CONSUMER PROTECTION vis-a-vis THE INSURANCE INDUSTRY:

Proposed Changes To Insurance Law And Practice

A Memorandum
submitted to
The Director-General of Insurance,
Malaysia
on
30th December, 1985

By

The Selangor and Federal Territory Consumers Association

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By

THE SELANGOR AND FEDERAL TERRITORY CONSUMERS ASSOCIATION

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PREFACE

In 1984 Malaysians bought no less than ½ million insurance policies and paid close to $2,000 million in premiums. In the forthcoming years even larger numbers of consumers will enter into insurance contracts. Over the years the consumer associations have witnessed an alarming increase in consumer complaints in insurance related matters.

To focus on the problems that consumers have, a one day seminar was organised by the Selangor and Federal Territory Consumers Association with the co-operation of the Malaysian Insurance Institute. The Seminar brought together representatives from the consumer movement with those of the insurance industry and government for a dialogue. The consumer's viewpoint was expressed in four papers entitled:

(1) "Principles and Practice of Insurance and Consumer Protection" (Dr. S. Sothi Rachagan)

(2) The Civil Law (Amendment) Act 1984 and Its Effects (Mr. Christopher Foo)

(3) Motor Insurance and the Consumer (Dr. Abdul Majid Nabi Baksh)

(4) Life Insurance and the Consumer (Mr. Gopalkrishnan K. Sundram)

The insurance industry's viewpoint was presented in three papers entitled

(1) Principles and Practice of Insurance (Puan Maizon Omar)

(2) Motor Insurance and the Consumer (Ms. Tan Lee Hoon)

(3) Life Insurance and the Consumer (Encik Amaruddin bin Tajuldin)

The final session of the Seminar comprised a panel discussion entitled "Consumer Protection in the Insurance Industry" and involved the following:

(1) Tuan Haji Shah b. Mansor (Director-General of Insurance, Malaysia)

(2) Mr. Arun H. Doshi (Persatuan Insurans Am Malaysia)

(3) Encik Amaruddin Tajuldin (Life Insurance Association of Malaysia)

(4) Dr. S. Sothi Rachagan (Selangor and Federal Territory Consumers Association)

The panel discussion concluded that the consumer's viewpoints and recommendations be presented in a memorandum to the Director General of Insurance and for consideration by PIAM and LIAM. This memorandum is in response to that decision.

The organisation of the text of the memorandum which focusses on 23 problem areas in consumer insurance is quite simple. Each of these problem areas is discussed by itself. The discussion involves the identification of the Law or practice of the insurance industry which generates the consumer problem, an analysis thereof and a proposal to remedy the problem whether by changing the practice or by amending the relevant legislation. The proposals for change are presented in summary form before the text of the memorandum.

I wish to record my thanks to Dr. Abdul Majid Nabi Baksh, Puan Maizon Omar, Mr. Christopher Foo, Miss Rita Reddy and Dr. Rokiah Talib for their assistance in preparing this memorandum and to Mrs. Chan Puat Heong for having typed the manuscript.

December, 1985.

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SUMMARY

OF

PROPOSALS

1. Principles of Insurance and Consumer Insurance

The Insurance Act 1963 be amended to provide for a separate section that defines and regulates "consumer insurance".

(Para 1.1 – 1.6)

2. Supervision of Insurance Documents – Proposal Forms, Policies and Brochures

The Director-General of Insurance

(a) pursuant to S. 16 of the Insurance Act 1963 to require the insurance industry to

(i) couch insurance documents in plain English with translations in Bahasa Malaysia, Chinese and Tamil;

(ii) introduce industry-wise standardised language for identical clauses;

(iii) introduce, where possible, industry-wise standardised documents for each class of insurance;

(iv) ensure that all documentation be printed in type of a size no smaller than the type known as ten-point times.

(v) ensure that all exemption clauses and exceptions are printed in red;

(b) introduce amendments to the Insurance Act 1963 to give the above statutory effect.

(Para 2.1 – 2.3)

3. Avoidance of Provisions of the Insurance Act 1963

The Insurance Act 1963 be amended so as to make void any provision in an insurance agreement seeking to negate the effect of any section of the Insurance Act 1963.

(Para 3.1 – 3.7)

4. Utmost Good-faith, Duty to Disclose and the Prudent Insurer

The law relating to the disclosure of material facts be amended to limit the duty to disclose to facts which a reasonable man in the proposer's circumstances would consider to be material.

Further, when an insurer discovers that the insured has failed to disclose a material fact or matter, the former should, unless he can prove fraud, be obliged to settle the claim.

(Para 4.1 – 4.5)

5. The Proposal Form and Duty to Disclose

There should be no further duty of disclosure for consumer insurance where proposal forms are utilised except to honestly answer the questions in the proposal forms.

(Para 5.1 – 5.2)

6. The Proposal Form and Basis of the Contract Clause

S. 15C (4) of the Insurance Act 1963 be amended to read:

"No policy of insurance shall be called in question by the insurer on the ground that a statement made in the proposal for insurance or any supporting evidence or document was inaccurate or false unless the insurer shows that such statement was on a material matter or suppressed a material fact and that it was fraudulently made by the policy-holder with the knowledge that the statement was false or that it suppressed a material fact."

(Para 6.1 – 6.4)

7. Incorporation Clauses, Proposal Forms and Cover Notes

The Insurance Act 1963 be amended to require that

(a) the proposal form and cover note contain express incorporation clauses in simple and clear-terms; and

(b) a sample copy of the insurance policy complete with the terms and conditions that apply be issued together with

the cover note. Alternatively, the terms of the policy be incorporated into the proposal form.

(Para 7.1 – 7.2)

8. Unvalued Policies, Sum Insured and Indemnity

The Insurance Act 1963 be amended to ensure that

(a) all consumer insurance policies be valued policies;

(b) the Persatuan Insuran Am Malaysia periodically compile a book of tables indicating the current market value of cars by model and year of manufacture, and, a book of tables indicating real property values, for purposes of ascertaining the sum insured and indemnity payable in instances of motor and fire insurance; and

(c) the excess-clause, the theft-clause and any other such clause designed to reduce the indemnity payable in instances of total loss to less than the sum insured be excluded from consumer insurance policies.

(Para 8.1 – 8.10)

9. Sum Insured and Average Clauses

The Insurance Act 1963 be amended to exclude the average clause from all consumer insurance policies.

(Para 9.1 – 9.3)

10. Double Insurance, Contribution and Rateable Proportion Clauses

The Insurance Act 1963 be amended to achieve the following:

(a) The insured be required merely to provide all information on other insurers and claims made against them at the time a claim is made;

(b) Contribution be an exercise undertaken by and amongst insurers albeit with the assistance of the insured; and

(c) Conditions ousting liability in instances of double-insurance, or, failure prior to the loss of notifying the insurer of double-insurance, be made void.

(Para 10.1 – 10.7)

11. Compulsory Arbitration Clauses

The Insurance Act 1963 be amended to exclude policy clauses which require arbitration, or make arbitration a condition precedent to any action in the Courts without however preventing the parties from making an agreement, after a difference or dispute has arisen to submit the difference or dispute to arbitration.

(Para 11.1 – 11.2)

12. Documentation in Relation to Claims

The required documents in any insurance claim be clearly stated in the cover note and policy issued to the isured and in the claim form the insured is required to complete.

The documents required from the claimant in a motor claim be limited to copies of the insured's

(i) police report;

(ii) vehicle log book; and

(iii) copy of the driving licence of the driver.

(Para 12.1 – 12.4)

13. Police Reports

The Persatuan Insurance Am Malaysia in conjunction with the police authorities device a special police report form for motor accidents which will

(a) seek by way of suitable questions all relevant information required;

(b) make adequate provisions for the inclusion of the required sketch-map of the accident; and

(c) make provision for the *immediate* issue of a carbon copy of the report lodged.

(Para 13.1 – 13.2)

14. Settlement of Claims

(a) (i) A specified period of two weeks be set for the processing of claims and an offer of settlement by the insurer of his "admitted liability".

(ii) Reference be made to an Insurance Arbitrators Bureau (see paragraph 23 below for details) for the disputed difference between the amount claimed by the insured and the admitted liability of the insurer.

(iii) Interest at current fixed deposit rates be made payable for any difference due from the date when payment was due to the date of actual payment.

(b) Payment, whether in partial or full settlement of a claim must be made by the insurer within seven (7) days of the claimant's acceptance of the insurer's offer of settlement – whether such acceptance is in partial or complete settlement of the claim.

(c) The DG1's report must provide a breakdown of the types of complaints received by Company so as to inform consumers of defaulting companies and assist them in making informed choices amongst insurers.

(d) The Director-General of Insurance arrange for suitable legislation that will give those buying houses, goods on hire purchase or on loans a choice of insurers instead of the

current practice of having the loan extending authority determine the insurer and nature of insurance to be effected.

(e) A complaints clearing Bureau be established within PIAM and LIAM to process all insurance related complaints.

(Para 14.1 – 14.2)

15. Total Loss, Salvage and Roadworthiness of Motor Vehicles

(a) Insurers who exercise subrogation and salvage rights in relation to motor vehicles inform the Road Transport Department of all motor vehicles that have been the subject of total loss indemnity and that the motor registration log books of all such vehicles be stamped with the words "subject of total loss indemnity" before they are sold under salvage rights.

(b) Persatuan Insuran Am Malaysia maintain a comprehensive register of all vehicles which are the subject of total loss awards.

(c) Arrangements be made with the Road Transport Department to conduct tests for the roadworthiness of the repaired or reconditioned vehicles before they are re-registered for use.

(Para 15.1 – 15.5)

16. Indemnity in Instances of Personal Injury and Death

A commission be set up with representatives of the judiciary, the insurance industry and consumers to review the compensation payable in instances of personal injuries and death. In particular, it is imperative to review

(a) the definition of the term dependant so as to include within its sphere all "actual dependants" of the deceased;

(b) the compensation payable to unemployed injured or their estate and/or dependants with regard to their future loss of earnings; and

(c) the limitations imposed on the courts discretionary powers to determine the "multiplicand" and "multiplier" used in assessing awards in instances of personal injury and death.

(Para 16.1 – 16.10)

17. Minimum Cover in Motor Insurance

(a) Minimum cover in motor insurance should be extended to include

(i) third party property damage; and

(ii) passenger and pillion rider cover.

(b) The term passenger should be given its plain lexical meaning and should expressly be taken to include members of the insured's family as well as his employees.

(Para 17.1 – 17.5)

18. No-Claim Discount Scheme

The insured earn his no-claim discounts for each accident free year and when he does make a claim he merely loose the last discount earned (in effect the no-claim discount be operated in a "step-up and step-down" fashion).

(Para 18.1 – 18.3)

19. No-Fault Motor Insurance Scheme

The Director-General of Insurance commission a feasibility study of a no-fault motor insurance scheme to consider, inter alia, the following options:

(a) A no-fault insurance scheme managed by the individual insurance companies or a bureau amongst them; and

(b) Claims up to a stated maximum be met from the scheme without compromising the right of the affected parties to contest via an Insurance Arbitration Bureau and the courts for the balance.

(Para 19.1 – 19.3)

20. Acquisition Costs, Commissions and Rebates

Agents who perform a function for the insured be paid a just commission, but, where the insured obtains his insurance direct from the insurer, the stipulated commission be returned as a rebate to the insured.

(Para 20.1 – 20.5)

21. Intermediaries

(a) The Director-General of Insurance require the insurance industry to review its system of rewarding its agents so as to weight it in favour of after-sales service.

(b) The Insurance Act 1963 be amended and practice governing underwriters and agents be changed to reflect the following:-

(i) All agents be registered and licensed;

(ii) Agents be not permitted to appoint sub-agents;

(iii) The utilisation of part-time agents be stopped forthwith;

(iv) Agents (as distinct from employees) be not permitted to collect any premiums from insureds and all commissions due to them be made by the insurance companies; and

(v) All agents (in both life insurance and general insurance) be required to pass a qualifying examination *before* marketing insurance.

(c) Rules and regulations with statutory force be devised to give effect to the current code of ethics evolved by NAMLIA.

(Para 21.1 – 21.6)

22. Forfeiture Rates in Life Policies

The immediate measures to be adopted must include

(a) the premium of a home service policy be collected not by agents but employees of the companies;

(b) that for a period of five years of non-payment of premiums the contract of insurance remain suspended and in abeyance and the insured be allowed to continue with the policy when he is able to commence payments. Suitable adjustments as to sum insured and for premiums can then be made to allow continuance of the policy, but, there should be no requirement to make back payments of unpaid premiums, or, any interest on the unpaid sums; and

(c) that all premiums previously paid in these suspended policies become for a period of five years a part of an escrow fund administered by the Director-General of Insurance.

On a longer term the industry should move away from home service policies and emphasise

(i) Workman's Compensation Schemes; and

(ii) Group Life Insurance Schemes effected by employers and managements.

(Para 22.1 – 22.2)

23. Insurance Arbitrators Bureau

(a) There be established an Insurance Arbitrators Bureau under the auspices of the Director-General of Insurance;

(b) The Insurance Arbitrators Bureau be backed by a council representing both the insurance industry and consumers;

(c) The Bureau arbitrate upon disputes between consumers and insurers should consumers so desire;

(d) The Bureau be guided not necessarily by strict legal rules but with good practice; and,

(e) Arbitration via the Bureau be not held to prejudice the rights of the parties to subsequently take legal action in the courts.

(Para 23.1 – 23.2)

MEMORANDUM

on

CONSUMER PROTECTION

vis-a-vis

THE INSURANCE INDUSTRY:

PROPOSED CHANGES TO INSURANCE LAW AND PRACTICE

1. Principles of Insurance and Consumer Insurance

1.1 The principles of insurance were designed at a time when the main form of cover was marine and the shipowner or charterer was the only one with the means of knowing the facts pertaining to the risk; the insurer did not. At Lloyds, principles were evolved which reflected these conditions and the English common law sanctified them. Hence the statement of Lord Mansfield:-

> "Insurance is a contract upon speculation. The special facts, upon which the contingent change is to be computed, lie most commonly in the knowledge of the insured only: the under-writer trusts to his representation, and proceeds upon confidence that he does not keep back any circumstance in his knowledge, to mislead the under-writer into a belief that the circumstance does not exist, and to induce him to estimate the risque as if it did not exist."
>
> *Carter v Boehm* (1766)

With the growth of mercantilism and the evolution of Lloyd's coffee house into the premiere insurance centre of the world there was every incentive for the common law to reinforce its earlier committments.

1.2 Today insurers underwrite many and varied types of cover and enter into contracts of insurance with the householder, the car-owner and many others. For the sale of the myriad policies they use a motley crew of intermediaries – underwriters, agents and sub-agents – engaging them with salaries and/or commissions to induce customers to buy more and more insurance. In Malaysia, according to the annual report of the Director-General of Insurance there were, in 1984, some 33,018 life insurance agents. Not even the industry is able to estimate the actual number of agents, sub-agents and sub-sub-agents who market general insurance.

1.3 Unlike marine insurance in the 18th century, the insurer today generally has the opportunity to ascertain most of the facts relevant to the risk insured. Insurers avail themselves of numerous techniques to elicit the relevant information. Statistical methods for assessing risks, inspection of property by surveyors and other experts, medical examinations and valuation reports are all utilised. Furthermore insurance companies inevitably require detailed proposal forms designed by them to be completed by the proposer. The insurance industry is highly organized and is supported by expertise and experience. Scrutton, L.J.'s 1928 contention that "... the underwriter knows nothing and the man who comes to him to ask him to insure knows everything ..." *(Rozanes v Bowen)* is no longer valid. The principles of insurance were evolved in an era and under conditions not consonant with today and present day realities.

1.4 The inequities occasioned by the principles and practice of insurance are particularly oppressive to consumers. The consumer faces distinct disadvantages that distinguish him from commercial purchasers. He lacks the experience, expertise, financial resources and the organisational backup that commercial purchasers have or are able to avail themselves. When aggrieved, the consumer is again, unlike commercial purchasers, generally unaware of his rights and the available redress. Even when aware, he can ill-afford the financial and emotional costs of litigation and the uncertainty and delay that is occassioned. The consumer then, is altogether in a different position vis-a-vis the seller of goods and services than the commercial purchaser.

1.5 Much of the initial reluctance to provide consumer protection arose from the failure to distinguish between different categories of purchasers: consumer purchasers and commercial purchasers. However, major developments in consumer protection as instanced by the Consumer Credit Act and the Sale of Goods Act of the United Kingdom have evolved by distinguishing consumer sales from other sales. In Malaysia, the Hire Purchase Act provides similar differentiation. It is also practicable to achieve this in insurance.

1.6 The changes sought are in respect of insurance effected by individuals in their "private" capacity, i.e. where effecting insurance otherwise than in the course of business. These can be more readily achieved by providing for a separate section in the Insurance Act 1963 that defines and regulates "consumer insurance".

2. Supervision of Insurance Documents – Proposal Forms, Policies and Brochures

2.1 With the introduction of the Insurance Act 1963 (Act 89) and its subsequent amendments the insurance industry was subjected to greater regulation. However, the protection of policy holders, in the sense of state regulation or supervision extends mainly to protection in the financial sense with some limited exceptions, for example with respect to intermediaries. An important provision of the Act is contained in Section 16 which provides for the control of form of proposals, policies and brochures by the Director-General of Insurance. This provision can be a fertile source of consumer protection but its potential is yet to be realised.

2.2 Policies are couched in legal terms and are in the English language. Most consumers find them very difficult to follow. As long as consumers do not understand what is said they will not be in a position to judge whether or not it meets their requirements. It has been argued that it is not possible to simplify legally worded documents. We reject this argument. In the United Kingdom some major composite insurers have recognised the problem in understanding documentation and have produced policies in plain English. Similar steps have been undertaken in the United States, Australia and India.

2.3 It is recommended that

(a) The Director-General of Insurance pursuant to S.16 of the Insurance Act 1963 to require the insurance industry to:

(i) couch insurance documents in plain English with translations in Bahasa Malaysia, Chinese and Tamil;

(ii) introduce industry-wise standardised language for identical clauses;

(iii) introduce, where possible, industry-wise standardised documents for each class of insurance;

(iv) ensure that all documentation be printed in type of a size no smaller than the type known as ten-point times;

(v) ensure that all exemption clauses and exceptions are printed in red.

(b) introduce amendments to the Insurance Act 1963 to give the above statutory effect.

3. Avoidance of Provisions of the Insurance Act 1963

3.1 Such consumer protection as the Insurance Act 1963 does attempt to provide has been negated by insurers incorporating appropriate provisions in their proposal forms and policies. The developments surrounding section 16A and 44A of the Insurance Act 1963 are illustrative.

3.2 S.16A was devised, inter alia, to prevent misleading statements and promises by insurers and their agents to induce consumers to enter into insurance contracts. Hence S.16A provides:-

> "Any person who, by any statement, promise, or forecast which he knows to be misleading, false, or deceptive .... induces or attempts to induce another person to enter into or offer to enter into any contract of insurance with an insurer shall be guilty of an offence and shall, on conviction, be liable to a fine not exceeding five thousand ringgit or to imprisonment for a term not exceeding one year or to both."

3.3 Furthermore, S.44 (2) sought to make the insurer liable for any such statements made by the agents:-

> "Any statement made or any act done by any such person in his representative capacity shall be deemed, for the purpose of the formation of the contract to be a statement made or act done by the insurer notwithstanding any contravention of section 16A or any other provision of this Act by such person."

Some insurers have attempted to overcome the S.16A and S.44A (2) provisions by requiring the following declaration in proposal forms:-

> "I declare that in the negotiation of this contract with your agent ... I am making this proposal independent of any statement made by your agent contrary to the provisions as contained in the Company's standard policy ... and to the best of my knowledge and belief, your agent has given no other information or knowledge, relating to any circumstances relevant to the acceptance of the risk."

3.4 Where an insurer's agent completes a proposal form which the proposer signs the courts have held that the insurer's agent is for those purposes the agent of the insured *(Newsholme Brothers v Road Transport and General).* In fact in all cases where the agent makes mistakes, mishears or misunderstands information, or completes signed blank forms, he is held to be acting as an agent for the proposer. However there were grounds for dispute since the courts have also held that if an agent has wider powers and has authority to issue cover notes or policies, the information he has is imputed to the insurer *(Stone v Reliance Mutual Ins. Soc.)* Insurers, of course do not relish ambiquities and hence required in their proposal forms the following undertaking:-

> "I agree that any person filling in completing or assisting in the completion of this proposal form wholly or in part does so as my agent and not that of the Company."

3.5 A 1978 amendment to the Insurance Act 1963 attempted to deal with this mischief by incorporating therein Section 44A (1) which provides

> "A person who has at any time been authorised as its agent by any insurer and who solicits or negotiates a contract of insurance in such a capacity shall in every such instance be deemed for the purpose of the formation of the contract to be the agent of the insurer and the knowledge of such person relating to any matter relevant to the acceptance of the risk by the insurer shall be deemed the knowledge of the insurer."

The insurance companies met this challenge by requiring a new declaration:-

> "I declare that in the negotiation of this contract of insurance with your agent ... I have given to your agent no other information, except those written in this proposal."

3.6 It is not certain how the courts will receive this 'creativity' of the insurers. Further, this was done in spite of the provisions of Section 16 of the Insurance Act 1963 which provides for the control of forms of proposals, policies and brochures by the Director-General of Insurance.

As the foregoing clearly demonstrates, the insurance industry has failed to regulate itself and the Director-General of Insurance has yet to exploit the full potential of Section 16 of the Insurance Act 1963. What should be evident is that consumer policy holders need protection through the regulation of the terms and conditions of the proposal-forms and policies by the Director-General of Insurance involving Section 16 of the Act.

3.7 It is proposed that the Insurance Act 1963 be amended so as to make void any provision in an insurance agreement seeking to negate the effect of any section of the Insurance Act 1963. The suggested amendment is as follows:-

Any provision in any insurance agreement whereby

(a) any liability imposed on the insurer or any right conferred on the insured by this Act to determine an insurance agreement is excluded or restricted;

(b) the insured is subject to any greater liability, in any manner whatsoever, of the insurance agreement than the liability to which he would be subject if the insurance agreement were determined in accordance with this Act;

(c) the insurer is relieved from liability for the acts or defaults of any person acting in connection with or in the course of the negotiations leading to the entering into the insurance agreement;

(d) except as expressly provided by this Act, the operation of any provision of this Act is excluded, modified, or restricted;

shall be void and of no effect.

4. Utmost-Good Faith, Duty to Disclose and the Prudent Insurer

4.1 An insurance contract is unique in that unlike other contracts it requires "utmost good faith" both from the proposer and the insurer. For insurance this means that the parties will be subjected to the contractual duty to avoid material misrepresentation as well as to disclose material facts. The principle has in practice been so evolved as to emphasise good faith from the insured to the extent that the unscrupulous insurer can avoid his liabilities.

4.2 The duty of disclosure of material facts be they sought or otherwise are determined by the standards of a "prudent insurer" in fixing the premium or determining whether he will take the risk *(Lambert v CIS)*. It matters not whether the proposer regards the matter as material; the test is the view of a prudent or reasonable insurer. Statute law in Malaysia accepts the Common law position as embodied in S.15(4)(a) of the Insurance Act 1963. This provision, dealing with life policies defines "material matter" or "material fact" as

> "such matter or fact which, if known by the insurer would have led to a refusal by the insurer to issue a life policy to the

> insured or would have led the insurer to impose terms less favourable to the insured than those imposed in the policy."

This is clearly inequitable. What is in fact called for is not good faith but clairvoyance on the part of the insured for he has to state not only what he in utmost good faith regards as material but what the mythical "prudent insurer" would regard as material.

4.3 The insured's task to reveal material facts is made invidious by the fact that particular classes of insurance will require the disclosure of different facts. The case law, both English and Malaysian reveal that many of the matters that have been held material using the common law test would surely be regarded as nothing more than useless information by a reasonable proposer:-

- An unsatisfied judgement outstanding against the insured was material for a fire policy *(Teh Say Cheng v Mercantile Insurance Co. Ltd.)*
- Criminal convictions even if they occurred twenty-four years previously are material *(Schoolman v Hall)*
- Past refusal by insurers to grant a motor policy was considered material for the purposes of a fire policy *(Locker and Woolf v Western Australia Insurance Co.)*
- The accident record of the proposer and of any driver who to his knowledge is going to drive the car is material *(Dent v Blackmoore)*

4.4 Perhaps the harshness of the rule as regards disclosure of material facts as best exemplified by the leading case of *Lambert v CIS.* Mrs. Lambert signed a proposal form for an "All Risks" insurance policy to cover her own and her husband's jewellery. No questions were asked, and Mrs. Lambert gave no information about any previous convictions although her husband, to her knowledge, had been convicted some years

earlier of receiving stolen cigarettes and had been fined. It was held that there was a duty of disclosure and the insurer did not have to pay. Yet MacKenna J., who delivered the leading judgement also said:

> "The present case shows the unsatisfactory state of the law. Mrs. Lambert is unlikely to have thought that it was necessary to disclose the distressing fact of her husband's recent conviction when she was renewing the policy on her little store of jewellery. She is not an underwriter and has presumably no experience in these matters. The defendant company would act decently if, having established the point of principle, they were to pay her. It might be thought a heartless thing if they did not, but that is their business, not mine. I would dismiss the appeal (of Mrs. Lambert)."

Laymen are generally not aware of the duty of disclosure and certainly unaware of what information would be regarded as material by a prudent insurer.

4.5 It is proposed that the law relating to the disclosure of material facts be amended to limit the duty to disclose to facts which a reasonable man in the proposer's circumstances would consider to be material. Further, when an insurer discovers that the insured has failed to disclose a material fact or matter, the former should, unless he can prove fraud, be required to settle the claim.

5. The Proposal Form and Duty to Disclose

5.1 Most consumer insurance applications are accompanied by proposal forms which include a printed questionnaire which the proposer is required to complete. The general rule is that the mere fact that an insured has answered questions in a proposal form does not relieve him of the general duty of disclosure *(Schoolman v Hall)*. This is particularly harsh. When a consumer has answered detailed questions he will logically assume that he is under no duty to supply any further information. If the insurer with his expertise and years of experience wishes to have

information to enable him to assess a risk and devises a questionnaire for this purpose than the insured should be relieved of any duty to disclose material information except in answer to questions posed by the insurer. Matters which insurers consider to be material should be the subject of clear questions in the proposal form.

5.2 It is proposed that there should be no further duty of disclosure for consumer insurance where proposal forms are utilised except to honestly answer the questions in the proposal form.

6. The Proposal Form and Basis of the Contract Clause

6.1 Most proposal forms contain a clause which states that the particulars and statements made by the proposer are true and that they shall be the basis of the contract between the proposer and the company. The main legal significance of the basis clause is that it converts every statement in the proposal form into a "condition", and therefore any untrue or incorrect statement be it of a material fact or not would amount to a breach of condition entitling the insurer to avoid payment.

6.2 The case of *China Insurance Co. Ltd. v. Ngau Ah Kau* decided by the Federal Court is illustrative. The trial judge concluded that though certain answers in the motor policy proposal form were incorrect the answers were not material. China Insurance Co. Ltd. however appealed against the decision and the Federal Court decided that it was not open to the judge to consider whether the answers were material or not. Hence China Insurance could avoid payment on the policy.

6.3 Fortunately, in so far as life insurance is concerned, the 1975 and 1978 amendments to the Insurance Act 1963 move in the right direction.

> S.15C (1) provides that a policy shall not be called in question by reason only of a mis-statement of the age of the life insured;

and

S.15C (4) provides that a policy may not be avoided on grounds of misrepresentation after two years of it being effected unless the insurer shows that

(a) the statement was on a material matter or suppressed a material fact; and

(b) it was made fraudulently by the policy-holder with the knowledge that it was false or that it suppressed a material fact.

There is no reason why there should be a two year period before justice is available. Indeed S.15C (4) should have its two year period of ineffectiveness removed and made applicable *to all policies of insurance.*

6.4 It is proposed that S.15C (4) of the Insurance Act 1963 be amended to read:

> "No policy of insurance shall be called in question by the insurer on the ground that a statement made in the proposal for insurance or any supporting evidence or document was inaccurate or false unless the insurer shows that such statement was on a material matter or suppressed a material fact and that it was fraudulently made by the policy-holder with the knowledge that the statement was false or that it suppressed a material fact."

7. Incorporation Clauses, Proposal Forms and Cover Notes

7.1 Consumers enter into a insurance contract principally by completing a proposal form in which all facts deemed necessary by the insurance company are sought and provided. The proposal form of most insurance companies contain a statement requiring the person seeking insurance "to accept a Policy of Insurance according to terms, exceptions and conditions expressed in and on the Policy". The insured is then required to buy the proverbial pig in the pole. The cover note issued to the insured by some insurers contains incorporation clauses which similarly provides the insurer a carte blanc to issue policies on

his own terms. Indeed the decision in *Wyndham Rather Ltd. v Eagle Star etc. Insurance Co.* suggests that the insured is bound by the policy terms included in the subsequently issued policy even if there were no such incorporation clauses. It is wholly inequitable that the prospective policy holder is required to apply for and accept a policy of insurance which will be issued to him sometime later and the terms and conditions of which he is ignorant.

7.2 Consequently, it is proposed that the law be amended to require that:

(a) the proposal form and cover note contain express incorporation clauses in simple and clear terms; and

(b) a sample copy of the insurance policy complete with the terms and conditions that apply be issued together with the cover note. Alternatively, the terms of the policy be incorporated into the proposal form.

8. Unvalued Policies, Sum Insured and Indemnity

8.1 The value of the property insured and the sum insured are crucial in any insurance contract for, inter-alia, they help determine the premium payable and the indemnity awarded. The law consequently requires the insured to state the value of the item insured and the sum he wishes to insure it for. The insurer, if he wishes, can seek to examine the item and assess its value before he consents to insure it. This apparently equitable situation is however compromised by a number of practices.

8.2 As the law currently stands the failure on the part of the insured to accurately state the value of the property insured could be construed as a breach of the duty of disclosure or as a breach of warranty. Failure upon renewal to disclose a change in the value of the property insured could also be regarded as the non-disclosure of a material fact (Bird; p. 241). Yet, for the consumer, the value of the property insured is especially in

recent times of high inflation, often, at best, a "guesstimate". Hence, it has to be ensured that in the absence of fraud a misstatement of the value of the property insured does not constitue grounds for avoiding a policy.

8.3 Failure to correctly estimate the value of the property insured also raises other problems for the insured. If the insured overvalues the property and then insures it for that sum it will result in him paying unnecessary premiums. By law, the excess premium paid in respect of an overvalued item is refundable. However, a refund of excess premium has certainly never been known to occur in instances of consumer insurance in Malaysia. Furthermore, because the policies issued are invariably unvalued policies, the overvaluation will not result in a higher indemnity (refer para 8.4 below). If the insured undervalues and underinsures his property, he will be penalised by the operation of the average clause (refer para 9.1 – 9.2 below).

8.4 In an unvalued policy the indemnity payable is determined in a number of ways. In Malaysian consumer insurance policies these are specified in the "market-value clause" or the "depreciated value clause". Often it is only one of these clauses that is included in a policy, but, in instances they may be fused into one clause as follows:-

> "It is hereby understood and agreed that in the event of a claim for total loss the Company's liability shall not exceed the market value of the vehicle hereby insured as on the date of accident/loss or the sum insured less appropriate depreciation whichever is the lower".

The rationals for the market-value and depreciated-value clauses are founded on the principle that the insured is entitled to only indemnity and not to any gain in instances of loss. The principle however has been so applied that in practice the insured obtains less than indemnity. An example will serve to establish the case. A motor car's value is determined by a number of factors important amongst which are the condition of the car, the year

of manufacture, and the price of a new car of the same model. Consequently, the market value of a car purchased for say $20,000 may a year later be $18,000. Depreciation on a one-year old car will, by reference to a table maintained by many insurers, be 20 per cent. By such a calculation, the value after depreciation of the said car is held to be $16,000. It is not unusual that under different circumstances the market-value of the car will be less than its depreciated value. By virtue of the "fused market-value and depreciated value" clause cited above, the insurer reserves the right to pay the lower of the two figures. Such a situation is clearly one-sided and inequitable.

8.5 The excess clause is a device employed by insurers to preclude liability for a stated initial amount in instances of all claims — be they for total loss or partial loss. The effect of such a clause is to make the insured his own insurer for a portion of the risk. The clause is objectionable, inter-alia, for the following reasons

(a) It amounts to a circumvention of the motor tariff rates stipulated by the government and the industry-agreed tariff rates in other areas of insurance. It represents an unapproved increase in premiums.

(b) It encourages inflated claims by insured who wish to overcome the reduced indemnity otherwise available to them. This in turn occasions a number of malpractices involving repair-shops, adjustors, and, sometimes, even the claims offices of insurance companies.

8.6 A variation of the usual excess clause is what has been commonly referred to as a theft clause. Such a clause stipulates the reduction either by a fixed amount or a percentage of the indemnity payable in the event of a total loss by theft. (This reduction is in addition to the prescribed excess clause). It is thus particularly penalising in that it is often an additional excess clause and is applicable along with the usual excess clause. It too circumvents the agreed tariff rates on premiums imposed by the government.

8.7 The market-value clause and/or depreciated value clause, the excess clause and the theft clause each by themselves are inequitable. Collectively, they serve, to mutiliate claims. The following case serves to exemplify the situation

Sum Insured	$30,000
Premium Paid	$ 1,032
Market-Value	$26,000
Depreciated Value (less 20%)	$24,000
Hence Gross Amount Payable	$24,000
Deduct 10% for Theft Clause	$ 2,400
Deduct $1,000 for Excess Clause	$ 1,000
Net Amount Paid	$19,400

In actual terms the effect of all these clauses is for the insured to pay a premium based on a value of $30,000 and yet in the case of a total loss be indemnified only to the extent of $19,400.

8.8 Unvalued policies present the consumer with a perplexing array of clauses and leave him confounded. The consumer clearly is unable to cater for his insurance needs and the efficacy of insurance is for him severely compromised. Moreover, these same clauses provide the unscrupulous amongst the insurers an opportunity to delay and even deny just settlement of claims. It is necessary therefore to make all consumer policies valued policies.

8.9 It has been argued that insurers cannot be expected to inspect each and every item they undertake to insure. Such a rationalisation is unconvincing, inter-alia, for the following reasons:-

(a) Valued policies, i.e. a policy where the amount to be paid in the event of a total loss is determined at inception, is common practice in marine insurance and some other classes of insurance. There is no reason why this cannot be extended to consumer insurance.

(b) In motor insurance, the insurer is clearly cognizant of the actual market value of most cars by model and year of manufacture since such information is utilised to process claims. Hence, the Persatuan Insuran Am Malaysia should be able to compile a book of tables indicating the current market value of most cars by model and year of manufacture.

(c) In householder and houseowner and fire policies for real property, it will be similarly possible to determine, with the assistance of the Association of Property, Valuers, a table of probable values by locality, property-type and material used. (In fact such assessments and tables are continually used for determining changes in property values by many financial institutions).

Modern insurers are better equipped in terms of experience and expertise than consumers to assess the value of the property insured.

8.10 It is proposed that

(a) consumer insurance policies be valued policies;

(b) the Persatuan Insuran Am Malaysia periodically compile a book of tables indicating the current market value of cars by model and year of manufacture, and, a book of tables indicating real property values for purposes of ascertaining the sum insured and indemnity payable in instances of motor and fire insurance;

(c) the excess-clause, the theft-clause and any other such clause designed to reduce the indemnity payable in instances of total loss to less than the sum insured be excluded from consumer insurance policies;

(d) the Insurance Act 1963 be amended to give statutory effect to the above.

9. Sum Insured and Average Clause

9.1 The value of the interest insured is also fundamental in instances of under-insurance, a predicament very likely in recent times of high inflation. When loss occurs the maximum amount recoverable is the sum insured and this regardless of the market value of the loss suffered. Consequently, consumers have to be protected against unintended underinsurance.

9.2 In situations of partial loss, under-insurance raises the spectre of the principle of average. The inequity of the average clause is that the insured is deemed to be his own insurer for the amount uninsured. For example if a house worth $200,000 is insured subject to average for $100,000, the insured will be entitled to only half of any partial loss. Hence if the actual loss is $120,000 he will be entitled not to $100,000 but rather $60,000. More shocking to the insured is the fact that in a situation of inflation an identical partial loss will obtain in each year a lesser payment despite the property being insured for the same amount and at the same premium. Such an alarming consequence is effected by an innocuous sounding average clause which typically will read as follows:-

> "If the property hereby insured shall, at the time of any loss, be collectively of greater value than the sum insured thereon, then the insured shall be considered as being his own insurer for the difference, and shall bear a rateable proportion of the loss accordingly. Every item, if more than one, of the schedule shall be separately subject to this condition."

9.3 It is proposed that the Insurance Act 1963 be amended to exclude the average clause from all consumer insurance policies.

10. Double Insurance, Contribution and Rateable Proportion Clauses

10.1 Insurance is for indemnity in instances of loss and an insured cannot utilise insurance for unjust enrichment. Nevertheless,

there is nothing wrong in an insured effecting as many policies as he wishes on the same property or against the same risk, so that he may be doubly insured.

10.2 It is important to remember that double insurance arises not always because the insured so desired. Indeed in many instances the insured is unaware that double insurance exists. This is because for double insurance to occur it is not required that the scope of the policies as a whole be the same. There may be an overlap between a motor and an employer's liability policy that can give rise to double insurance *(Albion Insurance Co. v Government Insurance Office of New South Wales)*. Similarly, a household policy may cover certain property owned by the insured, for example a watch, when it is taken outside the house. Such a watch when in a repairers shop might be covered by a policy held by the watch-repairer. In fact, in any situation where the bailor and bailee of an article both have policies covering the same risk, prima facie, there would be double insurance. When an insured suffers a loss, he is, and can claim under more than one policy he is of course, entitled to no more than a full indemnity, but he can at common law choose from which insurer to claim. The insurer who settles the claim none-theless is able to reduce his losses because he is entitled to claim a contribution from the other insurer or insurers and the law provides that the insurer claiming a contribution must sue in its own name *(Sydney Turf Club & Crowley)*.

10.3 To prevent fraudulent claims and to ensure that the insured is not indemnified in excess of his actual loss the insurer will legitimately require information of all other insurers of the property and claims made against them in the case of loss. The latter information is called for when a loss is incurred and it is only fair that this information be provided in the claim form that the insured will be required to complete. Should this be so stipulated as a condition in the insurance policy then there should be no further requirement from the insured. In such an event the "no fraud clause" which is invariably included in all

policies will suffice to ensure that there is no unfair enrichment. The typical no-fraud clause reads as follows:-

> "If any claim under this Policy shall be in any respect fraudulent or if any fraudulent means or devices are used by the insured or anyone acting on his behalf to obtain any benefit under this Policy all benefit thereunder shall be forefeited."

10.4 What insurance companies have done is to introduce a standard term in almost all indemnity insurances providing that if there is any other insurance on the property or the risk covered by the policy, the insurer will not be liable to pay or contribute more than its rateable proportion of any loss or damage. What this simply means is that it prevents the insured from recovering all his loss from one insurer and he is then compelled to claim the appropriate proportion from each. The insurers are relieved of the burden of having to claim contributions inter se. A typical clause of such a nature reads:-

> If at the time of any loss, damage or liability covered by this Policy there shall be any other insurance covering such loss, damage or liability or any part thereof the society shall not be liable for more than its rateable proportion thereof."

This is clearly inequitable. The insurer already benefits from contribution, a benefit that accrues to him solely by the effort and at the expense of the insured. To now insist that the time, expense and effort to effect contribution should be that of the insured is patently unfair.

10.5 More penalising than the above is the practice of insurance companies inserting into policies a condition requiring notification of double insurance with a proviso that failure to do so will result in the ousting of liability. A clause of this nature reads as follows:-

> "The insured shall give notice to the Society of any insurance or insurances already effected, or which may subsequently be effected covering any of the property hereby insured, and unless such notice be given and particulars of such insurance or insurances be stated in or endorsed on this Policy by or on

> behalf of the Society before the occurance of any loss or damage, all benefit under this Policy in respect of the property so insured shall be forfeited."

10.6 Perhaps most odious in this respect is the condition inserted into policies totally ousting liability in instances of double insurance. An example of this sort of condition is as follows:-

> "There shall be no liability under this insurance in respect of any claim where the insured is entitled to indemnity under any other insurance."

What then happens if there is double insurance and both policies contain such conditions? Logically the insured would be deprived of indemnity by both policies. Fortunately, the courts have not taken kindly to such clauses in policies and it is likely that the courts will invoke the equitable principle of contribution between the co-insurers. Nonetheless the uncertainty exists.

10.7 It is proposed that in relation to double-insurance the Insurance Act 1963 be amended to achieve the following:

(a) the insured be required merely to provide all information on other insurers and claims made against them at the time a claim is made;

(b) contribution be an exercise undertaken by and amongst insurers albeit with the assistance of the insured; and,

(c) conditions ousting liability in instances of double-insurance or failure prior to the loss of notifying the insurer of double-insurance be made void.

11. Compulsory Arbitration Clauses

11.1 Arbitration is, to the individual insured unaware of the mechanisms involved, a bewildering exercise. In the absence of

an established arbitration bureau in which the insured has confidence, arbitration does not and will not serve as a useful mode of resolving differences and disputes. Indeed, it provides the insurer with an additional device for delaying settlement of the claim and this has been used by less scrupulous insurers. Arbitration should be a matter of choice and utilised only when both parties so desire. Hence, policy clauses which require arbitration or make it a condition precedent to any action in the courts cannot justly be a part of standard form consumer insurance contracts. It must be noted that the legislature has already provided for the removal of similar clauses from another form of standard form contract – the Hire Purchase Agreement.

11.2 It is proposed that policy clauses which require arbitration or make it a condition precedent to any action in the courts be excluded from consumer insurance contracts by the incorporation of the following section into the Insurance Act 1963:

1. Subject to subsection 2 below,

Any provision in any agreement, policy of insurance or other document

(a) requiring differences or disputes arising out of a contract of insurance to be referred to arbitration;

(b) providing that no action or suit shall be maintainable upon such a contract or against the insurer in respect of any claim under, or difference or dispute arising out of, such a contract unless the claim, difference, or dispute has been referred to arbitration or an award pursuant to arbitration proceeding has been first obtained;

(c) providing that arbitration or an award pursuant to arbitration proceedings is a condition precedent to any right or action or suit upon such a contract; or

(d) otherwise imposing by reference to arbitration or to

an award made in arbitration proceedings any limitation on the right of person to bring or maintain any action or suit upon such a contract, shall not bind the insured.

2. Nothing in subsection (1) shall prevent the parties to a contract of insurance from making an agreement, after a difference or dispute has arisen out of a contract of insurance, to submit the difference or dispute to arbitration.

12. Documentation in Relation to Claims

12.1 In an attempt to establish the authencity of a claim and minimise further loss insurers require

(i) speedy notification of the loss;

(ii) particulars of the loss; and

(iii) proof of the loss.

The primary function of documentation in relation to claims and consequently the obligation of the claimant is to satisfy these requirements. It is however, possible for insurers to utilise the requirement for documentation at the time of a claim to frustrate, delay or deny settlement of claims.

12.2 In a motor claim for instance the claimant is required to submit a variety of documents, the number varying with different insurers. Insurers cite a number of reasons for requiring the documents. Some of the documents sought and the reasons cited for requiring them are provided below.

In all motor claims

(i) copy of the claimant's police report – to establish proof of loss

(ii) vehicle log book – to ascertain that the claimant retains an insurable interest at the time of the loss

(iii) copy of the driving licence – to determine that the driver of the vehicle is not disqualified from driving by order of a court of law

(iv) road tax disc – to verify that the vehicle is licensed to be on the road

(v) copy of the insureds/drivers identify card – to verify the identity of the claimant/driver

(vi) copies of the cover note and or policy – to save the insurer the inconvenience of locating his file copy.

Additionally, in third party claims

(vii) copy of the police report of the offending driver

(viii) police photographs showing the damage

(ix) police sketch maps (with key) of the accident.

These three are held to be necessary by the insurers to establish the authencity of a third party claim.

12.3 Clearly, a number of these documents cannot be justly required as of right from the claimant. The vehicle log book already contains all information obtainable in the road tax disc and hence there can be no legitimate reason for requiring the latter. The identity of the insured is already established when a policy is effected and a suitably deviced police report (see below paras *13.1 & 13.2*) will also serve to establish the identity of the driver. That it is inconvenient for the insurer to have to locate the office-copy of the policy documents cannot legitimately be held as sufficient grounds for requiring these of the insured. The police as a practice release copies of the police report of the other parties in an accident, and photographs of the accident vehicles and accident area, only to lawyers. To require these documents from a claimant greatly inconveniences him. The additional documents required in third party claims are more readily and cheaply obtained by the insurer.

12.4 It is recommended that

(a) the required documents in any insurance claim be clearly stated in the cover note and policy issued to the insured and in the claim form the insured is required to complete

(b) the documents required from the claimant in a motor claim be limited to copies of the insured's

(i) police report;

(ii) vehicle log book; and

(iii) copy of the driving licence of the driver.

13. Police Reports

13.1 The police report forms currently used are inadequate for claim purposes. The present practice is for the insured to make a written report or an oral report which the attending police official reduces into writing. At this stage all that the complainant can obtain is the report number. Copies of the report, whether typed or photostated and certified by a police officer of a specified grade, are obtainable only at a later date and this often at a different police station. This lengthy and cumbersome procedure also becomes costly when the police station involved is in another town or state. The police report forms utilised in Singapore, for instance, are more adequately designed.

13.2 It is recommended that the Persatuan Insuran Am Malaysia in conjunction with the police authorities device a special police report form for motor accidents which will

(a) seek by way of suitable questions all relevant information required;

(b) make adequate provisions for the inclusion of the required sketch map of the accident; and

(c) make provision for the immediate issue of a carbon copy of the report lodged.

14. Settlement of Claims

14.1 When an insurance company unjustly refuses or delays payments it has most clearly breached good faith and its contractual obligations. Consumer associations are continually faced with complaints regarding non-settlement of claims. The annual reports of the Director General of Insurance yearly contain references to non-settlement. Table 11.5 of the DGI's report for 1984, (reproduced here as Appendix A), is illuminating. The report also notes that 53 cases of motor complaints were in respect of court awards. (Non-disclosure by an insured of a judgement debt has been used by insurers to repudiate policies. Consequently it would only be fair to require the insurers concerned to give notice of their tardiness in settling court awards to their potential clients – to make the contract of insurance a contract of utmost good faith). The DGI's report only refers to written complaints received by his Department and represents merely the tip of the iceberg. Delays mean that a consumer in need of immediate payment is forced to accept less than his due. There clearly is an urgent need to speed up the settlement of claims and penalise defaulters.

14.2 It is proposed that

a. (i) A specified period of two weeks be set for the processing of claims and an offer of settlement by the insurer of his "admitted liability".

(ii) Reference be made to an Insurance Arbitrators Bureau (see paragraph 23 below for details) for the disputed difference between the amount claimed by the insured and the admitted liability of the insurer.

(iii) Interest at current fixed deposit rates be made payable for any difference due from the date when payment was due to the date of actual payment.

b. Payment, whether in partial or full settlement of a claim must be made by the insurer within seven (7) days of the

claimant's acceptance of the insurer's offer of settlement – whether such acceptance is in partial or complete settlement of the claim.

c. The DGI's report must provide a breakdown of the types of complaints received by Company so as to inform consumers of defaulting companies and assist them in making informed choices amongst insurers.

d. The Director-General of Insurance arrange for suitable legislation that will give those buying houses, goods on hire purchase or on loans a choice of insurers instead of the current practice of having the loan extending authority determine the insurer and nature of insurance to be effected.

e. A complaints clearing Bureau be established within PIAM and LIAM to process all insurance related complaints.

15. Total Loss, Salvage and Roadworthiness of Motor Vehicles

15.1 Based on the 1873 decision in *Rankin v Potter* property insurers have been held to be entitled to any materials left following damage where they have agreed to pay a loss in full. Indeed, where an insured has been indemnified in the case of a total loss he cannot also claim the salvage as this would give him more than indemnity. The insurers then have a right to subrogation; they can sell the salvage so as to minimise their loss. This is an accepted and acceptable insurance practice. In the motor insurance sector, however, this practice has been exercised without the necessary care and prudence.

15.2 "Total Loss" vehicles are generally purchased for salvaging parts which can enter the second hand spare parts market or for repair and sale as second hand cars. There currently exists no obligatory set of rules governing this practice. Purchasers of repaired "total loss" vehicles as indeed their subsequent insurers are generally unaware of the vehicle's accident history nor of its

actual roadworthiness. The repairs effected to these wrecks are often purely cosmetic in nature making such vehicles unsafe at any speed.

15.3 It has been argued that it is not the duty of insurers to ensure that repaired "total loss" vehicles are indeed roadworthy and that it is purely the rights and obligations of the seller and buyer of these repaired vehicles to ensure their roadworthiness. We reject this argument and consider it not only socially irresponsible but also as a shortsighted and an uneconomic approach. Unroadworthy vehicles occasion far greater loss in lives and property and are a greater liability to their issurers. It is in the interest of the insurance industry to exclude these "death traps" from the roads.

15.4 There is another cogent reason why the subsequent history of "total loss vehicles" needs to be monitored. The number of vehicles stolen each year has increased at an alarming rate. Stolen vehicles can be cannibalised for their spare part value, exported or sold in the Malaysian market to unsuspecting consumers. It is not inconceivable that the log book and the registration, chassis and engine numbers of the total loss vehicles can be used to "whitewash" or "legitimise" a stolen vehicle. It is imperative that the history of total loss vehicles be monitored and that they be removed from the market after being "cannibalised" for their spare parts value.

15.5 It is proposed that

(a) Insurers who exercise subrogation and salvage rights in relation to motor vehicles inform the Road Transport Department of all motor vehicles that have been the subject of total loss indemnity and that the motor registration log books of all such vehicles be stamped with the words "subject of total loss indemnity" before they are sold under salvage rights.

(b) Persatuan Insuran Am Malaysia maintain a comprehensive register of all vehicles which are the subject of total loss awards.

(c) Arrangements be made with the Road Transport Department to conduct tests for the roadworthiness of the repaired or reconditioned vehicles before they are re-registered for use.

16. Indemnity in Instances of Personal Injury and Death

16.1 The law governing indemnity in instances of personal injuries and death, unless provided for by specific contracts, is governed by the Civil Law Act 1956 and as amended by the Civil Law (Amendment) Act 1984. The significance of these statutes to the insurance industry is principally, though not exclusively, related to motor and industrial accident claims.

16.2 Claims related to personal injury and death are generally brought by

(a) the injured person

(b) the dependants of a deceased person

(c) the estate of a deceased person.

Appendix B tabulates and compares the heads of claims under which each of these categories of claimants can seek compensation under the Civil Law Act 1956 as it applied prior to the Civil Law (Amendment) Act 1984 and as it applies after the amendments. Appendix C presents five case studies and examines the awards likely under the old and new law. It is not intended in this memorandum to deal exhaustively with the effects of the amended law. The arguments presented here are merely intended to substantiate the view that the current law has serious flaws which render imperative an immediate review.

16.3 The Civil Law (Amendment) Act 1984 serves to severely penalise the unemployed, their dependants and estate. The

amendments provide that the injured or deceased must have been "... in good health but for the injury that caused his death and was receiving earnings by his own labour or other gainful activity prior to his death" before any assessment of the loss of earnings in respect of any period after the death of a person. It is difficult to accept that an unemployed will always remain so; that illness, lay-offs and resignations make a person always unemployable. The effect of the amendments is to convert a temporary misfortune into a permanent set-back and misery.

16.4 In an attempt to standardise and reduce the awards the amendments also provide that "... where the person deceased has attained the age of fifty-five years at the time of his death, his loss of earnings for any period after his death shall not be taken into consideration". This has the effect of penalising those capable of and in fact earning beyond 55 years of age. Where employment occurs beyond 55 years of age it is often because the employee is doing so to meet the peculiar financial needs of his dependants and his death will mean that there exists a real claim in dependancy. We are unable to see any logical grounds why an artificial maximum age should be set for claims and, more so, why 55 years should serve as the cut-off point.

16.5 The Civil Law Act 1956 provides that a claim by the dependants of a deceased person are limited to the spouse, parents, grandparents, children, step-children and grandchildren of the deceased. Yet the United Kingdom *Administration of Justice Act 1982,* which provided the impetus for our own 1984 amendments defines "dependant" even more widely. The U.K. Act includes the former spouse of the deceased, any person who was living with the deceased for two years in the same household immediately before the date of death, and any person who is, or is the issue of, a sibling uncle or aunt of the deceased. The 1984 Act failed to remedy the shortcomings in the Civil Law Act 1956.

16.6 Malaysian society is still predicated on the extended family system, the virtues of which our leaders have extolled. Yet, the dependants in such an extended family are not provided for. Similarly, the divorced wife even if she was receiving maintenance is precluded from making a claim. Also, as it stands, a brother or sister of a deceased person has no *locus standi* to sue for loss of dependancy although he or she may be wholly dependant on the deceased for financial support. The law as it now applies has in the interest of standardising and reducing the awards severely compromised the very real needs and right of these dependants. It also serves to disregard a fundamental characteristic of our social fabric – the extended family. The law needs to be amended to remedy these shortcomings.

16.7 The principal rationale of the 1984 amendments is that they serve to avoid speculative awards and move towards regulating and standardising them. The reason cited for such a regulation is that not to amend the 1956 Act would enhance uncertainty and consequently serve to substantially raise the premiums charged by insurers. The amendments, it has been argued, really benefit the consumers by holding down insurance premiums and, consequently, also fares in public transport.

16.8 We concede that there is a need to avoid speculative awards. However it must be noted that the Malaysian judiciary have consistently avoided speculative awards and the higher courts have not hesitated to trim the awards of the lower courts which have erred from the conservative line that is expected of them. Perhaps the most dramatic award made in the Malaysian courts was in *Underwood v Ong Ah Long* where the High Court awarded $2,017,440. This has been held to be a speculative award. What is less often cited is that on appeal the Federal Court reduced this award to $107,138. Even more conclusive evidence of the Malaysian judicial systems inherent conservative approach to awards is evidenced by its decisions pertaining to awards relating to the head of claim entitled "loss of consortium" under the Civil Law Act 1956 as it applied prior to the

1984 Amendments. The Federal Court ruled in *Chong Pik Sing & Anor v Ng Mun Bee @ Ng Chee Bee* that there lay no claim under this head. This was concluded despite the High Court having earlier dismissed an appeal against an award of $3,000 by the President of the Sessions Court in *Bas Mini Muhibah Sdn. Bhd. v Abdullah Salin.* Clearly, the Malaysian judiciary contains checks which make speculative awards wholly unlikely.

16.9 We reject the argument that the amendments are consumer oriented even if they serve to hold down the insurance premiums payable. It is inexcusable that the relatively wealthy motoring public should be the beneficiary of small savings in premiums at the larger expense of the injured or the dependants and estate of the deceased. Similarly, marginal benefits in public transport fares cannot justify unjustly low awards.

16.10 It is proposed that a Commission be set up with representatives of the judiciary, the insurance industry and consumers to review the compensation payable in instances of personal injuries and death. In particular, it is imperative to review

(a) the definition of the term dependant so as to include within its sphere all "actual dependants" of the deceased;

(b) The compensation payable to unemployed injured or their estate and/or dependants with regard to their future loss of earnings; and

(c) The limitations imposed on the courts discretionary powers to determine the "multiplicand" and "multiplier" used in assessing awards in instances of personal injury and death.

17. Minimum Cover in Motor Insurance

17.1 The current requirements of minimum cover in motor insurance as governed by the *Road Traffic Ordinance 1958* are that every

motor vehicle must have an insurance policy that protects the user from liability in respect of third party risks (S. 74). The following section (S. 75) defines the risk that must be so covered against as "any liability which may be incurred ... in respect of the death or of bodily injury to any person caused by or arising out of the use of the motor vehicle ..." As the law currently stands there is no cover for property damage for third parties and for passengers and pillion riders in motor vehicles.

17.2 It has been argued that insurance companies in fact do not as a practice offer Act cover but instead offer third party or comprehensive cover policies which do cover property damage for third parties. It has also been similarly argued that for an additional premium passenger and pillion rider cover can be similarly arranged. However, there are a number of constraints against the smooth operation of these provisions in relation to both the insured as well as the third parties involved. Inter alia the constraining factors are

(a) The failure of the insured to report the accident leads the insurer to refuse entertaining third party claims.

(b) Delay in reporting an accident can in instances constitute a breach of a policy condition giving rise to repudiation of any liability by the insurer.

(c) There is no priority of contract as between the third party and the insurer and hence the third party will be obliged to first bring an action against the offending party who will in turn have to rely on the provisions of his contract with his insurer to seek reimbursement.

17.3 In the United Kingdom the amendments in the law to effect compulsory cover for passengers and pillion riders did not occasion any significant increase in premiums. Malaysian insurer's policies of motor insurance also habitually extend cover to include Singapore and in Singapore the law requires compulsory cover for passenger and pillion riders and also

damage to third party property. That the same policy will extend greater cover to Singaporeans than it does to Malaysians is an untenable discrimination that the Malaysian insurance industry and the Malaysian government should not perpetrate. Most importantly, the motorised public should not grudge the cost of its social responsibility of ensuring adequate cover of those often less fortunate non-motorised road-users.

17.4 Passenger cover, it has been held, should not extend to members of the insured's family and his employees. The reason advanced for this is that no driver will contest a claim that he negligently caused personal injury to members of his family and thereby deny them indemnity by insurers. This argument is internally inconsistent and wholly untenable. If there is passenger cover there is no reason why the insured driver is going to distinguish between members of his family and other passengers or pillion riders. Moreover, it can be argued at least as cogently that the driver of a motor vehicle having family members as passengers or pillion riders will exercise a greater degree of care than otherwise. All passengers, regardless of their relationship to the driver are entitled to equal cover.

17.5 It is consequently proposed that

(a) Minimum cover in motor insurance should be extended to include

(i) third party property damage; and

(ii) passenger and pillion rider cover.

(b) The term passenger should be given its plain lexical meaning and should expressly be taken to include members of the insured's family as well as his employees.

18. No-Claim Discount Scheme

18.1 Insurers claim that the no-claim discount is designed to achieve the following:

(a) encourage good driving by rewarding accident free-drivers with lower premiums;

(b) minimise administrative costs by discouraging small claims.

When judiciously applied the no-claim discount scheme would, at least partially, achieve these objectives.

18.2 However, as it is currently applied, it is doubtful whether these objectives are equitably achieved. The insured earns after each claim-free year a specified percentage of his premium as a discount. The amount earned each year is added to the amount earned in previous years. Yet, when an insured makes a claim he looses all of his discount earned over the previous claim-free years. Hence an insured who has as a result of 5 or more years of claim-free years earned a discount of 55 per cent will because of just one claim loose all his entitlement to discounts.

18.3 It is consequently recommended that the insured earn his no-claim discounts for each accident free year and when he does make a claim he merely loose the last discount earned (in effect the no-claim discount be operated in a "step-up and step-down" fashion).

19. "No-Fault" Motor Insurance Scheme

19.1 Motor insurance in Malaysia is based primarily on the principle of negligence, i.e. the use of the "fault-rationale". Many of the weaknesses of this system stem from the law's inability to transform a set of essentially quasi-criminal tort rules admonishing a "wrong-doer" into a device for apportioning looses. The consequences of such a practice may be summarized as follows:-

(a) The occurence of the risk insured against is not always the result of fault. In many cases where proof is attempted the negligence alleged is merely a technically faulty reaction committed in a split-second.

(b) Even where there is genuine fault often no proof of it can be established.

(c) The litigation that follows clogs the legal system, giving rise to delays and its consequent innocent misrepresentations and perjuries. It also makes the more needy requiring immediate relief easy marks for small immediate settlements.

(d) The outcome of litigation is uncertain and far too often based on technicalities and the relative competence of the lawyers presenting the case.

19.2 It is thus necessary to consider the viability of no-fault insurance which meet payments on the basis of loss rather than fault. No-fault insurance schemes have been found to be viable in other countries. Accident insurance protection must be high enough to make the proceeds of accident insurance correspond roughly to the popular estimate of an adequate minimum payment. If this is done then no-fault insurance will serve to minimise litigation whilst ensuring a speedy and satisfactory settlement of claims. Such schemes are often rejected as not viable because of two primary assumptions: that the scheme should be managed by government and that the whole of a claim should be met out of the no-fault scheme.

19.3 It is proposed that the Director-General of Insurance commission a feasibility study of a no-fault motor insurance scheme to consider, inter alia, the following options:

(a) A no-fault insurance scheme managed by the individual insurance schemes or a bureau amongst them; and

(b) Claims up to a stated maximum be met from the scheme without compromising the right of the affected parties to contest via an Insurance Arbitration Bureau and the courts for the balance.

20. Acquisition Costs, Commissions and Rebates

20.1 Agents can and do play an important role by making available to persons in rural and remote areas insurance facilities that otherwise may not be available to them. For this, they should be justly rewarded. However, it is not in these areas of the country that agents are found, but rather, in the urban centres where there exists a conglomeration of insurance company offices. Indeed, the principal function of agents today is for companies to outsell its competitors and this has led to larger and larger commissions for agents.

20.2 The Life Insurance Association of Malaysia (LIAM) and the General Insurance Association of Malaysia (GIAM) have agreed tariffs intended to govern commissions and curb unhealthy competition. In fire insurance the effective tariff from 1 April 1985 is 40 per cent. The life insurance industry has an agreement that is expected to be effective 1 January 1987 confining first year acquisition costs to 40 per cent. Apparently no decision has been arrived at for subsequent commission payments. But these agreements are of little avail when insurance companies seek ways of avoiding their commitments. The situation in motor insurance is illustrative.

20.3 Each motorist is required to obtain the minimum Act Cover Insurance before he can pay the compulsory road tax; to that extent motor insurance is compulsory insurance. The premiums payable are determined by government. In an attempt to seek an upward revision of the tariffs, the industry claims that motor insurance is not profitable, and, that the premiums are not commensurate with the risks borne. Yet, the agreed tariff for underwriters is 22½ per cent, and for principal agents 15 per cent. These are of course, the officially agreed tariffs, but, "insiders" allege that payments up to 45 per cent are not unusual. Apparently, the additional payments are made by a number of devices which include passing-off commissions as management expenses.

20.4 It is important to determine why the industry pays out in commissions such a large percentage of what because of compulsory insurance is a "captive premium". Amongst the possible causes are:-

(a) Motor insurance is, despite claims to the contrary, a profitable enterprise worth competing for. Commissions and breach of the agreed tariffs is a way companies attempt to slice-off a larger share of this profitable business.

(b) The cash-before-cover provision makes motor business particularly attractive since it is a panacea for the cash-flow problems that companies may face. It also means readily available investment funds and returns. (These returns are normally not shown in the motor insurance portfolio, but rather as investment returns. They should logically be borne in mind when premium levels are determined).

(c) The favourable bias that an insurance company may have towards their underwriting firms. In these instances, the commissions paid are above that of the approved tariffs. The off-shot of a company breaching the tariff rates is that all other insurance companies will be caught in a vicious circle of matching up and bettering these wholly irrational levels of commissions. Such a practice will mean that the viability of the insurance companies, and consequently, the interest of their insureds will be undermined.

Commissions increase the cost of insurance and spiralling rates of commission can cripple the industry. The payment of commissions and its associated practices will have to be regulated.

20.5 It is proposed that agents who perform a function for the insured be paid a just commission, but, where the insured obtains his insurance direct from the insurer, the stipulated commission should be returned as a rebate to the insured.

21. Intermediaries

21.1 Insurance, it is said, is bought, not sold – a maxim that emphasises the assumption that it is the insured who seeks insurance. The Malaysian situation, as noted earlier, is virtually the reverse. An estimated 33,018 life insurance agents and an unknown number of general insurance agents compete with each other to win business for their respective companies. Amongst the grievances that consumers have against agents are that

(a) Most agents are unable to provide professional advice to policy holders on their insurance needs and many themselves do not understand the clauses contained in the policies. Hence, they are unable to present accurately, honestly and completely every fact essential to the client.

(b) A large number of agents resort to pestering and high pressure methods. They take advantage of friendships, and generally, take any opportunity to force their products down consumers' throats.

(c) Agents do not represent to their clients the importance of presenting accurate answers to questions in proposal forms. They also do not exercise due care in filling in the proposal form of those unable to read or write in the language of the proposal form.

(d) After-sales service, particularly those pertaining to claims, is lacking especially where agents move from one insurance company to another.

(e) Agents practice twisting, i.e. encouraging a policy-holder to discontinue a policy or to have a policy made paid up and then to effect a new one in another company or the same company. This is done despite the agents being aware that

(i) everytime a policy-holder moves his insurance from one company to another, he must commence again

the qualifying period before being eligible for a surrender value and come under the non-forfeiture system;

(ii) the annual premium for the same cover under the existing policy is lower than that called for by a similar new policy because the insured is now more advanced in age; and

(iii) the suicide clause and incontestible clause begin anew in a new life policy.

(f) Agents fail to service and in instances disappear with clients premium payments. The latter case involves fraud and a criminal breach of trust. Yet such allegations are difficult to prove since many policy-holders admittedly by their own carelessness do not maintain records of their payments. The situation is particularly harsh for the poorer and less informed policy-holders. The overall forfeiture rates in life insurance has deteriorated from 16.7 per cent in 1982 to 34.7 per cent in 1983. In Home-Service business the comparable figures are 49.9 per cent in 1982 and 61.1 per cent in 1983.

21.2 The National Association of Malaysian Life Insurance Agents (NAMLIA) has tried to raise the standard of practice amongst its agents by, amongst other measures, devicing a code of ethics. The sad fact is that only about 1,300 of the estimated 33,018 life insurance agents are members of NAMLIA. Codes of practice are perhaps well-meaning – at most they bind those who subscribe to the principles contained in them. It is only an attempt at self-regulation lacking the force of law. An insured would therefore have no legal remedy if the agent failed to act in accordance with the code.

21.3 The Life Insurance Association Malaysia in conjunction with the Malaysian Insurance Institute makes available training and assessment leading to the Basic Examination for Life Insurance

Agents. However almost half the number of agents are, because of previous contracts, not required to take the examinations and to date only about 6,000 others have passed these examinations. The professional standard requirements set up more than four years ago and meant to commence on January 1, 1981 have yet not been enforced. Even when enforced, insurance agents will be required to pass the basic examination only within two years of being appointed agents. Of course within the two year period they will be marketing insurance presumably without basic knowledge of life insurance!!

21.4 The situation in life insurance is at least progressive. In general insurance there is no equivalent move towards professionalism – just about anybody sells insurance policies.

21.5 The current system of commissions paid to agents, especially in general insurance, emphasises overwhelmingly, sales rather than after- sales service. To a large extent it is this that contributes to agents foisting on their clients all forms of insurance that the insured hardly needs and can ill-afford.

21.6 It is proposed that

(a) The Director-General of Insurance require the insurance industry to review its system of rewarding its agents so as to weight it in favour of after-sales service.

(b) The Insurance Act 1963 be amended and practice governing underwriters and agents he changed to reflect the following:-

(i) All agents be registered and licensed;

(ii) Agents be not permitted to appoint sub-agents;

(iii) The utilisation of part-time agents be stopped forthwith;

(iv) Agents (as distinct from employees) be not permitted to collect any premiums from insureds and all com-

missions due to them be made by the insurance companies; and

(v) All agents (in both life insurance and general insurance) be required to pass a qualifying examination *before* marketing insurance.

(c) Rules and regulations with statutory force be deviced to give effect to the current code of ethics evolved by NAMLIA.

22. Forfeiture Rates in Life Policies

22.1 Forfeiture rates are alarmingly high in Malaysia (Refer Appendix D). To cite the DGI's report "The overall forfeiture rate has deteriorated in recent years". Of particular concern is the alarmingly high rate of forfeiture in home service policies. In home service policies the insured not only does not share in the profits but also pays higher premiums to have his premiums collected at his home on a monthly basis. Home service policies are taken by the very poor sections of our community. Their premium contributions are higher as a percentage of the insured's total income than ordinary life policies generally are. Appendix E below lists the total premium earned from home service polices, the forfeiture rate and the estimated premium paid by the insureds concerned which is lost without any lasting benefits. It is not untrue to state that this represents the greatest injustice perpetrated by the insurance industry on our consumers. That drastic steps have not hitherto been taken to resolve this "legalised robbery" is most unconscionable and immediate measures are needed to remedy this situation.

22.2 The immediate measures to be adopted must include

(a) the premium of a home service policy be collected not by agents but employees of the companies;

(b) that for a period of five years of non-payment of premiums the contract of insurance remain suspended and in obeyance and the insured be allowed to continue with the policy when he is able to commence payments. Suitable adjustments as to sum insured and for premiums can then be made to allow continuance of the policy, but, there should be no requirement to make back payments of unpaid premiums, or, any interest on the unpaid sums; and

(c) that all premiums previously paid in these suspended policies become for a period of five years a part of an escrow fund administered by the Director-General of Insurance.

On a longer term the industry should move away from home service policies and emphasise

(i) Workman's Compensation Schemes; and

(ii) Group Life Insurance Schemes effected by employers and managements.

23. Insurance Arbitrators Bureau

23.1 Litigation is expensive, time consuming and emotionally exhausting. It is also common knowledge that a multitude of irrational and incidental factors make the difference in the verdict between a pittance and a windfall. The situation is rife with frustration and uncertainty in which the principal beneficiaries are "ambulance chasers" and their like amongst the legal fraternity. It is necessary therefore to evolve extra-legal judicial mechanisms for resolving the disputes.

23.2 It is proposed that

(a) there be established an Insurance Arbitrators Bureau under the auspices of the Director-General of Insurance;

(b) the Insurance Arbitrators Bureau be backed by a council representing both the insurance industry and consumers;

(c) the Bureau arbitrate upon disputes between consumers and insurers should consumers so desire;

(d) the Bureau be guided not necessarily by strict legal rules but with good practice; and

(e) arbitration via the Bureau be not held to prejudice the rights of the parties to subsequently take legal action via the courts.

APPENDICES

LIST OF TABLES

SELECTED REFERENCES

APPENDIX A

WRITTEN COMPLAINTS RECEIVED BY THE DIRECTOR-GENERAL OF INSURANCE

Nature of Complaints	Number of Complaints				
	1980	1981	1982	1983	1984
Against Life Insurers:					
Delay in settling claims	22	5	10	3	10
Amount of cash surrender value	5	9	13	7	7
Agency matters	2	5	8	3	11
Delay in the issuance of policy	–	–	2	–	5
Delay in reply to correspondence	12	2	5	1	1
Bonus entitlement	2	1	–	–	4
Repudiation of liability with reference to conditions of policy contract	7	15	12	1	3
Cancellation of policy	19	16	18	–	23
Miscellaneous	20	12	31	4	39
SUBTOTAL	89	65	99	19	108

Against General Insurers:

Delay in settling claims	247	169	322	188	273
Amount offered for settlement of claims	51	68	67	58	79
Cancellation of policy contract	170	112	25	11	18
Delay in reply to correspondence	102	33	46	56	43
Agency matters	19	25	28	16	8
Repudiation of liability with reference to conditions of policy contract	60	81	53	35	15
Delay in the issuance of policy	24	43	26	13	8
Refusal to renew policy	1	–	1	–	3
Delay in authorising repairs	80	52	45	28	34
No claims bonus entitlement	145	61	33	35	12
Miscellaneous	178	110	145	54	200
SUBTOTAL	1,077	754	791	494	693
TOTAL	1,166	819	890	513	801

Source: The Director-General of Insurance Report, 1984 p.26.

APPENDIX B

THE CIVIL LAW ACT 1956: A Brief Summary

OLD LAW	AMENDED LAW
Injured person can claim damages for:	Injured person can claim damages for:
1. Pain and suffering.	1. Pain and suffering. And if injured person is aware that his expectation of life has been reduced and this awareness causes him to suffer, the court can take this suffering into account when assessing damages for pain and suffering.
2. Loss of amenities	2. Loss of amenities.
3. Cost of care.	3. Cost of care.
4. Loss of earnings. There is no age limit and no limit on judge's discretion.	4. Loss of earnings – depends on age of injured person. If 55 and above – no claim. 31 – 54 – use formula to obtain number of years' purchase (55 minus age of injured person, remainder divided by two). 30 and below – years of purchase limited to 16.
Can claim loss of earnings if injured person wasn't earning at time of accident.	No claim if injured person wasn't earning at time of accident.
Can talk into account prospect of earnings being increased in the future.	Can't take into account prospects of earnings being increased in the future.
No deduction for living expenses.	Injured person's living expenses must be deducted from earnings.

OLD LAW	AMENDED LAW
5. Reduced expectation of life.	5. No claim.
6. Claim for special damages	6. Claim for special damages.
Dependants of deceased can claim damages for:	Dependants of deceased can claim damages for:
1. Deceased's pain and suffering before he died.	1. Deceased's pain and suffering before he died.
2. Deceased's cost of care before he died.	2. Deceased's cost of care before he died.
3. Loss of support – this would depend on age of dependants and amount of support extended.	3. Loss of support – this will depend on age of dependants, amount of support extended and age of deceased. If deceased is 55 & above – no claim. 31 to 54 – use formula to obtain number of years' purchase. (55 minus age of deceased at time of accident, remainder divided by two). 30 and below – years of purchase limited to 16. No claim if deceased wasn't earning at time of accident. Can't take into account prospect of earnings being increased in the future. And deceased's living expenses must be deducted from earnings.
4. Loss of service.	4. No claim.

OLD LAW	AMENDED LAW
5. Funeral expenses.	5. Funeral expenses.
	6. New claim for bereavement limited to \$10,000. If deceased is above 18 – only spouse can claim. If below 18 and unmarried – only parents can claim. Below 18 and married – No claim. Above 18 and unmarried – No claim.
7. Special damages.	7. Special damages.
Deceased's estate can claim damages for:	Deceased's estate can claim damages for:
1. Deceased's pain and suffering before he died.	1. Deceased's pain and suffering before he died.
2. Deceased's cost of care required before he died.	2. Deceased's cost of care required before he died.
3. Funeral expenses.	3. Funeral expenses.
4. Loss of earnings.	4. No claim.
5. Loss of expectation of life.	5. No claim.

OLD LAW	AMENDED LAW
5. Funeral expenses.	5. Funeral expenses.
	6. New claim for bereavement limited to £10,000. If deceased is
	Above 18 — only spouse can claim.
	If below 18 and unmarried — only parents can claim.
	Below 18 and married — No claim.
	Above 18 and unmarried — No claim.
7. Special damages.	7. Special damages.
Deceased's estate can claim damages for:	Deceased's estate can claim damages for:
1. Deceased's pain and suffering before he died.	1. Deceased's pain and suffering before he died.
2. Deceased's cost of care required before he died.	2. Deceased's cost of care required before he died.
3. Funeral expenses.	3. Funeral expenses.
4. Loss of earnings.	4. No claim.
5. Loss of expectation of life.	5. No claim.

APPENDIX C

THE EFFECTS OF THE CIVIL LAW (AMENDMENT) ACT 1984: SOME CASE STUDIES

The Effects: Some Case Studies

The Civil Law (Amendment) Act 1984 does serve to streamline awards of damages and to standardise the methods of calculation involved therein. However the manner in which this is to be now done results in the claimant not being fairly and justly compensated. The effects of the Act can be best demonstrated by examining the following situations:

(a) In *Yang Salbiah v Jamil Harun* (1981) 1 MLJ 292, a seven-year old school girl was run down by a bus and as a result became vegetative. She was not earning any income at the time of the accident and, as a result of her injuries, it was wholly unlikely that she would ever be gainfully employed. The court awarded her total general damages amounting to $129,178/- made up as follows:

Pain, suffering and loss of amenities	–	$ 70,000
Costs of future care ($150/- per month x 25 years)	–	$ 25,362
Loss of future earnings ($200/- per month x 25 years)	–	$ 33,816
Total		$129,178

This was an award under the old law. *Loss of future* earnings was awarded eventhough the claimant was only 7 years old at the time of the accident. The court recognised that but for the accident the claimant would in likelihood have earned some amount of money in due course of time.

Under the new law, Yang Salbiah would not be able to claim loss of future earnings because she was not working at the time of the accident. It is also doubtful if the court would award her *costs of future care* for a period of 25 years under the new law because the multiplier stipulated for a claimant below 30 years of age is 16 years. This last statement is really a piece of guess-work as the Act makes no mention of costs of future care and how these should be calculated.

(b) Raja, a 25-year old articled clerk in a firm of chartered accountants, was involved in a road accident which left him without the use of his hands. He had passed all his previous professional examinations and had only one more examination to pass in a year's time before qualifying as a chartered accountant. At the time of the accident, he was drawing a salary of $600/-.

Under the old law, a court would consider that Raja would in likelihood have qualified as a chartered accountant. The court would then consider how much Raja would be likely to earn as such and used that sum as a standard for setting the multiplicand. The average monthly earnings of a qualified chartered accountant would clearly be far in excess of that of an articled clerk. For the multiplier, the court would consider that Raja would have had another 30 years of working life but for his disability. The court would deduct about onethird of this and award Raja loss of future earnings for about 20 years at least.

Under the new law, however, Raja's loss of future earnings would be limited to 16 years because he was under 30 at the time of his accident. Also, the near certainty that Raja would be earning so much more in due course of time as a fully qualified professional would have to be disregarded. Furthermore, Raja would not even be awarded $600/- per month for his loss of future earnings because the Act says

that Raja's living expenses at the time he was injured should be deducted.

What if Raja barely managed to make ends meet with the $600/- he was earning? Being a bachelor living on his own, he needed to pay for rent, food, transport, clothes and the books for the exam he was studying for. In fact, Raja often used up his entire salary for these necessities. Under the new law, it would seem Raja would get next to nothing for loss of future earnings because his living expenses of nearly $600/- would have to be deducted from the $600/- he was actually earning.

Preposterous as it may appear, Raja's situation is really one created by the Act. It is already bad enough that Raja's bright prospects as a fully qualified chartered accountant cannot be considered; to take away what he needed for his living expenses is sheer heartlessness.

(c) Tan, 51, was a government-school teacher in good health due to retire at 55. He had two children aged 15 and 16 whom he had hoped to see through university. To support them, he had planned to give private tuition after his retirement to help finance his children's tertiary education. His world collapsed, however, when he became paralysed in a roadaccident.

Under the old law, a sympathetic court would have been prepared to consider evidence that Tan would probably continue to earn an income as a private tutor after his retirement as a school teacher. The court would also be prepared to consider using a multiplier of 7 or 8 years to cater for the completion of Tan's children's education.

Under the Act, not only is the court told not to take into account the probability that Tan would continue to earn an income after 55, but the court has also to limit itself to

applying a multiplier of only 2 years (55 minus 51 equals 4 divided by 2 equals 2).

Clearly then, this provision of the Act is not one of the better examples of justice being tampered with mercy. In fact, one may even question if it is at all representation of justice.

(d) Encik Mutang Tagal, the Barisan Nasional MP for Bukit Mas, Sarawak provided the following example:

X. a 56-year old judge dies in an accident and leaves behind an unemployed wife and two children who are still studying in the University. If the accident had happened before 1st October 1984, the judge's widow and children would have been able to claim damages for loss of dependency based on how much the judge was earning at the time of his death, the possibility of increments in his earnings, the amount of monetary support given by the judge to his family and the fact that the retirement age of a judge is 65.

The amendments change all this: if the accident happened after 1st October 1984, the family of the deceased judge would not be able to claim any damages for loss of dependency because earnings after the age of 55 cannot be taken into consideration, as with the fact that the judge could have worked till he was 65. The widow, however, would be able to claim $10,000/ for bereavement, a head of claim previously not available to her. The children, whether married or unmarried, whether adults or minors, cannot claim anything.

(e) In or about September 1984, one Mohd Nazri Mohd Darus was accidentally killed in an exchange of gun-shots between some policemen and some robbers near the

Pertama Complex in Kuala Lumpur. Nazri was a 20-year old unmarried undergraduate of the Universiti Teknologi Malaysia who was not earning a salary. He was the fourth children in a family of 6 children and had entered the University with the help of a Public Services Department Scholarship. His father, 52 years old, worked as a security guard while his mother was a housewife. The parents nurtured great hopes that Nazri would one day graduate from the University and go on help out the family financially. These hopes have of course been shattered by Nazri's tragic death.

If, say, the policemen had been found responsible for the accidental killing of Nazri, and therefore there was somebody to be sued, Nazri's parents might have been able to persuade the court that Nazri would one day be earning an income on which they would be dependant. After all, a 7-year old girl with a shortened life span in a vegetative state was given $200/- per month for loss of future earnings; what more a university undergraduate at the threshold of a reasonable income. Failing that, Nazri's parents could always fall back to suing in the name of Nazri's estate. They would then be able to claim for "monies lost during lost years". The estate claim would already have automatically attracted $4,000/- for loss of expectation of life and all that had to be done was for the court to decide on how much Nazri would have been able to earn in the future for a computation of the "monies lost during lost years". Nazri's own expenses would of course have to be deducted as these monies would not in any event go to the estate.

If, however, Nazri's parents were to claim under the new law, there would not be any possibility of them claiming as dependants because at the time of Nazri's death, Nazri was not earning any income. An estate claim would likewise be futile because the Act has abolished the claims for

damages for loss of expectation of life and for monies lost during lost years.

Unlike the widow of the judge in the previous example, Nazri's parents cannot even claim the $10,000/- for bereavement because Nazri, though unmarried, was already 20 years old and no longer a minor. All that Nazri's parents can hope to claim would be the funeral expenses (which have been spent already), a claim allowable under the old law as well.

Some General Comments

Five case examples have been given to compare and contrast the law before and after the Act. Admittedly, not all the amendments passed have been discussed. Yet, the few which have come under focus leave one with the distinct feeling that something is not right. All five examples are capable of being modified and any modification would still result in one general conclusion: the Civil Law (Amendment) Act 1984 has the main effect of drastically restricting and reducing the scope and size of awards in serious personal injury claims and in claims where death is involved.

APPENDIX D

FORFEITURE AND SURRENDER RATES IN LIFE POLICIES

(In percent)

Year	Forfeiture Rate			Surrender Rate		
	Combined	Ordinary	Home Service	Combined	Ordinary	Home Service
1974 ...	37.7	35.9	73.2	1.79	1.82	0.89
1975 ...	33.7	31.8	73.1	2.02	2.03	1.79
1976 ...	34.6	33.8	54.8	2.47	2.49	1.75
1977 ...	32.3	30.4	70.4	2.41	2.43	1.88
1978 ...	27.8	26.4	61.2	2.15	2.17	1.45
1979 ...	24.0	23.1	52.3	2.25	2.28	1.29
1980 ...	22.6	21.2	65.6	1.90	1.92	1.34
1981 ...	17.2	16.4	50.0	2.51	2.52	1.82
1982 ...	17.3	16.7	49.9	2.18	1.19	1.95
1983 ...	18.1	34.7	61.1	1.93	1.94	1.53

Source: The Director General of Insurance Report, 1984 p.47.

APPENDIX E

HOME SERVICE POLICIES: TOTAL PREMIUM PAID, FORFEITURE RATE AND FORFEITED PREMIUM (EXCLUDING SURRENDERED POLICIES)

Year	Sum Insured		Annual Premium		No. of Policies		Forfeiture Rate	Forfeited* Premium $m
	$m	% Increase	$m	% Increase	No. of Units	% Increase		
1974	99.1	28.6	8.7	24.3	72,862	18.9	73.2	6.37
1975	107.6	8.6	9.2	5.7	76,406	4.9	73.1	6.73
1976	141.6	31.6	12.4	34.8	96,188	25.9	54.8	6.80
1977	168.4	19.0	14.1	13.7	106,349	10.6	70.4	9.93
1978	191.3	13.6	16.1	14.2	116,651	9.7	61.2	9.85
1979	222.2	16.1	18.9	17.4	129,159	10.7	52.3	9.88
1980	268.3	20.7	22.7	20.1	147,426	14.1	65.6	14.89
1981	315.5	17.6	25.9	14.1	159,676	8.3	50.0	12.95
1982	367.1	16.3	29.4	13.5	174,736	9.4	49.9	14.67
1983	404.5	10.2	30.8	4.8	180,037	3.0	61.1	18.81

Source: Derived from The Director General of Insurance Report, 1984 p.47–48.

*Estimate based on Annual Premium and Forfeiture Rate

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