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Study Guide

THE FUNDAMENTALS OF SHORT-TERM INSURANCE: ONLINE CPD COURSE 2020 / 2021

Anna Bouhail ©

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Course summary

The fundamentals of short-term insurance are an on-line course considering the important concepts applicable to short term insurance. The course is an introductory /refresher course outlining concepts that need to be considered when assessing the short-term insurance needs of a client. The concepts are applicable both to retail and personal lines insurance.

Time allotted for course

The course consists of 5 topics with an assessment that needs to be completed. The time allotted for each aspect is as follows:

Topic number	Title	Word count	Level	Time allotted
Topic 1	Overview of short-term insurance	5054	Entry level	50 minutes
Topic 2	Short term insurance principles	3687	Entry level	40 minutes
Topic 3	Risk underwriting	1279	Entry level	15 minutes
Topic 4	Agreement of terms & conditions of cover	2884	Entry level	30 minutes
Topic 5	Claims process	5171	Entry level	45 minutes
	Assessment			45 minutes

Total time	**4 hours**

Assessment and certification

After completion of the workshop the learner must complete an electronic assessment on the learning management system.

- **Form of assessment:** Multiple Choice Questions
- **Number of questions**: 20 questions
- **Duration:** 60 minutes
- **Competency mark:** 60%

Upon obtaining a competency mark of 60% the learning will receive a certificate of completion. The learner will be afforded an opportunity to re-do the workshop should a competency mark not be attained.

Course accreditation

CPD Category: Online program

COB Category: Short-term Insurance: Personal Lines | Short-term Insurance: Commercial Lines

Financial planning component: Risk Management

Advice component: Insurance (short-term)

Accreditation valid until: 31 May 2021

CPD Points allocated: 4.0 points/hours on completion and pass of online assessment

FPI approval number: FPI20050204

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Ordering information
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TOPIC 1 OVERVIEW OF SHORT-TERM INSURANCE

LEARNING OUTCOMES

After studying the topic, the learner should be able to-

- Give an overview of short-term insurance
- Explain the purpose of the Short-Term Insurance Act (53 of 1998) and related concepts.
- Explain the basic requirements of the Short-Term Insurance Act that apply to insurers.
- Explain how the Short-Term Insurance Act controls intermediaries.
- Explain how the Short-Term Insurance Act regulates Short-term insurance policies and protects individual policy holders.

1.1 Introduction

The history of insurance mainly deals with the United Kingdom, simply because most insurance practice developed there. Whenever a need for protection against financial loss has arisen, it has led to the development of some form of insurance.

Insurance can be explained as a system where the losses of the few are paid from the premiums of the many.

Because of the fear of losing their property, people developed a system where they could spread the risk. Different types of insurance developed in response to the needs of people. Insurance companies were there to provide protection against financial loss by people, eliminating worry about losing or damage to their property. Other classes of insurance have developed in a similar manner.

1.2 Short-term insurance

Short term insurance is insurance that runs for only short periods of time (or for short terms) - a month or a year, or for any other agreed period, before it needs to be renewed, re-rated, reassessed or reissued. This is unlike a life or pensions policy that is issued and then runs until the insured either dies or goes on retirement.

Short term insurance also focuses in general on material goods that can be insured – such as buildings, motor vehicles, goods in transit, or to protect the insured against liability that arises as result of his activities, and which cause damage to other parties' property or lives.

1.3 Insurance Products develop through client needs

The marketplace normally dictates what happens to any product and insurance is no exception. Demand and supply are factors to be reckoned with.

Insurance products that we know today are all the result of needs expressed by its numerous consumers, and the eventual pressure of the user group, and competition on the insurer to review current products, and develop or modify products, to meet needs of its consumers.

The risk to the insurer is to lose these clients to competitors, or alternative risk control methods. These alternatives are not always satisfactory or effective, for either insurer or insured.

1.4 Personal lines insurance

Personal lines insurance policies are standard, general policies bought by individuals to cover their personal assets. These policies cover includes the following:

- House owner's insurance (buildings)
- Householders insurance (contents)
- Personal motor
- All risks insurance
- Personal computers
- Small craft
- Personal accident insurance
- Personal liability insurance

It is usual for these policies to provide different types of cover under a single policy, usually with a single combined premium for all the sections (payable annually or monthly). This is known as a personal lines multi-peril policy.

The private individual in insurance is the man in the street. The individual often comes into contact with insurance when he buys a house or a motorcar.

The supplier of finance will usually insist that the buyer proves valid insurance, not necessarily via the supplier. Therefore, this is often the first point of contact with insurance.

1.5 Commercial lines insurance

Commercial insurance policies cover business and commercial risks of businesses.

These policies cover the following classes:

- Fire and perils
- Accident
- Theft
- Loss of money
- Goods in transit – damage or loss to goods being transported on a conveyance
- Personal accident
- Business all risks
- Fidelity – fraudulent actions by employees
- Liability
- Accidental damage
- Motor, including motor traders internal and external risks
- Business interruption
- Machinery breakdown
- Contractors all risks
- Fidelity guarantee and guarantees and bonds
- Money, plate glass and other minor classes

There is a further undefined segmentation that exists in the commercial lines market between commercial entities, corporate entities and industrial entities. The description of these entities are as follows:

- **Corporate entities:** The types of firms whose shareholding may be listed on the Johannesburg Stock Exchange. They often comprise of diverse businesses/entities with a multitude of complex risk scenarios for which a normal multi-peril policy cannot apply. A special policy known as an Assets All Risks Policy could be used in these cases.
- **Industrial entities:** Industrial entities are those involved in the manufacturing segment of the economy and could range from the large corporate to a small entity. Industrial risks include manufacturers, engineering works, panel beaters, and other small private enterprises.
- **Commercial entities:** those entities involved in commerce such as banks, insurance companies, department and retail stores.

Because of the great differential between businesses as outlined above, it is essential that a representative understands the business of the client in order to fully understand the risks to which each client may be exposed and to offer the appropriate solutions.

1.6 Niche or specialist markets

Niche markets are those for which certain insurers provide cover for limited specialised risks. It is important to note that there are a host of insurers and underwriting managers who design and sell specialist products not included in the above for specialist risks such as the hospitality industry, specialist classes of liabilities, bonds and guarantees and it is important for the representative to have a good working knowledge of the market.

In the commercial lines' environment, particular niche markets would be as follows:

- Marine
- Aviation
- Agriculture
- Livestock
- Bloodstock
- Construction
- Computer fraud
- Director's and officer's
- Engineering

Each of these is discussed in the subsections following.

1.6.1 Marine

Marine insurance as a specialist market specifically refers to cover to the hulls of watercraft. Hull damage relates to the vessel and associated machinery of the vessel. It also includes loss caused by pirates at sea.

In addition, cargo on ships is covered by a marine cargo policy.

1.6.2 Aviation

All aspects of aviation, including the airfields, aircraft, damage and liabilities, are handled in the aviation segment of the insurance industry. This may also include commercial airliners, small aircraft, gliders, micro-lights, hang gliders and para gliders owned by individuals.

It should be emphasised that personal accident cover in relation those participating (crewing) in the above is specifically excluded in the multi-peril and standard personal accident policies and can only be covered in the aviation market.

1.6.3 Agriculture

This mainly concerns damage to growing crops and plantations. The buildings and equipment of a farm are normally insured by a farmer's multi-peril policy. Therefore, the average crop farmer will have two policies. The growing crops themselves will be covered for disease, fire, hail and storm damage to the crop under the agricultural policy.

1.6.4 Livestock

Specialist Livestock insurers will offer cover on livestock (cattle, sheep or goats) for death, specified disease, infertility or impotence of bulls for registered breeding herds. For commercial herds cover is usually provided for catastrophes such as fire and lightning.

1.6.5 Bloodstock

This is cover exclusively for thoroughbred breeding and racing horses. This provides cover for death resulting from "all risks of mortality" including accidents to racing and breeding stock as well as death by humane destruction as a result of injury to an animal.

Cover is also available for infertility of stallions, the insurance of unborn fetuses and foals.

Insurance is also available on horse-related risks relating to leisure horse cover such as show jumpers and dressage horses.

1.7 Terminology relevant to Short-term insurance

The following terminology is relevant to short-term insurance:

- **Agent:** A person who acts on behalf of another and in the case of insurance is the intermediary between the proposer and the insurer.
- **Asset:** A person who acts on behalf of another and in the case of insurance is the intermediary between the proposer and the insurer.
- **Attestation:** The signing clause in a contract of insurance.
- **Broker:** A professional full-time independent agent or intermediary.
- **Brokerage:** The commission or fee paid to the brokers by the insurers for placing business with them.

- **Cancellation:** A term appropriately used for policies cancelled on breach of a material term or in terms of a cancellation clause in the policy.
- **Claim:** A demand made by the insured for payment, in terms of the policy contract, after the occurrence of loss or damage covered by the policy.
- **Claim form:** A form supplied by an insurer to enable an insured to lodge a claim in terms of the policy.
- **Commission/ brokerage:** The payment made to intermediaries by insurers for placing business with them.
- **Contract:** An agreement made by two or more parties with the intention of creating a legal obligation between them.
- **Contract of insurance:** An agreement between insurer and insured whereby, in return for the payment of a premium, the insurer undertakes to indemnify the insured upon the happening of a specified event.
- **Cover:** The protection provided by insurance.
- **Disclosure:** The duty of the parties to a contract of insurance to reveal all material facts to each other before it is concluded and prior to each renewal.
- **Insurance policy:** A document that is evidence of a contract of insurance.
- **Insurance:** A risk transfers arrangement whereby the responsibility for meeting losses passes from one party (the insured) to another (the insurer) on payment of a premium.
- **Insured:** A person or organisation who takes out insurance.
- **Insurer:** A company or society transacting insurance business.
- **Intermediary**: A person who arranges insurance on behalf of another.
- **Liability:** A claim upon one's assets by another person.
- **Policy**: Written evidence of the terms of an insurance contract.
- **Policyholder:** The insured person.
- **Premium:** The money paid by the insured to the insurer for cover as provided in the policy.
- **Rejection:** Is the suggested term for the rejection of a claim to an indemnity under a valid policy.
- **Short**-term insurance: Insurance that operates on a year-to-year basis and which the insurer or the insured may terminate.
- **Third party**: A person who is not party to a contract
- **Underwriter**: An insurer or a person who makes decisions on whether or not to accept insurance business.
- **Underwriting**: The process of assessing a proposal for insurance to decide on its acceptability and if so, on what terms.
- **Void**: Refers to a policy that never existed as a lawful contract so that no rights and obligations came into being.

- **Void Contract**: A contract that cannot be enforced by either party.
- **Write (Insurance Business**: Provide insurance cover.

1.8 Standard term of a short-term insurance policy

The standard duration for Short term insurance contracts is normally one year and are then reviewed by insurers. The contract can then be renewed or declined, or terms and conditions altered.

Personal lines and small retail policies can be issued for a monthly period and a monthly premium.

In many of the cases the onus is on the insurer to justify cancelling or rejecting a policy after reviewing it. Avoidance or a cancellation of a policy or the rejection of a claim should be based on facts that the insurer is able to prove in court.

The decision to avoid/cancel/reject is so important that it should be discussed with management within the company on every occasion that it is contemplated. No decision should be taken without full consideration of the claim file and the underwriting file.

Where there are co-insurers, it is desirable to ensure that every co-insurer agrees to the avoidance/cancellation/rejection. The extent to which the co-insurers' consent is necessary and the extent to which they are bound by the decision of the lead insurer depend on the terms of the policy.

1.9 Short term insurance products explained

In short term insurance, the products are the actual types of policy documents that are provided by the insurers to cover the client's property or to otherwise safeguard his assets or interests.

In the same way that ordinary retail products are sold to meet a specific need of a customer, so short-term insurance products are sold to provide a specific solution to a client's need.

Premiums charged, and other terms and conditions, such as deductibles, or survey requirements may vary, but the policy wording does not.

There are not many market-agreed wordings, and most insurers offer specifically written policy wordings to their customers. This means that the product is, in most instances, unique and readily identifiable as an offering by a specific insurer.

Personal lines policies are not market agreed and may differ from company to company.

All insurers have different brand names for their products, even though the basic cover and categories are more or less the same. Insurers have different rating methods for the separate sections, based on their own statistical information about risk spread and they may also impose different restrictions and requirements for each class of business.

Excesses and cover may also differ from insurer to insurer. Some insurers provide additional cover under certain classes at the same rate that another insurer provides, to entice clients. Some companies provide value added products (such as legal advice or roadside assistance) either free of charge or at a small premium.

Another development over recent year has been the paperless (electronic) underwriting of policies. Clients phone in and the whole policy is written over the telephone, with the voice recording then forming the basis of the insurance contract between insurers and insured.

Some insurers have so called niche market insurance cover and specialises in one type of cover only, i.e. liability policies or contractors all risk.

The latest development is rewarding insureds for not claiming against their policy for a certain period and then refunding the whole premium or a portion of premium paid in over that period to the insured.

In certain instances, short term insurance is provided by the state, in terms of general risk offerings, such as SASRIA cover, for riot and labour unrest, or in terms of compulsory insurance such as the Unemployment Insurance Act, or Compensation for Occupational Injuries and Diseases Act.

1.10 The Short-term insurance Act

In South Africa, insurance companies must comply with the Short -Term Insurance Act No. 53 of 1998. This lays down various regulations, which insurers must comply with specifically.

The Short-Term Insurance Act contains the legislated requirements of rules and regulations that govern the short-term industry.

The Short-Term Insurance and Long-Term Insurance Acts ensure that insurers remain solvent and can discharge their duties to the public, and also ensure that the insured public is protected. It also spells out the legal requirements of brokers and other intermediaries as regards to their conduct and payment of premiums to insurers. Insurers are required to register, and strict conditions are imposed on registration. Unregistered persons are forbidden to do insurance business.

It is necessary to have Short-term insurance legislation that regulates the short-term industry. It also enables a policyholder to make informed decisions regarding Short-term insurance products, and to ensure that the parties involved conduct business fairly and with due care and diligence.

The reason for the existence of a Short-Term Insurance Act lies in the differences between short and long-term insurance. Short-term insurance focuses on the replacement value of objects (e.g., a motor vehicle) in the event of a loss (indemnity insurance), with personal accident and sickness also covered, whereas Long-term insurance focuses on the life events, such as death or retirement of a person (non-indemnity insurance).

Each type of insurance business therefore has its own legislation/regulations governing its insurers and the way they conduct, manage, market and maintain their business.

In short, the purpose of the Short-term Insurance Act is to provide for the registration of short-term insurers and to control certain activities of short-term insurers and intermediaries and for matters connected therewith.

1.10.1 Different types of policies

The Short-term insurance Act defines the different types of policies as follows:

- **Accident and health policy:** Policy that provide benefits in terms of a disability event, health event or death event.
- **Engineering policy:** Policy that provides benefits to cover risks relating to-
    - Machinery or equipment (other than a motor vehicle) in the carrying on of business
    - Erection of building or other structures
    - Installation of machinery or equipment
- **Guarantee policy:** A policy to provide benefits to cover risks relating to the failure of a person to discharge and obligation.
- **Liability policy***:* Policy to provide benefits to cover risks relating to incurring of a liability.
- **Miscellaneous policy***:* Policy to provide benefits to cover risks otherwise not defined in any other short-term insurance policy.
- **Motor policy:** Policy to provide benefits to cover risks relating to the possession, use or ownership of a motor vehicle
- **Property policy:** Policy to provide benefits to cover risks relating to the use, ownership, loss or damage to movable or immovable property
- **Short-term reinsurance policy***:* A reinsurance policy in respect of a short-term policy

- **Transportation policy:** Policy to provide benefits to cover risks relating to
    - Possession use or ownership of a vessel, aircraft for the conveyance of persons or goods by air, space, land or water
    - Storage treatment and handling of goods so conveyed

1.10.2 Free choice provisions in the short-term insurance act

There are cumbersome provisions regarding the free choice given to a person who is required to provide insurance in connection with money loaned, goods leased, or credit granted.

Such a customer is entitled to prior written notification of the free choice of insurer, whether to use a new policy or an existing policy or both, and the intermediary who is to render services in connection with the transaction.

The customer must be told whether the value of the policy benefits will exceed the interests of the creditor. Where such a customer chooses to have two policies involving two intermediaries, there is going to be considerable complications regarding the servicing of the policy, the collecting of premiums and the handling of claims.

Consent of the insured is required to insure against risks other than mortgage insurance (e.g. home loan insurance – fire, etc. cover on the building of the house). Insurers handling this type of credit insurance will have to draw up a standard document advising the customer of the free choice.

1.10.3 Aspects relating to intermediaries (Insurance brokers)

(I) Commission

Commission in the Short-Term Insurance industry means the money, which is paid to representatives and intermediaries in respect of the business that is generated by the representative/intermediary. Commission is therefore the representative's and intermediaries' earnings for the insurance business that he generates for the insurer.

The Short-Term Insurance Act stipulates the maximum commission payable to intermediaries. These are as follows:

- Motor policy, maximum commission: 12,5% of the premium payable under the policy
- Non-motor maximum commission: 20% of the premium payable under the policy
- Collective policies written through Lloyd's: 20% of the premium payable under the policy
- Any other policy written through Lloyd's: 25% of the premium payable under the policy

These rates are payable only when the premium has been paid to the insurer. Also note that in terms of the new Short-Term Insurance Act, the intermediary may also deduct any refunds due to policyholders, when determining the net amount due to the insurer.

(II) Collection of premiums

The Short-term Insurance Act deals with the collection of premiums by intermediaries in Section 45. This section highlights that no intermediary shall "receive, hold or in any other manner deal with premiums payable under a short-term policy" (not including short term reinsurance policies) and short-term insurers may not permit such dealing in premiums, unless the intermediary is authorised to do so by the short-term insurer in accordance with the Regulations.

To collect premiums on behalf of a short-term insurer, the intermediary must be authorised by the Insurer in writing; and furnish an Insurance Guarantee Fund representing 30% of the estimated annual premiums handled, with a minimum of R100 000 and maximum of R50 000 000.

Premiums for a policy can be paid in different ways:

- The premium can be paid annually (less popular).
- Monthly payments made by debit order (more popular-more convenient).
- Some insurers have a quarterly or half-yearly payment method.

The undertaking by the insurer to provide policy benefits shall be suspended until the insurer has received the first (or only) premium, or until arrangements to its satisfaction have been made for the provision of the premium by debit order, stop order, credit card or another instrument approved by the Registrar.

If a premium has not been paid on its due date, the insurer shall notify the policyholder of the non-payment, and the policy shall remain in force for a prescribed grace period (maximum of one month), or for such longer period as may be agreed between the parties. If the overdue premium is not paid by the end of any such period, the policy shall, provided there is sufficient value, be made paid-up (continue without further premium payments). If there is not a sufficient value, the policy shall be surrendered / lapsed. The insurer must inform the policyholder of these events in writing.

Policy wordings, as well as the debit order form which must be completed by the insured, have a clause which details when the premium is payable. It will also state what will happen if the insured fails to pay the premium.

It is normal practice for insurers to represent debit orders that have been returned. However, if the debit order is returned with "payment stopped" the contract is immediately cancelled.

If two or more orders are returned, the policy is cancelled from the due date of the first returned debit order.

Where premiums are paid in cash, the recipient must be given a written receipt stating the name, address and telephone number of the recipient, the policy number and the name of the short-term insurer.

(III) Other stipulations

The Short-Term Insurance Act stipulates that no person shall render services as an intermediary for a short-term policy, unless short-term insurers and/or Lloyd's underwriters are the only underwriters of the policy concerned. The only exception to this rule is when it has specifically been approved by the Registrar.

No bribes are allowed – no person shall offer any valuable consideration as an inducement to enter into or cancel a short-term policy.

Intermediaries are not to receive, hold, or deal with premiums in any manner, unless authorised in writing by the insurer, and in accordance with the regulations forming part of the Act.

1.10.4 Binder agreements

Binder agreements are an established feature of the Short-Term insurance industry. A binder agreement is simply an outsourcing agreement between an insurer (principal) and a third party (broker, administrator or underwriting manager). The insurer mandates the binder holder to perform certain functions for and on behalf of the insurer in connection with administration of insurance policies and claims.

The proposed new section 48A of the Short-Term Insurance Act and section 49A of the Long-Term Insurance Act are aimed primarily at tidying up the regulatory regime applicable to binder agreements between insurers and other parties who act on behalf of the insurer.

There is a clear distinction between binder holders and independent intermediaries. Independent intermediaries should ideally charge a fee to the client, and not receive commission or any other remuneration from the insurer. Their sole role should be to advise and educate consumers regarding financial services and products. Binder holders may take the form of intermediaries performing administration services for one or more insurers while also acting as a sales or distribution channel.

Alternatively, binder holders may act solely in an underwriting or administration capacity where sales and distribution are via independent intermediaries or tied agents. As this can be confusing to consumers, it is essential that clear and meaningful disclosure is made to the consumer regarding roles, responsibilities and any real or potential conflicts of interest.

Some intermediaries can be authorised to issue policies and settle claims on behalf of the insurer, subject to a written agreement that sets out:

- The kinds of policy, the rates to be used, and the maximum sum insured.
- The scope of the claim settling authority.
- In addition to normal commission, how the intermediary is to be paid for these services.
- The name of the insurer must be disclosed to the policyholder, and the fact that the intermediary is acting in terms of the binder agreement.

1.10.5 Policy holder protection rules

Before the introduction of FAIS Act, these rules - promulgated in terms of the Long and Short-term Insurance Acts - were designed to protect clients when they took out a life assurance policy or a short-term insurance policy. Some of the provisions of the Policyholder Protection Rules, particularly those relating to what clients must be told about these policies, now overlap with those under the FAIS Act.

Besides stipulating that clients must be given enough information to ensure that they make an informed decision about taking out a policy, the Policyholder Protection Rules state that before selling a policy to a client, a broker or agent must give details of expected increases in the premiums, explain the consequences of non-payment, and give the client the surrender value of the policy at various stages.

The agent must tell the clients whether he or she represents only one company or is an independent broker able to sell a range of products.

If the agent represents a company, the agent must tell clients the nature of his or her relationship with that company - for example, if that company pays the agent most of his or her remuneration.

In terms of the Policyholder Protection Rules, clients enjoy a 30-day cooling-off period during which time they can cancel a policy that they have accepted, but not yet claimed under. This is intended to counter the effects of high-pressure sales tactics.

The Policyholder Protection Rules places certain responsibilities on the insurers.

Insurers are obliged to send clients documentation confirming the policy and including important information, such as how much your premium is; what they are paying a loading for if applicate, for example, poor health; what the ongoing expenses on any investment element of a life assurance policy are; and how to institute a claim.

Another important issue the Policyholder Protection Rules addresses is what happens when clients switch policies. In the life assurance industry, in particular, sales people often encourage consumers to cancel one assurance contract and replace it with another. This is not always in the consumers' best interests and may simply be a ploy to earn more commission.

The Policyholder Protection Rules stipulate, among other things, that when clients cancel one policy to take out a new one, clients must be told all the implications, including how this will affect their benefits; the additional costs incurred; any tax disadvantages; any new waiting period before benefits are paid; any risks to their future insurability; and any additional investment risks.

Section 55 of the Short-Term Insurance Act determines that the Advisory Committee or the Registrar, after consultation with the Advisory committee, may determine rules that ensure that all policies are enforced and managed in terms of sound insurance practices. They may also vary or recall any such rule. The time frames that relate to the lapsing of any rule are part and parcel of their powers.

These rules may provide the following

- Particular imports may not appear.
- Information must be made known.
- Policyholders may cancel policies under certain conditions and within specified periods, and the legal consequences of such.
- The different arrangements applicable to the various policies.
- Determine and implement fines and the circumstances of such.
- Publish rules and variations in the Gazette relating to variations and rescission requirements inviting all interested persons to make written representations in relation to any matter within a specified period of 21 days in this regard.

The policy holder protection rules of the Short-Term Insurance Act provide insurance holders with certain protective measures. These measures are discussed in the subsections following.

(I) Policies issued to minors

Section 52 of the Short-Term Insurance Act highlights the rules regarding polies issued to minors. According to this section of the Act, a minor is a person who is younger than 18 years.

A minor who has attained the age of 18 years may, without the consent of his or her guardian, enter into or deal with a short term insurance contract and pay the premium due under the policy with money which he or she has earned or which is at his or her disposal, and a policy benefit under the policy shall be provided to the minor who may deal with it as he or she thinks fit without the consent of his or her guardian.

This minor will be held responsible for the payment of premium and terms and conditions of the policy as if he were an adult, for as long as he benefits from the policy.

The minor would also have the power to negotiate changes in the terms of the policy if these changes are in the individual's interest as if he has attained his majority (reached the age of 21 years).

(II) Issuance of policy

Natural persons who are insured under short term policies (personal line business) must be provided with a copy of the document embodying the contract within 30 days being entered into or varied.

A policyholder and anyone else who entered into a short-term policy, shall be entitled, against payment of a fee, to be provided upon request, with a copy of the policy.

(III) Disclosures

These apply only to policies issued to natural persons acting otherwise than for the purposes of his or her business. A statutory notice must be given to policyholders and prospective policyholders, informing them that they have the right to the following information:

About the intermediary

- Name, physical and postal address, and telephone number.
- Legal status and any interest in the insurer.
- Whether or not in possession of professional indemnity insurance.
- Details of how to institute a claim.
- Rand amount of fees and commission payable.
- Written mandate to act on behalf of the insurer.

About the Insurer

- Name, physical and postal address, and telephone numbers.
- Telephone number of compliance department of the insurer.
- Details of how to institute a claim and/or complaint.
- Type of policy involved.
- Extent of the premium obligations of the policyholder.
- Manner of payment of premium, due date of premiums and consequences of non-payment.

The holder must be informed of any material changes to the information above.

If the information was given orally, it must be confirmed in writing within 30 days.

TOPIC 2 SHORT-TERM INSURANCE PRINCIPLES

LEARNING OUTCOMES

After studying the topic, the learner should be able to-

- Explain the principles of insurance, including the concepts of insurable interest, insurable risk, duty of disclosure, indemnity, average, compensation, subrogation, proximate cause and contribution.
- Describe the different types of cover (including self-insurance/funding, e.g. aggregate excesses) available, and the implications and benefits thereof.

2.1 Introduction

Before one can begin to determine the insurance needs of a client, there are some basic insurance principles that need to be understood. These principles are considered in the subsections following.

2.2 Insurable interest

Insurable interest is the legally recognised financial relationship between the insured and the financial loss that he suffers following a loss. One can insure only those things with which one has a legally recognised financial relationship, for example, one can insure one's house against fire because if it burns down one will suffer a financial loss.

Legally recognised relationships include the following:

- Owners and joint owners of property
- Mortgagees and mortgagors
- Bailees (a person holding another's goods and having a duty of care for those goods)
- Agents
- Executors and trustees who can insure the property for which they are legally responsible
- The relationship with your spouse. Husbands and wives have unlimited insurable interest in each other's lives. (Other examples exist for long-term insurance.)

2.3 Insurable risk

Risk is the subject matter of an insurance contract; the possibility of a loss against which insurance is taken out.

In order for a risk to be insured, there are certain basic requirements that must be met. These requirements are as follows:

- The cause of the loss must be accidental or fortuitous.
- There must be insurable interest.
- The loss must not be intended for personal gain by fraudulent means.

2.4 Duty of disclosure

Disclosure means to make known, reveal or expose to view, all of the information that the client needs to know about the financial product and the terms and conditions of the product he is purchasing. The obligation to disclose begins as soon as the negotiation for the insurance contract begins. The client must be in a position to make an informed decision.

It is therefore legislated, through the Financial Advisory and Intermediary Services (FAIS) Act, that various aspects of financial arrangements be made known to clients by Representatives who sell them financial products.

In addition, the client also has a duty to disclose all factors that might influence the risk for which they are seeking insurance.

2.5 Indemnity

Indemnity is when a person's financial position is restored, as a result of insurance, back to what it was immediately before the person experienced a loss. Indemnity and insurable interest are closely linked, as the principle of indemnity means that the insured cannot recover any amount exceeding the extent of his insurable interest.

2.6 Compensation

In short-term insurance personal accident and liability are examples of compensation policies. In the event of a loss the insured is paid an agreed amount of money. This differs from indemnity policies, where insured items are restored, repaired or replaced or the monetary value thereof is paid.

2.7 Third-party insurance

Third party insurance covers injury to other parties and damage to their property.

This is the most basic form of cover, which provides no cover for the policyholder's own loss or damage. There are several important exclusions to this cover. Such exclusions may include the following

- Death or injury to members of the insured's household.
- Death or injury to people who are employed by the insured.
- Loss or damage to property belonging to the insured or which is in his custody or control.
- Losses which are already covered by the Road Accident Fund Act - insured persons cannot sue the negligent driver.

2.8 Underinsurance

Underinsurance refers to inadequate insurance coverage held by a policyholder. In the event of a claim, underinsurance may result in economic losses to the policyholder, since the claim would exceed the maximum amount that can be paid out by the insurance policy. While underinsurance may result in lower premiums paid by the policy holder, the loss arising from a claim may far exceed any marginal savings in insurance premiums.

(I) Consequences of underinsurance

An insurance policy, having a sum insured or limit of indemnity will not pay out more than that amount in any one claim. In fact, under many insurances the sum insured, or limit of indemnity represents the maximum amount that can be claimed in any period of insurance.

Therefore, a consequence of underinsurance is that no claim will be paid for an amount greater than the sum insured or limit of indemnity.

2.9 Average

Average is a concept used by insurers to deal with underinsurance. If a policyholder is under-insured, he will not be paid in full when a loss occurs. The amount of any loss will be divided between the insurer and the insured, based on the full value of the property. Underinsurance occurs when an item is insured for less than its intended insurance replacement value the basis of settlement should be either market or replacement value.

It is important that the insured should not select against the insurer by understating the value at risk and must therefore pay his full share into the insurance pool. The premium that he pays should be based on the amount of financial value at risk and not part thereof.

If the insured understates the insured value, he will be paying an incorrect amount of premium and therefore be underinsured. Should he then have a claim, the principle of average will be applied.

2.10 Subrogation

Subrogation is the legal provision under common law by which one party, usually an insurer, stands in the place of the insured, so as to have the benefit of the insured's rights and remedies against a third party.

Subrogation therefore means the right of one person to take over, or assume, the legal rights of another person.

Example

Elias is aware of how important insurance is. He has thus taken out insurance to cover his new car. One morning on his way to work, a car collides with his car. As a result of the collision, caused by the negligence of the other driver, Elias's car is severely damaged. There is R50 000 worth of damages.

Elias' insurer arranges for the repair of his car. The insurer now has the right, through a process of subrogation, to recover the monies paid from the other driver's insurer or the driver himself where the driver is uninsured.

The subrogation clause states that insurers have the right to assume the insured's right to claim against the third party. This means that the insurer may act as though they were the insured the insurer may begin acting before they pay out the money for repairing the damages to Elias's car.

2.11 Proximate cause

In an insurance contract, it is necessary to state the perils that are covered or excluded, so that all parties to the contract know exactly what perils are covered.

It is necessary, therefore, to examine the cause of loss in some detail because the insurer is only liable for losses proximately caused by an insured peril.

Proximate cause means the active, efficient cause that sets in motion a train of events that bring about a result, without the intervention of any force started and working actively from a new and independent source.

Examples of proximate cause is as follows:

- Damage is caused by smoke resulting from a fire, the fire is the proximate cause of the damage caused by the smoke.
- Damage caused by water used to extinguish a fire is proximately caused by fire.
- A person sustains accidental injury and is taken to hospital, where he contracts a disease from a patient in the next bed and dies from the disease, the accident is not the proximate cause of death.
- A wall is weakened by a motorcar that collides with it and the wall in its weakened state is subsequently blown down by a high wind, the proximate cause of the collapse of the wall is the wind (and not the impact of the motor car).

2.12 Contribution

Where the same risk is insured by two different insurers, contribution will apply in the event of a claim, in respect of that particular occurrence.

The definition of contribution is the right of an insurer to call upon other insurers similarly (though not necessarily equally) liable to the same insured to share the cost of an indemnity payment.

Insurance is intended to indemnify the insured in the event of a loss. However, if there is more than one policy covering the same item, the policy's condition of contribution is applied.

Contribution in many instances could arise from clients not clearly understanding or being unaware of what they are covered for, which results in them acquiring duplicate cover.

The representative needs to be very careful in such instances to check for these types of situations as more often than not, insurers are tending to state that where more than one policy exists for the same risk, such insurer will not pay in the event of a claim. If both insurers adopt this policy, then this could result in there being no cover.

2.13 Excess

An excess, or first amount payable as it is sometimes called, is an amount of money that the insured must pay each time there is a claim. This helps to avoid small claims and provides the insured with a reason to prevent losses.

These may be voluntary or compulsory. Many insurers offer a discount in premium if the policyholder agrees to bear a voluntary excess in addition to the stated excess.

2.14 Types of perils and hazards

A peril is something that causes a loss and a hazard is something that influences the damage caused by a peril, for example, accident damage to your car is a peril, but the heavy traffic and dangerous road conditions are hazards. The table below provides examples of perils and hazards.

Table 2.1: Perils versus Hazards

Peril	Hazard
A fire causing a building to burn down	The building had a thatch roof
A storm which causes a tree fall on the building	The tree was old and unstable
A crime incident	There were no burglar bars on the windows
A motor accident	Dense traffic on wet roads

2.14.1 Moral and physical hazards

Hazards can either be physical or moral. Physical hazards relate to the physical environment, for example, keeping flammable liquids in a building, and, as explained above, heavy traffic and dangerous road conditions.

Moral hazards relate to attitudes and behaviour of people, especially the tendency of individuals to alter their behaviour because they are insured.

Examples of moral hazards are as follows:

- Dishonesty - a person who claims fraudulently.
- People who inflate claims in the belief that it will result in a fair settlement by insurers.
- People who misrepresent the true facts of the risk.
- Carelessness - a driver who drives under the influence of alcohol increases the chances of an accident.

It can be difficult to separate moral and physical hazards, such as the manner in which the car is driven or maintained and not the car itself.

2.15 Risk

Risks can further be divided into particular and fundamental risks.

2.15.1 Fundamental risk

Fundamental risks are generally impersonal in origin and affect large parts of society or even the population of the world and are regarded as commercially uninsurable.

However, in some cases insurance is available for risks that are outside the control of a person or a group of people. These risks normally affect many people and the loss is often catastrophic.

Examples of catastrophic events are earthquake, tsunami, war, riot, drought/famines, economic recession and the resulting unemployment.

Fundamental risks can be caused by social, political or natural factors.

Suppose, for example, that a family is planning a holiday to Egypt and a few days prior to their departure there is a terrorist attack at the Pyramids just outside of Cairo. There is nothing they can do to prevent a civil unrest or war in the country, but they must consider the risk of this happening and ruining their holiday. Whilst there is an impact on the family's trip, the severity of the impact would differ depending on whether they are in Egypt at the time, or still in South Africa awaiting their departure to Egypt.

2.15.2 Particular risk

A particular risk is one which affects individuals, and which arises from individual causes that can be identified.

Particular risks are personal in origin and affect individuals or small groups, for example, fire, theft, or vehicle accidents.

Example

Thieves break into your home and goods are stolen. This is a particular risk because it affects only you and your family and not society as a whole.

In general, risks which are not particular fall into the fundamental class.

2.15.3 Speculative risk

Speculative risks, on the other hand, are normally taken in the hope of some gain. For example, it is not possible to insure the possible winnings that one hopes to receive from gambling.

It is however difficult to be dogmatic about this, as practice is changing and the division between pure and speculative are becoming more blurred as time passes. Take the case of the credit risk that can be seen as a speculative risk.

The goods have been sold on credit in the hope that a gain will result, but a form of credit insurance is available which will meet some of the consequences should the debtor default. Extremely strict underwriting criteria are applied to this type of risk, because of the nature of the risk.

However, insurance is not normally available for those risks where the outcome can be a gain. Speculative risks are entered into voluntarily, in the hope that there will be gain. There would be truly little incentive to work towards achieving that gain if it was known that an insurance company would pay up, regardless of any effort by the individual. Using the terminology of hazard, we could say that there would be a remarkably high risk of moral hazard.

We should, however, be clear that the pure risk consequences of speculative risks can be insured against and insurers are being asked to handle the results of speculative risks.

An example of a speculative risk that becomes a pure risk as a consequence, is bad debt. Profit is made on a venture or sale, which is a speculative risk. The subsequent collection of the debt or the non-collection can result in a loss, thus fitting the definition of pure risk.

The pure risk consequences of speculative risks are certainly insurable, but not the speculative risk itself. Take as an example the marketing of a new line in clothing. The risk of the new line selling is clearly speculative. It is a risk knowingly entered into in the hope of financial gain. This, after all, is the very essence of business activity.

However, the risk that the line will not sell is not the only risk to which the enterprise is exposed; the factory in which the garments are to be made could be damaged, designs could be stolen, and suppliers of essential materials could have fires or other damage resulting in them being unable to supply the raw material. All of these risks are pure risks, which are insurable, but they arose directly from the decision to take the speculative risk of making the new line of clothing in the first place.

2.15.4 Pure risk

Pure risks arise due to human "error" or actions, or natural phenomena. These are risks that may or may not happen, for example theft, liability, motor accident or an electrical short circuit and are generally insurable.

Example of pure risk includes the following:

- When you drive to work in the morning you either have a car accident or you do not.
- A lightning strike occurs that impacts all the electrical appliances in your house, but not the house next door.

Insurance is mainly concerned with pure risks –with an undesirable result that can only result in loss or prejudice.

In general, an insurable risk must be financially quantifiable in monetary terms.

2.16 Severity of risk

Severity is the magnitude of the consequences of a loss. The severity of a risk is used in calculating the retention of an insurer before the use of reinsurance. For this there are three definitions:

- **Estimated maximum loss (EML):** The estimated maximum loss is the estimated amount of a loss that could occur as the result of an insured peril. An example could be a total failure of the sprinkler system.
- **Probable maximum loss (PML):** The probable maximum loss is the maximum loss that is possible to happen as a result of an insured peril, such as a factory in several buildings - it is probable that one building can be destroyed but not all, as a result of an insured peril.

- **Maximum possible loss (MPL):** The maximum possible loss is the total loss of property as a result of an insured peril, such as a factory in several buildings and all the buildings are destroyed as a result of an insured peril.

2.17 Frequency of risk

The frequency of risk is the average number of losses of a particular type that may occur in a year. This frequency is extracted from statistics and trends of the particular peril. Such as how many burglaries occur in a particular area in a year.

2.18 Self-insurance

Self-insurance occurs in those instances where the insured elects to bear the costs of any damage or loss to his assets himself.

A common example of an individual opting for self-insurance would be by way of an additional voluntary excess. Note that self-insurance is a conscious decision rather than simply neglecting to take out cover. It often involves creating a specific fund out of which to pay losses and has tax benefits.

The following are consequences of self-insurance:

- Accumulating a substantial savings fund, which may not be relative to the amount of premium saved
- The loss, or accumulated losses could exceed the amount saved in the fund; therefore, requiring the loss to be funded from cash flow
- A substantial loss could occur before adequate funds are accumulated.

The following are advantages of self-insurance:

- Premiums should reflect an appropriate discount for the self-insured proportion which can be invested to cover future losses. As this fund grows, so the percentage of self-insurance can be increased, resulting in further premium discounts.
- Run-of-the-mill claims can be paid out of a self-insured (emergency) fund, without the necessity of paying premium for these. This has the advantage of protecting the claims experience resulting in better premiums.
- Tax advantage

A disadvantage of self-insurance is that the funds allocated to the insurance fund could be required for other purposes.

2.18.1 Aggregate excesses

An aggregate excess is a form of self-insurance whereby the insured agrees to accept for his own account an agreed amount on losses from defined risks. The insurer resumes its normal responsibilities when that limit is exceeded.

2.19 Market value, retail value and replacement value

Indemnity can be on a market, retail or replacement value basis.

In the event of the insured being covered for replacement value, the insured is entitled to receive the replacement value of any item lost or damaged beyond repair. If the sum insured is lower than the replacement value, the condition of average will apply. This applies specifically to the house owner and householder sections of a policy.

In the all risks section the sum insured will be paid for specified items, whereas unspecified items will be subject to the applicable limits.

Replacement value for motor may be paid depending on the age or mileage of the vehicle as specified in the terms and conditions of the policy. Thereafter retail or market value will apply as specified in the terms and conditions of the policy.

2.20 Reinsurance

Reinsurance is a means by which an insurance company can financially protect itself together with other insurance company(ies) against the risk of losses, which are larger than it wishes to carry for its own account.

Individuals and corporations obtain insurance policies to provide protection for various risks such as hurricanes, earthquakes, lawsuits or collisions. Reinsurers, in turn, provide insurance to the insurance companies.

2.21 Premiums

Premiums is the amount paid by the insured for the insurer to accept the risk. The premium is set during the underwriting process depending on the risk assumed by the insurer. However, other factors that affect the premium is considered in the subsections following:

2.21.1 SASRIA/NASRIA

It is important to note that in South Africa insurance is available against the fundamental risk of riot (or unrest), strikes and the like. This cover is provided by the South African Special Risks Insurance Association (SASRIA) who are owned by the Government. It is important to note that this cover does not include acts of war.

NASRIA provides the same cover as SASRIA, however is applied in Namibia.

This is a specific premium for cover relating to riot, strikes and unrest. There are varying classes of cover, each with its own applicable rate or cost.

SASRIA applies to fire, specified working expenses, motor and contractors and Plant All Risks section of a policy.

It is necessary to disclose the SASRIA/NASRIA portion of the premium to the client.

SASRIA/NASRIA cover is not automatically renewable, however is generally dealt with during the renewal process.

2.21.2 VAT

VAT is a tax applied to the total premium including the debit order charge and SASRIA.

2.21.3 Reinsurance

Reinsurance has no impact on the premium payable by the insured. This is an internal arrangement between the insurer and reinsurer.

2.21.4 Fees and premium

Fees generally have no relation to the premium, as they are amounts charged by an intermediary or insurer for services rendered and should be separately disclosed to the client. In the case of a large number of corporate businesses, the intermediary invoices the customer for a fee for the services they will provide. In this instance commission is not paid by the insurer.

TOPIC 3 RISK UNDERWRITING

LEARNING OUTCOMES

After studying the topic, the learner should be able to-

- Explain the purpose of underwriting.
- Name the underwriting criteria.
- Explain the importance of surveys.

3.1 Introduction

During the process of insurance, a proposer offers their assets, also called the subject matter of insurance, to an insurer who through the process of underwriting decides whether they are willing to accept the risk, at what premium and whether they want to impose certain terms and conditions. This decision is based on their experience and underwriting rules and retention limits.

It is necessary to try and establish how soon the insured will claim, how frequently and how severe the claims will be – based on this a premium is determined. This is possible based on the statistical information that the insurer uses as well as the loss history of the proposer.

In insurance, a person would have a claims trend, meaning the way things are going, and if nothing significant happens, the trend will continue as it has in the past. That is why it is imperative that the insurer knows the claims history of the proposer and this will usually be checked at claims stage with the previous insurer.

Some risks are higher than others which refers to the fact that on some items (subject matter of insurance) or under certain circumstances, a risk will be higher, meaning the probability of an incident happening is increased. The higher the probability, the higher the risk, and therefore, the higher the premium that will be charged.

3.2 The purpose of underwriting

The basic purpose to underwrite any risk is to evaluate all risks on a similar basis and then to limit the insurance company's exposure to unacceptable risks by way of claims made against it. The process of underwriting entails a series of questions that assists to assess a risk scientifically in order to determine whether to accept the risk or not. If the risk is accepted it determines the terms and conditions as well as the premium.

Insurance is based on good faith therefore the insurer trusts that the insured is supplying full and honest facts, and vice versa. Once the proposer accepts the above and the two parties agree on the premium, terms and conditions, start date, premium debit order date and cover, the proposer is now the insured.

3.3 Underwriting criteria

Underwriting criteria refers to the basic requirements, as well as additional requirements or financial loadings or discounts that an underwriter will consider in order to correctly, evaluate and rate the risk. In addition to these, other factors are also considered when setting the underwriting criteria.

In doing so the underwriting criteria may result in the following:

- **Loading:** A loading is a percentage of premium rate, which is added to the standard rate to cover the additional risk exposure in the event of a claim.
- **Discount:** A discount is a percentage of premium/rate, which may be deducted from the standard rate for the reduction of risk.
- **Co-insurance clause:** A co-insurance clause is a requirement that the insured must undertake to carry a specified percentage of the sum insured as a self-insured proportion of the risk.
- **Excesses:** Excesses or first amounts payable are imposed by underwriters to firstly reduce the liability of the insurer in respect of a claim, and secondly to create a sense of responsibility in the insured to take due care. Voluntary excesses are also requested in some instances where the insured may opt to pay a higher voluntary excess to reduce the premium.
- **Franchises:** A franchise is a type of excess which is a specified amount that any loss must exceed before the underwriter is liable to pay a claim. When a loss exceeds the amount of the franchise, the underwriter would normally be obliged to pay for the entire loss without any deduction. If the loss exceeds the amount of the franchise, there is no excess payable by the insured.

Example

Personal accident – temporary total disability benefits have a seven-day (7-day) franchise applied.

If the disability exceeds seven (7) days, the benefit will be payable from the first day of the disability. If the disability is less than seven (7) days, there is no benefit payable.

Fire – the underwriter requires a R10 000 franchise. A fire occurs, and the loss is assessed at R5 000. The insured receives no claim settlement. If the fire damaged was assessed at R12 000, the insured would receive a claim settlement of the entire loss of R12 000 with no excess deduction.

Additional requirements may be in the form of the following:

- Valuation certificates to prove the value of the insured item.
- Security certificates to prove the measures of security taken to reduce the risk exposure.

3.3.1 Underwriting criteria relating to the target market

The general underwriting criteria relate to the type of product that is underwritten by a particular insurer.

This relates to the chosen field of the company and type of product, whether for general insurance or a niche market, which the insurer is willing to offer.

These underwriting criteria would generally include limits of acceptance and types of insurable items.

3.3.2 Underwriting criteria relating to the nature of the risk

The nature of insurance is such that the contributions for similar risks are pooled together by the insurer. The underwriter must manage the pool as effectively and profitably as is possible. In order to do so, the underwriter will assess the risk each person brings to the pool. Two main aspects of hazards are considered when this assessment takes place, namely physical and moral hazards.

All of the above examples have a greater risk impact to the insurer. This causes the underwriter to consider additional risks and consequences for these greater exposures. He then considers which of these greater risks he is willing to accept and imposes additional terms and conditions and premium for insuring them. The identified additional risks and specific terms and conditions then become the underwriting criteria.

Example

The increased fire risk that a thatched roof presents, results in a loading of premium and additional preventative measures such as a lightning conductor, for the insured.

The increased risk that the age of a driver may present will result in an additional excess and/or a higher premium being imposed.

Once possible risks have been identified it is necessary to consider the following:

- **Frequency of loss:** How often losses may occur
- **Magnitude:** The possible extent of each loss
- **Maximum possible loss:** Value of assets at risk.

When preparing and calculating a quotation for insurance purposes, each additional risk to which the client is exposed as well as the nature thereof, needs to be factored in terms of the underwriting criteria, to ensure that the client is paying the correct premium for their risk exposure.

3.4 Surveys

Surveys are recorded descriptions of the risk and hazards to which it is exposed. These are used to apply underwriting criteria to quote on the risk.

The survey gives the underwriter the information required to make a judgement on acceptance, terms and premiums of a risk. It also assists the client in that it highlights areas of potential loss and which should be remedied in order to mitigate risk and therefore premium, through risk management.

Although it has become standard practice with some insurers to do a survey report for each new client or risk, surveys are generally required at inception of a risk, as required by underwriters at renewal, or after a loss.

It is imperative to obtain a survey when the risk or hazards are complex and may require the expertise of a professional insurance surveyor to analyse the premises and risk exposure.

TOPIC 4 AGREEMENT OF TERMS AND CONDITIONS OF COVER

LEARNING OUTCOMES

After studying the topic, the learner should be able to-

- Understand the concept of insurance as a contract.
- Present a quotation to a client and obtain acceptance.
- Outline the structure of a policy document.
- Describe the disclosure process in terms of fees and premiums.
- Explain the record-keeping process.
- Understand the renewal and review of policies procedures.
- Explain replacement of policies.
- Outline the collection of premiums process as applied in short-term insurance.

4.1 insurance as a contract

An insurance policy is a contract or agreement between two or more parties, which is legally binding.

Once the proposed insured has agreed to a certain quotation it is important that one explains the terms and conditions of the cover to the client to ensure that the client fully understands what is covered and what is not.

A contract of insurance could not exist unless the terms of the contract are fully understood and agreed by the parties.

It is important to remember that the policy document that the insured receives from an insurance company is not the actual contract but is the evidence of the contract's existence. The contract is the original proposal form, which gives details of the risk that has been given to insurers on which a quotation has been offered and accepted by the insured.

The terms and conditions are contained in the policy wording and include endorsements, restrictions, exclusions, warranties and conditions of insurance.

4.2 Presenting a quotation

In the ambit of the FAIS requirements, it is imperative that the client be furnished with all the relevant information to make an informed decision.

An insurance quotation for the client, therefore, must include, in a language the insured understands. The insurance quotation must include the following:

- A covering letter.
- The comparison of cover proposed, which includes all relevant quotes received, and their comparison to the client's current cover.
- A recommendation of cover proposed.
- Awareness of risk exposure and possible solutions in which these risks can be addressed.
- Full details of the intermediary, product supplier(s) and any other relevant party to the recommendation proposed.

In presenting the above to the client, the representative must highlight all of the proposed changes in cover and benefits, as well as the applicable exclusions/restrictions as detailed in the terms and conditions.

Upon the client's acceptance of the recommendation or of a specific quotation, it may be necessary to obtain additional information or documentation, from the client, to conclude the transaction. It is necessary to take note of specific time limits in respect of these requirements, as the failure to obtain such information or documentation may result in a delay of cover being granted to the client.

4.3 Obtaining acceptance

The recording of the client's acceptance is critical to the validity of the policy. This can be done in various manners, such as a recorded telephone call between the client and representative, or in writing by the signing of an acceptance form with the intermediary.

Without such acceptance from the client, the contract will be null and void.

4.4 The policy document

Upon the client accepting the quotation, the representative confirms the receipt of the closings or acceptance form and follows the steps as outlined below. It is necessary for the insurer to confirm that the quote issued is the same as the quote accepted by the client. This is critical, as in some instances the premium value quoted might change slightly, or the risk address might change.

The policy document may now be issued in accordance with the insurer's procedures.

The representative of the insurer and the intermediary are responsible for checking that once the policy documents are received, the policy schedule accurately reflects the sums insured for the various sections of the policy, and that the premium, stated benefits and exclusions are in agreement with the quotation.

For quality assurance, one needs to ensure that all of the following agree:

- Premiums quoted, and premiums charged.
- Benefits offered, and benefits provided.
- Loadings, restrictions and exclusions applied.
- Excesses applied, and excesses quoted.
- Insured property provided, and insured property stated in the policy schedule.

Section 47 of the Short-term Insurance Act places a specific requirement on insurers to issue a policy (or at least a document embodying the contract, with access to a copy of the full policy) within 30 days after entering into or changing such a policy.

The policy wording consists of a number of sections, each serving a different purpose. The sections are considered in the subsections following.

4.4.1 The heading

This gives the full name of the insurer, address of the insurer's head office, details of the complaints and compliance departments, as well as the financial services provider (FSP) number and all details of any other product suppliers that may be party to the policy for certain risks or sections thereof (such as an underwriting manager or intermediary).

4.4.2 The preamble

This details the basic essentials and components of the contract. This clause usually states the payment terms of the agreed premium to be paid by the insured, and acknowledgement that the details supplied in the proposal form constitute the basis of and are incorporated in the contract.

4.4.3 The operative clause

The operative clauses are standard printed clauses. It details the hazards and perils for which cover is provided and for which losses the insurer is prepared to make payment to the insured.

4.4.4 The exceptions

This details the risks or losses that are not covered by the terms and conditions of the policy.

4.4.5 The general conditions

These are rules governing the application and interpretation of the contractual conditions as a whole for example, a claim will only be processed if all the premium payments are up-to-date, or time limits for notification of claims.

4.4.6 The policy schedule

The policy schedule differs in each policy and contains the client's details. This groups together the various features that are unique to the particular insurance relating to the following:

- Insured's personal details
- Description of the risks insured
- Amount and nature of cover required
- Premium to be paid by the insured
- Applicable excesses

4.4.7 The specification

This applies to special risks which are not specifically covered by the operative clause and to which a premium loading, restrictions or additional excesses are often applied, such as a thatched roof.

4.4.8 The endorsement

These are clauses attached to a policy which may either restrict or extend the general terms and conditions of the cover or which may reflect changes in circumstances or the nature of the risks, such as additional security measures to reduce risk, or the acquisition of additional assets which increases the sum insured.

4.5 Fees and premium disclosures

It is a FAIS requirement that at the time of quotation or at renewal, all aspects making up the premium the client pays are disclosed. This disclosure includes:

1. Premium charged per section, and excesses applicable thereto
2. SASRIA/NASRIA premium charged per section
3. Additional loadings or discounts
4. Administration fees
5. Broker fees and commission
6. VAT

Points 1 to 3 is relevant to each section of the policy whereas administration fees, VAT and broker fees and commission is an overall amount for the policy and not per section.

At any time that the premium may change, it is necessary to disclose all the above, apart from during quotation or at renewal.

4.6 Record-keeping

It is imperative that the representative documents all relevant information obtained from a client during this process and that all subsequent documentation obtained on behalf of and presented to the client are kept on file. This enables the representative to accurately reflect on the recommendations made to the client in the event of a dispute.

As per the FAIS requirements it is vital that the intermediary or representative keep a record for each client, which should reflect the following:

- A copy of the record on which the insured items were recorded.
- A copy of all quotations considered.
- A copy of the recommendation made to the client.
- A copy of the client's acceptance of the recommendation or alternative quote.
- Copies of all additional documentation and information required.
- A copy of the policy schedule with the terms and conditions of the policy wording.

4.7 Review of policies

It is imperative to re-confirm information from the policy holder each year to ensure that the holder remains adequately covered. In the short-term environment this confirmation happens on an annual basis during a renewal process.

In addition to the above, inflation also has a role to play and gives rise to problems both for the policyholder and the insurer:

- It may result in underinsurance for the policyholder, with the result that average may be applied in the event of a loss.
- The effect for the insurer is that the company is not receiving the amount of premium actually required to cover the insured risks, while the cost of claims continue to increase.

The manner in which insurers deal with the effect of inflation, is to build in an inflation index to the sum insured, which gives rise to an equivalent premium increase for cover provided.

4.8 Renewal of policies

In cases where insurers would like to retain a client, it is a standard procedure that the insurers will send out renewal policy schedules (notices) for policies that are due for renewal. These could be sent out to the client directly or to the intermediary concerned who in turn will refer and discuss the renewal notice with the client. There is no obligation for an insurer to invite renewal.

The purpose of renewal notices is to communicate a change in rate of premium if applicable and to remind the client to ensure that the values of his assets have been adjusted in line with the inflation factor, to ensure that he remains adequately covered for the next year. During the renewal process it is necessary to review the terms and conditions of cover as well as the values of the assets covered.

A renewal notice may even impose restrictions or conditions of proposed continued cover to a client, so that they can adequately manage the risk.

Again, in the renewal process disclosures come into the forefront. These disclosures would include the following:

- Any increase in premium, if applicable.
- Where applicable, any variations in cover or limits, as well as any changes to the terms and conditions of the policy.

The intermediary will evaluate all the rates, terms and conditions to see that they are fair and will re-negotiate with the insurer, if necessary. When satisfied, the intermediary will contact the client to discuss the renewal.

Documentation required for disclosures in the event of a review or renewal would include any additional valuation certificates that may apply, and details of variations in the policy schedule or terms and conditions.

In the event of a renewal, the intermediary needs to keep record of the negotiations between the intermediary and client, as well as any changes in policy schedule or terms and conditions agreed. The revised schedule replaces the schedule in the policy document and details the cover for the next period of insurance.

In addition, ensure that the client fully understands his rights and obligations to obtain copies of any of the above-mentioned documentation.

The client must be fully informed of the following implication:

- All fees and charges applicable.
- Special terms and conditions, including loadings, excesses and restrictions.
- The implications on vested rights in terms of no claim bonuses.

The intermediary should advise the client of comparative products and cover available and the premium thereof. This information must be discussed with the client.

If the current cover is to continue, the renewal premium should be paid by the client on, or before, the renewal date of the policy.

Once the insurer has been advised of the changes in the risk details, and the policy has been amended, a revised schedule can be sent to the client.

There are some exceptional cases in the renewal process in which the insurer will not send out a renewal notice to a client because of a high moral hazard, or claims experience, but will notify the intermediary that they will not be renewing the policy.

4.9 Changes to the contract

Changes to the contract can be made at the time of issue of the policy, or subsequent to the policy being issued.

An endorsement to a policy overrides the terms and conditions of the original policy and therefore amends the contract itself. It is particularly important that these changes are correctly recorded.

Endorsements can affect the following sections of a policy:

- The amounts insured.
- The details of the subject matter of the insurance, for example, a new risk address or a different vehicle.
- Addition or deletion of sections insured for.
- Increase in the premium payable as a result of a general premium increase, or higher premiums for a single insured as a result of the loss history.
- Change of payment methods and banking details.
- Additional premiums as a result of amendments to the policy.

Changes to policies must be recorded, as these changes could have an impact on the potential severity of losses and could leave the insured without appropriate cover if they are not recorded.

4.10 Replacement policy

Should it become apparent to the intermediary during the renewal process, that more favourable terms and conditions are available in the market, the intermediary should present the client with the option to renew the current policy, as well as quotations and recommendations on the alternative covers available.

The insurer of the existing policy, being replaced, needs to be notified of the intention not to renew the policy in terms of the conditions of the current policy.

Example

Mr. Jones, who is insured with ABC Insurers, is informed by his intermediary that his current policy is up for renewal. During the review of the renewal terms and conditions his intermediary advises him that more affordable cover is available.

He arranges to meet with his intermediary who presents him with the terms and conditions of the current renewal, as well as the terms and conditions of an alternative product.

Upon consideration of the intermediary's presentation, it would appear that there is truly little difference in the terms and conditions of the two policies, and that Mr. Jones would in fact benefit from a lower premium charge for a higher value of cover.

Mr Jones accepts the new quotation and requests his intermediary to cancel his current cover and to transfer his portfolio to the new insurer.

4.11 Collection of premiums

The collection of premiums in the short-term marketplace has wide-ranging consequences. The type of collection can affect the terms of the insured's policy.

Where the intermediary is handling premium collections, he must adhere to the following conditions:

- Be authorised by the insurer in writing.
- Furnish a guarantee representing a regulatory portion of the estimated annual premiums handled in the year, with the limits of the regulatory requirements.
- Include a statement of premiums being paid with the payment.

This guarantee is usually affected through the IGF facility administered by the South African Insurance Association (SAIA), as per Part 4 of the Regulations referring to Section 45 of the Short-term Insurance Act, although other forms of secure guarantee can also be arranged, such as bank guarantees. This is a protection for the client in the event of the intermediary not paying over the premium.

The Regulations also require that all premiums, net of refunds due and the amounts due to the intermediary for services provided, are paid over to the insurers as follows:

- For renewals, within 15 days after the end of the month in which they are collected.
- For new business, within 15 days after the end of the month in which the policy incepted.

4.11.1 Due date of premium

In insurance practice, due date has one of the following meanings:

- In the case of a new policy, the inception date of the policy.
- In the case of the renewal premium, this is the same as new business; the premium is therefore due on or before the renewal date.

4.11.2 Methods of payment

Premium for a policy can be paid in the following ways:

- The premium can be paid annually, half-yearly or quarterly. This method is still used by clients. However, because of economic reasons, it is becoming less popular.
- Monthly payment by debit order.

4.11.3 Non-payment of premium

The premium is due on a certain date and must be paid by that date. Insurers may not automatically cancel or reverse the cover because payment to the intermediary is deemed to be payment to the insurer, if the premium has been paid to the intermediary by the insured, and the intermediary does not submit the insured's payment during the required period.

One of the conditions applicable to admitting claims is whether or not the premium payments received are up to date.

The policy wording and/or the debit order form that the client signs, tells the client when premium is due. It is practice for insurers to resubmit unpaid debit orders to the bank for processing. However, if the debit order is returned as "payment stopped", the policy is cancelled immediately. The effective date of the cancellation will be the due date of the first returned debit order.

TOPIC 5 THE CLAIMS PROCESS

LEARNING OUTCOMES

After studying the topic, the learner should be able to-

- Describe the general claims procedure.
- Understand the concept of burden of proof as applied in short-term insurance.
- Name the rights of the parties after an insured event.
- Name the consequences of a fraudulent claim.
- Explain how average is applied in short-term insurance.
- Define the concept betterment
- Explain how contribution is dealt with.
- Outline the recovery process.

5.1 Introduction

In the event of the insured suffering a loss or damage because of an insured peril, and if that loss is covered by the terms of the policy, the insured may submit a claim to his insurer.

This claim is an application by the insured for the repair of damage or indemnity for the loss in terms of the insurance contract between the insured and the insurer.

Therefore, one needs to ask the following:

- Is there a policy in force that covers the item lost or damaged?
- Is the proximate cause an insured peril?
- Have the policy terms and conditions been complied with?
- Are premiums up to date?

For the event to be covered, the following conditions must be satisfied:

- An insured event must occur resulting in a loss or damage to an insured asset or a liability of the insured.
- The insurer must be advised of such loss or damage within the time stated in the policy.
- It must be confirmed that the policy covers the appropriate type and cause of loss.
- The insurance contract must be enforceable, specific to the disclosure on behalf of the insured.
- The claims must be legal in that the insured cannot gain financially from his own illegal actions.
- The claims process for different categories of assets are dealt with in different ways, therefore upon notifying the insurer of the claim and the above confirmations, the relevant requirements will be communicated to the insured.
- Where an insurer provides a claim form which requires additional supporting documentation to be submitted, it is the responsibility of the insured to complete the form and submit all the relevant details requested.

5.1.1 Insured perils

An insured peril relates to an insured event. As discussed earlier a peril is the cause of the damage or loss, such as a flood, fire or accident.

It is however possible that certain perils are not insured, such as war, civil unrest or riot, or the consequence of a criminal act committed by the insured, whether intentional or not.

The exclusions to the insured perils, however, would be detailed in the terms and conditions of the policy wording. Therefore, when a claim is submitted, the peril needs to be confirmed in terms of the policy wording as an insured peril, for the claim to be accepted or processed.

5.2 General claims procedure

It is imperative to note that each insurer has their own particular claims procedure with their relevant requirements. This may differ further between the different classes of business insured by the same insurer.

It is therefore especially important that once a potential claim has been communicated to the relevant insurer, that the claims process for that claim is confirmed and communicated to the client.

However, in general, the insured must give notice as soon as possible of any event that may result in a claim. This is especially important in connection with liability risks, or where the insurer might want to insist on extra precautions.

If a claim then results, the insured must, as soon as possible take the following actions:

- Submit full details in writing.
- Provide the required proof and documentation, and immediately forward any third-party claim or summons to the insurer to deal with.
- In case of theft, notify the police, and cooperate in trying to recover the stolen property.
- For the loss of property, notify the police, of requested to do so by the insurer.

Insurers cannot allow an unlimited time between the reporting of the event to the insurer (usually within 30 days), and a full claim being made. Unless they agree specially, the maximum allowed is 24 months. This limit does not apply to business interruption, fidelity, personal accident/stated benefits, third party liability and where there is pending legal action, but some sections of the policy have their own special requirements.

The insured, if asked to do so, must assist the insurer in the recovery of lost or stolen property. If he does not do so, he must refund the claim settlement, if required by the policy.

The claims technician/negotiator will further evaluate the terms and conditions and excesses that apply.

Compliance with the terms and conditions of the policy can be checked as follows:

- When a claim is submitted to insurers, it is unlikely that all the relevant details will be available, but as much information as possible should be obtained.
- The insurer will probably appoint a loss adjuster and this person will be able to investigate further.
- The loss adjuster will require details of the cover under the policy and it is likely that he will advise the insurance company as to whether the terms and conditions have been complied with.

If no loss adjuster is appointed, it is the claims technician/negotiator's job to check the claim form that is be completed by the insured to ensure that all terms and conditions have been complied with and that all documentation and information is complete.

The claims technician/negotiator will then, depending on the size of the loss, appoint a claims assessor or loss adjuster and/or call for a fully completed claim form and supporting documentation.

5.2.1 Role of the insured in the claims process

In the event of a loss or damage to an insured item, it is the responsibility of the insured to make every effort to notify the intermediary or insurer of the incident as soon as possible.

In many instances it will be required that the insured reports the incident to the police and obtain a case number for the incident. It is critical that the insured provides accurate and detailed information regarding the incident in the police report. This would be necessary in cases of attempted theft, theft or a motor vehicle accident.

The insured must obtain quotations for repairs or valuations for the items lost when required by the insurer. This documentation is often then required as supporting documents to the claim form submitted.

The insured may then be contacted by relevant parties appointed by the insurer to assess and facilitate the claims process. It is then the insured's responsibility to co-operate to the best of his ability to ensure a smooth and speedy resolution.

5.2.2 Role of the intermediary in the claims process

Where an intermediary is involved in a claims process, it is his responsibility to assist the client with the following:

- Confirming the relevant claims processes and all the insurer's requirements.
- Being the communication link between the insured and insurer.
- Aid the insured in completing claim forms, but not completing them himself, and wherever necessary.
- Submitting the claim forms to the insurer on the insured's behalf.
- To keep the insured informed of the claims process throughout the investigation and resolution thereof.

5.2.3 Role of the insurer in the claims process

Upon receipt of the advice of the incident, the insurer provides a nominated individual to deal with the claim. This person is often referred to as a claim's technician/negotiator. It is the responsibility of the claims technician/negotiator to evaluate the liability of the insurer in respect of the claim submitted.

Where necessary the claims technician/negotiator will appoint a claims assessor or loss adjuster to further investigate the reported claim and to provide recommendations to the insurer regarding their liability.

Upon receipt of the assessor or loss adjuster's report, the claims technician/negotiator will analyse the report and determine the necessary action from the insurer's office and facilitate such action as is deemed appropriate.

The following actions could arise:

- Accept and facilitate the settlement of the claim.
- Reject the claim by sending a rejection notice to the intermediary or client.
- Escalate the claim for further investigation, legal advice or management decision, whichever is applicable.

5.2.4 Role of the claim's assessor in the claims process

A claims assessor evaluates a situation and assesses the damage caused by the incident.

Claims in which an assessor's report may be required are as follows:

- **Burglary:** An office was burgled, and a quantity of goods taken. The assessor would be sent to examine the circumstances and assess the nature and value of the goods stolen. He reports to the insurer whether the terms and conditions of the policy have been followed and may in addition record any suspicious circumstances.
- **Fire:** There is a fire in a warehouse. An assessor is sent out to investigate and report on the cause of the fire and the extent of the damage. Any implications to other sections of the multi-peril policy must also be reported on, such as business interruption.
- **Motor accident:** Assessors employed by some insurers are situated at Motor Assessment Centers. In addition. they travel to where the undrivable damaged vehicle may be stored.

5.2.5 Role of the loss adjuster in the claims process

The insurer will appoint a loss adjuster at their discretion. Loss adjusters would typically be appointed for claims arising from non-motor losses or damage. Normally the designation Loss Adjuster is reserved for those who are members of the Institute of Loss Adjusters.

When a loss adjuster is appointed, he will follow the following process:

- Require full details of the cover under the policy.
- Contact the client and arrange to meet.
- Investigate the circumstances of the loss and it is here that he will ensure that the terms and conditions of the policy have been complied with.
- Organise quotations and liaise with repairers.

- Send a final report to the insurer, who will then accept, or reject liability for the damage or loss.

If no loss adjustor is appointed, then the claims technician/negotiator must check all the documentation to ensure that he has enough information to decide or recommend on the insurer's liability.

(I) Loss adjusters' reports

When a loss adjuster, or any investigator for that matter, sends in his report, there will be information in it which could be sensitive and could upset the holder, even lead to his suing the company.

It is, therefore, particularly important that claims technicians at insurance companies do not give copies of these reports to anyone, who may in all innocence give it to the insured, nor should they be given to the insured directly.

These reports are paid for by the insurer and at no time are they for the consumption of the intermediary or insured.

5.2.6 Role of the legal advisor in the claims process

A legal adviser may be called upon in the following instances:

- To provide advice on the legal liability or otherwise of the insurer.
- To provide advice on other legal implications from the information received by the insurer.
- To provide guidance to the claims department in the recovery of monies or salvage process once a claim has been finalised.
- Where litigation may be considered.

5.3 Burden of proof

The insured must prove the loss. The insured must further prove insurable interest in the loss or damage incurred.

If the insurer wishes to claim that an exception operates then it is up to the insurer to supply the proof thereof.

5.4 Rights after an event

The insured cannot abandon property to the insurer, but the insurer can take possession of damaged property. They must deal with the property in a reasonable manner; otherwise they can be liable for any further damage that results from their actions.

The insurer can take over the rights of the insured immediately and recover against third parties. Subrogation proceedings will be at the insurer's expense, but the insured must cooperate.

Liability to third parties might exceed the limit under the policy, so the insurer has the option of paying the insured the limit of indemnity and withdrawing from the claim.

5.5 Fraudulent claims

Any fraudulent claim is forfeited. This includes insureds who, for example, intentionally set fire to their own property, or arrange to have it set fire to or stolen.

5.6 Appeal of rejected claims

All insurers have a system of reviewing all claims, to ensure that all procedures have been correctly followed. In the event of a claim being rejected, the insured has the right to appeal.

The first appeal would be directed to the insurer concerned, and in the event of the claim still being rejected, the insured has six (6) months (prescription period) (unless stated otherwise in the term and conditions of the policy), from the date of rejection, to start legal action against the insurer. It is not enough to give notice of legal action; the insured must also pursue this to finality.

The alternative option is for the insured to appeal to the Short-term Ombudsman, who will call for all necessary documents and decide thereon.

5.7 How average is applied

Average will apply where the insured is underinsured, whether deliberately or accidentally. If the damage results in a total loss, the sum insured will be paid out, which amount will be insufficient for the client to replace the lost or damaged item.

If the insurance is on replacement value conditions, the basis for average is calculated as follows:

$$Amount\ to\ be\ paid = \frac{Sum\ insured}{Cost\ of\ replacement} \times Loss$$

The subsections following considers how average is applied in different circumstances.

5.7.1 Average applied to fire

Average applied to fire as per the formula above.

For example, a company owns a factory. The cost to rebuild the factory would be R1 000 000. The company says that it could only sell the factory for R500 000.

The company, therefore, only insures it for R500 000. The factory gets damaged in a storm and the damage is R100 000.

The insurer will not pay the full R100 000 as the company only paid a premium for R500 000 but will apply the average formula.

$$Amount\ to\ be\ paid = \frac{Sum\ insured}{Cost\ of\ replacement} \times Loss$$

$$Amount\ to\ be\ paid = \frac{R500\ 000}{R1\ 000\ 000} \times R100\ 000 = R50\ 000$$

5.7.2 Average and household contents insurance

Insurers try to prevent this by means of on-site surveys and valuations by professionals who evaluate the furniture and household contents to be insured. If a surveyor or valuator is appointed by the insurer and there is a subsequent loss, and it is shown that the valuator's figure was too low and was used as a guide by the insurer to establish the sum insured, then the following would occur, as the sum insured was based on the company's recommendations, the insured would be within his rights to insist that average could not be applied.

Even if the property was a total loss, the company would be liable for that correct amount. If litigation then followed, it is likely that the courts would find for the insured.

5.7.3 Average applied to personal accident/liability policies

Average is not applicable to personal accident and liability policies, which are not policies of indemnity.

5.7.4 Average applied to motor insurance

It is also rare to find average applying in motor insurance, where it is usually relatively easy to ascertain the value of the vehicle using a published vehicle value index, but should someone end up being underinsured, the principle needs to be used in order to ensure indemnity.

5.7.5 Average applied to policies of compensation

Average applies only to policies of indemnity as does subrogation and contribution. It is important to note that these do not apply to policies of compensation. For example, the death and disablement sections of a personal accident policy.

5.8 Betterment

The amount payable is the cost of replacing property of the same kind or type, or repairing it in as good as new, but not better than new, condition. If the performance or value of the replaced item is greater than the original, the insured bears the cost of the difference in price (betterment) of the item. This is particularly the case of computer and technological equipment.

5.8.1 Replacement value conditions

The replacement value conditions apply when property is insured for its replacement value and in the event of loss (notwithstanding its condition) is replaced by a new item.

5.9 Contribution (dual insurance)

The definition of contribution is that where two or more policies are in force each pays its ratable proportion of any loss.

In the event of the same risk being insured by two different insurers, contribution will apply in the event of a claim in respect of that particular risk.

The formula for adjusting the loss is as follows:

$$Amount\ to\ be\ paid = \frac{Sum\ insured\ Company\ A}{Total\ sum\ of\ all\ policies} \times Loss$$

For example, ABC (Pty) Ltd has a warehouse, which is bonded to ABC Bank.

ABC (Pty) Ltd forgot that when the bond was incepted, a policy was issued to cover the warehouse against fire and flood.

ABC (Pty) Ltd wants to insure the warehouse, so they acquire a policy through XYZ Insurance Company.

The policy through the bank has a sum insured of R1 000 000. The one through XYZ has a sum insured of R1 500 000. There is a fire at the warehouse that causes R100 000 worth of damage.

ABC (Pty) Ltd submits a claim to XYZ Insurers for the damages.

They send out a loss adjuster, who finds out that there is another policy through the bank.

Based on this finding, the insurer uses the contribution clause in the policy wording to settle ABC's claim.

This clause states that "if there are two or more policies covering the loss, each policy will pay its proportional share of the claim".

In the case above, they would work out the amounts as follows:

- Policy through ABC Bank: R1 000 000
- Policy through XYZ Insurer: R1 500 000
- Total sum insured: R2 500 000

Therefore, the insurance through ABC Bank will be as follows:

$$Amount\ to\ be\ paid = \frac{R1\ 000\ 000}{R2\ 500\ 000} \times R100\ 000 = R40\ 000$$

Therefore, the insurance through XYZ Insurance will be as follows:

$$Amount\ to\ be\ paid = \frac{R1\ 500\ 000}{R2\ 500\ 000} \times R100\ 000 = R60\ 000$$

Contribution can also be applied where it is difficult to establish blame, such as in the case of a motor vehicle collision in an intersection where both parties carry some degree of negligence. In this instance contribution would be applied in establishing how much of the damage each party would bear. This is known as contributory negligence. In every case the amount of contributory negligence is decided on the facts in each individual case.

5.10 Recoveries

Recoveries is a means of controlling the cost of claims by an insurer in recovering some of its expenses.

When a claim is reported, consideration is given to the following:

- Salvage: Is there any salvage available and is it economical to recover?
- Policyholder: Is there any excess payable by the policyholder?
- Dual insurance: Is there any other insurance on the same risk?
- Subrogation: Is there a third party from whom recovery is possible? And
- Co-insurance or Reinsurance: Are there co-insurers to the risk and is reinsurance applicable?

It may happen that more than one recovery option exists, such as subrogation and salvage, in which case the processes need to happen simultaneously.

In assessing the recovery prospects, the following should be considered:

- **Probability of making a recovery:** Based on the merits of the claim and potential responsibility, issues arising, bearing in mind that the third party may have a counter claim
- **Economic viability of the recovery:** the cost-effectiveness to pursue the recovery.
- **Potential value of salvage:** Consideration must be given to whether the salvage has any value, and whether the amount of the potential recovery exceeds the cost of disposal.
- **Dual insurance:** Possibility of any other insurance cover in full or in part and assessing the potential amount to be recovered taking economic viability into account
- **Recoveries from co-insurers and reinsurers:** Establish the amount of contribution from co-insurers and/or reinsurers.

A recovery agent in an insurer's office is responsible for the following

- Identification of recovery opportunities.
- Assessing recovery prospects.
- Contacting the recovery source.
- Pursuing the recovery.

All recovery actions taken must be documented and communicated to the client, where appropriate. The recovery options are considered in the subsections following.

5.10.1 Salvage of goods

The issue of salvage arises when the insurer has accepted a claim in respect of a loss of an insured asset including those that are beyond repair. Such assets become the property of the insurer. Motor salvage is probably the most common example, but there can also be salvage under the fire and accident classes under the multi-peril policy.

Examples of these can include the following

- Partially-damaged machinery.
- Office contents such as furniture or equipment.
- Stock.
- Stolen vehicles and other articles recovered through police intervention.

(I) Average and salvage

If there is underinsurance and there is salvage, the client is entitled to his ratable share of the salvage recovery.

Such an example could be water damage to furniture where there was a total loss of R500 000. The sum insured is R25 000 thus, there is a 50% underinsurance. If the sale of the salvage realises R10 000, the client would be entitled to R5 000 of the salvage monies.

(II) Write off on vehicles

When the vehicle is damaged beyond economical repair, usually to the extent of 70% of the market value of the vehicle, the insurers treat the vehicle as a write-off and will pay the insured (or finance house if its interests are noted in the policy), the reasonable market or retail value of the vehicle in its pre-accident state.

The excess will be deducted from the settlement. Insurers will then take over the salvage to sell for their own account and ideally, they should cancel the registration.

It does happen that an insured specifically requests cash in lieu of a write-off, in which case the insured may keep the salvage and the settlement is adjusted accordingly. Insurers are reluctant to do this because they normally have salvage contracts with salvage contractors who are bound by the agreement to accept all wrecks no matter their condition.

In some instances, the insured prefers to keep the reasonably good wreck, which is without too much damage, as they may be able to repair the vehicle with second-hand parts.

The insurer would then reduce the settlement figure by the amount or percentage that they would receive from their salvage contractors. This may happen where the insured owes more than the market value to a finance house and believes that he can in fact have the vehicle restored to a roadworthy condition. Therefore, finance houses and insurers often offer credit shortfall cover.

In this case the cover in terms of the policy - both own and third-party damage - should be suspended until such time that an engineer's report is received confirming that the repairs are complete, and the vehicle is roadworthy.

5.10.2 Subrogation

The principle of subrogation has been discussed and applied in previous chapters. However, the subrogation process in a recovery would be as follows:

- **Notification:** The insured must be notified of the insurer's intention to take over the rights of the insured in claiming against the third party.
- **Investigation:** Regarding the circumstances and to determine the economic viability of proceeding with the legal process.
- **Evaluation and negotiation:** To determine whether a legal case exists, or to negotiate a settlement arrangement with the third party.
- **Settlement:** Requesting reimbursement upon the third-party accepting responsibility, or legal liability is proven in court.

It is imperative for the insurer to keep the insured informed throughout the above process and to document any decisions made or settlements reached.

5.10.3 Contribution (dual insurance)

Once the involvement of another insurer has been identified, the following steps are taken:

- Notification: The insurer approaches the dual insurer to confirm interest and policy cover provided.
- Investigation: Establishing that the policies provide substantially the same cover, and that the subject matter and insurable interest are the same under both policies.
- Evaluation and negotiation: To determine the amount each insurer is liable for in terms of the claim.
- Settlement: Each insurer pays their portion to the insured.

It is imperative for the insurer to keep the insured informed throughout the above process and to document any decisions made or settlements reached.

5.10.4 Recovery of money

When an insurer has accepted and paid for the repair of the damage of an insured's vehicle, and the accident was caused by the negligence of a third party, the insurer may recover their financial expense, and the excess paid by the insured, from the third party. This course of action is available to the insurer in terms of the principle of subrogation. The excess if recovered by the insurer will be reimbursed to the insured.

5.10.5 Reinsurance

The loss may be reinsured, in which case the reinsured portion of the loss is recovered from the reinsurer. This does not affect the contract of insurance with the insured unless it is made a condition of the