Insurance[1]

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Recommended Book:

1. General Principles of Insurance Law by E.R. Hardy Ivamy;
2. Insurance & Islamic Law by Dr. M. Muslehuddin (348.97 MUI)

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Chapter 1 – Meaning, classification etc. of Insurance

MEANING OF INSURANCE

In simple words insurance means purchase of security. Insurance is a contract whereby the insurer, in return of premium, undertakes to pay indemnity, or a certain sum of money, to the insured or to his nominee, on the happening of a specified event. The specified event, may be either,

a. uncertain in their incidence, i.e. may or may not happen, e.g. fire, theft etc.; or
b. certain in their incidence, but the time of incidence is uncertain, e.g. death.

SOME TERMS INVOLVING INSURANCE

a. Parties to the contract of insurance

In an insurance contract, there are two parties:

1. Insured or assured

The party to be indemnified is called the insured or assured. Any person capable to enter into a contract, may be an insured. The guardian, on behalf of a minor or an insane person, may enter into a contract of insurance in respect of the property of the minor or insane person.

2. Insurer

The party who undertakes to indemnify the insured is called the insurer or underwriter, so called because he subscribes or underwrites the policy. A company can be an insurer, if permitted by its memorandum of association. Similarly, a firm can be an insurer, where it is authorised by the partnership deed.

b. Subject matter of insurance

The physical object of the insured, or liability of the insured against third parties or actionable claim against the insured, which is insured, is called the subject matter of insurance.

c. Insurable interest

The legal and pecuniary interest of the insured in the subject matter of insurance is called insurable interest.

d. Premium

The consideration paid by the insured to the insurer for undertaking the risk is called premium.

e. Policy

The instrument which contains the terms and conditions, endorsement etc. of the contract of is called policy. It is the conclusive evidence that a contract of insurance exists between the insurer and the insured.

CLASSIFICATION OF CONTRACTS OF INSURANCE

Insurance may be classified in three different ways.

a. On the basis of perils affecting subject matter / According to the nature of the event on the occurrence of which the sum insured becomes payable

There are four main classes of insurance:

1. Marine insurance, where indemnity is payable on the happening of marine peril;
2. Fire insurance, where indemnity is payable on the happening of fire;
3. Life insurance, where the sum insured becomes payable on the happening of death;
4. Personal accident insurance, where the sum insured becomes payable on the happening of any specified accident affecting human body.

b. On the basis of interest affected / According to the nature of the interest affected

There are three main classes of insurance:

1. Property insurance, e.g. marine insurance, fire insurance, burglary insurance, fidelity insurance, solvency insurance, livestock insurance etc.;
2. Personal insurance, e.g. life insurance, personal accident insurance, sickness insurance etc.;
3. Liability insurance, where the insured insures against liability to third parties arising otherwise than contract:
   (i) Public liability insurance, e.g. liabilities connected with motor vehicles, or with production facilities, such as Union Carbide gas accident in Bhopal, India.
   (ii) Employees liability insurance.

c. On the basis of indemnity / According to the nature of insurance

There are two classes of insurance:

1. Contracts of indemnity, i.e. where loss sustained can be fully recovered by indemnity, e.g. marine insurance, fire insurance, burglary insurance etc.
2. Contracts not of indemnity, i.e. where the loss sustained cannot be recovered by indemnity, or where actual recovery is not possible, since the loss is such that it cannot be estimated in terms of money, e.g. life insurance, personal accident insurance, sickness insurance etc.

SUBJECT MATTER OF CONTRACT OF INSURANCE AND SUBJECT MATTER OF INSURANCE

The subject matter of the contract of insurance must be distinguished from the subject matter of insurance.

a. Subject matter of the contract of insurance

The contract of insurance secures for the insured payment of indemnity or a sum of money on the happening of a certain accident. The subject matter of the contract of insurance is, therefore, money and money only.

b. Subject matter of insurance

This may be one of the following:

1. Physical object

The subject matter of insurance in,

(i) marine insurance, fire insurance, burglary insurance, fidelity insurance, livestock insurance etc. is the property of the insured;

(ii) life insurance, personal accident insurance and sickness insurance is the body of the insured.

2. Liability imposed on the insured

The subject matter of insurance in liability insurance is the liability of the insured against third parties.

3. Chose in action, i.e. actionable claim

The subject matter of insurance in,

(i) solvency insurance is the debt against the loss of which the insured seeks to protect himself;

(ii) license insurance, patent insurance etc. is the monopoly itself and not the physical object to which the monopoly attaches.

NATURE OF CONTARCT OF INSURANCE

The contract of insurance is a type of contingent contract and is perfectly valid. Section 31 of the Contract Act 1872 provides that 'A "contingent contract" is a contract to do or not to do something, if some event, collateral to such contract, does or does not happen.' For instance, A contracts to pay B Tk. 500,000 as indemnity, if B's house is burnt, provided that B pays A Tk. 2,500 as premium. This is a contingent contract, since its performance depends upon the happening of an uncertain event.

Lord Mansfield described insurance as **'a contract upon speculation'**.[2]

A contract of insurance resembles to some extent with a wagering or gambling agreement, in the sense that the insurer promises to pay indemnity to the insured on the happening of loss, which may or may not happen. Even though it depends upon an uncertain event, yet it is neither a speculative nor wagering agreement. The reasons are as follows:

a. The object of an insurance contract is to protect the insured against losses on the happening of some uncertain future event. While, the object of a wagering agreement is to gamble for money and money only. Thus where A agrees with B that if it rains today, A will pay B Tk. 100 and if it does not rain, B will pay A Tk. 100, there is a wagering agreement.

b. In an insurance contract, the insured has an insurable interest, i.e. pecuniary interest, in the subject matter of insurance. Whereas, in a wagering agreement, neither party has any such interest, excepting the resulting gain or loss. This is the main distinguishing feature of a valid contingent contract as compared to a wagering agreement. If either party has any insurable interest, it will not be a wager.

c. A contract of insurance (except life, personal accident and sickness insurances) is based on the principle of indemnity. While, in a wagering agreement there is no question of indemnity, as it does not cover any risk.

d. A contract of insurance is based on logical calculation of risks and the amount of premium is ascertained after taking into account various factors affecting risk. Whereas, in a wagering agreement there is no question of any calculation, whatsoever, it being a mere gamble.

e. A wagering agreement is about wining and losing only. While, in an insurance contract there is no question of wining and losing. Here the insured is indemnified only for the loss which he has actually sustained. He neither gains anything by the happening of the event insured against, nor makes a profit out of his loss.

f. An insurance contract creates liability, whereas a wagering agreement does not create any liability.

g. An insurance is based on public policy, while, a wager is not based on public policy.

Thus, a contract of insurance, being a contingent contract, is an absolutely valid contract.

HISTORICAL DEVELOPMENT OF INSURANCE

a. Marine insurance

In the 12th to 13th century in Italy the concept of insurance evolved with marine insurance.

Between 13th and 14th century, the practice of insurance gradually spread northwards: from Italy to the Netherlands to United Kingdom. At that time, marine insurance business was conducted along with general trading activities.

In the 16th century, marine insurance was firmly established in the mercantile transactions of Lombard Street of London, which was then a centre for trade and commerce. Lombard Street was named after the merchants of Lombardy of Italy. Soon insurance transactions multiplied, disputes became inevitable and customs of Lombard Street proved inadequate.

In 1575, the Chamber of Assurance was established to register policies and to settle disputes. The Chamber played vital role during the formative period of insurance. The coffee houses of London also played important role in the development. Here ship owners, Sea Captains, merchants and traders used to congregate for business transactions.

In 1680, Edward Lloyd opened one such coffee house. In this house the practice of individual underwriting took shape.

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[2] Carter v Boehm (1766) 3 Burr, at 1909.

In 1720, the Bubble Act granted Royal Charter to transact insurance business on an exclusive basis to two companies: the Royal Exchange and the London Assurance.

In 1824, the monopoly was repealed and many new companies were formed. These, together with the Lloyds' underwriters, constituted marine insurance market.

In 1871, the Lloyds' Act was framed to set up the Corporation of Lloyds'. Today, Lloyds' is globally regarded as the strongest or the soundest insurance organization in the world.

In 1906, the Marine Insurance Act was passed to codify marine insurance laws.

b. Fire insurance

After marine insurance, fire insurance was introduced. This is a German concept.

In 1666, the Great Fire of London, which practically destroyed London, demonstrated the need for fire insurance.

In 1680, Dr. Nicholas Barbon, a London builder, started a fire office to insure buildings against fire. Soon, others followed him.

In 1708, a fire office was established to insure goods and merchandises. Each fire office had their own fire brigade and fire mark, which were fixed to buildings to indicate that they were insured by a certain fire office.

In the beginning of the 19th century, there were at least 32 fire offices in London.

In 1832, fire offices of London formed one common fire brigade.

In 1858, the Association of English and Scottish Fire Office was formed. The Industrial Revolution of the 19th century played important role in developing fire insurance business. Some five fire offices extended operations to the USA, British colonies and to different parts of Europe.

In the beginning of the 20th century, the Lloyds' commenced fire insurance business.

c. Life insurance

In 1583, the first life insurance was conducted.

In 1774, the Life Assurance Act was passed requiring presence of insurable interest at the time of effecting policy.

d. Accident insurances

In 1848, the Railway Passengers Assurance Co. was established to cover accidents sustained during travelling by railway.

In 1880, the Employer's Liability Act made the employers liable, under certain circumstances, to pay compensation to the workers. This created the need for liability insurance. The same year the Employer's Liability Assurance Corp. Ltd. was formed.

In 1887, burglary insurance was introduced.

In 1897, the Workmen's Compensation Act made the employer liable for industrial accidents.

In 1898, motor insurance was introduced.

In 1900, consequencial loss of profits policy was introduced.

Between 1909 and 1910, aviation insurance was introduced.

Insurance in India

In the beginning of the 19th century, marine insurance was introduced in India.

Between 1797 and 1810, many marine insurance companies were established in Kolkata (Calcutta), which was then East India Company's centre for trade and commerce.

In 1825, the Alliance British and Foreign Fire Insurance Co. was established in Madras, which introduced fire insurance.

Insurance in Bangladesh

Between 1947 to 1971, about 49 insurance companies of various origin, viz. British, American, Australian, Indian, West and East Pakistan, transacted life and general insurances. Out of 49 companies, 7 companies were of East Pakistan origin.

In 1972, the Government of Bangladesh by the Bangladesh Insurance (Nationalization) Order, nationalized the insurance business. Only foreign life insurance companies were allowed to operate.

The same year, the Government also established the Bangladesh Insurance Academy, under the Ministry of Commerce, for insurance-education and training.

Under the Order of 1972, five insurance corporations were established:

1. Jatiya Bima Corp;
2. Teesta Bima Corp.;
3. Karnaphuli Bima Corp.;
4. Rupsa Jiban Bima Corp.;
5. Surma Jiban Bima Corp.;

The Jatiya Bima Corp. was the custodian corporation to supervise and control the activities of the other four subsidiary corporations. Teesta and Karnaphuli conducted the business of general insurance, while Rupsa and Surma conducted the business of life insurance. The basic idea behind creating two corporations in each main branch was to encourage competition under a nationalized system. But unnecessary administrative expenses for maintaining two corporations in each sector and an apex institution at the top out-weight the advantages of limited competition.

In 1973, the Insurance Corporations Act abolished the five corporations and instead established two corporations: the Sadharan Bima Corp. and the Jiban Bima Corp., the former to conduct general insurance and the latter to conduct life insurance. This structure still exists.

In the 80's, insurance business was opened to private insurance companies.

Chapter 2 – Insurable Interest

INSURABLE INTEREST

The pecuniary and legal interest of the insured in the subject matter of insurance is called insurable interest.

The insured must be the owner of the subject-matter of insurance, or he must be in such a position that injury to it would affect him adversely. He must be 'so situated with regard to the thing insured that he would have benefit by its existence, loss from its destruction.'[3]

In the case of a marine insurance, the owner of the ship runs a risk of losing his ship, the charterer of the ship runs a risk of losing his freight and the owner of cargo runs the risk of losing his goods and profits. All these persons are interested because they all run a risk, have something at stake, something to lose by the happening of the peril insured against. So, the ship-owner has insurable interest in the ship, the charterer in the freight and the cargo-owner in the goods and profits.

In the case of a fire insurance, a sub-contractor, who supplies material to a ship-builder for installation in a vessel, runs the risk to be materially adversely affected by the loss or damage to the vessel by reason of the incidence of fire.[4] The sub-contractor, therefore, has insurable interest in the vessel.

In the case of a life insurance or personal accident insurance, the insured is clearly prejudiced by the loss of life or limb. So, the insured has insurable interest in the life or body.

In the case of a liability insurance, the insured will suffer prejudice by the happening of an accident for which he is responsible to third parties.[5] He has, therefore, an insurable interest for the purposes of a liability insurance policy.

NATURE OF INSURABLE INTEREST

An interest, to be insurable, must have a pecuniary value.[6]

Insurable interest may be based on ownership, which may be either sole or joint, absolute or limited. Insurable interest may also be founded on contract.[7] Thus, a bailee, who is responsible for the safety of goods bailed,[8] has insurable interest in them. The mere fact of possession, if lawful,[9] is also sufficient to give an insurable interest.

The insurable interest must be actual and real, and not a mere expectation. The mere expectation of acquiring an interest, however probable, does not give a person the right to insure the property, out of which the expectation arises.[10]

NESESSITY FOR INSURABLE INTEREST

The insured must have insurable interest in the subject matter of insurance, otherwise the policy is invalid. If the insured has no insurable interest in the subject matter, then he cannot be prejudiced by its destruction. It is the existence of insurable interest in a contract of insurance that differentiates and distinguishes it from a mere wager.

Most of the insurances are effected by the insured in respect of his own person or property. Occasionally, the insured may, for his own benefit, effect an insurance on the person or property of another, and then the question of insurable interest becomes important. Thus, the insured may effect a personal accident policy, against a loss which he may suffer by reason of an accident to a third person. To render such an insurance valid, the assured must have an insurable interest in such person's safety,[11] and this interest must be of a pecuniary nature.

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[3] Lucena v. Craufurd (1806) 2 Bos & PNR 269, HL (marine insurance) at 302, per Lawrence J.

[4] Stone Vickers Ltd. v. Appledore Ferguson Shipbuilders Ltd. (1991) 2 Lloyd's Rep 288 (marine insurance)

[5] Prudential Insurance Co. v. IRC (1904) 2 KB 658 (life insurance)

[6] Halford v. Kymer (1830) 10 B & C 724 (life insurance).

[7] Lucena v. Craufurd (supra)

[8] Crowley v. Cohen (1832) 3 B & Ad 478.

[9] Thus, a finder has an insurable interest: Marks v. Hamilton (fire insurance) as reported 21 LJ Ex 109 per Pollock CB, 110.

[10] Devaux v. Steele (1840) 6 Bing NC 358 (marine insurance)

[11] Shilling v. Accidental Death Insurance Co.(1857) 2 H & N 42

DESCRIPTION OF INTEREST

a. The general rule

Although the insured must have insurable interest in the subject-matter of insurance, yet as a general rule, he is not required to provide a specific description as to the nature and extent of the insurable interest.[12] The insured is only required to specify the subject matter of insurance, and such description is sufficient to cover any interest which he may have in the subject-matter, whether as owner or otherwise.[13]

b. Exceptions to the general rule

A specific description of the insurable interest is, however, required in the following cases:

1. Express condition

Where the insurer makes it an express condition that certain kinds of interests must be specified, e.g. in the case of goods held in trust or on commission, then the insured is required to specify it.

2. Consequential loss policy or policy for prospective profits

Where the insurance is against consequential loss, a specific description of the insured's interest is required.[14]

Similarly, where the insurance is for recovery of prospective profits[15], then the insured is required to specify it.

THE TIME FOR INSURABLE INSTEREST

a. Insurable interest at the time of the loss sometimes essential

1. Fire and marine insurance

In the case of a fire insurance, in order to recover from the insurer sums payable under the policy, the insured must show that he had insurable interest in the object destroyed, both at the time of effecting the insurance and at the time of the loss.[16] If he had then no interest, he can have suffered no loss, and is, therefore, entitled to no indemnity.

In the case of a marine insurance, in order to be indemnified, the insured must prove that he had insurable interest at the time of the loss. He need not prove that he had insurable interest at the time when the insurance is effected.

2. Life insurance

In the case of a life insurance, the insured must have an insurable interest at the time at which the policy is effected.[17] It is immaterial whether or not he later ceases to have such an interest, e.g. where before the debtor, whose life is insured, dies, he pays the creditor the amount of the debt.[18]

b. Retrospective insurance

Although at the date of effecting the insurance, the subject-matter may, in fact, have been destroyed eg by fire, the contract may, nevertheless, in some cases be valid, and operate to indemnify the assured notwithstanding such destruction, since the insured is, in fact, prejudiced by reason of the happening of the peril insured against, and he has, therefore, an insurable interest existing at the date of effecting the insurance. To render such a contract valid, it is necessary to establish,

1. that both the insured and the insurer were ignorant of the loss at the time of making of the contract of insurance;[19]
2. that they both intended the contract of insurance to apply to such a loss.[20]

If these two cannot be proved, the policy is void, and the premium must be returned.[21]

Similarly, where the fact of loss is known to both the parties, but its amount is unascertained, a contract indemnifying the assured against such loss would be equally valid;[22] since, in this case the contract is still a contract on a contingency.

[12] MacKenzie v. Whiteworth (1875) LR 10 Exch 142 (marine insurance)
[13] London and North-Western Rly Co. v. Glyn (1859) 1 E & E 652 (fire insurance)
[14] Inman SS Co. v. Bischoff (1882) 7 App Cas 670 (marine insurance)
[15] Prospective profits means profits or remuneration which has already been ascertained at the date of insurance, or which must necessarily be earned in the ordinary course of events. In Lucena v. Crqufurd (supra) it was held that an insurance for recovery of propective profits is an anomaly, since prospective profit is in the nature of an expectancy. But the insurability of such profit is well recognised.
[16] Sadler's Co. v. Badcock (1743) 2 Atk 554 (fire insurance)
[17] Dalby v. India and London Life Assurance Co. (1854) 15 CB 365 (life insurance)
[18] Ibid.
[19] Mead v. Davison (1835) 3 Ad & El 303 (marine insurance) per Lord Denman CJ
[20] Giffard v. Queen Insurance Co. (1869) 12 NBR 433, where property covered by an ante-dated policy was held to be insured 'burnt or not burnt'.
[21] Pritchard v. Merchant's and Trademan's Life Assurance Society (1858) 3 CBNS 622 (life insurance), where a payment of premium after the assured's death by a policy holder was held not to revive the policy, the contract referring to the future event of the assured's death.
[22] Bradford v. Symnodson (1881) 7 QBD 456, CA (marine insurance).

Chapter 3 – Proposal

WHAT CONSTITUTES A PROPOSAL

An alleged proposal, which is capable of being accepted, must fulfil the following conditions:

a. It must be intended by the party making it to be a proposal;
b. It must be complete.
c. It must be communicated to the other party;[23]
d. It must be in force at the time when the other party purports to accept it.

WHO MAKES THE PROPOSAL

In general, the proposed insured makes the proposal, to the proposed insurers. He may have been invited by the insurers to communicate with them; but whether the invitation comes to him from the insurers directly, or through the medium of an agent, or whether it is given to him personally, or only as a member of the public through an advertisement, the position remains unchanged. He must submit his proposal, which the insurers may accept or decline at their pleasure. The proposal, therefore, proceeds from the proposed assured, when he has filled up the proposal form and forwarded it to the insurers.[24]

USUAL CONTENTS OF PROPOSAL FORMS

The contents of proposal forms vary according to the nature of the proposed insurance. They also vary according to the practice of different insurers. All proposal forms, however, contain questions which the proposed insured is required to answer, and these questions, whatever the nature of the insurance, are framed on the same general guidelines.

The matters to which the questions relate may be classified as follows:

a. Description of the proposed insured

This includes his name, address and occupation.

b. Description of the risk proposed to be insured

This varies according to the nature of insurance. Thus, in the case of personal accident insurance, the proposed insured is usually required to state his age, weight and height. In the case of property insurance, a full description of the property proposed to be insured must be given. In the case of liability insurance, the circumstances out of which the liability may arise must be stated.

c. Description of circumstances affecting the risk

Questions relating to description of circumstances affecting the risk are directed to ascertain whether there are any special circumstances connected with the proposed insurance tending to show that the risk is greater than usual. These also vary according to the nature of insurance. Thus, in the case of personal accident insurance, the proposed insured is usually asked for details as to his present and past state of health, and as to any existing physical defects. In the case of property insurance, a description of the nature and situation of any building containing the property proposed to be insured, and of any measures taken to prevent or minimise loss may be needed. In the case of liability insurance, a description of the state of the proposed insured's premises, the nature of his business, or the machinery and appliances used, or a statements as to the number or persons employed by him, may be required, according to the nature of the proposed insurance.

d. Previous history of the proposed insured.

This falls under two heads:

1. Experience of the proposed insured

The proposed insured is required to state whether he has, in the past, suffered loss by the peril proposed to be insured against, or whether he has ever been exposed to the danger of loss.

2. Relations of the proposed insured with other insurers

The proposed insured is required to state whether he has ever made a similar proposal to other insurers,[25] whether such proposal was declined,[26] or accepted at a higher premium, whether any previous policy has been cancelled, or its renewal refused,[27] or whether he has ever claimed under a similar policy.[28] He may also be required to state whether he is already insured,[29] or intending to be insured[30] with other insurers, and whether the proposed insurance is intended to be in substitution for other insurances or as an additional protection.

e. Declaration as to statements made in the proposal

The proposal form concludes with a declaration that the statements made in the answers to questions are true, and that the proposed insured agrees that they are to be the basis of the contract of insurance.

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[23] Rose v. Medical Invalid Life Assurance Society (1848) 11 Dunl (Ct of Sess) (life insurance), where the insurers stated, in a letter handed to their own agent, the premium at which they were willing to accept the proposal, but the agent never handed over the letter to the proposed assured.
[24] Linford v. Provincial Horse and Cattle Insurance Co. (1864) 34 Beav 291 per Lord Romilly MR, at 293
[25] Hambrough v. Mutual Life Insurance Co. of New York (1895) 72 LT 140, CA (life insurance).
[26] Holt's Motors Ltd. v. South East Lancashire Insurance Co. Ltd. (1930) 35 Com Cas 281, CA (motor insurance).
[27] Biggar v. Rock Life Assurance Co. (1902) 1 KB 516 (accident insurance).
[28] Reid & Co. v. Employers' Accident and Live Stock Insurance Co. (1899) 1 F (Ct of Sess) 1031 (accident insurance).
[29] Citizens Insurance Co. of Canada v. Persons (1881) 7 App Cas 96, PC (fire insurance).
[30] Re Marshall and Scottish Employers' Liability and General Insurance Co. Ltd. (1901) 85 LT 757 (accident insurance).

Chapter 4 – Cover Note

COVER NOTE

A cover note is a note to cover risk. It is also called Interim Protection Note (IPN). It is issued when the proposal is under consideration. It is a preliminary un-stamped document.

PURPOSE OF COVER NOTE

A proposal is not necessarily accepted at once, since the proposed insurers may take time to consider it. There is, therefore, an interval of time between the making of the proposal and its acceptance. So, it is the practice of insurers in the case of some types of insurance, e.g. marine, fire, motor and burglary insurance, to give the proposer protection by the issue of a cover note. Cover notes are not issued in life insurance.

Issue of a cover note does not mean acceptance of a proposal.

FORM OF COVER NOTE AND ITS ISSUE

Usually, the cover note is printed in a common form. No formal document is, however, necessary to bind the proposed insurers. Cover may be given informally, e g by a letter. Even verbal cover is sufficient, and the verbal cover may be given by the agent submitting the proposal, if his authority extends that far.[31]

Cover note is issued by the insurers or by the duly authorised agent of the insurers, through whom the proposal was submitted.

DURATION OF COVER NOTE

Cover note comes to an end,

a. when the period of validity, which is expressly stated in it, expires; or
b. when the proposal is rejected by the insurer; or
c. when the policy has been issued, replacing the cover note; or
d. when it is exhausted by a declaration, made as per its terms and conditions.

The question of the duration of the cover note is of little significance where the proposal is accepted, since the cover note comes to an end when the policy is issued.[32] It is only where the proposal is rejected, then the question becomes important.

INCORPORATION OF TERMS OF POLICY

A cover note may contain the terms and conditions subject to which it is issued. It, however, may not contain any term at all. In that case, it incorporates the conditions of the company's policy, e.g. in Queen Insurance Co. v. Parsons[33] the cover note stated that the proposer 'had proposed to effect an insurance against fire, subject to all the usual terms and conditions of this company.'

Sometimes the cover note incorporates the terms of the policy not by referring to them directly, but by referring to the proposal form which itself alludes to them.[34]

EFFECTS OF COVER NOTE

The insured will be indemnified for loss occurring within the period of validity of the cover note, provided that he has complied with all the conditions precedent and subsequent, e.g. payment of premium. After issue of a cover note, liability for loss cannot be disowned by the insurer. Therefore, as soon as a claim is lodged, the insurer is bound to issue the policy. The claim will be settled under the policy and not under the cover note.

[31] Stockton v. Mason and the Vehicle and General Insurance Co. Ltd. and Arthur Edward (Insurance) Ltd. (1978) 2 Lloyd's Rep 430, CA (motor insurance) per Lord Diplock, at 432.
[32] Roberts v. Security Co. (1897) 1 QB 111, CA (burglary insurance) per Lopes LJ, at 115.
[33] (1881) 7 App Cas 96, PC.
[34] Wyndham Rather Ltd. v. Eagle Star and British Dominions Insurance Co. Ltd. (1925) 21 LlL Rep 214, CA.

Chapter 5 – Acceptance

WHAT CONSTITUTES AN ACCEPTANCE

There cannot be an acceptance so long as the terms of the contract of insurance are still under discussion, since there is no contract until complete agreement has been reached, and nothing remains to be done by either party.

The proposal, therefore, must be complete, and the acceptance must be in the very terms of the proposal, meaning the acceptance must be unqualified.

If the acceptance departs from the proposal by introducing fresh terms, then such an acceptance is equivalent to a counter-offer, which must in its turn be accepted before the parties are bound. In the absence of acceptance, the insured cannot be sued under the policy for the premium, nor can he enforce the policy against the insurers.

MODES OF ACCEPTANCE OF A PROPOSAL

Where the proposal is made by the proposer, the acceptance may be signified by the insurers in one of the following ways:

- **a.** By a formal acceptance
- **b.** By the issue of a policy
- **c.** By acceptance of the premium
- **d.** By the conduct of the insurers

a. By formal acceptance

If, however, the acceptance is subject to a condition, there is no contract until the condition is fulfilled.

b. By issue of a policy

The issue of the policy is a conclusive intimation that the insurers have accepted the proposal.[35] They are, therefore, bound by their acceptance, and from it they cannot recede.

The policy, as an enforceable contract of insurance, is complete as from the date of its issue, even though no premium has been paid at the time of the loss in respect of which the proposer seeks to enforce it. By the terms of the policy, however, he may be precluded from enforcing it in respect of any loss happening before he has complied with its condition.

c. By acceptance of premium

Where no policy has been issued before the loss, the receipt of the premium and its retention by the insurers, may raise the presumption, in the absence of any circumstances leading to a contrary conclusion, that the insurer has definitely accepted the proposal. In that case the insurer is bound to issue a policy and is liable to indemnify the insured, in the event of loss.

d. By conduct of insurer

Where no policy has been issued, nor the premium paid, the facts may clearly show that the insurer has accepted the proposal, and that there is a binding contract between the parties, on the part of the proposer to pay the premium, and on the part of the insurer to issue a policy. Mere demand for premium may raise the presumption that the insurer has accepted the proposal. In that case the insurer is bound to accept premium, when tendered, and are liable to indemnify the insured in the event of loss.

ACCEPTANCE OF A PROPOSAL FOR COUPON INSURANCE

In the case of coupon insurance, the proposed insured receives a proposal form by purchasing a specific article of a specific company. He is required to duly fill in the proposal form and send it to a specific address. The company, offering the proposal form, reserves the right to accept or reject the proposal. Upon acceptance of the proposal, a policy or beneficiary certificate is issued to the insured.

In general, the insured is not required to pay any premium. He may, however, be required to pay a registration fee.

EFFECT OF ACCEPTANCE

- **a.** When a proposal is accepted, a binding contract comes into existence. Acceptance puts an end to negotiations and to the duty to disclose;
- **b.** The parties are bound to each other, the insured to pay the premium, if not already paid, and the insurer to issue the policy and to indemnify the insured in the event of loss.

[35] Wright v. Sun Mutual Life, Insurance Co. (1878) 5 AR 218 (life insurance)

Chapter 6 – Uberrimae Fidei, i e utmost good faith

DISCLOSURE OF MATERIAL FACTS

Material facts are those facts by which the insurers assess risk.

The insured must disclose all material facts relating to the subject matter of insurance which are within his actual or presumed knowledge.

Facts within the actual knowledge of the insured means facts known to him.

Facts within the presumed knowledge of the insured means either facts ought to be known to him, or facts which can be reasonably expected to be known to him, or facts which he could have discovered by making reasonable inquiries.

The object of disclosure of material facts is to help the insurer, by every means, to estimate the risk which he is about to undertake and the proper value thereof.

TEST OF MATERIALITY

The test adopted by the court in determining whether a fact is material or not is whether non-disclosure of the fact would influence a prudent insurer in determining whether he will take the risk or not, or in fixing the premium, where he chooses to take the risk.

It is important to note that whether the non-disclosure of a fact would influence a particular insurer is irrelevant. Similarly, the insured's opinion as to whether the fact not disclosed is material or not, is also irrelevant.

MATERIALITY IS A QUESTION OF FACT

Whether a particular fact is material or not is a question of fact, i.e. it depends upon the facts and circumstances of each particular case. Therefore, a fact material in one case may not be material in another.

The duty to disclose material fact is not a continuous duty. It continues up to the date of the formation of contract. However, the duty revives with the alternation in existing policy or with the renewal of expired policy.

CONSEQUENCE OF NON-DISCLOSURE ON POLICY

Being a contract uberrimae fidei, a material fact goes to the very root of the insurance contract. Therefore, any concealment of material fact either intentionally, negligently, fraudulently, or by mistake, error of judgement or even to his failure to appreciate its materiality renders the contract voidable at the option of the insurer.[36] In **Bufe v. Turner**[37] the insured had a ware-house next to a boat builder's shop. One day, the shop caught fire, which was extinguished. The ware-house was insured the same evening, without disclosing the fire incident. Two days later, the shop again caught fire and engulfed the ware-house. The insured claimed indemnity. It was held that the insurer is not liable to indemnify, since the insured has concealed the first fire incident, which was a material fact.

Similarly, in **Candogianis v. Guardian Assurance Co. Ltd.**[38] the proposal form of a fire insurance policy contained the question 'Has the proponent ever been a claimant on a fire insurance company in respect of the property now proposed or any other property? If so, state when and the name of the company. The insured answered 'Yes, in 1917 from Ocean Insurance Co., in respect of burning of a car. But he concealed the fact that in 1912, he made another claim against another insurer in respect of burning of another car. It was held that since the insured had partially concealed material fact, the insurer is not liable to indemnify.

Again, in **Harrington v. Pearl Life Assurance Co. Ltd.**[39] after examination by the doctor of the insurance company, the insured's proposal for life insurance was accepted in May 1912. But since no premium was paid, the proposal never came into force. On 1st October 1912, he made another proposal, stating that there have been no material change in his health since his medical examination. Again this proposal was accepted but no premium was paid. On 6th November 1912 he fell ill and on 8th November he paid the first premium and he died the same day. It was held that the insurance company was under no obligation to issue the life insurance policy, since the circumstances had changed on 6th November and no disclosure of it had been made.

CONSEQUENCE OF NON-DISCLOSURE ON RETURN OF PREMIUM

When the insurer avoids a policy on the ground of non-disclosure of material fact, the return of premium will depend on the terms of the policy. Where the policy is silent on this matter, then full premium has to be returned to the insured. On the other hand, the policy may contain a stipulation to the effect that full premium will be forfeited where the insured conceals any material fact. In that case return of premium is not possible.

FACTS NORMALLY MATERIAL

a. Exposure to more than ordinary danger

All facts are material which suggest that the subject matter of insurance by reason of its nature, condition, user, surrounding and other circumstances is exposed to more than ordinary danger from the peril insured against. Thus in a fire insurance it is material that threats have been made to destroy the property insured.[40]

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[36] Bufe v. Turner (1815) 6 Taunt 338, 2 Marsh 46.
[37] Ibid.
[38] (1921) 445 Kut .
[39] (1913) 30 TLR 24.
[40] Greet v. Citizen's Insurance Co. (1880) 5 AR 596 CA.

b. Special motive of insured

All facts are material which show that the proposed insured in effecting the insurance is actuated by some motive, and not merely by ordinary prudence. Thus in a marine insurance it is material that the ship to be insured is carrying goods insured at a value greatly exceeding their real value.[41]

c. Greater liability of insurer

All facts are material which suggest that in the circumstances the liability of the insurer may be greater than would normally be expected. Thus in a marine insurance it is material that the ship to be insured was previously seriously damaged and grounded.[42]

d. Moral hazard i.e. question of moral integrity of the proposed insured

All facts are material which show that the proposed insured, by reason of his previous experience in matters relating to insurance, is not a person whose proposal can be accepted in the ordinary course of business and without special consideration. Thus it is material that the proposed insured has suffered loss in the past from the peril to be insured against,[43] or that other insurers have refused to grant or to renew an insurance similar to the insurance proposed.

e. Facts regarded as material by insurer

All facts are material which are to the knowledge of the proposed insured regarded by the insurers as material.

FACTS NOT NORMALLY MATERIAL

a. Facts within the actual or presumed knowledge of the insurer, e.g. the fact that burglary of motor cycle has increased.
b. Facts which the insurers could have discovered by making inquiry in the case where they choose to make inquiries themselves.
c. Facts as to which the insurer waives information.
d. Facts which diminish the risk.
e. Facts which are superfluous to disclose by reason of any condition or warranty, express or implied, e.g. in a marine insurance the fact that the ship to be insured is seaworthy.
f. Facts which are trifle, e.g. in a life insurance, the fact that the proposed insured has a mild form of epilepsy.[44]

BURDEN OF PROOF

The burden of proving that the insured has failed to perform his duty to disclose or broken a condition relating to disclosure, lies on the insurer.

Where non-disclosure is alleged, the insurer must prove:
a. that the fact not disclosed was material;
b. that it was within the knowledge of the insured; and
c. that it was not communicated to the insurer.

Where breach of condition relating to disclosure is alleged, the insurer must prove:
a. that by express stipulation, the duty to disclose is made contractual;
b. that the non-disclosure alleged to have been made is a breach of duty as defined in the stipulation; and
c. that the insured was guilty of the alleged non-disclosure.

Chapter 7 – Premium

AMOUNT OF PREMIUM

The consideration paid by the insured to the insurer for undertaking the risk is called premium. Any consideration sufficient to support a simple contract may constitute the premium in a contract of insurance.

The amount of the premium is purely a matter of contract, depending on the insurer's estimate of the risk. Most insurers issue tables of premiums, showing the rate charged by them for each class of risk undertaken. In framing these tables they are guided, as far as, possible by experience. The premium is usually charged at the rate of so much per Tk 100 of the amount insured, e.g. when the insured amount is Tk. 481,620 and the premium is charged @ 0.50 % of the amount insured, then the amount of premium is Tk. 2,408.

In Bangladesh, the rate of premium or tariff is determined by the Central Rating Committee, which is headed by the Chief Controller of Insurance, under the Ministry of Finance. The rates are revised from time to time.

MODE OF PAYMENT OF PREMIUM

Normally, the premium is payable in money. If the parties agree, payment can be made by cheque, bill of exchange, promissory note or by settlement of account.

TIME FOR PAYMENT OF PREMIUM

Apart from an express condition in the policy, it is not necessary, for the insured to pay the premium at the time of submitting proposal. After acceptance, the insured becomes bound to pay the premium, and is therefore, liable in an action by the insurers, if he fails to do so.

In practice, premium is received with the proposal. Usually, the policy contains a stipulation to the effect that the insurance is not to come into force until the premium has been paid. The payment of the premium is thus made a

[41] Ionides v. Pender (1874) LR 9, QB 531.
[42] Russel v. Thornton (1860) 6 H & N 140, 30 LJ Ex. 69.©
[43] Rozanes v. Brown (1928) 32 LIL Rep 98 CA.
[44] Mutual Life Insurance Co. v. Ontario Metal Products.

condition precedent to the liability of the insurer, and he is not responsible for any loss happening before payment. When the premium is paid and accepted after the due date, its effect is retrospective, in the absence of any agreement to the contrary.

EFFECT OF PAYMENT OF PREMIUM

The acceptance of the premium by the insurer leads to the inference that there is a concluded contract of insurance. The insured thereupon becomes entitled to receive a policy from the insurer.

The making of a demand for the premium leads to the same inference, unless the demand is refused, in which case there is a repudiation of the contract by the insured, which releases the insurer from liability.

When the insurers accept the premium, knowing that the policy was procured by the fraud, misrepresentation or non-disclosure on the part of the assured, then they are estopped from contending subsequently that the contract is voidable by reason of the insured's breach of duty. Similarly, if they accept the premium with knowledge that the insured has broken a condition subsequent, e.g. by increasing the risk, they cannot avoid the contract.

PAYMENT OF PREMIUM TO WHOM

Premium may be paid:

a. to the insurer; or

b. to the duly authorised agent of the insurer, where the proposal has been submitted through an agent.

RIGHT TO RECLAIM A RETURN OF PREMIUM

The right to a return of premium depends on the fact that the risk contemplated is never run, and there is, in consequence, a failure of consideration in that the insured obtains no benefit from the protection for which he has paid. If, therefore, no part of the risk is ever run, the whole of the premium must be returned. The insured may be entitled to a return of part of the premium where there has been a partial failure of consideration. The policy, however, may specify that the premium will not be returned in any event.

a. Right to a return of whole premium

The right to a return of the whole of the premium arises in the following cases:

1. Where the parties are not ad idem;[45]
2. Where the insured has no insurable interest in the subject-matter.[46]
3. Where the policy is ultra vires the company;[47]
4. Where the policy is illegal;[48]
5. Where the policy has been avoided on the ground of innocent misrepresentation or non-disclosure by the insured;[49]
6. Where there has been fraud or breach of good faith on the part of the insurers;[50]
7. Where the subject-matter has already been destroyed; and
8. Where the subject-matter is incapable of identification;[51]

b. Right to a return of part of the premium

In certain cases the insured may be entitled to a return of part of the premium. This may occur:

1. Where there is an express term to that effect in the policy, e.g. the insurers may reserve to themselves the right of putting an end to the policy, or the assured may be given the right to surrender it at any time upon notice. In these cases the stipulation provides for the return of a part of the premium proportionate to the unexpired part of the period of insurance;[52] and
2. Where the insurance company goes into liquidation.

NO RIGHT TO A RETURN OF PREMIUM

There is no return of premium in the following cases:

1. Where there has been no failure of consideration[53] on the part of the insurers, e.g. where the property insured is destroyed by an excepted peril;[54]
2. Where though there is a failure of consideration, the failure is attributable to the conduct of the insured, e.g. where the insured has been guilty of fraud;[55] and
3. Where there is an express condition in the policy that the premium is to be forfeited on the happening of specified events, e.g. where there is a stipulation avoiding the policy in the event of any statement in the proposal being untrue.[56]

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[45] Fowler v. Scottish Equitable Life Insurance Society and Ritchie (1858) 28 LJ Ch 225 (life insurance); Hyams v. Paragon Insurance Co. (1927) 27 LlL Rep 448, where the insured was illiterate and the agent of the insurers had innocently misrepresented the extent of the contract.

[46] Routh v. Thompson (1809) 11 East 428 (marine Insurance).

[47] Re Argonaut Marine Insurance Co. Ltd. (1932) 2 Ch 34, where the insurers of marine risks issued a fire policy.

[48] Brewster v. National Life Insurance Society (1892) 8 TLR 648, CA (life insurance), where, by mistake of the agent of the insurers, the form of the policy was not in accordance with the law.

[49] Imperial Bank of Canada v. Royal Insurance Co. (1906) 12 OLR 519.

[50] In consequence of which the insured has been induced to enter into a contract different from that which he intended to make: Carter v. Boehem (1766) 3 Burr 1905 (marine insurance)

[51] Horneyer v. Lushington (1812) 15 East 46 (marine insurance), where the assured has no property answering the description of the subject-matter contained in the policy.

[52] Sun Fire Office v. Hart (1889) 14 App Cas 98, PC (fire insurance)

[53] Failure of consideration occurs where the risk never attached to the property insured.

[54] Loraine v. Thomlinson (1781) 2 Doung KB 585 (marine insurance).

[55] Feise v. Parkinson (1812) 4 Taunt 640 (marine insurance) per Gibbs CJ, at 641: 'Where there is fraud, there is no return of premium.

Chapter 8 – Policy

A Policy is a final, stamped and conclusive insurance document.

CLASSIFICATION OF POLICIES

All policies of insurance may be classified in two ways:

a. According to the description of the subject-matter

Two types of policy fall within this class:

1. **Policies in which the description of the subject-matter is so precise as to confine the insurance to a specific object,** e.g. marine, fire, life and personal accident policy and policy against loss by defalcations of a particular employee, or by the insolvency of a particular debtor;
2. **Policies in which the description of the subject-matter is expressed in general terms so that the insurance is capable of applying to any object falling within the description,** e.g. public liability policy and policies of insurance on property generally.

b. According to the amount recoverable

Two types of policy fall within this class:

1. **Unvalued policies**

   In the case of an unvalued policy, the sum to be paid to the insured is not fixed by the policy, but left to be ascertained after the loss has happened, e.g. marine, fire and most policies of insurance on property and policies of insurance against liability;

   The sum specified in the policy as the insured amount, merely indicates the amount beyond which the insurers are not liable.

2. **Valued policies**

   In the case of a valued policy, the amount recoverable is fixed by the policy, e.g. life and personal accident policies.

   All personal accident policies belong to this class, and, as the value of life or limb cannot be measured, the sum fixed in the policy is not open to objection on the ground of over-valuation. In the case of insurance on property, the value of the subject-matter may be fixed by agreement and inserted in the policy as the amount recoverable in the event of loss.

   In the event of a partial loss, however, the valuation has no effect, and the insured must prove and is entitled to recover the actual amount of his loss.

Difference between life and marine and fire insurance

a. Subject matter of insurance

In life insurance, the subject matter of insurance is the life of the insured, while in marine and fire insurance, the subject matter of insurance is the property of the insured.

b. Nature of event insured

In life insurance, death is bound to happen, but the time of happening is uncertain. Whereas, in marine and life insurance, the accident may or may not happen.

c. Indemnity

Life insurance is not a contract of indemnity. The sum insured is paid without any proof of loss, since the loss resulting from death cannot be estimated in terms of money. Hence, in life insurance, actual recovery is not possible. While, marine and fire insurances are contracts of indemnity. The amount of actual loss, not exceeding the policy amount, is paid. Hence, actual recovery is possible.

d. Time of insurable interest

In life insurance, insurable interest must be present at the time of effecting the policy. In a marine insurance, the insured must have insurable interest at the time of loss, and he need not have such interest at the time of effecting the policy. Whereas, in a fire insurance, insurable interest must exist both at the time of effecting the policy and at the time of loss.

e. Duration of contract

Life insurance is taken for ten, twenty or thirty years or for the whole life. Fire insurance is a yearly contract. While, marine insurance is effected for a certain period, which could be either more or less than a year.

FORM AND CONTENTS OF POLICY

a. Form of policy

In general, there are no strict rules as to the form of a policy. In practice, standard forms of policy are used, and these vary from company to company.

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[56] Duckett v. Williams (1834) 2 Cr & M 348 (life insurance) .

b. Contents of policy

The contents of the policy will vary according to the type of insurance. So, too, will the contents vary from company to company. In general, a policy may be divided into four parts:

1. Heading

The heading usually sets out the name of the insurers, the reference number of the policy, the period of insurance, the sum insured and the amount of the premium.

2. Body of policy

In the body of the policy, the actual contract between the parties is to be found. The following matters are usually dealt with:

- **I.** Recitals, in which the fact that a proposal has been made and that the premium has been paid may be stated.
- **II.** The details of the particular insurance, e.g. the name and address of the insured, the description of the subject matter, the amount of insurance and the period of insurance.
- **III.** The event insured against.
- **IV.** The premium.
- **V.** The undertaking of the insurers, and exceptions from liability.
- **VI.** Stipulations and conditions.
- **VII.** Incorporation of other stipulations, including those indorsed on the policy, or contained in the proposal form or any other document.

3. Back of the policy

Nothing printed or written on the back of the policy forms part of the contract contained in the policy, unless made part thereof by express incorporation. The following matters are dealt with on the back of the policy:

I. Terms and conditions of policy

The terms and conditions, which regulate the rights and duties of the parties are, in practice, indorsed on the back of the policy and made part of the contract by express incorporation.

II. Special terms agreed between parties

Special terms agreed upon by the parties are usually printed on a slip of paper and gummed or otherwise affixed to the policy.

If they are affixed to the face of the policy, they form part of the contract. But if they are affixed to the back of the policy, they do not form part of the contract, unless clearly so intended.

III. Consent of insurers

Where, by a condition subsequent of the policy, the consent of the insurers is required, e.g. in the case of assignment of subject matter insured under the policy, or alteration of risk, or another insurance being effected on the same subject matter, such consent is usually required to be signified by a signed memorandum indorsed on the policy.

4. Docket, i e summary of the policy

When a policy is folded, the outside portion occupies the place of a cover. On this there is frequently printed a docket, i.e. summary of the policy, and there may be in addition various notices or warning addressed to the insured. These may be made part of the policy by the clause of incorporation. They do not form part of the contract, unless clearly so intended.

COMMENCEMENT OF POLICY

A policy comes into force from the first day of the period of insurance and the insurers become liable to pay for the loss.

The policy, however, may provide that it will not come into force until certain condition precedents have been fulfilled, e g the payment of the premium.

DURATION OF POLICY

The policy remains in force until the expiration of the period of insurance. Usually, the policy fixes the precise hour at which it is to expire. Otherwise it expires at midnight of the last day specified.

The policy may, however, cease to be in force at an earlier date by reason of one or other of the following causes:

a. Payment of indemnity

Since the liability of the insurers under the policy is to pay the sum insured and no more, payment of the full sum insured discharges them from any further liability, and the policy thereupon ceases to have effect.

b. Cancellation or surrender

Under an express condition, the insurers may reserve the right to cancel the policy at any time, by giving notice to the insured and refunding a rateable proportion of the premium. Similarly, the insured may be entitled, by giving notice to the insurers, to surrender the policy before the expiration of the period of insurance and to receive back a rateable proportion of the premium. In this case, the policy ceases to be in force as soon as the notice of cancellation or surrender is served.

b. Liquidation of insurers

If the insurers, being a company, go into liquidation, the policy issued by them comes to an end.

c. Breach of condition precedent or subsequent

Breach of a condition precedent of the policy, e g non-payment of premium, renders the policy voidable ab initio, at the option of the insurers. In this case, the period of insurance never begins to run and no claim can be made under the policy, even though the loss may have taken place before the insurers have elected to avoid the policy.

Again, breach of a condition subsequent of the policy renders the policy voidable ab initio, at the option of the insurers, e g where the consent of the insurers have not been obtained in the case of assignment of subject matter insured under the policy, or alteration of risk under the policy, or another insurance being effected on the same subject matter. The avoidance in this case dates only from the breach.

CANCELLATION OF POLICY

a. By act of the parties
The parties may cancel a policy by mutual consent. Further, a condition in the policy may enable either party to cancel it.

b. By an order of the Court
The Court may, by an order, cancel a policy, which is voidable ab initio. A policy becomes voidable ab initio when it is induced by fraud, misrepresentation, or non-disclosure of material fact on the part of the insured.

Similar conduct on the part of the insurers or their agents also renders a contract voidable ab initio.[57]

ALTERATION OF POLICY

The parties may alter the terms of the policy by mutual consent.

Since the policy is a written instrument, any alteration must be made in writing. An alteration may be done by an endorsement on the policy, or it may be contained in a separate memorandum. The policy may, however, contain an express stipulation prescribing the manner in which and the person by whom any alteration of the terms of the policy may be made.

Alteration can be done,

a. by inserting words, whether by filling in blanks or by interlineations;
b. by striking out words, with or without the substitution of different words; or
c. by defacing the policy, or if it is under seal, by tearing off the seal.

RECTIFICATION OF POLICY

Rectification means correction of the policy. Rectification is required when both the parties intended to contract on the same terms, but due to some mistake of expression, some items were incorrectly stated in the policy.

Rectification of a policy can be done in two ways:

a. By act of the parties
The parties may rectify a policy by mutual consent.

b. By an order of the Court
The Court may, by an order, rectify a policy, provided that the party seeking rectification proves:

1. the existence of a policy;
2. The terms of such policy; and
3. The terms which are incorrectly stated in the policy.

The presumption is that the policy contains the real terms between the parties.

RENEWAL OF POLICY

Unless renewed, on the expiration of the period of insurance, the policy comes to an end and the liability of the insurers ceases.

Renewal is usually effected by means of a renewal receipt, given in exchange for the renewal premium; but a fresh policy may be issued.

In general, the policy contains a stipulation regarding renewal, which may be framed in three ways:

a. that the policy is renewable by mutual consent;
b. that the policy is renewable at the option of the insured; or,
c. that the policy is renewable, unless either party notifies the other that he does not intend to renew it.

In practice, shortly before the expiration of the policy, the insurer sends to the insured a ‘renewal notice’, specifying the renewal premium. This is a proposal to renew the policy. Payment of the renewal premium by the insured is his acceptance of the proposal.

On the other hand, where the insurer has taken no steps in this matter, a request for renewal of the policy made by the insured amounts to a proposal, and receipt of the renewal premium by the insurer constitutes an acceptance.

LAPSE AND REVIVAL OF POLICY

A policy, which is not renewed at or before the expiration of the period of insurance, or of the days of grace, if any, is said to ‘lapse’, and the liability of the insurers ceases.

The parties may revive a lapsed policy by mutual consent.

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[57] Blake v. Albion life Assurance Co. (1878) 4
CPD 94 (life insurance)

After the lapse of a policy, a request for premium made by the insurer, is a proposal to revive the policy. Payment of the premium by the insured is his acceptance of the proposal.

Similarly, a request for revival of the policy made by the insured amounts to a proposal, and receipt of premium by the insurer constitutes an acceptance.

PERILS INSURED AGAINST IN THE POLICY

The peril insured against may be any peril in respect of which the insured seeks and the insurers are willing to give protection. Certain perils are of every-day occurrence and are insured against in the ordinary course of business. Other perils can only be insured against with difficulty, if any.

For the purpose of ascertaining what is the peril insured against, reference must be made to its description in the policy. It must, therefore, be described with accuracy and precision; for, although the words used to describe it are to be construed liberally, they are still restricted to their plain and ordinary meaning and do not extend to other perils which, though analogous in their operation, so not fairly fall within the scope of the words actually used.

EXCEPTIONS IN THE POLICY

The peril insured against is usually described in the policy in general terms, and it is the practice of insurers, with the view of qualifying their undertaking, to introduce exceptions which expressly exclude their liability where the loss is caused or where the peril brought into operation by certain specified causes.

The exceptions introduced by the insurers will vary in accordance with the type of insurance concerned, e g in the case of motor insurance, there is often an exception stating that the insurers will not be liable where the vehicle is being driven in an unroadworthy condition;[58] whereas in the case of personal accident insurance an exception is usually inserted excluding liability for death or disablement from disease.

Exceptions to be found in most types of policies

a. Non-marine policy

The usual exceptions relate to the following cases:

1. Foreign enemy;
2. Riot;
3. Civil commotion; (a stage between a riot and a civil war)
4. Military or usurped power;
5. Insurrection, meaning a rising of the people in open resistance against established authority with the object of supplanting it, e g the uprising of the Mozambique National Resistance (Renamo) against the Frelimo Government in 1982 in order to over throw it;
6. Hostilities, meaning a state of war;
7. Civil war;
8. Terrorism;

b. Marine policy

Various losses for which the insurers are not liable to indemnify the insured are as follows:

1. losses not proximately caused by the perils insured against;
2. losses caused by the wilful misconduct of the assured;
3. losses caused by delay;
4. losses caused by ordinary wear and tear;
5. losses caused by inherent vice;
6. other losses e.g. those caused by vermin.

Chapter 9 –Various kinds of loss

LOSS

Loss means detriment. The maxim is causa proxima non remota spectatur, i.e. the insured shall be indemnified for the loss which is directly caused by the peril insured against.

A loss may be either partial or total.

PARTIAL LOSS

This occurs when the subject matter insured is only partially lost. In **Francis v. Boulton (1895)** a barge, carrying a cargo of rice worth £ 450, sank. On being salvaged after two tides, the rice was found to be so damaged that the consignee refused to accept it. Later it was dried for £ 60, and sold for £ 110. It was held that partial loss has occurred, since the rice remained in specie. This would have been an actual total loss if it did not retain its commercial description.

The insured will not be indemnified for trifle partial loss.

Partial loss may be of ship, cargoes and freight. Salvage charges and some general average contributions may be recovered as partial loss.

[58] Clarke v. National Insurance and Guarantee Corporation Ltd. (1964) 1 QB 199, (1963) 3 All ER 375, CA (motor insurance), where nine people were being carried in a car designed to carry four, and it was held that exception applied, and that the insurers were not liable.

TOTAL LOSS

This occurs when the subject matter insured is totally lost. It may be either actual or constructive.

Actual total loss

a. Actual total loss of ship

This occurs,

1. When the ship ceases to remain in specie, e.g. when the ship, which has sunk, has been reduced to pieces of iron;
2. When it is seized or captured by enemies; In **Anderson v. Marten** during the Russo-Japanese War, a ship was captured and while being taken to a Court of Prize, it wrecked. It was held that actual total loss has occurred;
3. When it is lost at sea, and could not be recovered within a reasonable time. Later if that ship is found, the insurer will own it.

b. Actual total loss of cargo

This occurs,

1.. When it ceases to remain in specie or losses it commercial value. In **Roux v. Salvador** due to inflowing of sea water, a cargo of hides reached the stage of incipient putridity. If it would have been carried to its destination, it would become entirely putrid, and become valueless as hides. It was sold at an intermediate port. It was held that actual total loss has occurred.

2. When it is seized by pirates;
3. When it is missing;
4. When it is transformed into an entirely new thing and becomes valueless, e.g. cement turned into stone.

c. Actual total loss of freight

This occurs,

1. When both the ship and the cargoes are lost and the freight can no longer be earned;
2. When the voyage is abandoned on the ground that the ship is severely damaged, or where the cargoes could not be salvaged even by trans-shipment to another ship;
3. When the voyage is frustrated, e.g. where a ship is chartered and the charter is to commence from a certain port, and on a certain date and on way to that port a casualty prevents the ship to reach the port in due time and consequently the charter party is frustrated, and an actual total loss of freight occurs.

Constructive total loss

This occurs when the subject matter insured is reasonably abandoned because its actual total loss appears to be unavoidable, or cannot be avoided without an expenditure which would be greater than its value.

a. Constructive total loss of ship

This occurs,

1. When the insured losses its control and possession and it is unlikely that he will be able to recover it. Mere uncertainty is not enough. In **Polurrian SS Co. v. Young (1915)** a ship left England for Turkey. Soon, Turkey and Greece waged a war. The Greeks captured the ship and confiscated her cargo of coal as contraband item. Six weeks later the ship was released on proof that the Captain was not aware of the war condition. It was held that no constructive total loss has occurred, since the release was not unlikely**,** but merely uncertain.
2. When its cost of salvage or repair would be greater than its value; In **Irving v. Manning (1847)** a ship worth £17,500 was damaged. Its estimated cost of repair was £ 10,500, and its estimated value after repair would be £ 9,000. It was held that constructive total loss has occurred.
3. When, due to some peril, it is rendered un-navigable without any reasonable hope of repair.

b. Constructive total loss of cargo

This occurs,

1. When the insured losses its control and possession; In **Rickards v. Forestal Land Timber Co. (1942)** during the World War II, ships entered Germany under German control and order. A ship entered Germany but was eventually lost. The insured of cargo sued the insurer for indemnity alleging constructive total loss. While the insurer pleaded unjustifiable deviation. It was held that constructive total loss has occurred.
2. When it's cost of repair etc. would be greater than its value; In **Farnworth v. Hyde** cargoes had to be unloaded in damaged condition. The cost of unloading, warehousing, re-conditioning, re-forwarding re-shipment etc. were likely to be greater than its value. It was held that constructive total loss has occurred.

c. Constructive total loss of freight

The general principles of constructive total loss applicable to ship and cargoes, also apply to freight. In **Guthrie v. North China Insurance Co.** a ship bound from Chittagong to Dundi, wrecked 50 miles away from Dundi. Notice of abandonment was given and the insurer salvaged the cargoes and brought it to Dundi under a salvage contract. It was held that constructive total loss of freight has occurred.

Notice of abandonment

In the case of constructive total loss the insured must give the insurer a notice of abandonment within a reasonable time declaring that the insured has unconditionally abandoned his interest in the property insured, in favour of the

insurer. Failure to give such notice within reasonable time will entitle the insured to indemnity for partial loss and not for constructive total loss.

Chapter 10 – Doctrine of Proximate Cause

MEANING OF PROXIMATE CAUSE

Peril insured against means the contingency against which the insured seeks to protect himself. The insurer is liable to indemnify for any loss proximately caused by the peril insured against, but he is not liable for any loss which is not proximately caused by the peril insured against. 'Every loss that clearly and proximately results, whether directly or indirectly, from the event insured against is within policy.'[59] The maxim is causa proxima non remota spectaur, i.e. the proximate and not the remote cause is to be looked into, and if the peril insured against causes the loss, the assured will recover indemnity.

'The question, which is the causa proxima of a loss, can only arise where there has been a succession of causes. Wherever there is a succession of causes which must have existed in order to produce the loss, or which has, in fact, contributed, or may have contributed to produce it, the doctrine of proximate cause has to be applied for the purpose of ascertaining which of the successive causes is the cause to which the loss is to be attributed within the meaning of the policy.

The application of the doctrine varies according as the question is whether the loss was caused by the peril insured against or whether the peril was brought into operation by an excepted cause.

WAS THE LOSS CAUSED BY THE PERIL INSURED AGAINST?

The doctrine of proximate cause must be applied for the purpose of ascertaining whether the loss was caused by the peril insured against. Its application will vary according as to whether:

a. The last cause is the peril insured against.
b. The peril insured against is not the last cause, but a preceding cause.
c. The causes are concurrent and independent.

a. Where the last cause is the peril insured against

Where the last of the successive causes happens to be the peril insured against, the loss is caused by the peril insured against.[60] There in no necessity to inquire into the preceding causes and to ascertain which of them brought the peril into operation,[61] unless the further question arises whether the peril was caused by an excepted cause.

b. Where the peril insured against is not the last cause but a preceding cause

Where the peril insured against is not the last cause, but a preceding cause, it is necessary to consider whether the last cause is so intimately connected, either immediately or by transmission through a chain of circumstances, with the preceding cause that the loss which is the effect of the last cause in none the less the effect of the preceding cause, and is, therefore, within the policy as being caused by the peril insured against.[62]

It is necessary to distinguish between two cases:

1. Where the sequence of causes is uninterrupted, i.e. where there is no break in the sequence of causes; and
2. Where the sequence of causes is interrupted, i.e. the chain of causation is broken.

1. Where the sequence of causes is uninterrupted

Where the peril insured against is not the last cause but a preceding cause, and there is no break in the sequence of causes from the peril insured against to the last cause, and each cause in the sequence is the reasonable[63] and probable[64] consequence, directly and naturally resulting[65] in the ordinary course of events[66] from the peril insured against, the cause of the loss within the meaning of the policy is the peril insured against.

Thus, where an accidental fall, whether from a horse, or otherwise, is followed by disease which is either caused by the fall itself,[67] or directly attributable to the weak condition of the assured in consequence of the fall,[68] the death though caused by the disease, is proximately caused by the accidental fall.

Similarly, death due to a surgical operation rendered necessary by the accident, is death by accident.[69]

The operation of the doctrine of proximate cause is not affected by the number of causes that may intervene between the peril and the loss. Thus, a scratch may produce septicaemia, which develops into septic-pneumonia resulting in death. Nevertheless, the death is proximately caused by the scratch.[70]

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[59] Stanley v. Western Ins. Co. (1886) 3 E.X. 74.
[60] Trew v. Railway Passenger's Assurance Co. (1861) 6 H & N 839, Ex Ch.
[61] Winspear v. Accidental Insurance Co. (1880) 6 QBD 42, CA.
[62] Reischer v. Borwick (1894) 2 QB 548, CA (marine insurance)
[63] Stanley v. Western Insurance Co. (1868) LR 3 ExCh 71 (fire insurance)
[64] Isitt v. Railway Passenger's Assurance Co. (1889) 22 QBD 504.
[65] Ibid.
[66] Pugh v. London, Brighton and South Coast Rly Co. (1896) " QB 248, CA.
[67] Fitton v. Accidental Death Insurance Co. (1864) 17 CBNS 122.
[68] Isitt v. Railway Passenger's Assurance Co. (supra)
[69] Fitton v. Accidental Death Insurance Co. (supra)
[70] Mardorf v. Accident Insurance Co. (1903) 1 KB 584.

2. Where the sequence of causes is interrupted

Where the peril insured against is not the last cause but a preceding cause, and there is no sequence of causes, and the last cause is a fresh and independent cause[71] intervening between the peril and the loss, the cause of the loss within the meaning of the policy is the intervening cause.[72]

Thus, where a person weakened by a railway accident is run over in the street by a bus which, owing to his weakness, he is unable to avoid, his death is due, not to the railway accident, but to an extraneous and independent cause, i.e. the street accident.[73]

Similarly, loss of profits[74] and other consequential loss[75] cannot be recovered under an ordinary policy, since they are not proximately caused by the peril insured against.[76]

c. Where the causes are concurrent and independent

Where the causes are not successive but concurrent in their operation, and continue to operate on the subject-matter of insurance until they cause the loss, the loss is attributable to one cause as much as to the other.[77]

Thus, where the assured is drowned while bathing, his death is caused by accident, and it is immaterial that he fell into the water in a fainting fit, and that the water into which he fell was so shallow that he could not have been drowned if he had not remained unconscious.[78]

Similarly, where the assured is injured in an accident, and, whilst confined to his room, catches a cold, which, in consequence of his weak state of health, develops into pneumonia and ends fatally, his death is caused by the accident.[79]

WAS THE LOSS CAUSED BY AN EXCEPTED CAUSE?

The question frequently arises whether the peril insured against or an excepted cause is the cause of the loss within the meaning of the policy.

If the peril and the excepted cause operate independently on the subject-matter of insurance and the consequences of each are separate and can be distinguished with precision, there is no real difficulty. Once the facts are ascertained, it is clear that the consequences of the peril, being unconnected with the excepted cause, is a loss covered by the policy.[80]

Thus under a personal accident policy, if the assured is killed by accident, it is immaterial that, at the time of the accident, he was suffering from an excepted disease which might have proved fatal if he had lived long enough, but which in no way contributed to the accident from which he, in fact, died.[81]

It is equally clear that the consequence of the excepted cause, being unconnected with the peril, is not a loss covered by the policy.

The doctrine of proximate cause must be applied for the purpose of ascertaining whether the loss was caused by an excepted cause. Its application will vary according as to whether:

a. The excepted cause precedes the peril insured against.
b. The peril insured against precedes an excepted cause.
c. The causes are concurrent and independent.

a. Where an excepted cause precedes the peril insured against

It is necessary to distinguish between two cases:

1. Where the sequence of causes is uninterrupted

Where an excepted cause precedes the peril insured against, and the peril insured against causes the loss, and there is no break in the sequence of causes from the excepted cause to the peril insured against, and the peril insured against is merely a link in the chain of causation inasmuch as it is a reasonable and probable consequence of the excepted cause, the cause of the loss within the meaning of the policy is the excepted cause.

Thus, a farmer who is neither short-sighted nor deaf, attempting in broad daylight to cross a railway main line of an approaching train, which he ought to have noticed, exposes himself to obvious risk of injury; and, if he is killed by the train, his death, though caused by accident, is attributable to his want of care, and falls within the scope of an exception relating to exposure to obvious risk of injury.[82]

2. Where the sequence of causes is interrupted

Where an excepted cause precedes the peril insured against, and there is a break in the sequence of causes, and the peril insured against, which causes the loss, is a fresh and independent cause intervening between the excepted cause and the loss, and the connection between the excepted cause and the peril

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[71] Fition v. Accidental Death Insurance Co. (1864) 17 CBNS 122.
[72] Clan Line Steamers Ltd. v. Board of Trade (1928) 2 KB 557, CA.
[73] Isitt v. Railway Passenger's Assurance Co. (supra)
[74] Theobald v. Railway Passenger's Assurance Co. (1854) 10 ExCh 45.
[75] Molinos De Arroz v. Mumfurd (1900) 16 TLR 469.
[76] Re Wright and Pole (1834) 1 Ad & El 621 (fire insurance).
[77] Crown Bank v. London Guarantee and Accident Co. (1908) 17 OLR 95.
[78] Reynolds v. Accidental Insurance Co. (1870) 22 LT 820.
[79] Isitt v. Railway Passenger's Assurance Co. (supra)
[80] Stanley v. Western Insurance Co. (1868) LR 3 ExCh 71 (fire insurance)
[81] Hope's Trustees v. Scottish Accident Insurance Co. (1896) 3 STL 252.
[82] Cornish v. Accidental Insurance Co. (1889) 23 QBD 453, CA

insured against is accidental only and not causal[83], the cause of the loss within the meaning of the policy is the peril insured against.

Thus, where a person who has been injured by a shell is killed by a passing car, because owing to his crippled condition, he is unable to get out of the way, the war is not the cause of his death within the meaning of an exception against the consequences of hostilities, nor is an isolated act of burglary committed during an air raid a loss caused by hostilities within the meaning of a similar exception.[84]

b. Where the peril insured against precedes an excepted cause

It is necessary to distinguish between two cases:

1. Where the sequence of causes is uninterrupted

Where the peril insured against precedes an excepted cause, and the excepted cause produces the loss, and there is no break in the sequence of causes from the peril insured against to the excepted cause, and the relation of cause and effect between the peril insured against and the loss is established, the cause of the loss within the meaning of the policy is the peril insured against.

Thus, where an accident is followed, in the ordinary course of events, without the intervention of any extraneous cause, by a disease causing death, the death is caused by the accident, not by the disease; it is, therefore, immaterial that the particular disease is excepted by the policy.[85]

2. Where the sequence of causes is interrupted

Where the peril insured against precedes an excepted cause, and there is no sequence of causes, and the excepted cause, which produces the loss, is a fresh and independent cause, and its connection with the peril insured against is accidental only, the cause of the loss within the meaning of the policy is the excepted cause[86].

Thus, where a man is weakened by an accident is attacked by a disease wholly unconnected with the accident, an exception against disease applies.[87]

c. Where the causes are concurrent and independent

Where the loss is caused by the action of two concurrent and independent causes, one of which is the peril insured against, and the other an excepted cause, the loss is not within the policy, since it may be accurately described as caused by the excepted cause, and it is immaterial that it may be described in another way which would not bring it within the exception.[88]

Thus, where an employee of the assured is an accessory to the theft of the assured's goods by third parties , the loss is within an exception against theft by the assured's employees.

MODIFICATION OR EXCLUSION OF THE DOCTRINE OF PROXIMATE CAUSE

The policy may, however, by the terms in which the exception is framed, modify the application of the doctrine of proximate cause or exclude it altogether, and the assured may be disentitled from recovering although the loss is only remotely caused by the excepted cause.

Thus, where the assured, an officer in command of soldiers guarding a railway, is killed by a train whilst inspecting his men, at a time when it is exceptionally dark owing to the lights being obscured under military regulations, his death is to be regarded as caused by war within the meaning of an exception which includes war as a remote cause.

[83] Lawrence v. Accidental Insurance Co. (1881) 7QBD 216.
[84] Winicofsky v. Army and Navy General Assurance Association Ltd. (1919) 88 LJKB 1111.
[85] Fitton v. Accidental Death Insurance Co. (1864) 17 CBNS 122.
[86] Livie v. Janson (1810) 12 East 648 (marine insurance)
[87] Cawley v. National Employers' Accident and General Assurance Association (1885) 1 TLR 255
[88] Saqui and Lawrence v. Stearns (1911) 1 KB 426, CA, per Fletcher Moulton LJ 435.

Chapter 11 – Making of Claim

MAKING OF CLAIM

When the loss has taken place, the insured becomes entitled to enforce the policy and the insures become liable to pay the amount of the loss in accordance with its terms. The respective rights and duties of the parties are usually defined by the terms and conditions of the policy.

No claim is maintainable on a policy of insurance, unless all the conditions precedent and subsequent of the policy have been duly performed, since it is essential that at the time of the loss the policy should be valid. Moreover, there are certain duties as regards the making of the claim imposed on the insured by law or by the stipulations of the policy. The due performance of these duties may be made a condition precedent to the liability of the insurers.

The duties of the insured as regards the making of a claim are as follows:

a. Duty to give notice of loss;
b. Duty to furnish particulars of loss;
c. Duty to furnish proofs of loss; and
d. Duty to make no fraudulent claim.

a. DUTY TO GIVE NOTICE OF LOSS

The duty of giving notice of loss seems to exist apart from any stipulation in the policy, since the fact of the loss is one which the insured must be assumed to know, whilst the insurers cannot reasonably be expected to know.

Further, the duty of good faith seems to impose the obligation of giving notice so that the insurers may be in a position to take the necessary steps for ascertaining the cause and extent of the loss.

In practice, the policy almost invariably contains a condition requiring the insured to give notice, and specifies the manner in which it is to be given. Whether a failure to give the required notice merely suspends the insured's rights under the policy until it is actually given, or whether, by his failure, he loses his rights under the policy altogether, depends on the language in which the particular condition is framed.

The giving of notice is regulated by the following rules:

1. Mode of giving notice

In the absence of an express condition to the contrary, the notice of loss need not be in writing, a verbal notice being sufficient. Where there is an express condition that the notice must be in writing, the insured must fulfil the condition, and he is not absolved by reason of the fact that the insurers may have received notice of the loss either verbally or from another source.

2. Notice by whom given

In the absence of an express condition to the contrary, the notice of loss need not be given by the insured himself. It is sufficient if it is given by his agent, his legal representatives, or by any person purporting to act on his behalf.

3. Notice to whom given

The notice need not, as a general rule, be given to the insurers personally. It is sufficient if it is given to an agent, who is authorised to receive notice on their behalf. The insured is entitled to assume, in the absence of information to the contrary, that the agent through whom he negotiated the policy has authority to receive notice of loss.

4. Time of giving notice

The notice should be given within the prescribed time, i e within the time fixed by the stipulation, or within a reasonable time, as the case may be. The condition usually provides for the notice to be given 'forthwith' or 'as soon as possible' after occurrence of loss.

b. DUTY TO FURNISH PARTICULARS OF LOSS

It is almost an invariable practice of insurers to insert in the policy an express condition requiring the insured to make a claim containing full particulars of loss or damage within a specified time. Unless this condition is complied with, no claim is payable.

The various stipulations in use necessarily vary in the details required according to the nature of the insurance. They are, however, framed on the same general lines and usually provide as follows:

1. The insured is required to deliver particulars of the loss;
2. The particulars to be delivered must be given with such details as are reasonably practicable;
3. The particulars should be delivered within the prescribed time.

1. Delivery of the particulars of the loss

The insured is required to deliver particulars of the loss. For this purpose, a 'claim form' is usually provided by the insurers in which the insured is required to state the cause, nature and extent of the loss.

2. Sufficient details must be given

The particulars to be delivered must be given with such details as are reasonably practicable. Whether the details given are sufficient to satisfy the condition is a question of fact, depending partly on the means of information at the claimant's disposal, and partly on the time within which the particulars have to be delivered.

3. **Particulars should be delivered within prescribed time**

The particulars should be delivered within the prescribed time, i e within the time fixed by the stipulation or a reasonable time, as the case may be.

The stipulation as to time may be of the essence of the condition, so as to render it obligatory on the insured to furnish the particulars within the prescribed time, and may thus be a condition precedent to the liability of the insurer.

On the other hand, the stipulation may not be a condition precedent and the insured may be entitled, notwithstanding the stipulation as to time, to furnish particulars at any time, even after the expiration of the prescribed period, although, until he has done so, he is unable to enforce his claim.

Whether the stipulation is a condition precedent or not is purely a question of fact, depending on the language of the particular policy. The stipulation when standing alone in the policy, or when coupled with a statement to the effect that in default of compliance therewith no claim shall be payable under the policy, is clearly a condition precedent.

c. DUTY TO FURNISH PROOFS OF LOSS

The insurers are usually empowered, by a stipulation in the policy, to call on the insured to prove that the loss is covered by the policy, and to verify the particulars given by such documentary or other proofs as they may require. Delivery of proofs, if required, is usually a condition precedent to the liability of the insurers.

In requiring proofs, or in deciding whether the proofs given are sufficient, the insurers cannot act capriciously, unreasonably or unjustly. It is sufficient if the insured lays before them evidence with which reasonable men would be satisfied.

The nature of proofs that may be required must necessarily vary according to the nature of the insurance. For instance, in fire insurance the proofs may consists of books of accounts, vouchers and invoices, and the insured may be required to supplement the information contained in them by a written or verbal explanation.

The insurers may, by their conduct, waive their right to demand proofs in accordance with the condition.

d. DUTY TO MAKE NO FRAUDULENT CLAIM

Since it is the duty of the insured to observe the utmost good faith in his dealings with the insurers throughout, the claim which he puts forward must be honestly made; and if it is fraudulent, he will forfeit all benefit under the policy whether there is a condition to that effect or not. The insured must make a full disclosure of the circumstances of the case.

There is usually an express condition in the policy to the effect that if the claim is in any respect fraudulent, or if any fraudulent means or devices are adopted by the insured, all benefits under it are to be forfeited.

Usually, fraudulent claim consists of an exaggeration of the extent of the loss. An exaggerated claim is to be considered fraudulent in the following cases:

1. Where the insured clearly intended to defraud the insurers;
2. Where the over-estimate of his loss is so excessive as to lead to the inference that the insured cannot have made the claim honestly, but must have intended to defraud the insurers;
3. Where the over-estimate, though not deliberately put forward with the direct fraudulent intent of inducing the insurers to pay the full amount claimed, is made for the purpose of fixing a basis on which to negotiate with the insurers.

Chapter 12 – Payment of Loss

CALCULATION OF THE AMOUNT RECOVERABLE

The object of calculating the amount recoverable is to ascertain the pecuniary value of the loss, since the obligation of the insurers is to make good the loss by a payment of money.

a. Valued policies

In the case of a valued policy, the amount recoverable by the insured is fixed by the policy, e g a personal accident policy and certain policies of insurance on property.

All personal accident policies belong to this class, and as the value of life or limb cannot be measured, the sum fixed in the policy is not open to objection on the ground of over-valuation. In the case of an insurance on property, the value of the subject-matter may be fixed by agreement and inserted in the policy as the amount recoverable in the event of loss.

In the case of total loss, the insured has to prove only the fact of his loss, to recover the full insured amount. In the event of partial loss, however, the valuation has no effect, and the insured must prove the extent and value of his loss, and the amount recoverable is calculated accordingly.

b. Unvalued policies

In the case of an unvalued policy, the sum recoverable by the insured is not fixed by the policy, eg policies of insurance against liability and most policies of insurance on property.

The insured amount mentioned in the policy merely indicates the maximum amount beyond which the insurers are not liable. Consequently, in the case of loss, the insured must prove the extent and value of his loss, and the amount recoverable is calculated accordingly.

c. Successive losses

Recovery of indemnity in respect of loss under the policy does not prevent the insured from recovering for a second loss, and any number of subsequent losses can be entertained during the period of insurance.

The insured amount mentioned in the policy is the maximum amount beyond which the insurers are not liable. In that case the policy is exhausted as soon as the maximum sum has been paid; or it may limit the number of claims that can be entertained e g maximum three claims.

Sometimes the policy contains a ‘self-renewing’ or ‘automatic reinstatement’ clause, providing that, on the happening of a loss, subject to a further payment of premium, the policy is to remain in force for the full amount of insurance.

d. Simultaneous losses

Where the same occurrence gives rise to a number of losses, eg where a motor accident involves the insured in liability to a number of persons, he is entitled to be indemnified by the insurers against the whole of his liability, unless precluded by the terms of the policy.

In the case of simultaneous claims, the insured amount mentioned in the policy, which is the maximum amount payable, may apply only to the liability to a particular individual; and payment in respect of a particular claim of the full amount specified in the policy does not necessarily discharge the insurers from liability to indemnify the insured up to the limit fixed by the policy in respect each succeeding claim which may be put forward. To discharge the insurers from further liability, the policy must make it clear that once the maximum sum has been paid their liability is to cease

TO WHOM PAYMENT IS TO BE MADE

Payment must be made either to the insured himself, or to a duly authorised agent, or in the case of death to the nominee of the insured.

FORM OF PAYMENT

Payment must be made in cash, unless the insured agrees to accept some other form of payment, e g cheque

Some short notes:

DOUBLE INSURANCE

Double insurance applies only to the contracts of indemnity. When the subject-matter is insured with two or more insurers and the total sum insured exceeds the actual value of the subject-matter, it is known as double insurance. For instance, A insures his motor-cycle worth Tk 1,00,000 with three insurers: with X for Tk. 50,000, with Y for Tk. 40,000 and with Z for Tk. 15,000 = Tk. 1,05,000. There is a double insurance, because the aggregate of all the policies exceeds the total value of the motor-cycle. However, if A insures with X for Tk. 50,000, with Y for Tk. 40,000 and with Z for Tk. 10,000 = Tk. 1,00,000, there is no double insurance.

In the case of loss, the assured may claim payment from the insurers in such order as he thinks fit, but he will not get more than his actual loss. The advantage of double insurance is that it protects him against loss, in the event of one or more of the insurers becoming insolvent, he can recover up to the value of the policy from the solvent insurer. The insurers as between themselves are liable to contribute to the loss in proportion to the amount for which each one is liable.

It is important to note that there is no double insurance in the case of life and personal accident insurance. Human life is priceless and a person can get his life insured with as many insurers as he likes.

CONTRIBUTION

This doctrine applies only to contracts of indemnity. According to this doctrine, in the case of double insurance, all insurers must share the burden of claim in proportion to the amount assured by each. For instance, A insures his motor-cycle worth Tk 1,00,000 with three insurers: with X for Tk. 50,000, with Y for Tk. 40,000 and with Z for Tk. 15,000 = Tk. 1,05,000. Later the motor-cycle is completely destroyed by fire.

X should pay = 50,000 ÷ 1,05,000 × 1,00,000 = Tk. 47,619.047
Y should pay = 40,000 ÷ 1.05,000 × 1,00,000 = Tk. 38,095.238
Z should pay = 15,000 ÷ 1,05,000 × 1,00,000 = Tk. 14,285.714

Tk. 99,999.999

The insured can sue both X, Y and Z, or just X or Y or Z. Where he sues X only and recovers from him the full amount of loss, i.e. Tk. 1,00,000, X is entitled to claim contribution from Y Tk. 38,095.238, and from Z Tk. 14,285.714.

The essential conditions of the doctrine are as follows:

a. There must be double insurance, i.e. there must be more than one policy from different insurers covering the same interest, the same subject-matter and the same peril which has caused the loss.

b. There must be either over-insurance or only partial loss. It the amount of different policies is just equal to the value of the subject-matter destroyed, the different insurers are liable to contribute towards the loss up to the full amount of their respective policies and as such the question of contribution does not arise at all.

c. The assured must recover the whole of his loss from one or more of the insurers, and not from all the concerned insurers in proportion to the amount assured by them.

SUBROGATION

Subrogation is the substitution of one person in place of another in relation to the claims, rights, remedies or securities of the substituted person. The doctrine applies only to contracts of indemnity.

According to the principle of indemnity, the insured can recover only the actual amount of loss caused by the peril insured against and cannot make a profit of his loss. Where the loss has arisen without anybody's fault, the insured can make the claim against the insurer only. But where the loss has arisen out of tort or mischief by some third party, the insured becomes entitled to proceed against the insurer as well as the wrong-doer. But since a contract of insurance is a contract of indemnity, the insured cannot be allowed to recover from both and thereby make a profit of his loss. He can make a claim against either the insurer or the wrong-doer. If the insured elects to be indemnified by the insurer, the doctrine of subrogation comes into play and as a result, the insurer steps into the shoes of the insured and is subrogated to all the alternative rights and remedies of the insured against third parties in respect of the property destroyed or damaged, until he, i.e. the insurer, recoups the amount he has paid under the policy. Where something more is recovered under subrogation rights, the excess shall belong to the insured.

The doctrine will apply where the insured has recovered full indemnity in respect of his loss from the insurer. If the amount of insurance claim is less than the actual loss suffered, the insured can keep the compensation amount received from any third party with himself to the extent of deficiency, and if after full indemnification their remains some surplus, it shall belong to the insurer, to the extent the insurer has paid under the policy.

The insured should assist the insured in enforcing the rights against third parties. Any action taken by the insurer is generally in the name of the insured, but the cost is to be borne by the insurer.

The insurer gets only such rights which are available to the insured. As such the insurer can recover only that which the assured could himself have recovered.

REINSURANCE

An insurer assuming larger risk from the direct insurance business may arrange with another insurer to off load the excess of the undertaken risk over his retention capacity. Such arrangement between two insurers is termed reinsurance. Thus by the device of reinsurance the original insurer transfers a part of the risk to the re-insurer.

A reinsurance contract does not affect the original insurer's contractual obligation to the insured under the original contract of insurance.

If for any reason, the original policy lapses, the reinsurance comes to an end. Further, if the original contract is altered without the consent of the re-insurers, the re-insurers are discharged. Hence a policy of reinsurance is co-extensive with the original policy.