



## Insurance Litigation

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### Insurance Contracts

In the realm of insurance, the **insurance policy** is a contract (generally a standard form contract) between the insurer and the insured, known as the policyholder, which determines the claims which the insurer is legally required to pay. In exchange for payment, known as the premium, the insurer pays for damages to the insured which are caused by covered perils under the policy language. Insurance contracts are designed to meet specific needs and thus have many features absent in many other types of contracts. Since insurance policies are standard forms, they feature boilerplate language which is similar across a wide variety of different types of insurance policies.

It is pertinent to note that Insurance contracts fall within the realm of private law where two consenting parties namely, the insured and the insurer enter into a written contract specifying and agreeing on the terms and conditions set out in such contract (i.e. the policy of insurance) by which the parties are strictly bound. Thus it is unequivocal that insurance contracts are not subject to public law concepts such as unreasonableness and proportionality. This distinction is a vital consideration in determining insurance disputes inasmuch as an insurance contract cannot be reopened by court other than in accordance with the applicable common law subject to variation by statutory provisions. Common law applicable to insurance contracts in Sri Lanka in terms of the

Introduction of English Law Ordinance is that life and fire insurance shall be same as would be administered in England. Therefore rest of the laws relating to insurance shall be governed by Roman Dutch Law. The terms and conditions of insurance contracts are standard terms used internationally by all insurance companies due to the concept of Re-Insurance and those clauses are insisted by the Re Insurers who take over major portion of the risk. Sometimes over 90% of the risk is re insured with a local or foreign re insurance company which in turn re insures their risk with other re insurance companies. If the risk sought to be covered is very large there are instances where the entirety of the risk is passed on to a Re Insurance company and the local insurance company gets only a commission. There are regulations / directions that govern the percentage of re insurance. However the primary insurance contract is distinct and separate from the reinsurance contract. The concept of re insurance is dealt with under a separate heading in this paper.

The insurance policy is generally an integrated contract, meaning that it includes all forms associated with the agreement between the insured and insurer. In some cases, however, supplementary writings, such as letters sent after the final agreement, can make the insurance policy a non-integrated contract. Every contractual term in the policy at the time of delivery, as well as those written afterwards with the consent of both parties as policy riders and endorsements form part of the written policy. The policy must also refer to all papers which are part of the policy. Oral agreements are subject to the parol evidence rule, and may not be considered part of the policy. Advertising materials and circulars are typically not part of a policy.

### **General Features of an Insurance Contract**

The insurance contract or agreement is a contract whereby the insurer will pay the insured, if certain defined events or perils occur. Subject to the "fortuity principle", the event must be uncertain. The uncertainty can be either as to when the event will happen (i.e. in a life

insurance policy, the time of the insured's death is uncertain) or as to if it will happen at all (i.e. in a fire insurance policy, whether or not a fire will occur at all).

- Insurance contracts are generally considered contracts of **adhesion** because the insurer draws up the contract and the insured has little or no ability to make material changes to it. This is interpreted to mean that the insurer bears the burden if there is any ambiguity in any terms of the contract. Insurance policies are sold, sometimes, without the policyholder even seeing a copy of the contract.

- Insurance contracts are **aleatory** in that the amounts exchanged by the insured and insurer are unequal and depend upon uncertain future events. In contrast, ordinary non-insurance contracts are commutative in that the amounts (or values) exchanged are usually intended by the parties to be roughly equal.

- Insurance contracts are **unilateral**, meaning that only the insurer makes legally enforceable promises in the contract. The insured is not required to pay the premiums, but the insurer is required to pay the benefits under the contract if the insured has paid the premiums and met certain other basic provisions.

- Insurance contracts are governed by the principle of **utmost good faith** (*uberrima fides*) which requires both parties of the insurance contract to deal in good faith and in particular it imparts on the insured a duty to disclose all material facts which relate to the risk to be covered. This contrasts with the legal doctrine that covers most other types of contracts, namely *caveat emptor* (let the buyer beware). In the United States and United Kingdom, the insured can sue an insurer in tort for acting in bad faith. The term "bad faith" is generally equivalent to "unreasonable" in court, and the court decides whether the insurer's behaviour is,



in fact, unreasonable. In most instances, insurance companies are not permitted to put their interests above those of the insured, so to prove bad faith in court, the policyholder only has to show that the insurance company reneged on the contract and had absolutely no reason for failing to pay on the claim.

(Source: Porter K. (2007), *The Legal Environment of Insurance*, §5.17. AICPCU)

### **Parts of an Insurance Contract**

- **Declarations** - identifies who is an insured, the insured's address, the insuring company, what risks or property are covered, the policy limits (amount of insurance), any applicable deductibles, the policy period and premium amount. These are usually provided on a form that is filled out by the insurer based on the insured's application and attached on top of or inserted within the first few pages of the standard policy form.
- **Definitions** - define important terms used in the policy language.
- **Insuring agreement** - describes the covered perils, or risks assumed, or nature of coverage, or makes some reference to the contractual agreement between insurer and insured. It summarises the major promises of the insurance company, as well as stating what is covered.
- **Exclusions** - take coverage away from the Insuring Agreement by describing property, perils, hazards or losses arising from specific causes which are not covered by the policy.
- **Conditions** - provisions, rules of conduct, duties and obligations required for coverage. If policy conditions are not met, the insurer can deny the claim.
- **Endorsements** - additional forms attached to the policy form that modify it in some way, either unconditionally or upon the existence of some condition.

Endorsements can make policies difficult to read for non-lawyers; they may modify or delete clauses located several pages earlier in the standard insuring agreement, or even modify each other. Because it is very risky to allow non lawyer underwriters to directly rewrite core policy language with word processors. Insurers usually direct underwriters to modify standard forms by attaching endorsements preapproved by counsel for various common modifications.

- **Policy Riders** - A policy rider is used to convey the terms of a policy amendment and the amendment thereby becomes part of the policy. Riders are dated and numbered so that both insurer and policyholder can determine provisions and the benefit level. For instance, common riders to group medical plans might include name changes, change to eligible classes of employees, change in level of benefits, or the addition of a managed care arrangement such as a Health Maintenance Organisation or Preferred Provider Organization (PPO).

### **The concept of 'no fault insurance'**

In Sri Lanka the concept of 'no fault insurance' is not applicable. In its broadest sense, "**no-fault insurance**" is a term used to describe any type of insurance contract under which an insured is indemnified for a loss by their own insurance company, regardless of fault in the incident generating loss. In this sense, it is no different from first-party coverage. However, the term no-fault is most commonly used in the context of automobile insurance laws in the United States, Canada, and Australia, in which a policyholder (and his/her passengers) is not only reimbursed by the policyholder's own insurance company without proof of fault, but is also restricted in the right to seek recovery through the civil-justice system for losses caused by other parties.

### Advantages and Disadvantages of 'no fault insurance'

No-fault insurance has the goal of lowering premium costs by avoiding expensive litigation over the causes of accidents, while providing quick payments for injuries or loss of property. The victim's insurance company would only pay out the claim, while the driver-at-fault's insurance company would pay out a claim and charge that party a higher insurance premium as they are now higher risk. While this may disadvantage the victim's insurance company, as the at-fault driver's insurance company can recoup the claims quicker through raised premiums, accidents happen between drivers of both insurance companies with an equal chance of drivers from both sides being at fault, so this in theory should even out.

Critics of no-fault insurance argue that it does not punish reckless or negligent drivers sufficiently, with only raised premiums and a higher risk rating, and no legal settlements. Detractors of no-fault insurance also point out that legitimate victims with subtle handicaps find it difficult to seek recovery under a no-fault system. In response, proponents of no-fault insurance point out that automobile accidents are inevitable and that at-fault drivers therefore should not necessarily be punished; moreover, they note that the presence of liability insurance insulates reckless or negligent drivers from financial disincentives of litigation. Also supporting no-fault insurance, in regions with high numbers of uninsured motorists, at-fault parties are often "judgment proof" (i.e., unable to pay their liability damages) in any case. Another criticism is that some no-fault jurisdictions have among the highest automobile-insurance premiums, but this may be more a matter of effect than cause (i.e., the financial savings from no-fault may simply make it more popular in areas with higher automobile-accident risk).

### Overview

Most common law countries have a "traditional tort" liability system for auto

insurance in which recovery is governed by principles of provable negligence. However, twelve U.S. states and the Commonwealth territory of Puerto Rico require policyholders to operate under a "no-fault" scheme in which individuals injured in automobile accidents are limited in their ability to seek recovery from other drivers or vehicle owners involved in an accident. In the case of economic (medical and wage-loss) damages, most no-fault systems permit injured parties to seek recovery only for damages that are not covered by available first-party insurance benefits.

(Source: Insurance Information Institute)

### Warranties and Other Policy Terms

#### Classification of Terms

All insurance policies contain provisions inserted for the benefit of the insurer, which are intended to restrict liability under the policy in one manner or another, or to impose requirements upon the assured in order to assist the insurer in dealing with claims. These have been the subject of judicial interpretation for over 200 years. In particular, warranties which, when not fulfilled, discharge the insurer from liability, have been the subject of criticism by the courts.

#### Nature of Warranty

Any attempt at a comprehensive definition of the term "warranty" in insurance law is complicated by the sometimes indiscriminate use of the word to refer to clauses in policies which do not possess the traditional attributes of a warranty, and by changes in legal terminology over the years. It has a different meaning from a warranty in the general law of contract. An insurance law warranty is a term of the contract of insurance in the nature of a condition precedent to the liability of the insurer. Typically it is a promissory term whereby the assured promises either that a given state of affairs existed prior to the inception of the insurance or that it will continue to exist during the currency of the risk, and breach of the warranty discharges the



insurer's liability on the policy from the time of the breach.

Thus the liability of the insurer is made to depend upon the existence of the thing warranted by the assured. If, for instance, in a motor policy there is a warranty that the assured had never been convicted of a motoring offence, the insurer's liability will not attach if the warranted statement was untrue, and if there is a warranty in a buildings policy that a security alarm shall be maintained on the insured premises, the insurer's liability will cease if the alarm ceases to be operative.

The essential characteristics of a warranty are briefly these:

- (i) it must be a term of the contract;
- (ii) the matter warranted need not be material to the risk;
- (iii) it must be exactly complied with; and
- (iv) a breach discharges the insurer from liability on the contract notwithstanding that the loss has no connection with the breach or that the breach has been remedied before the time of loss.

A peculiarity of marine insurance, and insurance law generally, is the use of the terms **condition** and **warranty**. In English law, a condition typically describes a part of the contract that is fundamental to the performance of that contract, and, if breached, the non-breaching party is entitled not only to claim damages but to terminate the contract on the basis that it has been repudiated by the party in breach. By contrast, a warranty is not fundamental to the performance of the contract and breach of a warranty, while giving rise to a claim for damages, does not entitle the non-breaching party to terminate the contract. The meaning of these terms is reversed in insurance law. Indeed, a warranty if not strictly complied with will automatically discharge the insurer from further liability under the contract

of insurance. The assured has no defense to his breach, unless he can prove that the insurer, by his conduct has waived his right to invoke the breach.

(Source: MacGillivray on Insurance Law, Chapter 10, Eleventh Edition, Sweet & Maxwell)

### **Motor Vehicle Insurance**

The modern motor vehicle policy covers the assured against a variety of different risks. In addition to providing cover against third-party risks and, in many instances, the costs of litigation associated therewith, it provides cover against the risk of personal injury or death to the assured while travelling in the insured vehicle, the risks of loss of or damage to the vehicle itself, and, frequently, a variety of ancillary risks such as loss or damage to the contents of the car, destruction of or damage to the garage in which the car is kept, the cost of legal representation in the criminal courts and the cost of hiring a replacement vehicle while the insured vehicle is being repaired. Accordingly, a motor insurance policy can simultaneously be a liability cover, a personal accident insurance and property insurance. These characteristics have been responsible for the wide range of terms and conditions usually found in motor policies, and they also create a far-reaching catalogue of facts material to the several risks embraced by the policy which have to be considered at inception or renewal.

(Source: MacGillivray on Insurance Law, Chapter 29, Eleventh Edition, Sweet & Maxwell)

In Sri Lanka, amendments were introduced to the Motor Traffic Act no. 14 of 1951 by way of Motor Traffic Amendment Act No. 8 of 2009 whereby a mandatory requirement to notify the insurer of litigation was introduced in order to prevent frauds that were committed at the expense of insurance companies. Section 21 of the said amending Act reads thus;

*“S 21: Section 106 of the principal enactment is hereby repealed and the following section substituted therefor:-*

106(1) No sum shall be payable by an insurer under the provisions of section 105 in respect of any decree-

(a) Unless before or within seven days of the commencement of the action the plaintiff in the action in which such decree was entered has **given notice of such action to such insurer;** or

(b) So long as execution of such decree is stayed pending appeal

106(2) Every notice given under subsection (1) shall-

(a) Specify the name of the court in which such action is instituted

(b) Specify the number assigned to the action

(c) Specify the names of the parties to the action

(d) Specify the number of the insurance policy in respect of which the action is instituted

(e) Specify the nature of the action; and

(f) Require the insurer to answer the plaint before a date to be specified in such notice.

106(3) Every notice shall be accompanied by a copy of the plaint filed in the action.

106(4) An insurer to whom such notice is given shall be made a party to such action and shall be entitled to defend such action.” (Emphasis added)

### **Applications for Declarations of Non-Liability by the Insured under Section 109- Recent Developments**

In the recent Judgment of the Supreme Court of Sri Lanka in **Kushan Ediriweera v. Union Assurance Limited et al SC Appeal 65/2016 decided on 11<sup>th</sup> September 2020** a question arose

as to whether an insurance company is entitled to a declaration of non-liability under Section 109 of the Motor Traffic Act No. 14 of 1951 where the driver has driven the vehicle after consuming intoxicating liquor.

In the said case, admittedly, at the time of the accident the 1<sup>st</sup> Defendant driver was driving the vehicle after consuming intoxicating liquor. The 2<sup>nd</sup> Defendant was the registered owner of the said vehicle and it was further admitted that the 1<sup>st</sup> Defendant drove the said vehicle under express or implied permission of the 2<sup>nd</sup> Defendant.

It was also common ground that the vehicle in question was insured by the added 3<sup>rd</sup> Defendant Insurance Company in terms of insurance policy No. LMMVDP/00162. Further it was not in dispute that the said insurance policy had a term under **general exceptions** which stated that;

“*The Company is not liable under the policy in respect of: ..... 5) any accident or loss damage arising directly or indirect (Sic) whilst the insured driving such motor vehicle having consumed any intoxicating liquor or drugs or any person having consumed any intoxicating liquor or any drugs driving such motor vehicle*”.

It was the position of the Added Defendant Insurance Company that, since there was a term in the policy as stated above denuding the liability when the vehicle was driven by the insured or any person having consumed intoxicating liquor or drugs, the 1<sup>st</sup> Defendant driver fell within the category of ‘named person’ under Section 102(4) (c) (i) of the Motor Traffic Act and as such the added defendant was entitled to a declaration of non- liability in terms of Section 109 of the said Act. Thus, the added defendant moved to dismiss the action against him in limine.

Their Lordships of the Supreme Court considered the relevant statutory provisions as well as the intention of the legislature in enacting the subject provisions in the Motor Traffic Act more particularly Section 99(1) [Necessity to have a third-party insurance for a vehicle to be



driven on a public road], Section 102(4) and Section 109.

The first part of **Section 109** reads as follows; “No sum shall be payable by an insurer under Section 105 in respect of any decree if, in proceedings commenced before or within three months after the institution of the action in which the decree was entered, the insurer has obtained from a court of competent jurisdiction a declaration that a breach has been established of a condition specified in the policy, being one of the conditions enumerated in Section 102(4)”

It is important to note that **Subsection 102(4)** which allows certain conditions to be incorporated in the policy which states as follows;

“102(4). Nothing in subsection (1) shall apply in the case of any condition in a policy of insurance, being a condition which-

(a) excludes the use of the motor vehicle to which the policy relates-

(i) for business purposes, except by the insured, or by some other named individual, in person;

(ii) for business purposes, other than the business purposes of the insured;

(iii) for the carriage of goods or samples in connection with any trade or business;

(iv) for the carriage of persons or goods for fee or reward;

(v) for organized racing or speed testing;

(vi) on a contract of letting and hiring;

(b) provides that the motor vehicle shall not be driven by a person other than-

(i) the insured or any person driving with his express or implied permission;

(ii) the insured or any person employed by him;

(iii) any person or persons named in the policy;

(c) provides that the motor vehicle shall not be driven by-

(i) any person or persons named in the policy;

(ii) any person who is not the holder of a driving licence;

(iii) any person whose driving license has been cancelled or suspended or who is for the time being disqualified for obtaining a driving licence; or

(d) in the case of a motor cycle which has no side car attached thereto, provides that no person other than the driver shall be carried thereon;

(e) excludes liability for injury caused or contributed to by conditions of war, riot or civil commotion.”

It was the 3rd Defendant’s position that the 1<sup>st</sup> Defendant Driver can be considered as a named person in terms of subsection 102 (4) (c) (i).

In conclusion His Lordship Gamini Amarasekera J at page 28 of the Judgment held as follows;

*“As indicated above under our law liability arises with the proof of fault of the wrong doer. Hence, what was intended to remedy by the third-party insurance cover is the harm caused by the fault. Proof of Drunkenness or acts of negligence and recklessness are decisive in proof of fault of the wrong doer. If in the guise of naming drivers, it is allowed to claim non-liability on such wrongs, the object of bringing in mandatory insurance to cover third-party risks would fail, since it makes the wrong doers, whose fault was to be remedied by third -party cover, excluded drivers. Thus, such naming is contrary to the public interest, which the legislature intended to safeguard by providing mandatory third-party insurance. **Thus, I am not inclined to think that the legislature intended to allow naming of***

drivers under Section 102(4)(c)(i) in a manner to defeat the public interest as found in the said impugned item 5 of the policy; In other words, such naming allows to remove the fault which was to be remedied, from the remedy provided by introducing mandatory third-party cover making the remedy redundant." (Emphasis added.)

The Supreme Court also answered the 3<sup>rd</sup> and 4<sup>th</sup> questions of law raised by the Appellant in the affirmative which effectively means that;

i. The driver of the motor vehicle in question being a person driving with express permission of the policy holder and holding a valid driving license, was an authorized driver in terms of the insurance policy. Thus, the Added Defendant cannot now say that an authorized driver who has breached the general exceptions of the policy is an excluded driver.

ii. The law requires every person who uses a motor vehicle on the road to obtain insurance for third party claims. To widen the exceptions set out in Section 102 (4) in such a manner so as to include the 10 conditions of the policy, which are specifically excluded by Section 102(1) of the Act, would defeat the very purpose of requiring to obtain insurance for third party claims.

### Marine Insurance

Generally standard clauses apply in Marine Insurance policies. For example the Marine Insurance Act of the United Kingdom includes, as a schedule, a standard policy (known as the "SG form"), which the parties were at liberty to use if they wished. Because each term in the policy had been tested through at least two centuries of judicial precedent, such policy was extremely thorough.

However, it was expressed in rather archaic terms. Therefore, in 1991, the London market produced a new standard policy wording known as the MAR 91 form and using the Institute Clauses. The MAR form is simply a general statement of insurance; the Institute Clauses are used to set out the detail of the insurance cover. In

practice, the policy document usually consists of the MAR form used as a cover, with the Clauses stapled to the inside. Typically, each clause will be stamped, with the stamp overlapping both onto the inside cover and to other clauses; this practice is used to avoid the substitution or removal of clauses.

Because marine insurance is typically underwritten on a subscription basis, the MAR form begins: *We, the Underwriters, agree to bind ourselves each for his own part and not one for another.* In legal terms, liability under the policy is **several** and not **joint**, i.e., the underwriters are all liable together, but only for their share or proportion of the risk. If one underwriter should default, the remainder are not liable to pick his share of the claim.

Typically, marine insurance is split between the vessels and the cargo. Insurance of the vessels is generally known as "Hull and Machinery" (H&M). A more restricted form of cover is "Total Loss Only" (TLO), generally used as a reinsurance, which only covers the total loss of the vessel and not any partial loss.

Cover may be on either a "voyage" or "time" basis. The "voyage" basis covers transit between the ports set out in the policy; the "time" basis covers a period of time, typically one year, and is more common.

Specialist types of marine policies include;

- **Newbuilding risks:** This covers the risk of damage to the hull while it is under construction.
- **Yacht Insurance:** Insurance of pleasure craft is generally known as "yacht insurance" and includes liability coverage. Smaller vessels, such as yachts and fishing vessels, are typically underwritten on a "binding authority" or "lineslip" basis.
- **War risks:** Usual Hull insurance does not cover the risks of a vessel sailing into a war zone. A typical example is the



risk to a tanker sailing in the Persian Gulf during the Gulf War. War risks cover protects, at an additional premium, against the danger of loss in a war zone. The war risks areas are established by the London-based Joint War Committee, which has recently moved to include the Malacca Straits as a war risks area due to piracy. If an attack is classified as a "riot" then it would be covered by war risk insurers.

- **Increased Value (IV):** Increased Value cover protects the shipowner against any difference between the *insured* value of the vessel and the *market value* of the vessel.

- **Overdue insurance:** This is a form of insurance now largely obsolete due to advances in communications. It was an early form of reinsurance and was bought by an insurer when a ship was late at arriving at her destination port and there was a risk that she might have been lost (but, equally, might simply have been delayed). The overdue insurance of the Titanic was famously underwritten on the doorstep of Lloyd's.

- **Cargo insurance:** Cargo insurance is underwritten on the Institute Cargo Clauses, with coverage on an **A, B, or C** basis, **A** having the widest cover and **C** the most restricted. Valuable cargo is known as specie. Institute Clauses also exist for the insurance of specific types of cargo, such as frozen food, frozen meat, and particular commodities such as bulk oil, coal and jute.

(Source: Birds, J. Birds' Modern Insurance Law. Sweet & Maxwell, 2004.)

**Certain clauses commonly found in insurance contracts which are relevant to insurance litigation**

a) Arbitration Clause- Generally insurance contracts have a clause which

states that if any difference arises as to the amount of any (quantum) loss or damage such difference shall independently of all other questions be referred to the decision of an arbitrator/s. Therefore, if there is a dispute regarding the quantum it will be referred to arbitration.

b) However, if there is a total rejection of a claim by the insurer such matter will have to be decided by a Court of Law.

c) Time limit or Liability Clause- Such clause states that in no case whatsoever shall the insurer be liable for any loss or damage after the expiration of a specific period of time (eg: within 6 months or 12 months) from the happening of the loss or damage unless the claim is the subject of pending action or arbitration.

d) Forfeiture Clause- A clause which provides that if the claim be made and rejected and an action or suit is not commenced within a specific period of time (eg: within 3 months) after such rejection all benefits under the policy shall be forfeited.

The aforementioned time limit clauses are extremely important in the context of insurance litigation. This is due to the fact that a significant number of cases brought in by the insured fail for not complying with such express terms included in the policy.

The rationale to introduce and give effect to such limitation clauses is justified. For instance, insurance companies receive an innumerable amount of claims annually which amounts to a very significant aggregate claim amount. In terms of accounting principles the insurance companies are required to provide for such claims. Thus if the insurance companies are to provide for all such claims in their books of accounts indefinitely it would have a significant impact on the financial status of such company. Therefore the limitation clauses have a pivotal role in this regard. In these circumstances these

limitation clauses are applicable notwithstanding the general provisions of the Prescription Ordinance. Furthermore these clauses are standard terms used internationally and English courts have interpreted these terms and are referred to in text books as referred to below.

In this regard the following authorities are relevant which uphold the effect of time limit clauses;

**i. Colinvaux's Law of Insurance 8<sup>th</sup> Edition Pages 321 (Paragraph 9-32) and 322 (Paragraph 9-35):**

**At Page 321 (Para 9-32) under the heading "The statutory limitation period":**

*"By s.5 of the Limitations Act 1980, an action on a contract must be brought within 6 years from the date of the accrual of the action, although under s.8 the period is 12 years if the contract is by way of a deed. **The limitation period can be varied by contract.**" (emphasis added)*

**At Page 322 (Para 9-35) under the heading "Variation of the limitation period":**

*"Contract terms varying the limitation period - It is permissible in insurance, as in other forms of contract, for the parties to agree that there is to be a shorter or, for that matter, longer limitation period. A policy term in a liability policy which requires the assured to commence proceedings within 12 months from the insurers' denial of liability, failing which the claim is deemed to have been abandoned, is effective to defeat a claim by the assured even though there had been no claim against him by the third party at the time of the expiry of this period."*

**ii. "MacGillivray on Insurance Law" 11<sup>th</sup> Edition Page 545 Para 19-054**

under the heading "**Contractual time limit for bringing suit**", which reads, *inter alia*, as follows;

*"A policy sometimes contains a limitation clause either barring a claim after the expiry of a stated time from the loss or excluding liability for a loss unless the assured has begun proceedings within a stipulated time."*

**iii. The Law of Contract by C.G. Weeramantry, Volume II page 797**

*"It is not contrary to public policy for parties to enter into an agreement not to plead limitation. Such an agreement is valid and enforceable in English law if supported by consideration, whether it be made before or after the limitation period has expired. The same observation holds good for our law, except that such an agreement need not be supported by consideration."*

In the cases of **Ceylinco Insurance Company Ltd -Vs- Sugath Senarath Ratnayake CALA No.14/2004** and **Nazu Tex International (Pvt) Ltd -Vs- Ceylinco Insurance Co. Ltd SC(CHC) Appeal**, the Court of Appeal and the Supreme Court recognised that parties to a contract have the right to vary the limitation period by agreement and that such clauses are valid and binding.

**iv. Colinvaux's Law of Insurance 6<sup>th</sup> Edition Pages 164(Paragraph 9-07)**

*"Policies sometimes provide that if a claim has been made by the assured and rejected by the insurer, the claim is deemed to have been abandoned unless proceedings are commenced by the assured within a stated period ----- . Such clauses are enforceable even though compliance by the assured is impractical."*

**v. Halsbury's Law of England, 4<sup>th</sup> Edition Vol 25 at paragraph 482.**



*“As a general rule the stipulations is (sic) to be construed as a condition precedent to recovery, and no claim is maintainable unless the duty is performed in accordance with the terms of the stipulation. The fact that the failure was due to circumstances beyond the claimant’s control is immaterial.”*

### **The Concept of Reinsurance and the National Insurance Trust Fund Act**

#### Reinsurance

Reinsurance is insurance that is purchased by an insurance company (insurer) from another insurance company (reinsurer) as a means of risk management. The reinsurer and the insurer enter into a **reinsurance agreement** which details the conditions upon which the reinsurer would pay the insurer's losses (in terms of excess of loss or proportional to loss). The reinsurer is paid a **reinsurance premium** by the insurer, and the insurer issues insurance policies to its own policyholders. The main reason for insurers to buy reinsurance is to transfer risk from the insurer to the reinsurer, but reinsurance has various other functions as explained below.

Almost all insurance companies have a reinsurance program. The ultimate goal of that program is to reduce their exposure to loss by passing the exposure to loss to a reinsurer or a group of reinsurers. Therefore, they are 'transferring some of the risk to the reinsurer or a group of reinsurers'. In the USA, insurance, which is regulated at the State level, permits an insurer only to issue policies with a maximum limit of 10% of their surplus (net worth), unless those policies are reinsured.

The main functions of reinsurance include the following:

- Risk transfer

With reinsurance, the *insurer* can issue policies with higher limits than it would otherwise be allowed, therefore being permitted to take on more risk because some of that risk is

now transferred to the reinsurer. Reinsurance has gone from a relatively unsophisticated business to a highly sophisticated endeavour. The reason for this is the number of reinsurers that have suffered significant losses and become financially impaired. From 2000 onward, reinsurers have become much more reliant on actuarial models and tight review of the companies they are willing to reinsure. They review their financials closely, examine the experience of the proposed business to be reinsured, review the underwriters that will write that business, review their rates, and much more. Almost all reinsurers now visit the insurance company and review underwriting and claim files and more.

- Income smoothing

Reinsurance can help to make an insurance company’s results more predictable by absorbing larger losses and reducing the amount of capital needed to provide coverage. The risk factor is diversified with the reinsurer bearing some of the loss incurred.

- Surplus relief

An insurance company's writings are limited by its balance sheet (this test is known as the solvency margin). When that limit is reached, an *insurer* can do one of the following: stop writing new business, increase its capital, or buy "surplus relief".

- Arbitrage

The insurance company may be motivated by arbitrage in purchasing reinsurance coverage at a lower rate than they charge the insured for the underlying risk, which can be in the area of risk associated with any form of the asset that is being issued or loaned against. It can be a car, a mortgage, an insurance (personal, fire, business, etc.) and the like.

In general, the *reinsurer* may be able to cover the risk at a lower premium than the *insurer* because:

- The *reinsurer* may have some intrinsic cost advantage due to economies of scale or some other efficiency.
- Reinsurers may operate under weaker regulation than their clients. This enables them to use less capital to cover any risk, and to make less prudent assumptions when valuing the risk.
- Even if the regulatory standards are the same, the *reinsurer* may be able to hold smaller actuarial reserves than the cedant if it thinks the premiums charged by the cedant are excessively prudent.
- The *reinsurer* may have a more diverse portfolio of assets and especially liabilities than the cedant. This may create opportunities for hedging that the cedant could not exploit alone. Depending on the regulations imposed on the reinsurer, this may mean they can hold fewer assets to cover the risk.
- The *reinsurer* may have a greater risk appetite than the insurer.

### **The Effect of the National Insurance Trust Fund Act No.28 of 2006**

The National Insurance Trust Fund (“NITF”) incorporated by Act no. 28 of 2006 and amended by Act No. 28 of 2007 comes under the purview of the Insurance Regulatory Commission of Sri Lanka incorporated by the Regulation of Insurance Industry Act. No. 43 of 2000, as amended. The NITF is at present the only reinsurer in the country and comes under the purview of the Ministry of Finance.

As per the mandatory requirements of the NITF Act, local insurance players must cede 20% of their reinsurance premiums to the NITF. A subsequent gazette passed under the same Act requires the Insurance Companies to reinsure 20% of their insurance value. However, the market practice has been to reinsure 20% of the Insurance Company’s reinsurance premiums

with the NITF which is in conformity with the provisions of the NITF Act.

Furthermore, it should be noted that the NITF is at liberty to decline reinsurance premiums if the reinsured amount exceeds its capacity. In addition, it operates the health insurance scheme for civil servants (known as *Agrahara*) and runs a general-insurance business. Government departments are required to obtain insurance coverage, only from either the NITF or Sri Lanka Insurance Cooperation, the other state-owned insurer.

The NITF, as a State owned reinsurance firm has recorded a profit of Rs. 3.5 billion during the year 2009 and has been given an “AAA” rating by RAM ratings.

As at end August 2010, 99.89% of NITF investments have gone into the government securities which the RAM Ratings Lanka says is less risky and has contributed a major portion to NITF’s profits.

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