudiated. However, there are situations where the insured violates a condition, which can prejudice the claim.

Courts have taken a cue from the insurers manuals and have utilised the non-standard claim settlement method to ensure that the insured is not punished disproportionately. The NCDRC in the case Kesarben vs United India Insurance Co. Ltd. (2000), was the first top level court to rule on this.

NCDRC quoted several Supreme Court Cases and pointed out certain important principles that are intended to help insureds in distress after a loss. The main of these is the case B.V. Nagaraju vs M/S. Oriental Insurance Co. (1996).

**a) Main Purpose Rule:**

The Supreme Court quoted Carter's "Breach of Contract"() to stated that: “Notwithstanding the general ability of contracting parties to agree to exclusion clauses which operate to define obligations there exists a rule, usually referred to as the "main purpose rule", which may limit the application of wide exclusion clauses defining a promisor's contractual obligations.” Thus in the case Glynnn v. Margetson & Co. [1893 AC 351, 357], Lord Halsbury, L.C. stated: It seems to me that in construing this document, which is a contract of carriage between the parties, one must in the first instance look at the whole instrument and not at one part of it only. Looking at the whole instrument, and seeing what one must regard ..... as its main purpose, one must reject words, indeed whole provisions, if they are inconsistent with what one assumes to be the main purpose of the contract.”

**b) Reading down the exclusion clause:**

Following this the SC felt that where required, exclusions clauses must be narrowed. “Even if one were to make a strictly doctrinaire approach, the very same conclusion would emerge in obeisance to the doctrine of 'reading down' the exclusion clause in the light of the 'main purpose' of the provision.... The effort must be to harmonize the two instead of allowing the exclusion clause to snipe successfully at the main purpose”.

**C) Doctrine of Fundamental Breach:**

Courts developed the doctrine of fundamental breach, by wide exclusion clauses were read down to the extent to which they are inconsistent with the main purpose, or object of the contract.

**d) Violation to be material to the loss:**
The Supreme Court again referred to the violation being material to the loss by stating: "The reasoning that the extra passengers being carried in the goods vehicle could not have contributed, in any manner, to the occurring of the accident, was barely noticed and rejected sans any plausible account; even when the claim confining the damage to the vehicle only was limited in nature. We, thus, are of the view that in accord with the Skandia's case, the aforesaid exclusion term of the insurance policy must be read down so as to serve the main purpose of the policy that is indemnify the damage caused to the vehicle, which we hereby do."

Supreme Court also allows claims to be settled as non-standard

In the case Manjeet Singh vs National Insurance Company Ltd. (2017), the Supreme Court in para 5, stated that: "The violation of the condition should be such a fundamental breach so that the claimant cannot claim any amount whatsoever. As far as the violation in carrying passengers is concerned, this has consistently been held not to be a fundamental breach and, in this behalf, we may make reference to the judgments of this Court in the case of National Insurance Co. Ltd. v. Swaran Singh, (2004) 3 SCC 297, National Insurance Co. Ltd. v. Nitin Khandelwal, (2008) 11 SCC 259, Lakhmi Chand v. Reliance General Insurance, (2016) 3 SCC 100 and B.V. Nagaraju v. Oriental Insurance Co. Ltd., (1996) 4 SCC 647.

In Lakhmi Chand case (supra), this Court held that to avoid its liability, the insurance company must not only establish the defense that the policy has been breached, but must also show that the breach of the policy is so fundamental in nature that it brings the contract to an end.

In the present case, the appellant who is the owner, was not at fault. His driver gave a lift to some passengers. Carrying such passengers may be a breach of the policy, but it cannot be said to be such a fundamental breach as to bring the insurance policy to an end and to terminate the insurance policy.

The driver, on a cold wintery night, gave lift to some persons standing on the road. It was a humanitarian gesture. It cannot be said to be such a breach that it nullifies the policy. No doubt, these passengers turned against the driver and stole the truck, but this, the driver could not have foreseen. In the cases cited above, such claims where there is breach of policy, have been treated to be non-standard claims and have been directed to be settled at 75%."

However, this case needs to be understood as there are two issues:

1. It may be noted that in the above case, violation of allowing in the passengers by the driver was not considered a material breach as such.
2. What merited non-standard settlement was that the passengers stole the truck. Such an act owing the carelessness of the insured owner would have merited full repudiation, because the carrying of passengers against the policy provisions became the proximate cause of a major loss (it directly caused a loss owing to a risk not allowed in the policy). However, the court took cognisance of the fact that the owner was not at fault. Hence from being an issue that could be considered meriting a full repudiation, the Supreme Court reduced it to a non-standard settlement making the insurer pay 75% of the assessed loss. This can be considered to be the real of meaning of a non-standard settlement.

**Conclusion** Given the nature of claims and the various situations that go behind the occurrence of the loss, it is necessary that the materiality of the breach and whether it is fundamental or not, has to be examined before a claim is fully repudiated. Thus, the steps envisaged in claim settlement as seen above can be revived in the claim manuals of insurers:

- Where the breach is only technical and not material, no action needs to be taken, and the claim can be settled in full.

Where the breach is one that can be rectified by collection of premium, collect the difference in premium and pay the loss in full. Where necessary, rectification of the policy also needs to be done by the insurer.

Where the breach has caused a real loss, and a material breach of the policy term is proved but the insured has shown his innocence of having committed a fundamental breach as seen above, the claim can be settled on non-standard basis.

**The question arises then as to what is technical as against material.**

The Madras High Court in the case M/S.Opg Energy (P) Ltd vs The New India Assurance Company (2013) stated that "15. 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." In the case dealt with by the Supreme Court (UII case), the surveyor stated that the loss due to the building was due to subsidence, but the term subsidence was not found excluded in the policy, but was assumed by the surveyor/insurer to be not covered in the flood/inundation clause.

In a more recent case namely Gurshinder Singh vs Sriram General Insurance Co. Ltd. (2020), the Supreme Court of India considered a claim where in a motor vehicle theft case the FIR was filed immediately, but the insurer was intimated of the claim late. The SC commented: "18. We concur with the view taken in the case of Om Prakash (supra), that in such a situation if the claimant is denied the claim merely on the ground that there is some delay in intimating the insurance company about the occurrence of the theft, it would be taking a hyper technical view. We find, that this Court in Om Prakash (supra) has rightly held that it would not be fair and reasonable to reject genuine claims which had already been verified and found to be correct by the investigator.

We find, that this Court in Om Prakash (supra) has rightly held that the Consumer Protection Act aims at protecting the interest of the consumers and it being a beneficial legislation deserves pragmatic construction. We find, that in Om Prakash (supra) this Court has rightly held that mere delay in intimating the insurance company about the theft of the vehicle should not be a shelter to repudiate the insurance claim which has been otherwise proved to be genuine.


# IN INSURANCE WHY INTERMEDIARIES MUST FIGHT IT

Fraud in Insurance has been defined by the IRDAI in their circular of 22.01.2013 as: "Fraud in insurance is an act or omission intended to gain dishonest or unlawful advantage for a party committing the fraud or for other related parties." Fraud in insurance can take many forms. It can be committed by any party involved in any part of the insurance value chain related activity. Insurance frauds are dynamic in nature and therefore it is a constant challenge for those managing or fighting frauds to sense their origin or direction or extent. Fraud can be committed in a variety of ways as insurance has many complex concepts and procedures that open up avenues for cheating the system.

**The Seriousness of Fraud Losses**

Fraud erodes many of the underlying principles of insurance. Fraud is therefore to be viewed with alarm, as against the traditional complacent mindset that sees fraud as a 'victimless crime' and that it affects only the concerned insurers. The objective of insurance is to provide protection for all, by offering need-based covers and collecting policyholder money (premium) for it. If this premium is lost or drained off due to fraud/corruption, it will undermine the economic welfare intended. Insurance pays for real losses arising from a covered peril to those eligible for indemnity. When frauds occur, the insurers suffer erosion of their funds and hence capability to pay claims.

Further, if there is a feeling among public that fraud claims are being paid, it will make the public lose confidence in insurance. Hence fraud has wide public ramifications and all insurance stakeholders should initiate prevention, detection and reporting of frauds.

**Fraud is a Crime**

Fraud is a financial crime. It is wilful and deliberate, and done for illegal financial gain. Abuse is another form of loss faced by insurers, where people indulge in activities that are inconsistent with business ethics which result in an unnecessary rise in claim costs. It bleeds the system. Inflated bills submitted in a claim is an instance of abuse.

**Insurance Frauds – Causes**

These can be analysed as under:

- **Sales Process Based**

  Insufficient know your customer (KYC) process and improper sales practices by the intermediaries and the insurers. Many of the frauds and abuses arise from the behavioural (moral hazard) side of a customer. People do not mind gaming the system and when claims do not happen, they try to take advantage by using unfair means to get claims or allow the policy to lapse and take insurance coverage after a loss takes place.

Collusion between intermediaries/ insurer employees and prospects are also possible and some sales persons may introduce phantom insureds to make claims. Similarly, insureds may move or be moved from insurer to insurer to take advantage of laxity in the vigil of a particular insurer.

- **Underwriting or Risk Coverage Based**

  Inadequate underwriting of the business. Avoidance of leakages and frauds depend on capturing the relevant risk details and ensuring insurability in all its aspects. Full disclosures are needed for which the insurer must act diligently and thereafter the underwriter must size up the risk in all its dimensions. The underwriters can seek to have a pre-acceptance inspection, medical check-ups, reports with regard to pre-existing deficiencies, past insurances and claims etc. Underwriting has to understand the nature of insureds and their risks, the nuances of the behaviour of claims and so on. Good underwriters are key to preventing insurance frauds and their skilling needs to be increased, owing to the deficit created during the tariff days.

- **Owing to Absence of standard Fraud Protocols**

  In the absence of standard fraud procedures, anyone in the insurance value chain can get induced to commit fraud and abuse. The processes in the insurance sector must not only try to elicit the truth but also must not allow anyone an opportunity for fraud or abuse. Unexplained cost increases in any area that is higher than the usual points to possibilities of fraud.


- **Not Cutting out the traditional fraud opportunities.**

  Inadequate underwriting of the business. Avoidance of leakages and frauds depend on capturing the relevant risk details and ensuring insurability in all its aspects. Full disclosures are needed for which the insurer must act diligently and thereafter the underwriter must size up the risk in all its dimensions. The underwriters can seek to have a pre-acceptance inspection, medical check-ups, reports with regard to pre-existing deficiencies, past insurances and claims etc. Underwriting has to understand the nature of insureds and their risks, the nuances of the behaviour of claims and so on. Good underwriters are key to preventing insurance frauds and their skilling needs to be increased, owing to the deficit created during the tariff days.

- **Inadequate Internal Control and Checks, especially in the claims area:**

  Insurers and intermediaries need to have proper internal control and check systems to avoid and prevent internal frauds either by themselves or in collusion with other parties. There should be due diligence in the selection of surveyors and claim investigators. It is possible to collude with intermediaries, hospitals, workshops and even non-existent establishments to commit frauds.

**Fraud Investigation**

Fraud investigation is a difficult and risky exercise. The culture of the organisation needs to support all fighters of frauds. Everyone in the system needs to view frauds in the fundamental insurance sense and keep looking for root causes and system errors. Decision making errors should not be seen as frauds and vice versa.

Fraud investigation can be internal for insurer employees or external involving outside persons or institutions. Fraud investigation can be document based or by field investigation, or it can and should use technology and lab tests.

Investigations can be done by the insurer employees, outside agencies (private investigators) and retired police personnel and officially by police authorities when proper FIRs are filed.

There are advantages and disadvantages when the investigation is done by internal experts or by outside experts. Internal experts know the insurance domain and can zero in on the insurance angles very quickly. Outside experts can expertly handle the criminal aspects, but can miss the insurance angle. Both the types of investigators can fall into simplistic approaches and catch on to a technical view, which may lead them to the wrong results or have a person victimised because of their shallow understanding of the real issues involved. They view, for instance, breach of a circular as a fundamental error without understanding that circulars can be advisory and the concerned Officer has to use discretion when underwriting or settling a claim. They do not understand or refuse to understand, also because of prejudice or the misleading trails provided to them.

**Understand Frauds in the Context of Risk and Indemnity**

Fraud investigation in insurance should begin with the fact that is insurance frauds needs to be understood in the context of risks, which are diverse, dynamic and unforeseen. So, care need to be taken that there should be no innocent victims, whether internal or external.

**Practical Aspects of Investigation**

- The terms of reference should be specifically on the fraud committed after proper application of mind on the issue. Complaints may arise that keep raising false alarms. The serious fraud must be identified from the chaff, so that effective action can be taken against the offenders. In addition, there must be an effort to understand the root cause and take preventive action. A proper fraud ERM template is be put into effect.

- Going after the real perpetrators is important. There have been many scams in the marketing of insurance and in the recent Insurance Act Amendment, multi-level marketing has been banned owing to the many scams that happened in the past, but almost no one in the marketing area has been booked for making or encouraging such frauds.

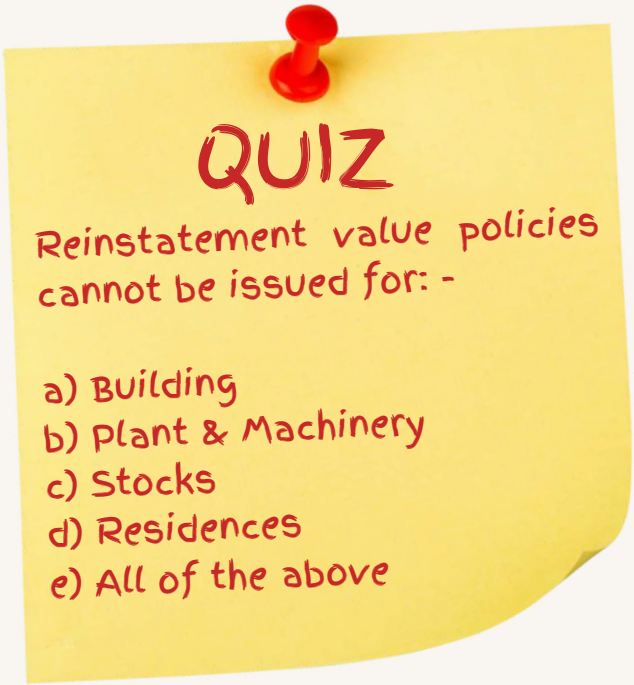
- Underwriting frauds happen when uninsurable risks are insured and persons given the claim. It can happen when important loss avoidance clauses or warranties are omitted either with a fraud intent or a serious judgement error. Lack of understanding the frequency, severity and latency of losses are critical factors to understand potential losses, for which careful underwriting is required.

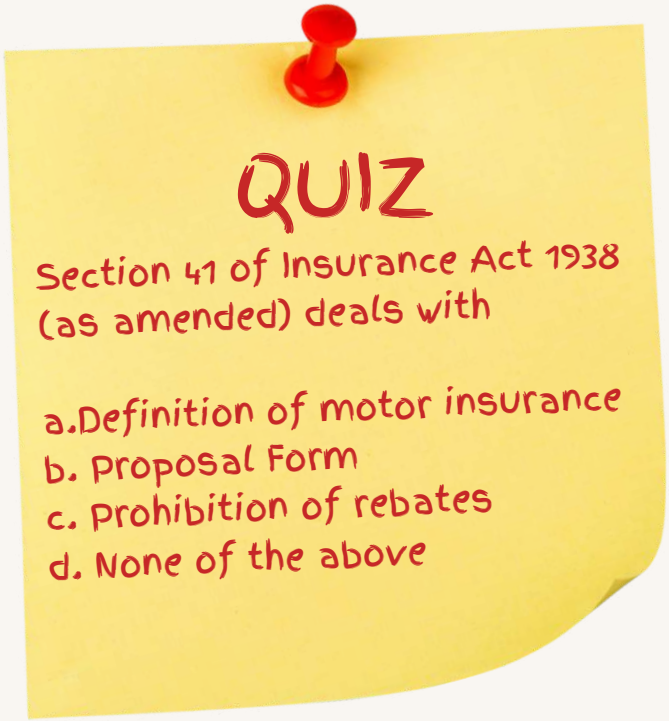
- Managing claims properly. Each department has its own unique claim pathways and specialised investigations may be required. There can be physical based frauds, document-based frauds, accounting based frauds, obsolete goods/machinery/ building based frauds, a whole host of medical condition and care frauds, repair and total loss frauds in motor and so on. There could be an organised racket in many areas which are much more dangerous than random frauds. Investigators should not take the easy route and overlook the underlying systemic risk of frauds.

- The hard work and success of one insurer or stakeholder in fighting frauds has to be supported by all insurers and intermediaries. There are has to be fraud exchange and the names of blacklisted insureds and claiming institutions should be made available to all insurers so that their future activities are not allowed in the insurance area. 'Naming and shaming' may also be required as well as criminal prosecutions.

- Finally, 'whistle blowing need to be encouraged seriously with rewards. There has to be widely advertised publicity to encourage reporting of frauds from the public. Insurers should ensure that claim by 'cashless' does not lead claims behind the back of the insureds. The insured should be fully aware and agree to the claims paid, whether to repairers, hospitals or financial institutions.

**Fraud is an increasingly important issue in financial services and especially in insurance. The initiatives to investigate and fight fraud must be nurtured as a cultural issue by the industry and every aspect of short-changing and loss whether by insurers, policyholders, intermediaries or other repairing or certifying agencies need to be arrested.**



# CASE STUDY

## ON FIRE POLICY CLAIM CAUSED BY RIOT AND MALICIOUS DAMAGE

**Facts**

Due to a tragic accident to four workers when they were sleeping in a factory, in which three of them died and the other was critically injured, an uncontrolled crowd of 150-200 persons, driven by grief and rage, broke into the factory and inflicted property damage, primarily by shutting down the furnace by use of force, even after being told that it may lead to explosion and casualty. In the claim which was filed, the surveyor stated that the damage to the furnaces of the insured's factory was a consequential loss.

The moot question is whether the loss is covered under the RSMD clause or is there any kind of exclusion that applies and whether the damage to the furnace can be said to be a 'consequential loss'?

**Discussion**

- The Standard Fire and Special Perils Policy is a named peril policy, covering various named perils including RSMD. These perils, so covered, have general as well as specific exclusions. The Fire Policy does not define RSMD. So, one has to go by the terms of the law in force.
- As provided under Section 146 of the Indian Penal Code, 1860, a riot is simply an unlawful assembly where the assemblage may conduct an activity accompanied by the use of force or violence, where property may be damaged or lost. The word 'violence' in this context is not restricted to force used against persons only but it extends also in force used against inanimate objects.
- It is the onus of the insured to prove that the loss occurred by an insured peril and it is for the insurer to disprove that a covered loss did not take place or that a clear and undisputed exclusion applies which does not permit the payment of the claim. As per the survey report, the insured has given enough evidence that a sudden and unforeseen riot had taken place. This was proved because the police registered a case under the section relating to the occurrence of a riot.
- 1.It is therefore clear that the loss took place owing to the sudden and unforeseen assemblage of an outraged crowd, who in their emotional outpouring owing to the deaths that happened in the factory, rampaged across the factory. All damage has

been caused by the action of trespassers who used violence and force to create damage in their violent anger. The police filed FIR under sec. 447 criminal trespass, sec. 147 rioting, sec.149 unlawful assembly.

- Riot, Strike, Malicious Damage clause covers loss of or visible physical damage or destruction by external violent means directly caused to the property insured but excluding those caused by:

  1. Total or partial cessation of work or the retardation or interruption or cessation of any process or operations or omissions of any kind.
  2. Permanent or temporary dispossession resulting from confiscation, commandeering, requisition or destruction by order of the Government or any lawfully constituted Authority.
  3. (Permanent or Temporary dispossession of any building or plant or unit or machinery resulting from the unlawful occupation by any person of such building or plant or unit or machinery or prevention of access to the same.
  4. Burglary, housebreaking, theft, larceny, or any such attempt or any omission of any kind of any person (whether or not such act is committed in the course of a disturbance of public peace) in any malicious act.

- In the context of sec.147, 'loss by visible physical damage or destruction by external violent means directly caused to the property insured' has taken place. Exclusions mentioned in the clause does not apply i.e., there was no cessation of work etc., there was no dispossession and no record of occupation (sudden unforeseen damage instead happened in a violent manner), no loss by burglary etc.

- In the context of the riot that took place, the crime was sudden, violent and unforeseen both as to timing and extent of loss as in this case.

There is normally no scope for the management or workers to react to it, much less to fuel it (moral hazard and fraud factors) in this case. In the case of strike, it is an industrial action and can create damage which may create slow and deliberate occurrences of losses. The management can be indirectly responsible for the strike (moral hazard and fraud is possible) and hence all losses that can also be slow in emerging which may not be held covered. Similar can be case for malicious damage.

- Riot has thus to be distinguished from strikes which can naturally create the chance of consequential loss arises due to prolonged strike. When the loss is sudden, violent and unforeseen and neither the insured nor the perpetrators had any specific idea of what they will do or what will happen by their action, the loss wholly falls on direct loss and is payable if they are property damage. In the circumstances leading to the referred claim, it is clear that there was no possibility of any degree of moral hazard or fraud –factors that can raise issues for denying liability.

- It is also clear that the proximate cause of the loss is a sudden riot where the question of consequential losses does not arise.

Consequential losses are slow losses or losses such as defined under General Exclusion No. 9 of the Standard Fire Policy, i.e. "Loss of earnings, loss by delay, loss of market or other consequential or indirect loss or damage of any kind or description whatsoever." Consequential losses mean losses that are not directly linked and where the damage triggers losses which are not coverable because they are not 'pure risks' such as loss by delay or if they arise out of pure risks they have to get covered by other policies, such as a policy for loss of earnings.

- Hence it is strange that the surveyor opined that the damage to the furnaces of the insured's factory was a consequential loss. However, it may be noted that the onus on the surveyor or insurer to factually prove it. An unbroken sudden chain of events cannot be a consequential loss. The Surveyor's Regulation 2015 casts onus on the Surveyor to 'examining, inquiring, investigating, verifying and checking upon the causes and the circumstances of the loss in question' (13. (1)(e). They must satisfy the queries of the insured and give reasons for turning down the claim as per the Regulation.

- Courts tend to look at insurance losses in a holistic manner and every claim has to have a logic. If there is an accidental and unforeseen damage caused by a peril insured against, then there is an onus to indemnify, unless a clear exclusion prevails. The loss must not be in the category of a business or speculative loss (profit or loss), but a pure risk-based loss (loss or no loss). The case in question is clearly a pure risk, wholly unforeseen by all concerned. The suddenness of the loss rules out insurance problems such as moral hazard or fraud.

- Thus, if a physical loss or damage has occurred by a covered peril, and the loss does not fall within a clear exclusion that is in the policy, claim payment follows logically. Claim payment cannot be considered on the basis of stretched logic either to pay or to deny.

No technical reasoning or consideration should stand in the way of paying the claim.

**Conclusion**

Considering the facts and circumstances as seen in the case, it is clear that physical loss and damage has been caused to insured property due to a sudden and unforeseen occurrence of a riot, where the insured or their employees had no prior knowledge or foresight of it. All loss or damage are proximately caused by the action of the rioters and no consequential loss possibility is seen, given the suddenness and severity of the occurrence.

Notes:

The Delhi High Court in the case Usha International Limited vs United India Insurance Co. Ltd. on 2 September, 2005 went deep into the question of RSMD arising from a cyclonic loss. It went into the views of then Chairman IRDAI, New India Assurance Co and others. The court stated: 'The term 'riot' means a public disturbance involving (1) an act or acts of violence by one or more persons part of an assemblage of three or more persons, which act or acts shall constitute a clear and present danger of, or shall result in, damage or injury to the property of any other person or to the person of any other individual or (2) a threat or threats of the commission of an act or acts of violence by one or more persons part of an assemblage of three or more persons having, individually or collectively, the ability of immediate execution of such threat or threats, where the performance of the threatened acts or acts of violence would constitute a clear and present danger of, or would result in, damage or injury to the property of any other person or to the person of any other individual.' This definition brings the occurrences which are the subject matter of this petition within the ambit of the word 'riot' and beyond the purview of the exclusion clause. The FIR records that 10 persons had forcibly entered the premises of the Petitioner and committed theft of some movable properties despite the resistance of the Petitioner's employees. The Respondents were, therefore, liable to be indemnifying by the Petitioner against theft under the Fire Police 'C'. Viewed in this analysis, the theft on which the claim is predicated would be payable on both the policies."

Thus, the court struck down the exclusion in the policy against theft owing to RSMD. Similarly, if a court was approached it is possible that exclusions such as consequential loss or "loss arising total or partial cessation of work or the retardation or interruption or cessation of any process or operations or omissions of any kind".

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