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Insurance Journal

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October, November, December 2021

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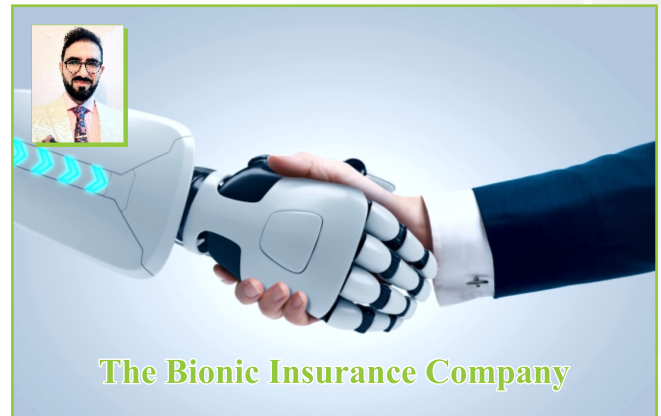
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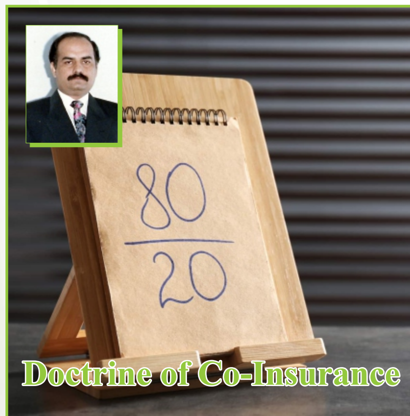

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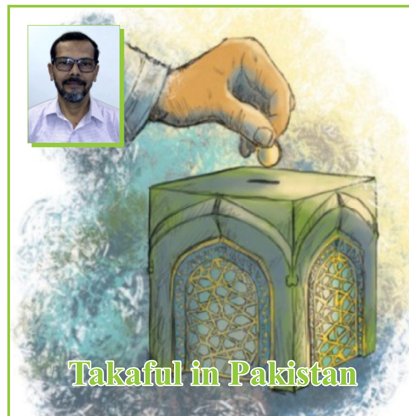
Takaful in Pakistan

Understanding Marine Cargo Insurance in COVID-19 Times

Crop Insurance in Punjab

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The Impact of Sehat Sahulat Programme on Private Health Insurance Sector

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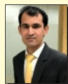

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INSURANCE SECTOR ON PAKISTAN STOCK EXCHANGE

(Quarter: July, August, September 2021)

Compiled By: Khurram Shahzad

Company	Paid up Capital (Rs. in Million)	Face Value Rs.	Higest Rate Rs.	Lowest Rate Rs.	Turnover of Shares	Announcement During the Quarter
Adamjee Insurance Company Limited	3,500	10.00	42.45	34.25	8,958,000	Dividend = 15%
Asia Insurance Company Limited	664	10.00	-	-	-	
Askari General Insurance Company Limited	719	10.00	21.50	19.10	459,500	
Askari Life Assurance Company Limited	1,502	10.00	8.49	6.25	3,182,000	
Atlas Insurance Limited	849	10.00	59.70	54.70	650,500	
Business & Industrial Insurance Company Limited	86	10.00	-	-	-	
Century Insurance Company Limited	503	10.00	21.20	18.00	191,000	
Crescent Star Insurance Limited	1,077	10.00	3.80	2.20	44,672,500	
East West Insurance Company Limited	1,361	10.00	98.79	98.79	1,000	
EFU General Insurance Limited	2,000	10.00	117.98	108.85	403,000	Dividend = 15%
EFU Life Assurance Limited	1,000	10.00	207.47	180.80	213,700	Dividend = 15%
Habib Insurance Company Limited	619	5.00	8.50	6.28	515,500	
IGI Holdings Limited	1,426	10.00	197.00	153.05	2,134,400	Dividend = 20%
IGI Life Insurance Limited	1,706	10.00	47.28	37.50	354,000	
Jubilee General Insurance Company Limited	1,985	10.00	44.85	40.06	1,778,000	Dividend = 30%
Jubilee Life Insurance Company Limited	873	10.00	343.00	258.15	1,097,900	
Pakistan General Insurance Company Limited	464	10.00	5.50	3.02	1,785,000	
Pakistan Reinsurance Company Limited	3,000	10.00	25.08	15.68	186,687,000	
PICIC Insurance Limited	350	10.00	1.89	0.80	4,876,500	
Premier Insurance Limited	506	10.00	6.86	4.77	1,056,500	
Progressive Insurance Company Limited	85	10.00	-	-	-	
Reliance Insurance Company Limited	604	10.00	8.20	6.55	1,532,500	
Shaheen Insurance Company Limited	600	10.00	4.57	3.32	823,500	
Silver Star Insurance Company Limited	306	10.00	-	-	-	
Standard Insurance Company Limited	8	10.00	-	-	-	
The United Insurance Company of Pakistan Limited	2,950	10.00	8.38	7.05	1,345,000	Dividend = 10%
The Universal Insurance Company Limited	500	10.00	7.75	4.01	766,500	
TPL Insurance Limited	1,172	10.00	44.48	28.76	1,106,000	

The Government owned Insurer of Pakistan

Khalid Hamid
Chief Executive Officer
National Insurance Company Limited

The roles of Chairman and Chief Executive Officer were separated by rule 4 of the Public Sector Companies (Corporate Governance) Rules, 2013 and also in compliance with clause (xii) of the Code of Corporate Governance for Insurers 2016.

NICL's investment portfolio stands at Rs. 65 billion by year end 2021 mostly consisting of investment in government securities with having an investment income/return of around Rs.4.5 billion.

NICL pays Rs. 500 million to national exchequer (Ministry of Finance) on annual basis which is 25% of paid-up capital of the company.

During the year 2021, NICL paid Rs. 2.3 billion to the Federal Board of Revenue which is one of the highest paid revenues amongst government entities.

The Gross written premium of NICL in year 2019 was Rs. 10.6 billion, in Year 2020 was Rs. 15 billion and by end of year 2021 stand at above Rs. 20 billion. This is an increase of around 100% as compared to Year 2019 and 33.33% as compared to Year 2020, whereas the overall insurance industry growth in very minimal.

The total Staff Strength of NICL by Year end 2021 is 576.

NICL owns a commercial building in Karachi, one commercial building in Blue area Islamabad, Awami Markaz building in Larkana and Ex-Services International Hotel building at upper Mall road in Lahore and six units/offices at Liberty House, DUFC, Dubai. NICL also owns major part of prestigious heritage property, Shah-din building at upper Mall, Lahore. Besides these properties the company also owns two commercial plots in Lahore and one in Karachi.

A substantial amount of Rs. 2.29 billion has been recovered against real estate scams of Year 2009-10.

NICL has more than 250 clients having different multiple locations and risk covered against property, engineering and miscellaneous policies.

Centre, Punjab, State Life ink MoU for health insurance

Prime Minister Imran Khan witnessed the signing of a memorandum of understanding (MoU) by State Life Insurance Corporation (SLIC) and the federal and Punjab governments to ensure up to Rs1 million annual health insurance for the population of Islamabad and Punjab.

National Health Services Secretary Aamir Ashraf Khwaja, Chief Executive Officer of Punjab Health Initiatives Management Company Ali Razaq and SLIC Chairman Shoaib Javed Hussain signed the MoU for implementation of universal health coverage of Sehat Sahulat Programme in Punjab and Islamabad Capital Territory (ICT).

Special Assistant to the Prime Minister (SAPM) on Health Dr Faisal Sultan, Punjab Health Minister Dr Yasmin Rashid and senior officials were also present on the occasion.

During his visit to Lahore on December 13, Prime Minister Khan had announced Sehat Sahulat Programme for all residents of Punjab.

Through this social health protection initiative, the poor families holding the health cards will be provided free of cost health insurance to secure indoor healthcare services worth Rs1m per family per year from hospitals on its panel, according to a statement.

The services include open-heart surgeries, insertion of stents, management of cancer, neurosurgical procures, burn management, accident management, dialysis, intensive care management, deliveries, C-section and other medical/surgical procedures along with kidney transplant. There is a facility of inter-provincial/inter-district portability for availing free of cost services from any empanelled hospital in Pakistan.

SLIC had on November 11 won the contract for health insurance cards for the next three years. SAPM on Health Dr Faisal Sultan had earlier said the Ministry of National Health Services (NHS) along with the Punjab government started the process for procurement of an insurance company for the years 2022-25 to implement the Sehat Sahulat Programme as per the prime minister's directives.

From December 31, 2021, the Sehat Sahulat Programme and Qaumi Sehat Card will be gradually expanded to all permanent residents of ICT, Punjab and Gilgit-Baltistan.

The programme, entirely funded by the government, has already covered all permanent residents of the newly merged districts of Khyber Pakhtunkhwa, Tharparkar in Sindh and Azad Jammu and Kashmir along with persons with permanent disability and the transgender community.

The SAPM expressed the hope that the Sindh and Balochistan governments would also join the insurance programme soon to materialise the dream of national universal health insurance by providing Qaumi Sehat Cards to each and every citizen of Pakistan as this will keep them protected against catastrophic healthcare expenditures of millions of rupees for serious issues like cardiac surgeries, cancer treatment, renal failure and so on.

"Sehat Sahulat is the flagship programme of the government as per the vision and directives of Prime Minister Imran Khan, through which support and assistance are provided against

catastrophic healthcare expenditure. This scheme will bring robust improvement in treatment and access to quality healthcare services to population and will bring about a revolution in the health sector," Dr Sultan added.

IAP, CDC sign MoU

Insurance Association of Pakistan (IAP) and Central Depository Company of Pakistan Limited (CDC) signed a Memorandum of Understanding (MoU) for the digital aggregation of insurance products through CDC's Emalaak Financials platform, a statement said.

Under the regulatory impetus of Securities and Exchange Commission of Pakistan (SECP), the agreement aims to provide low-cost and centralised solution to insurance policy holders by providing comparative cost benefit analysis of different products on a centralised platform.

Sadia Khan, commissioner at SECP, presided the MoU signing ceremony at the CDC House in Karachi.

"This fintech solution of 'Emlaak Financials' is a landmark initiative of national significance, aiming to become 'digital financial super market' in Pakistan by leveraging the potential of technology to increase outreach for various financial products." CEO at CDC Badiuddin Akber said.

Addressing the occasion, Sadia Khan said digital transformation is expected to have an impact throughout the insurance value chain, from underwriting and pricing of products, their marketing and distribution, through to claims processing and the ongoing customer servicing.

This is expected to lead to a reduction in the protection gap as new market segments are accessed as well as an increase in the insurance penetration, she added.

NICL underwritten premium up 50pc

National Insurance Company Limited (NICL) reported over Rs15.5 billion premium underwritten till end of November 2021, grew by around 50 percent from the year 2019, a statement said.

This is a first that a company has achieved a milestone of crossing Rs15 billion target before year-end and all-time highest investment profit of approx Rs4.5 billion in the general insurance industry in 2021.

By year end, NICL sees the additional business reaching close to Rs20 billion. "This is a big achievement for the current regime as the stigma associated with the company has now been completely shifted to commendation in 2021 with almost 50% growth (as compared to 2019) in underwritten premium," NICL said in a statement.

The company termed it a 'landmark achievement' to be a part of ministry of Commerce's Silk Route Reconnect Policy and partner with the venture to promote trade of Pakistan with neighbouring and other far countries. "It is a milestone in making Pakistan a transit and transshipment hub by trucking."

Patrizia Kern
Head Marine, Corporate Solutions
SWISS Re Institute

For marine insurers, the transition to green shipping starts now

Adam Watkins
Chief Underwriter Marine & Head UK
SWISS Re Institute

The shipping industry is working flat out these days, driven by the surging demand for goods as the global economy rebounds from last year's pandemic slump. But all those container ships and tankers criss-crossing the oceans are also contributing a rising share of greenhouse-gas emissions.

In response, industry leaders in shipping, energy, infrastructure and finance banded together to issue a Call to Action for Shipping Decarbonisation before the COP26 climate conference in Glasgow. Their goal is for the shipping industry to be run entirely on net-zero energy sources by 2050.

Major insurers and reinsurers are going further, establishing the Net-Zero Insurance Alliance. This group, co-founded by Swiss Re, will allow the insurance industry to put its underwriting expertise to work in driving the global transition to a low-carbon economy.

Swiss Re is spurring shipping decarbonisation from both sides of our business. On the reinsurance side, we're working with our clients to promote sustainable underwriting and offering assistance to help them align their businesses with net-zero goals. By adopting a partnership approach and developing common goals, we can jointly monitor the progress in our journey to net zero.

At Swiss Re Corporate Solutions, we're working with our insurance clients so we're prepared to cover the risks involved in decarbonisation when new fuels and technologies are brought on line. We're also promoting safe and sustainable practices in the shipping industry through groups such as the Ship Recycling Transparency Initiative.

No more business as usual

The case for cutting CO2 emissions from shipping is clear. The industry currently accounts for nearly 3% of the global total, according to the International Maritime Organization. The IMO says that by 2050, greenhouse-gas emissions from the industry should be reduced by at least half from 2008 levels. But if business continues as usual, emissions could soar by as much as 130% over the next three decades.

The Call to Action for Shipping Decarbonisation ramps up the ambition. By 2030, zero-emission fuels should account for at least 5% of consumption in international shipping, and commercially viable zero-emission vessels should be operating on deep-sea trade routes. Industrial-scale projects should be carried out to demonstrate that zero-emission shipping is viable at scale as well as to push down costs related to the transition and boost demand.

While the private sector is leading the way, governments and regulators will also have to take policy action that makes zero-emission shipping and fuel production commercially viable and available to all. This point is made clear in the Call to Action, which was issued by the Getting to Zero Coalition, a partnership between the Global Maritime Forum, the Friends

of Ocean Action and the World Economic Forum. Swiss Re is a signatory along with more than 150 companies and organisations.

If meaningful progress on decarbonising shipping is to be made, then insurers must be prepared to cover the risks that ship owners will face in the green transition.

Fueling the net-zero transition

Among the challenges that must be overcome on the road to decarbonisation, the biggest by far is developing an alternative to bunker fuel that can be produced in sufficient quantities and at a reasonable price. The Coalition's definition of zero-carbon energy sources includes green hydrogen – hydrogen made from renewable electricity-powered electrolysis - and its derivatives such as ammonia and methanol, as well as sustainable biofuels.

On the reinsurance side of Swiss Re, we're working hard within our special lines businesses to coordinate between marine and our engineering colleagues on the provision of reinsurance for renewable energy assets - wind turbines, solar, wave. We're also working with clients to assist in the transition of their portfolios from oil and gas-based to renewable sources. This all feeds directly into the technologies needed to achieve zero shipping emissions.

As part of shipping's transition to greener fuels, a large part of the existing global fleet will eventually have to be replaced, and that will require technological advances and greater shipyard capacity. Awareness of the issues must be raised across the industry, and access to new technologies must be ensured for smaller operators.

Insurers have a critical role to play in the decarbonisation drive, and to do so we must be prepared to cover the risks that ship owners - who will bear the brunt of the costs - will face in the years ahead. Since technological innovation is at the heart of this process, insurers will have to find ways to cover new ships from the prototype stage, rather than waiting until the ships have a track record of performance.

To insure prototypes, insurers will need data. At Swiss Re Corporate Solutions, we're already working with shipping firms as well as classification societies and data companies to make sure we have the detailed information we need to measure and model risk and make it insurable.

On the reinsurance side, we're working with clients as they grapple with the challenges of measuring the exposure and carbon-intensity of their portfolios, and how they will report this information. Not all companies have the systems in place to capture and report this data, and we emphasise the urgent need to get these systems up and running.

New risks and solutions

The technological overhaul of shipping will create opportunities as well as challenges for insurers. Take refueling, which at present poses a minimal risk. Refueling with alternative fuels such as hydrogen could pose new dangers that insurers would have to consider. The magnitude of the risks themselves need further exploration for measurability. We can't yet know which alternative to bunker fuel will become the new industry standard, but we need to begin weighing the potential consequences.

Overhauling the shipping industry will require vast investment and commitment. For this, commercial firms and governments must work together, and international efforts such as COP26 are essential for forging consensus.

The Poseidon Principles for Marine Insurance are being developed with the participation and support of Swiss Re for hull and machinery portfolios. An analogous set of Poseidon guidelines for banks was launched in 2019, while cargo owners and charterers issued the Sea Cargo Charter last year. Such standards offer a methodology for gathering information to assess climate-related risks.

International collaboration

Leaders at COP26 made substantial progress on the broad net-zero agenda, including the commitment of USD 130 trillion of private capital to transform the economy for net zero. The shipping-decarbonisation push also made headway with the Clydebank Declaration for Green Shipping Corridors, which aims to establish at least six zero-emission maritime routes by the middle of this decade. A discussion was also held on opportunities for developing countries in providing zero-carbon fuels to global shipping.

Yet the pledges made in Glasgow weren't enough to put the world unambiguously on a sustainable carbon-reduction trajectory, analysis from the Swiss Re Institute shows. And history suggests that not all countries will deliver on the promises they've made. So now is the time for marine insurers to redouble their efforts and deliver on their own pledges to help decarbonise the shipping industry.

Marine insurers are essential to the shipping industry and global trade. To play their role in the green transition, they will have to step up and innovate just as their clients are doing. That means not just aligning their portfolios with the Paris Agreement goals, but laying the groundwork now so they're ready to offer insurance when new green ships hit the water.

Courtesy: Salman Saif

Riaz Hussain Khan Jadoon
Member Chartered Institute of Loss Adjusters (UK),
LLMIT (Lloyds & London Market),
Authorized Surveying Officer (The SECP),
MBA (UK), M.Com (Insurance)
Executive Director - Pakistan Inspection Company Pvt. Ltd.

The Bionic Insurance Company

The abundance of entertainment avenues in the form of almost unlimited videos on YouTube and other Platforms are taken for granted by the hyper-age children of these days. People of my generation would remember that TV Entertainment for children at our times was limited in the form of Cartoons aired either on Pakistan Television Network (PTV) or Shalimar Television Network (STN) also known as NTM. Avenues for physical entertainment such as grounds, parks and play areas were available much more than accessible to the hyper generation of these days.

I, along with my friends, would stick to NTM Channel and watch cartoons every-day at 7:00 PM and play our favourite characters the next day. A Cartoon Series “Bionic Six” was one of my favourites. The title characters of the series are a family of machine-enhanced human beings possessing unique powers after being augmented with bionic technology. Each family member is given specific bionic powers and, thus, they form a superhero team called the Bionic Six. Apart from possessing unique powers, they also had some unique gadgets in their possession to help them beat monsters and bad guys. These gadgets would include phones with video calls, watches with sensory technology and self-driving vehicles which would always fascinate me. My innocent mind would wonder if things like these could ever be made.

Good old times are gone. Now I am a grown-up man with kids of my own. And, it sometimes boggles my mind that all those imaginary gadgets are now in our daily use. From smart phones to smart watches, we have access to all the gadgets which in our childhood were available to imaginary characters in a truly imaginary world. The imaginary

gadgets of the past such as smart phones and watches have brought immense convenience and information on our fingertips.

The pace with which digital transformation is taking place in our personal and professional lives across the world is remarkable. The transformation is not limited to a particular society or industry but encompasses all sections of the society and industries globally. People want information quickly and buy products with ease. By the virtue of technology, they have a source to find the information needed, compare it with identical products and make a purchase from the comfort of their couches. For many, if their expectations are not met in a timely manner, they have alternatives to get whatever they need without any hassle.

The transformation brought by these magical gadgets in our personal and professional lives has given each one of us the opportunity and ability to become a Bionic Human and do wonders in our personal as well as professional lives.

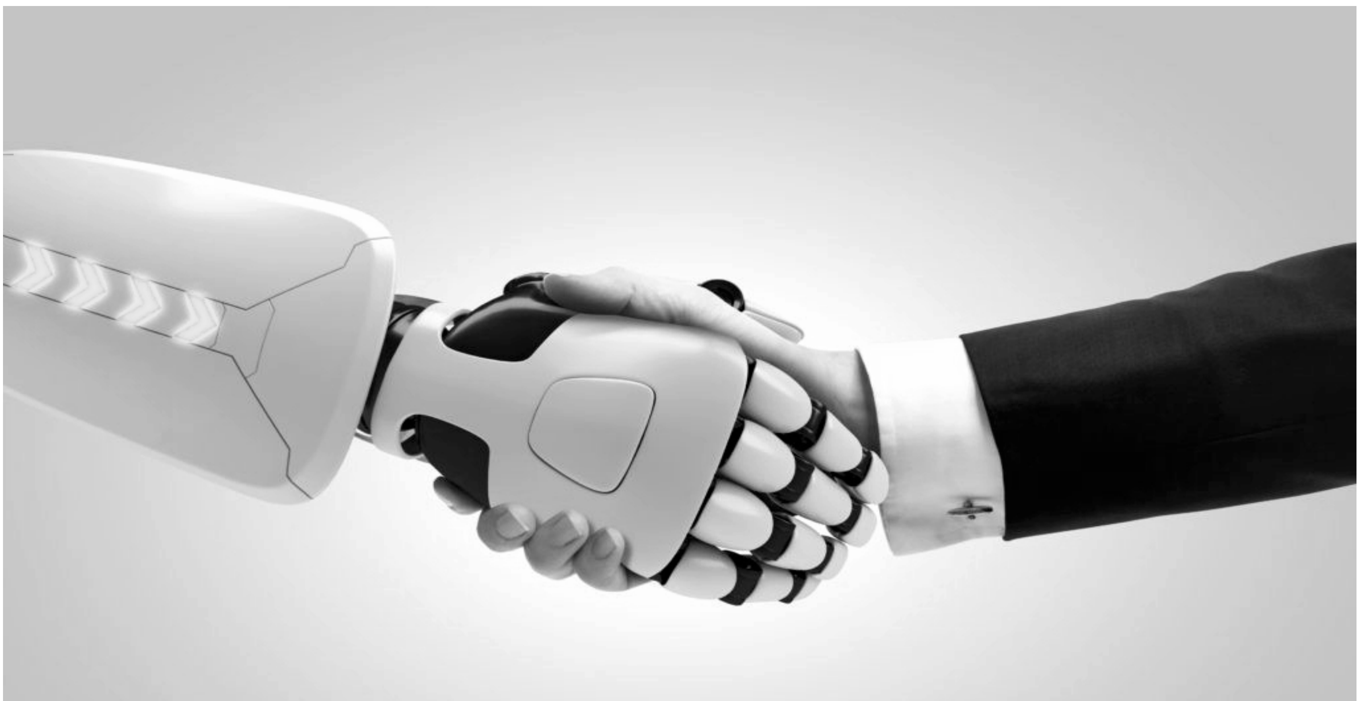
Going through some random articles on the web, I read the term Bionic Insurer being defined as an insurance company that combines human and technological capabilities to stimulate high levels of efficiency by bringing innovation resulting in customer satisfaction and growth.

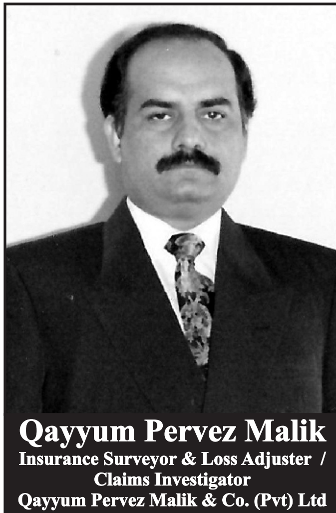
In this hyper age, every professional can use his / her potential to become and act as a Bionic Professional. Digital transformation in our industry has made communicating with Insureds much easier and quicker. On the other hand, the tech suave Policyholders also expect Insurers to respond better, faster and tailored to their personal needs.

To meet the high expectations, the Insurer would need to become the Bionic Insurer. The Insurers must understand that enabling digital transformation is a must in any industry and theirs is not an exception or as we put in insurance terminology "an exclusion". Understanding this is only one side of the coin, the second part is to practically work for the digital transformation. The second part is by far the most difficult, time consuming and hectic mission. The transformation to digitalization does not only require an appetite for learning of technologies but also solid determination to overcome the impediments confronted in its fulfillment.

We hear every now and then that digital transformation is essential to fulfill the needs of Customers. However, in my opinion, the Insurers need it more than their customers do. The investment in technology by Insurers today aiming to improve efficiency, reduce costs and benefit employees will help them tomorrow to alleviate risks posed by disruptive technologies and start-ups in the industry.

Finally, Insurers must come out of their traditional approach and encourage experimentation and new ways of thinking to become Bionic Insurance Company. Innovation requires research and the best way to do this is collaborating with technologists. By encouraging staff to experiment, apply new ideas, and engage with technologists / collaborators to co-develop, Insurers can withstand the cut-throat competitive environment and stay one step ahead of whatever comes next in this ever-evolving industry.





Qayyum Pervez Malik
Insurance Surveyor & Loss Adjuster / Claims Investigator
Qayyum Pervez Malik & Co. (Pvt) Ltd

Doctrine of Co-Insurance

Depending upon the magnitude, nature, type, class and demand of insured (Mortgagors/Mortgages) each and every risk is insured by following the under mentioned procedure and practice.

a. Risk to be underwritten by single independent Insurer.
b. Risk to be underwritten by multiple co-insurers independently.
c. Risk to be underwritten by multiple co-insurers collectively.

The principal of contribution as laid down in the Insurance policy as well as in co-insurance clause which is attached with the insurance policies at the time of underwriting a risk.

As per the principal of contribution the contribution condition stipulates that "at the time of any destruction of or damage to any property hereby insured there be any other insurances effected by or on behalf of the insured covering any of the property destroyed or damaged, the liability of the company hereunder shall be limited to its ratable proportion of such destruction or damage."

Such right of an insurer is already exists in common law and the principal of indemnity. Co-Insurance clause as attached with the insurance policy in case the risk is insured by multiple insurers, also set up lines for this procedure.

In case of high magnitude risks, the insured tends to be underwritten by more than one insurer setting up the percentage of coverage to be allocated to each of the participating insurers out of which the highest risk taker is given the status of a "Leader" who is responsible to issue a schedule insurance policy collectively as signed by all the co-insurers in order to share the risk among more than one insurers for financial security of the insured and to save the wastage of time by interacting with multiple insurers by issuing separate insurance policies etc., This arrangement provides the concurrence of all the insuring factors on which the collective policy is drafted which eradicate the turbulence of non-concurrence of terms of different contracts of insurance in case the risk is covered separately by multiple insurers. Under the circumstances the "schedule insurance" of risks underwritten by multiple insurers collectively by signing a single insurance policy is the best insurance arrangement any insured could have.

In above arrangement of insurance, the terms of contract, warranties, conditions, clauses etc. are discussed and finalized with the leading insurer who then takes the coinsurers on board. The proportion of risk to be allocated to each of the insurer is decided by the insured. Currently the premium is paid to each and every co-insurers through cheques separately. In case of any loss/damage to the insured's property the intimation of claim is served to the leader who then intimate the same to the co-insurers. As per prevailing practice, the surveyor is appointed by the leader with intimation to the co-insurers. Thereafter all the subsequent proceedings, assessment of loss, survey report along with all the relevant documentary evidence are properly and promptly shared with the co-insurers. The payment of claim so adjusted is also made by each of the co-insurer separately.

At times, each and every co-insurer used to appoint their independent surveyor to assess the loss along with the surveyor appointed by the leader but later, this practice was discontinued mostly and the surveyor is appointed by the leader.

Surveyor so appointed by the leader remain in touch with all the co-insurers/leader in order to provide the necessary update of the claim. The leader is also bound to pass on and provide each and every material fact, documentary evidence, update to the co-insurers. As per practice, the leader is also bound to share the intimation of loss as received from the insured with the co-insurers in time as stipulated in the contract of insurance. So, the impact/effect of late sharing of claim intimation, late sharing of relevant claim documents etc. shall be borne by the leader. Since the co-insurers follow the assessment of surveyor as appointed by the leader so it is the responsibility of the surveyor so appointed and the leader to keep the co-

insurers updated in all respect.

The issue of salvage handling, disposal must also be discussed with the co-insurers and the co-insurers must be taken onboard in this respect because they are the owner/beneficial of salvage in proportionate to their share in risk. The leader can't take any independent decision to dispose of the salvage at their own.

Similarly, any other recoveries from 3rd party under right of subrogation is to be allocated to the co-insurers by the leaders as a matter of legal bindings.

In short, the leader and the co-insurers have the same rights, liabilities, bindings, jurisdiction, ambit and relationship with the insured and subject matter of insurance in all respect to the extent of their proportionate share. As a matter of practices of the past as well as logical approach, legal rights, the co-insurers may appoint their independent surveyors to assess the loss under such insurance policies. Neither the insured nor the leader has the right to object, influence otherwise or stop them to exercise their rights.

Similarly, the risk inspection prior to accepting the risk may be conducted by the co-insurers. The leader may not take any kind of sole decision. Similarly, the leader may not go for any independent understanding, promises, undertaking, relax or restrict certain terms/conditions/warranties etc. at their own independent of the acceptance of co-insurers.

Keeping in view these factors in mind the matter should always be resolved and agreed among the leader, co-insurers and the insured in writing. It is better to send the intimation of claims independently to all the participants in the risk i.e., the leader and the co-insurers immediately after the happening of any loss and/or damage to the subject matter of insurance rather than sending claim intimation only to the leaders. In case the Leader delays this claim intimation and the same is not reached to the co-insurers within the stipulated period of time the insured may suffer the consequence thereof. However, it is decided in advance that the claim intimation shall be considered to be given to the leader shall be considered as delivered to the co-insurers as well then, the policy terms/conditions shall be considered as fulfilled.

Leader is also bound to share the survey report along with all the supporting documents to the co-insurers immediately after receipt of the same from the appointed surveyor in case the surveyor is appointed by the leader only.

Some policies e.g., standard fire policy, require the claim form to be submitted to the insurers along with the supporting documents to the insurers within a specified period of time, normally 15 days so, this issue must be decided prior to enter into the contract of insurance that whether this kind of information is to be shared with the leader only or the same is to be furnished to co-insurers as well.

In case of any ambiguity in the policy or attached clauses etc. the insured is required to raise the objection within a specified period of time. Under these conditions the insured is required to send their objections not only to the leader but to the co-insurers too.

All kind of policy endorsements require the co-insurers to be taken on-board and all such endorsements should be signed by the co-insurers as well.

The proposal form may also be shared with the co-insurers and the leader.

The leader is not liable in case any co-insurer become unable to pay the proportionate share of claim however, if this kind of insurance policy is issued on the basis of payment of claim by the leader as a whole and would recover the proportionate claim from the co-insurers then a different scenario may be generated. Because in that case, if the liability to pay the claim by the leader in full, would require the leader to select the co-insurers by signing an undertaking in respect of claims payment by the co-insurers to the leader setting out certain parameters in writing. In this case the leader is to pay the claim in full and would recover the share from the co-insurers. In this case it is also considered that the premium may also be charged by the leader in full and who would distribute the same to the co-insurers under some stipulation/agreement.

In case the leader is to pay the premium to the co-insurers after collecting the same from the insured then the leader would be liable to pay the share of premium to the respective co-insurers in-time if it is not otherwise stipulated/agreed.

It is also safe to select a panel of few independent insurers by the insured to underwrite the risk independently by issuing their independent but concurrent insurance policies with the similar terms/conditions, charging the premium in full direct from the insured and pay the claim in full to the extent of their sum insured. Each one of them may appoint the independent surveyor and all so appointed surveyor would conduct a joint survey and assess/adjust the loss jointly by issuing the joint survey report as happened in case of cotton ginning and pressing factories business.

Each type of insurance arrangement has certain merits and demerits which must be considered at the time of insurance arrangement best suited to the risk.

This practice is prevailing successfully since long. 99.99% claims are settled smoothly with the consensus among the insurers as well as the surveyors. The insured is taken on-board who, after discussion agree to accept the adjusted/assessed loss by discharging a usual letter of claim acceptance.

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Takaful in Pakistan

It has been a period of over 32 years since the Takaful system was developed in Malaysia as an alternative to conventional insurance. Now every Muslim country has Islamic insurance companies but the journey of Takaful towards its destination has been very slow. There are several reasons to this slowness. One of them is strong interest based insurance and banking which are dominant disallowing any breathing space to Islamic Insurance.

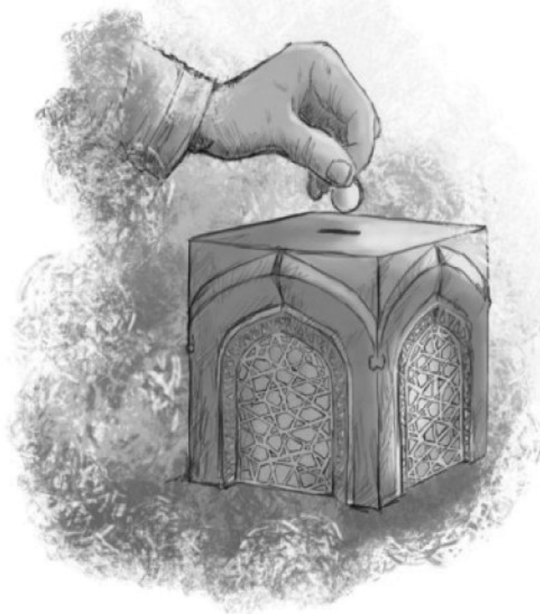
Takaful operations in Pakistan began in 2005. A considerable time has lapsed but there is no such result that we are proud to announce. Of course, it is a challenge for the current government that came into power with a slogan to develop Pakistan into a welfare state in line with the State of Madina.

Before coming to the actual point, it seems appropriate to mention here the history of Madina where Riba (interest) based system was operating when the Islamic state came into existence. At the beginning the system continued to exist in the Islamic state. But it was uprooted immediately once the alternative systems of Zakat and Bait ul Mal were introduced to support Muslim community financially in Madina.

The Takaful being human welfare, developed as an alternative to conventional insurance has existed in Pakistan for the last 17 years. It is the responsibility of the government to come forward and remove all the obstacles standing in the way of Takaful growth. No doubt, it is too hard but not impossible to get rid of the interest based insurance system from the society. The government should, at least, take steps to strengthen Takaful industry which will enable them to replace the conventional insurance gradually with Islamic insurance. Given below are some suggestions in respect of Takaful development in the country.

The Takaful as based on Shariah is the backbone of mankind's welfare and feeding line of trade and industry. Unfortunately, there are several types of taxes imposed on the Takaful Industry by the government. This industry being the welfare responsibility of the people, should be given some relief in taxes compared to conventional alternative with a view to boost up the takaful industry in the country. The stronger the takaful industry, the smoother will be the transition into an Islamic welfare state.

Another issue is per party single risk limit assigned by banks binding Takaful Operators to underwrite business within the limit fixed by the banks. The objective of allocating a risk limit is that the bank wants to



safeguard the interests of its borrowers to whom it advances money.

In my opinion, assigning per party single risk limits to Takaful operators is an illogical measure undertaken by banks when all Takaful companies have a per risk limit assigned by their Re-takaful treaty companies, which are not only expert but also having rich knowledge in the subject. The Re-takaful operators assign per party single limit after analyzing various parameters such as capital, solvency, financial strength, gross premium income etc. of respective takaful operators.

Under the umbrella of the treaty, the client of bank is safe as their interest is fully covered because when the operator covers a risk, it retains a small portion of that risk and the balance is passed on to its treaty. This is done with a view to spread the risk so that when a loss occurs, the operator may pay less from its own resources and the major portion of loss is recovered from its treaty. Hence in the presence of re-takaful treaty arrangements there is no need to do a further exercise of fixing the total exposure limit. The primary criteria for assigning bank limit after the treaty arrangements should be the speedy settlement of claim and good track record of the Takaful company because these are of the topmost performance and without it, banks cannot safeguard the interests of their borrowers.

It is worth mentioning that Takaful companies have made a lot of efforts to resolve the bank limit issue but has gone in vain. Hence, the government should look into the matter and incorporate some provisions in the regulations to remove such types of obstacles so that Shariah based welfare system in the country would flourish without any interference from other entities.

The Takaful is a service industry providing security to all traders, industrialists and individuals. Therefore, the importance of education is most important within this profession. Education makes the staff of the takaful company more efficient, skillful, resourceful and knowledgeable –necessary to perform better service as the subject of takaful is a normal human being and the object is to provide financial protection to put the person back in the same financial position as he was before the loss occurrence.

It would not be out of place to mention here that when the availability of skilled professionals is ceased, the growth of that industry also comes to a halt. Pakistani takaful industry needs more educational and training institutes to impart education and training to their personnel to keep Islamic insurance floating. The backing of the government in the form of funds on education particularly for the development of takaful will strengthen the industry to provide welfare to more and more people.

Last but not least, there is more required in order for the welfare of the people in the country. It is up to the government to come forward and take initiative towards its vision to develop Pakistan into a true welfare state in line with the State of Madina.

CORRECTION

In July, August, September 2021 issue of Insurance Journal, while reporting the results of IAP Elections 2021-22, the photo of New Chairman (2021-22) was wrongly published. The photo of Mr. AZFAR ARSHAD, the new chairman 2021-22 is published in this issue of Insurance Journal. Insurance Journal sincerely regrets the mistake.

Mr. AZFAR ARSHAD
Chairman IAP - 2021-22

Owais Khan
Senior Vice President
EFU General Insurance Limited

Understanding Marine Cargo Insurance in Covid-19 Times

The COVID-19 virus has an enormous impact on the supply chain of goods which could not have been anticipated before the outbreak. The shipping and the trading sectors, in particular, are grappling with operating difficulties due to implementation of quarantine and travel restrictions. Not only the delay in production of goods world-wide but goods arriving too late or diversion of goods due to country-specific restrictions have created a chaotic situation. The new normal now is living with COVID and this poses several questions for us as Insurers to address.

As a Claim professional, I always advice the Insureds to believe that it has never been more important for them to understand what their regular Marine Cargo Policy covers. The Insureds must understand what their insurance Policy covers and then discuss with Underwriters as to how could they Underwrite the risks specific to their Industry.

The following are some basics for the Marine Cargo Policyholders to Understand:

1-Does Marine Cargo insurance provide coverage for every type of Loss?

The Marine cargo insurance covers DAMAGES to goods that occur during the transport / transit of the goods. I would emphasize on the word "Damages" as loss caused without any physical damage would not qualify for coverage.

2-Which type of losses are covered if not all?

This depends on the type of coverage obtained by the Insured. Conventionally, the widest form of coverage an Insured could afford in Under Cargo Clause-A which covers most if not all losses unless expressly excluded. Some examples of exclusions are inherent vice, loss damage or expense caused by delay, insufficiency or unsuitability of packing, insolvency or financial default of the owners, charters or operator of the vessel, unseaworthiness of vessel or craft or unfitness of vessel or craft / Container or Conveyance for the safe carriage of the subject matter insured etc.

3-Which additional costs are covered?

Expenses incurred to prevent or minimize damages are covered, if there is an already existing or an imminent threat of material damage to the insured goods. Additional costs for reloading, temporary storage as well as reshipping or re-forwarding are covered subject to policy terms and conditions. The condition for indemnification, however, would remain the same i.e. material damage in transit.

4-Are delays in delivery of goods insured caused by the Corona-Crisis covered?

Delays in delivery can also lead to claims caused by late arrival. Losses that may happen due to delays in the supply chain are not material damage losses.

5-What should the Policyholder do in respect of Marine Cargo insurance if the completion of the insured transport is significantly delayed?

This constitutes a change of risk, which must be notified to the insurer without delay as soon as the policyholder becomes aware of it. The standard duration clause of Institute Cargo Clause-A Coverage states that Coverage is for the specified period and terminates on the expiry of 60 days after completion of discharge and not for indefinite period as expressly mentioned in the clause. If this time period is being exceeded, the insurer must duly be notified, so that the storage period can be extended, and the insurance policy amended accordingly.

6-What should a Policyholder do in the event of a Loss:

As soon as the Policyholder suspects a loss, it is essential that the policyholder immediately notifies the insurer. The insurer will often appoint a Surveyor / Loss Adjuster who is an authorized expert to clarify how the damage happened and determine the amount of claim and adjust the same according to the terms and conditions of the relative policy.

Thus, it is essential that Policyholders should understand what would a normal Marine Cargo Insurance Policy would cover and what not. Understanding the basics of Marine Cargo Insurance Policy would enable them identification of risks and consequently followed by obtaining the right kind of coverage to suit their specific needs.

Tanveer Ahmed
Chief Executive Officer
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Crop Insurance in Punjab

When we think about insurance we think about cars, factories, buildings, machinery, people etc. One form of insurance that does not get much attention but should be widespread, particularly in a country like Pakistan, is Crop Insurance.

Punjab is the most populous province of Pakistan with a population of over 110 million. With a share of 60% in the national economy, the province is the most prominent in the agricultural sector. It provides 76% of the country's annual grain production.

Crop Loan Insurance Scheme (CLIS) was introduced countrywide in 2008 by the SBP. It provides insurance coverage for five major crops, wheat, rice, sugarcane, cotton and maize. The cover provided under CLIS is against unavoidable loss of crop or part thereof resulting directly from the peril(s) such as Flood, Excessive Rains, Frost, Drought, Hailstorm, Cyclone, diseases like Viral, Bacterial and Locust attack. With the support of the government, the insurance premium is subsidized for subsistence farmers, defined as those having up to 25 acres of land for cultivation. The crop loan insurance scheme attracts premium subsidy support from the government. The maximum net premium rate is 2% per crop per season per borrower and the cover is from sowing to harvesting.

Since Rabi 2008/09 CLIS has been available for the aforementioned five major crops. The policy adopts a unique two-trigger indemnity procedure: 1) catastrophe losses as a result of an insured peril that exceeds 50 percent of the normal average regional area yield must first be declared by a competent authority, and 2) this opens the policy for a loss adjustment at the individual farmer level. For CLIS, the delivery channel is through linkage to agricultural credit for farmers through the banks. Crop insurance is compulsory for farmers who have taken seasonal loans from the banks. The scheme carries a maximum agreed indemnity limit of 300 percent loss ratio.

Now, the Punjab government is also providing crop insurance, which might be a game-changer for farmers of the province. The Punjab government has introduced Punjab Fasal Bema Scheme for the farming community in case of

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natural calamities/disasters. The first phase of the scheme was launched in Sheikhupura, Sahiwal, Lodhran and Rahim Yar Khan in Kharif 2018, it was applicable only to cotton and rice farmers.

When the government saw the importance of this scheme, the scope of this program was expanded in 2019 and it was started in 18 districts of Punjab. These 18 districts included Sahiwal, Sheikhupura, Lodhran, Rahim Yar Khan, Multan, Muzaffargarh, Narowal, Faisalabad, Rajanpur, Bhakkar, DG Khan, Kasur, Khanewal, Layyah, Mandi Bahauddin, Bahawalpur, Bahawalnagar and Okara.

Under this scheme, the Punjab government provided 100 percent subsidy on insurance premium to farmers owning 5 acres of land, similarly, the government also provided 50 percent subsidy on insurance premium to farmers of 5 acres to 25 acres and in the case of orchards also provided 50 percent subsidy on insurance premium to farmers.

In the first phase (Kharif 2018), insurance was applied to agricultural creditors (E-Credit, CLIS) as crop insurance schemes were mandatory for agricultural creditors of E-Credit, therefore, they were registered under the automated system. Moreover, agricultural creditors were asked to approach their respective agricultural banks. In the next phase (Rabi 2018) crop insurance scheme was brought to other farmers besides the agricultural creditors. For fasal bema, the farmers used to register themselves with the Department of Agriculture, Punjab.

For Kharif 2021/22 season crops, the process of insurance program registration has been started for cotton and paddy farmers in 27 districts of Punjab to compensate for climate change, natural disasters and locust damage. Similarly, South Punjab includes Multan, Lodhran, Khanewal, Vehari, DG Khan, Muzaffargarh, Rajanpur, Layyah, Bahawalpur, Bahawalnagar and Rahim Yar Khan Districts. The program will provide 100 percent subsidy on premium for farmers owning up to 5 acres of land and 50 percent subsidy on insurance premium for farmers owning 5 to 25 acres of land. Policy certificates will be issued to farmers who insure cotton and paddy crops in Kharif 2021/22. In case of loss of production at the tehsil level, an announcement will be made in December 2021 and the concerned insurance company will contact all the insured farmers in January 2022 and will be bound to compensate for the loss.

The most important point is that it does not cover crop damage at the level of an individual farmer or field. Rather, under this method, production loss or a specific geographical area (such as a district, tehsil, union council or village) is considered, however, the geographical area is usually called the Unit Area of Insurance or UAI. Under this method, in case of less than average production in UAI by area (index), area, production, index product pays compensation. Moreover, the loss is estimated on the average yield of a given area (tehsil) rather than the individual farmer's land. AYII is based on scientific principles and in this index, crop harvesting experiments are carried out scientifically in different places at the level of a specific area (tehsil) in Punjab.

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Business Interruption Insurance

The sole objective of buying an insurance policy is to put back the buyer in the same financial position as it existed before an unforeseen calamity resulting in material and financial loss to the insured. To meet this end a fire policy is bought with additional coverage of riot, strike, malicious damage, atmospheric disturbance, earthquake etc. in case of an incidence encompassing above stated mean of affecting loss or damage, the loss is made good by the insurer.

However, the fire covering along with its annexure stated above only gives back the property and /or equipment in term of money which enables the insured to rebuild and re-equip his factory. Obviously it takes time to restart production and consequent earning. During the period the factory is rebuilt and the machinery reinstalled the insured losses not only the profits he was making when his factory was in production but also continues to pay to idle staff and for the variety of overhead expenses, in addition there is always the fear of losing the client etc.

In order to secure protection against the loss of profit as also to cover the expenses incurred during the period between stoppage of production and restart of production special insurance cover has been designed and called Business interruption or Loss of Profit.

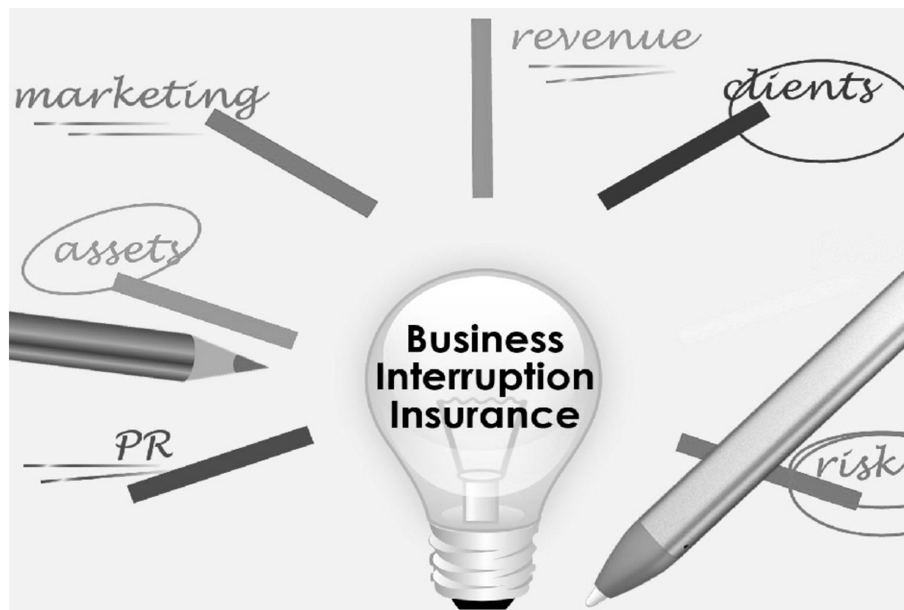
Objective of Business Interruption Insurance:

The objective of profit insurance is to indemnify the insured against the loss of profit caused as a consequence of damage, because of unforeseen incidence of a calamity or peril by:

- Making good the loss of net profit.
- Making a payment of those standing charges or overheads which continue to be payable,
- Defraying such additional expenditures as it necessarily incurred to maintain the turnover of the business. e.g. temporary repairing cost, erection or rent of temporary accommodation, charges for work being taken elsewhere, additional transport charges, overtime payment to staff and payment of salaries to staff though not working retained less any sum saved during the indemnity period in respect of surcharges and expenses of the business payable out of gross profits which may cease or be reduced in consequence of damage.

Basic Principles

The business of the insured is the subject matter of the Business interruption insurance. It is therefore necessary to have clear conception of elements of business relevant to profit clause of insurance as it is



necessary to have complete knowledge about type of construction, associated dangers and prevention thereto in case of fire insurance.

In every business there are expenses and there are profits. The expenses could be variable in nature and amount proportionate to the volume of business done e.g. purchase of raw material as also the expense could be standing once e.g rent, salary etc. the former are known as variable charges and latter as standing charges. The profit is the total income less total expenses.

Underwriting Considerations:

Indemnity Period – The selection of an adequate indemnity period the maximum period for which the indemnity is provided under the profits policy requires very careful consideration interruption of a business such as the big factory may continue for many months following damage due to non-availability of the plant rendered useless, locally, the delay which inspire of easement in conditions, could still be experienced in the re installment of the plant. This require cool calculation and careful consideration so as to provide a period long enough to ensure complete recovery of the business after the plant/or damage has been repaired and/or replaced.

Standing Charges - Respecting the considerations associated with standing charges it is certain that these charges would neither cease nor be reduced in the same proportion as turnover. However, doubts could arise and to allay any doubts as to the extent to which a certain charge would reduce in the event of damage it is best that the charge be insured in full.

Sum insured on gross profit – the sum of to be insured under the gross profit item is the total of the net profit, before deduction of any taxation, plus the total amount of the standing charges proposed for insurance. For the purpose of profit insurance this total amount is taken as gross profit. It should provide a margin for expansion of the business. it should be noted that it is not the past results but the future prospect of the business which the policy is designed to protect.

Accordingly, if the indemnity period exceeds 12 months the sum insured must be appropriate to the extent of the indemnity period e.g for 24 months indemnity period the total amount of annual gross total must be doubled.

Wages – if the business partly interrupted as a result of damage by one of the perils insured against there would be no employment for some of the workers. No doubt the insured would not like is his experienced, skilled and qualified workers to go into the employment of somebody else. He would like to retain them in his service despite there being no work for them. Payment of wages to such workers is definitely a loss to the insured. To make good this loss the insured should obtain full insurance cover of the wage roll for the same indemnity period as that taken for the gross profit item.

Auditor's Fees:
It is a matter of routine to include, in the insurance, an amount to cover the fees which would be payable to auditor for services render in collection of substantiation of a claim. The fee for such work, which would obviously be in addition to their annual fee normally included in the company standing charges, is not a matter which fall within the liability of insurer unless provision has been made by means of an inclusion of a separate item.

Supplier's Extension:

There is always a danger of a potential loss, large enough, arising from the interruption in supplying from a particular supplier affecting the overall profits of the insured. Thus creating a need for extending the cover in this direction also. So the policy is extended to cover loss resulting from interruption with the business in consequences of damage at the named supplier's premises by the action of insured peril.

Customer's Extension:

As loss can be sustained from the supplier premises loss can also be sustained from customers end. Profit also can be extended to cover loss resulting from interruption with the business in consequences of damage to property at the premises of the customer.

Admittedly the loss of a particular supplier would cause almost complete stoppage of the insured trading while the loss a particular customer would, in the usual course, affect only a portion of the insured trade, so it is very special cover and as such it is given to very valued clients. When this cover is issued complete detail including name, address, solvency etc. of each customer with a limit of liability not exceeding 5% of the annual turnover is ascertained.

Annexure to Fire Policy:

Business interruption insurance being of very delicate and sensitive nature requires very careful and discreet selection of risk. The balance sheet of the insured need minute study, scrutiny and assessment with the view determining the exact profit making potential of the firm, if the firm is not making any profit the cover is declined.

Loss of profit cover is never issued in isolation. It is issued so to say as an annexure to fire cover. If Business interruption cover is issued unaccompanied by fire cover it becomes void it has no meaning.

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The Impact of Sehat Sahulat Programme on Private Health Insurance Sector

Although, this was the best initiative of the Khyber Pakhtunkhwa government to start the Sehat Sahulat Programme (SSP). It was a state funded universal health insurance scheme which had rolled out in four phases and now is covering the entire population of KP province. Now, the Punjab including Islamabad, has decided to launch its Sehat Sahulat Programme (SSP) for its entire population in January 2022. The idea is to give health insurance coverage of Rs.1 million to each family which include in-patient hospitalization and maternity coverage. The coverage will be provided in government owned hospitals as well as a number of private hospitals on panel. The government has not considered the private sector health insurance companies by awarding the entire province to State Life Insurance Corporation (SLIC), a state owned company.

The government has decided to give three years contract to SLIC in Punjab with a premium of Rs.100 billion for entire province coverage of Rs.1 million in private and public hospitals. The private insurance sector fears that they may start losing clients as people would not want two health insurances at a time. This could be unfavourable for the private insurance sector which has an organic growth of around three decades. Government should consult the private insurance sector before giving the whole health insurance portfolio to SLIC. The monopoly of SLIC is not good. When SLIC is going to be the sole service provider of SSP both in KP and Punjab, the service delivery may be compromised due to lack of competition. If Punjab move out in parts with giving space to private insurance sector along with SLIC, the people of Punjab possibly can get better health insurance services in some well reputed private hospitals.

SSP will create demand for healthcare across the province and private sector may think of building small and medium size hospitals in poorer region and pockets. Already in KP, private sector is building hospitals in anticipation of business. This can very well happen in Punjab. However, such investment would come in general care. People still need specialized healthcare units in vicinity of their residence. Punjab government should look filling these gaps such as building specialized burn, cancer, and child/mother care centers. Then Punjab should think of working on coinsurance model by consulting the private insurance sector.

Even then the private insurance sector has an edge over the SLIC. Following are some salient features which are practicing private insurance companies to acquire health insurance business:

a. Private Insurance Companies are offering OPD coverage to their insured with credit facility in major hospitals as well as an option of reimbursement of OPD expenses if they get OPD treatment from the doctor of their own choice.

b. The insured persons are not bound to get IPD treatment from panel hospital and they can go any hospital of their choice.

c. There is no delay occur in provision of treatment / admission in hospital which can be an issue for SSP's panel hospitals due to over burden and patient may wait for months for the surgery.

d. Although, the SSP is currently available only for two provinces i.e. KP and Punjab whereas the remaining population of Pakistan can still rely on Private Health Insurance.

e. If a person / family covered by a private insurer and also have SSP coverage, it means they have dual insurance. If they use the SSP's insurance facility, then it can be the loss reduction factor for the private insurance company.

f. There will be a fixed annual coverage of Rs.1 million per family (with some sub-limits) that will be provided by SSP whereas the private insurance companies offer benefit limits according to the need and

budget of the insured.

g. A number of renowned, well-equipped, well-reputed and state of the art hospitals are available on panel network of private insurance companies whereas the most of them will not be available in SSP.

Besides the potential unintended consequences on the private sector insurance companies and public sector health facilities, one must appreciate the efforts of current government to revolutionize the healthcare for masses in Pakistan. A coverage of Rs.1 million per family for every citizen is very impressive. Many poor and low-income people die because of diseases that can well be dealt with if diagnosed and treated in time. Now they can reach out to hospitals in KP and soon that could happen in Punjab. This will invite private medical sector to invest in healthcare and provide efficient solution for people by building new hospitals in every corner of Pakistan. Overall, better healthcare may reduce the infant mortality rate, it may increase the average life and improve the overall productivity. The credit goes to the KP government for setting the example for others.

Salient Features	Sehat Sahulat Program, Khyber Pakhtunkhwa	Sehat Sahulat Program, Federal
Initial coverage for secondary care (Basic Treatment)	200,000 PKR per family per year	60,000 PKR per family per year
Additional coverage for secondary care (Basic Treatment)		60,000 PKR per family per year
Secondary care (Basic Treatment).	Emergency treatment requiring admission.	In Patient Services (All Medical and Surgical Procedures).
	Maternity Services (Normal deliveries, C-section).	Emergency Treatment requiring admission.
	Fractures and Injuries.	Maternity Services (Normal Delivery and C – Section).
	General Surgeries (Gallbladder, biopsy, colon, prostate, hernia).	Maternity Consultancy / Antenatal Checkups (4 times before delivery and one follow up after delivery).
	General Medicine (diabetes, hypertension, cardiac).	Maternal Consultancy for family planning, immunization and nutrition.
		Fractures / Injuries.
		Post hospitalization.
		Local Transportation Cost of PKR 1,000 (thrice per year).
		Provision of transport to tertiary care hospitals.
Coverage for tertiary care (Advanced Treatment)	400,000 PKR per family per year	300,000 PKR per family per year
	400,000 PKR per family per year **(Additional Coverage)**	300,000 PKR per family per year **(Additional Coverage)**
Tertiary care (Advanced Treatment)	Cardiovascular (Angioplasty, bypass)	In Patient Services (All Medical and Surgical Procedures).
	Diabetes	Heart diseases (Angioplasty/bypass).
	Artificial Limbs (Prosthesis)	Diabetes Mellitus Completion.
	Kidney Diseases (Dialysis)	Burns and RTA (Life, Limb Saving Treatment
	Breast Cancer Screening	End stage kidney diseases/ dialysis.
	Management of Neurosurgical Diseases	Chronic infections (Hepatitis/ HIV/ Rheumatology).
	Cancer Treatment (Chemo, Radio, Surgery)	Organ Failure (Liver, Kidney, Heart, Lungs).
	Kidney Transplant	Cancer (Chemo, Radio, Surgery).
	Accident and Emergency	Neurosurgical Procedure.
	ICU Care	
Total coverage for treatment	Health expenditure up to 1,000,000 PKR per family per year	Health expenditure up to 720,000 PKR per family per year
Amount of wage loss	250 PKR per day for three days	
Maternity Allowance	1,000 PKR (transportation)	1,000 PKR (transportation)
Transportation Allowance	2,000 PKR	1,000 PKR (three times per year)
Funeral Allowance	10,000 PKR	

2021 C L D 898

[Supreme Court of Pakistan]

Present: Umar Ata Bandial, Sajjad Ali Shah and Munib Akhtar, JJ

STATE LIFE INSURANCE CORPORATION OF PAKISTAN---Appellant

Versus

ATTA UR REHMAN---Respondent

Civil Appeal No.350 of 2020, Decided on 25th June, 2021.

(On appeal from the judgment dated 09.05.2018 of the Peshawar High Court, Peshawar passed in F.A.O. No.49-P of 2014)

Insurance Ordinance (XXXX of 2000)---

----S. 75---Life insurance policy---Duty of utmost good faith on part of insured---Scope---Insured mentioning in his insurance application that he never had heart disease, when in fact he had undergone heart surgery prior to signing up for the policy---Whether it was a deliberate concealment of a material fact know to the insured and, hence, breach of the duty of utmost good faith, which allowed the insurance-company to avoid the contract---Held, that insurance company did not merely rely on the answer given by the insured in his Personal Statement of Health---Insured was also thoroughly medically examined by a doctor of the insurance company's own choice, and said report gave the insured a clean chit by stating that his coronary state was perfectly normal---Insurance company was induced to issue the life insurance policy not on account of the statements made by the insured, rather, it was the examination by the insurance company's own medical examiner and his report that was clearly the most important factor, and instrumental in inducing the insurance company to go forward in the matter---Furthermore, the industry custom and practice uniformly followed was that insurers in the life insurance business did not issue policies without a thorough medical examination of the person proposed to be insured, and unless the resultant medical report was found satisfactory or acceptable---if therefore the medical examiner chosen by the insurer was negligent or the Standard Operating Procedures (SOPs) established for the examination (again, by the insurer) were so lax as to fail to result in a properly thorough examination (again, by the insurer) were so lax as to fail to result in a properly thorough examination, the burden of that fault laid on the insurer---In such a situation the insured could not be held to account for any non-disclosure such as would enable the insurer to escape liability on the policy unless there was fraud or a fraudulent misrepresentation---Nothing was available on record to show that the non-disclosure by the insured (i.e., his answer to having history of heart disease) was fraudulent---For a below had righty decreed the claim of the legal heirs of insured to the extent of the insured amount---Appeal filed by insurance company was dismissed.

Jubilee Insurance Co Ltd. v. Ravi Steel Company PLD 2020 SC 324 Distinguished.

MacGillivray on Insurance Law (14th ed., 2018) and State Life Insurance Corporation of Pakistan and another v.Shazia Mir Arshad 2019 CLD 1263 ref.

Muhammad Faisal and another v. State Life Insurance Corporation and other 2088 SCMR 456 not to be regarded as good law.

Sana Ullah Zahid, Advocate Supreme Court for Appellant.

Respondent ex-parte.

Dated of hearing: 3rd March, 2021.

JUDGMENT

MUNIB AKHTAR, J.--- One Mr. Abdul Rehman took out al life insurance policy with the appellant insurance company on or about 01.08.2002. The insured passed away on 07.02.2010 and the respondent, his legal heir, lodged a claim under the policy. That claim was rejected vide letter dated 15.04.2011. No specific reason, as such, was given as to why the claim was not accepted. The respondent commenced proceedings, on or about 25.11.2011, before the Insurance Tribunal constituted under the Insurance Ordinance, 2000 (“Ordinance”). Issues were framed and evidence led by the parties. By judgment dated 07.06.2014 the Tribunal decreed the claim in the cum of Rs.400,000/-, which was the insured amount. There was an appeal to the High Court, which was dismissed by means of the impugned judgment dated 09.05.2018. The appellant petitioned this Court, where leave to appeal was granted vide order dated 16.03.2020.

2. Before us learned counsel renewed the primary plea taken by the appellant, which was that there had been a breach of the duty of utmost good faith by the insured. It was submitted that for some years prior to the policy the appellant had a cardiac condition (i.e., coronary disease), which was so severe that it had even required a heart operation. That

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condition was continuing at the time of the policy. This was however not disclosed to the appellant when the insured applied for life insurance. This was a material concealment which vitiated the policy, and allowed the appellant to avoid the same. Reference was made to section 75 of the Ordinance, which puts the duty of utmost god faith on a statutory basis. Reliance was also placed on Jubilee Insurance Co.Ltd.v.Ravi Stell Company PLD 2020 SC 324 where, at para 8, section 75 and 76 were considered.

3. Expanding on the factual basis of his submissions, learned counsel submitted that the insured, an employee of WAPDA, had been suffering from diabetes and a heart condition for approximately 12 years prior to the taking out of the policy. He had been operated upon, and coronary artery bypass grafting was carried out in or around 1997. It was submitted that these medical conditions were concealed by the appellant. Learned counsel strongly relied on the evidence of one Dr.Suliman, DMS WAPDA Hospital Peshawar and the medical record/history of the insured that was produced by him. It may be noted that the doctor appeared as a witness summoned by the appellant. It was contended that the policy stood vitiated, thus relieving the appellant from liability in terms thereof.

4. We have heard learned counsel (the respondent being ex parte) and considered the record and the case relied upon. Contracts of insurance belong to that limited category which are regarded as being uberrimae fidei, i.e., of the utmost good faith. This rule was developed over centuries by the common law in its many facts and aspects and was regarded as fundamental to insurance law. Section 75 merely codified the central aspect of the rule. It had of course applied in full even under the predecessor legislation, the Insurance Act, 1938 ("1938 Act"), which did not have an equivalent provision. Interestingly, it appears that the central aspect of the rule, which allows a contract to be avoided for breach of utmost good faith, has now essentially been abolished in the United Kingdom: see the Insurance Act, 2015 (section 14) and the Consumer Insurance (Disclosure and Representations) Act, 2012 (section 2). Of course, it continues in full force in this jurisdiction. Notwithstanding the legislation just referred to, the rule continues to be treated in all its aspects in English treatises on insurance law. Obviously it is neither possible nor desirable to consider the whole of the rule here, in the entirety of its facts and aspects. However, in order to make intelligible our consideration of the submissions made by learned counsel some aspects will have to be touched upon. It will be convenient to set out certain extracts from a well-known treatise on the subject, Macgillivray on Insurance Law (14th ed., 2018). This work treats the rule in Chapter 17, which has the advantage that the effect of the UK legislation just referred to is not dealt with there, the same being taken up separately in other chapters of the work (see para 17-001). The general rule is set out in para 17-009 (in all the extracts below the internal citations are omitted):

"The General rule stated. Subject to certain qualifications considered below, the insured must disclose to the insurer all facts material to an insurer's appraisal of the risk which are known or deemed to be known by the insurer but neither known nor deemed to be known by the insurer. Breach of this duty by the insured entitles the insurer to avoid the contract of insurance so long as he can show that the nondisclosure induced the making of the contract on the relevant terms…."

The next para explains what is meant by facts known to the insured:

"Facts known to the insured. The duty of disclosure extends only to facts which are known (or deemed in law to be known) to one party and not to the other. "The duty is a duty to disclose, said Fletcher Moulton LJ in Joel v Law Union and Crown Insurance {{1908} 2 KB 863, 884}, 'and you cannot disclose what you do not know. The obligation to disclose, therefore, necessarily depends upon the knowledge you possess.'"

It will be seen that a breach of the duty will allow the insurer to avoid the contract only if (a) the fact not disclosed was material to the insurer's appraisal of the risk; (b) was known or deemed known or deemed known to the insured; (c) but was not known or deemed known to the insurer; (d) and it is for the insurer to show that the non-disclosure induced it to make the contract on the relevant terms. What is meant by inducement is explained in para 17-029;

"Inducement. To succeed in a defence of non-disclosure the insurer must prove not only that the insured failed to disclose a material fact but also that the non-disclosure induced the making of the contract in the sense that he would not have made the same contract if he had known the matters in question. This means that the non-disclosure must have been an effective cause of the underwriter making the contract on the terms agreed, but it need not have been the sole cause. The insurer must establish that, had he known the undisclosed circumstances, he would not have concluded it either on the same terms or at all. If he would have made the same contract, the non-disclosure cannot have made a difference. Inducement is shown if disclosure of the relevant act would have led the underwriter to ask further questions which, if answered correctly, would have prompted him to impose different terms…."

The Matters which the insurer knows or is deemed to know are set out, inter alia, in section 6 of the Chapter. One aspect of it relates to business practice and custom (para 17-082):

"Business practice and custom. The insurer is presumed to know not only the ordinary incidents of ordinary risks but the ordinary incidents of peculiar risks if he undertakes them. "Every underwriter," said Lord Mansfield, "is presumed to be acquainted with the practice of the trade he insures. If he does not know, he ought to inform himself" [Noble v Kennoway (1780) 2 Doug. KB 510, 512; 99 ER 326; [1780] EngR 105]. So, if insurers cover a building where celluloid is stored, and they are informed of it, they cannot afterwards complain that they did not know celluloid was inflammable. If, however, the insured carried on his manufacture or trade by an unusually hazardous or novel process outside the reasonable contemplation of someone familiar with it, he ought to

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disclose this fact."

With this conspectus of the rule in mind, we turn to the facts of the present appeal.

5. Among the record produced by the appellant at the trial were the statements made by the insured when the policy was taken out regarding his medical condition/history, and also the results of his medical examination (also carried out at that time). That examination was by a doctor of the appellant's choice. The section of the record titled "Life Proposed's Personal Statement of Health", signed by the insured and dated 30.07.2002 contained a number of questions, which had to be answered by the applicant regarding his medical condition and health status. One of those questions (No.7) was as follows:

"Do you now or have you ever had Small-Pox, Heart Disease, Diabetes, High Blood Pressure, TB, Cancer, Nervous or Psychological disorder? If so specify with dates."

This question was answered by the insured I the negative, i.e., "No". This answer, when read with the evidence of the aforementioned Dr. Suliman (which showed that the insured had a history of coronary disease and had undergone hearth surgery) established, learned counsel submitted, that there had been a deliberate concealment of a material fact known to the insured and, hence, breach of the duty of utmost good faith, which allowed the appellant to avoid the contract. We have carefully considered this submission. The record clearly establishes that the insured did have heart disease and had been operated upon on account thereof. The negative answer given to the question was a non-disclosure of a fact that was material. The question however remains whether this was a fact that was not to be deemed known to the appellant, and/or whether it induced it to issue the policy on the terms as stated therein.

6. The reason why the questions just mentioned remain is because the appellant did not merely rely on the answers given by the insured in the aforementioned "Life Proposed's Personal Statement of Health." The insured was also thoroughly medically examined by a doctor of its own choice. The doctor's report, also dated 30.07.2002, gave the insured a clean chit. In the sections relating to coronary matters (and indeed all others) the medical health/status of the insured was stated to be perfectly normal. The remarks of the examining doctor are also pertinent. He found the insured to be: "fit. First Class [sic]." When this medical examination and report are considered in the light of the evidence as a whole, it is clear that the appellant was induced to issue the life insurance policy not on account of the statements made by the latter and, as presently relevant, the response given to question No. 7 Rather, it was the examination by the appellant's own medical examiner and his report that was clearly the most important factor, and instrumental in inducing the appellant to go forward in the matter. Furthermore, it is a fact so well known that judicial notice can be taken of t that insurers in the life insurance business do not issue policies without a thorough medical examination of the person proposed to be insured, and unless the resultant report is found satisfactory or acceptable. This is the industry custom and practice uniformly followed in all cases. If therefore the medical examiner chosen by the insurer is negligent or the SOPs established or the examination (again, by the insurer)are so lax as to fail to result in a properly thorough examination, the burden of that fault lies on the insurer. In such a situation the insured cannot be held to account for any non-disclosure such as would enable the insurer to escape liability on the policy unless there is fraud or a fraudulent misrepresentation. In the actual facts of the present case, had the coronary condition of the insured prior to 2002 been so bad as learned counsel sought to make out before us it would certainly have been discovered by the appellant's own medical examiner. That he did not do so, and gave a report that essentially totally belied the stance subsequently taken by the appellant in its attempt to avoid the contract effectively puts paid to that stance. It cannot, in our view, be accepted and was rightly rejected by the Tribunal and the High Court.

7. The medical reports generated and statements made in relation to the issuance of life insurance policies have been given recognition in both the 1938 Act and the Ordinance. It is now necessary to consider those provisions, as they are also important for the outcome of the appeal.

8. As noted above, section 75 of the Ordinance codifies the central aspect of the duty of utmost good faith. Section 79 contains the remedies available to an insurer when there is, inter alia, a breach by an insured of the duty of disclosure. Section 80 then makes certain special provisions for a policy of life insurance. The 1938 Act also had a similar provision, in section45. For ease of reference these are set out in tabular form:

80. Policy not to be called in question on ground of misstatement after two years. Notwithstanding anything in section 79, …no policy of life insurance…shall, after the expiry of two years from the date on which it was effected, be called in question by an insurer on the ground that a statement made in the proposal for insurance or in any report of a medical officer, or referee, or friend of the policy holder, or in any other document leading to the issue of the policy, was inaccurate or false, unless the insurer show that such statement was on a material matter or suppressed facts which it was material to disclose and that it was fraudulently made by the policy holder and that the policy holder knew at the time of making it that the statement was false or that it suppressed facts which it was material to disclose: Provided that nothing in this section shall prevent the insurer from calling for proof of age at any time if he is entitled to do so, and no policy shall be deemed to be called in question merely because the benefits payable under the policy are adjusted on subsequent proof that the age of the life insured was incorrectly stated in the proposal.	45. Policy not to be called in question on ground of misstatement after two years. No policy of life insurance …shall, after the expiry of two years from the date no which it was effected, be called in question by an insurer on the ground that a statement made in the proposal for insurance or in any report of a medical officer, or referee, or friend of the insured, or in any other document leading to the issue of the policy, was inaccurate or false, unless the insurer shows that such statement was on a material matter or suppressed facts which it was material to disclose and that it was fraudulently made by the policy holder and that the policy-holder knew at the time of making it that the statement was false or that it suppressed facts which it was material to disclose: Provided that nothing in this section shall prevent the insurer from calling for proof of age at any time if he is entitled to do so, and no policy shall be deemed to be called in question merely because the terms of the policy are adjusted on subsequent proof that the age of the life insured was incorrectly stated in the proposal.

It will be seen that the two provisions are virtually identical. After two years, a life insurance policy cannot be avoided on the round of any falsity or inaccuracy in, or of , any statement made of the sort indicated in the provisions, unless the insurer is able to show that (a) the statement was on a material matter or suppressed facts that it was material to disclose; (b) it was made fraudulently by the insured; and (c) the insured knew at the time of making the statement that it was false or suppressed facts that it was material to disclose. The conditions are cumulative, i.e., the failure by the insurer to establish any one of them is fatal for the defence (and the onus lies on the latter). Section 80 was recently applied by this Court in State Life Insurance Corporation of Pakistan and another v.Shazia Mir Arshad 2019 CLD 1263 (leave refusing order of a learned two-member Bench). The insurer there sought to avoid a policy on essentially the same ground as here: that the insured had made a material misstatement regarding his health at the time the policy was taken out. Relying, inter alia, on section 80 it was held that the insurer was unable to do so. Reliance was place on a decision of the Supreme Court of India, where that Court had considered section 45 of the 1938 Act (which continues to remain in force there). Leave to appeal was reused. Here we must also notice an earlier leave refusing order of this Court (by a learned tow-member Bench), Muhammad Faisal and another v. State Life Insurance Corporation and others 2008 SCMR 456 ("Muhammad Faisal"). Interestingly, the matter originated as a summary chapter suit under Oder XXXVII, C.P.C. but eventually evolved into a suit under the 1938 Act. It was held in this Court that as section 45 had not been initially (and specifically) pleaded by the claimants it was not open for them to resist the insurer's avoidance of the policy on the ground of a materially false statement made by the insured (regarding his age at the time the policy was taken out). The plea under section 45 was, it appears, taken for the first time in this Court. In our view, this decision cannot, with respect, be taken to be authority for the proposition that the plea of section80must be taken by the claimants at the filing the claim (earlier, in a court of law and now before the Insurance Tribunal). Section 80 creates a legal bar which has to be overcome by the insurer, if it can do so in term thereof. The bar itself is automatic and, given that it is triggered merely by passage of the stipulated period, hardly requires any evidence to be led by the claimants. It is for the insurer to take the plea that it is not hit by the bar, and then establish its case by leading appropriate evidence that the three conditions stipulated therein exist. To this extent, what is said in para 4 of the decision in Muhammad Faisal cannot, with respect, be regarded as good law.

9. In the present case, the appellant did not take the plea that the bar contained in section 80 did not apply I the facts and circumstances of the case, Even otherwise, there is nothing on the record to show that the non-disclosure by the insured (i.e., his answer to question No.7) was fraudulent. On any view of the matter the statement made by him could not be taken by the appellant to defeat the policy and avoid the contract.

10. It is also pertinent to consider, briefly, section 81 of the Ordinance. It empowers, in subsection (1), the Insurance Tribunal to disregard, subject to the conditions of the section, any avoidance of the policy if it of the view that such avoidance would be "harsh and unfair", even if it is established that such avoidance was "on the ground of fraudulent failure to comply with the duty of disclosure or fraudulent misrepresentation". In the context of life insurance even if an insurer sere to overcome the bar created by section 80, section 81 may yet prevent it from avoiding the claim. It is interesting to note that subsection (3) provides, inter alia, that in "exercising the power conferred by subsection (1), the Tribunal …shall have regard to the need to deter fraudulent conduct in relation to insurance". It is to be expected that the Tribunal will take a robust view of its powers under section 81 and take recourse to it in a manner that achieves its objective and purpose. However, nothing definitive or binding can be said here regarding this provision as it was not involved in the present matter. What is said in this para is only by way of a signpost for the future.

11. It is left only to consider the decision relied upon by learned counsel, Jubilee Insurance Co. Ltd. v. Ravi Steel Company PLD 2020 SC 324. That was a leave refusing order of a learned two member Bench. The matter was not of life insurance, and involved facts and circumstances far removed from those at hand. In fact, as noted in the decision, there had been an earlier round of litigation up to this Court, which had ended adversely to the insurer. The matter decided by the cited decision arose out of an application under section 12(2), C.P.C.. This decision does not, with respect, have any relevance for the present appeal.

12. In view of the foregoing analysis and discussion, we conclude that there is no merit to the present appeal, which fails and is hereby dismissed.

MWA/S-31/SC

Appeal dismissed.

2019 C L D 526

[Lahore]

Before Abid Aziz Sheikh and Shahid Karim, JJ

Messrs ADAMJEE INSURANCE COMPANY LTD. Through Authorized Representative---Appellant

Versus

ZIA ULLAH and another---Respondents

E.F.A. No. 178155 of 2018, decided on 25th February, 2019

Insurance Ordinance (XXXIX of 2000)—

---Ss. 118(2) & 2(viii) --- Payment of liquidated damages---Calculation of Liquidated damages "at monthly rests at the rate five per cent higher than the prevailing base rate" per S. 118 of the Insurance Ordinance, 2000---Interpretation---Compounding of interest---"Monthly rests", application of---Scope---Compounding of interest was not part of law of Pakistan and law did not countenance compounding of interest as the same resulted in multiplication of liability---Construction that should be put on S. 118(2) of the Insurance Ordinance, 2000 was to calculate liquidated damages separately by adding monthly rests and each calculation of monthly rests was to be added to the nest calculation on liquidated damages and would not be added so as to compound the effect of the interest---Base rate for calculation of liquidated must therefore be calculated for each monthly rest separately and applied accordingly---Insurance Tribunal must not determine liquidated damages by giving definition of "monthly rests" as a compounding effect.

Messrs State Life Insurance Corporation of Pakistan v. Mst. Anwar Gulzar 2012 CLD 1014 rel.

Imtiaz Rashid Siddiqui and Umer Kasuri for Appellant.

Muhammad Mustafa Khalid and liaqat Ali Butt for Respondent No. 1

ORDER

This is an appeal under section 124 of the Insurance Ordinance, 2000 ("Ordinance, 2000") and challenges the order dated 6.2.2018 passed by the Insurance Tribunal, Lahore. The part of the order which has been called in question and which determines whether a compounding of interest is permissible or not in terms of section 118(2) of the Ordinance, 2000, is as follows:

"…Whereas "rests" means a balancing of an account made for the purpose of adding interest to principal for further computation and so far the compounding of interest "as" interest on six percent with half yearly rests. This definition is mentioned in the law Lexicon Encyclopedic Law Dictionary. Rests also means the periods when payments are due when In case on nonpayment, the interest accrued is added to the principal and interest is claimed both for the principal and for the interest added. This is defined in law terms and phrases judicially interpreted with legal maxims and a foreign legal words and phrases in ordinary usage."

2. Thus, the entire reliance of the Insurance Tribunal was on the definition of the term 'monthly rests' at a rate specified in subsection (2) of section 118 of the Ordinance, 2000. It may be stated that the parties are not at variance with regards to whether liquidated damages are to be paid or not and it is agreed on all hands that indeed liquidated damages is part of the final order made by the Insurance Tribunal and is payable as such. There is also no dispute regarding the definition of the term prevailing base rate' which too has been defined in section 2(viii) of the Ordinance, 2000 and means that:

"Base Rate" means the effective annual rate implied by the most recent repurchase rate that is published from time to time in circular by the Securities Department of the State Bank of Pakistan for 6 months Pakistan Treasury Bills, or, if such rate is not available, the most recent repurchase rate for 6 months Short Terms Federal Bonds, Or, if neither of such rate is available, the most recent repurchase rate for any other short term papers issued by Federal Government of an approximately similar tenure, whether in addition to or in substitution for any of the foregoing."

3. Thus, "base rate" means the effective annual rate applied by the most recent repurchase rate that is published form time to time in circular issued by the Securities Department of the State Bank of Pakistan for 6 months Pakistan Treasure Bills. The parties are on common ground that such a 'base rat' is indeed issued by the SBP and which ought to be applied in terms of subsection (2) of section 118 of the Ordinance, 2000, however, the diversions between the parties has occurred on account of the compounding which has been done by the impugned order and by which the liability in terms of the judgment and

decree of the Insurance Tribunal has increased manifold. This necessarily depends upon a construction to be put on the term 'monthly rests' at the rate of 5% higher than the provisional base rate. Whether the rate has to be calculated at monthly rests and is to be accumulated against the liability of the appellant or whether the liquidated damages ought to be calculated at monthly rests which will then be added to the next calculation and thereafter the liquidated damages to be calculated for the next monthly rests is a question which is engaged in this appeal.

4. Firstly, we may observe that the Insurance Tribunal has relied upon the definition of the term "rests" on the basis of dictionary meanings. Those definitions are inapplicable in the peculiar facts and circumstances of the case as well as the dispensation currently applicable in the legal paradigm where it is established by now that compounding of interest is an abhorrent and is not part of the law in Pakistan. It has been deprecated by the superior courts which do not count4enance the compounding of interest and which results in multiplying the liability on that basis against a person. The impugned order passed by the Insurance Tribunal does exactly that. The Provisions of subsection (2) of section 118 of the Ordinance, 2000 do not convey a meaning which has been attributed to that provision in the impugned order. Clearly, the construction that should be legitimately put on subsection (2) of section 118 is to calculate the liquidated damages at monthly rests separately and a mere reading of the provision would clearly give the impression that each calculation at monthly rests is to said calculation so as to compound the effect. This question arose before a Division Bench of this Court in Messrs State Life Insurance Corporation of Pakistan v. Mst. Anwar Gulzar (2012 CLD 1014) and the following observations which are pertinent in the context of the provenance and are reproduced as under:

"6. There is no judgment by a superior court on the point in issue namely, the meaning of the expression "prevailing base rate" used in section 118 ibid. It is therefore one of first impression to which we have given out due consideration. It is clear that LDS are to be calculated at monthly rests for the period that an insurer has failed to make payment due under a policy. Therefore, the entitlement of the decree holder is to be determined with reference to each month that payment is delayed. Some guidance in the matter may be obtained from the definition of the expression "base rate" given in section 2(8) of the Insurance Ordinance, 2000; this is reproduced below:-

"Base rate" means the effective annual rate implied by the most recent repurchase rate that is published from time to time in a circular issued by the Securities Department of State Bank of Pakistan for six months Pakistan Treasure Bills, or, if such rate is not available, the most' recent repurchased rate for six months Short Terms Federal Bonds, or, if neither of such rates is available, the most recent repurchase rate for any other short term paper issued by the Federal Government of an approximately similar tenor, whether in addition to or in substitution for any of the foregoing."

7. The SBP announces its base rate periodically sometimes on a six monthly basis and at other times on quarterly or monthly basis. Accordingly, for each monthly rest, the most recent base rate announced by the SBP is easily ascertainable. Accordingly, the expression "Prevailing base rate" used in section 118(2) of ibid refers to the six monthly SBP repurchase rate that is announced most recently before the monthly rest under consideration for calculating the LDS accruing during such period.

As a result, we hold that the expression "prevailing base rate" is dynamic in meaning as it varies from time to time depending on the six monthly repurchase rate announced by the SBP that is most recent in relation to the relevant monthly rest that is under consideration. To peg the base rate to a particular event as contended by learned counsel for the respondent/decree holder would burden one party, the insurer or the claimant, with the chance effect of a high or a low base rate as the case may be, without apportioning the benefit and/or burden of the impact of a dynamic rate.

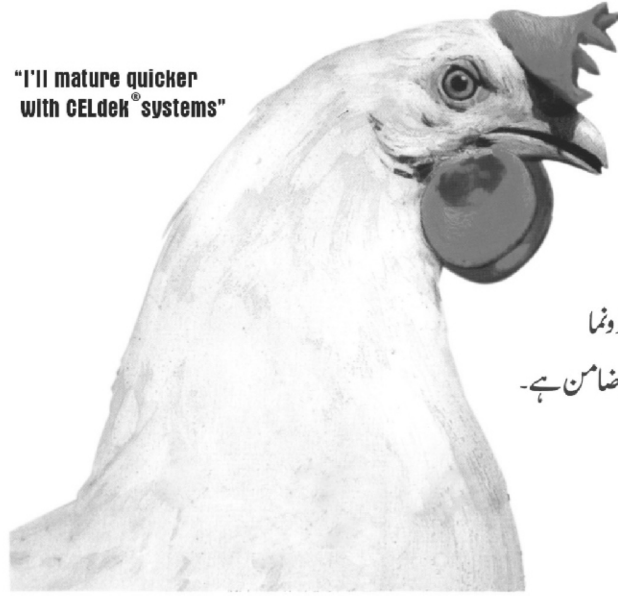
8. The question in issue is answered as stated above. It also follows from the reasoning given above that the resort to a weighted base rate in order to simplify the calculations is not justified. Consequently, a base rate must be calculated for each monthly rest separately and applied accordingly in the calculations in order to determine the accumulated LDS."

5. Thus, it was held by the Division Bench of this Court that the base rate must be calculated for each monthly rest separately and applied accordingly. The method of calculation by compounding liquidated damages to the next monthly rest was discountenanced. The learned counsel for the respondents argued that the judgment had been set aside by the Supreme Court of Pakistan. However, we have not been referred to any such judgment passed by the Supreme Court of Pakistan which has overridden the holding of the Division Bench of this Court. Therefore, the Insurance Tribunal went wrong in determining the liquidated damages by giving the definition a compounding effect. No such effect can be read in the provisions of subsection (2) of section 118 of the Ordinance, 2000.

6. In view of the above, this appeal is allowed. The impugned order dated 6.2.2018 passed by the Insurance Tribunal is set aside. Consequently, the Insurance Tribunal shall calculated the monthly rests separately and thereby calculated the amount on that basis.

KMZ/A-23/L

Appeal allowed



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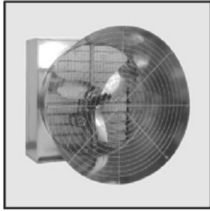
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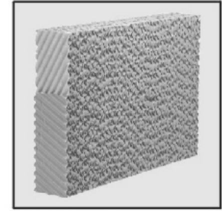
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EFU Life and The Legend Hotels and Resorts partner for EFU Life PRIMUS Loyalty Program

EFU Life Assurance Ltd, the leading insurance provider in the country has partnered with The Legend Hotels & Resorts for its PRIMUS Loyalty Program. The partnership will enable EFU Life high networth clients 'PRIMUS' to avail exclusive discounts and offers at The Legend Hotels & Resorts.

The agreement was signed by Mr. Zain Ibrahim, Executive Director & Chief Operations Officer, EFU Life and Mr. Muhammad Azeem Qureashi, Managing Director, The Legend Hotels & Resorts. They were joined by Ms. Aman Hussain, Head of Marketing, EFU Life and Mr. Faizan Shuja, Head of Alliances, EFU Life. The signing ceremony was held at EFU Life Head Office, Karachi.

Speaking on the occasion, Mr.Zain Ibrahim said “As a Company, we are driven to not only ensure our clients financial wellbeing but want their journey with us to be seamless by providing them unmatched service quality, convenience and adding more value through these partnerships.'

EFU Life PRIMUS Loyalty Program gives an unparalleled advantage to clients by offering exclusive discounts at over a hundred leading brands in the country, categories including Food, Lifestyle, Wellness, Leisure, and Insurance. These offers are a few taps away on EFU Life PlanIT mobile app, available on both Android and IOS platform.

The Legend Hotels and Resorts has hotels in Islamabad, Hunza, Skardu, and Chitral under its umbrella.

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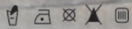

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