The Insurance Industry in Fiji: CONSUMER PROTECTION ISSUES

A Report by
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1 Introduction

The Insurance industry in Fiji has remained in focus for many years. Consumers of insurance products have continued to raise their concerns at the industry. Policy makers have also occasionally looked at the industry. To date, however, other than for the occasional pronouncements by court judges on aspects of insurance product brought before them in litigations, there has been neither any published work on the industry in Fiji, nor any detailed examination of the functioning of the industry. Even the industry regulator has not published any analysis of the industry other than for annual reports containing aggregate statistics.

The Consumer Council of Fiji, which has been the only national voice of consumers in Fiji since its establishment in 1976, has consistently been receiving complaints from consumers of insurance products. In 2006, the Council decided that there was a need for an independent study of the consumer protection aspects of the industry. The fact that the industry comprises a vital set of economic institutions in the country provided another reason for an examination of the industry.

This report carries the results of a study on the insurance industry in Fiji, focusing particularly on consumer protection. The study examined the following aspects of the industry:

a) The current legislations that govern the operations of insurance policies in Fiji;

b) Current policies, terms and conditions of each package provided by various insurance companies in life, health, travel, third party, vehicle, home content and housing insurance.

c) Examination of whether these policies are in line with the Consumer Protection Laws of Fiji.

d) Problems faced by the consumers of insurance products, including consumers for overseas medical evacuation, pharmaceuticals, and different medical tests.

e) Aspects for which consumers do not get any cover when they purchase different types of covers for life, health, travel, third party, vehicle, home content and housing insurance.

f) Policy changes that are required in insurance legislation to safeguard consumer interests.
The study commenced in October 2006. However, the major hurdle faced by the researchers was the lack of cooperation from the insurance providers in providing the necessary data/information to complete an objective study. Insurance companies even resisted providing copies of the policies of the various products they sold. No insurance company had all their policies readily accessible. Research officers who personally visited the various insurance company offices to acquire copies of policies were sent away with sales brochures on the products they sold. It was only through a final intervention of the Consumer Council in late January 2007 that the insurance companies responded. Though not all policies were supplied, this intervention resulted in enough policies supplied to enable the completion of this report.

It ought to be noted that this report concerns issues of consumer protection. As such, the report focuses on problem areas within the industry. That the industry continues to function and grow indicates that insurance consumers continue to provide adequate business to insurance companies; this is on account of various factors, including full satisfaction with the insurance products, lack of options in a concentrated market, and compulsion (for example comprehensive third party insurance, or property insurance as a condition of property loans). However, this provides no indication that the industry is characterized by all or most of the features of industry transparency and good governance. This report, therefore, aims to look at areas that need to be strengthened for better consumer protection and industry transparency.

It should also be noted that this report has benefited from comments from insurance providers and the industry regulator. First, results from the study were represented at a panel discussion in March 2007 where both, the regulator and the industry representatives were invited to participate. The regulator refused to participate in the discussion, but the Insurance Industry Council was present; the latter provided some useful comments on the draft summary. Second, a draft of the full report was sent to all insurance companies and to the regulator in May 2007. While it was a frustrating wait to get responses from the companies as well as the regulator, some companies did respond. The regulator responded three months later, stating that it reserved the right to further response after it sought clarifications from its legal advisor. While the latter did not materialise, the detailed comments to the report were useful in seeing the matter from the regulator’s perspective. In October, however, the regulator wrote to the Consumer Council stating the following:

1 Comments received from the RBF are cited in this report as RBF (2007).
We did indicate in our preliminary response that the Reserve Bank was seeking legal advice in certain areas of the report before reverting with our final comments. The Reserve Bank of Fiji, however, has decided at this stage not to pursue this matter further and accordingly we await your final report. We wish to emphasize that if there are any legal consequences arising from the publication of the Report, the Reserve Bank takes no responsibility for the same.

The letter also stated that the contents of the report ‘could prompt legal challenges against the Consumer Council and the authors of this report’. A similar letter was earlier written to the Consumer Council by one insurance provider.

In response to these positions, the authors undertook thorough re-examination of the report and the resources utilized for the report. The results were then discussed at a meeting called by the Consumer Council of Fiji in late October to which all providers of insurance services as well as the regulator were invited. This final consultation meeting with the stakeholders as very productive as a free exchange of views took place on the contents of the report.

Thus, while the report was initially completed in May 2007, much of 2007 was spent in getting responses from insurance providers and the regulator. The final report has benefited from both written and oral comments by these stakeholders. Needless to state, the responsibility for the contents of the reports lies with the authors of the report.
2

Insurance Providers

2.1 Providers

The insurance industry in Fiji comprises insurance providers, brokers, and agents. Table 2.1 shows the following features of the industry:

- There are 2 life insurers, 8 general insurers, 5 brokers, and 314 registered/licensed insurance agents in Fiji.
- Only 1 out of the 10 insurance companies is owned by Fiji citizens, while only 1 of the 5 brokers are Fiji owned. One insurance company and one broker are partly owned by Fiji citizens. In total, then, only 2 out of the 15 insurance providers and brokers (i.e. 13%) are totally Fiji owned businesses.
- There were 314 insurance agents in 2005; all these were Fiji citizens or Fiji owned.

<table>
<thead>
<tr>
<th>Category/Company</th>
<th>Incorporated in</th>
<th>Ownership</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Life</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colonial Fiji Life Limited</td>
<td>Fiji</td>
<td>Australia</td>
</tr>
<tr>
<td>Life insurance Corporation of India</td>
<td>India</td>
<td>India</td>
</tr>
<tr>
<td><strong>General Insurers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colonial Health Care (Fiji) Limited</td>
<td>Fiji</td>
<td>Australia</td>
</tr>
<tr>
<td>Dominion Insurance Company Limited</td>
<td>Fiji</td>
<td>Fiji</td>
</tr>
<tr>
<td>FAI Insurance (Fiji) Limited</td>
<td>Fiji</td>
<td>Australia</td>
</tr>
<tr>
<td>Fiji Care Insurance Company Limited</td>
<td>Fiji</td>
<td>Australia</td>
</tr>
<tr>
<td>New India Assurance Company Limited</td>
<td>India</td>
<td>India</td>
</tr>
<tr>
<td>Sun Insurance Company Limited</td>
<td>Fiji</td>
<td>Fiji</td>
</tr>
<tr>
<td>QBE Insurance (Fiji) Limited</td>
<td>Fiji</td>
<td>Australia</td>
</tr>
<tr>
<td>Tower Insurance (Fiji) Limited</td>
<td>Fiji</td>
<td>New Zealand</td>
</tr>
<tr>
<td><strong>Brokers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aon Risk Services (Fiji) Limited</td>
<td>Fiji</td>
<td>Australia</td>
</tr>
<tr>
<td>Marsh Limited</td>
<td>Fiji</td>
<td>New Zealand</td>
</tr>
<tr>
<td>Unity Insurance Brokers (Fiji) Limited</td>
<td>Fiji</td>
<td>Fiji</td>
</tr>
<tr>
<td>Connolly Insurance (Fiji) Limited</td>
<td>Fiji</td>
<td>New Zealand</td>
</tr>
<tr>
<td>Insurance Holdings (Fiji) Limited</td>
<td>Fiji</td>
<td>Fiji</td>
</tr>
<tr>
<td><strong>Agents</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>314 Registered Agents</td>
<td></td>
<td></td>
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</tbody>
</table>

(Source: RBF, Insurance Annual Report, 2005)
Table 2.2 shows the number of insurance companies operating in Fiji between 1972 and 2006.

<table>
<thead>
<tr>
<th>Year</th>
<th>No of Insurance Companies</th>
<th>No of Brokers</th>
<th>No of Agents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Life</td>
<td>General</td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td>2</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>2005</td>
<td>2</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>2004</td>
<td>2</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>2003</td>
<td>2</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>2002</td>
<td>2</td>
<td>8</td>
<td>4</td>
</tr>
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<td>6</td>
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<td>3</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>1978</td>
<td>5</td>
<td>9</td>
<td>Na</td>
</tr>
<tr>
<td>1972</td>
<td>6</td>
<td>18</td>
<td>Na</td>
</tr>
</tbody>
</table>

(Source: RBF (various years), Commissioner of Insurance (various years) and Bureau of Statistics (various years) Insurance Industry Annual Reports.)

In 1972, there were 36 licensed insurance companies, of which 24 operated the designated business. As Table 2.2 shows, the number of companies operating in Fiji declined from 24 in 1972 to 10 in 2006.

One likely reason for the decline in the number of insurance companies was the enactment of the Insurance Act in 1976. This, for the first time, provided a comprehensive regulatory framework for the insurance industry. The legislation placed numerous obligations on the insurance companies. Companies that found themselves unable to operate under this Act exited the industry.
2.2 Key Financial Data

Table 2.3 provides the financial data for the industry in the country. It shows the growth in total premium income for life and general insurance from 1990 to 2005 as well as insurance industry profitability. Figure 2.1 depicts the trend in the growth of insurance premium.

### Table 2.3: Key Financial Statistics, 1990-2005

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Premium Income ($m)</th>
<th>Assets ($m)</th>
<th>Operating Profit : General Insurance ($m)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Life</td>
<td>General</td>
<td>Total</td>
</tr>
<tr>
<td>1990</td>
<td>24.8</td>
<td>28.5</td>
<td>53.3</td>
</tr>
<tr>
<td>1991</td>
<td>32.1</td>
<td>36.8</td>
<td>68.9</td>
</tr>
<tr>
<td>1992</td>
<td>31.6</td>
<td>36.2</td>
<td>67.8</td>
</tr>
<tr>
<td>1993</td>
<td>37.3</td>
<td>42.8</td>
<td>80.1</td>
</tr>
<tr>
<td>1994</td>
<td>41.9</td>
<td>48.1</td>
<td>90.0</td>
</tr>
<tr>
<td>1995</td>
<td>50.4</td>
<td>51.3</td>
<td>101.7</td>
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<tr>
<td>1996</td>
<td>53.2</td>
<td>48.6</td>
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<td>56.3</td>
<td>59.0</td>
<td>115.3</td>
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<td>59.8</td>
<td>58.2</td>
<td>118.0</td>
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<td>2000</td>
<td>60.0</td>
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<td>2001</td>
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<td>66.7</td>
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<td>70.5</td>
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<tr>
<td>2004</td>
<td>74.2</td>
<td>109.6</td>
<td>183.8</td>
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</table>

(Source: RBF (various years), Commissioner of Insurance (various years) Insurance Industry Annual Reports.)

2.3 Products

Insurance companies provide a variety of products as indicated in Table 2.4. What is evident from the table is that 5 of the companies insure against loss or damage to assets in general, 5 offer travel insurance, 4 offer health insurance, and only 2 offer life insurance.

These numbers ought to be placed in the context of the size of the economy to discuss the degree of competition in the provision of the various products.
### Table 2.4: Insurance Products

<table>
<thead>
<tr>
<th>Product</th>
<th>Colonial</th>
<th>Dominion</th>
<th>Fijicare</th>
<th>LICI</th>
<th>New India</th>
<th>Sun</th>
<th>QBE</th>
<th>Tower</th>
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<tbody>
<tr>
<td>Burglary</td>
<td>✓</td>
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<tr>
<td>C. Third Party</td>
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<tr>
<td>Fidelity</td>
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<td>Fire</td>
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<td>House</td>
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<td>✓</td>
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<td>Loss of Profit</td>
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<td>✓</td>
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<tr>
<td>Machinery</td>
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<tr>
<td>Marine Cargo</td>
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<td></td>
<td></td>
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<tr>
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<td>Natural Disasters</td>
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<td>Product Liability</td>
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</tr>
</tbody>
</table>
2.4 Competition

Market failure and deadweight loss can accrue to consumers if firms engage in uncompetitive behaviour. Regulators must promote contestable and competitive market behaviour. It is often mentioned that movements away from contestable and competitive outcomes arise from collusive behaviour among firms. What is seldom mentioned is the fact that movements away from competition may arise through deliberate product differentiation, and/or through deliberate attempts to mystify the consumer through the withholding of full information until the transaction is completed. As discussed in this report, the insurance industry in Fiji engages in these kinds of activities. It is common knowledge that if the same kind of insurance policy is taken (health, life, motor vehicle, burglary, etc), the product provided by different insurance companies differ. Insurance companies also do not make their actual policies easily accessible to the public. These activities effectively thwart any movement towards competition and generate both over-priced products and under-proved services.

A comparison of the policies issued by individual insurance companies reveals that there is a significant degree of product differentiation. One example, for instance, is a vehicle insurance policy that covers for damages to the windscreen; while numerous policies may cover for this, they may have different amounts covered or have different conditions attached (for example, excess fee). Similar differences apply to all policy products offered by different companies. Product differentiation is a factor that reduces the degree of competition amongst insurance companies.

One evidence of collaborative action of insurance companies – bordering on cartel type behaviour – is the treatment given to the proposed code of conduct for the insurance industry. The industry, through the Insurance Council of Fiji, rejected the code of conduct drafted, pursuant to the legal requirements, by the Reserve Bank of Fiji in 2001. The consequence is that to date there is no formal code of conduct in the industry. Another example of anti-competitive behaviour, is the collective rejection of the RBF’s proposal to establish an external complaints committee to handle insurance industry disputes.

While anti-competitive behaviour in the industry is significant, the industry as a whole competes with other industries to get a larger share of the consumer dollar. Such competition is extremely high in the country. Figure 2.2 shows that there is only a marginal growth in the ratio of gross insurance premium to national income in Fiji. Any growth that was there during the past decade, was in the general insurance business rather than
in life insurance business. Life insurance performance improved during the early 1990’s, but thereafter began declining. This is understandable since Fiji is a small economy with a relatively low per capita income, a high degree of income disparity and a generally non-growing economy. Some likely explanations for the relative stagnation of life insurance could be rising individual FNPF balances, low population growth rate, restrictive insurance premiums, and rising life expectancy rates.

The degree of competition in the industry, however, can only be estimated by examining market concentration in the industry. For this, the market share of each firm needs to be estimated.

Market share of insurance companies, so far, has been difficult to estimate. This is for the reason that other than for one insurance company that is listed on the stock exchange in Fiji, no company makes its annual reports accessible to the public. Most companies also produce consolidated annual reports of operations around the Pacific region, thus making it difficult to estimate the market shares of the various companies with accuracy.

The only publicly available information is the claim by the Colonial
Fiji Life Limited that it has 70% of the life insurance business (http://www.colonial.com.fj/corp/today.htm). This would leave the other life insurance provider – LICI – a market share of 30%. The LICI, however, has not confirmed that its share is 30%. The regulator has also not commented on calls to verify this figure.

For the general insurance business, in the absence of firm data, employment in each firm can provide a proxy for the market shares; the caution, of course, is that increasingly the insurance companies have been relying on insurance agents to act on their behalf. The Reserve Bank of Fiji does not publish agency by insurance companies, though this information is collected by them. The Reserve Bank of Fiji does not provide any information on employment by companies as well.

For greater transparency of the industry, there is an urgent need for an amendment to the Insurance Act to require insurance companies to provide key disclosure statistics publicly. While the Reserve Bank provides some aggregate data in the insurance industry annual reports, individual company disclosures are not publicly available; nor is there any provision in the legislation which requires that such disclosure be made. Without public’s access to this, there can not be adequate public interest generated in ensuring that the consumers in the country receive the best and most efficient insurance services. This is also particularly important in light of the fact that only 2 of the 10 insurance companies are locally owned. It is also important to dispel, or otherwise, the widely held view that insurance companies operate as a cartel and, therefore, short-change consumers.

It is conceivable that the Reserve Bank of Fiji could have encouraged the insurance companies to voluntarily publish key statistics. The Reserve Bank, as the legally empowered regulator of the industry has to date not proposed the publication of key disclosure statistics by the insurance companies, either on a voluntary basis or through legislative amendments. This is indicative of the lack of the Bank’s focus on increasing financial transparency in the economy, which is a key foundation of the international financial institutions’ declared objective of improving financial transparency and economic governance.

Another facet of disclosure that is necessary is that related to consumer protection. Insurance policies must be made readily available to the public. So should reports of adverse practices by insurance companies; this responsibility falls in the RBF’s territory.
2.5 Insurance Agents

Insurance sales have traditionally been dominated by insurance agents. Figure 2.3 shows the trends in the employment of insurance agents from 1980 to 2005. There had been a rising number of insurance agents employed by insurance companies from the late 1980’s to the late 1990’s. From 1999 to 2003, there was a marked decline in the number of insurance agents, but the trend picked up again after 2003.

Commission paid to insurance agents is a better indicator of the significance of insurance agents. Insurance agency commission is a relatively significant sum in Fiji. Figures 2.4 and 2.5 show the commission expenses for general and life insurances. The marked increases in commission payments since around 2001, the year when gross premium incomes began to rise, stands out clearly.

The new competitive strategy of the industry was to stimulate competition amongst insurance agents. The consequence has been that the ratio of commissions to net premiums in the general insurance business has, as Figure 2.5 shows, a marked upward trend in the country (from around 8% in the 1990’s to 13% in 2005). A similar trend is noticeable for the life insurance business.

The reliance on insurance agents, therefore, increased significantly over the years. This also increased the gross commission of the insurance
agents, as well as the gross premium incomes for the insurance providers. Figure 2.5 shows the trend in the gross commission incomes of insurance agents.
2.6 Consumer Protection in Free Markets

The global trend in consumer protection is to follow a markets based approach as opposed to an interventionist approach in managing industry. The rationale behind this is that markets are able to provide outcomes that safeguard the interests of both consumers and providers of financial services. But it is also recognized that there are limits to the ability of markets to provide sufficient protection to consumers. Safety nets to correct market failures are needed to adequately protect consumers. The trend towards market based and market sensitive consumer protection regulations does not invalidate the need for basic consumer protection legislation and specific consumer protection institutions.

It is widely accepted that consumers of financial services face a variety of risks:

- **Prudential risk**: If a financial institution like an insurance company collapses, the consumer (insured) can lose all or part of his/her contribution. This is less of a problem in Fiji since a majority of insurance companies are multinationals.

- **Misconduct risk**: These arise from fraud, misinformation, misrepresentation, and the like. As the discussion in the following chapters show, this is a major problem area in Fiji. The view that since almost all insurance companies and other financial institutions in Fiji are foreign owned and can, therefore, be bailed out in the event of a collapse of the Fiji operations, needs to be taken with caution, since most of these companies are incorporated in Fiji without necessarily obliging the parent company to take responsibility for their liabilities in Fiji.

- **Complexity or unsuitability risk**: Due to the increasing complexity of insurance products, consumers may face difficulties understanding the product they are purchasing or be unable to match the products offered with their specific requirements.

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2 Poor financial management has been blamed for the financial collapse of Enron, World Com, Global Crossing, Adelphia and Tyco in the United States. Mismanagement has also been the cause of the collapse of Australian financial businesses HIH Insurance Limited, Estate Mortgage, Pyramid, Fincorp, Westpoint and more recently Australian Capital Reserve. These collapses underscore the need for prudential regulation of financial institutions to prevent consumers losing billions of dollars.
- **Performance risk**: changes in market circumstances may render a particular insurance product unable to provide the expected insurance coverage to the insured.

- **Market power risk**: markets where industry power is concentrated create pricing structures that are sub-optimal. This tends to result in not only prices that are higher than the marginal cost of providing the good/service, but also in a lower quantity and quality of good/service. This is a particularly significant risk in small economies, normally calling for state intervention through pricing and quantity/quality regulations.

- **Self-regulation risk**: many a time insurance industry bodies take the task of regulating the industry with benefits accruing to the consumer. The Australian and New Zealand Institute of Insurance and Finance and the Insurance Council of Australia, for example, perform this function in New Zealand and Australia, respectively. But there is a risk that such initiatives may fail to the detriment of consumers. Government regulation and NGO initiatives can provide a safety net for consumers.

- **Access to redress risk**: Insurance companies can collapse as witnessed in the collapse of HIH Insurance Limited in Australia in early 2000. Policyholders stand to lose all or part of their contributions in such cases. To remove this risk from consumers some avenues for redress need to be provided.

- **Sophistication and self-reliance**: In a market-oriented economy, increasing responsibility is placed on the consumer for their financial security. But a large proportion of consumers lack the sophistication or the time to make the right decisions that meet their objectives.

Market failure and the risks noted above arise from poor financial management of institutions, deliberate anti-competitive behaviour, misconduct, information asymmetry and certain peculiarities of consumer behaviour.

The presence of risks necessitate the enactment of comprehensive consumer protection legislation, and where such legislation is present, a diligent enforcement of the provisions of the legislation.
3 Industry Performance

3.1 Underwriting Surplus

Industry performance in terms of profitability has been sufficiently good to maintain two life and eight general insurance companies in the industry. This number has not changed since 1996. The continuing presence of this number of firms in the industry indicates that the industry is generating a sufficiently good return.

One important indicator of industry performance is underwriting surplus. This is the difference between the premium incomes on the one hand, and the expenses involved in earning the premium income and the losses paid out during the period, on the other.

Table 3.1, based on official statistics, shows that while the industry in general did not do too well between 1994 and 2000, its underwriting surplus ratio showed a steady increase from 2000 to 2005 when it reached a peak of 31%. Every major insurance category showed improving performance except for fire insurance; for fire insurance, the performance was mixed.

An examination of the losses paid out, given in Table 3.2, shows that there has been a steady decline in losses paid out relative to premium income from approximately 80% in 1999 to 50% in 2005. Householders insurance, personal accident, public liability, and workmen’s compensation did particularly well during this period.

Expense ratio, defined as the ratio of expenses incurred (in earning the premium) to total premium earned during the period, as shown in Table 3.3, showed a steady decline from around 34% in 1998 to about 20% in 2005. All categories of insurance, except medical and term life, showed declines.

Expenses involved in earning a premium are decomposed (as a Reserve Bank of Fiji requirement) into commission expense and acquisition expense. Commission expense is expenses involved in terms of payments of commission and fees to insurance intermediaries. For each of the past five years, there is a figure for acquisition expense in the industry financial reports.
Table 3.1: Underwriting Surplus Ratio: General Insurance

<table>
<thead>
<tr>
<th>Year</th>
<th>Fire</th>
<th>House-holders</th>
<th>Motor Vehicle</th>
<th>Marine Hull</th>
<th>Marine Cargo</th>
<th>Burglary</th>
<th>CTP</th>
<th>Personal Accident</th>
<th>Prof. Indemn.</th>
<th>Public Liability</th>
<th>Workm. Comp.</th>
<th>Medical</th>
<th>Term Life</th>
<th>Others</th>
<th>Total</th>
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Underwriting Surplus Ratio is the ratio of underwriting surplus to net premium.
(Date Source: RBF (various years))
### Table 3.2: Loss Ratio

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Date Source: RBF (Various years)
### Table 3.3: Expense Ratio – General Insurance

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<th>Year</th>
<th>Fire</th>
<th>House Holders</th>
<th>Motor Vehicle</th>
<th>Marine Hull</th>
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<td>24.5</td>
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<td>41.6</td>
<td>30.3</td>
<td>21.3</td>
<td>18.1</td>
<td>17</td>
<td>23.5</td>
<td>7.4</td>
<td>18.4</td>
<td>23.7</td>
<td>29.8</td>
<td>21.9</td>
<td>20.7</td>
<td>30.1</td>
<td>26</td>
</tr>
<tr>
<td>2000</td>
<td>35.3</td>
<td>32.9</td>
<td>19.3</td>
<td>19.5</td>
<td>18.6</td>
<td>21.9</td>
<td>10.3</td>
<td>21.5</td>
<td>43.7</td>
<td>23.7</td>
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<td>8.9</td>
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<td>1999</td>
<td>27.1</td>
<td>28</td>
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<td>17.7</td>
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<td>18.1</td>
<td>24.1</td>
</tr>
<tr>
<td>1998</td>
<td>48.5</td>
<td>37.1</td>
<td>33.1</td>
<td>50.9</td>
<td>31.9</td>
<td>32.6</td>
<td>23.3</td>
<td>37.4</td>
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<td>39.4</td>
<td>33.2</td>
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<td>26.9</td>
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<tr>
<td>1997</td>
<td>44.6</td>
<td>36.9</td>
<td>31.2</td>
<td>41.4</td>
<td>30.8</td>
<td>31.6</td>
<td>21.2</td>
<td>38.7</td>
<td>na</td>
<td>41</td>
<td>32.7</td>
<td>na</td>
<td>na</td>
<td>20.4</td>
</tr>
<tr>
<td>1996</td>
<td>44.6</td>
<td>37.8</td>
<td>29.7</td>
<td>49.3</td>
<td>29.8</td>
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<td>22.1</td>
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<td>na</td>
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<td>15.3</td>
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<tr>
<td>1995</td>
<td>41.3</td>
<td>30.3</td>
<td>28.8</td>
<td>19.3</td>
<td>24.6</td>
<td>26.6</td>
<td>20.6</td>
<td>29.9</td>
<td>na</td>
<td>28.6</td>
<td>25.7</td>
<td>na</td>
<td>na</td>
<td>26.1</td>
</tr>
<tr>
<td>1994</td>
<td>33</td>
<td>33</td>
<td>24.7</td>
<td>35.5</td>
<td>22.3</td>
<td>24.8</td>
<td>19.4</td>
<td>22.1</td>
<td>na</td>
<td>31.3</td>
<td>27.2</td>
<td>na</td>
<td>na</td>
<td>27.2</td>
</tr>
</tbody>
</table>

Date Source: RBF (Various years)
Acquisition expense refers to all acquisition costs other than commission, brokerage and similar charges paid or payable by the insurer, for example, selling and underwriting costs (like advertising and risk assessment), administrative costs of recording policy information, and premium collection costs (RBF Insurance Returns Manual, p. 23).

There, however, is another item, much larger than the acquisition expense, called ‘Expenses not included in Return 6G’. These items are not defined. Table 3.4 provides these figures for 1994-2005.

<table>
<thead>
<tr>
<th>Table 3.4: Total Expenses – General Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commission</td>
</tr>
<tr>
<td>------------</td>
</tr>
<tr>
<td>1997</td>
</tr>
<tr>
<td>1998</td>
</tr>
<tr>
<td>1999</td>
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<td>2000</td>
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<tr>
<td>2001</td>
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<tr>
<td>2002</td>
</tr>
<tr>
<td>2003</td>
</tr>
<tr>
<td>2004</td>
</tr>
<tr>
<td>2005</td>
</tr>
</tbody>
</table>

(Data Source: RBF (various years))

Annual insurance reports provide expenses for other years. However, the figures given for the two ‘overlapping years’ 1997 and 1998 do not tally. Expense figures for the years 1994 – 1998 are provided in Table 3.5. Figures in Table 3.4 and 3.5 show that in the newer classification, the 1997 total expenses were higher by $1.3m while 1998 total expenses were higher by $0.9m. Net Commission expenses were also shown as a higher percentage of total expenses in the newer reports. The discrepancies have not been explained by the regulator.

<table>
<thead>
<tr>
<th>Table 3.5: Expense Ratios, 1994-1998</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commission</td>
</tr>
<tr>
<td>------------</td>
</tr>
<tr>
<td>1994</td>
</tr>
<tr>
<td>1995</td>
</tr>
<tr>
<td>1996</td>
</tr>
<tr>
<td>1997</td>
</tr>
<tr>
<td>1998</td>
</tr>
</tbody>
</table>

(Data Source: RBF (various years))
The discrepancies notwithstanding, the tables show that commission expenses of earning industry premium for general insurance business as a proportion of total general insurance business declined by over a half from a peak of around 52% in 1994 to 25% by 1998, after which it again began to rise to reach 43% by 2005.

Commission expenses are in effect the cost of earning the insurance business. Other expenses are incurred to maintain and service the business earned by agents. Table 3.4 also shows that during 2001-05, while the cost of earning the business was around 40%, approximately 60% of all general insurance expenses were incurred in managing the businesses acquired. Detailed decomposition of management expenses ceased to appear as public information since the Reserve Bank took over compiling insurance statistics from the Bureau of Statistics; prior to this, management expenses were divided into salary expenses and other expenses.

The expenditure items not included in ‘Return 6G’ is 38% of total expenditure in the general insurance industry. This is a massive component. Return 6G requires the insurance companies to provide information listed in Table 3.6

The list is exhaustive. Given this, the content of the expenditure not included in the return for expenses needs to be ascertained. There is no explanatory note by the RBF on this in the annual reports. The question is: what are the expenses that are not included in Return 6G, given that Return 6G is an exhaustive list of all expenses of the industry?

Clarification from the RBF on this item indicated that possibly this item is wrongly specified, where instead of ‘Expenses not included in Return 6G’, it should read ‘Expenses included in Return 6G’. But this explanation is also not satisfactory, as if it were so, then there would be expenditure double-counting. This reporting format has been maintained by the RBF since the new reporting format was introduced in 1999. A lack of clarity on this term indicates a lack of any serious attention given in the RBF to the insurance industry reporting and its subsequent dissemination to the public.

In response to the discussion above, the Reserve Bank of Fiji provided written explanation through which it has modified its explanations and states that the item ‘Expenses not included in Return 6G’ appearing in the industry annual reports from 1998 to 2005, should rightfully have read ‘Expenses not included in Return 6A’. This explanation also leaves one key point made here intact - that for all the years from 1998 to 2005, the RBF provided incorrect information in the industry annual reports. This shows gross negligence on the part of the industry regulator in producing and disseminating industry information to the public.
Table 3.6: Expenses Included in Return 6G

<table>
<thead>
<tr>
<th>Particulars</th>
<th>Inside Fiji</th>
<th>Outside Fiji</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head office charges</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related body charges</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and Wages</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commissions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management fees</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FNPF</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Employee Costs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Directors’ fees</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expenses on accounting services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expenses on Advertising</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expenses on Auditing Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expenses on Computing Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expenses on Consultancy Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expenses on Donations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expenses on Doubtful Debts</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Expenses on Entertainment</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Expenses on Insurance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expenses on Interest Expense</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Expenses on Motor Vehicle Expense</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Expenses on Printing and Stationery</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Repairs and Maintenance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expenses on Rent and Rates</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expenses on Travel and Accommodation</td>
<td></td>
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<td></td>
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<tr>
<td>Depreciation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Expenses (attach details)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SUB TOTAL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Expense Allocation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Underwriting Expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management/Administration Expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Allocated</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Given, however, that the regulator corrected the error in response to this report, the issue is: what are the expenses that are not included in Return 6A. The ‘Expenses Return Manual’ produced by the RBF defines the items included in Return 6A as commission expenses and acquisition expenses. What, therefore, is left is ‘management/administrative expenses’.  

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3 The RBF’s Expenses Return Manual makes circular references to this item. This item appears in Return 6B, Row 8, which is described in the Returns Manual as ‘Management and administrative expenses as reported in Form 6G … Row 29’. Form 6G, row 29 is described in the Manual as: ‘As reported in Form 6B, Row 8’. Thus, the
If, therefore, the expenses not included in Return 6A are management and administrative expenses, the question becomes: in drawing the profit and loss account of general insurance business in Fiji, why does the regulator use the terminology ‘expenses not included in return 6A’ instead of the more simpler and well-accepted term ‘management and administrative expenses’?

Could it be that the regulator does not intend to show that the management and administrative expenses of the general insurance business in Fiji is over 35% of all expenses on average? This becomes a more serious matter given the fact that another expense item – ‘acquisition expense’ – includes items like ‘administrative costs of recording policy information and premium collection costs’. The definitions of ‘acquisition expenses’ and what appear as ‘management and administrative expenses’ indicate serious possibility of double counting of administrative expenses.

Whether, however, there is actual double counting in the annual reports, can only be ascertained by examining the annual reports of each general insurance company. These reports are not publicly available except for one company that is listed on the stock exchange.

This is another reason that makes full company financial disclosure essential if one were to more fully understand the insurance industry in the country. In the absence of such disclosure, the continuing negative image of the insurance industry amongst consumers in the country, would persist. This would not be conducive to the growth of the industry itself. Nor would it bring greater confidence of the consumers in the regulator of the industry.

### 3.2 Profit Trends

Profit figures for general insurance in Fiji have been compiled by the Reserve Bank of Fiji. Table 3.7 shows operating profit for general insurance from 1996 to 2005. The relatively low rates in the late 1990’s and the sharp increase after 2003 stand out.

It should, however, be noted that these rates are those that relate to the insurance companies’ operations in Fiji as declared by the companies to the RBF. While the figures are presumed to come from audited financial statements, it is not clear whether the RBF has at any stage examined whether there is any element of cost, price, activity, etc., transfer shown manual does not provide, and the insurance returns do not ask for, the breakdown of the management and administrative expenses in addition to all the expenses that are included in the statement of insurance acquisition expenses.
Fiji’s operations from a company’s other operations. When regulating the operations of multi-national corporations, it is vital that regulatory authorities examine possibilities of ‘transfer pricing’ before this is ruled out.

What is also necessary is for the industry to publish key disclosure statistics annually. When determining ‘key statistics’, the regulatory authority should aim to include best indicators that could be used to detect transfer pricing by operators in Fiji.

The predecessor to the Insurance Act 1998, (i.e. the Insurance Act 1976), had a clear provision (s50) that set maximum limits to what insurance companies could spend as management expense, including head office expenses. S50 of the 1976 legislation provided the regulator to prescribe limits to these. These limits were 40% of the net premium income for general and industrial life businesses, and 35% of the net premium for the ordinary life insurance business (s16, Insurance Regulations 1979). This provision compelled the regulator to be vigilant on detecting evidences of transfer pricing.

The 1998 Insurance Act, however, has no similar provision. This is a major problem that the Insurance Act 1998 has.

In response to this statement, the RBF stated: ‘This is not a problem and the basis of such expenses is based on what is prudent. For remittance of management and head office expenses, insurers are required to obtain RBF approval and the Bank carried out detailed analysis on all such expenses. In this regard, the non prescribed basis makes disclosure requirements more onerous for all amounts of remittances’. It should be noted that all remittance abroad, whether this be by individuals or by business houses, above prescribed limits need RBF approval. For business expense remittance abroad, the only requirement is documentary evidence of expenses involved. Multinational businesses raise invoices for services the head quarters provides to a subsidiary of a related company operating abroad. The RBF can not, legitimately, carry out detailed analysis of the invoiced amount. As such, the RBF justification is
3.3 Reinsurance and Retention

Insurance companies in Fiji have been transferring a part of the liability for risks that they accept, abroad through reinsurance. For life insurance, reinsurance is a very small proportion of the total premium income, averaging less than 2% per annum. Reinsurance is larger for general insurance. Figure 3.1 shows the retention ratios of premium paid in Fiji; this is defined as the ratio of gross premium net of reinsurance to gross premium. The figure shows that while there has been some fluctuations in premium retained, generally the trend in premium retention has been upward.

Reinsurance, in effect, transfers funds outside Fiji. But while the company loses some premium income, it also shares some risks with the reinsurance company. Over the past 15 years, such transfer of funds, and thus risks, was generally declining. Notable exceptions, however, continue to be fire insurance and marine hull insurance, where retention ratios have historically been less than 50%.

![Fig 3.1: Retention Ratio, General Insurance](image)

Date Source: RBF (Various years)
4
Laws, Regulations, and Consumer Protection

4.1 The Insurance Act 1998 and Consumer Protection

Fiji’s insurance industry is regulated by the Insurance Act, 1998. Prior to this, the industry was regulated by the Insurance Act 1976. The 1976 legislation was a consolidated legislation regulating general insurance, life insurance and insurance agents and brokers. Prior to this, there were 3 separate pieces of legislation - the Assurance Companies Ordinance (Cap 188), the Life Assurance Ordinance (Cap 189) and the Insurance Agents and Brokers Act, 1972.

The Insurance Act 1998 incorporates, according to the Attorney General, most of the provisions of the earlier act though in modified and strengthened form, together with containing new provisions to correct deficiencies of the then existing legislation, and/or strengthening the supervisory provisions of the industry. A major addition to the then existing law was the addition of provisions protecting consumers.

Part III of the Act establishes numerous ground rules setting out the responsibilities and duties of insurance service providers. The Attorney General explained the logic behind the provisions on consumer protection:

The Part makes insurer responsible for much of the conduct of the industry, This assignment of responsibility is based on the premise that insurers are the industry members in the best position to be able to influence industry practice, and are also likely to be the best able to afford the negative financial consequences that may arise from any malpractice which takes place in the industry (Attorney General, 1998: 93).

The intention of the new law, therefore, was to place the burden of the conduct of the insurance industry on the insurance providers themselves. For an industry that is as significant as insurance industry for the economy, such self-regulation can not be a sufficient basis of law. As discussed in this chapter, the outcome of the law, and the conduct so far,
thus, has been one that not only has continued to neglect consumer interests and rights, but also whatever consumer protection provisions are present in it, have generally been ignored by the regulator in terms of enforcements. The conduct of the regulator continues to be one focused on prudential regulation alone. Since 1998, not a single annual report of the industry has contained any commentary on consumer or policy-holder rights and interests.

The section on consumer protection (Part III) contains 12 sections. These are analysed here.

4.2 Conduct of Employees and Agents

S4 makes insurers liable for the actions of their agents and employees, irrespective of whether an agent or employee acted within the scope of his authority. The liability extends for the actions of any person in the industry on which an insured could be reasonably expected to rely on, or on whom the insured in fact relied on in good faith.

Where a person is an agent of one insurer in respect of one class of insurance business, and is the agent of another insurer in respect of another class of insurance business, the responsibility for the agent etc, is limited to the respective insurer of the class of insurance. If a person is the agent of more than one insurer and the person engages in any conduct relating to a class of insurance business in which the person is not the agent of any of those insurers, the insurers are jointly and severally liable for that conduct, as between themselves and the insured, despite the fact that the agent acted outside the scope of the authority granted by any of the insurers. If a person (principal agent) is an agent of an insurer and the principal agent appoints a second person (a sub-agent) to act as agent of the principal agent, then for the purpose of determining the ultimate responsibility of the insurer under this section the actions of the sub-agent are regarded as the actions of the principal agent irrespective of whether the insurer and principal agent have an agreement which forbids the principal agent from appointing a sub-agent, or the sub-agent acted outside

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5 The RBF commented to this section of the report proposing that there are benefits of self-regulation. The benefits, however, have not been stated in either the response to the draft report, or in any of the annual reports. One insurance company has also specifically proposed that self-regulation has ‘by and large’ worked well. It states that except for the occasional rogue player, the industry acts ethically. As an example, it cites the case of granting ex-gratia payments to victims of the 2000 riots, despite the fact that insurance companies won the legal battle on liability in cases of riots.
the scope of his authority.

The responsibility of an insurer extends so as to make the insurer liable to an insured in respect of any loss or damage suffered by the insured as a result of the conduct of the agent or employee. These responsibilities do not affect any liability of an agent or employee of an insurer to an insured.

Insurance companies and/or agents can not contract out of these responsibilities.

These provisions not only place greater responsibility on insurance companies (called insurers) to select quality agents and employees and to train them, it also aims to reduce the problem of misinformation by overzealous and/or negligent employees and/or agents. Misinformation could be in the form of wrong advice, or incomplete advice, particularly on the rights and obligations of the respective parties.

4.3 Payments to Intermediaries

Section 5 maintains the provisions of the older act on premium payment. It provides that paying premium to a broker or an agent (insurance intermediary) who arranged or effected the insurance contract is as good as paying these directly to the insurer. Such payments effectively discharge the payment obligation of the insured (the consumer) to that sum. This protects consumers from unscrupulous agents who may not remit the payments to the insurance company, thereby causing a policy to lapse or be forfeited.

The Act (s5(3)) provides further protection of the consumer. It specifies that payment by an insurer to an insurance intermediary of moneys payable to an insured, whether in respect of a claim, return of premiums or otherwise, under or in relation to a contract of insurance, does not discharge any liability of the insurer to the insured in respect of those moneys. This liability is only discharged when the payment is received by the consumer. Any agreement to contract out of the provisions of s5 is void.

4.4 Duty of intermediary to explain proposal and policies

It is also a requirement of the Insurance Act (s6) that an intermediary must:

- provide a reasonable explanation to a person proposing to enter into or renew a contract of insurance, of the contents of all
documents required to be signed by the person;

- communicate to the insurer all information of which the intermediary was aware at any time before or during any negotiation for a contract of insurance or for renewal of insurance which is likely to affect the contract; and

- provide a reasonable explanation to an insured whose policy was placed or procured by or through the intermediary of the contents of that policy and particularly the extent of cover and exclusions contained in the policy.

The obligations imposed by this section are in addition to and do not lessen the liability of an intermediary under the provisions of any other law, whether written or unwritten.

At first look, the provisions of this section appear to protect the interests of the consumers. However, the clause is very vague; it uses the term ‘reasonable explanation’. This term is not explained in the Act. As such it opens up the significant possibility of the widest range of interpretations of the term. What may appear reasonable to one, may be clearly unreasonable to another. A contextual interpretation is often preferred for such vague terms. The clause requires an intermediary to provide reasonable explanation on ‘contents of that policy and particularly the extent of cover and exclusions contained in the policy’.

The root of a policy is the extent of cover and exclusions. These are contained in the policy itself. However, the fine prints are what matter.

There is no evidence that any insurance company provides the coverage and exclusions on any policy in simply written language to any consumer, actual or potential. There is also no evidence that the companies have produced such a document for education of their intermediaries or employees.

The Reserve Bank of Fiji, which is required by law to ensure that insurance consumers’ interests are protected, sees no problem with either the fine prints of insurance policies, or the language that is used. It states: there are some language that are technical and specific to insurance as are those specific to Economics or Medicine or any other field and to try and replace them with simple English words for better understanding could lead to the words themselves been [sic] misconstrued and misrepresented (RBF, 2007).

Insurance policies examined for this report were found not to contain any technical word unique only to the insurance industry that was not
amenable to plain English interpretation. In consultations with insurance companies, at least one insurance provider agreed that domestic insurance policies can be made simpler while they would prefer commercial policies to remain as they are. The claim by the RBF that policies contain technical words used specifically for the insurance industry that can not be reduced to simple language, may be indicative of a lack of scrutiny of insurance policies. If this were so, it would be in breach of the Insurance Act.

There is also no evidence that the Reserve Bank of Fiji is monitoring whether s6 of the Act is abided by. S6 required that it is a duty of the insurance intermediary to explain insurance proposals and policies to consumers.

The RBF accepts that it does not monitor whether the intermediaries abide by this provision of the law. Its justification is that any monitoring of this provision would ‘make it inconsistent with the implicit imposition of Section 4 of the Act’ (RBF, 2007). S4 of the Act states that insurance providers are responsible for the conduct of their agents and employees in respect to any representation they make to consumers. The RBF does not explain how its duty to monitor that the law is followed would be in conflict with a duty placed on the insurers for the conduct of insurance agents and employees.

Another weakness of this provision is that there is no strong enough deterrent against breach of this provision. S6(2) provides:

An intermediary who contravenes subsection (1) is liable to the insurer and to the person for whom the intermediary is acting for any loss resulting from the contravention.

The remedy, therefore, has to be sought by the consumer. Given the litigation processes in Fiji, and legal literacy, this clause is ineffective in preventing breach of the provisions of s6.

A better alternative would have been to specifically require the RBF to monitoring the provision, and initiate prosecution. Alternatively, the RBF could itself be empowered (as s168 of the Act does for breach of certain other sections of the Act) to issue penalties to companies that breach the Act; companies would have the normal recourse to the courts.

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6 The British Insurance Brokers’ Association provides consumer advice to those who secure services through the members of the body. It also has useful information for consumers on its website (http://www.biba.org.uk/consumer/consumernotes/notes.html). Fiji does not have any such body that consumers can rely on for advice. In this context, the role of the RBF in terms of providing correct interpretations of policies is crucial.
of law or the Minister to appeal against any RBF imposed penalty. Such powers, together with a sufficiently deterring penalties, would ensure that this provision of the law would not be breached.

The RBF, however, takes a totally hands-off attitude to the industry’s relationship with insurance consumers. It argues that insurance is provided under contract law, and as such the RBF, not being a party to the contract, ‘cannot initiate such prosecution’ (RBF, 2007). The problem with the RBF as a regulator is that it has not been able to secure credible legal advice on the Insurance Act and its role under it. The Insurance Act is an act of the Parliament. Any breach of an Act of Parliament is a crime. For breaches of the law, therefore, prosecution is necessary. In this context, the RBF is the institution that by law is required to ensure that the Insurance Act is not breached. As such, it is totally within its duty and responsibility to initiate criminal proceedings against those entities that breach the Act.

The problem, however, is the Act itself as it specifies no penalty for the breach of this section of the Act. Schedule A of the Act lists the sections for whose breach there are penalties. S6, which is the core of consumer protection, is not listed as one of the sections whose breach carries a penalty. If consumer protection is to be taken seriously, then this gap in the Act needs to be remedied by an appropriate amendment to Schedule A of the Insurance Act.

4.5 Premium Payments

S7 of the Act requires intermediaries to remit any money received by them from consumers/insured persons, as a premium or an installment of a premium, to the insurance company within a specified period. It also provides that if a premium or installment is not received by the intermediary within 35 days after the day on which the cover provided by the insurer under the contract commenced or the first day of the period to which the installment relates, the intermediary ‘must notify the insurer in writing, within 7 days of the end of the month in which the relevant period expired’ that the intermediary has not received the amount.

S7 of the Act is apparently in conflict with s4 of the Act. By s4, the insurer is responsible for the conduct of an insurance company’s employee or an insurance company’s agent. S7(2)(b), on the other hand, provides the legal right to the insurance company to not to accept a risk that the contract or proposed contract relates to. S7(2) states:
(2) If
(a) money is received by an intermediary from, or on behalf of, an insured as a premium or an installment in connection with a contract of insurance or a proposed contract of insurance, and
(b) the risk, or part of the risk, to which the contract or proposed contract relates is accepted by or on behalf of an insurer,
the intermediary must pay such money to the insurer within 30 days following receipt of the money by the intermediary (emphasis added).

The term ‘and’ technically empowers the insurance company to reject the risk on which an insurance agent may have accepted money from a consumer. While one may argue that an agent was acting on behalf of an insurance company in accepting the risk and in accepting the money for this risk, an equally strong argument could be made that it is ultimately the insurance company that will decide to accept or reject the risk. After all, it is the insurance company that offers the insurance policy, not the agent (or a broker).

Thus, while s4 states that insurance companies are bound by the undertakings of an insurance agent or intermediary, s7 empowers the insurance companies to reject a risk that an agent may have accepted on behalf of the consumer.

What this means, in effect, is that the consumer cannot be certain that what the agent proposes to the consumer, and what the consumer pays for, would be legally effective. Situations could arise where a consumer signs an insurance proposal, pays the applicable premium, and remains content that he/she is under cover. Yet, until the policy is received and duly signed, there is no coverage for the consumer. In Fiji, there have been cases, as discussed in the next section, of significant delays in consumers receiving policy documents. In some cases, insurance companies specify that there would be no coverage unless an insurance certificate was issued by the company.

The section also does not make any provision of refund of the ‘premium’ paid by a consumer to the insurer (through the intermediary) in case the insurance company does not accept the risk.

Thus, while this section of the Act seems to be pro-consumers, it can place consumers under substantial exposures. Consumer rights are not adequately protected by the proviso contained in s7(2)(b).\(^7\)

\(^7\) The RBF does not accept that there is a conflict between s7 and s4, saying s7 deals with transmission of premium from intermediaries to insurers and that s4 overrides
Finally, while this section places a time limit within which an agent is to pay an insurance company, there is no such time limit on when an insurance company is to pay consumer/policy holder in case of a claim. This is inequitable as settlement can be deliberately delayed by the insurance company for long periods of time.

4.6 Fees/Charges, and Receipts

S8 of the Insurance Act requires the insurance intermediary to, as soon as practicable after the contract is effected:

- give to the insured particulars in writing of any fees or other amounts charged by the intermediary in respect of his services in connection with the contract, if so requested by the insured, and
- inform the insured of the name of the insurer and of the place of business of the insurer.

A receipt for all moneys received by the intermediary from the insured in respect of the insurance contract is also to be provided.

It also provides that if the contract is of a group contract of insurance, it is sufficient for compliance with this section if the intermediary gives the required particulars in relation to the group of contracts rather than to individuals. While this section of the law does not prevent the intermediary from giving the details to the individual members of a group policy, it also does not require that they provide such details to individuals.

4.7 Disclosure by Brokers

A broker is a person who, as a representative of an insured, carries on the business of arranging contracts of insurance for or in expectation of payment by way of brokerage, commission, fee, allowance, return or otherwise. Under law, brokers are to be registered by the Reserve Bank of Fiji.

While brokers are representatives of consumers/insured, they could enter into ‘binder arrangements’. A binder is an authority given by an insurer to an insurance intermediary to enter into, as agent for the insurer, contracts of insurance on behalf of the insurer as insurer; or to deal with provisions of s7. This is a persuasive argument, as s7 requires intermediaries to remit premium received by them to the insurers with 30 days. But this is only so if the risk is accepted by the insurer. Thus there remains a conflicting legal provision, as this section empowers the insurers to not to accept risks.
and settle, as agent for the insurer, claims against the insurer as insurer. S9 of the Act allows a broker to enter into a binder arrangement with an insurer through which he would arrange an insurance contract as agent for an insurer. If he were to do so, then he must, before arranging the contract, notify the intending insurer in writing, and in the prescribed form, if any, that in arranging the contract the broker will be acting under an authority given by the insurer to do so, and he will be arranging the contract as agent of the insurer and not of the intending insured.

In like manner, if a broker intends to act under a binder in dealing with or settling a claim, he must, before dealing with or settling the claim on behalf of the insurer, first, seek written approval of the RBF, and second, notify the insured/consumer in writing, and in the prescribed form, if any, that in dealing with or settling the claim the broker will be acting under an authority given by the insurer to do so, and the broker will be dealing with or settling the claim as agent of the insurer and not of the insured.

While such disclosure is designed to protect the interests of the insured, there are two major problems with this.

First, the law refers to ‘prescribed form’. To date, there has been no form that has been prescribed for agents to fill. This leaves the format and content of the written notifications entirely at the discretion of the brokers. This also indicates that the Reserve Bank has not been able to adequately supervise this aspect of the operation of the insurance market.

The second problem is that traditionally insurance brokers are regarded as working on behalf of the consumers/insureds. A binder agreement introduced in an insurance transaction suddenly could leave the consumer exposed and without the services of a broker. There is nothing in the Act that prevents a broker working on behalf of a particular insured, entering into a binder arrangement relating to a transaction with the same insured. This would possibly expose the insured to less than optimal broker service specifically, and more generally to a loss of confidence of consumers in brokers.

Another related issue concerns the remuneration of brokers. In Fiji, brokers earn both, a commission from the insurance companies as well as

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8 The RBF states that it has not developed any form this for because ‘a binder agreement can take various forms’. It also states that the requirement the broker seek approval from the RBF prior to entering in to a binder agreement, is sufficient for the RBF to supervise the operations of brokers (RBF, 2007). The intent of the law, however, is also to ensure that the insured is adequately informed that his broker will be acting for the insurance company and not on his behalf. By seeking permission from the RBF to do this does not do anything to inform the consumer of this changed role.
fees charged to their clients. However, at the moment, the invoices that brokers provide to their customers only shows the charges the clients (insureds) have to pay, not the full charges for the insurance product they arrange for their clients. In some countries, it is a requirement that such invoices also disclose the broker’s charge to the client as well as the amount that they get as commission from insurance companies for the business they provide the insurance company, and the total premium that the client is to pay. This would ensure that the insured can compare the actual cost of his insurance cover with the cost of claims incurred. One insurance company in Fiji supports measures that would provide full disclosure of information pertaining to broker incomes for insurance clients.

4.8 Conflict of Interest

S10 of the Act restricts the forms of remuneration that an insurer may offer a broker. It also restricts the basis on which remuneration may be paid to a broker by an insurer. The provision does not allow a broker to receive from an insurer or from a person on behalf of an insurer, a gift, benefit or other reward (however described) except as remuneration for services rendered to the insurer in arranging or effecting a particular contract of insurance, or except in connection with dealing with or settling a claim under a particular contract of insurance. Similarly, an insurer must not pay to a broker, and a broker must not receive from an insurer, in respect of the arranging or effecting of contracts of insurance by that broker with the insurer, remuneration at a rate or on a basis that has been varied from the normal rate or basis, on account of the number of contracts so arranged or effected, or the total amount of premiums paid or payable under such contracts; or the total amount of sums insured under such contracts. The RBF states that ‘fees paid by the insurance companies are standardized with the broking community for the different types of insurances arranged’ (RBF, 2007). These rates are known to the RBF. They, however, are neither established with reference to any publicly known template, nor are they known by the insured or the consumers. Given that the RBF takes its primary responsibility as that of ensuring that the insurance companies remain financially sound, there is no guarantee that the rates are fair to the insured. After all, the burden of the rates are transferred to the consumers of the product.

The intention of this provision is to limit the motivation or incentives for the broker to act in the interests of another party (either the broker himself, or the insurer) rather than, or in addition to, the con-
sumer/insured.

While the provision appears to protect the interests of the consumers, there is nothing in the published reports on the Reserve Bank of Fiji that indicates that it monitors the industry for breach of this provision. A breach of this section attracts, on conviction, a fine of $10,000 and to an imprisonment of up to 6 months. The Reserve Bank, however, has no mechanism in place to monitor adherence of insurers and/or brokers to the requirements of this section.

The second problem is that by allowing for a payment by the insurance company to a broker to assist in settlement of an insurance claim, the prospect of conflict of interest does potentially arise, despite the provision of a binder agreement.

The Act requires that all agents and brokers be licensed by the Reserve Bank of Fiji. The insurance companies are required by the Act (s11) to not cause or permit a person to arrange, or hold himself out as entitled to arrange, a contract of insurance as agent for that insurer unless the person has been licensed as agent of the insurer for the class of insurance business in which that contract is included.

4.9 Licensing Requirements

The law requires that no person can commence or carry on the business of an agent or broker in the country without a license to do so issued by the Reserve Bank of Fiji (s14). The RBF considers the following factors when deciding on applications for a license (s43): whether

- the applicant (or company’s senior manager) has sufficient experience in and knowledge of insurance matters;
- the financial standing and general character of the applicant are sound;
- the directors and other persons concerned with the management of the applicant are fit and proper persons;
- the applicant has appropriate accounting and reporting systems in place;
- the applicant is, and is likely to continue to be, able to comply with applicable provisions of this Act;
- in the case of an application for a Brokers license or renewal, the applicant has in force a contract of professional indemnity insurance and a contract of fidelity guarantee insurance acceptable to the Reserve Bank;
- in the case of an application for an agents license or renewal, the
applicant has been appointed by the nominated insurer; and

- there is any public interest reason for not granting a license or renewal to the applicant.

It is also a requirement that a person must not be licensed to carry on business as agent for more than one insurer in respect of any one class of insurance business. If a person has been licensed to carry on business as an agent for more than one insurer, the person must notify forthwith to each insurer for which he is the agent, the name of all other insurers for which he is the agent of and the classes of insurance business that the person has been licensed to arrange for each insurer.

The Act (s43(4)) also disallows the licensing of a person to carry on a business as broker if that person, or any director or manager of that person, is a director, manager, employee or shareholder of an insurer. However, the Reserve Bank may grant an exemption from this requirement if it is satisfied that no prejudice will be occasioned to any insured by such exemption (s43(5)).

There are numerous other provisions in the Act to ensure financial viability and continuity of insurance companies and brokers.

**4.10 Industry Conduct**

S3 of the Insurance Act gives the Reserve Bank numerous responsibilities. It requires the Reserve Bank to administer the Insurance Act and to perform all the functions assigned to it by the Act. These functions include:

(a) the formulation of standards governing the conduct of insurance business and insurance broking business in the Fiji Islands;
(b) the superintendence of the conduct of agents, brokers and insurers in the Fiji Islands;
(c) advising the Minister with regard to all matters concerning insurance;
(d) recommending to the Minister regulations for the carrying out of Government policies relating to insurance;
(e) the approval of standard terms and conditions contained in policies of insurance;
(f) the determination, with the approval of the Minister, of the rates of insurance with respect to any class or classes of business; and
(g) such other functions relating to the supervision of Fiji insurance business, or business incidental to Fiji insurance business, as are assigned to it by the Minister.
These powers are wide and demand responsibility. Through these, the Reserve Bank is empowered to regulate all aspects of the industry, including ensuring consumer protection.

4.11 Standards of Conduct of Insurance Companies, Agents and Brokers

While the Act requires the Reserve Bank to formulate standards governing conduct of the insurance business, to date no such standard has been put in place. In 2001 the RBF developed such a code and sent it to the insurance providers and brokers to ‘make a decision on this issue’ (Insurance Annual Report, 2003: 15). In 2004, the industry rejected the code. The RBF states that both, insurers and brokers ‘indicated’ that they ‘have their internal code of conduct and ethical standards …. which in many respects are quite stringent in their requirements’ (Insurance Annual Report, 2004: 16). The RBF accepted this position. The outcome is that to date, there is no code of conduct regulating the conduct of insurance companies. The referred to ‘internal code of conduct and ethical standards’ is neither summarized in the insurance industry annual reports, nor available as a separate published document, either as hard copy or electronic copy.

Internal codes of conduct, or developing and/or issuing standards that are publicly unknown, are no substitutes of the legal requirement (s3, Insurance Act) that the RBF formulate ‘standards governing the conduct’ of insurance business. The RBF has remained negligent in this respect.

4.12 Ministerial Advise

As regulator of the industry, the Reserve Bank of Fiji needs to regularly advice the Minister of Finance on the conduct of the industry, and on any likely policy or legislative matters. Again, on the basis of the fact that since 1998, there has been no ministerial statement on the insurance industry, and the fact that there are obvious gaps in the 1998 legislation in terms of its sufficiency in consumer protection, it is reasonable to conclude that the Bank has not provided any detailed analysis of the legislation, nor any far-reaching policy advice for the Minister to articulate. For any policy advice that may have been given to the Minister, the lack of any public articulation by the Minister on the insurance industry would possibly reflect the insufficiency of the public-interest element in such advice. Even advice on regulations that could be put in place, seem to be
missing as the only regulations put in place concern the commencement date of the Act, the forms for annual reporting of the businesses, and an amendment concerning the Fiji National Provident Fund.

### 4.13 Approval of Standard Terms and Conditions

A key requirement on the Reserve Bank is to approve the terms and conditions contained in insurance policies. To approve these, the insurance companies ought to be required to submit the policies to the Bank, and for the Bank to scrutinize these policies.

The Reserve Bank, however, does not maintain a set of all insurance policies on file. Nor does it have an inventory of all the policies that are current, or that were in place in the country. It is clear, therefore, that the Bank has not been carrying out this function of the Act, which is, in fact, a mandatory function. Such negligence on the part of the RBF has continued since 1998, without any attempt by the RBF management or the RBF Board to take corrective measures.

### 4.14 Rate Determination

The Reserve Bank is also required to determine, with the approval of the Minister, of the rates of insurance with respect to any class or classes of business.

To date, the Reserve Bank has not attempted to determine any rate for any class of insurance business. The Reserve Bank’s view on rate setting is that since the insurance industry is a private sector industry, rates ought to be established by the private sector and not through state intervention. This view would have considerable merit for a country where the private sector is well developed and functioning. In Fiji, the private sector is not only still in its infancy, but it also operates in a very small market setting. In small markets, the natural tendency is for the rise of highly concentrated markets, thereby causing concern on the weight of market concentration on market outcomes, like prices, quality and quantity supplied.

In addition, some classes of insurance business, are mandatory, like comprehensive third party insurance for motor vehicles. Mandatory insurance would require state intervention. The state can not on one hand make any payment to private companies of money, rate, fee or charge compulsory, while on the other hand neglect to establish the rates in the first place. Such a behaviour would be a neglect of state responsibilities.
As long as certain insurance policies are compulsory, it becomes the responsibility of the state to ensure that the premiums are at such levels that they not only reflect the true cost of providing the social good, but also are affordable. For insurance, the Reserve Bank initiates policies on these matters on behalf of the state.

The failure of the Reserve Bank in this respect, and therefore the neglect of the state, is a matter of concern as the law specifies that this is a function assigned to the Reserve Bank by the Act.

The RBF states that the Fiji market ‘has been a non tariff market since inception’, and that insurance companies ‘are better placed to charge the right rate or premiums commensurate with the risk they are taking on because they have the historical records of experiences in a particular risk category’ (RBF, 2007).

There are two fundamental problems with the RBF position. First, the acceptance by the RBF that it does not have historical records of the performance of various categories of risk insurance in the country is an alarming and a worrying response from the entity required by the law to regulate the insurance industry. The acknowledgment that it suffers from a lack of awareness of industry performance indicates that the RBF is not carrying out the functions bestowed to it by law, especially those relating to consumer protection. This is, to a large extent, expected since the RBF has been preoccupied with prudential regulation and not consumer protection.

The second problem is that the essence of regulation, and a law like the Insurance Act, is that regulation is necessary when there is market failure. The insurance industry in Fiji is a market that is highly concentrated. It certainly is not one that produces efficient price/premium and quality results. In such an environment, consumer protection requires regulation of prices and qualities/quantities.

Given the RBF’s insistence that only prudential regulation can serve to protect consumer interests, and given that the RBF is not aware of the various types of risks that consumers face (as noted in chapter 2), the possible solution is for ministerial direction to the RBF to carry out work to protect and advance consumer interests, failing which the consumer protection function, including the function of regulating prices and quantities/qualities need to be hived off to an independent authority specially created to carry out such a function in the financial sector and sectors that are highly concentrated.
4.15 Consumer Complaints Mechanisms

The Insurance Act regulates the industry and provides the RBF full power of regulation, including investigation if it feels this is needed (s72). Investigations can be done using numerous methods. In the market, consumers are the most useful source of information in market investigations. For the insurance industry, current, past and prospective policy holders are primary sources of information on the industry as concerns consumer issues.

The problem, however, is that there is no formal mechanism in Fiji for consumers to communicate with the insurance regulator. The RBF has so far not developed any institutional structure or framework within which information from policy holders could be gathered and analysed. Nor has the RBF established a consumer affairs section, or a consumer desk. It has also not appointed any staff member responsible for consumer complaints, or to liaise with consumers on insurance products. It is, then, small wonder that in 2005, only 8 complaints were received by the RBF (Insurance Annual Report, 2005: 14).

Another useful provision is that the Finance Minister has the right to a copy of any investigation report carried out by the Reserve Bank of Fiji. However, under the law, the minister has to initiate the process to get a copy of the report (s79(4)).

It is not known, and not reported in the industry annual reports, on whether the RBF has carried out any investigation or compiled any report, or even whether the Finance Minister has been provided with any such report. The RBF maintains that it does carry out ‘onsite examination’, and where it ‘warrants, the RBF fills the Minister in … otherwise, this is part and parcel of normal RBF prudential requirements’ (RBF, 2007). This statement notwithstanding, there is no information in any annual report on whether the RBF has investigated any insurance provider for contravening a provision of the Insurance Act (s72(1)(a)(ii), Insurance Act). Such information is vital for consumers. Public disclosure of investigation reports on violations of provisions of the Insurance Act by insurance companies is a firm measure that the RBF could take to send appropriate signals to the market for the market to function more efficiently.

4.16 Policy INVALIDATION

S124 of the Insurance Act provides that the failure ‘on the part of an insurer, broker or agent to comply with any provision of this Act does not
invalidate any policy issued by the insurer.’ The Act also provides that ‘a policy issued by an insurer through or as a consequence of the actions of an intermediary is not invalidated merely because the intermediary was not licensed under this Act.’

This provision can protect the consumer/policy holder if the insurance company or intermediary tried to invalidate a policy on account of its own lack of compliance with the provisions of the Act. However, the provision cuts both ways. A policy holder who tries to seek invalidation of a policy on account of a lack of compliance by the intermediary of the provisions of the Act, would be unable to do so. Thus, if a consumer was not fully informed of the pertinent details of a policy being sold to him/her, and the person purchased the policy, the law would disallow the policyholder from getting the policy invalidated and premium returned. There are two exceptions to this – one concerning life insurance, where a 28-day return period is allowed for, and for general insurance of Tower Insurance which allows for a 30-day return period for full refund. Otherwise, this provision is anti-consumer. The appropriate limitation ought to have been that the clause will only apply to policy invalidations sought by the insurer alone.

4.17 Return of Policy

S129 of the Insurance Act provides for the consumers of life insurance products to reject policies already paid for. This provision does not apply to any other type of policy in existence now. S129 of the Act provides that if an insured, on receipt of a life policy, or a policy in respect of any other prescribed class of insurance, objects to any term or condition of the policy, or decides that the policy is not required, or decides that the policy cannot be afforded, he/she may, in writing, advise the insurer of the objection or decision and return the policy to the insurer within 28 days of the receipt of the policy for a full refund of the premium. All life policies issued by insurance companies are also required to contain this provision.

This provision provides good protection to consumers. However, it is limited to life insurance policies, or policies that are prescribed by regulations. So far no policy has been prescribed by regulation to be included in s129 consumer protection. The RBF justifies the coverage of only life insurance policies under this provision on account of the fact that life insurance policies are long term in nature while other policies are short term in nature, thereby the insured is less tied to maintaining the contract.
There is also no indication that life insurance consumers are aware of this provision. No public education material is available from any institution, including the RBF, informing insurance consumers of the presence of this provision in law.

4.18 Conclusion

The Insurance Act 1998 has stronger provisions for consumer protection than the Insurance Act 1976. However, there are numerous weaknesses within the consumer protection provisions of the Act, both in terms of lack of completeness and lack of scope/coverage. There is an urgent need to amend the Act to include stronger provisions on consumer protection. There also is an urgent need to make a concerted effort to enforce the provisions of the Insurance Act. The regulator – the RBF – needs to do this, failing which the Board of the RBF needs to give a firm directive to the management to enforce the legislation. If the above does not produce any positive result, then a ministerial directive would be needed to ensure diligent enforcement of the consumer protection provisions of the Insurance Act.
5 Major Problem Areas

The insurance industry in Fiji continues to operate in an environment riddled with numerous problems, many of which are fundamental problems that need urgent attention. A major problem is that there is a lack of adequate monitoring of the industry to ensure that the Insurance Act is abided by. Other than this, and despite the introduction of some consumer protection provisions in the Insurance Act 1998, the industry still lacks sufficient legislation to protect consumers.

5.1 Informal Insurance Market

Over the past 2 decades, there has emerged a significant, and possibly a growing, ‘informal’ insurance market. Sometimes referred to as ‘self-insurance’ such a market is not illegal. Large organizations may opt to ‘pay itself’ a ‘premium’ for risks that normally would be covered by insurance companies. This is a legitimate activity.

The problem, however, emerges when the system expands to cover non-private entities. Thus, for example, while a household is totally within its rights to keep aside some funds each financial period to account for risks that a family may face, if the household begins to accept money from other households to cover for their risks, then it begins to function as a de facto, though not de jure, insurance provider.

Fiji has seen a rapid emergence of such informal providers of insurance services. The sector that is well known for such practices is organized labour. Some trade unions operate de facto insurance schemes, normally by establishing separate legal entities like welfare societies, thrift and credit unions, and the like. Table 5.1 provides some of the organizations that are involved in such schemes.

S3 of the Insurance Act requires the Reserve Bank to administer the Insurance Act. As part of this, it ‘must perform all the functions assigned to it by or under this Act.’ The key functions include ‘the formulation of standards governing the conduct of insurance business and insurance broking business in the Fiji Islands’, the superintendence of the conduct
of agents, brokers and insurers in the Fiji Islands; advising the Minister with regard to all matters concerning insurance; recommending to the Minister regulations for the carrying out of Government policies relating to insurance; the approval of standard terms and conditions contained in policies of insurance; and such other functions relating to the supervision of Fiji insurance business, or business incidental to Fiji insurance business, as are assigned to it by the Minister.

Table 5.1: Informal Insurance Providers/agents

<table>
<thead>
<tr>
<th>Trade Union</th>
<th>Related Body</th>
<th>Insurance Provision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiji Public Service Association</td>
<td>FPSA</td>
<td>Mutual Aid Benefit Scheme (MABS)</td>
</tr>
<tr>
<td>Fijian Teachers Union</td>
<td>Fijian Teachers Association Welfare Society</td>
<td>Medical</td>
</tr>
<tr>
<td>Public Employees Union</td>
<td>Public Employees Union Welfare Scheme</td>
<td>Medical/Health</td>
</tr>
<tr>
<td></td>
<td>Fiji Public Service Credit Union</td>
<td>Death Benefit (replacing Loan Protection Insurance Scheme in 1999)</td>
</tr>
</tbody>
</table>

‘Insurance business’ is defined by the Act (S2) as ‘the business of undertaking liability by way of insurance … in respect of a life, or any loss or damage, including liability to pay damages or compensation, contingent upon the happening of a specified event’ and any business incidental to the business. The latter includes the activities listed above.9

The Act, therefore, provides a comprehensive coverage for all businesses related to insurance, whether they are known as insurance business or by any other name. The content of the business is what matters.

The Reserve Bank, therefore, has continuously been breaching the Insurance Act by not regulating all insurance businesses in Fiji. Its main focus has been the regulation of businesses carried out by organizations registered as insurance organizations. It has paid no attention to organizations that are not specifically registered as insurance organizations, but that carried on, in effect, insurance business, or insurance-related work, or in effect work incidental to insurance business.

Such organizations currently are registered either under the Trade

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9 For no specified reason, the RBF denies that non-licensed businesses that provide insurance services or services that are incidental to insurance businesses are insurance businesses, but accepts that it has provided training workshops to such operators (RBF, 2007).
Unions Act, with such registration now being deemed to be under the Employment Relations Promulgation (2007), the Credit Unions Act, or Co-operative Societies Act.

5.1.1 Credit Unions Act

The Credit Unions Act, first promulgated in 1966, is aimed at regulating credit unions. The object of a credit union is specifically defined as including the following three and no more:

- to promote thrift among its members
- to receive the savings of its members either as payment on shares or as deposits, and
- to make loans to members exclusively for provident or productive purposes (s16).

The Act also lists what a credit union can do; these are:

- deposit money in any bank in Fiji or in the National Bank of Fiji;
- invest in any stock, debenture stock… or in any security of local loan of the Government;
- borrow money as provided by the Act;
- insure its loans, funds, and property against loss;
- draw, make, accept, endorse, executive promissory notes, bills of exchange, bills of lading, warrants and other negotiable or transferable instruments; and
- do all such other acts and things incidental or conducive to or consequential upon the attainment of its objects (s17).

Given the above, credit unions do not have any legislative authority to be in any insurance business, or any business that is incidental to an insurance business.

5.1.2 Cooperatives Act

The Co-operative Societies Act, first promulgated in 1944, is aimed at regulating co-operative societies. The Act does not provide any clear definition of what the objectives of a co-operative society ought to be. However, the Act states that ‘a society which has as its object the promotion of the economic interests of its members in accordance with co-operative principles’ ... may be registered under this Act (s3).

‘Economic interests’ can be widely defined and may include provi-
sion of insurance services to its members. The Act makes no specific provision for the society providing insurance services. But if insurance services were to be provided, these would have to be limited to the ‘members’ of the society. Members are individuals who are over 18 years of age. As such, insurance for the family members would be prohibited. This is the maximum that the Cooperative Society could be stretched, to include provision of insurance services.

In any case, the enactment of the Insurance Act in 1976 deemed any insurance business by any organization, or any business incidental to insurance business carried out by any organization, including a co-operative society, coming under the regulatory powers provided by the Insurance Act.

Under current law the entire insurance business and business incidental to insurance business is regulated by the Insurance Act. Provision of insurance services by organizations not registered as insurance providers is contrary to law. The operation of the informal insurance market is also contrary to law. S13 of the Insurance Act restricts the insurance business to only those entities that are body corporates and that are licensed under the provision of the Insurance Act. Penalty for the breach of this provision is, on conviction, a fine of $20,000.

The presence of the informal insurance market also indicates that the Reserve Bank of Fiji has not kept pace with the developments outside the RBF office. A lack of continuing industry research, and the RBF’s outright refusal to develop a sustained interface with consumers of insurance services, have provided the fertile ground in which the informal insurance market has emerged.

5.2 Illegal Operations by Insurance Companies

There is evidence within the industry of illegal operations by insurance companies themselves. One particular insurance company – FijiCare Insurance Limited - operates an insurance broker service too. On one of the policies cited, the title page of the policy document stated: ‘This insurance policy was arranged through your Broker: Direct FijiCare’.

Brokers are expected to work for and on behalf of insurance consumers. When an insurance company begins to operate an insurance brokerage, the confidence that the Insurance Act intended to offer consumers disappears. Whether other insurance companies also operate brokerage services, or maintain relationships that are less than arms-length, is not known. It is also not known whether the industry regulator had been aware of this.
5.3 Informal Insurance Agencies

A related problem is that there have emerged numerous informal insurance agents and intermediaries. This is particularly the case with trade unions that have negotiated with insurance companies what are called ‘group insurance schemes’. While group insurance schemes tend to reduce the premium that individual members of the scheme pay, the fact is that the negotiating entity on behalf of the insured (or possible insured) begins to act as an insurance agent, albeit for the insured. In many cases, these ‘informal’ agents receive from the insurance companies a ‘collecting’ fee, which ranges between 3% and 10% of the premiums. For all intents and purposes, therefore, these entities are receiving commissions from insurance companies. Such fees run into significant sums for the larger institutions.

Organisations that receive commissions from insurance companies, either to defray the costs of any form of liaison with members of the group scheme, or as gross earnings, are acting as insurance agents. Under law, all insurance agents ought to be registered.

This is another area that the Reserve Bank of Fiji has not been able to examine to date. The extent of such informal agency is significant. Table 5.2 lists some of the trade unions that are involved in such practice, whether these be in return for a ‘collection fee’, or not.

<table>
<thead>
<tr>
<th>Union</th>
<th>Agent</th>
<th>Policy</th>
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<td>Fiji Teachers Union</td>
<td>Fiji Teachers Union Co-operative Thrift and Credit Society Ltd</td>
<td>Motor vehicle</td>
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<td>Fiji Bank &amp; Finance Sector Employees Union</td>
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<td>Association of USP Staff</td>
<td>AUSPS</td>
<td>Medical group insurance scheme</td>
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<tr>
<td>(Fiji Police Force)</td>
<td>Fiji Police Force Credit Union</td>
<td>No information released</td>
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Another, though not too similar case of informal insurance agency described above, is when insurance agents engage non-registered persons to market their products. While full data on the extent of this practice is not available, what is known is that some registered insurance agents engage ‘employees’ to do all that a registered agent can do. These employees may either work in the offices of the registered agents, and therefore handle all queries from insureds or potential customers on insurance
products, or be engaged as independent contractors to the insurance agent.

The Insurance Act (s14) requires that only a person registered can commence or carry on the business of an insurance agent or broker. The person could also be a body corporate. There, however, is nothing in law that would prevent the registered agent/broker to engage others to assist or carry out their work. The only limitation is that the person so hired must not hold himself or itself as an insurance agent/broker unless the person is licensed (s15).

While this part of the law is clear, when insurance products are being promoted or even sold, there is normally no formal recording of the communication between the potential client and the ‘agent’. If it were made known to an insured that he was liaising or dealing with a non-registered person, it would not be very difficult for an insured to take the matter of breach of law up for a speedy resolution. A mandatory display of certified identity cards holding out the bearer to be an insurance agent could possibly reduce the problem of misinformation or mis- or non-communication with consumers.  

5.4 Breach of S6 of the Insurance Act

As noted in Part III, s6 of the Insurance Act requires intermediaries to provide a reasonable explanation to a person proposing to enter into or renew a contract of insurances, ‘of the contents of all documents required to be signed by the person’.

In the conduct of actual insurance business, this provision is consistently, and arguably in many cases deliberately, breached by insurance industry employees, agents and intermediaries.

There are two major reasons for this. These concern a lack of awareness of the details of the policies by insurance industry employees and agents, and the second concern misrepresentation.

5.4.1 Awareness

The insurance industry in Fiji has a relatively limited market for a wide range of insurance products. Fiji is a small economy, with a relatively small middle-class population. Economic growth and the associated

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10 Possible exceptions to this are brokers, who carry identifications to protect them against possible professional indemnity claims; and corporate agents, for example banks, that act as insurance agents.
growth in personal incomes are also relatively low. The potential for growth of the insurance industry within the personal insurance realm, therefore, is rather limited. In like manner, the growth of businesses – small, medium or big - has remained relatively depressed in Fiji. These, therefore, do not produce a rapidly growing market for insurance products.

To counter the above, insurance companies have continued to engage in product differentiation. This involves not only continuously varying the products that they themselves offer, but also continuing to marginally differentiate their products from those of their competitors.

The ever-changing nature of the insurance products, therefore, call for a continuous education of the insurance industry employees and/or agents.

In 1999, the year for which the last official statistics on employment in the insurance industry is available, there were 694 employees in the insurance industry. In 2005, 314 persons were registered as insurance agents.

The number of people involved with insurance, therefore, is pretty large.

There is no indication at all – either in the Reserve Bank of Fiji’s annual report on the industry, or in terms of responses from the insurance companies – that there is a systematic education program for insurance industry employees or agents. LICI was the only agency that responded with details of a 22-week training program that contained 5 weeks of training on ‘product information on various plans’, 4 weeks on ‘term rider and critical illness benefit’ (i.e. medical requirement, sum under consideration, whom to sell and who not to sell), and 5 weeks on policy servicing (i.e. assignment and transfer, revival, claims servicing and other services). The RBF (2007) states that Colonial also does ‘extensive training of its own agents’. There, however, is no record in the insurance industry annual reports of any formally accredited training program designed by the industry for insurance agents.

S43(1)(a) of the Insurance Act imposes on the Reserve Bank of Fiji a responsibility that before granting a license to an agent, it should be ‘satisfied’ that the applicant ‘has sufficient experience in and knowledge of insurance matters’.

This requirement is a very general requirement - of knowledge of ‘insurance matters’, rather than a specific requirement that the agents be fully aware of insurance policies that they would be dealing with.

There is no national or formal examination on insurance policies that the agents ought to pass before they are given an insurance agent’s li-
cense. Not developing such a system is a major lapse on the part of the Reserve Bank of Fiji. A lack of such examination or a formal process to test the knowledge of the applicants of the specifics of insurance policies also creates possibilities of arbitrariness in RBF decision making. The RBF relies on the insurance companies to ensure that the agents ‘have the requisite skills to perform’ their duties (RBF, 2007). What the ‘requisite skills’ are, and how these are to be measured, have not been the concerns of the regulator.

A freelance insurance industry personality, with vast experience of the industry, both as a consumer and as an expert assessor and advisor, asserts that the ‘biggest problem’ within the insurance industry is that the insurance industry employees and agents do not themselves know the policies that they sell.

There is considerable merit in this view, formed over many years of dealing with insurance companies, employees, agents and insureds. Testimony of one insured, given in Case Study 1 below, shows that the insurance agent was totally unaware of the details of the policy that he was selling.

A related problem is that registered insurance agents can employ persons who are themselves not registered agents. Such a practice is widespread in the country.

The problem continues to exist largely because of a lack of enforcement of the Insurance Act by the Reserve Bank of Fiji.\(^\text{11}\) Even a casual examination of employment data within the industry would indicate a large proportion of ‘unclassified’ insurance industry workers. When insurance industry data was collated by the Bureau of Statistics, comprehensive data on employment in the industry was provided in the industry annual reports. This practice ceased when the reports began to be compiled by the Commissioner of Insurance based at the Reserve Bank of Fiji. The Commissioner began focusing exclusively on prudential supervision of the industry rather than on the consumer interest side of the industry products.

5.4.2 Salesmanship and Misrepresentation

Insurance agents are in the business of insurance only for the prospect of making the maximum profit out of this business. Profit for insurance agents emerges from the value of sales that they do. Obviously, sales

\(^{11}\) The RBF states that there has been some enforcements done already (RBF, 2007). Details of these, however, are not known.
revenue is dependent to a significant extent on the salesmanship skills of an agent. Insurance sales often could become very difficult to make if potential customers have a doubt about the product that they are purchasing. Doubts concerning the product emerge when the potential client would feel that the product would not result in any net gain for him/her, or that his/her money would be wasted on the product.

An important way in which agents avoid the possibility of doubts in potential clients is to withhold information from the consumers. One agent expressed this to the effect that the less questions asked by the customer on the product the better, so agents aim to not to create an environment where customers begin to raise questions about the product. This view applies to most optimizing agents.

The standard practice in the industry in Fiji is for agents and employees to provide product brochures to customers.

Product brochures are advertising tools in the industry. They contain information on the product that makes the product attractive to the customer. Brochures are neither the subject matter of the insurance contract between the insurer and the insured, nor can they be made a subject matter of litigation. Like advertisements, brochures provide only an intent of the seller to make a sale. The sale itself is on the basis of the product quality. Thus, the industry in Fiji relies almost entirely on advertisements to make sales. Invariably, customers are not provided the policy document in advance of the sale, or before they paid the premium, or even before they signed the insurance proposal form. While in law there is nothing that prevents a consumer from asking for a copy of the policy, agents do not readily provide copies of these. Accessing insurance policies has been most difficult in Fiji; the only exception to this is the range of products provided by Dominion Insurance Company Ltd, which provides all its policies on its website except the medical insurance policies. Mandatory public release of policies is the only certainty that can be provided for public access to policies.

The standard process in which insurance products is sold in Fiji is shown in the actual case of a life insurance product sold to a client in November 2006 by an agent of the Colonial Mutual Life Assurance Co Ltd (Case Study 1).

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12 Copies of policies were even denied by every insurance company that research assistants for this project visited in person; companies visited were all insurance companies except Colonial. The only material made available to them were product brochures.
Case Study 1: Actual Sales Process

Consumer wanted a life insurance. The family contacted an insurance agent who showed them numerous brochures of life insurance packages. He could not explain to the consumer the details on these and promised to come later with the full details. When he came, he scribbled some numbers on a piece of paper and tried to explain the details of the packages. The consumer kept this page. On it were written:

$20,000

Payment over 10 years only

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The consumer understood the package to be one where if the person survived to and after 70 years, he would get $4,000 back each year (totaling $20,000) by year 74, and a bonus on the 74th year.

The consumer got his medical report done on the form provided by the agent at the recommended doctor. After the report, the agent brought a document for the consumer to sign and make the first payment; he signed it and made the first payment. The policy document was provided to the consumer after the payment was made. The policy has no record of a bonus payment.

There emerge numerous problems with such practices. First, and foremost, this is a breach of the law. Second, the lack of a provision of complete information to the clients is potentially fraudulent. In effect what this does is to get consumers to agree to a product whose characteristic they neither understand, nor would possibly know of until after they have purchased the product. Once purchased, the consumer is left to bear the consequence of the action.

Third, the above could form the basis of misrepresentation. In the law of contract, misrepresentation is strictly interpreted as containing 4 ingredients: that a false statement was made, that the statement was one of fact, that it was addressed to the policy holder, and that it was intended to induce and did in fact induce the contract. Remedies for the policy holder, on proof of misrepresentation, depend on the nature of misrepresentation. Three specific types of misrepresentation are possible: fraudu-
lent misrepresentation, negligent misrepresentation, and innocent misrepresentation.

The RBF accepted that the case cited is a case of misrepresentation ‘where the consumer by law has the right to rescind the contract’ (RBF, 2007). The assessment of the RBF is correct. However, the process described above is only one example of the practice that seems to be prevalent in the industry.

The Insurance Act itself has a provision for consumers of life insurance products to reject policies already paid for. This provision does not apply to any other type of policy in existence now. S129 of the Act provides that if an insured, on receipt of a life policy, or a policy in respect of any other prescribed class of insurance, objects to any term or condition of the policy, or decides that the policy is not required, or decides that the policy cannot be afforded, he/she may, in writing, advise the insurer of the objection or decision and return the policy to the insurer within 28 days of the receipt of the policy for a full refund of the premium.

This provision can provide consumers a potential relief. But whether policy holders are aware of this provision, is not known. So is the case on whether insurance agents inform their clients of this provision. What is certain, however, is that generally consumer behaviour in Fiji is such that return of purchased items is rare, even if the items are of poor quality or non-affordable. The extent of policy returns is not known; the industry Annual Report makes no reference to returns of insurance policies.

At least one policy sighted – that of Colonial’s Bula Saver – the policy attempts to limit the operation of this provision of law by providing grounds for the return of policy or objections: ‘The grounds upon which the Policyowner may do so are where he object to any form or condition of the policy; where he decides that the policy is not required; or where he decides that the policy can not be afforded’. The law does not require any reason for the policy owner to specify to return a policy. However, Colonial’s conditions require not only a reason to be stated, but also, presumably, the reasons to be justified. If, for example the holder cites inability to afford the policy, Colonial may require the policy holder to prove this ground. This was not the intention of the legislation.

This practice by the company, which is contrary to law, has been not only been ignored by the RBF, but actually has been endorsed by the RBF. The endorsement is on the ground that the insurer is required to inform the policy holder of the s128 rights (RBF, 2007). The RBF argument presumably is that all that Colonial is doing is to inform the policy holder of this right. Such casual approach to policies that conflict with the law is indicative of the RBF’s unwillingness, or at worst its inability, to
adequately administer the Insurance Act and to monitor the practices of insurance companies.

It should also be noted that the 28-day return period provision is not application to other categories of insurance consumers purchase.

Except for the Comprehensive Third Party insurance, insurance practice in Fiji essentially involves the law of contract. Litigation on the validity of an insurance contract in Fiji is relatively limited. Legal precedents, therefore, are rather limited in this area. This keeps matters on insurance practice out of discussion within the public domain. Educational value that litigation produces, therefore, is relatively non-existent in Fiji.

One recent case, involving fire insurance, highlights some of the key issues involved in a lack of complete information being provided to consumers by insurance agents and/or employees.

**Case Study 2: Actual Sales Process**

On 8 November 2005, Imraz Iqbal, the owner of a newly established small business visited the office of Dominion Insurance with the view to get his business premise insured for fire protection. He was given a document to read, fill out and sign. The 2 pages document contained certain declarations and information on the cover that he requested, which was for $40,000 fire insurance. The document stated that upon signing the contract he would “accept the policy subject to the terms and conditions it contains”. The employee did not produce any policy for Iqbal to cite, read or sign. Iqbal left under the impression that the document he had signed was the policy and contained the terms and conditions. ‘At no point’, stated Iqbal in a letter to the insurer, was he ever asked if he was aware, or made aware, that there was a separate document that outlined conditions not specified by the contract he had just signed.

In December 2006, after a military takeover of the elected government, Iqbal’s office premises burnt down in a fire. The premise was located close to a military checkpoint that was active at that time. The insurance company denied liability on account that the fire was a result of “suspected arson”, and that arson was not covered.\(^\text{13}\)

\(^{13}\) In response to this, the Reserve Bank of Fiji states that arson ‘is always an exclusion under any policy’ because insurance ‘operates under the dictum of accidental damage and not [damage] on purpose’ (RBF, 2007). This is a narrow interpretation of the foundations for insurance, as insurance is founded on the dictum of ‘risk’, and arson is always a risk in modern societies. This necessitates a distinction between self-infliction of a damage and damage caused by other parties. One insurance company –
Iqbal met with the insurer where the employee selling the product to Iqbal admitted that she did not show Iqbal the terms and conditions of the policy before it was signed. Her explanation was that she assumed that Iqbal was ‘aware of the terms and conditions’ when she issued him the proposal.

A vital piece of information - that arson was not covered by the fire policy - was conveniently left for the insured to find out not only after the contract had been signed and the policy paid for, but only after the event that the insured thought was covered for by his policy. The General Manager of the insurer was made aware that the employee of the company did not inform Iqbal of this exclusion. The employee acknowledged this in the presence of the Manager, as well as accepted that Iqbal was not shown or given a policy document when he had signed the proposal. The Manager still decided against accepting the liability.

The second matter concerning this case is that there was no definitive proof that the cause of the fire was arson. Police investigations did not produce any final result, nor was any arsonist apprehended. The reason for the denial of liability by the company was that ‘suspected arson’ was the cause of the fire.

Iqbal is seeking legal redress for, inter alia, this matter, a process that may cost thousands of dollars for a policy worth $40,000.

5.5 Non-Disclosure of Information

The insurance industry in Fiji is renown for not-disclosing all the key coverage scope of insurance policies. The cases highlighted above are just some of those that were brought to the attention of the researchers. There are other serious cases where the insurance companies continue to accept premium but then decline liability of the amount insured for various reasons.

Numerous cases of motor vehicle insurance have come to light. The most frequently occurring complaint is that while insurers (either through agents or directly or their employees, or through group insurance schemes) accept a policy on the declared valuation of a vehicle, upon a claim on account of an accident, they ‘revalue’ the vehicle (through their assessors) and provide for a claim on the basis of the new valuation. Vehicle values continue to fluctuate, depending on the taxation regime, im-

Sun Insurance – states that it insures for arson, as long as it is not self-inflicted or is intended to defraud the company.
port requirements, and wear and tear. Furthermore, valuation of a vehicle after an accident can only be a speculation since it can not be returned to the ‘market’ in its pre-accident condition before repairs are done.

The RBF provides no remedy for this possibly fraudulent practice but to state that vehicle owners can seek independent valuation of the assessors’ assessments (RBF, 2007), a process that is bound to be costly since the challenge would, ultimately, require the insured to seek judicial remedies.14

Insurance companies argue that to avoid this problem, consumers can get a company approved valuer to value their asset and use this for insurance purposes. The costs of such valuation, however, would need to be paid by the insured. This also raises the significant possibility of dispute if the insurance company valuers place values different from the market values on the item to be insured.

It is argued here that it is fraudulent of insurance companies to accept a premium on a declared value of a vehicle insured, and then dispute, using a whole coterie of assessors, lawyers and valuers to write down, the valuation of the item. Accepting a higher premium on a declared valuation, then writing down the valuation upon a claim is clearly a case of obtaining money by false pretences – here the pretence being that the valuation was accepted by the insurer.

The same applies to many other property insurances, particularly home contents insurance, house insurance, and travel insurance.

5.6 The Fine-Print Problem

The often-repeated problem of hiding important conditions of a contract in ‘fine-prints’ is clearly illustrated in many insurance contracts in Fiji. The ‘fine-prints’ literally enable important conditions and exclusions to remain beyond the attention of the average insurance consumer in Fiji.

14 One insurance company has objected to the use of the terminology ‘fraudulent’ to refer to the practice of accepting premium for a declared value of motor vehicles and then refusing to honour claims on this basis, stating: ‘There is no basis whatsoever for an allegation that this is fraudulent. Fraud is a criminal offence that requires a very high level of proof of deliberate misconduct. There is no evidence of this…. To suggest that insurance companies are acting fraudulently is not only based on an incorrect understanding of the law but a gross misstatement of the correct position’ (private communication). The authors examined the entire issue, including the statement by the same company that in ‘order to rate an insurance product, a maximum value is needed’, and stand by their statements.
Not a single insurance policy of contract cited was printed in a font size that could be comfortably read, or was in a language that could be easily understood by an average consumer in the country.

Most policies cited were in font-sizes ranging from 7 to 9 rather than the more readable 12 font size. A document that is in small prints is not only stressful to a reader’s eye, but fine prints also create an inbuilt tendency in readers to skip through or ignore the sections finely printed and focus on the ‘user-friendly’ components.

The second associated problem is that the language used is constructed without correct English grammar. An appearance is given that the language is legalistic. What is certain is that most conditions are long-winding and confusing to an average reader. This makes understanding a standard insurance contract very difficult for an insurance consumer.  

Discussions with a wide range of those insured – including university graduates and unionists – show that most of them do not read the policies in detail, or if they read them, they do not totally understand the policies. This is especially so in terms of their understanding of the coverage and exclusions of a policy. Even major litigation – like those concerning coverage of businesses during the 2000 coup – had confusions over the coverage and exclusions as a major point of contention.

5.7 Negligence

Cases of negligence within the insurance industry abound. This ranges from negligently misleading customers/prospective customers, to not providing full range of information that customers require to make their decisions. Even in cases of current/ongoing policies, negligent conduct continues.

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15 One insurance company disagrees with this and states that its ‘policy wordings are relatively easy to read, and the exclusions that are applied from time to time would be clearly understood by anyone who read the policy’ (personal communication). It also states that it ‘issues plain English policy wordings with every new product sold’, and that it provides a ‘30-day free look period for all new insurance policies sold’ under which if anyone was unsatisfied with the policy, one could seek full reimbursement and termination of the policy. While a full-refund within 30-day period may be the case for this company, it is by no means the general practice.
**Case 3: House Insurance**

In 2003 a property owner transferred his house insurance from one company to another. The premium for the house, then at the declared value of $100,000, was $450. The initial value on which the insurance was paid — in 1995 — was lower than the current market value in 2006. The owner decided to insure the property for the market value of $150,000 in 2006. The insurance company raised the premium to $756 and levied a charge of $167. In 2007, when the renewal notice came, it came only for $167. It also came only on the initial valuation, which was $100,000. The cover for this new sum excluded fire coverage. Only when the owner enquired on the discrepancy, were these corrected. Had the owner, himself a busy person with paperwork piling on his desk daily, signed a cheque for only $167, the house would probably have been without fire cover, unknown to the insured.

When companies amend policies, there is a commercial obligation on them to inform the insured of the amendments. In any case, any unilateral amendment of policies should, by law, be declared illegal.

It ought to be noted that normally general insurance terms are for a 12-month period. At the end of 12 months, the contract comes to an end. Thereafter, a new contract begins, which may have new terms offered to the insured. The insured has the freedom to accept the new terms in the new contract or reject them. So far as the law is concerned this is the correct position. However, when insurance companies offer ‘renewals’, these are extensions of the same contract of insurance rather than a ‘new contract’. If the terms of a contract are changed in a renewal notice without notifying the insured, then this would cause a problem. It is this that needs to be declared illegal.

**5.8 Other Breaches of Law: Breach of S128**

S128 of the Insurance Act requires that the following documents must not contain anything inaccurate or likely to mislead an insured:

- a form of proposal for insurance,
- a policy document, or
- any endorsement of a policy document, or
- any form of written matter used by an insurer which describes the terms or conditions of, or the benefits to be or likely to be derived from a policy of insurance.
The law places the responsibility of monitoring these documents on the Reserve Bank of Fiji. S128(2) empowers the Reserve Bank to give an insurer a written notice requiring the insurer to submit to the Reserve Bank the listed documents. If the Reserve Bank considered that a document submitted does not comply with the requirement that it not be inaccurate and non-misleading, it can give the insurer written notice setting out particulars of the way in which the document is misleading or otherwise fails to comply with the law; and invite the insurer to make submissions to the Reserve Bank on any matter set out in the notice. If in 14 days of the RBF notice, the insurer made no submission to the Reserve Bank, or having taken into account the submissions made by the insurer, the Reserve Bank remains unsatisfied, the Reserve Bank may give the insurer a written direction to change the relevant document in the way specified in the notice. The latter disallows the insurance company from using the said document.

What the above mean is that the Reserve Bank, in effect, is required to examine every insurance proposal, every policy document, every endorsement of a policy document, and any form of written matter used by an insurer which describes the terms or conditions of, or the benefits to be or likely to be derived from a policy of insurance. S3 of the Insurance Act specifically requires the RBF to approve the standard terms and conditions of each and every insurance policy. Unfortunately, however, the Reserve Bank does not do this, nor does it have on file a full set of policies offered to the public, let alone a full set of subsidiary documents.\(^\text{16}\)

This is a major area of neglect of responsibility by the RBF.

Another area of neglect is that the RBF does not monitor whether the insurance companies abide by the requirements of S129(5). Under this, life insurance companies are required to inform each new policy holder, either through the policy itself, or through annexures to the policy as approved by the Reserve Bank, that the policy holder has a right to return the policy to the insurance company in return for a full refund of the premium within 28 days of receiving the policy.

Except for the LICI policies, no other insurance company complies with this requirement. Yet, the Reserve Bank, as regulator, has made no statement on this breach in its annual report, nor has it, apparently, taken any action against the insurance companies who are in breach of this provision of the law.

\(^{16}\)The RBF states that ‘policy documents have been obtained and sighted .. but are not kept in a full set batch…” (RBF, 2007). However, during research it was established that the RBF did not have the complete set of insurance policies on file.
5.9 Another Breach of Law: Transfer of Policy

S135 of the Insurance Act states: ‘The owner of a life policy on which premiums have been paid for at least 3 years may, in writing, request the insurer concerned to … treat the policy as a paid-up policy….. On receiving a request … the insurer must vary the policy to a paid-up policy for an amount to be certified by the actuary’ (emphasis added). Case Study 4 illustrates another case of an insurance company breaching provisions of the Insurance Act.

Case Study 4: Paid-up Policies
In 2006 an insurance company paid a death claim to a beneficiary. The beneficiary queried the amount paid. The insurance company wrote to the beneficiary saying that the ‘policy was in paid up position’, the premiums were not paid from fortnightly due 19/2005 therefore only part of sum assured was payable’. In January 2007, the beneficiary wrote to the insurance company querying this explanation: ‘You advised that the above policy was in paid up position. I cannot understand how you determined the paid up value of only $1000’. The beneficiary claimed $10,000, the death benefit under the policy.

This case highlights the following:

a. the breach of the law by the insurance company in declaring a policy to be in paid-up position without the written request of the insured.

b. the failure of the insurance company to inform the insured of the changed status of the policy, or that the policy was surrendered on account of non-payment of premium (s138), or that it was a paid-up policy (s138(6)).

c. the apparent non-utilisation of an accredited actuary to determine any paid up policy value;

d. illegally converting the policy to a paid-up position rather than to follow provisions of S137 of the Insurance Act;

e. the ‘conversion’ of an ordinary life insurance policy into an ‘industrial life policy’ illegally, and

f. even if the conversion of the policy to industrial life policy was proper, the offer of a settlement sum without the approval of the Reserve Bank of Fiji was not.
The option of converting a life insurance policy to a paid-up one is provided for in law. To do so, the policy holder needs to do so in writing. Insurance companies, as Case 5 demonstrates, normally do not inform their clients of this requirement.

**Case 5**: Colonial Life’s Bula Saver policy contains the provision of paid-up option that policyholders can exercise. However it states: ‘This policy at the option of the Policyowner can be made paid up provided that the policy has been in force for two years and has acquired sufficient surrender value to enable this policy to be paid up’. The law provides for no such condition on surrender value. The Policy also does not state the requirement of converting through writing. By not specifying the requirement that policies can be made paid up only in writing, the insurance company is, in effect, not informing the policy holder of the correct legal position.

### 5.10 Policy Terminations

Life insurance policies can be terminated by either the insurance company or the consumer. The following forms of termination are recognized by the Reserve Bank of Fiji, as per its reporting of the insurance industry:

1. **Termination on Death**: This is termination of policy upon the death of the insured.

2. **Termination on Maturity**: This is termination of policy upon maturity of the policy.

3. **Termination on Expiry of Term**: This is termination of policy upon the expiry of the term of the policy.

4. **Surrender**: This is applicable to policies that have residual values, and where the policyholder has formally requested the insurer to cancel the policy. This is termination of the policy by the policy holder.

5. **Forfeiture**: This applies to policies that have no residual value. According to the Reserve Bank of Fiji, ‘Policies only start to attain a residual value after all the acquisition costs have been recovered, which usually
takes at least the first two years’ (private communication). This is termination of the policy by the Insurer. In this case, the insured receives no payment.

The first three forms of termination are relatively less controversial as payouts are as per the insurance contract. The major problems that emerge concern the last two forms of terminations: surrender and forfeitures.

5.10.1 Surrenders

Surrenders are done by the policy holder. These are for various reasons, like inability to pay, loss of job, migration, etc., the reasons may or may not be personal to the policy holder.

S136 of the Insurance Act makes provisions for surrender of life insurance policies. It states that the owner of a life policy which has been in force for at least three years may, in writing, request the insurer who issued the policy to surrender the policy. Upon this written/formal notification, the insurance company is required to pay the policy holder an amount equal to the surrender value of the policy less the amount of any debt owing to the insurer under, or secured by, the policy.

The term ‘surrender value’ is not defined in the Insurance Act. Nor do life insurance policies contain any statement on the calculation of the surrender value of a policy. A literal interpretation of ‘surrender value’ is the value of the policy at the time of its surrender. The issue, therefore, is the valuation of the policy at surrender. This is not provided for in either the legislation, or any regulation. The RBF has also not considered it necessary to provide a template for the calculation of the surrender value.

It is likely that on a request for surrender, from the total premium paid to that date the insurers deduct costs of writing the policy (acquisition and commission expenses) and managing it (management and administrative expenses). In this case, therefore, the insurance, the consumer needs to have access to the books of the insurance companies to ensure that the sums deducted are true reflections of the costs incurred by the company. There, however, is no provision for the policy holder to do this. Failing this, the only option left for the policy holder is to seek RBF’s intervention. For this, there is no clearly laid down procedure for the policy holder to follow to seek RBF intervention, and for the RBF to calculate the surrender value. There is no evidence that the RBF has carried out any cost analysis of life insurance products; without a historical data base, and without a template to calculate the marginal cost of providing a service of a particular type to an additional consumer, the RBF would not be able to
make a sensible determination of the surrender value of a policy.

Consumers, therefore, neither have any knowledge of what the surrender value of a policy would be before they purchase the policy, nor can they be assured that they would be paid a just and fair surrender value.

This is a major breach of the Insurance Act, as surrender value of a policy is a vital piece of information concerning life insurances. The Reserve Bank of Fiji has not insisted that insurance companies provide the consumers full details on what the surrender values of different forms of life policies would be during different periods of the policy term. This is indicative of a lapse of responsibility on the part of the regulatory authority, as by Insurance Act (s6), the consumer is to be informed of all pertinent details of a policy.

Of greater concern is that even though s136(2) requires that insurance companies pay the surrender value of the policies to policy holders, the law itself makes provisions for the insurance companies to avoid paying the surrender value of the policy. S136(4) of the Act states that an insurance company can formally apply to the Reserve Bank to ‘suspend or vary the Insurers obligations to make payments’. The RBF may suspend or vary the obligation to pay the surrender value if it is of the opinion that such payments would prejudice-

(a) the financial stability of the insurance company; or
(b) the interests of all the policy holders of the insurer.

The policy holder, in this case, is left with no redress as the law itself provides the regulator of insurance industry to determine whether a surrender value needs to be paid or not. There is no provision in the Act for the RBF to require the policy holder to make submissions to the RBF, or to demand that the company making the claim of a prejudiced financial stability of the company or a prejudiced interest of existing policy holders, to open their books to the RBF or the insured.

While there is provision in the Act (s167) for policy holders not satisfied with a decision of the RBF to appeal to the Minister, and to proceed to seek redress in the High Court. For the appeal to the Minister, there is no regulation on the matters that the Minister would take into consideration in making his decision.

Thus, payment of the surrender value of a policy to a policyholder is not guaranteed. The RBF states that the provision is not intended to deny payment of surrender values, but only to allow these payments to be made ‘when the Reserve Bank things fit’ as the ‘key issue .. is to ensure the
long term financial sustainability of the company’ (RBF, 2007).

What is also clear is that policies cannot be surrendered before payment of premium for 3 full years. The only option that a policy holder has if she/he wished to terminate the policy within the first 3 years of the policy, is to cease payments, and lose all the premium paid to that date. Such policies are said to be forfeited. This is the legal provision in Fiji.

Whether this information is correctly communicated to a prospective policy holder at the time of the purchase of the policy is doubtful. The RBF states that this issue has been the subject of discussion in annual meetings that the Governor of the RBF has with life insurers (RBF, 2007). The Reserve Bank, which regulates the industry, however, has not carried out any study on this aspect of life insurance policies. The amounts involved in surrenders and forfeitures are significant.

S136(3) of the Insurance Act requires that every policy issued ‘must have either printed on it or annexed to it, in a form and manner acceptable to the Reserve Bank, a notice informing the insured of the rights’ that a policy holder can formally surrender the policy if it is in force for 3 years.

While policies do contain the right to surrender, the two life insurance companies vary in the extent of information they provide on surrender value. The Colonial Life and Health Company makes no information available in the policies. It, therefore, maintains the full right to calculate the surrender value of the policies. Whether the Reserve Bank examines the formulae used in calculating individual surrender values is not known; the lack of any reference to this in the RBF’s annual reports on the industry indicates that the Bank does not look into how surrender values are calculated. It, however, checks the ‘adequacy of values’ (RBF, 2007), but only in light of the wider prudential issue of company financial viability rather than the rightful amount due to a policy holder.

There is an additional problem area in the Colonial life policies. These policies inform the policy holder that policies can be surrendered after being in force for 2 years: ‘The Policyowner can apply in writing to surrender this policy, after the policy has been in force for two years and at least two years’ premiums have been paid’.

The issue is whether an individual contract can override the provisions of a legislation. While one may construe a legal interpretation that any deviation from the legislative requirement by a party can only be enforceable as long as it is not against the interests of the non-proposing party, the provisions of the law on seeking RBF approval to vary or suspend the payment provisions could possibly be invoked by the insurance company to secure a position that is against the policy holder. Granted that this provision would be entertained by the RBF only in cases of a
claim by the company of financial or solvency problems. But the fact remains that the RBF has not made any comment on the seemingly conflicting positions on surrender values in Colonial Life Policies and the Insurance Act.

The other life insurance company, the LICI, on the other hand, has a statement that the surrender value would be at least 30% of the total premium paid during the years after the first year. However, this is only conditional. The full statement on the surrender value is as follows:

**Guaranteed Surrender Value:** This Policy can be surrendered for cash after the premiums have been paid for at least three years. The minimum surrender value allowable under this policy is equal to 30 per cent of the total amount of the within-mentioned premiums paid excluding the premiums for the first year and all extra premiums and/or additional; premiums for Accident Benefit that my have been paid provided that if a portion of the Sum Assured had become payable or had been paid on the Life Assured surviving to the stipulated dates (s) prior to the date of maturity the premiums prior to the date(s) of such survival shall be excluded for calculating the surrender value. The cash value of any existing vested Bonus additions will also be allowed.

As obvious from the quotation, the provision is long winding and unintelligible to an average reader. Such language is the norm in insurance policies. Nonetheless, the surrender value of a minimum of 30% applies only to premium paid after the first year and not the total premium paid.

The insurance industry regulator’s position on refund of premium for those surrendering their policies was articulated by the Commissioner of Insurance in 1978; this position has not been commented on or amended since then. An extract, albeit lengthy, from the 1978 Annual Report of the Commissioner of Insurance explains its position:

*In our view the withdrawal of a policy holder should neither benefit nor harm the continuing policyholders; but if any conflict of interests should develop in balancing the two sets of equities involved, they should be resolved in favour of the persisting policyholder.*

Accordingly, *the maximum benefit to which a withdrawing policyholder would be entitled is his pro rata share of the assets*
accumulated by the company on behalf of the block of policies to which his policy belongs – his asset share. But in practice a policyholder must and does get less than the asset share imputable to a surrendered policy. There are at least five reasons for this.

Firstly a small portion of the asset share must be withheld to offset adverse mortality selection. Since persons in extremely poor health are not likely to surrender their policies whereas those who do surrender are on the average in better health and can be expected to live longer than those who do surrender, the present value of future benefits for the remaining policyholders is greater than their pro rata share of the assets accumulated for the payment of death claims, and by the same token the present value of future benefits for the surrendering policyholders in the instant before withdrawal is less than their pro rata share of the fund.

Secondly account must be taken of adverse financial selection. Cash surrenders tend to increase sharply during periods of economic crisis and depressions. These terminations not only reduce the inflow of cash to the insurance company but, if cash is demanded, also increase the outflow of cash. This adversely affects the financial operations of the company in that (1) it has fewer funds to invest at the attractive rates of interest generally prevailing at such times and (2) under the most extreme circumstances the company may have to liquidate some assets at depressed prices. Apart from surrenders at a time of economic crisis, the right of the policyholder to demand the cash value of his policy at any time forces the company to maintain a more liquid investment portfolio than would otherwise be necessary, thus reducing the over-all yield on the portfolio. It is logical that policyholders who surrender their policies should be charged with the loss of investment earnings including any capital losses attributable to the surrender.

Thirdly, sound life insurance practice demands that each group of policies pays its own way in the long run, including provision for such adverse contingencies as wars, epidemics, asset losses and so on. Obviously, newly issued policies must depend upon accumulations already on hand for these protective margins during the early years and it is reasonable that something less than the actual accumulations under such policies be made available as a surrender value in the early years
by reason of the risk which these policies imposed on existing funds. It is also reasonable that in later years some deduction should be made from the actual accumulations to avoid any weakening in the security of the remaining policies in the group. It is also generally agreed that all policies should make some contribution to the permanent surplus of the company in order to provide the same sort of safety cushion and reservoir for the payment of acquisition expenses that was provided [to] them by the surplus contributed by earlier policies. This all means that the surrendering policyholder should receive something less than his policy’s share of the total accumulated.

Fourthly, in the case of a stock company, a deduction may be made from the asset share of the surrendering policyholder in recognition of the risk borne by capital funds. In any such deduction, allowance would be made for any profits already distributed to stockholders.

Finally, the cost of surrender must be deducted. All companies incur a certain amount of expense in processing the surrender of a policy. Some companies estimate the aggregate expenses that will be incurred in such transactions and spread the cost over all policies by adding it to the loading. Others charge the cost of the transaction to the particular policies involved by deducting it from the surrender value that would otherwise be available. Under the latter practice the cost of surrender is in effect a deduction from the assets share.

These arguments have merit. Insurance is, in essence, a business, aimed at producing the maximum surplus for the business owner. While some life insurance schemes are mutual benefit schemes, the fundamental remains – that this is a business aimed at maximizing profits.

The problem for the consumer, however, is not this logic. The problem is that consumers are not adequately informed of the consequences of surrendering a policy. There is no evidence that the insurance companies and/or intermediaries inform the consumers that the surrender value of their policies will be substantially lower than the premium that accumulate until surrender. There is nothing in the insurance company brochures on this matter. What little is there in the policy document, is not only in a language beyond the capacity of the average person in Fiji to understand, but is also provided to the consumer after the insurance contract is signed and the first premium paid.
5.10.2 Forfeitures

Policy forfeiture arises when a policy holder ceases premium payment before the end of three years of a policy, or where the policy has no surrender value left.

S137 of the Insurance Act makes clear provisions on non-payment of premia. It states that non-payment of premium by an insured cannot be a ground for forfeiture or termination of a life policy by the insurance company if at least 3 years’ premiums have been paid on the policy, and the surrender value of the policy (calculated as at the day immediately preceding that on which the outstanding premium falls due) exceeds the total of the amount of the outstanding premium, and the total of any other amounts owed to the company under, or secured by, the policy.

The law (s137) further provides that until an outstanding premium is paid, the insurer may charge interest on it on terms not less favourable to the insured than any prescribed terms; the outstanding premium and any unpaid interest charged on it are deemed to be a debt owing to the insurer under the policy.

Forfeiture of an ordinary life policy is only possible on grounds of non-payment of a premium if-

(a) the insurer has given the insured a written notice setting out the amount of the premium and the day on which it became, or will become, due, and stating that the policy will be forfeited at the end of 28 days after the giving of the notice or 28 days after the day on which the premium became, or will become, due, whichever is the later, if the amount due to the insurer has not been paid; and

(b) at least 28 days have elapsed since the day on which the notice was given or the day on which the premium became due, whichever is the later (s137(4)).

There is no other way in which an insurance company can treat an ordinary life insurance policy on account of non-payment of premium.

Life insurance policies are of 2 types: ordinary life insurance policies and industrial life insurance policies. Ordinary life insurance policies are policies of insurance upon human life, or the granting of annuities upon human life, but exclude industrial life business. Industrial life policies are policies where premiums are contracted to be paid at regular intervals of less than 2 months and the insurer expressly or tacitly undertakes to send
a person to the insured or to the insured’s residence or place of work to collect the premium.

For industrial life policies for which less than one year’s premiums have been paid, the policies can not be forfeited only because of the non-payment of any premium unless the premium has remained unpaid for at least 4 weeks after it became due (s138). An industrial life policy on which premiums have been paid for at least one year, but less than 2 years, must not be forfeited only because of the non-payment of any premium unless the premium has remained unpaid for at least 8 weeks after it became due. In like manner, an industrial life policy on which premiums have been paid for at least 2 years, but less than 3 years, must not be forfeited only because of the non-payment of any premium unless the premium has remained unpaid for at least 12 weeks after it became due. If an industrial life policy on which not less than 3 years premiums have been paid is forfeited because of the non-payment of any premium, the insurer must, without requiring an application from the insured, grant a paid-up policy for an amount not less than an amount calculated by the actuary and approved in writing by the Reserve Bank. The insurance company must notify the insured in writing of the fact that a paid-up policy has been granted and must specify the amount of the policy and the contingency upon which the policy is payable.

Here again, there is a breach of law in the Colonial Life policies. Colonial policies state that if there was a default in the payment of any premium before such policy has been in force for two years, and two years’ premiums have been paid, this policy shall be forfeited and become void as from the date the unpaid premium fell due. It further states that Colonial shall not be required to give notice to this effect to the policyholder.

The Insurance Act, on the other hand, clearly specifies that the insurance company can not forfeit a policy on account of non-payment without giving a written notice.

The LICI policies also conflict with the Insurance Act. The Insurance Act (s137) clearly states that until an outstanding premium is paid, the insurer may charge interest on it on terms not less favourable to the insured than any prescribed terms. The LICI policies make no reference to interest charges. Instead, the LICI reduces the sum insured. There is no provision in the typical policy on the option of interest charges. The law, on the other hand, does not provide for a unilateral reduction of the sum insured.

Colonial has also attempted to, very cleverly, undermine the intent of the Insurance Act. It has stripped from the ordinary life insurance coverage certain covers and provided them separately. One such item is ‘term-
life’. Under this, it charges a separate premium (e.g. of $183/year for $50,000 insurance cover for 15 years) to provide a benefit that is not even clearly stated. The policy states that for this premium, it provides ‘the payment of the [sum insured] on the death of the Life Insured prior to [maturity date]’. The same applies to another component called ‘Total and Permanent Disability’ Insurance, and ‘Critical Illness’ Insurance. Because these are, what it calls, ‘rider benefits’, it requires that there be no premium arrears. If there was a premium arrear, then Colonial will ‘change the benefit to one with a level premium and reducing the sum insured’. This, in effect, breaches the intent of s137. Such an attempt to avoid the law appears to be, prima facie, illegal. The insurance industry regulator claims that it is aware of such a practice but believes that it is not in conflict with s137 of the Act. This position of the RBF is, again, a flawed legal position.

The values involved in forfeited policies in Fiji are significant. Table 5.1 shows the number of policies involved in different categories of terminations, while Table 5.2 shows the value of premiums involved in different categories of terminations of life policies.

### Table 5.1: No. of Policies Terminated

<table>
<thead>
<tr>
<th>Year</th>
<th>Death</th>
<th>Maturity</th>
<th>Expiry of Term</th>
<th>Surrender</th>
<th>Forfeiture</th>
<th>Net transfers</th>
<th>Others</th>
<th>Total Terminated</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>2.4%</td>
<td>7.9%</td>
<td>0.1%</td>
<td>20.8%</td>
<td>68.2%</td>
<td>0.0%</td>
<td>0.7%</td>
<td>18266</td>
</tr>
<tr>
<td>2000</td>
<td>1.6%</td>
<td>7.6%</td>
<td>7.4%</td>
<td>36.3%</td>
<td>46.1%</td>
<td>0.0%</td>
<td>1.0%</td>
<td>19983</td>
</tr>
<tr>
<td>2001</td>
<td>2.1%</td>
<td>8.9%</td>
<td>0.2%</td>
<td>25.2%</td>
<td>61.4%</td>
<td>0.0%</td>
<td>2.2%</td>
<td>18622</td>
</tr>
<tr>
<td>2002</td>
<td>1.9%</td>
<td>6.2%</td>
<td>-0.1%</td>
<td>21.1%</td>
<td>69.9%</td>
<td>0.0%</td>
<td>1.1%</td>
<td>21249</td>
</tr>
<tr>
<td>2003</td>
<td>2.3%</td>
<td>9.2%</td>
<td>0.0%</td>
<td>24.9%</td>
<td>62.1%</td>
<td>0.0%</td>
<td>1.5%</td>
<td>17128</td>
</tr>
<tr>
<td>2004</td>
<td>2.5%</td>
<td>10.9%</td>
<td>0.0%</td>
<td>26.8%</td>
<td>58.0%</td>
<td>0.0%</td>
<td>1.7%</td>
<td>16345</td>
</tr>
<tr>
<td>2005</td>
<td>1.8%</td>
<td>9.2%</td>
<td>0.1%</td>
<td>21.8%</td>
<td>57.4%</td>
<td>0.0%</td>
<td>9.7%</td>
<td>20048</td>
</tr>
<tr>
<td>Avg</td>
<td>2.1%</td>
<td>8.6%</td>
<td>1.1%</td>
<td>25.3%</td>
<td>60.4%</td>
<td>0.0%</td>
<td>2.5%</td>
<td>18806</td>
</tr>
</tbody>
</table>

(Date Source: RBF (Various years))

Table 5.1 shows that of all policies terminated during 1999-2005, approximately 86% were on account of surrenders and forfeitures. On average during the past 7 years, 60% of all policies were forfeited while 25% were surrendered.

In terms of the value of premium involved, as shown in Table 5.2, of all policies terminated during 1999-2005, approximately 87% were on account of surrenders and forfeitures. On average during the 7 years 1999-2005, 69% of all policies were forfeited while 18% were surren-
Thus, surrenders and forfeitures comprise a very large share of all life insurance policies terminated. Terminations through surrenders and forfeitures involve a very large number of individuals – running into approximately 16,120 persons per year on average. Terminations also involve approximately $14m per year in premium, with surrenders accounting for, on average, $2.9m per year and forfeitures to $11.2m per year in premium.

<table>
<thead>
<tr>
<th></th>
<th>Death</th>
<th>Maturity</th>
<th>Term Expiry</th>
<th>Surrender</th>
<th>Forfeiture</th>
<th>Others</th>
<th>Total Premium ($m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>2.6%</td>
<td>3.2%</td>
<td>0.1%</td>
<td>15.5%</td>
<td>73.9%</td>
<td>4.8%</td>
<td>14.097</td>
</tr>
<tr>
<td>2000</td>
<td>2.0%</td>
<td>3.1%</td>
<td>1.7%</td>
<td>14.6%</td>
<td>73.3%</td>
<td>5.4%</td>
<td>16.585</td>
</tr>
<tr>
<td>2001</td>
<td>2.0%</td>
<td>4.0%</td>
<td>1.6%</td>
<td>18.9%</td>
<td>66.8%</td>
<td>6.7%</td>
<td>15.540</td>
</tr>
<tr>
<td>2002</td>
<td>2.2%</td>
<td>2.8%</td>
<td>-1.2%</td>
<td>16.7%</td>
<td>75.2%</td>
<td>4.3%</td>
<td>18.050</td>
</tr>
<tr>
<td>2003</td>
<td>2.6%</td>
<td>4.3%</td>
<td>0.1%</td>
<td>19.2%</td>
<td>68.9%</td>
<td>4.8%</td>
<td>15.407</td>
</tr>
<tr>
<td>2004</td>
<td>2.8%</td>
<td>5.8%</td>
<td>0.1%</td>
<td>22.0%</td>
<td>63.5%</td>
<td>5.8%</td>
<td>14.969</td>
</tr>
<tr>
<td>2005</td>
<td>2.2%</td>
<td>5.9%</td>
<td>0.1%</td>
<td>17.9%</td>
<td>61.3%</td>
<td>12.5%</td>
<td>18.852</td>
</tr>
<tr>
<td>Average</td>
<td>2.3%</td>
<td>4.2%</td>
<td>0.3%</td>
<td>17.8%</td>
<td>69.0%</td>
<td>6.3%</td>
<td>16.214</td>
</tr>
</tbody>
</table>

(Date Source: RBF (Various years))

From discussion on surrender values, it is estimated that each year, insurance companies keep at least $2m in premium through surrenders and $11m through forfeitures. These sums are net earnings of the life insurance industry. A law and/or a practice that allows such ‘rent-seeking’ behaviour in the industry does not create an efficient market.

### 5.11 Reserve Bank Negligence on Life Insurance

The law requires the Reserve Bank to examine and approve all policies prior to their sale.

The Colonial Life policy has a clause that empowers it to attach provisions to the policies after the sale has been made. The condition states:

> All provisions and endorsements in this policy, together with those which may subsequently be attached hereto or endorsed hereon, shall be deemed to be part of the policy’ (underline added).
The consumer agrees to this condition by signing the policy contract. The issue is whether any consumer would agree to empower one party to the contract with such blanket authority to at anytime attach provisions during the term of the contract. The RBF agrees that policy amendments require the parties to agree to them (RBF, 2007). Unilateral power to amend contracts would be vehemently opposed by contractual parties in normal sales contracts. One would expect the same to apply in an insurance contract. However, the fact that this has not taken place may indicate lack of awareness of consumers on this provision of the insurance contract.

Given the unequal power relation between the insurance companies and the insured, it becomes the responsibility of the regulating authority to ensure that such provisions are not contained in insurance contracts. To date, the regulator has not examined this provision of the insurance contract.

5.12 Insurance Company and Broker Negligence

Insurance companies, agents and brokers in Fiji do not have a demonstrated practice of rapidly responding to enquiries from their clients. This not only raises questions of propriety of conduct of these businesses, but also possible illegal conduct.

The Insurance Act requires that all information that the intermediary was aware of at the time of the contract of renewal, be communicated to the insured (s6(1)(b)). Such information would include any change in the premium, and any amendment to the policy, even if this be a minor amendment. Case 6 illustrates that intermediaries continue to deny policy holders relevant information.

Case 6:

A newly insured person sought copies of documents she had signed other than the policy document. She contacted the agent who had arranged the policy. He informed her that he had sent all the documents and the file to the insurance company and that the insured had to ask the insurance company for the documents. When the insured contacted the insurance company she was told that the agent is required to provide those documents and not the insurance company. The insured is still without
these documents she needed to complete her own insurance file. She does not know what remedy she has now.

The Act is also weak in that it does not require an insurance company to inform all members of a group insurance scheme of the details of the contract (s8(2). For group insurance schemes, only one notice is sufficient. It then becomes the responsibility of the group to distribute the information, etc., amongst themselves. This creates a major problem as the law does not require the group scheme manager to distribute the information promptly. Case 7 highlights a typical problem.

### Case 7: Group Scheme Members not kept informed

An employee of a tertiary educational institution signed for a group life insurance scheme in 1998. This was done through a broker. In November 2006 the insured wrote to the broker enquiring on, inter alia, the maturity date of the policy. 5 weeks after the letter, the broker wrote to the insured and informed him that the group policy had ‘Lapsed’, thus there was no cover for the insured. It did not inform the insured of the date on which the policy had lapsed, or the causes for this. It further stated: ‘Please note that we are refunding premium to members after the policy has Lapsed, this is only done should there be a refund to be made’. The letter asked the insured to submit to it a statement of premium deducted for processing of the refunds. In response the insured asked for the reason of the lapse and the reasons for the insured not being informed of the lapse. Three months since the letter (i.e. by February 2007), he had not received any response from the broker.

The issue is clear here: had the insurer not enquired, he would have continued to believe that he had the necessary cover for which he had signed. Second, had he not enquired, there would possibly have been no refund of premium for him.

This is clearly an unsatisfactory state.

To date in Fiji, most insurance companies have not abided, either in full or in part, by the requirement that an insurance consumer must be given full information on the policy.

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17 The RBF states that members have every right to this information form the Group Scheme Manager or directly from the insurer as this is part of contract law (RBF, 2007).
5.13 S56 Rights of Consumers

S56 provides that an insured is entitled to, on written request, be provided by the insurer with a copy of any prescribed return or report. ‘Prescribed’ refers to any matter prescribed by regulations under s169.

Regulations prescribed so far include:

- Insurance Act 1998 - Commencement Notice
- Insurance Regulations, 1998 (L/N 152/98), and
- Insurance (Amendment) Regulations 2002 (L/N 108/02)

Of significance is the Insurance Regulations 1998 (LN 152/98). This Regulation prescribes the following returns or reports:

1. an auditor’s report of an insurance company or broker, required to be lodged with the Reserve Bank of Fiji;
2. A profit and loss statement, and a balance sheet of an insurance company and a broker;
3. A statement of revenue and distribution, and Balance Sheet for life insurers.

In effect, then, a policy holder with an insurance company can, on written request to the insurance company, be provided with the items listed above.

This is an extensive right that the policy holder can exercise. However, it is not known if policy holders have been informed of this right by insurance companies and/or agents, or whether the insurance industry regulator (the Reserve Bank) has at any time informed the consumers of this right. The RBF takes the position that the Insurance Act is a public document accessible to all consumers. The presumption of this position is that policy holders must know full details of their rights under the Insurance Act, a position that is legally sound, but practically not realistic.

It is also not clear whether insurance companies/brokers will respond to any such request positively. This matter could possibly be addressed by a code of conduct for the insurance industry.
5.14 Medical Insurance

Dissatisfaction against medical insurance in Fiji has been expressed widely. Dissatisfactions arise from:

- insurance companies not honouring the commitments that the insured believed the insurance company gave them,
- delays in approving medical treatments,
- delays in payments,
- unethical practices,
- negligence in handling medical outpatient treatment, and
- not informing clients fully and completely.

Other than these, there is a significant problem in terms of the coverage of the medical insurance schemes in Fiji.

The following sections, and cases 8 to 15, highlight different categories of problems with medical insurance schemes.

5.14.1 Negligence in Handling Medical cards

The efficient operation of Medical insurance requires identification of the insured by nominated doctors for the medical service. For this, insurance companies provide medical identity cards to policy holders. Without such a card, a policyholder would not be able to seek medical treatment under insurance. A delay in receiving such a card, either on entering insurance, or on renewal, would deprive the insured of the benefit of the cover.

Case 8: Negligence in Handling Medical cards

In 2006 a medical clinic provided medical services to a family that was covered by a medical insurance and that carried a valid health care card (Health Plus) through which medical clinics provide medical services and bill the insurance company in bulk. When the Clinic claimed payments for the services, the Insurance Company declined the claim saying that the insured family had nominated another doctor for treatment. The insurance company did not inform the clinic of this, nor did it withdraw the card. The sum involved in this case is relatively small (less than $100). The claimant has no recourse to recover this money short of seeking a judicial remedy.
Case 9: Wrong Card Case
A health Insurance company issued a card with incorrect name of the insurance group to the group members. The insured informed their broker of the error. The error remained uncorrected for many months.

Case 10: Delays in sending Health Cards
Whether as a deliberate strategy to avoid incurring claims, or as negligence, it took one particular insurance company 5 months to send the health card to members of a group. In July 2006 the insured wrote to the insurance company and the broker asking them to begin to take their responsibility seriously and avoid making excuses. The insurance company did not respond to the specific requests.

5.14.2 Communication

Communication between the parties involved in arranging an insurance for an insured, and an insured, is a major problem concerning medical insurance. Matters concerning the health of an insured are high-priority matters. Delays in responding to any query from an insured on his/her medical insurance could prove fatal to an insured. Yet, there is ample evidence that the medical insurance providers either do not communicate with the insured promptly, or in terms that answer the queries raised. Case 11 illustrates an ordinary example

Case Study 11: A particular medication comes in a tablet form as well as in liquid form. An insured was prescribed the liquid form of the medication. The nominated chemist did not have in stock the prescribed medication, but had exactly the same medicine in tablet form, which the insured took. The insurance policy did not cover the tablet form of the medication. The insured wrote to the insurance company asking for an explanation on this. He did not receive any satisfactory explanation. He then sought the assistance of the Consumer Council, which wrote to the company on his behalf. No satisfactory response was received.

Another related problem is that members of group schemes, negotiated by group managers, are not adequately informed of the coverage of the policies negotiated. Numerous group medical schemes are in existence in Fiji.
Dominion Insurance, for example, has group schemes with the Fiji Military Forces, the Fiji Police Force, the Fiji Teachers Union, the Fiji Cane Growers Association, the Fiji Public Service Association and the Carpenters Finance Limited, with membership of each scheme ranging from ‘approximately 100 to several thousand’ (http://www.dominioninsurancefj.enlighten.co.nz/schemes.aspx). Some group scheme managers provide the full insurance policy to members. The Fiji Teachers Union, for example, publishes the policy in its annual report. Other groups inform members that they could inspect the policy or policies could be sent to them on request. Policy documents, however, are long and legalistic documents, normally beyond full comprehension of an average member of the scheme. There is no evidence that any group scheme management or any medical insurer has produced for the members documents that are in simple language describing the coverage and exclusions. Sometimes simple matters, as Case Study 12 shows, prove disastrous for the insured.

**Case Study 12: Amended Coverage Scope**

A civil servant was in a group medical insurance scheme. The group managers renegotiated a policy package. In this process, the final coverage for an executive cover was amended from a 24-hour coverage in any country, to one that covered medical attention within Fiji. Thus, if the insured was traveling outside Fiji, and got ill, he was not covered. This specific information was not communicated to the insured, who remained under the impression that she was covered fully. On a private visit to Australia, she fell ill and was hospitalised. The insurance company refused to accept liability. Instead the insurance company stated that had the insured informed the insurance company, the company would have made its own arrangements to have her cured at a cheaper hospital in India. Finally, a portion of the costs was covered after protracted negotiation.

Some insured are not even clear on aspects of medical conditions that are covered. Case Study 13 provides one example.

**Case Study 13: An insured developed problems with her eyes, which later were found to be cataract growth. She believed that she was fully covered by her medical insurance. An operation was necessary, which took place in Fiji. The insurance company declined to accept liability on account that only an eye examination by a specialist was covered by her**
scheme and not any surgical procedure.

5.14.3 Conflict of Interest

Conflict of interest in business is not an irregular occurrence. Smaller economies, with fewer business houses, tend to see greater possibilities of conflicts of interest. It is for this reason that the well-known notion of ‘arms-length’ transaction needs to be applied vigilantly in Fiji.

Conflicts of interest in medical insurance industry arises when the parties involved in determining the liability of the insurance company have a pecuniary interest in denying liability. The two main parties involved in this are the insurer and the medical professional nominated by the insurance company to recommend treatment. Where the latter has a financial stake in the outcome, there is a significant possibility of conflict of interest. The fact that the insurance policies require that the insurance companies nominate the medical practitioner whose recommendation would be acceptable to the company, itself creates a lucrative condition for conflict of interest to arise, especially in a country where medical negligence litigation is relatively rare.

Case 14: Conflict of Interest

One particular insurance company listed one medical practitioner as its nominated doctor who was also a director of the company. Insureds complained that this nominated doctor did not normally recommend treatments that they expected or which other medical professionals had indicated as necessary. The insurance company took no action. The matter was finally resolved when it was raised in the Parliament.

One likely solution to minimize conflict of interest, especially in the medical insurance area, is for the appointment of a panel of between 3 to 4 medical practitioners whose recommendation would be followed by all providers of medical insurance. This panel needs to be appointed by the state, in possible consultation with the Fiji Medical Association and the General Practitioners body, and ought to comprise practitioners who are independent of any insurance company. The panel’s remuneration should be handled by the Ministry of Health and/or the regulator rather than insurance companies, from a fund specifically created for this purpose.
15.4.4 Shortcomings in Medical Insurance Policies

Medical insurance, like other forms of insurances, is a business aimed at maximising profits for the shareholders. As such, the way medical insurance has been structured so far, is not about providing optimal health services to the insured. It is for this reason that most insurance policies specify that if medical procedures/treatments are available in the government hospital system, the liability would be only for that rather than any alternative facility or treatment. The government facilities are relatively cheaper than alternatives, but in Fiji they are also least reliable. The operative condition in insurance policies is whether the treatment is ‘available’. Available does not mean it could be accessed immediately, or be of the same quality as alternatives. This creates a fundamental problem for insureds. Policy holders, either through representation from insurance salesmen, or through insurance company public relations exercises, feel that by getting an insurance, they would have access to the best medical service. This is far from the case, as case study 15 illustrates.

Case Study 15: Only Least Desirable Treatment Covered

An insured developed gallstones, which needed to be removed. Two procedures were available: cutting open the body to remove the whole gall bladder, done at the government hospital in Suva, and a method to remove the stones by a small incision in the body, performed at a private hospital in Suva.

The former required weeks to recover, while the latter facilitated recovery within a few days. The insurance company declined treatment at the better facility, costing $8,000, and opted for the open surgical procedure costing $1,405. the insured proceeded to have the better procedure done; the insurance company declined liability. The group insurance scheme manager could not provide any remedy to the insured.

Given the rapid advances in medical technology, it is vital that insurance policies provide for medically the best medical treatment rather than cover only for obsolete procedures. This, obviously, has implications for premium levels. As long as varied premiums are shown for varied categories of treatments, consumer interests could be take care of to the
extent possible within a laissez faire environment.

5.15 Deliberate Delays in Settling Claims

Another major area of concern is the claim by consumers that insurance companies deliberately delay settling claims. The greatest incidence of this claim is for medical insurance. Consumer complaints that insurance companies deliberately delay settlement for medical cases, especially where evacuations to medical facilities outside Fiji is concerned, are more than an insignificant number. There have even been claims that the delays have been fatal to the insureds, either in terms of irreversible deterioration in the health of the insured, or even death.

There is no provision in the Insurance Act that requires insurance companies to promptly settle claims made. In the absence of this, consumers are left entirely at the mercy of the insurance companies. Even litigation is expensive both in terms of monetary costs and time. In Fiji, there has been hardly any serious insurance litigation that has been concluded by the court within a period of one year. Long delays not only frustrate the insured, but also demoralizes them even to the effect that they lose interest in their own case.

There is, so far, no significant judgment in Fiji on whether it is a duty of an insurance company to promptly settle claims made. In other countries, like the US, courts have taken a very strict view on this, and have provided massive damages to the insured against insurance companies, as in Egan v Mutual of Omaha Insurance Co et. al, where the courts awarded $US2.5m as punitive damage and $US123,600 as compensatory damage against an insurer for failure to properly investigate a claim and settle it (RBF, Insurance Annual Report 1978: 8).

5.16 National Fire Service: Insurance Levy

The National Fire Service Act, 1994 provides for a levy to be imposed on insurance policies to generate funds for the National Fire Authority. S29 of the Act states:

The Minister may from time to time, after consultation with the Commissioner of Insurance.... make ... a levy order imposing a levy on any insurance policy or class of insurance policy written in Fiji, and the amount payable under such levy order shall be paid to the authority at the time and manner specified in such levy order.

The Act provides for a levy order to make different provisions in re-
lation to different classes of insurance policies.

Currently, the levy order is for the payment of 0.06% of the sum insured for all insurance policies on the following classes of insurance:

- commercial and industrial fire policies;
- domestic fire policies including homeowners and householders, and
- contractors’ ‘All Risks Policies’.

Insurance levy is the major source of NFA’s revenue; in 2002, it represented 72% of the total revenue of the Authority (of $4.73m). The figure stood at 74% in 2001.

Insurance levy, therefore, is the single largest source of funding for the National Fire Authority.

While the legal incidence of the fire levy is on the insurance companies, its economic incidence is on the consumer of the product on which the levy is placed. In effect, then, the insurance companies are no more than collection agents of the NFA as the insurance companies pass on the entire amount of the levy to the insured.

While consumers of the respective insurance products are required by law to contribute to the operation of the National Fire Authority, they do not have any control or authority over how their contributions are utilized by the Authority. There is no provision in the National Fire Service Act for representatives of insurance consumers to be appointed on the Board of the NFA.

Of greater concern is the fact that the NFA is immune from any prosecution on account of negligence or any other legal basis. Part V of the Act makes specific provisions for the protection of the NFA from liability. S26(1) of the Act states:

No action or proceedings shall be brought against the State or the Authority or any District Fire Officer or any officer or staff of any brigade or any person whatsoever to recover damages for any loss or damage or bodily injury or death which is due directly or indirectly to fire or to the performance in good faith for the protection of human life which is otherwise endangered by the performance of any service pursuant to Sections 12, 18, 19, 21 and 22 of this Act where the loss or damage …. is also due to or contributed by the Chief Fire Officer…. or failing to take any action, while he is acting in good faith in performance of his duties under this Act….
S26(3) of the Act states:

In any action or proceedings taken against the Authority... for their failure or neglect to make, or their negligence in making, adequate provision for the prevention of fire, the suppression and extinction of fires which may occur, and the protection of life and property endangered in fires, it shall be a defence to show that the provisions made were in accordance with the standards approved by the Authority under this Act and that the Fire District and its officers... had complied with all relevant requirements of the Authority...

In effect, then, insurance consumers who pay for the National Fire Authority, become virtually impotent in ensuring that their contributions are put to the use that a willing contributor would wish to.

In return for paying a legislatively enforced insurance levy to sustain the National Fire Authority, consumers of commercial, industrial and residential fire policies; private homeowners and householders policy, and contractors’ All Risks Policies’ are not assured of a return. Levies on other insurance policies in future can not be ruled out.

That the levy has an impact on both, the financial viability of insurance companies, as well as the interests of insurance consumers, the issue comes within the purview of the regulator’s responsibility. The RBF so far, has not taken this matter up for consideration.

5.17 Consumer Grievances

While the Insurance Act 1998 contains some provisions on the protection of consumers, it is silent on what consumers can do in case of a complaint on the breach of the Act, or on unfair dealing by an insurance company.

There is some evidence that consumers have sought the assistance of the Reserve Bank, as the regulatory agency for the industry. Unfortunately, however, the RBF refrains from seriously dealing with such complaints. The RBF’s view is that ultimately, the matter of insurance is that of a private contract between the insurance company and the insured; as such, if it can not be resolved by the parties, it ought to be resolved through a civil claim.

The RBF does not provide any information in the insurance industry annual reports on the nature of complaints made to it by consumers. It, however, provides brief statements on the number of complaints it re-
The Reports, however, do not state the ways in which it handles complaints. Its 2004 Annual Report states: ‘The Reserve Bank does not have the legal powers to arbitrate in disputes between policy holders and insurers’ (p. 15). That the regulator of the industry has no legal power to intervene in resolving insurance disputes, indicates the insufficiency of the law itself in handling insurance disputes. It was perhaps for this reason that in 2003 the RBF proposed the establishment of an ‘External Complaints Committee’, to deliberate and settle claims and disputes. The industry, however rejected the proposals, stating that ‘insurers have their own internal claims dispute facility and saw no need for a separate dispute resolution committee’ (Insurance Annual Report, 2004: 16). The RBF did not pursue this matter any further. The matter of consumer grievances, therefore, remains unaddressed.

The RBF, as regulator, has regular consultations with the industry through the Insurance Council of Fiji and the Licensed Insurance Brokers Association. This is a good indication of an interface with the industry. However, so far the regulator has made no attempt to create a mechanism for a regular consultation with the consumers of insurance. This may indicate a lack of a focus of the regulator on consumer interests.

5.18 Exposure of ‘Beneficiaries’: Case of Comprehensive Third Party Insurance

In 1948, the Colonial Government put in place the Motor vehicle (Third Party Insurance) Ordinance. The law was adopted by the independent government in Fiji. The objective of the law was to ‘make provision for compulsory insurance against third party risks arising out of the

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**Table 5.3: Complaints Lodged with RBF**

<table>
<thead>
<tr>
<th>Year</th>
<th>No of Complaints Lodged</th>
<th>Outstanding complaints at close of year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>2004</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>2003</td>
<td>12</td>
<td>7</td>
</tr>
<tr>
<td>2002</td>
<td>15</td>
<td>2</td>
</tr>
<tr>
<td>2001</td>
<td>13</td>
<td>3 (+ 4 sought legal redress)</td>
</tr>
<tr>
<td>2000</td>
<td>13</td>
<td>6 advised to seek legal redress</td>
</tr>
<tr>
<td>1999</td>
<td>39</td>
<td>5</td>
</tr>
<tr>
<td>1998</td>
<td>na</td>
<td>na</td>
</tr>
</tbody>
</table>

(Source: RBF, Insurance Annual Report, various years)
use of motor vehicles’.

Under this law, insurance companies can apply to get the licence to provide third party insurance (s3). Payment of third party insurance is compulsory for all motor vehicles. Three companies in Fiji now have the licence to provide compulsory third party (CTP) insurance.

The law provides, inter alia, provision for making of regulations to differentiate between different types of vehicles; s29(2) empowers the Minister to make Regulations prescribing premiums payable for the purpose of this Act may differentiate between different classes of motor vehicles and may differentiate between motor vehicles having regard to the purposes for which they are used or intended to be used.

Until 2000, however, no such regulations were made. The first time such a regulation came in effect was by the Motor vehicle (Third Part Insurance) Regulations 2000 (LN 12/2000). This regulation differentiated classes of vehicles, and rates of CTP insurance. However, in December 2000, the Regulations were quashed by the High Court on grounds that they were made without due consultation with the Insurance Council of Fiji.

This means that insurance companies that were differentiating between ‘classes of motor vehicles’ and rates charged thereon, that those that continue to do so now, are illegal. Classes so differentiated by one insurance company, with its own definitions, are:

1. **Private Car:** defined as a motor car which is used solely for social, domestic or pleasure purposes, or by the owner, being an individual his own carriage in relation to his profession, business or calling, provided that profession, business, or calling is not that of a commercial traveller or travelling salesman, or an insurance agent, inspector or assessor, or an indent or manufacturer’s agent.

2. **Business Car:** A motor car used for business purposes and not included in classes 1, 3, 4, 5, 6, 9, and 10. For the purpose of this definition the performance by Government or a local authority of any of its functions shall be deemed to be the carrying on of a business.

3. **Goods Vehicle:** A motor vehicle which is constructed or adapted or primarily used for the conveyance of goods or merchandise of any description in connection with trade, business or agriculture. For the purpose of this definition the performance by Government or a local authority of any of
its functions shall be deemed to be the carrying on of a business.

(a) Light goods vehicle with a carrying capacity of up to 3,050kg net weight

(b) Light goods vehicle as in (a) authorised under regulation 55 of the Traffic Regulations 1985 to carry excess passengers:
   i. Carriage of up to and including 11 passengers.
   ii. Carriage of more than 11 passengers.

(c) Heavy goods vehicle with a carrying capacity of over 3050kg net weight

(d) Heavy goods vehicle as in (c) authorised under regulation 55 of the Traffic Regulations 1985, to carry excess passengers:
   i. Carriage of up to and including 11 passengers
   ii. Carriage of more than 11 passengers

4. *Taxi*: (being a public service vehicle licensed and used for carrying not more than 6 passengers for hire or reward) or a Hire Car licensed as such and used for letting on hire with a driver

5. *Omnibus*: A motor vehicle licensed and used for carrying more than 6 passengers for hire or reward.
   (a) Vehicle having a seating capacity of not more than 11 passengers.
   (b) Vehicle having a seating capacity of more than 11 passengers.


7. *Motor Cycle*: A motor vehicle designed to travel on not more than 3 wheel and the net weight of which does not exceed 5 hundred weight, for whatever purposes used, other than as Police and Fire Brigade motor cycle.

8. *Trailer*: For whatever purposes used.

9. *Motor Trade Vehicles*
   (a) A motor vehicle or motor cycle to which plates in respect of a dealer's general licence issued under section 20 of the Traffic Act are affixed and which is used in compliance with the regulations made under the said Ordinance in respect of such a licence,
   (b) A motor breakdown ambulance

10. *Rental Car*: licensed as such and used for letting on hire without a driver.

11. *Miscellaneous Vehicles Not Otherwise Classified* e.g. Tractors, Hearse, Road Rollers, Mobile Cranes, Road Graders, etc.

As noted below, s10 of the MV(TPI) Act states that the sections of a policy that restrict the insured with respect to, inter alia, the number of persons that the motor vehicle carries, or the weight or physical character-
istics of the goods that the motor vehicle carries, the horse power of the motor vehicle, would be of no effect.

Such differentiation could only be done under regulations prescribed by the Minister. That insurance companies have been differentiating amongst vehicles without regulations is a breach of law.

The 2000 Regulations in effect provide for the maximum premium that apply to different categories of vehicles. But these were declared by the High Court as of no effect. The current rates are almost double the rates established by law in 2000. No subsequent regulation has been made on this. As such, the providers are free to levy rates they wish to.

Whether the Reserve Bank of Fiji, as regulator, has examined this aspect of the CTP insurance, is not clear.

There is one other matter that needs to be raised on this account. While the CTP Act states that the Act is controlled by the Ministry for Transport, the Insurance Act states that the Insurance Act covers all insurance businesses and businesses incidental to insurance. In law, if there is a conflict, the provisions of a new legislation override the provisions of an older legislation, unless the older legislation makes special provision otherwise, or is a more specific law than the new legislation. *State v Minister for Tourism and Transport, ex parte Tower Insurance Fiji Ltd* [2000] FJHC 107, however, reduced the authority of the Reserve Bank of Fiji as the insurance industry regulator, in favour of the Minister responsible for Transport at least in terms of setting third party insurance premium. This ruling was not what was pleaded for by the plaintiffs in the case; as such the judge’s statement can, at best, be regarded as *obiter*. The Reserve Bank, however, has not considered it appropriate to get a final determination on this issue. This is indicative of a laid-back attitude of the regulator towards comprehensive third party insurance. The RBF should, as a matter of practice, begin taking credible legal advice on its powers to regulate motor vehicle third party insurances.

In addition, whether the way the vehicles have been differentiated is lawful is open for discussion.

One practice of CTP insurance providers is that of exclusion of cover for various activities. The Motor Vehicles (Third Party Insurance) Regulation 3 provides for the type of insurance certificate that insurers are to provide. Included, as the 5th item of specification, is “Limitations as to use:”, with a note that limitations rendered inoperative by s10 of the Act are not to be included under this head.

S10 of the Motor Vehicles (Third Party Insurance) Act lists 8 characteristics which can not be used to avoid insurance liability; these are:

a) the age of physical or mental condition of persons driving the
motor vehicle; or
b) the condition of the motor vehicle; or
c) the number of persons that the motor vehicle carries; or
d) the weight of the physical characteristics of the goods that the motor vehicle carried; or
e) the times at which or the areas within which the motor vehicle is used; or
f) the horse power or the value of the motor vehicle; or
g) the carrying on the motor vehicle of any particular; apparatus; or
h) the carrying on the motor vehicle of any particular means of identification other than any means of identification required to be carried under the provisions of the Traffic Act.

The CTP policies in use now, have the typical limitations as to use as follows:

Premium has been paid for only for the use of the motor vehicle for the purpose set out in item No.___of the schedule on back hereof, provided however that a premium paid for the use of the motor vehicle for the purpose set out in item 2,3,4,5, or 10 of the schedule shall also cover use of the motor vehicle social, domestic or pleasure purposes, or the Owner's business within the limits set out in item No.1 (b) of the schedule, or in the case of a hire car, for the hirer's business. The motor vehicle must not be used for any other purpose unless the policy is endorsed and extra premium (if any) paid.

The schedule lists the categories of vehicles. The schedule, now, is based on the 2000 regulations. But until 2000, there was no legal basis for such differentiation.

Given, therefore, that the differentiation between the categories of vehicles without regulations is unlawful, the above limitation is also unlawful. In 2000, the High Court quashed the 2000 regulation on grounds of inadequate consultation with the Insurance Industry as required for under the law (State v Minister for Tourism and Transport, ex parte Tower Insurance Fiji Ltd [2000] FJHC).

In addition, numerous categories of differentiation – for goods vehicle, taxis and omnibuses - depend on the number of persons the vehicle is designed to carry. Some also depend on the weight of the goods that the motor vehicle is designed to carry. Clearly, then, the differentiation provided for in the 2000 Regulations, and the current CTP policies, appear to be unlawful.
Insurance companies provide numerous exclusion provisions in their policies, either directly listed as exclusions, or listed as conditions for the insurance liability. Typical exclusions are for the coverage of:

- Relatives of the insured
- A person living with the insured as a member of the family, and
- Use of the vehicle for any purpose other than those for which the premium was paid.

Conditions designed to avoid liability are generally those that expose the owner/insured when the vehicle:

- is driven by a person who does not have the owner’s permission
- is driven by someone who does not hold a valid driving licence
- is in unsafe condition
- conveys any load in excess of that for which it was constituted
- carries passengers for the hire or reward or in the pursuance of a contract of employment in contravention of the licence issued for the vehicle described herein,
- is driven by a person who is under the influence of intoxicating liquor,
- is driven by a person who is as a result of age or some physical or mental condition rendered incapable of driving such vehicle with safety.

Whether these conditions are lawful has been the subject matter of a few major court cases in Fiji.

One significant case was Kumar v Sun Insurance Company Ltd [2005] FJCA 63; ABU0072 of 2004S (11 November 2005). This concerned an appeal by 2 third parties injured in an accident involving a vehicle allegedly driven by someone under the influence of alcohol; he also did not hold any driving licence at the time of the accident, let alone one permitting him to drive the vehicle for the purpose set out in the policy. This enabled the insurance company to avoid liability. The injured parties attempted to get the insured to seek judicial remedy; when the insured failed to co-operate, the injured party – the third parties that the law aimed to protect – took it upon themselves to seek judicial remedy. The High Court found for the insurance company. So did the Court of Appeal.

The Court of Appeal decision raised the issue of the right of an insurance company to establish exclusions and conditions. The judgment holds that the law:

- contemplates the entitlement of the authorised insurer to specify or limit the persons covered, leaving it to the insurer to identify
or define who they might be. Once identified or specified, then the effect of the section is to ensure that their potential liability, in respect of bodily injury or death connected with the use of the vehicle, is fully covered, save for the permitted exceptions noted in the proviso (a) and (b) to s.6(1) of the Act.

The Court of Appeal, therefore, allowed insurance companies to establish their own conditions of exclusion and conditions enabling them to avoid liability. The third parties seeking judicial remedy argued that the principal purpose of the law was to cover for third parties injured by motor vehicles; the Court of Appeal stated this point, and its response, as follows:

[27] The principal argument advanced by the appellants was to the effect that whether by way of a proviso or condition, it was contrary to the spirit and intention of the Act for an insurer to exclude coverage for liability arising from an act of negligence on the ground that the driver was unlicensed.

[28] This submission depends upon the proposition that the policy should be applied in a way that reflects the primary purpose of the Act in requiring compulsory third party insurance. That purpose was described by Hutchison J, in Collinson v. Wairarapa (1958) NZLR 1 at 12, as being one to “ensure that, where persons suffer personal injury, then there will be means available for their compensation in proper cases.”, that is where that injury or, it might be added, a death occasioning loss to dependents, arose as the result of the negligent use of the vehicle: See also Stewart v. Bridgens (1935) NZLR 948 Leggate v. Brown (1950) 2 KB 564 and Commercial Union Assurance Co. Ltd. v. Colonial Carrying Co. of NZ Ltd. (1937) NZLR 1041.

[29] … yet it must yield to the wording of the Act in so far as it permits the insurer to define the persons or class of persons insured. In the present case, the policy wording has that effect, in so far as the proviso renders it applicable to the owner and driver but only where the driver is licensed.

[30] These grounds of appeal have accordingly not been made good. While there is a sound policy behind compulsory thirty party insurance which is designed to protect innocent persons in-
jured, or suffering loss as dependents, through negligence, there are also sound policy reasons in support of ....the present wording of the policy, so as to restrict coverage to those cases where the driver is licensed. Otherwise there is a potential for an exposure of authorised insurers to claims involving drivers who are unqualified, or disqualified from operating motor vehicles, which could be quite significant.

The law, as interpreted by the Courts, therefore, is that the CTP insurance does not cover all motor vehicles driven on the roads today. This is contrary to the intention of the legislation. The impact is severe on third parties.

**Case Study No 16: ‘Innocent’ Victims of Legal Interpretation**

In 2003, one Pranish Prakash Chand was traveling in a vehicle on his side of the road. The driver of another vehicle, one Ganpati Bala, allowed his vehicle to cross the centre line of the roadway and collided head-on with the vehicle containing Pranish Chand. Pranish Chand was seriously injured. The vehicle driven by Bala belonged to one Sandhika Chand, who had hired the vehicle out to Bala for $100 per week. Ganpati Bala supplied his own fuel and attended to maintenance. Bala was conveying one passenger in return for a payment of $35. The injured third party, i.e. Pranish Chand, commenced proceedings against Sandhika Chand and Ganpati Bala. Neither of them took steps to get the insurance company to pay under the CTP policy; judgment in liability against them was obtained by default and damages were proved at a hearing. The Defendant, an insurance company, had issued a Third Party policy to Sandhika Chand for the vehicle; the cover issued was for a goods vehicle. The premium was $90. The policy contained exclusions and defined the persons or classes of persons entitled to drive and enjoy cover under the policy. The main term was as follows:

**Limitations as to use -**

‘Premium has been paid for only the use of the motor vehicle for the purposes set out in item number 3 (A) of the schedule on back hereof, provided however that a premium paid for the use of the motor vehicle for the purpose set out in No. 2,3,4,5, or 10 of the schedule shall also cover use of the motor vehicle for social domestic or pleasure purposes, or for the Owner’s business
within the limits set out in Item No. 1 (b) of the schedule, or in the case of a hire car or rental car, for the hirer's business. That motor vehicle must not be used for any other purpose unless the policy is endorsed and extra premium (if any) paid.’

Item No.3 (a) of the schedule on back defined a goods vehicle [as defined above]. The Court (Chand v Sun Insurance Co. Ltd Civil Action 265/2005, High Court of Fiji, Lautoka Judgment 13/2006) defined the issues as follows:

i. Whether the insurance company is required to compensate the plaintiff - Chand - and therefore indemnify Ganpati Bala and Sandhika Chand.

ii. Whether the insurance company can refuse to compensate the third party on the grounds that allegedly a person was a passenger for a fee in the vehicle belonging to the insured when such alleged carriage of passenger for hire or reward was not within the knowledge of the plaintiff.

iii. Whether the insurance company can refuse to compensate the plaintiff on any grounds that is private to or is a breach as between the defendant and its insured or on any grounds whatsoever.

In other words, is the third party entitled to payment of the amount of his judgment from the Third Party insurer?

The Court, on the basis of Kumar v Sun Insurance, decided in favour of the insurance company.

The consequence is that Chand, an innocent third party victim of an accident, is almost permanently incapacitated, with no source of income, and no remedy in the country. Chand is now appealing the High Court decision. The Court, through Finnigan, J., stated:

This is yet another case of a blameless member of the public being deprived of what the legislature and the Courts clearly recognized is the protection he should have against impecunious wrongdoers.

One issue that this case raises is whether the court, originally in the Kumar case, which itself was based on precedents from another jurisdiction with different insurance conditions and remedies on the ground, was the legally correct interpretation of the law.

The third party insurance law is based on a very clear understanding: the protection of third party victims of a motor vehicle accident. The
law, as it stands, made or recognized no exception to this intention. The contextual interpretation of the law, therefore, would need to rehabilitate the intent of the law. This is especially necessary in light of the fact that CTP insurance is not a matter of the law of contract, where the terms and conditions placed by the insurance company take precedence; it is a matter of statutes, where the overriding matter in interpretation is the intention of the law. The view advanced in this report is that the judges in the Kumar case, being unduly moved by the impact of a contrary decision on insurance companies, did not correctly interpret the law on CTP insurance.

The Kumar judges, however, recognized the problem that their interpretation gave rise to. They stated:

[31] The result in this case is most unfortunate and there would be a public benefit served by creating a common fund under Act of Parliament to which authorised insurers should be required to contribute, that could provide cover to persons who are injured, and to the dependents of those who are killed, as the result of the actions of unlicensed drivers or through the use of uninsured vehicles, as well as in those cases where the vehicle concerned in the accident cannot be identified. Ample precedent for such a scheme exists in other jurisdictions.

What the case highlights is that there ought to be a recognition that unless the court provides a remedy to innocent parties, it becomes the onus of the legislature to provide an interpretation, or an amendment, that is totally unambiguous. In this regard, the regulator of the insurance industry, the Reserve Bank, also has a crucial role in ensuring that any supposed anomaly or ambiguity in the law regulating insurance is addressed, and in this role, ensure that the intention of the legislation on insurance is met. Such matters call for the regulator to provide advise to the Minister. Unfortunately, the Reserve Bank has remained silent on this issue.

Any measure that compels citizens to pay an insurance creates an enormous responsibility of the state. In the case of CTP insurance, the state has delegated this responsibility to the Reserve Bank of Fiji and the Ministry of Transport. It is vital that these entities, and especially the RBF as the insurance industry regulator, consider the mechanisms that can be put in place to take account of the public interest. The status of CTP insurance is unsatisfactory, both in terms of rates/premium and the coverage scope. The latter has been discussed above. As far as rates are concerned, the insurers argue that any regulation of the rates would make
the industry unsustainable and that the margins in this category of insurance are marginal. For this reason, the insurers resort to denying claims as far as they possibly can, thereby relying on contractual exclusion provisions.

It is vital, therefore, that the regulator(s) consider alternative means of ensuring that the objective of the compulsory third party insurance is attained; this may include possibly the creation of an accident compensation commission that could cover for compensation for various types of accidents, including motor vehicle accidents and accidents at workplaces.

Views expressed by insurance providers of CTP insurance vary. One provider of CTP insurance states that CTP insurance is working fine overall, and that if in some cases the system did not produce the desired result, it is not enough of a reason to amend the foundations of CTP insurance.

Alternatives proposed or accepted by other providers include:

- Creating a pool of uninsured risk which will cater for payments to innocent victims where exclusion clauses prevent any payment from insurance to them. Such a pool can be developed in each insurance company, or it can be created within the state system with rules of access by insurance companies to this fund, or jointly by the industry and the state.

- Establishment of an Accident Compensation Commission (ACC) which should take over all accidents, including motor vehicle accidents, workplace accidents, and general accidents. One insurance company providing CTP now, however, believes that an ACC would become a white elephant in Fiji.

- There be placed limits to liability for CTP for private vehicles. There are limits now on public service vehicle CTP claims; these are $4,000 per person or $40,000 for all passengers collectively.

- The limits for the PSV CTP claims are too low and need to be raised. The limit needs to be raised, or be topped from the fund created by uninsured risk.

- CTP is a beneficial legislation. As such, the Insurance Act must be amended to make it compulsory for all insurance companies to offer CTP insurance policies. Once this is done, the state must also consider whether it wants to let the market determine the premiums or whether it should regulate the rates.

The above indicates that there is an urgent need for a thorough review of the CTP legislation so that any legislation on compensating vic-
tims of motor vehicle accidents are adequately and fairly protected.
6
The Regulator’s Position

6.1 The Free-market Approach

The Reserve Bank takes the position that the insurance industry is a private sector industry. As such, the market ought to regulate the industry. The Reserve Bank, as the regulator under the Insurance Act, is largely to ensure that the industry remains viable, and that no individual insurance provider suffers bankruptcy. As such, its focus is entirely on prudential regulation.

The confusion that the Bank suffers from is: who is to be protected? Is it the consumer of the product, which would include thousands of commercial enterprises that utilize insurance services in their daily businesses, or is it the insurance companies.\textsuperscript{18} The current thinking seems to be that the individual insurance companies need protection from bankruptcy or liquidation. The RBF sees its role as one that will, by ensuring that the industry continues to be viable, protect policyholders’ interests. This is the crux of prudential regulation that it undertakes. This approach of the RBF is confirmed by the discussion of the industry in the various annual reports it takes out on the industry. Thus, the regulator sees that consumer interest can only be advanced indirectly through ensuring the survival of the industry. This is far from what consumer protection is all about. That the entire insurance industry needs to be protected, including from loss of confidence, is not a matter that seems to concern the regulator of the industry. The legislature, on the other hand, had clearly intended to provide protection to insurance consumers.

The outcome is that matters that would be important for consumers, including commercial consumers of insurance products, are left unattended to.

\textsuperscript{18} One possible source of the confusion could be a view within the RBF that the RBF Act supersedes the Insurance Act. Similar confusion surrounds the banking industry, where the RBF ignores protection of banking industry consumers.
6.2 On Imparting Full and Correct Information to Potential Clients

The RBF claims that it monitors whether insurance companies have any ongoing continuing education program for their employees and agents; this is done through discussions in the following forums:

a. Insurance Task Force Meeting;
b. Annual Governors Meeting with the Licensed Financial Institutions (LFI); &
c. Onsite Inspections of the LFI’s by the RBF.

During the Insurance Task Force Meeting and the Annual Governors Meeting, licensed financial institutions are required to provide brief descriptions of the training programs they have to enhance the skills of their employees and agents. This was deemed important as a result of skilled industry people migrating after the 2000 political upheaval. A result of this dialogue was the introduction of insurance seminars/courses by TPAF in 2006. In addition during onsite inspections, the RBF highlights the importance of training and skill enhancement of employees with the management of the licensed financial institutions. Companies are required to have documented procedure manuals in place and continuous management and technical insurance training are to be provided. The companies are also requested by the RBF during onsite inspections to allow their staff to undertake insurance training offered at various institutions, i.e. both local and correspondence exams.

The annual reports of the insurance industry, however, make no reference to the requirements on procedure manuals, training, and the industry’s attempt to ensure that it abides by the requirements on imparting full and correct information to clients.

6.3 On Employees and/or Agents being Aware of all Policy Details

The RBF states that the approval of the insurance agents licensing is subject to adherence to the relevant provisions of the Insurance Act 1998, governing insurance agents/employees, adherence to the ‘Code of Ethics’ signed with the insurer and any further requirements that may be issued by the Reserve Bank of Fiji. These are standard requirements which all insurance companies and their agents/employees are to comply with at registration and subsequent renewals. Again, through onsite inspections and discussions with the underwriting management, the awareness of the RBF policy is highlighted.

The above, however, provides no guarantee that the insurance
agents / intermediaries are thoroughly versed with all the insurance policy
details that come under their purview. As such, there is no assurance that
insurers’ employees and/or agents provide full details of the policies to
potential clients. The RBF relies on the insurance companies to follow the
law (s6(1)). In particular, the RBF imposes a lot of the responsibility on
the company in that the Principal Officer of the company has to approve
the agent to be an agent of the company. In so doing, the onus is on the
company to ensure that being a tied agent, the agent must issue the full
details of the policies to the potential client.

There, however, is no independent verification on whether the pro-
visions of the law are in fact abided by. Evidence abounds that these are
not, and in fact are habitually breached by insurance intermediaries.

In like manner, the RBF relies on the companies to assess the suit-
ability of the insurance agents. S43(1)(b) of the Insurance Act requires
the RBF to see if the financial standing and general character of the appli-
cation for a license is sound. The question that arises is the mode in which
the RBF accesses the financial standing, and general character of the ap-
licants.

The RBF states that it relies on the:
insurers to check the financial standing and the general character
of the agents before nominating the agents to carry out services
for the insurer. In addition, the application form on licensing the
agents does address the question of financial standing and gen-
eral character for insurance agents, which are Part VIII and IX of
the form. The application form has a section on nominated statu-
tory declaration where the nominating insurance company de-
clares and signs off on (personal communication).

The form refers to the ‘Application for Licensing as an Agent’ form
(Form 4, Insurance Regulations 1998). Part VIII requires the application
to provide details of an applicant’s employment history, qualifications
and experience (particularly in relation to insurance). Part IX, applicable
to the case of a corporate agent, director, general manager, secretary or
other similar person, requires the applicant to give details on whether the
applicant has been convicted of an offence in respect of conduct relating
to insurance or dishonest conduct or at any time been declared bankrupt.

The application form does not require the applicant to provide a po-
lice clearance report. This is a major weakness of the application form
for application to become, or to renew status as, an insurance agent.
6.4 RBF-Consumer Interface

The interface between the RBF as the regulator and the consumers is negligible. Occasionally, the RBF receives complaints from the insured/public against Insurance Companies. The RBF states that all complaints received are ‘investigated and analyzed. Required information is requested from the insurer and once assessment is made, the results are relayed accordingly to the complainant’ (personal communication).

The insurance industry annual reports do not contain any statement – whether on the basis of its investigations or as a matter of instilling confidence of consumers on insurance providers – that the relevant laws regulating the industry are followed.

6.5 Fraud and Abuse in the Industry

Insurance fraud is now a common form of fraud. Fraud increases the costs of providing insurance services. Two general insurance companies in Fiji provided estimates of the quantum they paid out on suspected fraudulent claims; for one this was at 10% of all payouts, while for the other it was 15%.

Fraud has direct bearing on the cost of insurance services. Fiji is no exception to insurance fraud. Insurance companies indicate that fraudulent claims often arise. Almost all insurance policies specify that if fraud is established, the policy holder would lose all benefit. This is a strong deterrent, but not strong enough to eradicate fraud from the industry.

Insurance companies also utilize assessors to, inter alia, investigate and assess whether a claim made is within the provisions of the policy. As long as the insurance companies have the final word on payment, fraudsters remain in a weak position if fraud is detected.

The problem, however, continues. This is because insurance companies do not subject the fraudsters to police for investigation and prosecution. As long as insurance companies refrain from handing over all cases of fraud to police for investigation and prosecution, fraud within the industry is likely to continue.

To eradicate insurance fraud, the Insurance Act ought to require that all cases of fraud detected by insurance companies be given to the police for action, and that insurance companies can not deny liability without handing over cases of fraud to the police. The proposed annual disclosure statements ought to also contain a statement on fraud detected in the industry. Any lesser option would continue to place the burden of rising
premiums and falling scope of coverage on the consumers in the country.

One other form of abuse found in Fiji is ‘influence peddling’. Some insurance companies have claimed that occasionally powerful people from the commercial and political world utilize undue influence on insurance companies to pay out claims where none should have been paid out, or a lower sum should have been paid out.

While it is expected that in smaller countries, there would be a tendency for a greater degree of influence peddling, this problem is by no means unique to Fiji. The onus has always been on the insurance companies to be not influenced by the strong and powerful. Influence peddling could border on the criminal. It, therefore, becomes the responsibility of insurance companies to tackle influence peddling head-on. But the reality that the strong and powerful in Fiji can also close the gates for the insurance train, needs to be recognized. This problem needs to be addressed within the larger framework of ensuring good governance and transparency within commerce in Fiji.
Conclusion

The insurance industry comprises 2 life insurers, 8 general insurers, 5 brokers, and 314 registered/licensed insurance agents. Two out of the 15 insurance providers and brokers (i.e. 13%) are totally Fiji owned businesses. The industry carries out significant product differentiation. Competition within the industry is relatively limited, with industry players utilising insurance agents to compete to generate greater businesses for them. There are evidences of cartel type behaviour in the industry. The industry does not have a formally accepted code of conduct drafted; a draft done by the Reserve Bank of Fiji was rejected by the industry in 2004. There is also no external complaints mechanism to handle insurance industry disputes. While anti-competitive behaviour in the industry is significant, the industry as a whole competes with other industries to get a larger share of the consumer dollar.

The market share of insurance companies has been difficult to estimate since, barring one, no firm provides any data on their financial operations in Fiji. Proxies, for example, firm employment data, are also not collated or provided. For greater transparency of the industry, there is an urgent need for an amendment to the Insurance Act to require insurance companies to provide key disclosure statistics publicly. This is particularly important in light of the fact that only 2 of the 15 insurance companies/brokers are locally owned. It is also important to dispel, or otherwise, the widely held view that insurance companies operate as a cartel and, therefore, short-change consumers.

Insurance consumers in Fiji face numerous types of risks. This necessitates the enactment of comprehensive consumer protection legislation, and where such legislation is present, a diligent enforcement of the provisions of the legislation.

Industry performance in terms of profitability has been sufficiently good to maintain two life and eight general insurance companies in the industry. Underwriting surplus ratio has showed a steady increase from 2000 to 2005. There has also been a steady decline in losses paid out relative to premium income from approximately 80% in 1999 to 50% in 2005. Householders insurance, personal accident, public liability, and
workmen’s compensation did particularly well for the companies during this period. Expense ratio showed a steady decline from around 34% in 1998 to about 20% in 2005.

Industry annual reports, prepared by the industry regulator, the Reserve Bank of Fiji have been providing erroneous data on the industry. There is no systematic procedure in place for the insurance regulator to check the industry of possible transfer pricing.

The industry is regulated by the Insurance Act, 1998. While the legislation provides for consumer protection mechanisms, the intention of the law was to place the burden of the conduct of the insurance industry on the insurance providers themselves. For an industry that is as significant as insurance industry for the economy, such self-regulation can not be a sufficient basis for consumer protection. The outcome of the law, and the conduct of the players and the regulator so far have been such that not only have consumer interests and rights been generally neglected, but also that whatever consumer protection provisions are present in the legislation, have generally been ignored by the regulator in terms of enforcements.

The conduct of the regulator continues to be one focused on prudential regulation alone. Since 1998, not a single annual report of the industry contained any commentary on consumer or policy-holder rights and interests. Breaches of the Insurance Act have been ongoing. The regulator has so far neglected to ensure that the law is abided by fully. It has also failed to ensure that the law is enforced vigilantly. The regulator has also not carried out its duty of advising the Minister on the shortcomings of the legislation. While the Insurance Act 1998 has stronger provisions for consumer protection than the Insurance Act 1976, there are numerous weaknesses within the consumer protection provisions of the Act, both in terms of lack of completeness and lack of scope/coverage. There is an urgent need to amend the Act to include stronger provisions on consumer protection. There also is an urgent need to make a concerted effort to enforce the provisions of the Insurance Act. The regulator – the RBF – needs to do this, failing which the Board of the RBF needs to give a firm directive to the management to enforce the legislation. If the above does not produce any positive result, then a ministerial directive would be needed to ensure diligent enforcement of the consumer protection provisions of the Insurance Act.

The industry in Fiji continues to operate in an environment riddled with numerous problems, many of which are fundamental problems that need urgent attention. A major problem is that there is a lack of adequate monitoring of the industry to ensure that the Insurance Act is abided by.
Over the past 2 decades, there has emerged a significant, and possibly a growing, ‘informal’ insurance market. There is also a sizeable ‘informal’ insurance agency business in Fiji. The regulator has not opted to regulate the informal market.

A major breach of the legislation is that on informing consumers of all relevant details on a policy. There is no policing of this by the regulator. There is no national or formal examination on insurance policies that the agents ought to pass before they are given an insurance agent’s license. A lack of such examination or a formal process to test the knowledge of the applicants of the specifics of insurance policies also creates possibilities of arbitrariness in RBF decision making.

A major problem is that the insurance industry employees and agents do not themselves know the policies that they sell. The unwillingness of a large part of the industry to provide customers with copies of policies before they sign on, is another major area that needs to be looked at. The industry in Fiji is renowned for not-disclosing all the key coverage scope of insurance policies. There are cases where some companies continue to accept premium but then decline liability of the amount insured for various reasons.

Another problem is the ‘fine-print’ problem; most policies are written in fonts that make reading the policies very difficult and stressful. Most policies also contain long-winding and confusing statements that make understanding a standard insurance contract very difficult for an average consumer.

The Reserve Bank is required by law to examine every insurance proposal, every policy document, every endorsement of a policy document, and any form of written matter used by an insurer which describes the terms or conditions of, or the benefits to be or likely to be derived from a policy of insurance. The law also requires the RBF to approve the standard terms and conditions of each and every insurance policy. The Reserve Bank has not been doing this, nor does it have on file a full set of policies, let alone a full set of subsidiary documents.

RBF also does not monitor whether the insurance companies abide by the requirements that life insurance companies are required to inform each new policy holder, either through the policy itself, or through annexures to the policy, that the policy holder has a right to return the policy to the insurance company in return for a full refund of the premium within 28 days of receiving the policy. Except for the LICl policies, no other insurance company complies with this requirement.

Policy terminations are also matters of significant concern. Of all policies terminated during 1999-2005, approximately 86% were on ac-
count of surrenders and forfeitures. On average during the past 7 years, 60% of all policies by number (and 69% by value) were forfeited while 25% by number (and 18% by value) were surrendered. Terminations through surrenders and forfeitures involve, on average, approximately 16,120 persons per year and $14m per year in premium. Surrenders account for, on average, $2.9m per year and forfeitures to $11.2m per year in premium. Thus each year, insurance companies keep at least $2m in premium through surrenders and $11m through forfeitures. These sums are net earnings of the life insurance industry. A law and/or a practice that allows such ‘rent-seeking’ behaviour in the industry does not create an efficient market.

Insurance companies, agents and brokers do not have a demonstrated practice of rapidly responding to enquiries from their clients. Under the law, for group insurance schemes, only one notice for the group is sufficient. There is no requirement that individual members need to be informed of any aspect of their policy. This provision of the law needs to be changed.

The law provides that an insured is entitled to, on written request, be provided by his/her insurer with a copy of an auditor’s report of an insurance company or broker, required to be lodged with the Reserve Bank of Fiji; a profit and loss statement, and a balance sheet of an insurance company and a broker; and a statement of revenue and distribution, and Balance Sheet for life insurers. It is not known if policy holders have been informed of this right by insurance companies and/or agents, or whether the regulator has at any time informed the consumers of this right. The RBF takes the position that the Insurance Act is a public document accessible to all consumers. The presumption of this position is that policy holders must know full details of their rights under the Insurance Act, a position that is legally sound, but practically not realistic.

Dissatisfaction against medical insurance in Fiji has been expressed widely. Dissatisfactions arise from:

- insurance companies not honouring the commitments that the insured believed the insurance company gave them,
- delays in approving medical treatments,
- delays in payments,
- unethical practices,
- negligence in handling medical outpatient treatment, and
- not informing clients fully and completely.

Other than these, there is a significant problem in terms of the coverage of the medical insurance schemes.
The National Fire Service Act, 1994 provides for a levy to be imposed on insurance policies to generate funds for the National Fire Authority; the rate now is 0.06% of the sum insured for all commercial and industrial fire policies, domestic fire policies including homeowners and householders, and contractors’ ‘All Risks Policies’. Insurance levy represents around 70% of the total revenue of the Authority. While consumers of the respective insurance products are required by law to contribute to the operation of the National Fire Authority, they do not have any control or authority over how their contributions are utilized by the Authority. This anomaly needs to be corrected.

There is some evidence that consumers have sought the assistance of the Reserve Bank, as the regulatory agency for the industry. The RBF refrains from seriously dealing with such complaints. The RBF’s view is that ultimately, the matter of insurance is that of a private contract between the insurance company and the insured; as such, if it can not be resolved by the parties, it ought to be resolved through a civil claim. This stand severely undermines the intent of the law on consumer protection. So far the regulator has made no attempt to create a mechanism for a regular consultation with insurance consumers.

Another major area of concern is on motor vehicle third party insurance. This insurance is compulsory. However, the industry has provided numerous exclusions to the coverage scope. This has led to numerous third party victims without any remedy under the insurance laws. It is vital that the regulator(s) consider alternative means of ensuring that the objective of the compulsory third party insurance is attained. There is an urgent need for a thorough review of the CTP legislation so that any legislation on compensating victims of motor vehicle accidents are adequately and fairly protected. Options that need to be examined include:

- Creation of an accident compensation commission that could cover for compensation for various types of accidents, including motor vehicle accidents and accidents at work places.
- Creating a pool of uninsured risk which will cater for payments to innocent victims where exclusion clauses prevent any payment from insurance to them.
- There be placed limits to liability for CTP for private vehicles. There are limits now on public service vehicle CTP claims; these are $4,000 per person or $40,000 for all passengers collectively.
- The limits for the PSV CTP claims are too low and need to be raised. The limit needs to be raised, or be topped from the fund...
created by uninsured risk.

- CTP is a beneficial legislation. As such, the Insurance Act can be amended to make it compulsory for all insurance companies to offer CTP insurance policies. Once this is done, the state may also consider whether it wants to let the market determine the premiums or whether it should regulate the rates.

The industry regulator takes the position that the insurance industry is a private sector industry. As such, the market ought to regulate the industry. The focus of the regulator is almost exclusively on prudential regulation. The outcome is that matters that would be important for consumers, including commercial consumers of insurance products, are left unattended to.

The interface between the regulator and the consumers is negligible. One possible solution to the lack of any focus of the regulator on consumer interests, is the separation of prudential regulation and consumer interest regulation, and handing over of the consumer interest regulation aspect to another body, like a Financial Services Ombudsman.
## Appendix I

### Analysis of Selected Insurance Policies

#### A.1: Life Insurance

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Not Covered</th>
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<tbody>
<tr>
<td>Endowment: If the life insured:</td>
<td>1. ‘any loss of life, or injury, directly or indirectly occasioned by, happening through or in consequence of’:</td>
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<td>a. war,</td>
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<td>b. invasion,</td>
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<td>c. act of foreign enemy,</td>
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<td></td>
<td>d. hostilities or warlike operations (whether war be declared or not),</td>
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<td></td>
<td>e. civil war,</td>
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<td></td>
<td>f. mutiny,</td>
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<td></td>
<td>g. ‘civil commotion assuming the proportions of or amounting to a popular uprising, riot, industrial relations dispute including strike, lock-out, military rising, insurrection, rebellion, revolution, military or usurped power, martial law or loot, sack or pillage in connection therewith’. [This exclusion is unclear the way it has been stated; whether it refers to the events listed as resulting from civil commotion, or arising within any relation to civil commotion (e.g. an industrial relations dispute)].</td>
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<td></td>
<td>h. confiscation or nationalisation or requisition or destruction of or damage to property by or under the order of any government or public or local authority;</td>
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<tr>
<td></td>
<td>i. any act or condition incident to any or all of the events listed above,</td>
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<td></td>
<td>j. any person or persons acting on behalf of or in connection with any organization the objects of which are to include the overthrowing or influencing of any de jure or de facto government by terrorism or any violent means, including chemical and biological operations to deliberately inflict death or in-</td>
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<td>1</td>
<td>jury.</td>
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<tr>
<td>k</td>
<td>capital punishment</td>
</tr>
<tr>
<td>l</td>
<td>suicide within 13 months of commencement or reinstatement of cover.</td>
</tr>
<tr>
<td>m</td>
<td>If insured dies at or less than 10 years, in which case premium, with interest, shall be refunded.</td>
</tr>
</tbody>
</table>

2. Coverage for Term Life, Accidental death, Total and Permanent disability, and Critical illness require additional premium to be paid on each separately.

3. If either proposal or any statement or declaration made by the policy owner or the life insured are found to be:
   a. untrue, or
   b. if any material fact affecting the nature of the risk is not disclosed to Colonial.

   The company voids the policy, in which case, all premium paid and benefit accrued are forfeited.

   [Whether the forfeiture of the premium and benefit is lawful, has not been investigated by the RBF.]

**Others**

4. Policy lapses (and premium paid is forfeited) if default on payment before 2 year’s premium has been paid. This is contrary to law.

5. If policy is forfeited because of default in premium payment within 2 years, any subsequent payment of premium and acceptance of premium by the insurer, does not comprise a reinstatement of the policy.

6. Colonial can attach ‘provisions and endorsements’ subsequent to the sale of the policy; policyowner agrees to this as part of the contract.

7. Payment requires that the policy holder or the beneficiary deliver the policy and any release form, to Colonial, and furnish proof to the satisfaction of the company:
   a. That policy benefits have become payable;
b. Of the age and identity of the insured, and  
c. That the person making the claim is entitled to do so.  
In the absence of the above, no payments are made.

**Terminal Illness:** If it is certified (from at least 2 of Colonial's medical practitioners and/or health providers) that life insured has a defined illness and is unlikely to survive 6 months, a sum of $25,000 + bonus is paid immediately, with the balance being paid upon death.

1. If policy is not 2 years old.  
2. If insured is less than 10 years old.

**Additional Conditions:**

1. **Term Life/Rider Benefit:**  
   * Additional premium to be paid (e.g. $183/year for $50,000 insurance for 15 years);  
   * premium increases each year  
   * Premium rate also changes during the term  
   * No bonus.  
   [What additional benefit goes to the insured is not stated.]

2. **Accidental Death:**  
   For a payment of $50/yr accidental death is covered. It applies when insured dies in an accident before reaching 65 years, or before maturity. No bonus accumulates.

   Accidental is defined as:  
   'death occurring directly and independently of all other causes from bodily in-

1. Any premium arrear disqualifies the insured from the term life cover.

1. If death is not accidental.  
2. If death is through:  
   a. Suicide  
   b. Capital punishment  
   c. Racing of any kind or training thereof, except on foot  
   d. Motor cycling  
   e. Any form of aviation except as a fare paying passenger in a fully licensed, standard aircraft operated by a recognised airline over an established air route or as a passenger in an aircraft flying under charter license. (thus excluded are
juries effected solely through external, violent, and unintentional means evidenced by a visible concussion on the exterior of the body, except in the case of drowning or of internal injuries revealed by an autopsy. Includes death through murder, battery and assault.

<table>
<thead>
<tr>
<th>Training flights, or employees on flights</th>
<th>f. Partaking of any drug (unless taken in accordance with the directions and prescriptions of a registered medical practitioner), or excessive consumption of alcohol. [Excessive consumption of alcohol is not defined, thus subject to dispute and possible denial of liability]</th>
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<tr>
<td>g. War (whether be declared or not), invasion, act of foreign enemy, terrorism (other than hijack of a commercial passenger aircraft, vehicle or vessel), civil war, rebellion, revolution or military usurped power</td>
<td>h. Involvement in any criminal activity other than as a proven victim or bystander.</td>
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### 3. Total & Permanent Disability

Provides an advance payment of part of the basic sum insured if the life insured becomes totally and permanently disabled before 65th year or maturity date.

**Definition:** as a result of an injury or illness which occurred while insurance cover was in force, insured is unable to engage in any business or occupation or to perform any and all work for compensation or profit for a continuous period of 26 weeks and, if in the opinion of Colonial, will be unable to ever undertake any such work. Included: if suffer, when covered, loss of sight of both eyes (total loss), or loss by severance of both hands at or above the wrists, or both feet at or above the ankle joints, or one hand at or above the wrist and one foot at or

<table>
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<tr>
<th>1. If injury causing disability occurred prior to cover.</th>
<th>1. If injury causing disability occurred prior to cover.</th>
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<td>2. If illness causing disability occurred prior to cover.</td>
<td>2. If illness causing disability occurred prior to cover.</td>
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<tr>
<td>3. Colonial’s opinion is that insured could in future undertake some work.</td>
<td>3. Colonial’s opinion is that insured could in future undertake some work.</td>
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<td>4. If eyesight loss is not total and permanent in both eyes.</td>
<td>4. If eyesight loss is not total and permanent in both eyes.</td>
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<td>5. If no notice in writing of the accident within 28 days.</td>
<td>5. If no notice in writing of the accident within 28 days.</td>
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<tr>
<td>6. If no proof that life insured has been totally disabled.</td>
<td>6. If no proof that life insured has been totally disabled.</td>
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<tr>
<td>7. If premium payment ceases upon the accident. (Thus colonial can extend the period during which it would make a decision, while insured would suffer loss of income thus be unable to pay premium, thereby causing cessation of benefit)</td>
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<tr>
<td>8. If disabilities result from:</td>
<td>8. If disabilities result from:</td>
</tr>
<tr>
<td>a. intentional self inflicted injury</td>
<td>a. intentional self inflicted injury</td>
</tr>
<tr>
<td>b. racing of any kind or training thereof, except on foot</td>
<td>b. racing of any kind or training thereof, except on foot</td>
</tr>
<tr>
<td>c. motor cycling</td>
<td>c. motor cycling</td>
</tr>
<tr>
<td>d. any form of aviation except as a fare paying passenger in a fully licensed, standard aircraft operated by a recognised airline over an established air route or as a passenger in an aircraft flying under charter license.</td>
<td>d. any form of aviation except as a fare paying passenger in a fully licensed, standard aircraft operated by a recognised airline over an established air route or as a passenger in an aircraft flying under charter license.</td>
</tr>
<tr>
<td>e. partaking of any drug (unless taken in accordance with the directions and prescriptions of a registered medical practitioner), or excessive consumption of alcohol.</td>
<td>e. partaking of any drug (unless taken in accordance with the directions and prescriptions of a registered medical practitioner), or excessive consumption of alcohol.</td>
</tr>
</tbody>
</table>
above the ankle joint.

Additional premium to be paid; for $50,000, 15 year term, this is $68.50/year; premium increases annually, and rate may change during term of insurance.

| 4. Critical Illness: Provides an advance payment of part of the basic sum insured if the life insured is diagnosed to be suffering from one of the defined illnesses becomes totally and permanently disabled before 60th year or maturity date. Additional premium to be paid; for $50,000, 15 year term, this is $127.50/year; premium increases annually, and rate may change during term of insurance. Defined Illnesses: 1. Heart Attack (Myocardial Infarction) 2. Coronary Artery By-Pass Surgery 3. Stroke resulting in Functional Loss 4. Life Threatening Cancer 5. Chronic Kidney Failure 6. Paralysis 7. Major Organ Transplant 8. Aortic Surgery 9. Heart Valve Surgery Each of these have been specifically defined. | consumption of alcohol. [Excessive consumption of alcohol is not defined, thus subject to dispute and possible denial of liability] f. war (whether be declared or not), invasion, act of foreign enemy, terrorism (other than hijack of a commercial passenger aircraft, vehicle or vessel), civil war, rebellion, revolution or military usurped power, or g. involvement in any criminal activity other than as a proven victim or bystander. |
# A.2: Medical Insurance

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Not Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indemnifies the ‘ultimate net loss’ in respect of specific expenses for up to but not exceeding the amount specified</td>
<td>1. Treatment at private facilities, unless pay additional premium.</td>
</tr>
<tr>
<td><strong>Fiji Public Hospital Benefit:</strong> In-patient and Day Care: In-patient or DayCare for a disability in any Government Hospital or Clinic at Government rates as per Fiji Government Gazette. All Daycare treatment will only be carried out in Government hospitals. If opt for treatment at a private clinic, an additional premium of 20% is required. Max benefit: F$5000 p.a. Max Limit for Prescribed Medicines any (sic) Disability: F$500 p.a. Prescribed medicines is defined as those prescribed by medical practitioner for cure or relief of insured’s disability, which may not be legally purchased without a medical practitioner’s prescription.</td>
<td>2. Any liability over $5000 pa 3. Any liability for prescribed medicines and disability over $500 pa. 4. Medicine that is available ‘over the counter’.</td>
</tr>
<tr>
<td><strong>Fiji Private Clinic or Daycare Benefit:</strong> Daycare surgery, in any Private or Medical clinic in Fiji, including services provided by Visiting Overseas Consultants. a. If treatment or procedure is available in Fiji public sector, and b. has been recommended by a Medical Practitioner appointed for the purpose by FijiCare. Maximum claims: * if treatment provided privately in Fiji but treatment available in public sector in Fiji: F$5,000 p.a. * if treatment is provided privately in Fiji but not available in public sector in Fiji: F$20,000</td>
<td>1. Only cover is for treatment availability; the time of availability of such treatment is not a consideration. For example, if public hospital can not perform a procedure within 3 months, the fact that it is available here means that the insured will not be covered for any-</td>
</tr>
</tbody>
</table>
thing more than $5000/pa if he opts for private treatment that is available immediately.

2. Quality of treatment is not an issue.

**Overseas Medical Evacuation Benefits (Medivac):**

i. must be recommended and certified first by a Medical Practitioner stating that treatment for disability suffered is not available in Fiji,

ii. a Medical Practitioner appointed for the purpose must recommend such treatment and will disregard alternative methods of treatment not available in Fiji.

Cover:
1. FijiCare may at its own option secure the appropriate evacuation overseas and the provision of the benefits described to a Preferred Hospital, or

2. Subject to paragraphs i & ii, the Insured may make his own arrangement for appropriate evacuation overseas and after having obtained prior approval from FijiCare for a course of treatment in a hospital other than in a Preferred Hospital.

a. in the event an Insured elects treatment for a disability at a hospital other than at a Preferred Hospital, the entitlement benefits of the Insured for treatment subsequently in relation to the same or substantially the same disability at any hospital (including a Preferred Hospital) shall not exceed NZ$30,000.

b. the benefits conferred shall not exceed NZ$30,000.

c. benefits are only claimable for treatment/procedure obtained in Australia or New Zealand unless FijiCare is notified beforehand of a potential claim and approval prior to treatment has been obtained.

3. All cost relating to Orthopedic surgery including hip and knee replacement, from administration till discharge, to be met by FIL, subject to 20% excess.

4. All cost relating to cardiac and cancer conditions from ad-
ministration till discharge, to be met by FIL, subject to 15% excess.

**Benefits:**
1. Diagnostic Services, Daycare Services, and Inpatient Services including services of Surgeons, Physicians and Specialists as well as Intensive Care, Special Nursing, Blood & Plasma, Medicines, Medical Supplies and Prostheses which are certified to be medically necessary will be provided in appropriate Preferred Hospitals in New Zealand or Australia as FijiCare shall determine according to the medical needs of the Insured and the availability of the required treatment. An Insured who elects to be treated at a hospital other than the preferred Hospital nominated by FijiCare shall be entitled to the benefits prescribed for such hospitals hereunder:
   a. in a preferred hospital arranged by Fijicare: $NZ80,000 per disability or evacuation benefit.
   b. In any other hospital arranged by the insured, reimbursement of 90% of all ‘reasonable and customary’ charges which have been previously approved by Fiji Care: $30,000

**Evacuation Benefits:** Each time a medical evacuation has been approved by FijiCare for an Insured in respect of any one disability for so long as the Overall Limit of Benefit for the same has not been exceeded:

*For the Insured*
1. Return Economy Airfares (or stretcher fares as may be Medically Required) to the airport where the nearest Preferred Hospital selected by FijiCare is located or the actual cost of fares to any other hospital but not to exceed the cost of travel to the preferred hospital
2. Cost of medical supplies or rental of medical appliances required for the care of the Insured on the journey from Fiji to the Preferred Hospital or from the Preferred Hospital to Fiji.
3. Return Cost of transportation by ambulance or taxi from airport of destination to Preferred Hospital selected by FijiCare (return on discharge).
4. Cost of board and accommodation other than when an inpatient is in the hospital during the period of necessary treatment when provided by the Preferred Hospital as charged, or when in a hotel, motel, boarding house, or with relatives or friends not to exceed NZ$50.00/day.
5. Costs of Visa application and Airport Taxes as charged.

| 1. If charges judged by insurance company as not ‘reasonable’ or ‘not customary’, there is no cover. |
| 2. Diagnostic procedures, including x-ray undertaken outside Fiji is not covered unless the medical practitioner designated for the purpose by FijiCare approves alternative procedures overseas. |

| 1. If not approved by FijiCare in advance of seeking treatment, no benefit is possible. |
For a Medical Attendant (approved to accompany insured; approval requires certification from Specialist or a designated Physician that presence of a medical attendant during the trip is a medical necessity):

1. Return Economy Airfares as for the insured.
2. Any additional cost of transportation by ambulance or taxi from the airport of destination to the Preferred Hospital selected by Fijicare.
3. Cost of taxi from the hospital to the hotel, motel or other accommodation and from such place of accommodation to the airport of departure for Fiji.
4. Cost of board and accommodation from the time of delivery of the Insured to the hospital until the time of the first reasonably available return aircraft to Fiji, when provided by the Preferred Hospital as charged, or when in a hotel, motel or boarding house as Charged but not to exceed NZ$150/day, or when in any other accommodation such as with relatives or friends NZ$50/day.
5. Cost of Visa application and Airport taxes as charged.

Limits for evacuation benefits for each evacuation: NZ$2,500 for accompanying attendant.

For any other Person approved to accompany Insured:
* Approval requires certification from the Medical Practitioner as appointed by Fijicare to state that it is medically necessary for the Insured to be accompanied.

1. Return Economy Airfares as per insured
2. Any additional cost as per accompanying person
3. Cost of taxi as per accompanying person
4. Cost of Board and accommodation from the time of arrival of the Insured to the hospital until the time of the first reasonably available return aircraft to Fiji, when provided by the Preferred Hospital, as charged, or when in a hotel, motel or boarding house, or with relatives or friends, as charged or no more that NZ$50/day.
5. Cost of Visa application and Airport taxes as charged.

Limits for evacuation benefits for each evacuation: NZ$2,500 for accompanying relatives etc.
All of the above need prior approval from Fijicare.
**Repatriation of Body & Funeral Benefits:**
If Insured dies overseas under provisions of this policy FijiCare will provide reimbursement for costs of embalming, coffin, transportation, or a contribution towards overseas funeral costs: maximum of NZ$3,000.

| 1. No benefit if insured is overseas not on provisions of this policy |

**Misc:** if insured under another company as well: If claimant was declined or cancelled by another insurer, he may be able to make a successful claim with FijiCare but will be subject to further review by FijiCare before the claim can be met.

| 1. If insurance period expires, but claim relates to the medical condition acquired during period of insurance, there is no cover. |

**Making Claims:**
Claims can only be made within the current period of insurance cover. Cover will extend to claims to be made outside of that period only if:-

1. the policy is renewed, so that the claim is then made in a subsequent period of insurance cover.
2. the policy is renewed for the claimant as a paid up individual (as opposed to Groups member).

Each medivac overseas is treated as a separate claim and not part of a continuing single claim course of treatment, and would be subject to a NZ$80,000 overall limit.

| 1. If insurance period expires, but claim relates to the medical condition acquired during period of insurance, there is no cover. |

**Group Scheme:**
1. If covered under a Group Scheme, and the Group decides to terminate the scheme or let it lapse, or an individual is no longer employed by the Group policyholder, an individual will be permitted to maintain cover providing he notifies FijiCare within 14 days of such termination, lapse or cessation of employment and applies and is accepted as an individual member.

2. FijiCare reserves the right to exercise an absolute discretion and make available in certain cases monies for approved treatment whether or not the treatment falls within the strict terms of this policy, up to a maximum of F$5,000.

**Not Covered**
This insurance does not cover claims arising directly or indirectly from or consequent upon:

1. War, invasion, act of foreign enemy, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection or overthrowing of government by force or military or usurped power;
2. Ionising radiations or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel; and the radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear
component thereof;
3. Naval, military, air force or police force operations.
4. All medical or surgical costs including other expenses directly or indirectly result-
ing from or consequent upon treatment for congenital conditions and deformities or
abnormalities.
5. a. Treatment for self-inflicted injury whilst sane or insane, attempted suicide or
injuries resulting from excessive consumption of alcohol or drugs.
b. Treatment for chronic alcoholism, drug addiction, allergy
d. Outpatient treatment for skin disorders, or long term chronic disorders unless
approved by the Medical Practitioner designated for the purpose by FijiCare.
6. Rest cures, sanatoria, or custodial care or periods of quarantine or isolation.
7. Rehabilitation including speech therapy, occupational therapy and psychological
assessment unless following acute procedures limited to a period of two (2) months or
F$5,000.
8. Organ Transplants including bone marrow transplants or related pre or after care
procedures or treatment.
9. Custodial or maintenance services for the permanently disabled.
10. Cosmetic, plastic surgery, or eye surgery for astigmatism unless necessitated
by an accidental bodily injury occurring while insured, and involving a claim covered
under this Policy and if it has been approved by the medical practitioner designated
for the purpose by FijiCare.
11. a. any dental treatment except as a result of accidental injury.
b. supply or fitting of optical or hearing aids except as a result of accidental injury;
c. examinations for checkup purposes not incidental to, or necessary for diagnosis
of illness or accidental bodily injury;
d. checkups or reviews with original overseas specialist unless medically neces-
sary and subject to prior approval by FijiCare.
e. general health examinations; including examinations required by Embas-
sies/High Commissions prior to issuing visas.
f. inoculations and vacci-
nations;
g. contraceptives and/or the fitting of contraceptive devices;
h. treatment pertaining to infertility unless approved;
i. whilst outside the geographic limits of the Republic of Fiji, no claims will be ente-
tained unless prior approval has been obtained from FijiCare before entering
upon any treatment.
12. Treatment or diagnosis of either H.I.V positive Acquired Immune Deficiency
Syndrome (A.I.D.S) or A.I.D.S Related Complex (A.R.C) or any related diseases re-
sulting therefrom.
13. Pregnancy, miscarriage or abortion unless unexpected life threatening compli-
cations arise in the mother.
14. Non medical services or charges such as telephone calls, taxis, use of radio,
television, newspapers ancillary charges, and the like.

15. Any physical or mental condition, which originated prior to the effective date of an Insured Person's inclusion hereunder unless disclosed in the Insured's Application form and accepted by FijiCare.

16. A defacto spouse is not covered, unless disclosed and approved as a depend-ent to be covered by FijiCare and that the requisite medical history for that defacto spouse has been lodged with and approved by FijiCare.

17. Excluding amounts to which an Insured Person is entitled to under current Workers Compensation Legislation, other group or individual insurance coverage including any travel Insurance Cover. The benefits payable under this policy are limited to the balance of expenses not covered by benefits payable under any other insurance coverage benefit or that calculated from the schedule of insurance of this Policy whichever is less.

18. Expenses incurred for services, which have not been performed or recom-mended by a legally qualified medical practitioner and approved by FijiCare.

19. Disabilities incurred in pursuit of an illegal [policy statement stops here – author]

20. Pre existing conditions will apply for thirty six (36) months, this includes any sickness or injury which when insured applied for this insurance:

(a) Insured was aware of, or
(b) In respect of which insured already had symptoms which would cause a rea-sonable person to seek diagnosis, care or treatment, or
(c) In respect of which a medical practitioner had already recommended treatment or further advice.

21. Decompression and associated treatment and travel costs necessitated by div-ing activities including the condition known as "Bends".

22. Any person having cancelled his cover or it having been terminated and who subsequently rejoins FijiCare may not claim for cardiac or cancer conditions until the expiry of 6 months from the date of rejoining.

23. Injuries or Illness arising out of the pursuit of dangerous sports, professions or activities including but not exhaustively, professional rugby, bungy jumping, para sail-ing, white water rafting, motor vehicle racing, horse racing, diving, water sports and amateur contact sports.

24. Treatment, which does not require hospitalisation or day care (such as outpa-tient visits to General Practitioners or Specialists) unless approved.

25. Routine Pharmaceuticals for chronic conditions whether by prescription or not, unless approved by FijiCare and subject to a maximum annual sub limit $500.

26. Physiotherapy or chiropractic, except in the case of serious injury and then sub-ject to a maximum of 2 month's treatment or $5,000.

27. Travel - any incident or accident which occurs while travelling outside the Geo-graphic Limits of Fiji.

28. FijiCare will only pay benefits as part of a course of treatment approved by Fijis-
29. FijiCare will not pay for any claim that was declined or cancelled by another insurer unless in an absolute discretion FijiCare agrees to meet the claim.

30. Long term illness such as Diabetes, Asthma, or Hypertension conditions are covered. However, for any related illness:
   a. in cases of pre-existing conditions, waiting period will apply as indicated under point 20 above before they are covered.
   b. if they are diagnosed after joining the scheme, they will be covered.

31. Palliative treatment for a terminal illness or Radiotherapy/Chemotherapy or any other treatment for the relief of symptoms of terminal illness is not covered.

32. Any Inpatient or Daycare treatment at Suva Private Hospital will not be covered.

33. If dependents are in the policy, but they do not comply with the requirements prior to acceptance of the policy.

34. a. If a written notice of any claim is not given to FijiCare within 31 days of it being incurred, unless it can be shown to the satisfaction of FijiCare that earlier submission was not reasonably practicable.
   b. Any claim notified to FijiCare after the expiration of twelve months of it being incurred shall be invalid and no payment will be made in respect thereof.
   c. If submitted without proof satisfactory to the Company of the death, illness, disability, injury or loss for which a claim is being made, or without all relevant bills receipts, tickets, coupons, contracts or agreements.
   d. If in the case of any medical claim, all pertinent and relevant supporting information is not supplied including, hospital and physicians bills, full physicians report stipulating diagnosis of the condition treated and when disability commenced, the summary of the course of treatment including medicines prescribed and services rendered. In the event of an overseas evacuation, the claimant must obtain from a designated Physician a medical certificate certifying that the claimant cannot be treated locally and the medical procedure or treatment required. The Certificate must also state whether evacuation is urgent and if approved, the date preferred and whether an accompanying relative or medical attendant is medically necessary.

35. If all statements and declarations made in respect of any claim against FijiCare by an Insured (or by a parent or duly appointed guardian if the Insured be a minor) are not certified as truthful and accurate by the claimant.

36. a. If prior to entering into the contract the Assured and/or an Insured did not disclose to FijiCare every matter he knew, or could reasonably be expected to be known to him and which was or could have been relevant to FijiCare's decision whether to accept the risk of insurance and, if so, on what terms.
   b. ditto, on seeking a renewal, extension, variation or reinstatement of the contract.
   c. The Assured's and/or Insured's duty of disclosure shall include disclosure
of all matters:
  i. that diminishes the risk to be undertaken by FijiCare
  ii. that is of common knowledge;
  iii. that the Assured and/or the Insured knows or, in the ordinary course of business ought to know;
  iv. unless compliance with the said duty is waived by FijiCare.
37. If the disclosure is fraudulent.
38. If any disability of illness arises outside Fiji.
39. Any law suit by the insured against medical practitioner(s) or hospital for neglect, malpractice, or other causes.

**Provision of Arbitrator:**
Any difference arising between the Policyholder or any Insured and FijiCare are to be referred to an Arbitrator to be appointed by the parties to the dispute. If the parties are unable to agree on a single arbitrator, 2 arbitrators are to be appointed (one by each party). In the event of further disagreement, an umpire shall be selected by the arbitrators. If the differences between the parties require medical knowledge (including any questions regarding the appropriate maximum indemnity for any medical service or an operation not listed in the Schedule of Surgical Fees), the arbitrators at FijiCare’s discretion may be registered medical practitioners and the umpire in such instance, shall be a Consultant Specialist Surgeon or Physician. The decision of the Arbitrators or the Umpire, as the case may be, shall be final and binding on the parties in difference.

**Cancellation:**
1. Insured can only cancel on the premium or installment premium date.
2. FijiCare can cancel policy any time upon giving 30 days notice.
3. 30% administration/cancellation cost will be deducted upon cancellation. But if a claim has been paid on the policy, there will be no refund of premiums.

**Renewal:**
Any renewal of the Policy is at the sole discretion of FijiCare, which may grant renewals on new, different, or more restrictive terms and conditions. FijiCare does not warrant to renew cover beyond the first or any subsequent contract for cover in the case of any group, member, spouse or dependent. [Thus, FijiCare may decline renewal in bad days for an insured (with age possibly), while continue to benefit from premiums when insured is younger and relatively less prone to illnesses.]

**Termination:**
1. Policy terminates upon retirement of insured, or when insured is no longer at work. This is included in individual policy contracts as well.
2. Policy coverage also terminates on the date an insured ceases to become a dependent. This applies to family coverage. Thus, a spouse who is not a dependent, or who ceases to be a dependent, is not covered.
### A.3: Travel Insurance

**Product: Travel Insurance**  
**Company: Tower**

<table>
<thead>
<tr>
<th>COVERED</th>
<th>NOT COVERED</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Medical &amp; Other Expenses: Illness or injury</strong> suffered while outside the country. Tower will pay the reasonable costs incurred outside the country for medical treatment including surgical, hospital, nursing, additional accommodation and related medical expenses approved by Tower up to the amount shown in the schedule of benefits for the plan selected.</td>
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<tr>
<td>In all cases, Tower will only pay costs incurred within 12 months of the illness or injury, and has the option of returning the insured to Fiji, New Zealand or Australia.</td>
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<tr>
<td>All costs relating to insured's medical repatriation.</td>
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<tr>
<td><strong>Special Benefits</strong></td>
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</tr>
<tr>
<td><strong>1. Accompanying Person:</strong> Reasonable travel and accommodation expenses incurred by one person, who because of the insured's severe illness or injury and with the approval of Tower's medical advisers, travels to insured, remains with insured or escorts insured back to Fiji.</td>
<td></td>
</tr>
<tr>
<td><strong>2. Dental Treatment Overseas:</strong> up to the amount shown in the schedule of benefits for reasonable costs incurred overseas for treatment to sound natural teeth as the result of an injury including on-going dental treatment which is incurred within 30 days of insured's return to Fiji, resulting from an injury which occurred overseas.</td>
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<tr>
<td><strong>3. Funeral Expenses:</strong> up to the amount shown</td>
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1. Medical or other expenses for injuries incurred while traveling within Fiji, or on connection flights (e.g. Nausori to Nadi).  
2. Medical or other expenses for injuries incurred in Fiji before traveling, but which require treatment while abroad.  
3. Loss arising from, or claims for:  
   a. any expense incurred in Fiji, other than the cover provided in the Special Benefits Accompanying Person, Dental Treatment Overseas and On-Going Medical Expenses;  
   b. any medical or dental treatment or surgery of an elective nature completed without the authority of Tower's medical adviser;  
   c. the normal maintenance of dental health other than the cover provided in the Special Benefit Dental Treatment Overseas;  
   d. the cost of private medical care where free or reduced cost care is available to the insured.
in the schedule of benefits for the reasonable funeral, cremation or burial expenses in the area where death occurred, or for the costs of returning insured’s body or ashes to Fiji excluding funeral and interment costs.

4. **On-going Medical Expenses**: up to the amount shown in the schedule of benefits for insured’s reasonable on-going medical expenses incurred in Fiji within 3 months of the overseas illness or injury.

5. **Pregnancy**: the reasonable costs incurred for emergency treatment for extraordinary medical complications occurring during the first 20 weeks of insured’s pregnancy. Tower will only pay costs incurred within 12 months of the occurrence.

2. **Personal Baggage**: Sudden and unforeseen accidental physical loss or damage to personal baggage. Tower will pay the indemnity value up to the amount shown in the schedule of benefits for the plan selected. The amount for individual items and for video cameras is as shown in the schedule of benefits unless otherwise stated in the certificate of insurance. In all cases an item, pair, or set of articles e.g. a camera with attached or unattached lenses or accessories shall be deemed to be one item. (Motor vehicles, motorcycles, trailers, caravans, watercraft, aerial devices and their accessories are not deemed to be personal baggage).

**Special Benefits:**

1. **Emergency Purchases**: up to the amount shown in the schedule of benefits for emergency purchases of essential items of clothing and requisites, if insured is deprived of his personal baggage for at least 12 hours from the time of arrival at the overseas destination. If insured is deprived of his personal baggage for a further 72 hours, Tower will reimburse him up to the amount shown in the schedule of benefits for the plan selected. The amount for individual items and for video cameras is as shown in the schedule of benefits unless otherwise stated in the certificate of insurance.

2. **Passport**: only replacement cost, and not cost of getting a replacement (e.g. time consumed, expenses in acquiring a replacement, etc).

3. **Loss or damage to, or claims for:**
   a. bicycles, surfboards, windsurfers

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<table>
<thead>
<tr>
<th>1. If loss or damage is:</th>
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<tbody>
<tr>
<td>a. not sudden</td>
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<tr>
<td>b. not unforeseen</td>
</tr>
<tr>
<td>c. not accidental</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Emergency Purchase:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. if not 12 hours from time of arrival</td>
</tr>
<tr>
<td>b. if not at destination overseas (e.g. if in transit and need to stop overnight, or for longer than 12 hours, there is still no cover)</td>
</tr>
<tr>
<td>c. if arrive back in Fiji and baggage is lost/damaged.</td>
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</tbody>
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<thead>
<tr>
<th>3. Passport:</th>
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<tbody>
<tr>
<td>only replacement cost, and not cost of getting a replacement (e.g. time consumed, expenses in acquiring a replacement, etc).</td>
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<tr>
<th>4. Loss or damage to, or claims for:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. bicycles, surfboards, windsurfers</td>
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</table>
to the amount shown in the schedule of benefits for insured’s additional costs.

ii. Passports: the reasonable replacement costs if suffer the loss of passport.

or similar water equipment, other than when they are in transit on licensed commercial transportation or for fire or burglary from locked accommodation premises;

b. bonds, negotiable instruments, vouchers, deeds, stamps, manuscripts, securities of any kind, bullion, gold, precious metals or precious stones;

c. breakage of glass or fragile or brittle articles;

d. items used in any trade, business or profession;

e. household effects and home appliances not travelling with insured, works of art and vehicle accessories;

f. theft or deliberate damage of insured’s personal baggage left unattended in a public place or left in any unlocked vehicle, building, room or other location;

g. software or programmed data;

h. sporting equipment when in actual use.

3. Loss of Deposits and Cancellation: Abandonment or alteration of travel due to any unexpected event outside insured’s control. Tower will pay up to the amount shown in the schedule of benefits for the plan selected, for insured’s irrecoverable travel or accommodation deposits or expenses paid in advance in Fiji and once the journey has commenced, any additional expenses insured is required to pay.

Special Benefits:

i. Curtailment: up to the amount shown in the schedule of benefits for the plan selected, less any refund of cancelled return ticket, for the reasonable additional accommodation and

1. If travel or accommodation expenses/deposits are not:
   a. paid in advance
   b. paid in Fiji.

For Special Benefits:

1. If return to Fiji not through the most direct route.

2. If return ticket not purchased in Fiji or before departure.

3. If travel resumed after 12 months

4. If cause of return was not a life-threatening illness, injury or death of spouse, defacto, children, grandparents, mother, father, sister, or brother in Fiji.
travel expenses incurred in returning directly to Fiji due to the curtailment of travel resulting from any unexpected event outside insured’s control, provided that insured purchased a return ticket to Fiji before departure.

**ii. Resumption of Travel:** up to the amount shown in the schedule of benefits for the economy class transport costs to enable insured to return overseas to continue original travel arrangements within 12 months of an occurrence. Provided insured returned to Fiji as a result of a life-threatening illness, injury or death of spouse, defacto, children, grandparents, mother, father, sister, or brother in Fiji, and:
- i. policy duration was at least 14 days;
- ii. less than 50% of policy duration has been used;
- iii. the illness, injury or death was unexpected and first occurred after departure from Fiji;
- iv. insured had not otherwise claimed for cancellation or curtailment for the same event;
- v. a pre-paid return ticket had been purchased before departure from Fiji.

**4. Rental Vehicle Insurance Excess:** Any insurance excess insured is required to pay in the event of a claim under his rental vehicle hire contract. Tower will reimburse up to the amount shown in the schedule of benefits for the plan selected. In all cases, the vehicle must be hired from a licensed rental vehicle agency; and insured must comply with the conditions of the rental vehicle hire contract.

**5. Accidental Death and Permanent Disablement:** up to the amount shown in the schedule of benefits for the plan selected for injury suffered outside the country during the period of insurance, which causes accidental death or permanent disablement within 12 months of the injury.

| 5. If return is when more than 50% of policy duration has been used. |
| 6. If illness/injury of listed relatives occurred at any time before insured left Fiji. |
| 7. Loss or damage to, or claims for: |
| a. the default of a travel agent; |
| b. the inability or negligence of a tour operator, charter airline or wholesaler to complete insured’s travel arrangements. |
| c. insured’s curtailment or cancellation for medical reasons unless on written medical advice; |
| d. insured’s disinclination to travel or his personal wishes; |
| e. insured’s failure to check-in at correct departure time; |
| f. insured’s financial circumstances; |
| g. government prohibition or regulation other than grounding of aircraft by government agency; |
| h. cancellation due to lack of numbers. |

<p>| 1. If injury did not take place outside the country. [Thus if injured at Fiji airport while departing, there is no coverage] |
| 2. If permanent disablement or death caused after 12 months of injury. |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3. If outside the 16-60 age group.</strong></td>
<td><strong>4. Loss or damage to, or claims for:</strong></td>
</tr>
<tr>
<td></td>
<td>a. accidental death or permanent disablement resulting from or occurring whilst engaged in work for a business, trade or profession;</td>
</tr>
<tr>
<td></td>
<td>b. death or permanent disablement directly or indirectly resulting from disease or natural causes or medical or surgical treatment unless rendered necessary by an injury covered in this policy.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>6. Money &amp; Travel Documents</strong></th>
<th><strong>1. If money/documents are not lost from:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss from insured’s person, locked accommodation or locked vehicle, of insured’s cash, travellers cheques, postal notes, credit cards, money orders, petrol coupons, travel tickets, or vouchers for pre-paid travel or accommodation. Tower will pay up to the amount shown in the schedule of benefits for the plan selected.</td>
<td>a. the insured’s person</td>
</tr>
<tr>
<td>b. locked accommodation, or</td>
<td></td>
</tr>
<tr>
<td>c. locked vehicle</td>
<td></td>
</tr>
<tr>
<td>[Thus loss from a bag, or with the bag, is not covered].</td>
<td>2. Loss:</td>
</tr>
<tr>
<td>a. if left unattended in a public place, unlocked vehicle, room or other location;</td>
<td></td>
</tr>
<tr>
<td>b. if sent by post, courier service or cargo.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>7. Travel Delay or Missed Connection</strong></th>
<th><strong>1. If delay is equal to or less than 6 hours, even if connection is lost.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Irrecoverable additional travel costs necessarily incurred on a regular airline or established charter service to reach insured’s ticketed destination; reimbursement up to the amount shown in the schedule of benefits for the plan selected, provided that the airline with which insured is travelling is delayed at least six hours and causes insured to miss onward connecting flight. Tower will also reimburse up to the amount shown in the schedule of benefits for the plan selected for reasonable additional meal and accommodation costs if flight is delayed for at least six hours.</td>
<td>[thus: if connection is missed, and insured’s delay is 5 hours, there is no coverage]</td>
</tr>
</tbody>
</table>

In all cases insured must supply written confirmation from the carrier for the length and reason for any delay and that no alternative flight was available at the time; |

1. If written confirmation from the carrier of the delay and missed connection is not provided to Tower. |
2. If insured did not book and pay for tickets prior to leaving Fiji. |
3. If insured does not check in according to his itinerary. |
4. If insured does not check in according to his itinerary. |
5. If receipts for all additional expenses are not provided. |
6. Loss or claims for costs resulting from rescheduling or canceling of travel arrangements by any supplier.
8. **Strikes and Hi-Jacks**: Irrecoverable additional travel and accommodation costs due to the cancellation or curtailment of public transport services as a result of a strike or hi-jack, up to the amount shown in the schedule of benefits for the plan selected.

1. If public transport is curtailed due to reasons other than strikes or hi-jacks

9. **Liability Protection**: Legal liability for loss or damage to property including injury, death or illness arising from accidents occurring outside the country during the period of insurance, provided such legal liability is established in a court of Fiji or in a court of the country in which the accident occurred.

**Special Benefits:**

- **Legal Costs**: up to the amount shown in the schedule of benefits for all costs incurred by insured with Tower’s consent in defending claims.

- **Wrongful Arrest**: up to the amount shown in the schedule of benefits in reimbursement for legal costs as the direct result of insured’s false arrest or wrongful detention by any government or government agency.

**Other Exclusions: the following are not covered at all:**

1. Loss, damage or liability caused by or arising from, or claims for:
   a. acquired immune deficiency syndrome (AIDS), human immunodeficiency virus (HIV) or sexually transmitted diseases;
   b. air travel unless insured is a ticketed passenger on a regular airline or established charter service;
   c. any condition for which insured is receiving, or is on a waiting list to receive in-patient hospital treatment, examination or investigation, or for which he is travelling overseas to obtain medical treatment, examination or investigation;
   d. any consequential loss, loss of enjoyment or loss of income other than the cover...
provided in 5 Accidental Death and Permanent Disablement;
e. any medical costs and other expenses incurred overseas after the date when in-
sured can, in the opinion of Tower’s medical advisers, be safely repatriated to Fiji, New Zealand or Australia;
f. any person lawfully in insured’s accommodation premises;
g. insured’s criminal activities;
h. any physical defect, infirmity, existing or recurring illness, injury or disability of
which insured is aware or for which he has received medical examination, consul-
tation, treatment, investigation and/or medication in the 6 months prior to the
commencement date of this policy;
i. any time or date device or any item of which it forms part, arising from its failure to
recognize any date, character or value as the correct date, character or value (e.g.
Year 2000);
j. any professional sporting activity;
k. extreme versions of any sport;
l. or occurring in high altitude or remote areas except as part of an organised tour;
m. mountaineering, rock climbing;
n. or occurring during any international ocean voyage (whether or not insured has
actually entered international waters) or more than 25 nautical miles from the
mainland except as a fare-paying passenger on a licensed cruise ship;
o. parachuting, hang or tow gliding, microlite flying, sky diving, paragliding and/or
parasailing;
p. football, pot holing, bungy jumping, rodeo activities, polo, hunting;
q. training, competing or racing other than on foot;
r. underwater activities involving the use of artificial breathing apparatus unless an in-
ternationally recognised diving qualification is held;
s. white water activities;
t. any terminal condition;
u. any unreasonable or criminal or reckless or wilful act, omission, any disregard for,
or failure to comply with any provision in or notice or order under any legislation by
the insured;
v. asbestosis or any related disease;
w. receivership, statutory management, administration, bankruptcy, liquidation, fi-
nancial collapse or adverse financial position of an airline, transport provider, tour
operator, travel agent, wholesaler or tourist resort;
x. confiscation, detention, requisition or destruction by customs or other authorities;
y. continued medication, drugs or treatment;
z. deliberate exposure to exceptional danger except in an attempt to save a human
life;
aa. depreciation, mildew, mould, rot, corrosion, rust, insects, vermin, wear and tear,
gradual deterioration, any process of cleaning, dyeing, repairing or restoring or ac-
tion of sunlight;
ab. depression, anxiety, nervous disorders or mental illness;
ac. military, naval, air service operations, heavy manual work or hazardous work;
ad. nuclear weapons material or ionising radiation or contamination by radioactivity
from any nuclear waste or from the combustion of nuclear fuel including any self-
sustaining process of nuclear fission or fusion;
ae. or occurring in any country where insured ordinarily resides other than the cover
provided in Section 3 Loss of Deposits and Cancellation;
af. pregnancy known to exist at the date of inception of this policy and for which in-
sured has been receiving medical treatment or medication, childbirth or postnatal
medical care other than the cover provided in Section 1 Special Benefit Preg-
nancy;
ag. self-inflicted illness or injury, suicide, voluntary abortion, influence of alcohol or
drugs;
ah. insured’s trade, profession or business or any activity for financial return whether
for profit or not.

2. Loss, damage, cost or expense of whatsoever nature directly or indirectly caused by,
resulting from or in connection with any of the following regardless of any other cause
or event contributing concurrently or in any other sequence to the loss:
(a) War, invasion, acts of foreign enemy or enemies, hostilities or warlike operations
(whether war be declared or not), civil war, mutiny, civil commotion assuming the
proportions of or amounting to a popular rising, military rising, insurrection, rebel-
lion, revolution, military or usurped power, or any act of any person or persons act-
ing on behalf of or in connection with any organisation the objects of which are to
include the overthrowing or influencing of any dejure or de facto government by
terrorism or by any violent means; or
(b) Any act of terrorism. An act of terrorism means an act, including but not limited to
the use of force or violence and/or threat thereof, of any person or group(s) of per-
sons, whether acting alone or on behalf of or in connection with any organisa-
tion(s) or governments), which from its nature or context is done for, or in connec-
tion with, political, religious, ideological, ethnic or similar purposes or reasons, in-
cluding the intention to influence any government and/or to put the public, or any
section of the public, in fear.
(c) Any loss, damage, cost or expense of whatsoever nature directly or indirectly
caused by, contributed to by, resulting from, or arising out of or in connection with
any action taken in controlling, preventing, suppressing, retaliating against, re-
sponding to, or in any way relating to any act of terrorism.

3. Burden of Proof: If Tower alleges that if any loss, damage, cost or expense is not
covered by this insurance, the burden of proving the contrary is upon the insured.

<table>
<thead>
<tr>
<th>Other Grounds for Denial of Liability: If insured:</th>
</tr>
</thead>
</table>
| 1. Does not inform Tower immediately when insured becomes aware of any circum-
stances that may give rise to a claim. |
| 2. Does not provide to Tower the completed claim form within 30 days if the insured |
is asked to fill in a claim form

3. Does not advise any change in his health that occurs before departure. Tower is not obliged to insure the change in his health;

4. Makes a claim that is false or fraudulent in any way;

5. Causes or facilitates loss or damage or incurs liability by any unreasonable, reckless or wilful act or omission;

6. Does not immediately notify the carrier in writing of any loss or damage to his personal baggage, money and passports if the loss or damage occurred when under their custody or control;

7. Does not inform the Police within 24 hours and obtain a written report if it appears that there has been loss, theft, burglary or malicious damage;

8. Does not take all reasonable steps to prevent further loss or damage;

9. Does not provide documentary proof of purchase if he wishes to claim for any property purchased during the period of insurance;

10. Does not consult immediately and follow the advice of a registered medical practitioner if he has suffered any injury or illness;

11. Does not provide at his expense any medical certificate or report that Tower may require to consider the claim. Tower may conduct a post mortem examination at its expense;

12. Does not provide Tower immediately with full particulars of any claim made against him by another person, all legal documents served on him and allows Tower to instruct a solicitor of its choice to conduct his defence. Insured must follow the recommendations of that solicitor as to the conduct or continuation of the defence, failing which there is no liability. That solicitor shall be entitled to confer with Tower when necessary as to the details of the case and the conduct or continuation of insured’s defence;

13. Incurs any expense without Tower’s prior approval;

14. Discusses a claim made on insured by another person with them, or does not refer them to Tower;

15. Does not comply with all Tower’s requests relating to the claim including providing all co-operation, information and assistance;

16. Does not allow Tower to take over for Tower’s own benefit and settle any legal right of recovery insured may have and he must co-operate fully in any recovery action;

17. Does not inform Tower if he is permanently migrating. (The period of insurance will expire 7 days after his arrival in the country of his migration destination);

18. Does not establish that he complied with all his obligations under this policy and that none of the exclusions apply.

Other Pertinent Matters:

1. Cancellation: a. Insured may cancel the policy at any time before his departure by writing to Tower and returning his certificate of insurance and the policy booklet. If he has suffered no loss or damage and incurred no liability during this period, Tower may refund the paid premium in full.
b. Insured may cancel the policy at any time after his departure by writing to Tower and returning the certificate of insurance. If he has suffered no loss or damage and incurred no liability during this period, Tower will refund 80% of the unused portion of the premium. [The term 'unused' is not defined, thus is open to an interpretation provided by Tower, which may be to the disadvantage of the insured]

c. Tower can cancel the insurance at any time by writing to the insured and giving at least 14 days notice, in which case, it will refund the unused premium.

d. Tower can cancel the policy with immediate effect, and avoid any liability if insured makes a claim which is false or fraudulent in any way

2. Making Changes to the Policy: Insured can have the policy altered at any time as long as Tower agrees in writing to such alteration before it takes effect. Tower can also, in exceptional circumstances, alter the terms of this insurance by writing to the insurance, with the change taking effect 14 days after the date of that letter.

3. Other Insurance: Tower will only pay over and above the cover provided by any other existing policy, private or reciprocal government medical scheme, except for the cover under Section 5 Accidental Death and Permanent Disablement.
## A.4: House Owners (Property)

<table>
<thead>
<tr>
<th>Covered</th>
<th>Not Covered</th>
</tr>
</thead>
</table>
| **Dwelling and Contents:**                                             | 1. If premium not paid in full within 30 days of inception or each renewal.  
| 1. Any loss or damage to the property insured occurring during the period of insurance within Fiji, with the liability for each item is not to exceed the sum insured for each item. | 2. Damage through flood if the insured property is less than or equal to 500 meters from a river, stream, watercourse or the sea and,  
|                                                                       | 3. Damage through flood if it is directly or indirectly related to a cyclone. [In effect, then, flood damage is not covered if flood is due to a natural rise in river, or drains as natural rises inflicting damages are due to heavy rain, which is indirectly related to cyclones]  
|                                                                       | 4. Damage through falling trees or branches if:  
|                                                                       | a. tree is in insured’s property,  
|                                                                       | b. loss/damage caused by insured (e.g., cutting branches),  
|                                                                       | c. loss/damage directly or indirectly related to cyclone. |

* ‘Dwelling’ is defined as the private dwelling, residential flat, all domestic buildings of permanent construction, underground services, walls, gates, fences, swimming pools, spa pools and removal of debris, and professional fees incurred in rebuilding or repair of any damage.  
* ‘Contents’ is defined as all domestic furniture, furnishings, fixtures and fittings, home appliances, household and personal effects.

2. Indemnification by payment or at the option of Dominion by reinstatement or repair if the property insured should suffer loss or damage arising from:  
   a. Fire. Lightning, Explosion  
   b. Flood, if the insured property is more than 500 meters from a river, stream, watercourse or the sea and that the flood is not directly or indirectly related to a cyclone.  
   c. Water discharged, overflowing or leaking from any water cooling or heating system installation.  
   d. Impact by vehicles, animals, aerials, aircraft or man made aerial devices or articles therefrom.  
   e. Earthquake, volcanic eruption and/or
subterranean fire, tidal wave or tsunami.
f. Accidental damage for which insured is responsible, to underground services between the building and the public mains.
g. Accidental breakage of fixed glass, fixed mirrors, fixed basins, lavatory pans, cisterns, fixed shower bases or baths.
h. Falling trees or branches where the tree is not within insured's property and where the loss or damage is not caused by insured.
i. Acts of Authorities where such act is by any lawfully constituted public authority for the purpose of preventing or controlling fire or any other insured peril.

<table>
<thead>
<tr>
<th>Legal Liability:</th>
<th>1. Any legal liability directly or indirectly arising from or related in any way to or contributed to in any way by or to:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a. The engagement in any trade, business or profession.</td>
</tr>
<tr>
<td></td>
<td>b. The ownership, possession or use of any mechanically propelled vehicle, watercraft or aircraft.</td>
</tr>
<tr>
<td></td>
<td>c. The actions of any domestic animal</td>
</tr>
<tr>
<td></td>
<td>d. Fines, punitive or exemplary damages,</td>
</tr>
<tr>
<td></td>
<td>e. Liability assumed by agreement</td>
</tr>
<tr>
<td></td>
<td>f. Liability for damage to property belonging to or under the control of the insured or any member of the Insured's family.</td>
</tr>
<tr>
<td></td>
<td>g. Liability imposed under Workers Compensation Ordinance.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Optional Peril: Cyclone</th>
<th>1 If buildings not entirely enclosed, or all outside doors, windows and roofs not permanently in place</th>
</tr>
</thead>
</table>
Gale, Hurricane or Tropical cyclone as shown on the policy schedule and an additional premium has been paid and is subject to the following conditions:

- Only buildings which are entirely enclosed with all outside doors, windows and roofs permanently in place and the contents of such buildings are covered.
- For any loss or damage occurring after expiration of 7 days on the day of acceptance by cover.
- Loss or damage to the insured interest by water or rain if such loss or damage is caused by water or rain entering the building through openings in the walls or roofs made by the cyclone.

2. If loss/damage occurs before expiration of 7 days on the day of acceptance by the Dominion of the cover.
   - Loss or damage to the insured interest by water or rain unless such loss or damage is caused by water or rain entering the building through openings in the walls or roofs made by the cyclone.
   - Loss/damage caused by sea, tidal wave, high-water, flood, erosion, subsidence or landslide.
   - Loss/damage to solar heating equipment, water tanks, gates, fences, awnings, blinds, signs, power and/or telephone poles and appurtenances, aerials, masts, satellite dishes, decorative masi, thatching or any other outdoor fixtures or fittings of any description.
   - Loss/damage to buildings or their contents in course of construction, reconstruction or repair.
   - Deterioration of frozen or freezer/cooler goods/stock resulting from electricity power failure.
   - Loss/damage to buildings or their contents for which a certificate from an accredited engineer has not been accepted by Dominion, the certificate to be no more than 7 years old at inception date of the policy or any subsequent renewal date.

4(a). If insured did not use due diligence to minimise any loss or damage.
   - Any subsequent damage, should it relate to any damage to buildings or contents caused by a peril covered by this extension that oc-
curred prior to the commencement of this insurance or during the term of this insurance which damage had not been made good.
(c) All fixed glass on the ground and first floor levels are not protected by cyclone shutters constructed and affixed in accordance with the recommendations of the engineer whose certificate Dominion approved. If such shutters are not in place immediately following an official cyclone warning and do not remain in place during the time the official cyclone warning remains in force.

| Optional Perils: Burglary | 1. Where this extension has been specified in the policy schedule and an additional premium paid.
* "Burglary" means and is limited to theft accomplished by violence or threat of violence to persons, or violent and forcible entry to or exit from any enclosed building. | 1. If theft is by occupants normally residing or who have previously resided in the residence.
2. Theft from any residence which is let or sub-let.
3. More than 15% of the sum insured applicable to this extension in respect to any one item. |
| Additional benefits (a) To Dwelling Insurance | 1. Loss of rent receivable for the period reasonably necessary for reinstatement following loss or damage defined in ‘Dwellings and Contents’ b(i to ix) above during which the insured premises are uninhabitable. Liability limited to 10% of the sum insured.
2. Architects, engineers and other professional fees incurred in the rebuilding or repairs to the property for which a claim has been accepted is included within the sum insured.
3. Loss or Damage to the building arising out of or in the course of a burglary or attempt thereat. | To Contents (b):
1. If loss/damage from electric current is to radios, stereos, televisions, video recorders, computers and electronic equipment. |
(b) To Contents Insurance
1. Reasonable additional accommodation expenses in the event that the house is damaged and made uninhabitable due to loss or damage defined in 'Dwellings and Contents' b(i to ix) above during which the insured premises are uninhabitable. Liability limited to 10% of the sum insured.
2. Loss or damage caused by electric current burning out household electrical appliances up to $500 but excluding radios, stereos, televisions, video recorders, computers and electronic equipment.
3. Spoilage of frozen foods caused by breakdown of electric motors but limited to $500 any one period of insurance.
4. The Insured property is covered whilst temporarily removed to other premises anywhere in Fiji against loss or damage as defined in 'Dwellings and Contents' 2(a. to i.) above.

(c) To Dwelling and Contents
1. The sum insured shall not be reduced by the amount of any claims paid in respect of perils defined covered, but subject to payment of any appropriate extra premium required by the Dominion,
2. The cost of demolishing and removing the debris including contents for which a claim has been accepted is included within the sum insured.

Other Exclusions

1. Excluded Property: Policy does not cover loss or damage to the following types of properties.
   b. Any property used for business, trade or professional purposes.
   c. Livestock, trees, growing crops, retaining walls, land, drainage systems, dams, reservoirs, canals, culverts, aqueducts, tunnels, bridges, docks, piers, wharves, breakwaters or mining property located above or underground.
d. Cash, negotiable checks, money orders, stamps, credit cards, invoices, other negotiable instruments.

2. Excluded Perils and Events: If loss/damage or liability claimed for arose, directly or indirectly from, or was related in any way to, or was contributed to in any way by:

a. Riot, malicious acts, civil commotion, civil disturbance, civil war, insurrection, popular rising, rebellion, revolution, terrorism, sabotage, subversive acts, military rising, military or usurped power, invasion, war and hostilities, strikes or locked-out workers, persons taking part in labour disturbances or any activities in connection therewith, any action of military, police, security or other authorities or instrumentality whether governmental or not, including any loss damage or liability directly or indirectly resulting from any of the above;

[Note however, that if Dominion agrees to extend policy to include loss or damage to insured property from Riot, Malicious Acts, Civil Commotion, Strikes or Locked-out Workers, and an additional premium has been paid, this will be covered. In this case, damage/loss from riots, malicious acts, civil commotion, strikes or locked-out workers, are covered. Riot, however, is defined as an act of a group of at least 12 persons, who in the execution of their common purpose cause public disturbance tumultuously with violence and damage to the property of others, not amounting to a Civil Commotion. Strike is defined as a deliberate act of damage by a group of workers of at least 12 persons or one half of the entire workforce (if the workforce is less than 24 persons), refusing to work as usual in an attempt to force the employer to accept their demands or to protest against any terms of employment enforced by the employer. Locked-out Workers is a deliberate act of damage, by a group of workers of at least 12 persons or one half of the entire workforce (if the workforce is less than 24 persons), to protest against the termination or suspension of a fellow employee by the employer. Civil Commotion is an act of a large number of people acting together disrupting public peace and disturbance tumultuously with violence and a chain of destruction of a large number of properties, indicated by the cessation of more than one half of the normal activity of commercial/shopping or business areas or schools or public transportation in one city or town for at least 12 hours consecutively commencing immediately before, during or after the event. Malicious Acts is an act of any person(s) deliberately causing damage to the property of others driven by vengeance, hatred, anger or vandalistic intentions, except such acts done by the employee(s) of the Insured, or any person(s) on behalf of the Insured, or by person(s) entrusted by the Insured to maintain or keep such property, or by thieves or robbers.

Thus, even if the policy is extended to include these events, cover applies only if the definitions are met.]
b. The actions of any political or vigilante group;
c. Looting, sacking and/or pillaging;
d. Permanent or temporary dispossession resulting from confiscation, commandeering, requisition by any lawfully constituted authority or body, or unlawful occupation by any person.
e. The actions of the police, any armed forces or any lawfully constituted body where such actions are in connection with i, ii, or iii above;
f. Any deliberate fire, whether to the insured property or not, and whether started by the insured or not (thus damage from arson excluded);
h. If Damage/loss caused at the time property had been unoccupied or unattended for more than 7 consecutive days.
i. Wear, tear, depreciation, mildew, mould, rot, corrosion, rust, gradual depreciation, contamination, pollution, mechanical breakdown, neglect of maintenance, defective workmanship material or design, or structural alterations or repair.
j. Any consequential loss of any kind.
k. War, invasion, act of foreign enemy, hostilities or warlike operations (whether war be declared or not) civil war, mutiny, civil commotion assuming the proportions of or amounting to a popular uprising, military rising, rebellion, revolution, insurrection, terrorism, military or usurped power.
l. Nuclear weapons material or ionising radiation or contamination by radioactivity from any nuclear waste or from the combustion of nuclear fuel.
m. Subsidence, landslip, erosion, settling, cracking or removal or weakening of support.

Note: Onus is on the Insured to prove that the damage/loss did not occur due to any of the exclusions if a policy claim is to succeed.

Policy becomes void, and no benefit accrues if:
1. Alteration: If any alteration after the commencement of this insurance takes place whereby;
   (a) the trade, manufacture carried on or nature of the occupation or of other circumstances affecting the property insured be changed in such a way as to increase the risk of destruction or damage.
   (b) the building insured or containing the insured property becomes unoccupied for more than 14 consecutive days.
   (c) The Insured's interest ceases except by will or operation of the law.

2. Fraud: If fraud committed by insured at any time. It is also void if insured or any other insured, at any time, intentionally conceals or misrepresents a material fact or circumstance concerning:
   (a) the policy
   (b) the property insured
(c) insured’s interest in the property insured; or
(d) a claim under the policy including the value of any property lost or damaged.

3. Claims:
   a. If insured does not:
      i. immediately notify Dominion of any occurrence which may give rise to a claim.
      ii. within 30 days submit in writing full particulars of the claim in such a form or manner as may be reasonably required by Dominion so that any claim is not prejudiced.
      iii. inform the Police if any theft burglary, arson or malicious damage has occurred or is suspected.
      iv. take all reasonable steps to prevent further loss or damage.
   b. In the event of any claim, if Dominion is prevented from:
      i. Entering any premise where loss or damage has occurred and keeping possession of the property and dealing with salvage in a reasonable manner. No property may be abandoned to Dominion.
      ii. Taking proceedings in the name of the insured to obtain relief from any third party and undertake the conduct, control or compromise of any such proceedings.

4. Other Insurance: If at the time of any loss/damage/liability there is any other insurance covering such loss/damage/liability or any part thereof, Dominion will be liable only for the amount of loss not covered by such other insurance.

5. Cancellation and Variations:
   a. Insured can cancel the policy at any time in which case Dominion will refund 80% of the unused basic and burglary premium. No refund will be given in respect of any cyclone premium.
   b. Dominion can cancel the policy or amend the terms, exclusions and limitations after 4.00pm on the 14th day following dispatch or written notice to the Insured’s last known address. The Insured shall be entitled to a return of premium proportionate to the unexpired period of the cancelled policy.

6. Subject to Average: If at the time of any loss/damage insured by this policy the sum insured is less than 90% of the actual value then the insured will be considered as being his own insurer for the difference and shall bear a ratable proportion of the loss accordingly. Each item of this policy shall be separately subject to this condition.

7. Jurisdiction: Notwithstanding anything contained in this policy to the contrary the indemnity provided herein shall not apply to:
   (a) Any matter where an action for damages is brought in a court of law outside Fiji and not subject to Fiji law or where an action is brought in Fiji to enforce a foreign judgment whether by way of reciprocal agreement or otherwise.
   (b) Costs and expenses of litigation which are not incurred within Fiji.

8. Suit or Legal Action: No suit or legal action on this policy for the recovery of any claim will be sustainable in any court unless all the requirements of this policy shall
have been complied with, and unless commenced within twelve months after the date of the loss. [This condition aims to waive an insured’s right to legal remedy. The way the statement is constructed, however, does not specifically require the insured to waive the right; it is constructed in the form of a statement of law. If it is the latter, then the condition is of no effect].

9. Premium Payment: Unless alternative premium payment terms have been agreed in writing, the policy becomes null and void 14 days after the original inception date or any subsequent renewal date unless full annual premium has been paid.

10 Proposal: The truth of the statements and answers in the proposal form or any other written submission submitted by the Insured or on the Insured's behalf are conditions precedent to any liability of Dominion and to make any payment under the Policy.

11. Policy Amendment: Any amendment to the terms and conditions of the policy must be evidenced by written confirmation signed by Dominion.

12. Debt Offset: Any claim payment payable under this policy may be used to settle any other premium or other debt owed by the Insured to the Dominion.

13. Indemnity Value: Unless otherwise agreed and endorsed within the policy, the property is insured for its indemnity value and not its replacement value or any other agreed value. This means that the market value and accumulated depreciation will be considered when any claim is adjusted. [This creates significant confusion as depreciation relates to the historical value and not market value.]

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**Product: House Owners Policy**

**Company: New India Assurance Co. Ltd**

<table>
<thead>
<tr>
<th>COVERED</th>
<th>NOT COVERED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Indemnifies insured against any loss or damage to the property insured caused by the stated contingencies, the indemnification being done through reinstatement, or repaid.</td>
<td>1. Live stock, 2. motor vehicles and accessories in or on the said vehicles, 3. craft designed for use on water, or in air and accessories, 4. deeds, bills of exchange, promissory notes, cheques, securities for money, documents or any kind, stamp collections, manuscripts, medals &amp; coins unless declared and insured in separate sums.</td>
</tr>
<tr>
<td>1. Fire, Explosion, Lightening, Thunderbolt</td>
<td>1. Storm and/or tempest</td>
</tr>
<tr>
<td>2. Burglary, housebreaking or any attempt thereat and theft consequence thereof.</td>
<td>1. If the private dwelling, private boarding house, and/or residential flat is left unfurnished.</td>
</tr>
<tr>
<td>3. Larceny or Theft</td>
<td>1. If theft from that part of buildings in the sole occupancy of the insured</td>
</tr>
</tbody>
</table>
or his spouse, unmarried children or servants permanently residing with him whilst such part is left without an inhabitant therein – meaning if room is not occupied, there is no cover.

2. If theft from that part of buildings which is not in the sole occupancy of the insured or his spouse, unmarried children or servants permanently residing with him or which is lent, let or sub-let by him. Thus, if there is guest, that part is not covered.

3. If theft is of cash, treasury notes, bank notes, savings certificates, stamps, money orders, postal notes and bonds.

4. If there is of contents whilst permanently contained in any boarding house.

4. Earthquakes: if damage/destruction is directly caused by:
   a. Earthquake, subterranean fire or volcanic eruption.
   b. Fire occasion by or happening through or in consequence of earthquake, subterranean fire or volcanic eruption excluding destruction or damage caused by tidal wave consequent upon earthquake or volcanic eruption.
   c. Tidal wave which is deemed to include sea water rising beyond boundaries of the normal spring tide level.

   1. If damage is indirectly caused by earthquake, subterranean fire or volcanic eruption.

   2. Liability: NIA not liable for the first minimum of F$1000 for each claim or series of claim arising out of one event and/or 5% of sum insured whichever is greater.

5. Riot strike or civil commotion: This mean
   a. the act of any person taking part together with others in any disturbance of the public peace (whether in connection with a strike or lock out or not) not being an occurrence mentioned in special conditions of exclusion.
   b. the action of any lawfully constituted authority in suppressing or attempting to suppress any such disturbances or in minimizing the consequences or any

   1. Any destruction or damage occasioned by or through or in consequence directly or in directly by any of the following occurrences,
      a. war, invasion, act of foreign enemy, hostilities or warlike operations (whether war be declared or not), civil war.
      b. Mutiny, Riot, Strike, Lock-out, civil commotion each one assuming the proportions of or amounting to a
such disturbance.
c. the willful act of any striker or lock-out worker done in furtherance of a strike or in resistance to a lock-out, and the action of any lawfully constituted authority in preventing or in attempting to prevent such act or in minimizing the consequences of any such act.

d. Permanent or temporary dispossession resulting from confiscation, commandeering or requisition by order of the de jure or de facto government any lawfully constituted authority [sic].
e. fraud or fraudulent claim.
f. If insured does not take all reasonable precautions, and uses due diligence and minimizes damage.
g. Loss of earnings, loss by delay, loss of market or other consequential or indirect loss, destruction or damage of any kind to description whatsoever.
h. Loss, destruction or damage resulting from total or partial cessation of working or the retarding or the interruption or cessation of any process or operation
i. Loss, destruction or damage occasioned by permanent or temporary dispossession resulting from the unlawful occupation by any person of the building provided that NIA is not relieved of liability in respect of physical damage to the property insured occurring before dispossession or during temporary dispossession.

6. Malicious Damage:

1. destruction arising out of or in the course of burglary, housebreaking, popular rising.
c. Military rising insurrection, rebellion, revolution, military or usurped power, or any act of person or persons acting on behalf of [sic] in connection with any organization, the objects of which include the overthrowing or influencing of any de jure or de facto government by terrorism or by any other violent means.
**Defined as the malicious act of any person (not being a tenant of the insured) not being an act amounting to or nominated in connection with an occurrence mentioned in condition on Riot, Strike or Civil extension.**

<table>
<thead>
<tr>
<th>Exclusions</th>
<th>Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Theft, larceny or any attempt thereat</td>
<td>2. Stock, merchandise, plant and machinery in the open unless forming part of permanent structure</td>
</tr>
<tr>
<td>2. Stock, merchandise, plant and machinery in the open unless forming part of permanent structure</td>
<td>3. Building in course of construction or alteration or their contents unless such buildings are entirely enclosed and under roof, glasshouses.</td>
</tr>
</tbody>
</table>

All the exclusions under riot, strike or civil commotion above.

<table>
<thead>
<tr>
<th>Damage by Electric Current (Fusion)</th>
<th>Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Includes destruction or damage to any part of household electrical machines or apparatus (excluding radio and television installations or apparatus) forming part of buildings (if the policy insures buildings), and contents (if the policy insures contents), caused by the actual burning out of such part or parts by electrical current therein.</td>
<td>1. Loss of use, depreciation, wear and tear.</td>
</tr>
<tr>
<td></td>
<td>2. Destruction or damage to lighting or heating elements, fuses or protective devices electrical contacts at which sparking or arcing occurs in ordinary working provided that in the event of destruction or damage to any part or parts of sealed or semi-sealed refrigeration units (forming part of refrigerators, air-conditioners or the like) caused by the actual burning out of such part or parts by the electrical current therein the company at its option will pay the cost of rectifying the unit or of its replacement with a similar unit.</td>
</tr>
<tr>
<td></td>
<td>3. Repair and replacement of such sealed or semi-sealed refrigeration units after 12 years from the date of manufacture of the unit.</td>
</tr>
</tbody>
</table>

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<tr>
<th>Accidental Breakage of Glass and Fixtures:</th>
<th>Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Fixed glass, fixed wash basins, lavatory pans, lavatory cisterns and sinks where this policy insures building or where the insured has a legal liability for such breakage</td>
<td>1. Loss or damage:</td>
</tr>
<tr>
<td>b. Glass forming part of furniture (including glass table tops, fixed or unfixed) where this policy insures building or where the</td>
<td>a. To glass forming part to any glass house, conservatory or any portion of the premises occupied for trade purposes.</td>
</tr>
<tr>
<td></td>
<td>b. To property damage or in imperfect condition at the time of the occurrence giving rise to the claim</td>
</tr>
<tr>
<td></td>
<td>c. To mirrors or glass ordinary carried by hand or to glass in radio and</td>
</tr>
<tr>
<td>insured has such legal liability for such breakage</td>
<td>television sets, clocks, vases, ornaments, pictures and the like</td>
</tr>
<tr>
<td>c. a telephone handset being the property of Fiji Posts and Telecommunications Limited.</td>
<td></td>
</tr>
<tr>
<td>All the belonging to the insured (or for which he is legally responsible)</td>
<td>d. Where fracture does not extend through the entire thickness of the property damaged</td>
</tr>
<tr>
<td></td>
<td>e. Caused by storm and/or tempest, the sea, tidal wave, high water, flood, erosion, subsidence, landslide or earthquake.</td>
</tr>
<tr>
<td>f. Cracks in glasses are not covered.</td>
<td></td>
</tr>
</tbody>
</table>

| 10. Bursting, leaking or overflowing of water tanks, apparatus or pipes | 1. If impact is by listed things belonging to or under the control of the insured/occupier or member of their families permanently residing with them. |
| 11. Impact damage: loss/damage caused by impact with residence or the walls, gates or fences pertaining thereto by any road vehicle, horses or cattle, and by falling trees and/or parts thereof excluding loss/damage caused by or subsequent upon the felling or lopping of trees within the insured’s premises | 1. Liability limit: $100, but only to the extent to which the sum insured on the contents is not otherwise exhausted. |
| 12. Damage to Residence: cost of repairing damage not otherwise recoverable arising from 2, 5, 7 and 10 above, or from breakage or collapse of TV or wireless aerials or masts. | 1. If servant’s residence not stated in schedule |
| 13. Servants’ Goods: loss/damage (other than larceny and theft) to clothing and personal goods of the insured’s servants is and so far such property is not otherwise insured, whilst contained in the insured’s residence or residence where servant is residing with the insured or any member of his family. | 2. If servant not resident with the insured or any member of the family. |
| 14. Public Liability: Owner or occupier liability for the residence referred to in policy for accidents in or about the said residence, causing bodily injury to any person not being a member of the insured’s family or household or in his service. | 1. Liability under contract |
| Limit: Liability for events from any one occurrence not to exceed $20,000 | 2. Injury or damage arising out of or incident to- |
| | a. the insured’s profession or business; or |
| | b. the use of lifts, or vehicles or |
| | c. the carrying out of alterations, additions, repairs or decoration or |
| | d. damage to surrounding property, |
costs/expenses if incurred on written consent of NIA.

<table>
<thead>
<tr>
<th>Appendix: Policy Analysis</th>
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<tr>
<td>147</td>
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</table>

- unless caused by parts of the said residence falling thereon or
- e. Any occurrence in respect of which a claim is made against the insured as owner of a private boarding house or residential flat.

15. Compensation for Insured’s Death:
- a. For fatal injury to the insured occurring in the residence and occupied by him, occasioned by outward and visible violence caused by burglars or house breakers or fire (provided that in the last mentioned event a fire brigade attends or is forthwith summoned), the company will pay the sum of $2000 or one-half of the total sum insured on contents in, whichever is less, if death ensures therefrom within 90 days of such injury.

Limit of Liability: During any period of insurance, $2000, or one-half of such total sum insured, whichever is lower, but only if the insurance under this policy covers the contents of the residence aforesaid.

- b. If two or more persons are named as the ‘the insured’, the amount recoverable in respect of each shall be limited to a proportionate part of the total sum insured hereunder, except in cases where certain of the insured may be nominated as the person or persons to be covered in respect of this contingency.

Limit: if insured or beneficiary sustains fatal injury and there is cover under another householder’s policy in force which contains a benefit for the same result, total liability shall not exceed that proportion of the sum provided which sum bears to the total amount of all such benefits under all householders policies.

16. **Debris Removal**: Cost of removal of

<p>| |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>1. If debris arises for any other reason</td>
</tr>
</tbody>
</table>

- 1. If death occurred outside the residence, e.g. burglars chased insured outside and he was killed by some event outside, like assault or a fall, or if because of fire, insured runs outside and is injured outside.

- 2. If there is no visible violence caused by burglars, or house breakers, or fire.

- 3. For fire as the cause, if no fire brigade is summoned forthwith.
debris consequent upon damage arising from perils insured under (1), (2), (5) and (7) of this section, to the extent of 10% of assessed loss or $1000 whichever is less.

<table>
<thead>
<tr>
<th><strong>17. Temporary removal of contents</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The indemnity in respect of perils insured under (1), (2), (4), (5), (7) and (10) is also provided to an amount not exceeding 20% of the sum insured on contents for any portion of the contents whilst-</td>
</tr>
<tr>
<td>(i) Temporarily removed within Fiji other than to a furniture repository.</td>
</tr>
<tr>
<td>(ii) On the person or in transit within Fiji.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Extensions: For Additional Premium, the following are covered:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Not Covered</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>1. Extension: Storm and/or Tempest</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>If a valid engineers certificate is submitted, insurance under this policy extends to include destruction of or damage to the property insured caused by storm and/or tempest.</td>
</tr>
</tbody>
</table>

*Conditions:*

a. All provisions of this policy apply as if they had been incorporated herein and for the purpose hereof any destruction or damage as aforesaid shall be deemed destruction or damage by fire.

b. All fire insurance covering that identical interest thereunder be extended concurrently and in the same manner and for the total sum insured thereon

c. Insured to use due diligence to minimize damage

d. All fixed glass on ground and the first floor levels including external windows, fixed glass panels, skylights or glass doors be protected by cyclone shutters constructed and affixed in accordance with usual standards, which are to be in place immediately following an official cyclone warning and are to remain in force.

1. There is no liability before the expiration of 7 days on the day of acceptance by the company of the cover, evidenced by the issue of a cover note, certificate or policy.

2. If any damage to buildings or contents by any of the insured perils occurred prior to the commencement of this insurance, such damage not having been repaired or made good, the company is not liable for any damage occurring subsequently.

3. Shutters: a. If shutters are not in place immediately following an official cyclone warning, and

   b. If shutters are not in place immediately following an official cyclone warning and do not remain until the warning is in force.

5. No claim admitted in respect of:

   a. Loss or damage caused by sea,
### Reinstatement of Sum insured

If there is loss by storm and/or tempest, sum insured will be reduced by the amount of such loss, but may be reinstated upon application to NIA and payment of full annual premium based on the amount of loss.

### tidal wave, high-water, flood, erosion, subsidence or landslide

c. Loss or damage to gates, fences, awnings, blinds, signs, solar heating devices, power and/or telephone poles and appurtenances, aerial masts, decorative masts, roof thatching or any other outdoor fixtures or fittings of any description.

d. Loss or damage to buildings or their contents in course of construction, reconstruction or repair unless such buildings are entirely enclosed a matter with all outside doors, windows and roofs permanently in place.

e. Loss or damage to buildings (or contents contained therein) not constructed in conformity with regulation, codes and/or by laws pertaining to prevailing building standards.

b. (vi) Loss or damage to all materials, goods or stocks in open yards or compounds.

### 2. Extension: Flood damage

Covers loss and damage caused directly by flood which means flood or overflow of sea excluding tidal waves.

### Destruction or damage caused directly or indirectly by

- a. overflow of the rivers
- b) Water discharge or leaking from pipe, water system or water rain
- c) Water discharge or leaking from pipe, sprinkler or drench installation or tank connected therewith
- d) erosion, subsidence or landslide
- e) to gates, fences, textile awnings, blinds, signs and other property in the open air unless such property comprises or forms part of a payment structure designed to function without the protection of walls or roofs.

### 3. Extension: Loss of rent (where building insured)

1. Loss of rent in the event of the in-
1. Loss or damage during any period in excess of 30 consecutive days during which the building is left unoccupied, unless with the written consent of the company.
2. Any consequence of war, invasion, act of foreign enemy, hostilities (whether war be declared or not), rebellion, revolution, insurrection or usurped power.
3. Loss or damage occasioned by confiscation, commandeering, requisition or destruction of or damage to property by order of the government de jeer [sic] or de facto or any Public Municipal or Local Authority of the country or area in which the property is situated if such loss is occasioned by or arises out of any of the occurrences referred to in 2 above.
4. Loss of or damage to property occasioned by its undergoing any process necessarily involving the application of heat.
5. Loss or damage by or in consequence of the sea, tidal wave, high-water, flood, erosion, subsidence or landslide.
6. Loss or destruction of or damage to any property whatsoever or any loss or expense whatsoever resulting or arising therefrom or any consequential loss.
7. Any legal liability of whatsoever nature directly or indirectly caused by or contributed to by or arising from ionizing radiations or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel for the purpose of this exclusion only combustion shall include any self-sustaining process of nuclear fission.
8. Loss destruction damage or legal liability or indirectly caused by or contributed to by or arising from nuclear weapons material.
9. Loss or damage by or in consequence of Sabotage and Terrorism.

B. Unmet Conditions

1. If the Insured does not give notice in writing to NIA of any other insurance or insurance already affected, or which may subsequently be effected, covering any of the perils insured, except the perils public liability and compensation for death. This applies irrespective of whether the other insurance policy or insurer disputes liability or does not accept claim.

2. If the said notice is given but is not stated in or endorsed on or attached to the Policy by or on behalf of NIA before occurrence of any loss or damage.

If these conditions are met, NIA would be liable only for the ratable proportion of the liability.

3. Insured is to give notice in writing to NIA forthwith, on the happening of any loss or damage or any accident and in every case where legal or other proceedings are commenced or threatened, such notice containing full information available of all details on the loss, etc, or/and litigation. The Insured is also to lodge claim within 15 days after the happening of any loss, etc., together with, at his own expense, producing to the Company all such books, vouchers, and other evidence as may be reasonably required by or on behalf of NIA. Insured is also to make a statutory declaration (if demanded) of the truth of the claim and of any matters connected therewith. NIA can avoid liability for any failure to abide by these conditions.

4. If insured, without the written consent of NIA, incurs any expense of litigation, or negotiate, pay settle, admit, or repudiate any claim.

5. If insured does not allow the NIA to, on the happening of any loss, etc., to enter any building where the loss/damage has happened and to take and keep possession of the property insured and to deal with the salvage in a reasonable manner.

6. If insured abandons the property to the NIA.

7. If Insured does not allow NIA to undertake in the name and on behalf of the insured the absolute conduct, control, and settlement of any proceedings, and to take proceedings at its own expenses and for its own benefit, but in the name of the Insured, to recover compensation or secure indemnity from any third party in respect of anything insured by this Policy.

Other Exclusions:

1. Fraud: If the claim in any respect is fraudulent, or if any fraudulent means or devices are used by the Insured or anyone acting on his behalf, to obtain any benefit under the Policy.

2. If the loss or damage be occasioned by the willful act or with the connivance of the Insured or if the Insured or anyone acting on his behalf hinders or obstructs the Company in doing any of the acts referred to in [sic - Condition 4 above]

3. If a claim made is rejected, and an action or suite is not commenced within 3 months after such rejection, all benefits under this Policy are forfeited.
1. The Policy can be cancelled at any time at the request of the Insured, in which case NIA shall retain or be entitled to recover the 'customary Short-period rate for the time during which the Policy has been in force' [the rate is not specified].

2. NIA may at any time, by giving written notice to the Insured, cancel this Policy, in which case NIA will, on delivery of the Policy to the Company, refund to the Insured the amount of unearned premium, calculated on a pro rata basis.

**Arbitration**

There is provision for one or two arbitrators to be appointed to settle all disputes.
## A.5: Burglary

<table>
<thead>
<tr>
<th><strong>Covered</strong></th>
<th><strong>Not Covered</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Loss or damage of items in the schedule (separately provided to policy) within the premises.</td>
<td>1. Loss or damage in or of items in any garden, yard, open verandah, outbuilding or other appurtenances.</td>
</tr>
</tbody>
</table>
| 1. Theft consequently upon actual forcible and violent entry upon the said premises or any attempt there at. | 1. If loss/damage is due to theft and larceny *not* occasioned by:  
- *actual forcible,*  
- *visible, and*  
- *violent* entry. |
| 2. Theft or any attempt thereat by a person feloniously concealed on the said premises. |  |

Major Error: insertion of 'not' in liability: ‘THE COMPANY AGREES THAT if at any time during the period of insurance… any of the property insured… be lost or damaged as the result of [conditions specified] the company will not pay to the Insured the value … of the property lost or the amount of the damage or as its option reinstate or replace such property or any part thereof.’

<table>
<thead>
<tr>
<th>Covered</th>
<th>Not Covered</th>
</tr>
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</table>
| 2. Theft as aforesaid from the premises specified of cash, notes, negotiable cheques, postal notes, post office money orders, negotiable securities and/or stamps the company will pay to the insured the amount of such not exceeding in the total sum of $50. | 1. Theft of cash, notes, , negotiable cheques, postal notes, post office money orders, negotiable securities and/or stamps, of a value above $50.  
2. 10% (or sum specified) of every claim  
3. Documents, manuscripts, business books, patterns, models, plans, designs unless specially mentioned as insured by this policy.  
4. Loss or damage due to theft or any attempt thereat committed by:  
a. Any of the insured’s family.  
b. Any person or persons whilst lawfully on the premises (e.g. employee).  
5. Loss or damage by or consequent upon fire.  
7. Loss or damage which at time of the happening of such loss or damage is insured by, or would, but for the existence of this policy, be insured by any other policy, other than a burglary policy.  
8. Loss or damage arising from: |
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<tbody>
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<td>7.</td>
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<tr>
<td>8.</td>
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<tr>
<td>9.</td>
<td>Any consequence of war, invasion, act of foreign army, hostilities (whether declared or not), civil war, rebellion, revolution, insurrection or military or usurped power.</td>
</tr>
<tr>
<td>10.</td>
<td>Any loss/damage/expense arising, or any consequential loss directly or indirectly caused by or contributed to by or arising from ionizing radiations or contamination by radio activity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel, including self-sustaining process of nuclear fission.</td>
</tr>
<tr>
<td>11.</td>
<td>Loss, destruction or damage directly or indirectly caused by or contributed to by or arising from nuclear weapons material.</td>
</tr>
<tr>
<td>12.</td>
<td>If insured does not take all reasonable precautions for safety and protection of the property insured.</td>
</tr>
<tr>
<td>13.</td>
<td>If insured does not comply with all statutory obligations, bylaws, and regulations imposed by any public authority for the safety, use and storage, or the property insured.</td>
</tr>
<tr>
<td>14.</td>
<td>Void for misrepresentation, misdescription or non-disclosure in any material particular.</td>
</tr>
<tr>
<td>15.</td>
<td>If there is any alteration in the premises insured to an extent that particulars and information given to the company are no longer correct statement of facts.</td>
</tr>
<tr>
<td>16.</td>
<td>If the interest of the insured ceases except by Will or operation of law.</td>
</tr>
<tr>
<td>17.</td>
<td>For the period the premise is unoccupied and remains so for a period exceeding 30 consecutive days.</td>
</tr>
<tr>
<td>18.</td>
<td>If insured does not give a written notice to the Company of any insurance effected covering any of the property insured.</td>
</tr>
<tr>
<td>19.</td>
<td>If upon the happening of any event giving rise or likely to give rise to a claim, the insured does not:</td>
</tr>
<tr>
<td></td>
<td>a. Give immediate notice to the police</td>
</tr>
<tr>
<td></td>
<td>b. Take all practicable steps to discover the guilty person(s)</td>
</tr>
</tbody>
</table>
Appendix: Policy Analysis

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c. take all practicable steps to recover the property lost
d. give immediate written notice to the company
e. within 30 days after loss/damage give written account of all loss/damage and their values.
f. Give Company a statement giving details of any other insurance(s) of the property insured
g. Give the Company all such proofs and information with respect to the claim as required by the Company, and if required, a statutory declaration of the truth of the claim and of any matters connected with it.

20. For loss of cash taken from the safe following the use of the key to the said safe, or any duplicate belonging to the Insured, unless such key was obtained by threats or violence.

21. If all glass windows, openings etc are not duly protected by burglar-proof bars.

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**Product: Burglary Insurance Policy**

**Company: Dominion**

<table>
<thead>
<tr>
<th>Covered</th>
<th>Not Covered</th>
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<tbody>
<tr>
<td>1. Indemnify the insured by payment, reinstatement or repair if:</td>
<td>1. If loss/damage is due to theft and larceny not arising from:</td>
</tr>
<tr>
<td>a. the property insured, whilst within the premises, be stolen following actual forcible and violent entry of the premises by thieves (other than employees) or by thieves unlawfully concealed thereon; or</td>
<td>a. actual forcible, and</td>
</tr>
<tr>
<td>b. there is any damage to the Premises owned by the Insured or for which the Insured is legally responsible arising from</td>
<td>b. violent</td>
</tr>
<tr>
<td>2. If theft by employees.</td>
<td>entry by thieves.</td>
</tr>
<tr>
<td>3. Shortages due to clerical or accounting errors and loss due to errors in receiving or paying out.</td>
<td>1. Loss or Damage to any plate or stained glass or any decoration or lettering thereon.</td>
</tr>
<tr>
<td>2. Loss or Damage to Current Coin Bank and Currency Notes, Cheques, Postal Notes, Money Orders, Travellers Cheques, Current Postage and Revenue Stamps and negotiable instruments.</td>
<td>2. Loss or Damage to Current Coin Bank and Currency Notes, Cheques, Postal Notes, Money Orders, Travellers Cheques, Current Postage and Revenue Stamps and negotiable instruments.</td>
</tr>
<tr>
<td>3. Not more than their value as materials in respect of business books, plans, patterns, moulds, models, designs or documents of any kind.</td>
<td>3. Not more than their value as materials in respect of business books, plans, patterns, moulds, models, designs or documents of any kind.</td>
</tr>
<tr>
<td>4. Loss or Damage to any cash register or money drawer which is kept locked outside normal business</td>
<td>4. Loss or Damage to any cash register or money drawer which is kept locked outside normal business</td>
</tr>
</tbody>
</table>
such theft or attempted theft.

**Employees Personal Effects** (but excluding motor vehicles) are covered but only whilst the effects are in or about premises owned or occupied by the Insured.

Temporary removal covered.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>5.</td>
<td>Loss for which at the time of its occurrence indemnity is provided by or would but for the existence of this Policy be provided by any other existing Policy or Policies except in respect of any excess beyond the amount which would have been payable under such other Policy or Policies has this insurance not been effected.</td>
</tr>
<tr>
<td>6.</td>
<td>Loss or Damage resulting from fire or explosion [but loss or damage caused by the explosion of any explosive used by the thieves for the purpose of breaking open any safe or strong-room in the premises (but not by fire resulting from such explosion) is covered]</td>
</tr>
<tr>
<td>7.</td>
<td>Loss occasioned by or through or in consequence, directly or indirectly, of any of the following occurrences: (a) War, invasion, act of foreign enemy, hostilities or war-like operations (whether war be declared or not) civil war, mutiny, civil commotion assuming the proportions of or amounting to a popular uprising, riot, military rising, rebellion, revolution, insurrection, terrorism, sabotage, military or usurped power. (b) Nuclear weapons material or ionizing radiation or contamination by radioactivity from any nuclear waste or from the combustion of nuclear fuel. (c) Earthquake, Tidal Wave, Cyclone or other convulsion of nature</td>
</tr>
<tr>
<td>8.</td>
<td>not be liable to indemnify any person or corporation whose interest has not been declared.</td>
</tr>
<tr>
<td>9.</td>
<td>If the insured does not take 'all reasonable precautions for the safety of the property insured as regards selection and supervision of employees, securing all doors and windows and other means of entrance and otherwise.</td>
</tr>
<tr>
<td>10.</td>
<td>If not all protections measures which existed at the commencement date of this insurance and which Dominion was aware of were maintained and/or kept fully operational at all times.</td>
</tr>
<tr>
<td>11.</td>
<td>If the insured does not: a. Immediately notify Dominion and the Police of any occurrence which may give rise to a claim. b. Immediately take all practical steps to discover the guilty person or persons and to recover the property lost.</td>
</tr>
</tbody>
</table>
c. Within 30 days submit in writing full particulars of the occurrence and/or claim in such a form or manner as may be reasonably required by Dominion so that any claim is not prejudiced.

d. Take all reasonable steps to prevent further loss or damage.

12. If at the time of any loss, damage or liability there is any other insurance covering such loss, damage or liability or any part thereof, Dominion shall be liable only for the amount of loss not covered by such other insurance.

**Other points:**

1. The Insured can cancel policy at any time; company to refund 80% of the unused premium.

2. The company can cancel policy or amend the terms, exclusions and limitations after 4.00pm on the 14th day following despatch or written notice to the Insured’s last known address. The Insured shall be entitled to a return of premium proportionate to the unexpired period of the cancelled policy.

**Jurisdiction:**- indemnity provided shall not apply to:

1. An action for damages brought in a court of law outside Fiji and not subject to Fiji law or where an action is brought in Fiji to enforce a foreign judgment whether by way of reciprocal agreement or otherwise.

2. Costs and expenses of litigation which are not incurred within Fiji.

**Premium payment:** Unless alternative premium payment terms have been agreed in writing, this policy will become null and void 30 days after the original inception date or any subsequent renewal date unless the full annual premium has been paid to the Dominion.

**Proposal:** The truth of the statements and answers in the proposal form submitted by the Insured are a condition precedent to any liability of the Dominion to make any payment under this Policy.
# A.6: Fire Insurance

**Product: Fire Insurance Policy**  
**Company: New India Assurance Policy**

<table>
<thead>
<tr>
<th>Covered</th>
<th>Exclusions (Not Covered)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Property listed in the schedule if it is destroyed or damaged due to:</td>
<td>1. If it is caused by its own spontaneous combustion, fermentation and natural heating, or by its undergoing any heating or drying process.</td>
</tr>
<tr>
<td>1. Fire</td>
<td></td>
</tr>
<tr>
<td>2. Lightning</td>
<td></td>
</tr>
<tr>
<td>3. Explosion</td>
<td>1. Loss, destruction of or damage to boilers (other than domestic boilers), economizers or other vessels, machinery or apparatus in which steam is generated or their contents resulting from their own explosion.</td>
</tr>
<tr>
<td>4. Aircraft, other aerial devices and articles dropped there from.</td>
<td></td>
</tr>
<tr>
<td>5. Impact damage by vehicles and animals</td>
<td></td>
</tr>
</tbody>
</table>
| 6. Water discharged – over-flowing or leaking from any pipe or water system on account of burst pipes installed in or on the building or on adjoining buildings or by water from watermain outside the building. | 1. Loss or damage caused directly or indirectly:  
   a. In consequence of storm and or tempest  
   b. From any sprinkler or drencher installation or tank connected therewith  
   c. Rainwater  
   d. Flood (unless additional premium paid) |
| 7. Riots, strikes, civil commotion or malicious damage | 1. War, invasion, act of foreign enemy, hostility or war like operations (whether war be declared or not), civil war, mutiny |
| 8. Earthquake – loss or damage caused by fire, shock, volcanic eruption or overflow of sea or tsunami. | 1. Tidal wave, overflow of the sea.  
   2. Subsidence, landslides, erosion or any action of sea |
<p>| 9. Fusion damage – Damage caused by actual burning out by abnormal electric current, switchboards and permanent | 1. Damage caused by lighting or heating elements, fuses or protective devices and electric contacts at which sparking or arcing occurs in ordinary working. |</p>
<table>
<thead>
<tr>
<th>Appendix: Policy Analysis</th>
<th>159</th>
</tr>
</thead>
<tbody>
<tr>
<td>wiring up to a limit of $1000 with an excess of $100.</td>
<td></td>
</tr>
<tr>
<td>10. Cyclone, storm and/or tempest: for an additional premium</td>
<td>1. No coverage upto 7 days from date of acceptance of policy and issue of certificate or policy. 2. No claim in respect of: a. Loss/damage by water or rain unless caused by water/rain entering building through openings in the walls or roof made by storm/tempest. b. Sea surge, tidal wave, high-water, flood, erosion, subsidence or landslide. c. Gates, fences, and any outdoor fixtures or fittings. d. If under construction or reconstruction unless fully enclosed e. If not constructed in conformity with regulation, codes, bylaws pertaining to prevailing building standards f. Any material, goods, stock in open yards or compound. g. If no shutters put in place immediately following cyclone warning.</td>
</tr>
<tr>
<td>11. Property insured whilst being temporarily removed from any other part of insured’s premises or to any other premises within or in transit within Fiji upto a maximum of $5,000.</td>
<td>1. If property removed in excess of 90 days, except if done with the written consent of the insurance company.</td>
</tr>
<tr>
<td>12. Covers any addition, physical alteration or improvement to the value of property insured, except stock-in-trade and merchandise to an amount not exceeding 5% of sum insured if company notified of the above within 1 month and pay additional premium.</td>
<td></td>
</tr>
<tr>
<td>13. Upto $5000 to refill fire extinguishers used to extinguish fire at the premise or prevent the imminent loss threatening the property.</td>
<td></td>
</tr>
</tbody>
</table>
### Other Exclusions

1. Loss or damage during any period in excess of 30 consecutive days during which the building is left unoccupied unless with the written consent of the company.
2. Goods held in trust or on commission, money, securities, stamps, documents, manuscripts, business books, computer systems records, patterns, models, moulds, plans, designs, explosives unless specially mentioned as insured by this policy.
3. Destruction or damage directly or indirectly caused by nuclear weapon material, ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel.
4. Sabotage and terrorism
5. Cyclone/tempest/storm unless opted for at additional premium.
6. Mechanical or electric down to any electrical machine, apparatus, fixtures or fitting provided that this exclusion shall apply only to the particular electrical machine, apparatus, fixtures or fitting so affected but resultant damage to other property is covered.
7. Wear, tear, depreciation
8. Loss by theft during or after the occurrence of any insured peril.
9. If the insured’s interest ceases except by will or operation of law.
10. If no notice is given to company of any other insurance covering any of the property insured under this policy, all benefits are forfeited. If informed, company liable only upto the ratable proportion of the destruction/damage.
11. If company not informed in writing of the happening of the loss/damage within 30 days.

### Disclosure:

1. Insured is required to disclose ‘everything’ he knows ‘or could be reasonably expected to know’ that a prudent insurer would want to take into account in deciding the acceptance of the proposal to insure. And the insured is required to inform the company ‘every time’ he makes any change to his risk and everytime the policy is renewed. This is a term of the contract. A non-disclosure would lead to the company avoiding the liability.
2. Company can at anytime terminate the policy on notice to that effect being given to the insured; company needs to repay a ratable proportion of the premium for the unexpired term.
3. Insured can terminate the policy at any time, but no refund of premium is provided for.
4. Averaging: If the property insured was of greater value than sum insured (i.e. underinsured), policy holder assumed to self insure for the balance; company liable only upto the ratable proportion of the loss.

Provision for 1 or 2 Arbitrators to be appointed by the parties to deliberate on differences.
## Product: Fire Insurance Policy
### Company: Dominion

<table>
<thead>
<tr>
<th>Covered</th>
<th>Exclusions (Not Covered)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Property listed in the schedule if it is destroyed or damaged due to:</td>
<td>1. Motor vehicles, motor cycles, watercraft, outboard motors, aircraft and accessories unless this property forms part of the stock of the business however such stock will not be covered whilst being driven, towed, sailed or flown.</td>
</tr>
<tr>
<td></td>
<td>2. Livestock, trees, growing crops, retaining walls, land, drainage systems, dams, reservoirs, canals, culverts, aqueducts, tunnels, bridges, docks, piers, wharves, breakwaters or mining property located above or underground.</td>
</tr>
<tr>
<td></td>
<td>3. Jewellery, precious stones, works of art, precious metals or bullion other than stock or plant of your business</td>
</tr>
<tr>
<td></td>
<td>4. Cash, negotiable checks, money orders, stamps, credit cards, invoices, other negotiable instruments.</td>
</tr>
<tr>
<td>1. Fire</td>
<td>1. Any loss or damage to property undergoing any process involving the application of heat.</td>
</tr>
<tr>
<td>2. Lightning</td>
<td></td>
</tr>
<tr>
<td>3. Explosion</td>
<td>1. Damage to any Pressure Vessel and its contents caused by explosion of that Pressure Vessel. &quot;Pressure Vessel&quot; includes any boiler, economiser, or other vessel which, under normal operating conditions, is subject to applied or generated fluid pressure, but does not include:</td>
</tr>
<tr>
<td></td>
<td>a. Any boiler used solely for domestic purposes.</td>
</tr>
<tr>
<td></td>
<td>b. Any vessel subject to pressure applied solely by weight of the vessels contents.</td>
</tr>
<tr>
<td></td>
<td>2. Loss recoverable under any Boiler Explosion or Sprinkler Leakage policy, but this exclusion does not apply to loss in excess of the amount recoverable under that policy.</td>
</tr>
<tr>
<td>4. Aircraft and other Aerial Devices and articles dropped therefrom.</td>
<td></td>
</tr>
<tr>
<td>5. Impact by animals or land vehicles but excluding loss or damage to property in the open.</td>
<td></td>
</tr>
</tbody>
</table>
| Water Damage as a direct consequence of water discharged or leaking from any pipe or water system installed in or on the building(s) and/or an adjoining building(s) and/or by water from a water main outside the building(s). | 1. Destruction or damage caused directly or indirectly by:  
a. Water discharged or leaking from any sprinkler or drencher installation or any tank connected therewith.  
b. Rainwater. |
| Leakages or Spillage of material (other than water) in the form of a gas, vapour or liquid | 1. Damage to the leaked or spilt material.  
2. Cost of removing or recovering the leaked or spilt material.  
3. Cost of rectifying the fault that permitted the leakage or spillage.  
4. Damage to goods in transit.  
5. Leakage or spillage caused by and happening during the course of repairs or alterations.  
6. Damage to the vessel, device, pipe or other equipment from which the material has leaked or spilt. |
| Sprinkler Leakage, meaning leakage or discharge of any substance from an Automatic Sprinkler System, including collapse of a tank that is part of the system | 1. Amount of the deductible shall be 7.5% of the sum insured or $2500 whichever is the greater during any one period of 72 consecutive hours in respect of each item/column. |
| Earthquake, subterranean fire or volcanic eruption. | 1. Amount of the deductible shall be 7.5% of the sum insured or $2500 whichever is the greater during any one period of 72 consecutive hours in respect of each item/column. |
| Tidal Wave caused by or happening through or following earthquake. | 1. Damage to radio, television, audio, computer and electronic equipment of any kind.  
2. Damage to vacuum tubes and thermion valves.  
3. Damage to flexible or trailing leads between the point of permanent electricity supply and any machine or apparatus.  
4. Damage to electrical contacts at which sparking or arcing occurs in ordinary working. |
### Demolition

The cost of demolishing and removing the debris including contents for which a claim has been accepted is included within the sum insured. Also, the cost of temporary repairs and other measures necessary to secure the property or to make it safe or suitable for continued use.

### Professional Fees

Architects, engineers and other professional fees incurred in the re-
| Building or repairs to the property for which a claim has been accepted is included within the sum insured. |

**Capital Addition:** policy extends to cover property (including, but not limited to, alterations, additions, and improvements to existing property) situated anywhere in Fiji and acquired by the Insured during the period of insurance.

1. Stock in trade or property of any kind expressly excluded from this insurance;
2. Any appreciation of the value which is not due to a physical alteration, addition or improvement.
3. If within 90 days of acquisition particulars of each property acquired are not given to the Dominion and an additional pro-rata premium paid.
4. Liability under this extension does not exceed 5% of the sum insured or $100,000 (whichever is the lesser) in respect of each item/column insured.

**Employees Personal Effects:** are covered under this policy but only whilst the effects are in or about premises owned or occupied by the Insured, or elsewhere whilst being worn, kept, carried or used by employees acting in the course of their employment.

1. Motor vehicles.
2. Liability under this extension is discharged by payment of claims to the Insured as trustee for the employees.

**Money:** Covers loss or damage to current coin, bank and currency notes, cheques, postal notes, travellers cheques, money orders, unused postage stamps, franking machine credits, tickets, redeemable vouchers and tokens, and other negotiable instruments, where the loss or damage results from an insured peril. Provided that: (a) cover under this extension does not apply to loss recoverable by the Insured under a policy of Money or Burglary insurance except to the extent that the loss exceeds the amount so recovered.
<table>
<thead>
<tr>
<th>Appendix: Policy Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Dominion’s Liability under this extension is limited to $1000.</td>
</tr>
<tr>
<td><strong>Other Interests</strong> - Where the Insured is under an obligation to insure the interest of any person or corporation having an insurable interest in any of the insured property, Dominion will indemnify the Insured and that person or corporation as if a separate policy had been issued to each. Any cash claim settlement will be paid to the other interested party(is) whose receipt thereof shall be a full and sufficient discharge to the Dominion.</td>
</tr>
</tbody>
</table>
| 1. Dominion will not be liable to indemnify any person or corporation whose interest has not been declared to Dominion by the time indemnity becomes payable; and  
2. Dominion’s liability will not be increased beyond the amount that would be payable if this extension had not been incorporated in the policy. |
| **Protection Costs**: Policy extends to indemnify the Insured for any costs reasonably incurred by the Insured for the purpose of fighting or controlling any Insured Peril that involves or threatens to involve Insured Property. |
| **Social Club Property** - Policy extends to cover the property of any pension fund, social club, sports club, or similar entity, whose activities are principally for the benefit of the Insured's employees. |
| 1. Liability will be discharged by payment of claims to the Insured as trustee for members of the entity concerned. |
| **12 Temporary Removal** - The Insured Property (other than stock) is covered whilst temporarily removed elsewhere on the same premises or to other premises anywhere in Fiji and in transit to and from those premises. |
| 1. Amount recoverable in respect of the property so removed will not exceed the amount which would have been recoverable had the loss occurred in that part of the premises from which the property is temporarily removed. |
| **13 Optional Perils**: Dominion provides cover for the following optional perils on the payment of an additional premium: Cyclone, Flood, Riot, Malicious Acts, Civil Com- |
motion, Strikes or Locked-Out Workers, and Looting, Sacking and/or Pillaging.

| Optional Peril – Cyclone | 1. If buildings are not entirely enclosed with all outside doors, windows and roofs permanently in place.  
2. Any loss or damage occurring before the expiration of 7 days after 4pm on the day of acceptance by the Dominion of this cover.  
3. Loss or damage to the insured interest:  
a. by water or rain unless such loss or damage is caused by water or rain entering the building through openings in the walls or roof(s) made by the cyclone.  
b. sea, tidal wave, high-water, flood, erosion, subsidence or landslide.  
c. to solar heating equipment, water tanks, gates, fences, awnings, blinds, signs, power and/or telephone poles and appertances, aerials, masts, satellite dishes, decorative masi, thatching or any other outdoor fixtures or fittings of any description.  
d. loss/damage to buildings or contents in the course of construction, reconstruction or repair.  
e. Deterioration of frozen or freezer/cooler goods/stock resulting from electricity power failure.  
f. Loss or damage to buildings or their contents for which a certificate from an accredited engineer has not been accepted by the Dominion. Any such certificate must not be more than 7 years old as at the inception date of this policy or any subsequent renewal date.  
4. If the insured did not use due diligence to minimise any loss or damage.  
5. If any damage to buildings or contents was caused by a peril covered by this extension occurred prior to the commencement of this insurance or during the term of this insurance, no liability for any subsequent damage.  
6. If all fixed glass on the ground and first floor levels are not protected by cyclone shutters constructed and affixed in accordance with the recommendations of the engineer whose certificate Dominion has approved. If such shutters are not in place immediately following an official cyclone warning and to remain in place during the time the official cyclone warning remains in force. |

| Optional Peril - Flood | 1. Water discharged or leaking from any fire protection sprinkler or drencher installation or from any tank in connection with any such installation. |
by water which, through flood, has risen or overflowed beyond the normal boundaries of any river, watercourse or body of water other than the sea.

<table>
<thead>
<tr>
<th>Optional Peril – Riot, Malicious Acts, Civil Commotion, Strikes or Locked-Out Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss or damage to insured property from Riots, Strikes, Civil Commotion, strikes or locked-out workers as shown on the attached schedule.</td>
</tr>
</tbody>
</table>

2. Subsidence and landslip.
3. Damage caused during the course of any repairs or alterations.
4. Damage to carpets or other fixed or loose floor coverings.
5. Damage to any building component, fixture or fitting which is constructed with wooden chip or particle board or composite building material.
6. Any loss or damage where the flood water level within the premises is less than 30 centimetres above the ground floor level.

<table>
<thead>
<tr>
<th>1. Amount of the deductible shall be 2.5% of the sum insured or $2,500 whichever is the greater during any one period of 72 consecutive hours in respect of each item/column.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Riot if the riot is not:</td>
</tr>
<tr>
<td>a. an act of group, and</td>
</tr>
<tr>
<td>b. by at least 12 (twelve) persons, who in the execution of their common purpose cause public disturbance tumultuously with violence and damage to the property of others.</td>
</tr>
<tr>
<td>3. Strikes if it is not:</td>
</tr>
<tr>
<td>a. a deliberate act of damage, and</td>
</tr>
<tr>
<td>b. by a group of workers, and</td>
</tr>
<tr>
<td>c. by a group of at least 12 persons or one half of the entire workforce (if the number of workers is less than 24 persons), who, are refusing to work as usual in an attempt to force the employer to accept their demands or to protest against any terms of employment enforced by the employer.</td>
</tr>
<tr>
<td>4. Locked-out Workers if it is not:</td>
</tr>
<tr>
<td>a. a deliberate act of damage,</td>
</tr>
<tr>
<td>b. by a group of workers,</td>
</tr>
<tr>
<td>c. by at least 12 persons or one half of the entire workforce (if the total number of workforce is less than twenty-four persons), to protest against the termination or suspension of a fellow employee by the employer.</td>
</tr>
<tr>
<td>5. Malicious Acts if it is:</td>
</tr>
</tbody>
</table>
Insurance Industry in Fiji

| | a. not an act of any person(s) deliberately causing damage to the property of others driven by vengeance, hatred, anger or vandalistic intentions,  
b. done by the employee(s) of the Insured, or any person(s) on behalf of the Insured, or by person(s) entrusted by the Insured to maintain or keep such property, or by thieves or robbers. |
|---|---|
| 6. Civil Commotion if it is not: | a. an act of a large number of people,  
b. acting together  
c. disrupting public peace and disturbance tumultuously with violence, and  
d. a chain of destruction of a large number of properties, indicated by the cessation of more than one half of the normal activity of commercial/shopping or business areas or schools or public transportation in one city or town,  
e. for at least 12 (twelve) hours consecutively commencing immediately before, during or after the event. |
| 1. Deductible is 7.5% of the sum insured and the sub limit is 50% of the sum insured for stock and or contents. | | Optional Peril – Looting, Sacking and/or Pillaging  
Loss or damage to insured property from Looting, sacking and/or pillaging directly resulting from riot, civil commotion, strikes or locked out workers. |
| Numerous terms are defined in the policy: | Insurrection/Popular Rising is an uprising of a majority of the people in the capital city of the country, or in three or more of the towns in the country within 12 (twelve) days, demanding a change in the government de jure or de facto, or open resistance against the government de jure or de facto, not amounting to a rebellion  
Usurped Power is a situation where the established order has been overthrown and replaced by some illegal authority which is in a position to lay down rules of conduct and also ensure that the rules are obeyed.  
Revolution is an uprising of the people with force to make a radical change to the current public administration system of the country or to overthrow the established government de jure or de facto, not amounting to a Rebellion.  
Rebellion is a state of organised resistance against the established authority with |
the object of supplanting or overthrowing it with force using firearms which threatens the existence of such authority.

*Military Rising* is an act by a group of home or foreign armed forces personnel consisting of at least 30 (thirty) persons using force with the intention to overthrow the established authority or to cause public disorder and disturbance.

*Invasion* is an act by the military power of one country to penetrate or invade the territory of another with the object of permanently or temporarily occupying and taking control over such territory.

*Civil War* is an armed conflict between regions or political factions within the territorial limits of a country with the object of gaining legitimate power.

*War and Hostilities* is a widespread armed conflict (whether or not war has been declared) or a warlike situation between two or more countries, including military exercises of a country or joint-military exercises between countries.

*Subversive Acts* is an act by any person on behalf of or in connection with any organisation with activities directed towards the overthrow by force of the government de jure or de facto, or to the influencing of it by terrorism or sabotage or violence.

*Terrorism* is an act by any person using force to create public fear in an attempt to achieve a goal that according to public opinion has a political background.

*Sabotage* is a destructive act against property or the obstruction of work process or causing the reduction in value of work, by any person in an attempt to achieve a goal that according to public opinion has a political background.

*Looting* is the appropriation of property belonging to another by any person (excluding those employed by or under the control of the Insured), with the intention of permanently depriving the other of it.
## A.7: Motor Vehicle Insurance

<table>
<thead>
<tr>
<th>Items Covered by Policy</th>
<th>Items Not Covered by Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Section 1: Loss or damage to vehicle</td>
<td>1. Insurance company is entitled to the vehicle if written off and/or parts are replaced.</td>
</tr>
<tr>
<td>II. <strong>Accidents:</strong> Insurance claimable if vehicle is accidentally damaged, or maliciously damaged by a person other than the owner.</td>
<td>1. If the vehicle is stolen and recovered New India will be entitled to vehicle if written off and/or parts if replaced.</td>
</tr>
<tr>
<td>III. <strong>Theft:</strong> If vehicle is stolen and recovered payment will be made for recovery and repair. If it is uneconomical to recover and repair, or if vehicle is stolen and not recovered, New India will pay the vehicles’ market value or sum insured which ever is less.</td>
<td>1. If entitlement is provided to benefits under workers compensation or motor vehicle third party insurance act.</td>
</tr>
<tr>
<td>IV. <strong>Windscreen breakage:</strong> the cost of reinstating the windscreen to maximum indemnity as mentioned in the schedule.</td>
<td></td>
</tr>
<tr>
<td>V. <strong>Medical expense:</strong> If insured or person traveling with insured at the time of accident involving the vehicle incurs medical, dental, hospital, chemist and ambulance expenses as a result of accident the New India will reimburse up to $100 aggregate.</td>
<td></td>
</tr>
<tr>
<td><strong>Towing:</strong> If vehicle damaged in any accident cannot be driven, New India will pay for towing it to safety or nearest repair centre.</td>
<td></td>
</tr>
</tbody>
</table>

**Claim only for:** current market value or sum insured, whichever is less. This if vehicle is a write-off, the insured sum is not necessarily paid if the market value at that time – and not at the time of the insurance – is estimated by the company to be lower than the sum insured. But if the market value is higher than the sum insured, then the sum insured is paid, not the market value.

**Section 2 Legal Liability (personal & property)**
### VI. Legal liability:

1. If owner held legally responsible as a result of an accident caused by or in connection with use of the insured vehicle/caravan/trailer which it is towing, New India will pay damage in respect of:

   a. Death and bodily injury to persons other than:
      
      i. friend or relative residing with owner/insured or with whom owner/insured lives
      
      ii. employee who at time of accident was engaged in insured’s services.
      
      iii. any person driving the vehicle or entering or alighting from or about to enter of to alight from of being conveyed by the vehicle.

   b. Damage to Property, other than that belonging to:
      
      i. Owner/insured or in his physical or legal custody or control
      
      ii. any relative or friend of insured ordinarily residing with insured/owner

1. No claim for death, or bodily injury or property of:

   a. friend or relative residing with owner/insured or with whom owner/insured lives
   
   b. Employee who at time of accident was engaged in insured’s services.
   
   c. Any person driving the vehicle or entering or alighting from or about to enter or to alight from or being conveyed by the vehicle.

2. No claims for damage to Property of:

   a. Owner/insured or in his physical or legal custody or control
   
   b. any relative or friend of insured ordinarily residing with insured/owner

3. Does not protect against third party policy liability, or for an amount equal to or less than liability as required by the third party policy.

4. Aggregate liability for death, bodily injury or damage to property is limited to the amount stated in the Schedule.

### Legal Cost:

Legal cost charges and expenses incurred by insured if with written consent of insurer.

### Legal Defence:

The insurer will defend insured or any other party concerned under the policy in court if considered necessary, and/or will under take defence in court if any event had occurred due to an accident caused by the insured vehicle.

### Other Exclusions/Non-Coverage

1. If the vehicle is used for any other purpose that is not stated in the proposal or policy except for commercial vehicles if they are used for private use.

2. If vehicle is driven by a person:

   a. Who was under the influence of alcohol or drugs that exceeded the legal limit prescribed in s17 of the Traffic Amendment Act 1986.
   
   b. who is convicted of alcohol or drugs related charges governing the use of motor
vehicle.
c. who fails or refuses to permit a specimen of blood or breath test after being law-
   fully required to do so under the Traffic Amendment Act 1986 or any statutory
   provision.
d. who is under the influence of intoxicating liquor or drugs.

3. If vehicle was driven by a person who:
a. does not have the appropriate license to do so.
b. does not have a valid and current driving license
   (But not if the driver is charged with theft or illegal use of the vehicle.)

4. if the vehicle is being used in an unsafe condition or unroadworthy condition or
   without proper certificate of fitness or is loaded contrary to law.
5. If vehicle is modified from manufacturers specifications without insurer’s knowl-
   edge and agreement.
6. If vehicle is being used in or tested in preparation for racing or any motor sport.
7. If vehicle is being let for hire, fare or reward or used to carry passengers for
   hire, fare or reward, unless this use has been stated in the proposal and agreed by
   the company.
8. Loss or damage to tyres unless it is the result of damage to the vehicle for
   which a claim is payable under the policy.
9. Loss of use of vehicle, depreciation, wear, tear, rust, corrosion and existing de-
   fects.
10. Damage to or failure or breakage of the engine, transmission, mechanical or
    electrical systems unless arising from an external accidental cause.
11. Loss due to failure to secure vehicle after it has broken down, been damaged
    by fire or involved in an accident.
12. When more than one person is insured under this policy, for loss resulting from
    or occasioned by any of them stealing, or dishonestly or illegally using the vehicle.
13. For loss or damage caused by lawful seizure of vehicle or by other operations
    of law.
14. For loss or damage caused by arising from any war, whether war has been de-
    clared or not, hostilities, civil war or rebellion.
15. For loss or damage caused by or arising from radioactivity or the use, existence
    or escape of any nuclear fuel, nuclear material or nuclear waste.
16. For sabotage and terrorism risks.
17. If insured does not immediately advice the company of any event that may give
    rise to a claim
18. If insured does not submit full details in writing on the claim form within 30 days
19. If the insured does not inform the police if any crime is suspected or 3rd party
    involved, and does not take all reasonable precautions to prevent further loss or dam-
    age.
20. If insured does not immediately send to the insured any legal process issued or
commenced against him.

21. If insured incurs any expense in making good any damage or expense of litigation or negotiate, pay, settle, admit or repudiate any claim without written consent of the company.

22. If any claim under the policy is false or fraudulent.

23. If at any time of loss, damage or liability there is any other insurance covering such loss, damage or liability or any part thereof, company liable only for its ratable proportion

24. Conditions in the schedule supersede the terms and conditions of the policy.

25. If vehicle is sold.

Other Issues:

1. Alteration: Company may alter the terms and conditions of the policy by delivering a written notice to the insured, which alterations shall be effective after the expiry of 14 days from the date of receipt. Insured can also have the policy altered with the alteration being effective from the date of mutual agreement.

2. Cancellation: (a) Insured can cancel policy in writing; insurer to refund balance of premium on ‘short period basis’ [term not defined]. No refund of premium if policy is used for more than 9 months
(b) Insurer can cancel policy in writing; insured to be refunded unexpired portion of the premium.
(c) if insurer has paid a claim on current market value, or sum insured, the policy is automatically cancelled with no refund on premium.
(d) if there is a claim under the policy, no refund is permissible.


<table>
<thead>
<tr>
<th>Product: Motor Vehicle Insurance Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Company: Dominion</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Covered</th>
<th>Not Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Indemnify insured by payment or at the option of Dominion by reinstatement or repair if: a. any vehicle insured should suffer sudden accidental physical loss or damage not excluded elsewhere within this policy. b. insured becomes legally liable for accidental physical loss or damage to property of others or for personal injury to passengers (who are not fare paying passengers)</td>
<td></td>
</tr>
</tbody>
</table>
arising out of the use of any vehicle insured.

<table>
<thead>
<tr>
<th>Liability:</th>
<th>Dominion’s liability in respect of any one accident or series of accidents arising out of one occurrence and also during any one period of insurance is limited to $100,000.</th>
</tr>
</thead>
</table>
| 1. Where vehicle is not a total loss, at Dominion’s option insured indemnified by either  
a. Repair of the vehicle to a condition substantially the same as its condition immediately before the loss. Spurious and pre-owned panel parts may be used.  
b. Payment of an amount equal to the cost of repairs as assessed above.  
2. Where the vehicle is a total loss:  
a. Where vehicle is less than 12 months old from the date of first registration or sale after manufacture, insured indemnified by payment of an amount equal to the replacement cost of the vehicle but not more than the sum insured.  
b. Where the vehicle is more than 12 months old insured is indemnified by payment of an amount approximating the market value of the vehicle immediately before the loss but not more than the sum insured. Where the market value is more than the sum insured Dominion will be entitled to possession of the wreck and retain the proceeds of its disposal in the ratio of the sum insured divided by the market value. |

| Additional Provisions/Benefits -full cover | 1. Reinstatement: Where a claim has been paid on the basis of a total loss cover on the vehicle concerned will be deemed to be cancelled as from the date of loss and no refund of premium is payable.  
2. Other Interests: (a) Dominion is not liable to indemnify any person/corporation whose financial interest has not been declared to Dominion by the time indemnity becomes payable, and |
|------------------------------------------|--------------------------------------------------------------------------------------------------|
| 1. Salvage Cost: Where a claim for loss/damage is accepted Dominion will also pay the reasonable cost of removing the insured vehicle to the nearest repairer or place of safety.  
2. Reinstatement: The sum insured shall not be reduced by the amount of any claim paid (other than for a total loss). The insured undertakes to pay such pro rata premium at the applicable rate for this reinstatement.  
3. Other Interests: Where the insured is under an obligation to insure the interest of... |
any person or corporation having an insurable interest in any vehicle insured, Dominion will indemnify the Insured and that person as if a separate policy had been issued to each.

4. Expediting Costs: Where a claim is payable Dominion will also indemnify the insured for such additional costs of express freight, air freight and overtime labour as are reasonably incurred for the purpose of expediting that reinstatement.

VII. 5. Employees Indemnity: This policy is extended to indemnify any employee of the insured, as if he or she were the Insured, against liability arising in connection with the use of any insured vehicle in charge of that employee.

(b) Dominion’s liability will not be increased beyond the amount that would be payable if this extension had not been incorporated in the policy.

2. Expediting Costs: Liability of Dominion will not be increased, by reason of this clause, by more than 10% of the amount for which Dominion would have been liable in the absence of this clause.

<table>
<thead>
<tr>
<th>VIII. Other Exclusions/Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The amount of deductible as specified in the policy schedule. For windscreen breakages, first $75 of any claim for windscreen breakage where there is no other damage.</td>
</tr>
<tr>
<td>2. Additional amounts to be paid as deductible, for under-age:</td>
</tr>
<tr>
<td>a. Where the driver is under 21 as at the date of loss an amount of $350.</td>
</tr>
<tr>
<td>b. Where the driver is over 21 but under 27 as at the date of loss an amount of $200</td>
</tr>
<tr>
<td>c. Where the driver has had held a driving licence (for the class of vehicle insured) for less than 2 years an amount of $200, additional to (a) or (b).</td>
</tr>
<tr>
<td>3. If damage due to:</td>
</tr>
<tr>
<td>a. war, invasion, act of foreign enemy, hostilities or warlike operations (whether war be declared or not) civil war, mutiny, civil commotion assuming the proportion of or amounting to a popular uprising, military rising, rebellion, revolution, insurrection, terrorism, military or usurped power.</td>
</tr>
<tr>
<td>b. Nuclear weapons material or ionizing radiation or contamination by radioactivity from any nuclear waste or from the combustion of nuclear fuel.</td>
</tr>
<tr>
<td>c. Earthquake, volcanic eruption, tidal wave or tsunami.</td>
</tr>
<tr>
<td>d. Confiscation, nationalisation or requisition by the order of any Government or Local authority.</td>
</tr>
<tr>
<td>e. Loss by theft and any consequent damage unless all doors were securely locked at the time of the theft.</td>
</tr>
<tr>
<td>4. If vehicle is let out on hire or is used for the business of carrying passengers unless</td>
</tr>
</tbody>
</table>
such use is noted in the policy schedule and this exclusion thereby deleted.

5. Whilst any vehicle is being tested in preparation for or engaged in racing, pacemaking, hill climbing, reliability trials, rallying or speed tests.

6. Being used other than in accordance with the category specified in the policy schedule or whilst being used for a purpose for which it was not designed.

7. Where the drivers have been restricted to “Named Drivers Only” as specified in the schedule any vehicle being driven by a person who is under the age of 27 or who has not had 5 years of continuous claims free driving experience immediately before the date of any loss.

8. Whilst being driven by any person who is not licensed to drive the type of vehicle insured, excepting where:
   a. the person is being taught to drive and is complying with all the requirements of the law and is of an age to obtain a license to drive the vehicle. This exception will not apply where the cover has been restricted to ‘Named Drivers Only’.
   b. the person has held but not renewed a license and is not disqualified from holding or obtaining a license without a further driving test providing such license previously held has not expired more than 30 days before the date of any loss or damage.

9. Whilst being driven without a current certificate of fitness or in an unsafe condition.

10. Whilst being driven by any person who:
   a. At the time of any event giving rise to a claim has a proportion of breath/alcohol or blood/alcohol concentration which exceeds the legal limit prescribed in Fiji.
   b. Following an event which gives rise to a claim under this policy fails or refuses to permit a specimen of blood or breath test to be taken after having been lawfully required to give such specimen.
   c. Arising out of the circumstances giving rise to any claim under this policy is convicted of any alcohol or drug related breach of the law governing the use of motor vehicles or
d. is in any way under the influence of intoxicating liquor or drugs.

11. Any consequential losses resulting from loss or damage to the insured vehicle.

12. Any loss, damage, failure or breakage of the engine, transmission, mechanical, hydraulic or electrical systems unless arising from an external cause otherwise insured and where damage also occurs to other vehicle components.

13. Loss or damage whilst being loaded or unloaded or in sea transit other than on a scheduled ferry service.
14. Liability for loss or damage to property belonging to or under the care, custody or control of insured or his driver or being conveyed or loaded on or unloaded from the vehicle.

15. Any liability for loss or damage to third party property or personal injury which has been accepted under contract or for which responsibility has been accepted and for which in the absence of such contract or acceptance insured would not otherwise be liable at law.

16. In respect of death or bodily injury sustained by:
   a. Any relative or friend who permanently reside with insured.
   b. Any employee of insured.
   c. Any person driving the vehicle at the time of the accident.

Other Exclusions

1 Fraud: If any claim under this policy is false or fraudulent in any respect, then the policy is void; no benefits will be paid, and if any benefit is already paid will be recoverable by Dominion.

2 Claims: If the Insured does not:
   a. Immediately notify Dominion of any occurrence which may give rise to a claim.
   b. Within 30 days submit in writing full particulars of the claim in such a form or manner as may be reasonably required by Dominion so that any claim is not prejudiced.
   c. Inform the Police if any theft, burglary, arson or malicious damage has occurred or is suspected.
   d. Take all reasonable steps to prevent further loss or damage.
   e. Immediately send to Dominion any legal process issued or commenced against the Insured and give all assistance to enable the claim to be settled or resisted.

3. If the Insured, without the written consent of Dominion:
   a. Incurs any expense in making good any damage or any expense of litigation.
   b. Negotiate, pay, settle, admit or repudiate any claim.

4. If the insured disallows insurer to enter any premises where loss or damage has occurred and take and keep possession of the property and deal with salvage in a reasonable manner. No property may be abandoned to the Dominion.

5. Other Insurance:
   If at the time of any loss, damage or liability there shall be any other insurance covering such loss, damage or liability or any part thereof, Dominion is liable only for the amount of loss not covered by such other insurance.
6. Cancellation and Variations:
a. The Insured may cancel this policy at any time in which case Dominion will refund 80% of the unused basic premium.
b. Dominion may cancel this policy or amend the terms, exclusions and limitations after 4.00pm on the 14th day following dispatch or written notice to the Insured's last known address. The Insured is entitled to a return of premium proportionate to the unexpired period of the cancelled policy.

7. Jurisdiction:
Notwithstanding anything contained in this policy to the contrary the indemnity provided herein does not apply to:
a. Any matter where an action for damages is brought in a court of law outside Fiji and not subject to Fiji law or where an action is brought in Fiji to enforce a foreign judgment whether by way of reciprocal agreement or otherwise.
b. Costs and expenses of litigation which are not incurred within Fiji.

8. Premium Payment: The policy becomes null and void 14 days after the original inception date or any subsequent renewal date unless the full annual premium has been paid to Dominion, unless alternative premium payment terms have been agreed in writing.

9. Policy Amendment: Any amendment to the terms and conditions of this policy must be evidenced by written confirmation signed by Dominion.

10. Suit or Legal Action: No suit or legal action on this policy for the recovery of any claim shall be sustainable in any court of law unless all the requirements of this policy shall have been complied with, and unless commenced within twelve months after the date of the loss.

11. Proposal:
The truth of the statements and answers in the proposal form or any other written submission provided by the Insured or on the Insured's behalf prior to the original inception date or each subsequent renewal date shall be a condition precedent to any liability of the Dominion to make any payment under this Policy.

12. Debt Offset:
Any claim payment payable under this policy may be used to settle any other premium or other debt owed by the Insured to the Dominion.
# A.8: Comprehensive Third Party Insurance

<table>
<thead>
<tr>
<th>COVERED</th>
<th>NOT COVERED</th>
</tr>
</thead>
<tbody>
<tr>
<td>All liability incurred by defined persons or classes of persons in respect of the death of or bodily injury to any person caused by or arising out of the use of such motor vehicle on a road in Fiji during the period of insurance.</td>
<td>1. Person driving without owner’s permission/order</td>
</tr>
</tbody>
</table>

**Person Covered:**
- 1. Owner of the motor vehicle
- 2. Any person who is driving on the Owner’s order or with his permission;

**Provided:** that the person driving holds a licence permitting him to drive a motor vehicle for every purpose for which the use of the motor vehicle is limited (see below – limitation as to use), or at any time within the period of 30-days immediately prior to the time of driving has held such a licence and is not disqualified for holding or obtaining such a licence.

**Limitation as to Use:** insurance is only for the use of the motor vehicle for the purpose set out in the schedule to the policy. (This schedule describes the classes of vehicles – private, business, goods, taxi, omnibus, fire brigade (including ambulance, police vehicle, and prison vehicle), motor cycle, trailer, motor trade vehicles, and rental car)

**Provided:** a premium paid for the use of the motor vehicle for:
- i. a business car, goods vehicle, taxi, omnibus, and rental car, also covers use of the motor vehicle for social, domestic or pleasure

- 2. Does not hold a valid licence to drive the class of vehicle insured (except if he had a licence for the class within 30 days prior to the event).

- 3. Driver disqualified from holding or obtaining a licence.

- 4. If motor vehicle is used for any purpose other than that permitted by the class of vehicle schedule. (Unless policy is endorsed and necessary extra premium paid).

- 5. The insurer shall not be liable in respect of any such claims by any person who at the time of the accident was
  - a. A relative (whose degree of relationship is not more than 4th) of, or a person living as a member of this family with the person using the vehicle at the time of the occurrence in respect of which such claims arises.
  - b. Driving or being carried in or upon or entering or getting on to or alighting from the said vehicle except as provided by S6(1) of the Motor Vehicles (Third Party Insurance) Act.

- 6a. Any liability which arises solely by virtue of the provisions of the Workmen’s Compensation Act or
purposes, or the owner’s business as long as it is used by the owner for his purposes as long as the purpose is not that of a commercial traveling salesman, an insurance agent, inspect or assessor, or an indent or manufacturer’s agent;

ii. a hire car, for the hirer’s business.

Motor vehicle must not be used for any other purpose unless the policy is endorsed and extra premium, if any, paid.

Conditions:
The person insured shall not use the motor vehicle nor shall the owner permit or suffer any person to use such motor vehicle:
(a) whilst such motor vehicle is in unsafe condition.
(b) to convey any load in excess of that for which it was constructed,
(c) to carry passengers (or the hire or reward or in the pursuance of a contract of employment in contravention of the licence issued for the vehicle described herein
(d) whilst any such person as aforesaid:
   i is under the influence of intoxicating liquor, or
   ii is as a result of age or some physical or mental condition rendered incapable of driving such vehicle with safety.

Cancellation: The NIA may at any time by giving written notice to the owner cancel this Policy. After cancellation, the insurer will, on delivery of the Policy and Certificate to the insurer, refund to the Owner the amount of unearned premium, calculated on a pro rata basis.

Issue of Legality:
The CTP policy of NIA provides limitation on the use of the vehicle for the category of

| b. any contractual liability [Contractual liability is not defined]. |
| 7. any liability in respect of any occurrence which happens when the motor vehicle is being used for any purpose other than those for which premium has been paid as stated under Limitation (column i). |
| 8. If the vehicle is used: |
  a. whilst it is in unsafe condition. |
  b. to convey any load in excess of that for which it was constructed, |
  c. to carry passengers for the hire or reward or in the pursuance of a contract of employment in contravention of the licence issued for the vehicle |
| 9. If the person authorized to use the vehicle: |
  a. is under the influence of intoxicating liquor, or |
  b. is as a result of age or some physical or mental condition rendered incapable of driving such vehicle with safety. |
| 10. Section 16 of the Act requires that where the death of or bodily injury to any person arises out of the use of the motor vehicle the owner and/or the driver shall forthwith notify the insurer. Neither the owner nor any other person are to, without the consent in writing of the insurer, make any offer, settlement or admission of liability nor incur the expense of litigation. If this condition is not abided by, here is no coverage. |
premium paid. This may be potentially in breach of the Motor Vehicles (3rd Party Insurance) Act. As noted in paragraph 5.18 above, the Act prohibits limitations on the basis of number of passengers in vehicles. It also makes no provision for differentiating different categories of vehicles without a ministerial regulation, which has not been made. The potential illegality is on two accounts. First, that the exclusion by the limitation is contrary to s10 of the Act. And second, that insurance companies are differentiating between categories of vehicles without any legal basis for this.
# A.9: Workmen’s Compensation Insurance

**Product: Workmen’s Compensation Policy**  
**Company:** Dominion

<table>
<thead>
<tr>
<th>Covered</th>
<th>Not Covered</th>
</tr>
</thead>
</table>
| Indemnifies insured against all claims made under the Workmen’s Compensation Act,  
and  
Covers costs and expenses incurred with the written consent of the Insurance Company in connection with any claim for such compensation. | 1. Temporary incapacity – i.e. weekly benefits (thus not all claims made under the Workmen’s Compensation Act are indemnified.  
2. If at the time of any loss, damage or liability, there is any other **insurance** covering loss, damage or liability, Dominion is liable only to cover the amount of loss not covered by any such insurance. |

**Other Exclusions**

1. If injury or disease is ‘caused by or arising from’:
   a. war  
   b. invasion,  
   c. act of foreign enemy,  
   d. hostilities or warlike operations (whether war be declared or not),  
   e. civil war,  
   f. mutiny,  
   g. civil commotion assuming the proportions of or amounting to a popular uprising,  
   h. military uprising,  
   i. rebellion,  
   j. revolution,  
   k. insurrection  
   l. terrorism,  
   m. military or usurped power  
   n. nuclear weapons material of ionizing radiation or contamination by radioactivity from any nuclear waste or from the combustion of nuclear fuel  
   o. Any unscheduled aerial flight or attempt at aerial flight,  
   p. Any process, treatment, conveyance, storage or handling of asbestos or materials containing asbestos,  
   q. Employment of any inshore oil or gas rig  
   r. Underground activities  
   s. Underwater activities
2. If Dominion not immediately informed of any occurrence which may give rise to a claim

3. If within 30 days full report of occurrence not submitted in the form and manner required by Dominion

4. If no reasonable steps taken to prevent further injury or disease.

5. If any information on legal processes commenced, etc not sent to Dominion immediately

6. If insured, without written consent of Dominion, proceeds with litigation, negotiates, pays, settles, admits, or repudiates any common law claim.

7. Any expenses, claims, liability for any action for damages in a court of law outside Fiji, or for action in Fiji to enforce a foreign judgment.

8. Costs and expenses of litigation which are not incurred within Fiji, even if action is in Fiji court.

**Unsure Status:**
1. Workers not directly employed by the insured
2. Joint employees (if working with another organization that does not have this insurance)

Insured can cancel policy anytime, with refund set at 80% of unused premium.

**Other Issues**

1. Dominion can cancel policy at any time after 4pm on 14th day following dispatch or written notice to the insured. For cancelled policy, insured is entitled to a return of unused premium.

2. Insured required to take all reasonable precaution to prevent accidents, and must comply with all statutory obligations relating to employee safety and occupational health.

<table>
<thead>
<tr>
<th>Covered</th>
<th>Not Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indemnifies insured against all claims made under the Workmen’s Compensation Act, and</td>
<td>1. If at the time of injury to any workmen there is other indemnity, whether effected by the company or by any other person, NIA not liable to pay or contribute more than a ratable proportion. Thus, if worker is self-insured against injury at workplace, NIA only liable to cover.</td>
</tr>
</tbody>
</table>
### Insurance Industry in Fiji

Covers costs and expenses incurred with the written consent of the Insurance Company in connection with any claims for such compensation.

Covers workers only in the direct employ of the insured, and actually engaged in the business or occupation to which the policy applies.

- 1. Workers not directly employed by the insured
- 2. Joint employees (if working with another organization that does not have this insurance)
- 3. If working directly for the insured, but doing work that is not listed in the insured’s declaration to the NIA.
- 4. If injury is, ‘either in origin or extent… directly or indirectly or remotely caused or contributed to by the following’, or contributed to by the following, either in origin or directly or indirectly, or proximately or remotely arises out of or in connection with:
  - a. war
  - b. invasion,
  - c. act of foreign enemy,
  - d. hostilities or warlike operations (whether war be declared or not),
  - e. civil war,
  - f. mutiny,
  - g. insurrection,
  - h. rebellion,
  - i. revolution,
  - j. military or usurped power.

Thus, if injury remotely caused by or connected with the military coup in Fiji, insured not covered.

- 5. Any expense incurred by insured for any litigation, or payment, or settlement, or admission of liability, if these are done without the written authority of the NIA.

Provision for 1 or 2 Arbitrators to be appointed by the parties to deliberate on differences.
### Product: Workmen’s Compensation Policy
**Company: Sun Insurance**

<table>
<thead>
<tr>
<th>Covered</th>
<th>Not Covered</th>
</tr>
</thead>
</table>
| Indemnifies insured against all claims made under the Workmen’s        | 1. Applies only to the entity ‘carrying on the business stated in the said Schedule and no other for the purpose of this indemnity at the address stated in the said Schedule’.
| men’s Compensation Act, and                                             | Thus, policy does not apply if the place of business is changed, or if the nature of the business changes during the course of the business. |
| Covers costs and expenses incurred with the written consent ‘to the    | 2. Does not cover for all costs and expenses in connection with claims for such compensation.                                              |
| Insurer in connection with the defence of any legal proceedings in    | 3. Insured indemnified only to the extent not exceeding the limitation expressed in the Schedule in all for damages, costs, expenses, and nothing above this amount. |
| which such liability is alleged’.                                       |                                                                                                                                           |

### Other Exclusions

1. If injury or disease is ‘caused by or arising from’:
   a. war
   b. invasion,
   c. act of foreign enemy,
   d. hostilities (whether war be declared or not),
   e. civil war,
   f. mutiny,
   g. insurrection,
   h. rebellion,
   i. revolution, or
   j. military or usurped power.

2. If liability is caused, directly or indirectly, or contributed to by, or arising from
   a. nuclear weapons material
   b. Ionising, radiations or contamination by radioactivity from any nuclear fuel or from any nuclear waste from combustion of nuclear fuel, including any self-sustaining process of nuclear fission.

3. If claims arises, directly or indirectly from, the Y2K transition.

4. For insured’s liability to employees of contractors to the insured.
5. Any employee who is not a “workman” within the meaning of the Law(s). [Thus, a director of a company is not covered under this].

6. Any liability of the insured which attaches by virtue of an agreement but which would not have attached in the absence of such agreement.

7. Any sum which the insured would have been entitled to recover from any party but for an agreement between the Insured and such party.

8. If insured does not give notice to the insurer of any personal injury as soon as practicable after information on this comes to the employer or his rep.

9. If employer, without written consent from insurer, incurs any expense of litigation or makes any payment, settlement or admission of liability.

10. If insured does not take ‘all reasonable precautions to prevent injuries’.

11. If insured made any alternation or repair, without the consent of the Insurer, to any ways, works, machinery, or plant after any injury to a worker until the insurer shall have had an opportunity of examining the same.

12. If no wages book carrying names and earnings of every worker employed by the Employer is kept.

**Unsure Status:**
Joint employees (if working with another organization that does not have this insurance)

**Cancellation**
Insured can cancel policy anytime by written notice, with refund or premium prorate.
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Insurance Regulations, 1998 (L/N 152/98)
Life Assurance Ordinance (Cap 189)
Motor Vehicles (Third Party Insurance) Act
Motor vehicle (Third Party Insurance) Ordinance
Motor Vehicles (Third Party Insurance) Regulation
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Reserve Bank of Fiji Act, 1985
Trade Unions Act

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Australian Government
AusAID