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THE FINANCIAL ACADEMY

INSURANCE FOUNDATIONS

Learning curriculum issued by the Financial Academy.

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This learning curriculum includes 8 chapters and is the main reference to pass the Insurance Foundations Professional Exam.


بسم الله الرحمن الرحيم

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Welcome to the learning curriculum issued by the Financial Academy. This book is designed to qualify candidates for the Insurance Foundations Professional Exam hosted in Financial Academy.

This book is a learning guide and FA did its best to ensure the accuracy of the content.

A map of the curriculum is shown at the end of the book that includes a detailed study plan, which can also be found on the Academy›s website: www.fa.org.sa

Or by contacting the Academy through the phone number: +966114662688 Fax: +966114662368

Note that the exam is based on this plan, and we advise candidates of the Insurance Foundations Professional Exam to make sure to have the latest updates on this curriculum.

The questions in this book have been designed as a tool to assist the candidate in reviewing various fields of the curriculum and to promote deep learning.

Candidates should not consider these questions as "Mock Exam" questions, or view them as an indicator to questions' level that will come in the exam.

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Studying this book may take up to 70 hours

Chapter One

Risk and insurance

Introduction

The first module of the book presents the idea of insurance, its emergence and development with time in accordance with changing and evolving human needs, and the insurance mechanism to transfer the risk from the insured to the insurer. We will also discuss the reinsurance mechanism that complements the insurance process by distributing and transferring risks from the insurer to the reinsurer.

1.1 The insurance

Learning objective

Introduce trainee to the beginning of the insurance and its foundation

The idea of insurance is based on cooperation between members of a society to bear the loss that affects one of them and its distribution to all members. From this fact we can conclude that insurance in its simple form has been practiced involuntarily since the early stages of communities. However, history has left no written reference except in the law of Hammurabi during the Babylonian era, where some similar types of insurance were known such as theft and marine insurance. Also, in the laws of Rhodes in the era of the Roman Empire with regard to the Law of General Average. This law provides for the distribution of the loss caused by the dumping of part of the goods to reduce the load of the vessel to save it from sinking, and the loss is shared proportionally by all parties with financial interests in the voyage to include; cargo, damage to the ship, and wages.

There are also many examples in the history of pre-Islam regarding families, tribes and relatives in the Arabian Peninsula who were contributing their financial resources, voluntarily and free of charge, in a common fund as a means to help those in need. The Prophet, peace be upon him, recognized these practices in the form of institutions in the Islamic state in the Arabian Peninsula around 650 AD.

Examples of these ancient Islamic practices include:

- Mecca merchants have set up funds to help victims of natural disasters and the dangers of trade journeys.
- They imposed a guarantee on traders called "Daman Khatar Attariq" (road risk insurance) against travel losses resulting from the dangers of trade routes.
- They provided assistance to prisoners and families of victims of murder through the so-called "Aqila" (Guarantor)
- There have been contracts called "Oukoud Moualat" (contracts of loyalty) to strengthen mutual understanding and to end mutual hostility and revenge.
- There was a union through the so-called "Hilf" (alliance), which is an agreement on mutual aid between people.

After this period, cooperative insurance emerged, and the most important one is fire insurance in Europe by the Workers Unions. Money was collected from members of the same trade in addition to charitable contributions, to fund losses caused by fire to those members. Based on this idea the following definition applies:

The insurance is a collaboration between a group of people where they incur the damage that affects one of them or a small number of them.

After the cooperative insurance stage, the middle-men operations appeared. Insurance and reinsurance companies were established. Insurance form of business has developed to the current form of public joint stock companies that utilize contracts based on statistics and various insurance laws and principles. From this approach other insurance definitions came to light: insurance is a cooperation between a group of persons (natural or moral) who fear a particular risk (to their own money, to themselves, or to their responsibilities). The formula of such cooperation is that the group contributes to the burden of damage to one or few members, each by the expected amount of exposure and Losses.

We comprehend from this definition the following:

A. The idea of insurance is based on distributing the damage to the largest possible number of people in order to reduce its effect. This means that the insurance cannot prevent the risk from happening, but it reduces its monetary effect.

B. The implementation of the insurance mechanism is carried out by insurance companies (and complemented by reinsurance companies) that manage the process by collecting premiums from a group of insured persons after identifying the probability and the amount of expected Losses. When a loss occurs to an insured, the insurance company indemnifies the insured for his loss through the distribution of premiums collected, in accordance with the terms and conditions of the insurance contract.

C. The relationship between the insured and the insurance company has turned into a contract called "insurance contract" that provides for the obligations and rights of each of the parties to this contract that has to be fulfilled in accordance with the insurance policy and relevant laws. Therefore, Insurance companies collect a premium from the insured, and in return indemnifies the insured in case of a loss and in accordance to the insurance contract.

1.2 The Risk

Risk is the most important unit in the insurance industry (the unit in this context means the fundamental part or element that the industry revolves around) compared to any another industry. If we assume that the motor industry is engine-based, the insurance industry is risk-based, so we will focus on understanding the risk.

1.2.1 Risk concept

Learning objective

introduce trainee to the meaning of risk and when the term is used

Several academics have attempted to define risk, for example:

- Uncertainty of a loss occurring.
- The possibility of an outcome being different from the expected.
- The Implementing Regulations of the Cooperative Insurance Companies Control Law define the term RISK as "Situation involving the chance of loss or no loss, but no chance of gain"
- The possibilities of having a negative outcome of any incidents.

Reviewing the list of synonyms and definitions suggests that risk involves a lack of knowledge about future events ('uncertainty', 'doubt', 'possibility', 'unpredictability') and whether there will be a loss. Most people define risk as a kind of uncertainty about the result of an event. When we use the

word "risk" there is a chance of an incident occurring, and when it occurs, we expect something undesirable to happen. The word "risk" means uncertainty about the future and its negative outcome that may leave us in a position worse than we are at this moment of time. Let us look at different risk classifications:

- Incidents or situations.
- Possibility of undesirable occurrence.
- Inability to predict the future impact of the risk comparing to the current situation.
- Uncertainty of loss or no loss in case of an incident.
- Possibility of loss occurrence.

If we can relate these elements together, we will find out that they are similar to each other in the following points:

- The idea of doubt (moral feeling that creates fear of having a loss due to unintentional incident that may occur). (Shukri, 44).
- Implied signals of having different levels of risk.
- Results may occur due to one or multiple reasons. (Alajmi, 6-1)

1.2.2 Risk and insurance

Learning objective

introduce trainee to the meaning of risk and when this term is used

We use the expression "risk" in different metaphorical usage to refer to different meanings, so when the word "risk" is used in insurance, it may refer to one of the following:

- Incident or incidents that if they occur, they obligate the insurance company to compensate/ indemnify the insured persons for the loss: such as the risk of car accidents, or fire to a building.
- Property Insured, such as vehicles, houses, goods, and ships.
- To describe the nature of the insured item. For example, if it is said "poor risk" it means the probability of the risk occurrence is high.
- Level of probability. If there is a high probability of occurrence, it will be described as high risk.
- Damage or loss. When goods are insured against the risk of fire or theft. Fire and theft are two kinds of risks that may occur. (Shukri, 44)

The best definition of risk: the possible financial loss to income or fortune because of certain incidents that harm individuals and properties. The loss is financial not moral, it may or may not occur, but not certain or impossible to happen. This loss could happen to the person itself, to properties or to third parties.

Risks are with us every day – each time we travel in a car there is a risk of an accident but our individual attitude to risk varies. Some people are considered risk-seeking, they enjoy risks perhaps it gives them a sense of excitement while others may be risk neutral. Finally, those who actively avoid risk are risk-averse.

Which of the three groups are more likely to buy insurance

1.2.3 Risk types:

We have examined risks and people's attitude towards risk. We are going to look at different classifications of Risk. There is a number of risk types, these are:

A. Financial Risks

We already know that the risk is a situation, incident, or a feeling of anxiety, doubt, and fear of leaving someone in the future in a condition worse than his situation now. Risks or financial risks are situations that can be specified and measured financially, meaning that they are related to the outcome of the risk not to the risk itself.

If the risk results can be measured financially, it will be classified as a financial risk. For example, losses that occur to properties, such as fire, theft, or work interruption due to fire, can be identified and measured. The car damage due to a crash or a rollover accident are also risks that can be measured financially. Personal injuries caused by an incident or accident can be identified and financially measured by the courts.

Financial risks are insurable and accepted by insurance companies (Insurable Risk)."

B. Non-Financial Risks:

Non-financial risks cannot be measured financially. They are difficult to be identified and measured financially due to the psychological and moral effects that vary depending on persons and circumstances. For example, when someone decides to buy a new car, and feels later that he is uncomfortable while driving it, this can be considered as a risk or loss that cannot be measured financially.

Measurement of the outcome of non-financial risks is usually not in monetary terms but by personal characteristics such as disappointment, unhappiness, joy, pleasure, etc.

For example, visiting a restaurant for the first time may involve an element of risk as to whether the outcome will be disappointment or enjoyment. Buying a car, choosing where to travel during vacation, and selecting a job involves a degree of risk (unknown outcomes, although the outcome may have some financial implications), a precise measurement in strictly financial term is not possible.

If a person had only one photograph taken as a child with his father that died, then that photograph would have a great value to the child. However, that value has an emotional or sentimental value, a value that we cannot measure financially.

Non-financial risk is a kind of risk that the insurance company does not accept to insure. (Uninsurable Risk)

Which type of risk, financial or non-financial, is usually considered as insurable and why?

C. Pure Risks:

- Pure Risks result in a loss (undesirable outcome) or at best no gain or loss (same condition as before). Examples of pure risks: the fall of a person on the ground might cause a wound or fracture or do not cause any injury, or a vehicle collision, which either causes a loss or does not cause any damage. Therefore, pure risk leads to:
- A loss
- or break-even (No loss)

Each time we travel in a car there is a risk of an accident. If there is no accident the position is unaltered, a break-even situation. If there is an accident a loss is suffered as a result of damage to the vehicle, injuries etc., there is no possibility of gain (apart from arriving safely at a destination) but there is a possibility of a loss.

Other examples of pure risk include fire, theft, explosion, and storm damage.
Can you think of other examples of pure risk?

D. Speculative Risks:

These risks may result in loss or gain such as equity investment, gambling and betting, as these activities can bring financial gains or losses or nothing can happen. Hence, the risk of speculation has three consequences:

- Loss
- No loss
- Potential gain or profit

The distinction between them is important for insurance, which you should understand because the risk of speculation is not insurable or is not insured by insurance companies.

Which type of risk, pure or speculative is considered insurable and why?

E. General/Fundamental Risks:

The types of risk, whether financial or non-financial, pure or speculative, are concerned with the consequences of events. This division is more related to the causes and effects of risks.

From this simple division, General/Fundamental risks relate to risks affecting large groups of individuals, which are the main risks that occur outside the control of an individual or a group of individuals and whose effects extend beyond the individual to the whole or a large part of society. These risks do not include widespread natural disasters (such as earthquakes, hurricanes, floods, famine and the like but also include general economic disasters and social revolutions, such as unemployment and inflation) and similar risks that can be classified as general/fundamental.

Since general/fundamental risks are caused by circumstances beyond the control of individuals who are exposed to losses, and where such losses are not the result of someone's own fault, it is the responsibility of society, not individuals, to deal with these losses, so social insurance must provide coverage against general/fundamental risks.

However, some general/fundamental risks such as earthquakes are covered by private insurance.

F. Particular Risk:

Unlike general/fundamental risks, particular risks are, to a large extent, individual risks in their origins and effects, such as fire, theft, disability and other risks that affect an individual or a group of individuals rather than the society as a whole.

The impact of risk makes the distinction between general/fundamental and particular risks. For example, a severe economic recession that causes public unemployment in a region is a general/fundamental risk because it affects the economy of the whole country or all or most of its citizens. For us as individuals, many of us may face the possibility of unemployment for any reason, so the risk of being unemployed is a particular risk.

1.2.4 Insurable Risks:

So far, we have developed an understanding of the meaning of risk, that it broadly involves a lack of knowledge about future events and whether there will be a loss. By examining the categories of risk, you are now aware that not all risks are insurable.

For a risk to be insurable, the following characteristics should be present:

- **It should be financial:** Any loss should be financially measured.
- **It should be a pure risk.** Generally, only pure risks are insurable i.e. a loss or break-even situation.
- **It should be fortuitous.** Fortuitous essentially means accidental and in this context means that any event must be out of the control of the insured. It must be accidental to the insured.

An insurable interest should be present: The principle of insurable interest stipulates that "there must be a legally significant interest between the applicant and the object or person subject to insurance that benefits from its non-damage or non-harm and its continued existence, and is affected if the risk is realized and this object or person is damaged or harmed".

> Former disgruntled employee fired by his boss recently. He returned to set fire to his workplace intentionally. Can we consider this situation Fortuitous?

Important notice: General/Fundamental risks relate to those which affect large segments of the population, while Particular risks relate to those that affect individuals or small groups of the population.

It cannot be stated with certainty that all risks are insurable – some general/fundamental and particular risks are but some are not. General/fundamental risks that satisfy the above criteria are usually insurable. Earthquake, storms, hurricanes and other natural disasters are in most cases considered by the insurance industry to be insurable.

1.2.5 Uninsurable Risks:

It has been established that risk that is insurable should be; a pure risk, be capable of financial measurement, be fortuitous (to the insured). It follows therefore that risks that do not have these characteristics (i.e. primarily speculative, those not capable of financial measurement and are not fortuitous), are uninsurable.

We will now consider other factors that may make a risk uninsurable, but before discussing and understanding these issues, it is important to bear in mind that society and the business world are not static environments. Attitudes and circumstances change over time and what is uninsurable today may be insurable tomorrow.

For example, the **Law of Large Numbers** means that in order for the risk to be insurable, there must be a large number of similar risks; the absence of large numbers means that it is impossible to predict the losses and thus the impossibility of calculating premiums. This rule held good for many years but it lost support when there was a demand to insure the Olympic Games for the first time and also the space satellites in its early stages.

Obviously not a large number of satellites existed, but nevertheless were insured, perhaps because of the nature of risks associated with the insurance industry. This shows how trends and attitudes change over time.

In 1601 AD, the United Kingdom passed a parliamentary legislation establishing the rules of the Marine Insurance Administration.

The legislation included the following statement:

"The loss of any ship ... cannot be incurred by one man; loss is manageable when distributed to a

large number of individual, but outweighs the possibility if carried by an individual or a limited group of individuals."

The preceding statement expresses the main rationale underlying insurance; the content of the statement is that a single loss can cause financial destruction for a single individual, but it is not a problem if it is shared by hundreds of individuals, i.e. "losses to a limited number (a few) borne by all (a large number)". Insurance companies use the Law of Large Numbers to determine the correct degree of risk and consequently the level of insurance premium, which simply states that the greater the number of similar risks (per insurance pool) the more accurate the results are.

If a coin is tossed in the air, the probability of its landing heads or tails is equal, 50/50. Despite knowing this it would be difficult to accurately predict the percentage of heads or tails if the coin is tossed 10 times. It is quite possible that the coin would have landed 7 times head and only 3 times tail. But toss it 100,000 times and we can predict with greater certainty that the outcome will be very close to 50% heads and 50% tails say 55/45 or 56/44 etc. Toss it 1,000,000 times and the situation could be 51/49 or 52/48 etc. That is the bigger the sample, the greater the accuracy.

Applying this principle to insurance enables insurers to predict more accurately future probability of losses and the degree of risk presented by contributors to the pool. It also helps to explain why insurers are willing to exchange statistical information as the greater knowledge is of assistance to everyone.

When people purchase insurance, they are buying a promise that if certain events happen (accident, fire etc.) which causes a financial loss, they will receive compensation. If the event does not happen then no financial compensation is required. That promise gives peace of mind that arises from financial security. In exchange, for a small known amount (the premium), the insured avoids the possibility of incurring a much larger unknown amount that could cause financial ruin.

Public Interest is essentially anything that involves the interests of the public or society as a whole. Situations that may be legally valid, and at the same time may be ethically or morally wrong are against public policy, therefore are not in the public interest.

It is impossible to arrange insurance against paying fines, even though the loss is fortuitous, financial, and pure and there is an insurable interest in it. A fine is a punishment for breaking the law and such an arrangement would be against public policy and not therefore insurable. It could encourage people to break the law and the deterrent effect (a warning to others not to do the same) would be lost. Encouraging people to break the law of another friendly country could also be against public policy.

(There are two shipments of meat in a French port ready to be shipped, one shipment to Saudi Arabia (SA) and the other one to the United States (US). The US shipment is insured while the Saudi shipment could not get insurance since the kind of meat is not allowed to enter Saudi Arabia).

Try to think of existing situations that can be against the general interest in KSA

Certain kinds of general/fundamental risks are also uninsurable usually because their financial consequences are so huge that the insurance industry could not possibly pay for the damages such as in a case of war and nuclear disasters. An example of a nuclear disaster is the Chernobyl incident. Its consequences were felt by several countries, and many are still suffering today from the effects particularly to agriculture.

Another uninsurable situation, is when the likelihood of a loss occurrence is high, and the insurance premium becomes high and unaffordable.

We cannot be too inflexible concerning general/fundamental and particular risks arising from social, economic, or political causes that would not normally be insurable. However, a general risk that is uninsurable may be insurable as a particular risk.

Example: In an economic recession causing widespread unemployment that is beyond the scope of the insurance industry and therefore uninsurable. However, an individual may be able to purchase insurance in the event of him being unemployed. In this case, this would be a particular risk.

1.2.6 Insurance as a risk transfer mechanism:

We have studied the risk, now we can turn to the role of insurance dealing with risk. We must emphasize that insurance does not prevent or eliminate risks because cars still collide and buildings are exposed to fire with or without insurance. However, the role of insurance is transferring the risk from a party who is insured to another party, the insurer (insurance company).

The Implementing Regulations define insurance as "transferring the burden of risk from the insured to the insurer and compensating those who suffer from damage or loss by the insurer."

When individuals buy insurance, they buy a promise that if certain risks (such as accidents or fire) cause financial loss, they will receive compensation, but if the accident does not take place, this promise gives some peace of mind as a result of financial security. For a small amount of money (premium), the insured avoids the possibility of incurring an undisclosed amount of money that may lead to financial collapse

> Retention of risk can be stressful for many people because they need to assume the risk of a loss and to compensate themselves and others (in case of being liable for the loss) for the damages incurred, which can negatively affects their financial ability and limits or their financial abilities for innovation and investment.

The primary function of insurance is to transfer risk, from the insured to the insurer (insurance company). To facilitate the risk transfer two other functions must be there; the common pool and fair and equitable premiums.

Insurers join together parties who want to share similar risks and set up a common pool to fund these risks. Insurers do not operate a single pool as the factory owner would not want to contribute to losses caused by motor owners and vice versa. There is therefore not one pool but a series of pools, one for motor, one for houses etc.

Individual risks introduced into the pool are not identical, each has a different degree of risk according to their individual hazards and the size of each risk may be different. It is important that every contributor should make a fair and equitable contribution, according to the degree and size of their risk.

Insurance is the mechanism for collection of risks in the common pool.

Insurers pay the losses of the few and share it among the many by operating a pool system. Insurers receive contributions, in the form of premiums, from all those who wish to join. They place the money into a pool and from this pool they make payments to compensate those who have suffered a

loss. Therefore, the pool must be big enough to pay all the costs and expenses of operating the pool.

In order for the pool to operate successfully everybody who joins must pay a fair and reasonable contribution according to the risk he transfers into the pool. This will depend partly on the size of the risk (value of a building for example) and the degree of risk (i.e. the possibility of a loss occurring). A car driver with a poor accident record would need to pay more than one with a good accident record. A house owner having a house of superior construction will pay less than the one having slightly inferior construction.

In determining the correct degree of risk, and therefore the level of premium to be paid, insurers make use of the Law of Large Numbers. This simply states that the greater the number (in one pool) the more accurately results can be predicted.

Applying this principle to insurance enables insurers to predict more accurately the future probability of losses and the degree of risk presented by contributors to the pool. It also helps to explain why insurers are willing to exchange statistical information that will benefit everyone involved.

One of the important aspects that needs to be considered when estimating risk degree is the rate of loss frequency (risk occurrence) and its extent of severity (which means the amount of loss in case of its occurrence). Insurance companies consider the risk of high frequency and low severity or low frequency and high severity as insurable. Therefore, insurance companies accept risks that have high frequency but it has low loss, or those that have low frequency but it has high loss. For example, motor insurance that has high percentage of risk occurrence but its severity is limited somehow.

There were a community of 1000 families each have a home. They decided if any home was burned they will contribute in equal shares to pay the price.

Who are the few?

Who are the many?

The community of 1000 families decided to collect the money contribution on a weekly basis instead of collecting it after the incident occurrence (to ensure the availability of money in case of a loss occurrence)

The problem is that how much money they have to collect from each family (considering the amount and degree of risk)

The community plan has proved successful. They are however concerned because in a particular year five homes will be damaged and one of them will be severe.

One of the community member suggests that they should ask other close communities to join their scheme.

What would be the advantages of extending the plan?

Can you think of any disadvantages?

The community plan has proved very successful. In fact the plan became more successful when some factories asked to join.

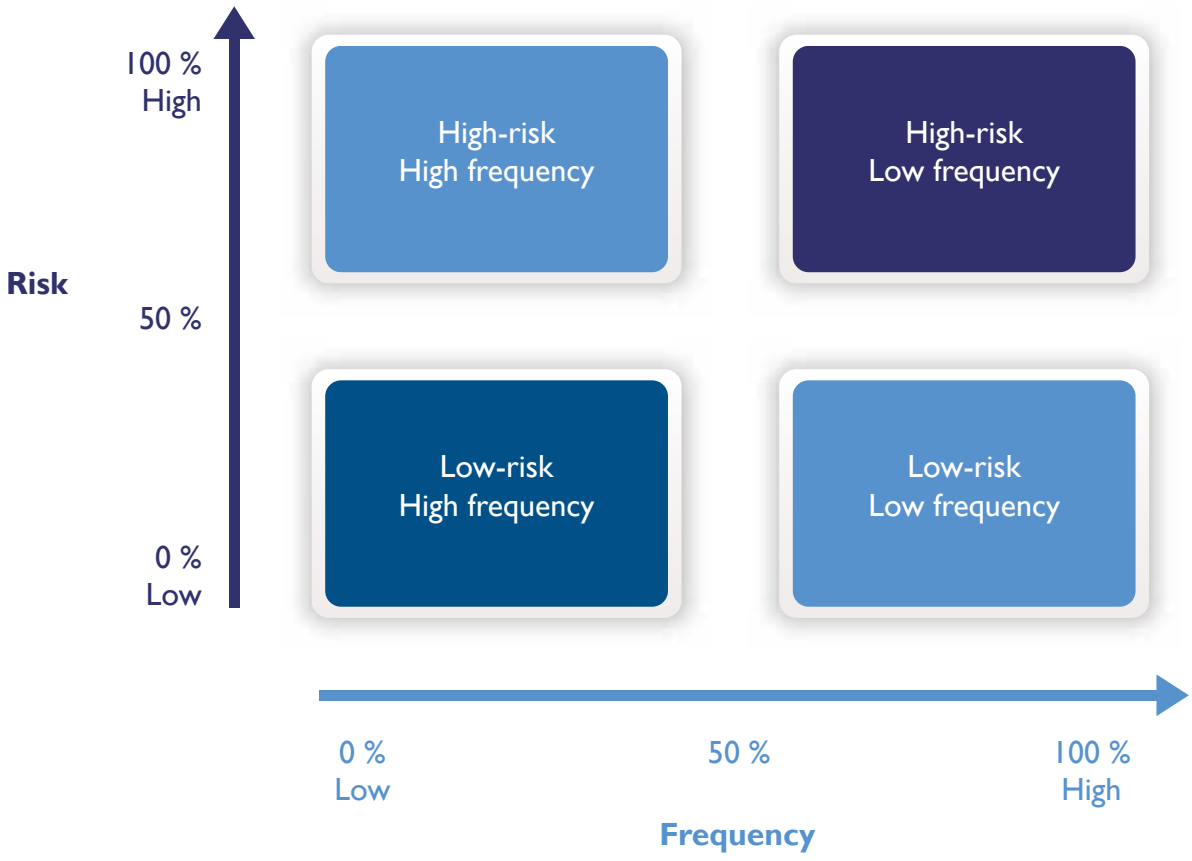
If they accept the factories to join, what is the factors that should be considered in estimating premium to be paid?

Write your answer here

1.2.7 Frequent and degree of risks

High frequency/low severity refers to incidents that occur often on an individual basis and are not financially severe. Most car accidents, thefts, or house fires would fall into this category.

Low frequency/high severity refers to incidents that do not occur very often but when they do, they may have serious financial consequences. Natural disasters such as earthquakes, hurricanes or tropical storms, a petrochemical fire etc. fall into this category.



How do you think an insurance company would deal with a risk that is high frequency and high severity?
How would you deal with a risk that is low frequency and low severity?

How would you categorize the previously mentioned community?

1.2.8 Main Perils and Hazard (contributing factor)

We have seen how an insurance pool operates and how insurers use the law of large numbers and the frequency/severity profile to help determining the degree of risk.

The study of the main perils and its hazards moves us one step further to analyze risks accurately:

A. Perils:

Perils are the phenomena and factors that cause loss or the main cause of loss. such as earthquake, hurricanes, fire, and petrochemical fire. Usually it is out of individual's control.

An example should make the distinction clear. Fire is a peril; it is something that can cause loss or damage. Construction of a building is a hazard that can influence the extent of damage if there is a loss. If we have two buildings, one constructed of brick and the other of wood. Clearly, the wooden building is the bigger risk for fire insurance. However, neither brick nor wood will, themselves cause damage but if a fire (the peril) starts then the wooden building will, all other things being equal, suffer greater damage.

The construction is a hazard; it will influence the outcome but will not cause a loss, while fire is a peril, which will cause a loss.

Insurers divided perils into three kinds: insured perils, excluded perils and unnamed perils.

- **Insured perils** are those specifically mentioned in the policy, and if they occur, the sum insured or the compensation will be given e.g. 'loss or damage caused by fire'. Fire is an insured peril.
- **Excluded perils** are also specifically mentioned in the policy that identify the situation where sum insured or compensation is not required e.g., 'loss or damage caused by fire excluding fire caused by explosion. So if an explosion causes a fire, the policy will not cover the loss as it is an excluded peril.
- **Unnamed perils** are perils not mentioned in the policy and usually they are not covered.

Think of perils under each policy and write under each of them the impact of the perils

- Insuring a company building against fire

- Insuring a storage of Television Company Limited against theft

- Insuring imported goods from china shipped by sea

B. Hazards:

Hazard is a condition that may create or increase the chance of loss arising from a given peril or under given condition.

Insurers divide hazards into three kinds – physical, moral and behavioral hazards.

- **Physical hazards** are relatively easy to understand. They arise from the physical aspects of a risk, such as construction of a building and its location and type of vehicle and the way of driving it. The triggers or the physical hazard contributing factors that cause the loss occurrence or increase its severity. For instance, bad electrical extension cord or driving a car over a street full of oil.

- **Moral hazards** arise from the immoral, unethical or illegal conduct of people. Usually the person insured and in the case of a business enterprise, it could be the employees or management.
  Moral hazard is always more difficult to detect because it is not physical or tangible and cannot be touched or seen. Examples of moral hazard include dishonesty by the insured, or people who do not consider deliberately inflating an insurance claim as dishonest.

  In liability situations, third party claimants often exaggerate their injuries and property damage and sympathetic physicians, lawyers, body shops and contractors may support these exaggerations and increase the cost of the claims

- **Morale hazard (behavioral)** is an increase in the hazards presented by a risk arising from the insured's indifference to loss because of the existence of insurance. In other words, Morale hazard arises from the insured's attitude and this differs from moral hazard, as there is no conscious or malicious intent to cause a loss.

  Poor morale hazard may eventually lead to physical loss or damage. A company's management and employees who are unorganized, untidy, or do not clean the factory floor, or do not follow correct safety procedures (obey no smoking signs (for example,) and/or leave machinery unguarded, are all signs of poor morale hazard that could eventually lead to an accident. Their attitude and behavior have increased the risk of a peril. Morale hazard acts to increase both the frequency and severity of losses when such losses are covered by insurance.

1.3 Reinsurance: Concept, Purpose, and Types

Learning objective

introduce trainee to the reinsurance, its types, how it works, and its benefits.

It is a technical process between insurance and reinsurance companies under which the insurance company transfers liabilities completely or partially to the reinsurance company for a premium (Fee). The insurance company will be in this situation as the insured and the reinsurance company becomes the insurer of the insurance company. It should be noted that the principal insurance company will remain responsible and liable the policyholders.

The Implementing Regulations of the Cooperative Insurance Companies Control Law in KSA define reinsurer as "an insurance or reinsurance company that accepts insurance contracts from another insurer".

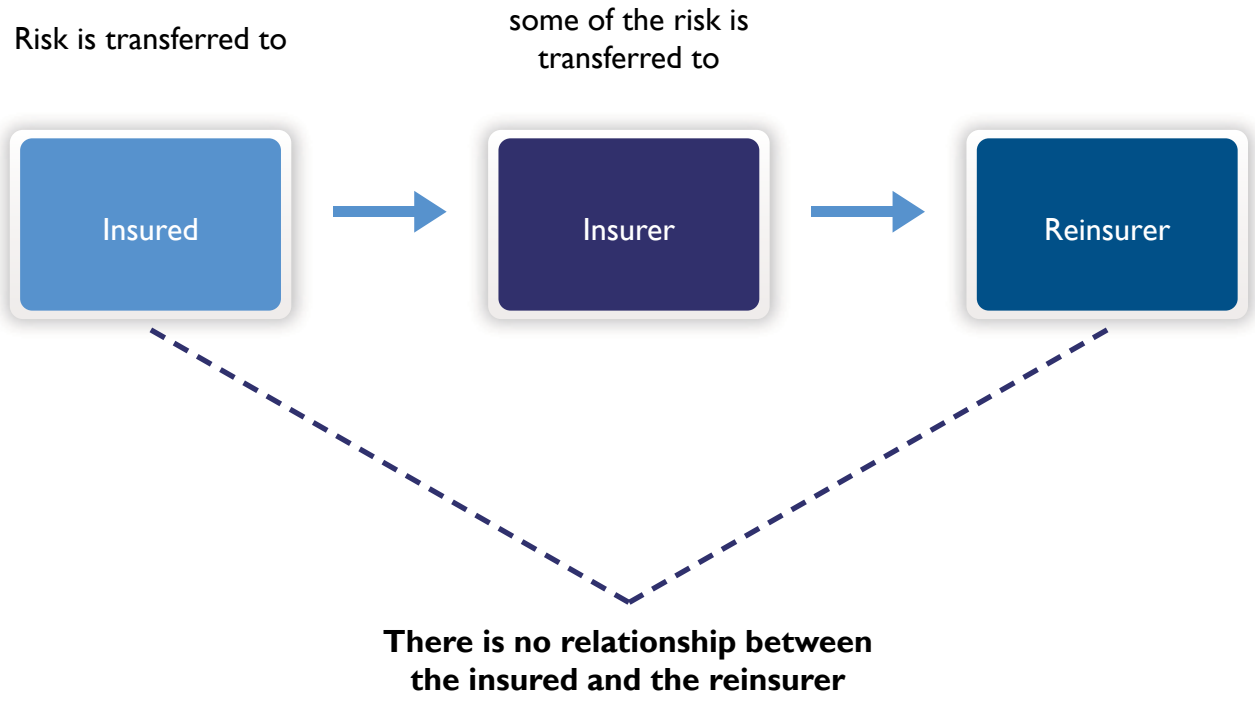
As for reinsurance, the Implementing Regulations define the term as "Transfer of the insured's risk from the insurer to the reinsurer and to indemnify the insurer by the reinsurer for any payments made to the insured against damages or loss".

A broker offers an insurer a risk from a client who already has several large policies, but it considers the risk too large or too hazardous to accept. What are the disadvantages to the insurer in refusing to accept the insurance?

.....

Instead of refusing the business, an insurer could decide to accept the risk and arrange to transfer some of the risk to another insurance company – a process known as reinsurance.

It is important to remember that there is no relationship between the insured and the reinsurer. There is a contract of insurance between the insured and the insurer and a similar arrangement between the insurer and the reinsurer but there is no legal or contractual relationship between the insured and the reinsurer. In fact, in most cases, the insured is not aware that there is any reinsurance.



As there is no relationship between the insured and the reinsurer, what do you think would be the financial consequences for the insured and the insurance company if the reinsurance company went into liquidation and was unable to pay any claims?

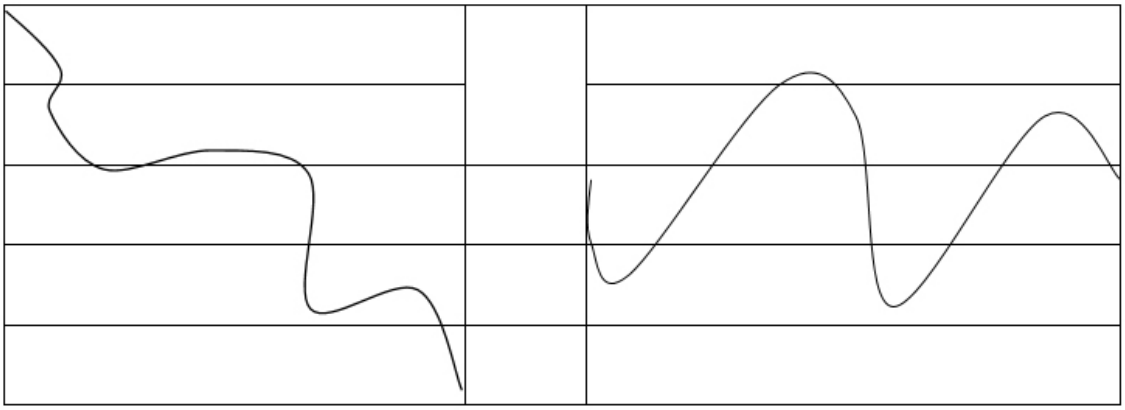
In addition to commercial considerations, there are also financial reasons for arranging reinsurance. Insurers are custodians of the common pool, which means that they are guardians of the funds that belong to their policyholders. Therefore, insurance companies have a duty to safeguard that pool of money and reinsurance is a way of protecting the interests of their policyholders and their pool of money.

Peace of mind:

In the same way that a policyholder secures peace of mind by buying insurance, insurers have the same objective. They would not want one single disastrous event or bad risk to jeopardize the common pool, which would cause financial problems to other policyholders. Reinsurance achieves this objective by providing protection, particularly against catastrophic losses.

Underwriting Stability:

A major expense for insurers is the cost of claims and an insurer would not like to have these costs fluctuating wildly from year to year. Reinsurance provides a method of ensuring that the underwriting results (premium minus claims equals underwriting result) and the loss ratio (claims ÷ premium) are stable each year.



Underwriting result

Consider the above figures of two insurance companies. In which insurance company would you prefer to be insured wit, and why do you think it is important that an insurance company does not allow its loss ratio and underwriting results to fluctuate wildly from year to year?

1.3.1 Types of Reinsurance contract from a technical point of view:

Reinsurance Contracts from a technical point of view (method of premium and risk distribution between the direct insurer and the reinsurer) are divided into two types: Proportional reinsurance and Non-Proportional reinsurance.

Proportional Reinsurance:

It means the insurer and reinsurer share the risk, premiums and claims, usually on a percentage basis. For example, the reinsurer may agree to accept, incur 25% of the risk, receive 25% of the original premium, and pay 25% of all claims.

The Implementing Regulations Cooperative Insurance companies Control Law in KSA define the proportional reinsurer as "the treaty of reinsurance is when the insurer commits to assign certain

risks in certain percentage that has already agreed upon by the reinsurer and the reinsurer commits to accept insuring the assigned risks".

Non-Proportional Reinsurance:

It means that the insurers and reinsurers do not share premiums and claims equally. Typically, it involves a deductible, usually quite substantial that the insurer must pay before the reinsurer will contribute to any claim. For example, a reinsurance policy issued with 10M SR excess only requires reinsurers to contribute when a loss exceeds this amount.

The Implementing Regulations of the Cooperative Insurance Companies Control Law in KSA define the non-proportional reinsurance as "the treaty of reinsurance when the insurer commits to assign certain risks in certain amount that exceeds the loss amount that the insurer will decided to be responsible for and the reinsurer commits to accept insuring the assigned risks".

Reinsurers agree to accept 15% of a risk. If the premium received by the insurance company is 150M SR how much reinsurance premium will reinsurers receive?

Reinsurers agree to reinsurer all losses that exceed 15M SR. The insurance company settles a claim for 25M SR. How much will they recover from reinsurers?

1.3.2 Forms of reinsurance from a legal point of view:

Reinsurance contracts from a legal point of view (the commitment of the direct insurer to cede or not to cede a part of the risk and the commitment of the reinsurer to take the risk or not to take it) are divided into two forms: Facultative reinsurance and Treaty reinsurance.

Facultative was the original method of arranging reinsurance but today the vast majority of reinsurance is treaty.

Facultative Reinsurance:

Facultative is a French word that means optional or by request, and insurers have to request facultative reinsurance when they need it. This means that the insurer has to contact the reinsurer, give details of the original risk, together with all material facts concerning the risk. If the reinsurer refuses or the terms are unacceptable, the insurer will need to find another reinsurer.

The Implementing Regulations of the Cooperative Insurance companies Control Law in KSA define Facultative reinsurance as ": reinsurance that occurs when the insurer previews the risk in a case-by case method for the reinsurer. The reinsurer has the option to accept or refuse the offered risks".

Although a specialist reinsurance broker can help, the process is time consuming, administratively expensive, and there is always uncertainty if the reinsurance will have acceptable terms.

It may be required however when:

- The treaty is full
- The risk is outside the treaty terms
- The risk is unusual

Why do you think the time delay and uncertainty cause problems for the insurance company?

Reinsurance Treaty:

A treaty is an agreement between insurers and reinsurers. Under the treaty, reinsurers are obliged to accept all the risks that are within the defined limits of the treaty. Treaties typically are signed for one year and then if both parties agree, it can be renewed. Therefore, Reinsurers agree in advance to accept reinsurance business given to them by the insurer. The major benefit to insurers is that they secure reinsurance protection and they know the cost of that protection immediately after they accept a risk from a client.

The Implementing Regulations of the Cooperative Insurance Companies Control Law in KSA define Treaty Reinsurance as the "Reinsurance that occurs when the primary insurers cede insurance of certain risks within certain amounts & percentages to the reinsurer and the reinsurer has agreed to accept reinsurance of the assigned risks".

The insurance company has a treaty with a reinsurer in which the reinsurer agrees to accept 25% of all fire policies issued by the insurance company. The reinsurer notices that the insurance company has agreed on a particular insurance term that they did not wish to reinsure. Can the reinsurer refuse to accept the reinsurance? Give reasons for your answer.

1.4 Co-Insurance and Self-Insurance:

Learning objective

introduce trainee to the conditions of co-insurance and how it differs from self-insurance

Co-Insurance

For the risk that is either too large or too hazardous for an insurer to accept, there is a second option apart from reinsurance. Instead of accepting 100% of the risk and then arranging reinsurance, the insurer can accept a lower percentage of the risk, an amount that is within its capacity, than the insured (or its advisor/broker) will need to find another local insurer (or insurers) to accept the remaining percentage of the risk.

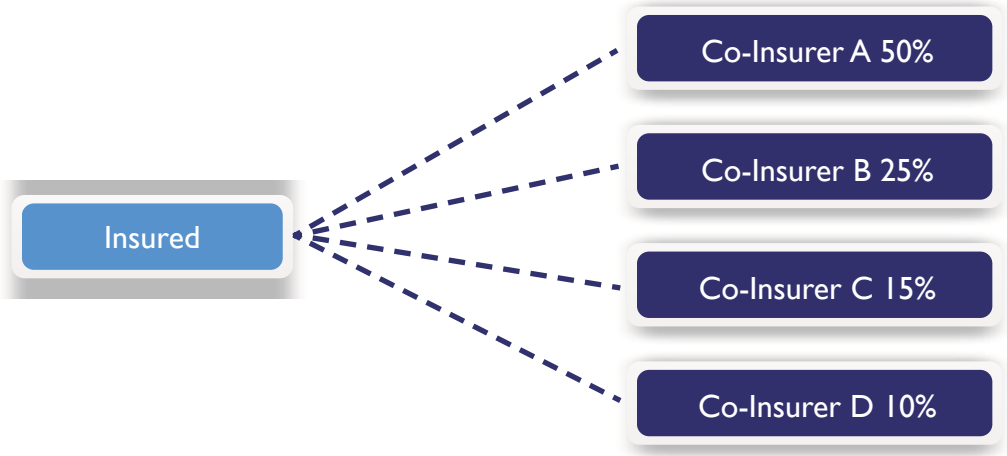
The insurers who share the risk, (usually along percentage lines) are co-insurers and the practice known as co-insurance. It is a common practice in many insurance markets and usually involves the insurance of larger risks, often arranged through an intermediary, typically an insurance broker.

The broker would probably prefer to place all the business with one insurer but if this is difficult, he will arrange co-insurance. It will be his responsibility to place the insurance 100% and not leave the insured with only partial cover. The broker will also handle a great deal of the administrative work.

The process is usually operated by the broker approaching an insurer whom he thinks will want

to accept this insurance. The first company decides the premium and other terms, may arrange an inspection and survey of the insured's premises, and will issue the policy, this insurer is called "the lead insurer". The broker will then approach other insurers who will have to decide whether they are prepared to follow the terms and conditions agreed by the lead company. The broker continues until the insurance is covered 100%.

It is important to note that each insurer is in contract with the insured but only up to his specified percentage.



If, in the case outlined above Insurer 'C' went into liquidation what effect do you think this will have on the insured and on the remaining three co-insurers?

Self-Insurance:

Insurance provides peace of mind, because the risk of losses of the few are shared by the many. Therefore, a loss that may be disastrous for an individual is acceptable when shared by several hundreds. There may however be circumstances when an individual or business may choose to retain the risk. This is self-insurance and should not be confused with no insurance. No insurance occurs when a person or business simply ignores the risk, does nothing and does not arrange to pay for any losses that may occur. Self-insurance is a deliberate and conscious decision to retain risk.

Self-Insurance as defined in the Implementing Regulations of the Cooperative Insurance companies Control Law in KSA means, "The retention of any risk by structured means, i.e. the company that is retaining the risk has set up a fund against a future event that is fortuitous and outside the control of the company".

A business faced with a risk that it considers small and well within its financial ability may choose to retain such a risk. The risk may be low severity/low frequency but even with high frequency, a wide geographical spread may bring it within their capacity to manage the risks themselves.

The business may decide to self-insure possibly by putting the equivalent of the premium aside, which can then be used to pay for losses. It should save on the insurer's administration costs and premiums and the funds could also generate a return if invested sensibly.

A clothing store has 250 shops, nationwide situated in all principal towns and shopping centers around the kingdom. Each shop has a plate glass front which if broken would cost at least 5,000 SR to replace. Why may this company choose not to insure this risk?

What disadvantages, if any are there in choosing to retain the risk?

1.5 Insurance Benefits

Learning objective

introduce trainee to benefits of insurance:

After identifying the concept, types, and mechanism of risk that transfers the risk from possible aggrieved people to insurance companies through the idea of insurance pool. Additional benefits to policyholders are listed below:

A. Peace of mind:

The premium paid is a known expense but in exchange of this, policyholders receive a promise that if certain events occur, they will receive financial compensation. They are paying a relatively small known expense in exchange for the possible avoidance of a larger unknown expense.

This provides policyholders with the principal benefit of insurance often described as, peace of mind because they are comforted by the knowledge that if a disaster should happen e.g. a fire destroying their home or business, financial compensation will be available.

B. Risk improvement:

Insurance companies often combine their resources and invest considerable sums of money in trying to reduce both the frequency and severity of losses. They examine and invest in new methods of loss detection, testing and developing firefighting equipment, new methods of repairs, the use of inflammable materials in consumer goods, methods of car repairs, crash testing and so on. This may be done in conjunction with other interested parties (e.g. manufacturers, governments, fire fighters) and sometimes independently.

They share this knowledge when advising their policyholders on how to avoid or minimize their risks. This results in lower claims costs and lower premiums. It also has the added advantage that less claims means fewer accidents and therefore less personal suffering and any loss of output is reduced.

C. Avoids capital retention:

If there were no insurance available, then businesses would need to take into consideration the impact of losses and the cost of rectifying them. Instead of paying a small known amount (the premium) they would need to set aside "just in case", capital that could be more advantageously used to expand and develop the business.

D. Encouraging new enterprises:

Starting a new business requires capital investment often raised from investors or banks. The assets and future profits of a business are usually the security for investors who would be reluctant to invest if insurance was not available. A fire could easily make a business unprofitable and a new business is even more vulnerable. Therefore, insuring assets and properties against fire will offer alternative protection for the investors and then encouraging the investments and helping in continuing it.

E. Investments:

As custodians of the pool, insurers have large amounts of money in their care. There is a time difference between receiving premiums and paying claims, which in the case of life (Protection & Savings) assurance can be several years. The funds are not left idle but are available for investment.

Insurers invest these funds in a wide range of investments, from direct equity investment in companies (stocks and shares), loans made to industry and governments, property, and securities with a fixed interest. The small premiums paid by thousands of individuals and businesses are not idle but circulate in the economy helping to stimulate national growth.

F. Import/Export:

Insurance is a commodity that, like other commodities is traded between countries, therefore a country that sells insurance is exporting, and a country that buys insurance is importing. As an intangible product, i.e. it has no physical presence; it is classified as invisible earnings. Other invisible earners include tourism and banking services.

A major business investing heavily in factories and equipment will want to protect that investment. If the country has either no industrial insurance or one that is inadequate, that business will arrange its insurance from overseas. Hence, that country will be an importer of insurance services. The overseas country that is providing or selling the insurance cover will receive the premiums and therefore be an export of the service.

G. Foreign Exchange:

International deals will be done in the currency of exporting country. Many countries have a currency problem and foreign exchange is a valuable commodity that is regulated and controlled. An established and financially sound insurance industry that can retain its own risks will assist those countries reducing the level of foreign currency exchange risk.

H. Create job opportunities:

Having a proper and successful insurance industry means creating job opportunities for the main participants whether in the insurance or re-insurance companies, the insurance and reinsurance service providers, and other sectors that benefit from the availability of insurance such as: the medical field, Auto repairs, general safety equipment, etc.

Chapter One
Revision questions:

1. In order for the risk to be insurable, it has to have the following characteristics?
2. Causes that make the risk uninsurable?
3. Law of large numbers helps the insurance companies in determining ?
4. The purpose of reinsurance?
5. Types of Reinsurance contract from a technical point of view?
6. Types of Reinsurance contract from a legal point of view?
7. Insurers divided hazards into three kinds?

Practical questions:

1. Briefly describe insurance benefits?
2. Insurers divided hazards into three kinds: list them and write an example for each
3. One of the reinsurance types is proportional reinsurance. Write an example that illustrates how it works

Chapter One
Answers of Chapter one Revision questions:

1. In order for the risk to be insurable, it has to have the following characteristics:

- **It should be financial loss.** Ability to measure it financially.
- **It should be pure risk.** Generally only pure risks are insurable i.e. a loss or break-even situation.
- **It should be fortuitous.** Fortuitous essentially means accidental and in this context means that any event must be outside the control of the insured. It must be accidental as far as he is concerned.
- **Insurable Interest:** The principle of the insurable interest stipulates that «there must be a legally significant interest between the applicant and the object or person subject to insurance that benefits from its non-damage or non-harm and its continued existence, and is affected if the risk is realized and this object or person is damaged or harmed.

2. Causes that make the risk uninsurable:

- Speculative risk
- Law of large number not applicable
- When the insurance against the general interest

3. Law of large numbers helps the insurance companies in determining:

- The correct degree of risk
- The level of insurance premium
- Precisely predicting the probability and amount of future loss

4. The concept and purpose of reinsurance:

It is a technical process between insurance and reinsurance companies under which the insurance company transfers liabilities completely or partially to the reinsurance company for a certain fees. The insurance company will be as an insured to the reinsurance company, but still as an insurer before the policyholders. The reinsurance also will be an insurer to the insurance company and this process is done by the insurance companies.

The Implementing Regulations of the Cooperative Insurance Companies Control Law in KSA define the reinsurer as "an insurance or reinsurance company that accepts insurance contracts from another insurer".

As for reinsurance, the Implementing Regulations define the term as "Transfer of the insured's risk from the insurer to the reinsurer and to indemnify the insurer by the reinsurer for any payments made to the insured against damages or loss".

5. Types of Reinsurance contract from a technical point of view:

Proportional Reinsurance:

It means the insurer and reinsurer share the risk, the premiums and claims, usually on a percentage basis. For example, the reinsurer may agree to accept, incur %25 of the risk receive %25 of the original premium and pay %25 of all claims.

The Implementing Regulations of the Law on Supervision of Cooperative Insurance companies in KSA define the proportional reinsurer as «the treaty of reinsurance is when the insurer commits to assign certain risks in certain percent that has already agreed upon to the reinsurer and the reinsurer commits to accept insuring assigned risks.

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It means that the insurers and reinsurers do not share premiums and claims equally. Typically, it involves a deductible, usually quite substantial that the insurer must pay before the reinsurer will contribute to any claim. For example, a reinsurance policy issued with 10M SR excess only requires reinsurers to contribute when a loss exceeds this amount.

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6. Forms of Reinsurance from a legal point of view:

Reinsurance Treaty:

A treaty is an agreement between insurers and reinsurers. Under the treaty, reinsurers are obliged to accept all the risks that are within the defined limits of the treaty. Treaties typically are signed for one year and then if both parties agree can be renewed. Reinsurers therefore agree in advance to accept reinsurance business given to them by the insurer. The major benefit to insurers is that they know they have reinsurance protection and they know the cost of that protection immediately they accept a risk from a client.

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Facultative Reinsurance:

Facultative is a French word that means optional or by request and insurers have to request facultative reinsurance when they need it. This means that the insurer has to contact the reinsurer, give details of the original risk, together with all material facts concerning the risk. If the reinsurer refuses or the terms are too high, the insurer will need to find another reinsurer.

The Implementing Regulations of the Cooperative Insurance Companies Control Law define Facultative reinsurance as ": reinsurance that occurs when the insurer previews the risk in a case-by case method for the reinsurer. The reinsurer has the option to accept or neglect the offered risks".

Although a specialist reinsurance broker can help, the process is still time consuming, administratively expensive and there is always uncertainty if the reinsurance will be at acceptable terms.

7. Insurers divided hazards into three kinds:

- **Insured perils** are those specifically mentioned in the policy, and if it occurred, the sum insured or the compensation will be given e.g. 'loss or damage caused by fire'. Fire is an insured peril.
- **Excluded perils** are also specifically mentioned in the policy that identify the situation where sum insured or compensation is not required e.g., 'loss or damage caused by fire excluding fire caused by explosion'. So if an explosion causes a fire, the policy will not cover the loss as it is an excluded peril.
- **Unnamed Perils** are perils not mentioned in the policy and usually they are not covered.

Practical Question

1. Insurers also divide hazards into three kinds – physical, moral and behavioral hazards.

- **Physical hazards** are relatively easy to understand. They arise from the physical aspects of a risk, such as construction of a building and its location and type of vehicle and the way of driving it. The triggers or the physical contributing factor in the insured item that cause loss occurrence or increase its severity. For instance, bad electrical extension cord or driving a car in a street full of oil.

- **Moral hazards (Intentional):** arise from the immoral, unethical or illegal conduct of people, usually the person insured but in the event of a business enterprise, it could be the employees or management.

  Moral hazard is always more difficult to detect because it is not physical or tangible and cannot be touched or seen. Examples of moral hazard include dishonesty by the insured, or people who do not consider deliberately inflating an insurance claim as dishonest.

  In liability situations, third party claimants often exaggerate their injuries and property damage and sympathetic physicians, lawyers, body shops and contractors may support these exaggerations and increase the cost of the claims

- **Morale hazard (Poor behavior)** is an increase in the hazards presented by a risk arising from the insured's indifference to loss because of the existence of insurance. In other words, Morale hazard arises from the insured's attitude and this differs from moral hazard, as there is no conscious or malicious intent to cause a loss.

Chapter Two

Insurance Principles

Introduction

The idea of the insurance industry is based on distributing the harmful consequences of one or several incidents to a group of people rather than one person, and evolved into a stand-alone system based on cooperation to face financial losses to the insured.

This system is based on technical and legal bases and objective principles, which requires a legal mechanism that is acceptable to the insurer and the inured to achieve their goals. In this chapter, we will focus on key principles that govern this relationship:

Six legal principles of insurance contract are known in the insurance industry:

- **Utmost good faith principle**
- **Insurable interest principle**
- **Indemnity principle**
- **Subrogation principle**
- **Contribution principle**
- **Proximate cause principle**

2.1 Utmost good faith principle

Learning objective

Introducing the trainee with the first principle of utmost good faith

In this principle, both the insurance company and the insured must not provide invalid or misleading information. They also must not keep from each other's any information material to the contract, and if one of the parties breached this principle, the contract will be void or voidable. The nature of the subject matter of insurance, the circumstances, and the facts surrounding it are considered material facts to the best of the insured knowledge.

When buying a product (a car, TV etc.), the buyer can examine the goods and the seller must answer all questions truthfully. The legal principle governing such contracts is caveat emptor - let the buyer beware - it is up to the two parties (but mainly the buyer) to ensure that they are satisfied with the terms. Neither party is under any obligation to volunteer any facts or information to the other. This is not the case with insurance.

In insurance, the insurer must rely on the truthfulness and integrity of the insured. In return, the insured must rely on the insurer's promise to pay future claims. Further only one party (the insured) knows all the facts about himself and the 'risk' to be insured, insurance is therefore subject to a much stricter duty than "let the buyer beware": it is the principle of Utmost Good Faith.

Utmost Good Faith is a duty of disclosure, because each party must voluntarily disclose all information; they cannot remain silent. Utmost Good Faith applies to both insurer and insured although it is a more onerous duty on the insured.

Utmost Good Faith is a duty of disclosure and all parties to the contract are obliged to disclose all

material facts.

The duty of disclosure begins at the start of negotiations and continues until the contract is in force. After that, both parties are subject to the terms and conditions of the contract. However, even if there were changes after inception, the insured should disclose them. Most insurance policies contain a condition that the insured must disclose any changes that increases the possibility of loss. Even without this condition, the insured should disclose any such changes because the essential terms of contract have changed.

Insurance contracts are issued for a period of time, 12 months being the most common. At expiry, insurers usually offer to renew the policy. The terms and conditions may change, but even if renewal is on existing terms, the renewal is a new contract. The duty of utmost good faith, therefore, revives at renewal and both parties must voluntarily disclose any changes.

A material fact is one that influences the decision of the insurer to determine contribution with 25% and more or on the policy terms or accepting the claim. Determining exactly what a material fact can be difficult especially for insureds who are new to insurance. A proposal form normally asks for those facts generally considered material by insurers. However, if there are other facts not covered by the proposal then the insured should voluntarily disclose them; staying silent is not an option. Many insurance companies remind potential insured to disclose any other information that may be relevant to the insurance. The general rule is; if in doubt regarding the relevance, disclose the information.

A material change is a change that increases the probability of risk occurrence or risk severity. Facts that require disclosure include:

- A full description of the subject matter of the insurance (Car, property, liability etc.).
- Any other policies covering the same risk.
- Previous insurance policies. Especially relevant if an insurance company has declined insurance or imposed special or restrictive terms.
- Details of previous losses and insurance claims.
- Any fact that increases the risk from the norm. For example, a car engine modified to make it go faster.

Some of the information disclosed will relate to the subject matter of the insurance and these are primarily physical hazards. Others relate to the person taking out the insurance and are primarily moral hazards.

There are some facts that do not require disclosure. These include:

- Facts of law. The assumption is that everyone knows the law and ignorance is not a defense.
- Facts of public or common knowledge. This could include well-known flood or crime areas, earthquake zones, war areas, trade and industrial processes.
- Facts that lessen the risk. Additional fire or security precautions for example.
- When further information has been waived. If there is blank or inadequate answers on a proposal that insurers do not follow up the assumption, than it is assumed that they have accepted the position and cannot later rely on facts they do not like.

A breach of utmost good faith is typically either non-disclosure i.e. failing to disclose a material fact or misrepresentation i.e. incorrect or inadequate disclosure.

A breach that is a deliberate misrepresentation of the facts may be fraudulent

and referred to as concealment. This breach leaves the injured party, typically the insurance company with the option to:

- Cancel the contract from the beginning – almost as if it never existed.
- Insurers usually discover breaches at the time of a claim and refusing to pay the claim is an option.
- Insurers may choose to charge additional premium or impose additional terms on the policy.
- They may choose to ignore the breach and just continue with the insurance.

Although unlikely, in the event that the insured suffers a breach, he will be able to recover any damages that he has suffered.

Applications of material facts and matters that need to be identified:

- Motor insurance: purpose of using the vehicle.
- Fire insurance: nature of building materials and use of the building.
- Theft insurance: nature of stock and its estimated value.
- Marine insurance: whether the cargo or part of it is carried on deck.
- Personal accident insurance: data on the proposer's health status which may cause an accident resulting in a fracture that has previously occurred.

The times where Utmost Good Faith principle must be considered:

Utmost Good Faith principle must be considered when filling the insurance form, while contracting, during negotiation period to conclude the contract and while the contract is in force. Additionally, the principle is considered again when renewing the contract, since the renewal is a new contract. The insured must inform the insurer of any changes that might affect the coverage or accepting it.

2.2 Insurable Interest Principle

Learning objective

Introducing the trainee to the insurable interest principle as to its existence for the contract to be entered.

Insurable Interest means that the person receiving the benefit of the insurance policy must have suffered a financial loss that is covered by the insurance policy.

Insurable interest refers to the individual or organization's right in insurance. It follows that a legal relationship, between the individual and the 'thing' being insured, must exist. This means that the individual will be liable for the loss or has legal responsibility due to the loss or damage of the insured item, and he will benefit financially if the insured item remain as it is.

The most common legal relationship is ownership. If the proposer owns a house, a corporate building, or a vehicle then he has the right for insurance, since he will be responsible for any loss or damage to the item.

The second legal relationship that gives the proposer the right is when he is entrusted with some items. In this case, the proposer will be responsible for any damage to the owner's property that he borrowed.

The third legal relationship that gives the proposer the right is leasing (tenancy). In this case, the proposer will be responsible for any damage to the original owner's property, since a rented gallery, house, or an apartment can be insured.

Insurable interest bases:

Four bases that govern identifying insurable interest and its legality:

A. Availability of several factors including insurable ownership, rights, interest, life, and responsibility.
B. This ownership, rights, interest, and life must identify the insurable interest.
C. The nature of relationship between the insured and the specified interest must exist.
D. A legal expression must exist for the relationship between the insured and the insurable interest. This expression exist by creating a contract between the insured and any other organization as an insurance company.

Conditions required in insurable interest:

A. Interest must be financial: meaning that emotion is not enough to create a financial interest.
B. Interest must be legal: meaning that a crime against law and general morality cannot be insured. Drugs, smuggled goods, and stolen goods cannot be insured too.

Insurable interests in properties:

The following are situations, other than full ownership, where the insured can have an insurable interest:

A. Full or partial partnership in properties.
B. Consigned goods and property restitution contracts of mortgagor and mortgagee.
C. Trustee of properties.
D. Guarantor for the insured's properties.
E. Agent: business agent responsible of insuring his client's property liability.

Applications of insurable interest:

Income insurance due to death:

- A person has an insurable interest in his life on any amount of money and for any person he designates.
- A husband has an insurable interest on his wife's life and vice versa.
- A mortgagee has an insurable interest on his mortgagor's life limited to the amount of debt. As for the mortgagor, he does not have an insurable interest on the mortgagee's life.
- An insurer has an insurable interest on the insured's life limited to the sum insured.
- A film producer has an insurable interest on the actor's life.
- An employer has an insurable interest on his agent's life.

General insurance:

- An owner has an insurable interest on what he owns.
- A person has an insurable interest on the properties he has, even if it belongs to someone else such as the items he was entrusted with.

- Both the mortgagor and the mortgagee has an insurable interest on the subject matter of a mortgage.
- A husband has an insurable interest on his wife's properties if she is living with him and he is using these properties as well.
- A mortgagee has an insurable interest on the mortgagor's life but not his properties.
- A shareholder has no insurable interest on the properties of a company that he owns a share of its stock.
- An owner of a part has an insurable interest limited to the part he owns.

Insurable interest varies according to the type of insurance whether Marine Insurance, Life (Protection and Savings) Insurance or General Insurance.

Marine Insurance:

In marine insurance, there must be insurable interest at the time of loss not necessarily at policy inception. The nature of marine business is such that goods can be in transit for several months and its ownership could change during the journey. Therefore, the person who may have taken out the insurance may not be the person who suffers the loss.

Life (Protection and Savings):

It has been established that in life (Protection & Savings) insurance insurable interest need to be present when the policy is taken out and not necessarily when the loss occurs - the opposite of Marine Insurance. This may seem a strange position but is not really a problem. If for example a bank requires a life (Protection & Savings) policy as a condition for a substantial loan, the debtor takes out the insurance on his life and names the bank as the beneficiary for the proceeds. If the loan is paid, the insured can simply change the beneficiary, or cancel the insurance.

General Insurance:

For all other policies, insurable interest must exist at policy inception, during the policy validity, and when the loss occurs. If there is an absence of insurable interest when the insurance starts then the contract may be considered invalid and if there is no insurable interest at the time of the loss then there will be no loss to the insured.

2.3 Indemnity Principle

Learning objective

Introducing the trainee to the indemnity principle and the main benefit of insurance which is to indemnify the insured for the covered losses.

Indemnity in many ways is linked to Insurable Interest. Insurance contracts to be valid must have Insurable Interest i.e. the insured must suffer financially from the loss or damage to the 'thing' insured but that Insurable Interest is limited to the financial interest.

An owner has Insurable Interest in his own property but only to the extent of the value of that property. If he recovers more, he would be financially better off after a loss than before a loss. This would breach the principle of indemnity and renders insurance an adventure proposition.

The Principle of Indemnity is to put the insured in the same financial position after a loss as he was in immediately before the loss. In theory, he should be neither better off nor worse off. In practice, this is very difficult to achieve but it does not detract from the basic principle, which many consider the foundation of insurance.

Indemnity is therefore the financial interest that the insured has in the insured item. However, it is not possible to place a monetary value on a human life and we all have an unlimited interest in our own life and limbs.

Therefore, life (Protection & Savings) insurance and personal accident policies (excluding medical expenses) are not policies of indemnity and the principle of indemnity does not apply to them.
If the insured is to be in the same financial position after a loss as he was before the loss, it is necessary to establish the value of any items lost or destroyed at the time of loss.

Example:

Ali has a car model 2008 insured with a comprehensive insurance policy. He had a car accident that damaged the headlights and the radiator.

To determine the indemnity amount, we need the current or previous value of these parts before the accident. If Ali was given a replacement (new for old) value, he would be able to purchase similar new items whereas before the loss he had old items, so he would be better off. To apply the indemnity principle, it is necessary to make a deduction from the new price to make allowances for the age and previous use of these items, known as wear and tear and depreciation.

Indemnity should not include any element of profit. Therefore, a shopkeeper who has his stock damaged should be indemnified with the cost price to replace that stock – it is not the selling price, which would include his profit.

In liability insurance, the amount of indemnity would be limited to the damages suffered by the third party at cost.

Having established the meaning of the principle of indemnity, insurance contract states that the method of providing indemnity is at the option of insurers. The typical policy lays down four options and insurers will normally elect the option that is most convenient and least costly to them.

Methods of providing indemnity:

A. Monetary payment:

In the majority of cases, this is the most convenient method. Insurers reimburse the insured by a check or a transfer to his bank account in accordance with SAMA's instructions.

B. Repair

Insurers may arrange for a damaged item to be repaired at their expense. Collision damage to motor vehicles is a common example where insurers arrange repairs. In some cases, insurance companies own or have a financial interest in repair shops, which helps them to control costs. Alternatively, they may receive discounts from repairers due to the volume of business.

C. Replacement

Insurers may choose to replace an item that has either been lost or damaged beyond repair. Glass, jewelry, house contents insurance are examples of replacement. Again, the insurance company usually gets the benefit of discounts for the volume of business they supply.

D. Reinstatement:

Reinstatement tends to refer to buildings or machinery and is similar to repair. Insurers may choose to rebuild the damaged building themselves, which is an option rarely exercised because of the problems it can cause to insurers. Normally, they would expect the insured to arrange the work and limit their role to verifying that the work is in order and within the policy terms, and in turn they will reimburse their insured.

A vehicle is damaged in an accident. The insured takes it to a garage who estimates the cost of repairs at SR1,000. He submits a claim to his insurers but due to their bulk purchasing power, insurers can have the vehicle repaired for SR 850. The insured states that he does not want to have the vehicle repaired. He requests a cash settlement of SR1, 000. How in your opinion would the company react to this?

Indemnity is a principle underpinning insurance but in order to satisfy the needs of policyholders it must be flexible. Insurers have policies that alter slightly the strict principle of indemnity, but achieve the overall objective of attempting to put the insured in the same financial position after the loss as he was immediately before the loss. Some of these options are:

A. Agreed Value:

In some cases, it may be difficult to assess the value of an item on the day of loss, especially if that item is rare e.g. an antique work or a master's painting. In these circumstances, insurers offer an agreed value policy. In these contracts, the value to be paid in the event of a total loss is agreed at inception of the policy.

Note only the total loss value is agreed, any partial loss would be handled in the usual manner e.g. cost of repairs. It does mean; however, that if the value changes between inception and loss date (which could be up to a year later) the agreed value that is paid may differ from the indemnity value on the day of the loss.

Agreed value policies are rarely used in non-marine insurance, but are very common in marine insurance where the value of cargo can fluctuate during a long voyage, and replacing the goods may be difficult in view of the time and distances involved.

(A cargo sent to the Kingdom from China was insured for SR300,000. In case the whole cargo was damaged, the insurance payment must be in full regardless of the cargo's current value; however, if it is partial damage, the cost is calculated with the actual value of the cargo on the day of the loss).

- A painting insured for SR100,000 on an agreed value policy is destroyed in a fire. Its value on the day of the loss was SR75,000. How much will the insured receive? Give reasons for your answer.

- While the painting was displayed in the gallery, one of the visitors touched it and it fell on the floor. The bottom left side of the frame was damaged. In this case, how would indemnity be provided?

B. First Loss:

A situation may arise when the insured feels the probability of a total loss is so remote that full insurance is not necessary. For example, in a large warehouse containing heavy goods it is unlikely that thieves could remove all the contents in a single loss. In these circumstances a first loss policy, which permits less than full value insurance, is appropriate.

The insured selects the amount they feel is the maximum they could suffer from any one loss and this becomes the first loss sum insured and is the maximum payable in respect of any one claim. The full value of the property is noted but only for information and to aid in premium calculation. It does mean that if the insured has made a mistake and does suffer a loss in excess of the first loss sum insured he would not be able to receive a full indemnity.

In addition to these two types of policy, many other policies contain conditions that can affect the amount the insured can receive as indemnity.

A company has generators that weighs 5 tons and worth SR100,000 each, and its warehouses are located in the industrial area. The company made a first loss insurance claim for SR300,000 only. Some thieves wanted to steal all the generators, but ended up having 4 only. How much should the insurer pay for the insured?
Give reasons for your answers.

Why in your opinion did the company insure just three of the generators when it actually has a warehouse full of generators?

What are the policies that are not considered as indemnity policies and this principle does not apply on them (----------)?

C. Average:

It was stated earlier that insurance is based upon the common pool and that all contributors must contribute to the pool according to the degree and size of the risk being introduced. In the event that somebody undervalues his property, he will not be making a fair and equitable contribution, as he will be paying less premium than his risk demands. Insurers, therefore, penalize the insured for any underinsurance by reducing his claim at the same proportion that the sum insured is to the full value. Unless there is a claim, the underinsurance may not be discovered and it will be too late to recover unpaid premiums possibly going back several years.

Example

If a shopkeeper insures his stock for SR 50,000 but at the time of the loss, the full value of his stock was SR100,000 then the claim will be reduced by the same proportion – 50%. If the claim was SR15,000 he will receive SR 7,500. It can be expressed as follows:

$$\frac{\text{Sum Insured at time of loss}}{\text{Full Value at time of loss}} \times \text{Loss} = \text{Claim Payment}$$

Replacing these with figures above:

$$\frac{\text{SR 50,000}}{\text{SR100,000}} \times \text{SR15,000} = \text{SR 7,500}$$

If average applies then the insured will not receive a full indemnity.

D. Sum Insured:

The sum insured is insurer's maximum indemnity and they cannot pay more than this amount. In the event the insured suffers a total loss of a property that is underinsured, he will not receive a full indemnity. However, some policies have sub limits or inner limits. (Average does not apply in case of Total Loss whereas the insured receives the full sum insured)

For example, house insurance may have a limit in any one item or a limit in respect of valuables.

E. Deductibles:

Also known as 'excess'. These are the first amounts payable by the insured and are deducted from any claim payment. Some deductibles are voluntary, which means that the insured has elected to have the deductible usually in return for a reduced premium. Others are compulsory because insurers have imposed them, usually to encourage the insured to be careful.

Deductibles are considered part of the premium paid later only when damage occurs. Therefore, there are varying percentages of deductibles in either some types of personal insurances or general insurance, where deductibles are compulsory but also help in increasing or decreasing the premium.

(When premium increases, deductibles decreases.
When deductibles increases, premium decreases)

However, (deductibles and premium might increase for some policies that recorded a high rate of losses during the insurance period. The premium and deductibles would be increased to insure the insured's contribution in fair premium in the insurance pool, and to encourage the insured to raise precautions and protections).

F. Reinstatement (New for Old):

This condition simply states that indemnity will be the full cost of replacement without any deductions for wear and tear i.e. he will receive the value of new goods. The condition is quite common in policies covering commercial buildings and machinery where deductions in any event may be quite small but where huge funds are needed to continue the business. The reinstatement condition is available in house insurance policies and referred to as 'new for old'. The reason is to avoid hardship, so if the homeowner loses a substantial part of his home indemnity alone may not provide enough to refurnish the home. Although not common in KSA, in other parts of the world, notably the UK almost every home policy is on this basis.

2.4 Subrogation Principle

Learning objective

Introducing the trainee to the subrogation principle as it is applied in insurance.

It is the individual or organization's right when providing indemnity to another individual, in conformity with an insurance contract, to take the insured rights related to the case concerned, to recover from a third party once the insurer paid for the loss.

When the insurer provide indemnity to the insured for a loss caused by third party, it is just and fair to let the person who caused the loss be financially responsible of the damages. Thus, the company has the right to subrogate on behalf of the insured in claiming indemnity from losses from the third

party who caused it, after it provides indemnity for the insured.

Subrogation supports the Principle of Indemnity and does not apply to insurance policies that are not contracts of Indemnity.

The principle of indemnity is to place the insured in the same financial position after a loss as he was in at the time of the loss. There are circumstances, however, when an insured has the possibility to claim monetary reimbursement from more than one party. If he did successfully, he would receive two payments and make a profit from his loss. This breaches the principle of indemnity.

Example

"A" is waiting in his car at a red traffic light. "B" is approaching the red light but failed to apply break in time and crashes into the rear of A's car causing serious damage. Fortunately, "A" has an insurance policy that will pay for the repairs to his car. However, he also has the option to make a claim against "B". What he cannot do is make two claims, one against his own insurance company and the other against B's.

In this example, if A chooses to ask his insurance company to pay his claim (which is the sensible option as "B" may not be willing to pay him) then the insurance company can act in A's name and try to recover from "B" (or his insurers).

Therefore, the principle of subrogation states: An insured cannot recover his loss a second time from another party if his insurer has settled his claim. Those rights of recovery pass to the insurer.

Subrogation principle is a right for the insurer only after settlement of the claim: many claims take months or even years to be settled such as catastrophic fires or severe physical injuries. Because of that, the insurer will not want to wait until it recovers indemnity from the third party or until the insured starts taking procedures that might ruin its chances of success.

Insurance policies, therefore, have a policy condition that states insurers may pursue a claim against another party in the insured's name before payment. Effectively insurers can start recovery actions immediately after they are aware of the loss.

In Saudi Arabia, the Right of Subrogation is given through a power-of-attorney from the insured to the company for subrogation in the following two cases:

a) Third party Liability for the Loss.

b) Defending the insured in repudiating liability or in determining the indemnity amount.

In addition to legal rights of the insurance company against a negligent party, Subrogation rights, can also happen under a contract e.g. tenancy or warehouse agreements. A breach of a contract term may entitle one party to compensation. If appropriate, these rights could pass to insurers.

When insurers agree to pay a total loss claim, e.g. when a car is so badly damaged that repairs are impossible, there may be some salvage value in the damaged property. As the insured has received a full indemnity, if he kept the salvage he would be in an improved position.

Therefore, the rights in the salvage pass to insurers as part of their subrogation rights.

Insurers have subrogation rights only in respect of losses for which they have provided an indemnity.

If there are uninsured losses such as loss of wages, car hire then the insured can still attempt to claim these from the third party.

In many of the larger insurance markets insurers enter into agreements not to recover from each other. The reasoning is the principle of 'swings and roundabouts' (what we gain on the swings we lose on the roundabouts and the result is stalemate). This is due to the large number of claims and consequently the large number of times motor insurers are trying to recover from each other.

In some countries, in motor insurance policies, the insurers have an agreement called "knock for knock" under which each insurer pays the claim for the motor vehicle under their policies and refrain from proceeding against the insurer of the opposite vehicle.

Applications of the subrogation principle:

- Breach of trust insurance: an insurer pays the indemnity and has the right to sue the guilty to receive the indemnity he might have paid to the insured.
- Theft insurance: an insurer, who paid indemnity, has a right in the stolen goods.
- Fire insurance: if a mortgagee insured a mortgage, and the house was burned and the insurance company paid the indemnity for it, then the company subrogates the mortgagee right against mortgagor with what it has paid for in indemnity.
- Marine and fire insurance: insurance company takes abandoned items and waste and sell it for its own account, which means that it subrogates the insured ownership of the items he received indemnity for.
- Income and personal accidents insurance: it is noticeable that subrogation principle does not apply to life or personal accidents insurance, since the idea of the principle is to prevent the contractor from receiving a double indemnity for the loss. The loss that results when the insured risk occurs cannot be estimated in cash in personal accident insurance, and therefore, subrogation principle cannot be applied in these cases.(Almasri 176)

2.5 Contribution Principle

Learning objective

Introducing the trainee to the contribution principle, how it is applied, and methods of contribution.

Contribution principle is the insurance company's right in making a claim for contribution when paying a covered claim (indemnity) knowing that there are other policies with other insurers that cover the same loss

To apply the contribution principle, the following conditions or legal requirements must be present:

A. Two or more indemnity policies must be available.
B. Same interest (same insured) must be covered in these policies.
C. All policies must cover the cause of loss.
D. All policies must have the same subject matter of insurance.

E. All policies must have coverage for the same loss.

F. All insurance policies covering the risk must be in force when the loss occurs.

If an insured takes out two insurance policies covering the same risk, he would have dual or double insurance. To allow recovery from both insurance companies would breach the principle of indemnity. Contribution is similar to subrogation; it exists to support the Principle of Indemnity and like subrogation, applies only to contracts of indemnity.

Dual insurance is usually unintentional but may happen through a misunderstanding.

Examples include:

- The company secretary and financial manager both believing it is their responsibility to deal with the company's insurance.
- The owner of goods and the owner of the warehouse both insure goods stored in the warehouse.
- Cover under two overlapping policies e.g. holiday insurance and a house policy.

Insurers allow for dual insurance by a contribution condition in their policies, which states that in the event of more than one policy they will only pay their share. This is the contribution or other insurance condition.

The share that each insurer agrees to pay is their rateable proportion of any loss. There are two methods of calculating an insurers' rateable proportion, based on either sums insured or independent liability.

A. Contribution methods:

The goal of contribution method is to prevent the insured from claiming the full sum of indemnity from one insurer, as this will force insurer to go back to other insurers to pay their share of the sum of claim.

There are two ways to explain the meaning of "rateable proportion":

First Method: Sums Insured Method:

In this method, the contribution to be paid by each insurer is calculated by apportioning it according to the sums insured.

Saud ensured his house with SR10,000 at Riyadh Insurance Company, with SR20,000 at Jeddah Insurance Company, and with SR30,000 at Dammam Insurance Company. If the house suffered a loss of SR6,000, how much will the Riyadh Company pay of this loss?

$$\frac{\text{Sum insured under individual policy}}{\text{Total Sum Insured}} \times \text{Loss} = \text{Payment}$$

Riyadh Company will pay = 6,000 x (10,000 ÷ (30,000 + 20,000 + 10,000)) = SR1,000

This method has an obvious negative side, there are several policies subject to different conditions. Some policies include some but not all conditions or a different way to assess and settle claims. Thus, we can accurately identify the method used in each policy to deal with a claim, instead of just focusing on calculations regardless of policy condition. For instance, if one or all policies were subject to average condition and there was an underinsurance, then is it fair for an insurer, who has the right to apply rateable proportion condition, to apply contribution principle as if the average condition was never there? Perhaps it will complicate claims settlement, but it is the ideal fair way.

The great majority of contribution principle calculations apply to property insurance, especially fire insurance. Insurers tend to use standard methods for contribution principle calculations, which have been included in official agreements among large groups of insurers.

As for property insurance policies not subject to average condition and cover the same subject matter of insurance, the loss is settled according to each policy sum insured relative to total sum insured of all policies. This is done in the previous example. However, when applying contribution principle on policies not subject to average condition (property insured are not the same in all policies), the sum insured will be used for calculations also, but in a different complicated way called "Arithmetic Mean".

Second Method: Independent Liability Method:

For the policies subject to average condition or indemnity limits to sum insured for single losses even if it is not subject to rateable proportion condition, the "Independent Liability Method" will be used to apply the contribution principle. "Independent liability" can be defined as the sum payable by each insurer as if the insurer was only responsible for the loss.

$$\frac{\text{Independent liability of each policy}}{\text{Total Independent liabilities}} \times \text{Actual Loss} = \text{Policy Indemnity}$$

The alternative method is suitable for policies that are not identical; they may include deductibles, loss limits, or when average applies. They are also suitable for non-property policies e.g. liability insurances.

Example:

Abdulaziz insured his house with SR20,000 at Riyadh Insurance Company and SR10,000 at Jeddah Insurance Company. If his house suffered a loss of SR4,500 and the house's actual value at the day of loss was SR45,000, then there are three steps to solve this:

First Step:

Finding the sum payable by each insurance company in case it was the only insurer.

To calculate Riyadh Insurance Company's liability, the following average condition is applied:

$$\frac{\text{Riyadh Insurance Company's Sum Insured}}{\text{The House's Actual Value at the Day of Loss}} \times \text{Loss}$$

$$\frac{\text{SR 20,000}}{\text{SR45,000}} = \text{SR 2,000}$$

To calculate Jeddah Insurance Company's liability, the follow average condition is applied:

$$\frac{\text{SR 10,000}}{\text{SR45,000}} = \text{SR 1,000}$$

The total of what the two companies paid = SR3,000

The average condition prescribes that insured must insure himself with the difference between the value of subject matter of insurance and sum insured.

In the example above, 10,000 + 20,000) – 45,000) = SR15,000

$$= \frac{\text{SR } 15{,}000}{\text{SR}45{,}000} \times 4{,}500 = \text{SR}1{,}500$$

Second Step:

If the total of insurance companies' liabilities was SR3,000 as in the previous example, less than or equal to the loss value, then each insurance company payment equals its independent liabilities.

Third Step:

If the total of insurance companies' independent liabilities was bigger than the loss, then a contribution will be made to pay for the loss with a percentage of what the independent liabilities of each insurance company represents out of the total independent liabilities.

Example:

Faisal insured his house with SR30,000 at Riyadh Insurance Company and SR50,000 at Jeddah Insurance Company. If the house burned and suffered a loss of SR1,000, and its value before the fire was SR70,000, how much will each company pay if each policy included average condition?

First Step:

since the two policies included average condition, independent liability method must be followed.

$$\text{Riyadh Company} = \frac{\text{SR } 30{,}000}{\text{SR } 60{,}000} \times 1{,}000 = \text{SR } 500$$

$$\text{Jeddah Company} = \frac{\text{SR } 50{,}000}{\text{SR } 60{,}000} \times 1{,}000 = \text{SR } 833.33$$

Now that the total of insurance companies' independent liabilities equals SR1,333.33, which exceeds the loss, then each insurance company will contribute in paying loss value according to the percentage of what its liability represent out of the total independent liabilities as follows:

$$\frac{\text{Independent liability}}{\text{Total Independent liabilities}} \times \text{Loss} = \text{Riyadh Company}$$

$$\text{Riyadh Company} = \frac{500}{1{,}333.33} \times 1{,}000 = \text{SR } 375$$

$$\text{Jeddah Company} = \frac{833.33}{1{,}333.33} \times 1{,}000 = \text{SR } 625$$

Example:

If Bandar had two insurance policies on personal liability, one with SR30,000 at Riyadh Insurance Company and another with SR60,000 at Jeddah Insurance Company. How much will each company pay if Bandar was subject to a legal responsibility to a third party to pay SR50,000?

First Step:

Since the two policies are for liability insurance, then the independent liability method will be followed.

If Riyadh Company's policy was the only policy, then it will pay SR30,000 and will take its ultimate liability even though the loss is SR50,000. As for Jeddah Company, it will take liability for the full loss SR50,000, since the indemnity in its policy is SR60,000.

Second Step:

Riyadh Insurance Company =

$$\frac{\text{Independent liability}}{\text{Total Independent liabilities}} \times \text{Loss} = \text{Riyadh Company}$$

= 50,000 × (30,000 ÷ (30,000 + 50,000)) = SR 18,750

Jeddah Insurance Company =

$$\frac{\text{Independent liability}}{\text{Total Independent liabilities}} \times \text{Loss} = \text{Jeddah Company}$$

= 50,000 × (50,000 ÷ (30,000 + 50,000)) = SR 31,250

Which means that each insurance company will pay its share of the total of independent liabilities.

The correct method is the one that is most appropriate for the circumstances.

Similar to subrogation, larger insurance markets have agreements on contribution. When contribution is appropriate (if it is less than a certain amount, only one insurer will pay) which policy should take preference? A policy that is more specific would pay first. For example, if one policy covers jewelry and another a diamond ring. If the policies are contributory, then diamond ring is more specific than jewelry. The diamond ring policy will pay and the insurance company will not seek contribution when the loss occur. It is important to determine the cause of loss before making a decision regarding settlement. In most cases, there is only one cause of loss, but in other, there could be more than one. In such circumstances, Proximate Cause Principle rule will help in determining the cause of loss.

After identifying the cause, it is essential to interpret the policy wording to see if the loss is covered under the insurance policy or not.

B. Non-contribution clause:

Some policies include what is called non-contribution clause and its wording may be as follows:

"This policy would not pay any claim if the insured has the right to receive indemnity for any other policy".

This means that the policy would not contribute to a covered loss whenever there is another policy available to cover the loss. An addition to the clause wording might be done by stating: With an exception of any additional amount to the sum payable by the other policy as if this policy did not exist (Alajmi, 2-27).

2.6 Proximate Cause Principle

Learning objective

Introducing the trainee to the importance of determining the proximate cause and classifying perils

When a loss occurs, it is important to determine the cause of loss before making a decision regarding settlement. In most cases, there is only one cause of loss, but in other, there could be more than one. In such circumstances, Proximate Cause Principle rule will help determining the cause of loss.

After identifying the cause, it is essential to interpret the policy wording to see if the loss is insured or not. Proximate Cause can be defined as: the effective cause leading to a chain of consecutive events that eventually result in a loss without intervention form any other factor established from a new independent source that breaks the chain connection (Alajmi, 2-27).

Perils related to insurance claims can be classified as follows:

- **Insured Peril**

  This is a peril specifically mentioned in the policy as covered. A fire policy will specifically mention that losses caused by fire are insured.

- **Excluded Peril:**

  This is a peril specifically mentioned in the policy that are not covered. A fire policy specifically mentions a fire caused by an earthquake is not covered.

- **Uninsured Perils:**

  These are perils not mentioned in the policy. If the cause of loss is an unnamed peril, it is not covered. The fire policy does not mention the peril of theft. It is therefore neither insured nor excluded peril but simply an unnamed peril.

If there is a series of events, there must be a direct link between the cause and resulting loss. Each action should be the natural consequence of the previous with nothing new intervening to change the effect. The proximate cause is not necessarily the first or the last cause but is usually the dominant cause. The cause that has set in motion a chain of events that results in a loss. (Alajmi, 2-29).

Applications of the proximate cause:

A. Fire insurance:

A Fire insurance policy insure the losses resulting from a fire such as financial losses caused by large amounts of water sprayed to extinguish the fire. Additionally, losses caused by water include losses caused by throwing objects from windows to minimize the impact of fire and destruction of adjacent properties to avoid spread of fire. These are all examples and applications of the proximate cause principle

B. Personal accident insurance:

An insured has an insurance policy that covers personal accident only and not diseases. As an example; while climbing, the insured fell down, wet his clothes, and had a severe flu. Here, what caused the flu is the proximate cause which is falling while climbing.

C. Breaking glass insurance:

An insured has a breaking glass insurance policy, with the exception of losses caused by fire. Fire broke in the nearby warehouse and people crowded around. One person threw a rock to break the store's glass and stole what is inside. The losses are subject to the proximate cause principle which is breaking the glass and not the fire in the nearby warehouse. This means that the insurance company will be responsible of the loss caused by breaking the glass and the robbery resulting from it (Almasri, 182).

Chapter Two
Revision questions:

1. What is a material fact?
2. List some of the material facts that are required to be disclosed?
3. When Utmost Good Faith principle must be considered?
4. When Insurable Interest is considered for all types of insurance policies discussed?
5. What is the relation between the reinstatement method and the Indemnity Principle?
6. According to the law in Saudi Arabia, what are the cases where an insurer can subrogate the insured?
7. The Contribution Principle is subject to a number of methods. List these methods and explain how each one works.

Practical questions:

Answer the following question:

1. If a shop owner insured his merchandise for SR50,000 but at the time of loss, the total value of the merchandise was SR100,000 and the amount of loss was SR15,000. What is the indemnity amount that the insured will receive?

Chapter Two
Answers of Chapter Two Revision questions:

1. What is material fact?

A material fact is any fact that increases the risk or makes it more serious than others in the same category. It is also related to the manners or personality of the insured, his manager, or his employees.

2. Material Facts that are required to be disclosed are:

- A full description of the subject matter of the insurance. The car, property, liability etc.
- Any other policies covering the same risk.
- Previous insurance, especially insurance relevant to an insurance company that has declined insurance or imposed special or restrictive terms.
- Details of previous losses and insurance claims.
- Any fact that increases the risk from normal. For example, a car engine modified to make it go faster.

3. When Utmost Good Faith principle must be considered?

Utmost Good Faith is a duty of disclosure and all parties to the contract are obliged to disclose all material facts.

The duty of disclosure begins at the start of negotiations and continues until the contract is in force. After that, both parties are subject to the terms and conditions of the contract. However, even if there were changes after inception, the insured should disclose them. Most insurance policies contain a condition that the insured must disclose any alteration that increases the possibility of loss. Even without this condition, the insured should disclose any such alteration because the essential terms of contract have altered.

4. When Insurable Interest is considered for all types of insurance policies?

Marine Insurance:

In marine insurance, there must be insurable interest at the time a loss occurs and not necessarily at policy inception. The nature of marine business is such that goods can be in transit for several months and its ownership could change during the journey. Therefore, the person who may have taken out the insurance may not be the person who suffers the loss.

Life (Protection and Savings):

It has been established that in life (Protection & Savings) insurance insurable interest has only to be present when the policy is taken out and not necessarily when the loss occurs - the opposite of Marine Insurance. This may seem a strange position but is not really a problem. If for example a bank requires a life (Protection & Savings) policy as a condition for a substantial loan, the debtor takes out the insurance on his life and names the bank as the beneficiary for the proceeds. If the loan is paid, the insured can simply change the beneficiary, or cancel the insurance.

General Insurance:

For all other policies, insurable interest must exist at policy inception, during the currency of the policy, and when the loss occurs. If there is an absence of insurable interest when the insurance starts then the contract may be considered invalid and if there is no insurable interest at the time of the loss then there will be no loss to the insured.

5. What is the relation between the reinstatement method and the Indemnity Principle?

Reinstatement tends to refer to buildings or machinery and is similar to repair. Insurers may choose to undertake to rebuild the damaged building themselves, which is an option rarely exercised because of the problems it can cause to insurers. Normally, they would expect the insured to arrange the work and limit their role to verifying that the work is in order and within the policy terms. They then reimburse their insured.

6. The Contribution Principle is subject to a number of methods. List these methods and explain how each one works.

First Method: Sums Insured Method:

In this method, the contribution to be paid by each insurer is calculated by apportioning it according to the sums insured.

Second Method: Independent Liability Method:

For the policies subject to average condition or indemnity limits to sum insured for single losses even if it is not subject to rateable proportion condition, the "Independent Liability Method" will be used to apply contribution principle. "Independent liability" can be defined as the sum payable by each insurer as if he was the only insurer responsible for the loss.

Practical Question:

1. If a shop owner insured his merchandise with SR50,000, but at the time of loss the total value of the merchandise was SR100,000 and the amount of loss was SR15,000. How much will the indemnity he receives be?

$$\frac{\text{Sum Insured at time of loss}}{\text{Full Value at time of loss}} \times \text{Loss} = \text{Claim Payment}$$

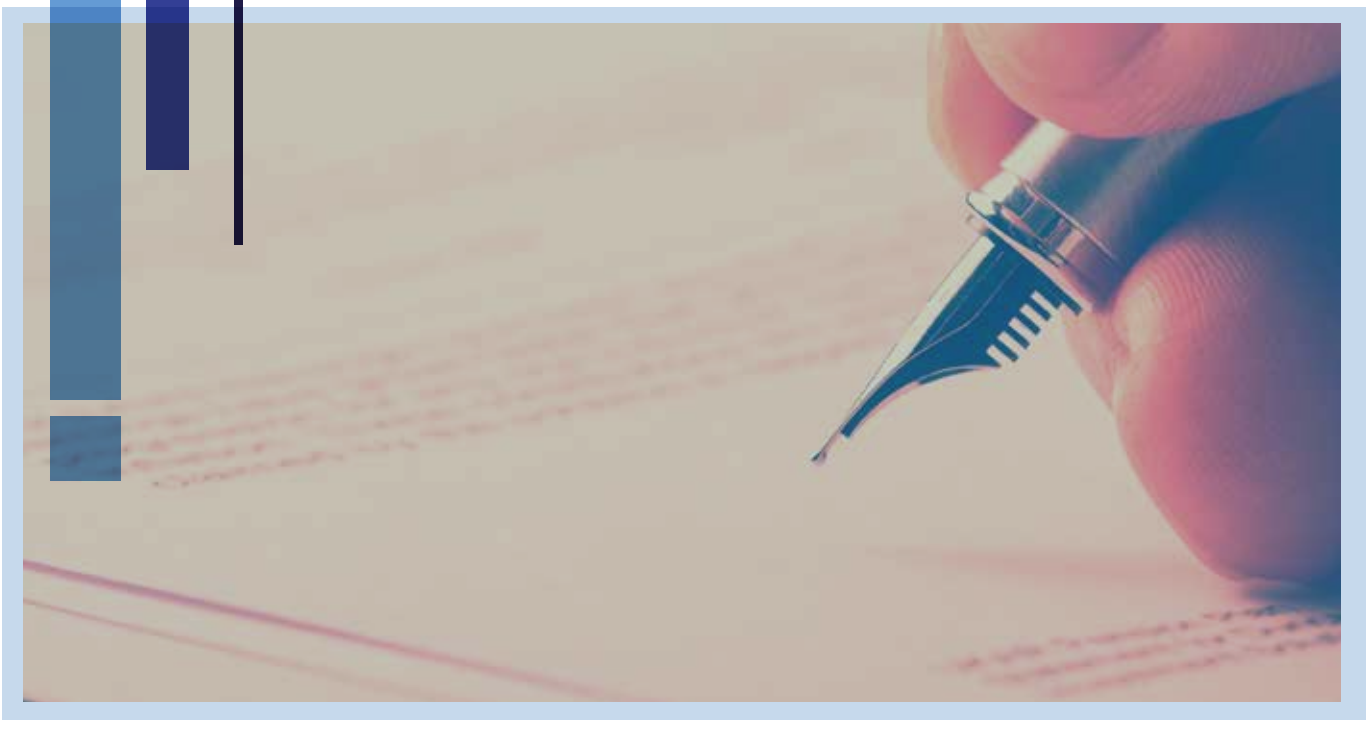
Replacing these with figures above:

$$\frac{\text{SR } 50{,}000}{\text{SR}100{,}000} \times \text{SR}15{,}000 = \text{SR } 7{,}500$$

If average applies then the insured will not receive a full indemnity since he will be in a better position than the one he was in before the loss. This is because he reduced the insured item value to get a reduced premium, but the indemnity will be the same as the actual value of the item insured.

Chapter Three

Insurance Contract



Introduction

After we have talked about the main unit in the insurance industry, which is the risk, then identified the principles governing insurance as an idea that has developed and spread, we will to talk now about the insurance contract that governs the relations of the parties who have committed reciprocal obligations towards each other's while convinced of the idea of insurance that performs functions beneficial to them.

The essence of an insurance contract is having knowledge of the contract, its definition, characteristics, and composition. Therefore, our discussion about the insurance contract will be divided into three sections. First, we will discuss the definition of the contract, then we will move on to the characteristics, and lastly, we will look at its composition.

3.1 Defining the insurance contract

Learning objective

Introducing trainee to the definitions of the insurance contract from a legal and religious point of view

Insurance is a contract whereby the insurer undertakes to accept certain types of risks that the insured fears and wishes not to bear alone in return for a premium or contribution paid by the insured.

This type of contracts has developed substantially so that risks became subject to sharing among different institutions and businesses after being born by the person that suffered the loss alone. We now have motor vehicle insurance, medical insurance, disability insurance, old age insurance, fire insurance, and many other. We also have marine insurance that covers damages to goods shipments by sea and rivers including sinking, collision and fire. Other types are agriculture insurance, industrial insurance, personal accidents insurance, theft insurance, Life (protection and savings) insurance and liability insurance.

Therefore, the definition of insurance contract is:

"A contract whereby the insurer undertakes to pay to the insured or to the beneficiary an amount of money, an income or any financial compensation in the event of an insured accident or the realization of the risk specified in the contract, against a specified amount of money or periodic installments paid by the insured to the insurance company". (Alkaline, 99).

In this definition we find that there is a legal relationship between two parties: The first is the guarantor known as the insurer (the insurance company), and the second who is exposed to this risk is called the insured. This relationship established by the consent of both parties results in reciprocal obligations, whereas the insured pays a certain amount of money called premium, and the insurer pays a sum of money when the insured risk occurs.

There is also another aspect in the insurance process that is the technical aspect, which is the idea of insurance itself. Without this technical aspect the definition of the insurance contract will be incomplete. The definitions given by the authors were generally incomplete may be because they

took into consideration only one of the two aspects in the insurance process. Therefore, and in order to provide a comprehensive definition for the insurance contract, authors must take into consideration the two important aspects of the process: the legal aspect and the theoretical aspect.

Part of the doctrine defined the insurance contract as:

"A contract whereby the insurer undertakes to indemnify the insured for certain types of risks feared by the contracted parties, and the insured wishes not to bear them alone, in exchange for a so-called premium or contribution paid by the insured."

Others define insurance as:

"A technical operation carried out by regulated bodies whose task is pooling as many similar risks as possible through a clearing process in accordance with the Statistics law. Accordingly, the insured or his appointee shall, in case of realization of the insured risk, receive financial compensation paid by the insured in return for the payment of the insured of the premiums as agreed in the insurance policy". (AlKilani, 100).

Another definition:

"An indemnity contract whereby one of the parties who is the insurer undertakes to pay to the other party who is the insured or the beneficiary from the insurance coverage, a financial compensation upon the realization of the damage, in accordance with the provisions of the contract, against a fee called the insurance premium paid by the insured to the insurer in the amount, time and manner stipulated in the contract". (Zuhairi 22)

3.2 The main Insurance Contract Elements

Learning objective

Introduce trainee to the main elements of the insurance contract

The definition of insurance contract highlights a number of key elements:

A. A fact that a person / group is at risk of either:

- To his person or body (as in life - protection and savings - and personal accidents insurance).
- To his money or properties (as in fire, theft, and motor insurance).
- Being liable/ Liabilities (as in public liability and professional liability insurance).

B. As a result, this person, institution or group at risk resorts to insurance in order to obtain protection, requesting to contract an insurance company by paying a specific amount of money (the premium), either as a single payment or in periodic payments (this party is called the insured in the insurance contract).

C. The insurance protection sought by the insured is to receive compensation when the insured risk or the accident is covered by the insurance contract. The insured may request that the indemnity be paid to others, as in liability insurance where indemnity is paid to the injured third party (beneficiary).

D. The other party of the insurance contract is the insurance company which, against the premium paid, indemnifies the insured or the beneficiary as stipulated in the insurance contract when the insured risk is realized or the insured accident occurs.

E. Compensation stated above has number of forms:

- Cash payment to the insured or beneficiary.
- Payment of a periodic salary
- Replacement of the damaged part
- Reinstatement of the damaged insured items or properties to the same condition prior the accident.

F. Technically, the insurance mechanism is highlighted as follows:

- The insurance company contracts as many insureds as possible.
- These insureds are all exposed to a particular risk (e.g. traffic accidents such as collision in vehicle insurance or fire in property and building insurance).
- Each one of the insureds pays to one fund or to an insurance portfolio an amount of money equivalent to his risk exposure. When the risk occurs for some of the insureds in a specific period of time, everyone contributes, each according to the size of his own risk exposure, to the losses resulting from the occurrence of the risk or the occurrence of the insured accident. This contribution must have already been paid in advance and is represented by the insurance premiums.
- It can be clearly seen that insurance is nothing but a cooperative process carried out by the insureds themselves, while the insurance company only manages the collection of these contributions and pays compensations to the aggrieved parties due to the occurrence of the insured accident or risk. (Alanbki, 41).

3.3 Insurance contract elements

Learning objective

Introduce trainee to the insurance contract elements that must be present in order for the contract to be valid and the insurance coverage to take effect

The insurance contract is entered into once the offer of one of the contracted parties is accepted by the other party. The definition of the contract expands to refer to these two elements (offer and acceptance) on condition these be reflected in the subject of insurance (the insured item or object).

Contract is not valid unless five conditions are present:

- Availability of its elements and conditions of validity
- The availability of these elements by mutual consent.
- Consent does not exist unless the right will is manifested
- This manifestation of will must stem from the contracted parties
- A legitimate subject of insurance and a legitimate purpose.

Here we will discuss the five elements of the insurance contract as follows:

First element: Consent

Consent is the expression of the will of each of the contracted parties. These wills must meet. Two elements are required for the existence of consent:

- Capacity
- A will free from defects.

This means that the consent by itself it is not enough unless there is a true consent. The consent is not considered to be true unless manifested by a qualified person and the will of any one of the contracted parties is not defective. (Alanbiki, 46)

Second element: Parties to the insurance contract:

This element relates to the parties to the contract and the capacity element:

A. Identifying the contracted parties:

The two parties to the insurance contract are the insurer (the insurance company) and the second party is the insured who contracts the insurance company to insure himself against a particular risk. The insurance applicant who submits the insurance application form, and the insured who is exposed to the insured risk, and the beneficiary of the insurance, may be a one person who meets the three characteristics, as in the case of the person who insures his shop against the risk of theft for his benefit; he is the insurance applicant who contracted with the insurance company, and also the insured person who is exposed to the insured risk , as well as the beneficiary who concludes the insurance for his benefit.

B. capacity of contracted parties

• Capacity to rights and obligations:

It is the eligibility of a natural person to acquire the legitimate rights and obligations and be in the eyes of the law eligible to perform these rights and obligations. Every natural person is a legal person that enjoys this capacity since birth.
Also the moral person, which is a legal entity, is eligible to acquire rights and obligations because the moral personality means in fact the capability to acquire rights and bear obligations. (Alanbiki, 48).

• Capacity to perform

It is the eligibility of the person to perform the rights.This legal capacity lies in the discretionary power of a person, and the reason is that the will of a person is only expressed through discretionary powers. Therefore, whoever is capable of fully using discretionary powers is a fully legally capable person.

• Lack of capacity:

A person, who is non-discretionary, has no legal capacity, for example:
- A non-discretionary child is a child who is under the legal age in a particular country. In some cases, the discretionary age is estimated to be seven years. Anyone who has not attained the age of seven is considered to be a non-discretionary person lacking capacity and has no right to dispose of his assets. All his action are voidable and cannot perform any contract (Alanbiki, 48).

Mad and insane:
Madness means the imbalance of the mind, so that it prevents sound acting and speaking except rarely. It is the imbalance of ability in differentiating between the right and the wrong. The insanity, however, is also the imbalance of the mind but the words of the insane will at times be similar to normal people and at some other times like the words of a mad person. The insane is considered to have a child's mind.
The heedless and the foolish: their capacities are incomplete; the headless is a person who wastes his wealth and acts without purpose or for a purpose that wise religious people do not consider a valid purpose.

- Will free from defects:

The validity of the contract requires the existence of consent which must be true. Consent is not considered to be true unless stemming from a capable person. The defects of will are manifested in the following cases:

- The existence of consent with error and fraud.
- Obtaining consent by coercion.
- Exploitation of need.

The following defects apply to the insurance contract:

- Making a mistake while concluding the contract by concealing information from the insurance company or giving incorrect information without evidence of bad faith from the part of the insured. In this case, the insurance contract is voidable in favor of the insurance company.

- The contract of insurance shall be interpreted in accordance with the general rules. Clear conditions are to be complied with, but vague conditions shall be interpreted in favor of the insured. If there is a conflict between the copies of the contract, the version with the insured shall prevail. If there is a conflict between the printed condition and the condition typed or handwritten, the handwritten condition shall prevail if it amends the printed one (alanbiki, 50).

Third element: The subject matter of insurance

The insurance subject matter must be either an asset, benefit, obligation, an act, or an omission. The insurance subject matter must satisfy four conditions:

- The subject matter must be legally correct: this means that the contract is not proper unless its subject matter, i.e properties, business or benefits, are legitimate or permissible (lawful).
- The insurance subject matter must be existing at the time of the conclusion of contract. For example, in fire insurance, the building and its contents should actually exist when applying for insurance.
- The insurance subject matter should be known to the parties: the insurance subject matter must be defined and known to eliminate ignorance. As such, in insurance contracts, insurance companies usually conduct a physical inspection on the vehicle when they receive an insurance application or proposal.
- The ability to deliver: This means that the insurance company is able to meet the insured's desire to insure things that are realistic and not impossible.

Fourth element: the purpose in insurance contract:

This is the direct purpose that the obligor intends to reach from his obligation. In the insurance contract, it represents the motive for the insured to pay the insurance premium in order to obtain insurance protection. The purpose should be legitimate in order to make the will produces its effect. The will must be directed to a legitimate purpose that does not conflict with public order or morals, in order to protect the society from manipulations, and direct the demand for insurance to legitimate and lawful matters. The purpose should be kept away from mistake, fraud or coercion. (Alanbiki, 53).

The purpose should be present at the time of application and during the whole insurance period.

Fifth element: the consideration in insurance contract:

According to this element, and for the contract to be enforceable, each party has to provide something of value, whether money, goods, services, or any promise whereby the declaring party legally commits to make an act or an omission. Those for whom the commitment is made will have the right to expect that the promise be fulfilled or to claim its fulfilment. In the insurance contract, the consideration represents the payment of the premium by the insured in return for receiving the insurance protection. In contrast, the insurance company provides insurance protection against receiving the premium (Alankabi, 56).

3.4 Stages of the insurance contract until conclusion:

Learning objective

Stages of the insurance contract until final conclusion in practice

In practice, the conclusion of the insurance contract passes through several consecutive stages consisting of the following steps:

A. Insurance proposal

B. Insurance offer (price and conditions)

C. Acceptance (mutual consent)

D. Temporary cover note (issuing policy)

E. Insurance policy

F. Managing the contract or the insurance policy (policy endorsements, such as additions, amendments and deletions)

G. Renewal and expiration of contract (non-renewal)

3.5 Insurance contract characteristics

Learning objective

Clarifying the characteristics of the insurance contract and the role of parties to the contract

The insurance contract meets with other contracts with most of their characteristics. However, the insurance contract differs from other contracts in some characteristics due to its special nature.

Accordingly, this contract has general characteristics and special characteristics, which we will review as follows:

A- Obligatory to the two parties:

The reason for the obligation of each party to the insurance contract is the obligation of the other party.This means that the parties to the contract are committed to each other.The insurer commits to provide the guarantee while the insured commits to pay the premium. Consequently, the relationship between the parties is a contractual and reciprocal relationship.
It is not valid to object that the insurer is not providing the guarantee unless the risk is realized. The obligation to provide the guarantee does not stand, and the insurer does not indemnify the insured if the risk did not occur. That is because the obligations are determined when the contract is entered into and they represent the effects of the contract that must be adhered to. Actually, the reciprocal obligations are set at the time the contract is concluded not when the contract is being under implementation (Alkilani, 102).

B- Indemnity Contract:

This fact of the insurance contract means that each party gets a return for what it gives. The insured pays the insurance contribution or premium in return for the protection against the consequences of certain risks he fears during the validity period of the contract. The agreement of the parties to the insurance contract to avoid losses excludes any form of donation to the contract even if the loss or the risk did not occur, and also does not deny the fact that it is an indemnity contract, even if its effects extend to other parties strangers to the contract, as in the case of third party liability insurance.

C - Consensual Contract:

The insurance contract is a consensual contract. The purpose of the contract and its subject matter are the elements related to offer and acceptance without the need for a specific form. This means that there is no need to write the insurance contract.

Contracts are essentially consensual by law. However, contracted parties are used to document the contract in writing due to the large amount of details and conditions.

The Insurance contract is in its essence a consensual contract despite the remarks of some scholars whom they believe it is not. Some see that the insurance contract is a formal contract while others see that it is an in-kind contract. Some others simply consider it an in-kind contract. We are of the opinion that the insurance contract is a consensual contract that enters into effect once there is an offer and acceptance. The payment of the premium has no effect whatsoever on the qualification

of the nature of the contract, because the payment is not a pre-condition for its conclusion, even though the parties may agree to change it to a formal or an in-kind contract. If a party considers that the contract shall not enter into effect unless the premium is paid to the other party then the contract becomes formal and in-kind at the same time. The contract shall in this case be qualified as formal contract since the parties have to affix their signatures on the contract, and in-kind because the contract shall not enter into effect unless the first premium is paid.

D - Contingent contract

The contingent contract is a contract that the parties thereof cannot know, at the time of contract conclusion, what is to give or take. The insurance contract is qualified as such because the payment of the indemnity (the sum insured) depends on the occurrence of the risk. The contract from the legal perspective stipulates the relationship between the insurer and the insured based on contractual provisions. The obligations of each of the parties is contingent to the occurrence of the risk and the time of occurrence.

We can say that the insurance contract is a contingent contract because its purpose is to bear a risk that may or may not occur and because in most insurance contracts the possibility of a loss occurrence exists. As such, it is not possible to predict, at the time of contract conclusion, what will be the benefit or the loss. This is what makes the insurance contract surely a contingent contract.

E - Continuing contract:

The insurance contract is a continuing contract because the obligations of one or both parties are performed periodically over time. The insured›s obligation to pay the premium is a continuous and recurring commitment for regular intervals during which annual premiums are paid during the insurance period. Also the insurer›s commitment to insure the risk is for the whole period of the contract. This is sufficient to say that the contract of insurance is a continuing contract (alkilani, 104).

F - Adhesion contract:

The insurance contract is a contract of adhesion because the insurer sets the conditions under which he dictates his will to the insured. The latter can only accept or refuse the conditions as dictated, since he does not have the freedom to bargain or discuss their main contents.

There are those who believe that the insurance contract is not a contract of adhesion, even if it contains printed conditions formulated by the insurer to serve his interests, and argue that the insured can refuse the contract and resort to another insurance company, and that he is not obligated to contract with the company that has written those conditions even if there is a possibility to describe any of these conditions as not negotiable. The insurance contract is a conditional contract because its existence depends on the occurrence of a risk insured, and the obligation of the insurer is pending on a clear condition.

G – Cooperation contract:

Insurance is one of the means of cooperation among individuals and bodies. Thanks to the contract, the risks that a single person would have to bear are turned into collective risks shared by a group of people who cooperate together to bear the consequences. The owner of the store that is burnt by fire may result in bankruptcy to that owner unless he had insured his store against the risk of fire. However, if the owner takes precautions by insuring his store, the damage, when it occurs, will be distributed among a large number of other owners who have insured their stores as well (alkilani, 105).

H - Insurance contract is a contract of good faith:

This means that the insurance contract must be implemented in good faith. This characteristic plays a major role in the insurance contract, whether at conclusion or during implementation, and is greater than the role that this characteristic play in the other contracts. The insurer, in many circumstances, cannot have a real idea about the insured risk and its size except through the information given by the insured when applying for insurance.

Therefore, the applicant must be honest in making statements, which means that good faith, as one of the insurance contract characteristics, interferes in its conclusion as well as during implementation on the basis that the insured should do his best to limit the size of the risks when they occur and refrain from anything that would increase those risks. The insured also has to declare all circumstances that may increase the size of the risks, and refrain from causing the risks himself, and try to limit their extent and restrict risks in the narrowest scope. If the insured does not comply with the good faith principle, he will lose his right to the insurance. The reason behind it is that the intentions of the contracted parties are what the contract is all about (Alkilani, 106).

I - The commercial status of the insurance contract:

The insurance contract is more of a commercial nature, so that it is considered a commercial act on the basis that the insurer is a trader who insures against the risks on property and persons in favor of others in order to gain a profit. Therefore, this contract is commercial by nature. However, this principle does not apply to all parties even if we accept the commercial nature of the contract as an act of the insurer. This principle does not apply to the contract as an act of the insured in all cases, because it is not correct to say that life insurance is a commercial act for the insured himself, since he will not gain after his death. This is also true in general types of insurance. We cannot consider insurance as a commercial act for the insured person because his will is not geared towards making a profit and because what he seeks is simply to recover his loss as a result of the occurrence of the insured risk.

It is also a commercial contract since the insurer is a commercial company that receives fixed or specified premiums and since this company is established with a huge capital to be invested for the purpose of making profits, which makes it a commercial act.

This is the definition of the contract and its elements from a legal perspective, and this is why the structure of the insurance contract from the insurance perspective is as follows:

A contract does not have to be in writing to be a valid contract. However, in a complex matter such as insurance, it is advisable to have the details in writing. There is clearly an opportunity for disagreement if changes are not confirmed in writing. Documents serve several purposes including:

A. Information: Standard documents are used, which help insurers receive information in a consistent manner. This reduces the possibility of receiving irrelevant data or missing important information.
B. Record Keeping: Insurers need to know their potential liabilities, reinsurance requirements etc.
C. Discrepancies: The documents clarify discussions and agreements and ensure that insurers satisfy the policyholder's requirements.
D. Disputes: Reference to the appropriate document can often resolve disputes at an early stage.

The result is a range of documents for different purposes, which we shall examine in this chapter. Several will be familiar as they were discussed in earlier chapters. Others will be completely new to you.

3.6 Proposal Forms and policy structure:

Learning objective

Introduce trainee to the insurance process and its main required documents until the issuance of the insurance contract (Policy)

Proposal Forms

Proposal forms are the most convenient way for the insurer to receive information concerning the proposed risk. Proposal forms can be quite plain or can be a form of advertising, particularly for personal classes of insurance.

A brochure helps to sell the insurance product, and the proposal when completed is detached and sent to the company. The policyholder retains the brochure for information purposes. Brochures may contain a note that the brochure is not part of the contract and is 'for information only'. It is however advertising and like all advertising, it cannot mislead or misinform the client.

You will recall that marine insurance and sometimes large and complex fire risks do not use proposal forms. Briefly, explain the reasons for this.

Insurance Policy Forms

Learning objective

Introduce trainee to the structure of insurance policy and its main components and sections

When the insurer has accepted the proposal, terms agreed and the premium is paid (or the insured has promised to pay the premium), then the contract is in force and subject to the laws of contract, irrespective of the existence of a policy wording. The policy is the evidence of the contract, not the actual contract.

The Implementing Regulations of the Cooperative Insurance Companies Control Law in Saudi Arabia define the Insurance Policy as **"Legal document/contract issued to the insured by the insurer setting out the terms of the contract to indemnify the insured for losses and damages covered by the policy against a premium paid by the insured".**

Every insurer has its own style of policy wording. Policies may be of different forms and vary from one company to another. They may also be in some sort of a small booklet, bound in plastic covers with explanatory notes to clarify some terminologies for easy use.

The class of business determines the length of the document. A simple personal accidents (PA) policy may be a few pages, but a house insurance with its numerous sections or a fire and perils policy for a large manufacturing risk, with extra perils, warranties etc. could be quite a bulky document with several pages.

In the UK, the Plain English Campaign has had a major influence on insurers' approach to policy wording. It has made them consider the structure, layout, and language used and many policies try to use clear, everyday language and define any words that may be unfamiliar or capable of misinterpretation.

Whilst we have stated that every insurer has their individual style, all policies contain eight sections. They are:

A. Heading:

The section at the top of the policy giving the insurer's name, possibly the company logo and the registered address.

B. Preamble:

Usually found immediately below the heading (which means a preliminary statement or introduction).

The preamble contains two essential points:

- The proposal is the basis of the contract and the proposal form is incorporated in the contract. The proposal is not confined to just the proposal form. Other documents, correspondence, discussions etc. are part of the proposal, and therefore part of the contract.
- Reference to the consideration of the insured (has paid or agreed to pay the premium) and the consideration of the insurer (will provide the insurance as detailed).

C. Operative Clause:

An important section of the policy as it sets out precisely the cover provided by insurers and the circumstances when they will pay (Covered risks). They often start with the phrase 'The Company will pay' and then the details follow. The Operative Clause can be very short, (certain All Risks Policies) or quite lengthy (a motor policy).

Why is the Operative Clause on an All Risks Policy much shorter than that of a named perils policy?

D. Exclusions:

Also known as exceptions, they detail what the policy does not cover.

Exclusions can be classified into one of three categories:

- Risks considered uninsurable in the normal insurance market. Sonic bangs, radioactive contamination and war risks. These risks are the most common.
- To avoid confusion certain risks are more appropriately insured under another policy. The theft policy may exclude money; the Public Liability (PL) policy excludes liability arising from the use of motor vehicles and so on.
- There are risks that insurers are prepared to consider, usually because they are extra hazardous, only after making further enquiries and possibly requesting additional premium and/or other terms.

Give an example of two exclusions:

- The first - because the cover is available under another policy.
- The second - when the risk is insurable but excluded because it is considered by the insurer as an additional hazard to the risk.

E. Conditions:

All insurance policies are subject to conditions - either implied i.e. not written in the policy or expressed i.e. they are written in the policy. They lay down rules that govern the behavior of both parties during the period of the policy.

Implied conditions are present for all policies and they are:

- That the subject matter of the insurance (property etc.) actually exists and is identifiable
- That both parties have observed utmost good faith
- That the insured has insurable interest

Written as part of the wording are the express conditions. They vary according to the type of contract but several are common to most policies. Conditions can be:

General, which means they apply to the whole contract. These include:

- Alterations /amendments
- Cancellation
- Claims Notification
- Fraud
- Reasonable Care
- Subrogation
- Co-insurance
- Arbitration

If general conditions apply to the entire contract, then particular conditions are conditions that relate to a particular or an individual section of the policy and not the entire contract.

Conditions vary according to the timing of the event for example; some relate only after a claim has occurred. There are three headings:

- Conditions before the contract: these are mainly the implied conditions but may also be written into the wording. They apply before the contract is formed.
- Conditions during the contract: these apply after the contract is in force and are the majority of the conditions. They include taking proper care, fraud, cancellation, alterations etc.
- Conditions before liability: these conditions apply after a claim, and if the claim is to be paid these conditions must be enforced. Subrogation, contribution (other insurances), claim notification are examples.

F. Cooperative profit sharing clause:

Ten Percent (%10) of said Net
Surplus shall be distributed to all Policyholders, each proportionately to his premium, by reducing

the premium of the following year.

G. Signature:

The policy is signed by a senior official of the company, typically the managing director or general manager. The signature is printed on the policy and usually countersigned or initialed by the official checking the contents before forwarding to the client.

H. Schedule:

The six sections of the policy discussed so far are a standard document for each type of policy. The policy forms are mass-produced and the schedule contains all the information concerning the individual risk that makes it an individual contract.

The schedule may include the following information:

- Name of the insured
- Postal address
- Risk address
- Description of business
- Inception Date
- Renewal date
- First and annual premium
- Policy number
- Sums Insured
- Description of property insured (if large a separate specification may be attached)
- Excess or deductibles
- Special conditions
- Name of broker or agent

3.7 Warranties and endorsements

Learning objective

Illustrate the importance of warranties and their role in the insurance contract and the changes that occur to the policy during the policy period and how it works.

Warranties:

What is the definition of a warranty?

Some people argue that warranties are part of the policy conditions and not a separate section of the policy. The argument is academic; the main point is that a breach of warranty entitles the aggrieved party (nearly always the insurer) to repudiate the entire contract. In that sense they are more 'important' than the conditions where although a breach might entitle insurers to repudiate the contract (e.g. fraud). Many breaches of conditions may entitle insurers only to repudiate an individual claim (breach of subrogation condition) or to impose stricter terms (e.g. failure to declare a premium adjustment condition).

Despite the seriousness of a breach of warranty, insurers in practice tend to be more moderate

in their approach and unless it is very serious do not repudiate contracts for a single breach. They would not wish to lose an otherwise good policyholder and it is unlikely that they would repudiate a claim if the breach is not connected with the loss.

Endorsements

During the period of a policy, changes are inevitable. The insured may change his motor vehicle, or property owners may buy and sell properties, change declared values or add or remove items from the schedule. Insurers prepare an endorsement detailing the changes made to the terms of the insurance.

As stipulated for in the Unified Compulsory Motor Insurance Policy in KSA, the endorsement is "An agreement between an insurer and the insured, subsequent to the issuance of the Policy, whereby items of coverage are added to, amended or removed from the basic coverage, and which should be attached to the Policy and deemed an integral part thereof".

One of the typical images of using endorsements is the case where the insured changes his insured vehicle according to the motor insurance policy, in which case the insured informs the insurance company. In turn, the insurance company, if it accepts to make the change, will inform the insured of any additional conditions or provisions that it may wish to impose (the value or performance of the new vehicle may be much higher than the old one). If the insured agrees to the new conditions, the endorsement will then amend the policy by stating the details of the new vehicle and any additional conditions (higher deductible) or additional premiums that must be paid.

3.8 Cover Notes and Certificates of Insurance:

Learning objective

Trainee will be able to know the role of the cover notes and certificates of insurance and when it can be used and its benefit.

Cover Notes:

The policy is the written evidence of the contract and contains all the details of cover provided. Preparing the formal document takes time and it is not always possible, in fact, it is very rare for the document to be ready from the first day of the insurance.

In the meantime, the insured may need to show to a third party that insurance is in force. If a property is a collateral for a loan, the bank may insist on insurance or a contractor may need to prove insurance to his principal before commencing work. The cover note serves this purpose. Cover notes simply state that insurance is in force and gives brief details of the cover. Notes are temporary and not needed once the policy is issued. The cover note may be a pre-printed form often in a numbered document, or it could take the form of a letter from the insured to the insurer.
Cover notes can be informal and vary between insurers as to content, style and appearance. They all, however, serve the same purpose. They are proof - if proof is needed - that insurance is in force and insurers are preparing the policy documents.

Certificates of Insurance:

Certificates of insurance serve a very similar purpose as cover notes; they confirm that cover is in force. When insurance is compulsory, the authorities may ask the insured to confirm that cover is in force.

It would be cumbersome to carry the entire policy document and as they differ from company to company, it would be difficult for the authorities e.g. the police to be sure that the policy was valid. Certificates are therefore required and they are in a standard format recognizable by all concerned.

Marine cargo insurance uses certificates of insurance, and they become part of the shipping documents. The certificate of insurance contains information concerning the shipment which will be substantially the same as that contained in a policy i.e. description of goods, conveyance, voyage, sum insured etc. Marine Insurance plays a vital role in the international system of trade, although not legally required, the insurance policy together with letters of credit, bills of exchange, bills of lading, are necessary documents to facilitate the smooth exchange of goods and money around the world.

A vendor selling his goods overseas will naturally want payment for those goods when they leave his warehouse. A purchaser buying those goods will not wish to pay for them until they have safely arrived in his warehouse, possibly thousands of miles away. Journey times may take several months and there is clearly a problem if both parties are to be satisfied.

A step-by-step example will make the process clear.

- Rashid in Riyadh agrees to purchase machine parts from a company based in Manchester, UK.
- Rashid visits his bank in Riyadh and obtains a letter of credit.
- The letter of credit is sent to the supplier's bank in the UK.
- To obtain the money the supplier sends the goods to Riyadh and confirms by giving the shipping documents including the certificate of insurance to the bank.
- The UK supplier receives his money.
- The UK bank sends the shipping documents to Riyadh.
- The goods are in transit between UK and Riyadh
- The goods arrive.
- To collect his goods Rashid needs the shipping documents, to collect these he needs to pay the bank in Riyadh.
- Therefore, the supplier gets his money from the bank, the bank collects the money from the buyer and the buyer collects the documents from the bank and collects his goods, so every party is satisfied with the transaction.

The journey from the UK to Saudi Arabia could take several weeks. If there is a problem e.g. the boat sinks or an accident destroys the goods, the banks and/or Rashid have lost their money. Consequently, the banks will require a marine insurance policy to cover the goods during the journey. The certificate of insurance is an essential part of the shipping documents and is proof that a policy is in force.

As the certificate of marine insurance is part of the shipping documents if the goods change hands, the insurance certificate also changes hands with the goods. This is different from other classes of general insurance (non-life – Protection and savings) business. If a motorcar or a building is sold, the insurance is not sold with the property. The identity of the policyholder is an important underwriting consideration for insurers and they may not wish to give cover to the new owner.

Why do you think that a bank involved in an international transaction will insist on marine cargo insurance?

3.9 The Importance and the Content of Claim Forms

Learning objective

Introduce trainee to the claim model and its components, and the procedures that are carried out by the insurance company to settle the claim.

Generally, policyholders notify insurers (or their brokers) of a claim by telephone who send a claim form to the insured for completion and return. To satisfy the claim notification condition the insured should return the claim form within a reasonable time.

Typical questions on a property claim form and their reason for insurers asking them include:

- Name, address and policy number - enables insurers to locate the underwriting file
- Date of Loss - to check if the loss occurred during the insurance policy period.
- Cause of Loss – to ascertain if the peril is insured
- Details of damaged property – to check that the policy insures it
- Insured's relationship to the property – check on policy cover and insurable interest
- Value of the property – to check the sum insured and for average.
- Cost of repairs or replacement – the basis of the insured's claim
- Details of any other party involved – checking for possible recovery through subrogation
- Other insurances – to check for double insurance

A liability claim form will ask for details of the incident and extent of injuries or property damage to third party as a guide to the size of the claim expected.

Once a claim form is received by the claims department, the claims adjuster will make a number of checks before proceeding. Typically, these are:

- That there are no outstanding premiums
- Loss date is within the period of insurance
- Name, address, occupation, previous claims, and other information agree with the underwriting file
- Cause of loss is an insured peril
- There is no breach of a warranty or condition
- That the sum insured (for property insurance) is adequate
- The amount claimed is reasonable

In the event of doubt of any of these issues, further enquiries may be necessary.

Some claims do not require a claim form. Large losses where loss adjusters are carrying out a detailed investigation make a claim form unnecessary.

What action would you recommend if the information on the underwriting file contradicts the information on the claim form?

3.10 The Importance and the content of Renewal Invitations

Learning objective

Illustrate the benefit of renewal invitations and why it is used in the insurance company

The majority of policies run for 12 months. There is no obligation on either side to renew unless otherwise stipulated for in the regulations or the contract.

The code of Market conduct regulation in the KSA stipulates that "Companies must inform customers of the policy renewal or expiry date in a timely manner to allow customers to arrange continuing insurance coverage".

Also article 7 of the Unified Compulsory Motor Insurance Policy in the KSA stipulates that "The insurer shall notify the insured of the expiry date of the policy (20) working days before it expires, so that the insured can renew or replace the Policy with another policy from another insurer". The insurer will issue a renewal notice just before the renewal date (three to four weeks is a typical period), which brings to the insured's attention that the period of insurance is ending and indicating the renewal premium required. There is no obligation to issue a renewal notice, but it is clearly in the insurer's interests for retention of the business.

The renewal notice will indicate the premium required by insurers to continue the insurance for a further 12 months. It will contain brief details of the insurance, policy number and possibly where and how to pay. The renewal notice may also contain a warning or reminder to the insured of the duty of utmost good faith and that he must notify any changes or alterations to the risk.
The new period of insurance is a new contract, albeit with the same terms and conditions as the expiring contract.

What effect does the renewal, being a new contract, have on the insured's duty of utmost good faith?

3.10.1 Grace Period

Learning objective

Identifying the grace period, when the insurance company provides it to its clients, and what is the benefit of doing so?

Many insurers will insist that they receive the renewal premium before the renewal date. If there is non-payment, then the implication is that the insured does not want to renew the insurance and the policy will lapse.

There are cases however, when the insured has not paid the premium by the due date but it is his intention to renew. The renewal notice may have been lost, the insured was on holidays when the notice arrived or the check for payment may be missing. To take all this into consideration, Insurance companies allow a period of time, (7 to 14 days is typical but could be 30 days) for the insured to pay the premium. This is known as the grace period, during which if the premium is paid the policy will continue without any interruption in cover.

Grace period do not apply, if the insured indicates that it is not their intention to renew.

The Finance Director of a company returns from vacation on the 5th of September and discovers the renewal notice for the company's public liability on his desk. The renewal date was 1st of September and he immediately prepares a bank check and sends it to insurance company by messenger. Several weeks later, a customer makes a claim against the company alleging injuries received in a showroom on the 3rd of September two days before the premium was paid. Do you think insurers will deal with claim? Give reasons for your answer.

3.11 Long-Term Agreements: Invitations

Learning objective

Illustrate a long-term agreement and when the insurance company offers this agreement to the client, and the mutual benefits of both parties (insured – insurer)

Long-term agreements are agreements between the insured and insurer whereby the insured agrees to offer the risk for insurance to the insurer for a stated number of years (three is typical) at the same terms and conditions in force at expiry. In return, insurers offer a premium discount (%5 or even %10).

Insurers do not have to accept the offer, and if insurers revise the terms and conditions of the insurance, this becomes a counter offer and the insured does not have to accept the new terms. Long term agreements help insurers retain business, especially on a large commercial contract where the expenses of surveying and policy preparation are incurred in the first year.

Both sides benefit from a long-term agreement, the insured from the reduction in premium and the insurer retains the business.

Long-term agreements are not long-term contracts, each contract is for 12 months, the agreement is simply an opportunity for the insurer to retain business while the terms of the policy remains unchanged.

Chapter Three
Revision questions:

1. State the insurance contract elements
2. What are the rights and obligations capacity in natural and moral persons?
3. Where can we find the defects of will in the insurance contract?
4. State the eight sections of the insurance policy:

Practical question

1. What are the typical questions on a property claim form that have to be answered and why it is important to answer it?

Chapter Three
Answers of Chapter Three Revision questions:

1. State the insurance contract elements

The insurance contract is entered into once the offer of one of the contracted parties is accepted by the other party. The definition of the contract expands to refer to these two elements (offer and acceptance) on condition these be reflected in the subject of insurance (the insured item or subject).

Contract is not valid unless five conditions are present:

- Availability of its elements and conditions of validity
- The availability of these elements by mutual consent.
- Consent does not exist unless the right will is manifested
- This manifestation of will must stem from the contracted parties
- A legitimate subject of insurance and a legitimate purpose.

2. What is the rights and obligations capacity for natural and moral persons?

• Rights and obligation capacity:

It is the eligibility of a natural person to acquire the legitimate rights and obligations and be in the eyes of the law eligible to perform these rights and obligations. Every natural person is a legal person that enjoys this capacity since birth.

Also the moral person, which is a legal entity, is eligible to acquire rights and obligations because the moral personality means in fact the capability to acquire rights and bear obligations. (Alanbiki, 48).

• Capacity to perform:

It is the eligibility of the person to perform the rights. The legal capacity to perform lies in the discretionary power of a person, and the reason is, the will of a person is only manifested through discretionary powers. Therefore, whoever is capable of fully using discretionary powers is a fully legally capable person.

3. Where can we find the defects of will in the insurance contract?

- Making a mistake while concluding the contract by concealing information from the insurance company or giving incorrect information without bad faith. In this case, the insurance contract is voidable for the benefit of the insurance company.

- The contract of insurance shall be interpreted in accordance with the general rules. Clear conditions are to be complied with, but vague conditions shall be interpreted in favor of the insured. If there is a conflict between the copies of the contract, the version with the insured

shall prevail. If there is a conflict between the printed condition and the condition typed or handwritten, the handwritten condition shall prevail if it amends the printed one (alanbiki, 50).

4. State the eight sections of the insurance policy:

- Heading
- Preamble
- Operative Clause (main body of the policy)
- Exceptions
- Conditions
- Cooperative clause
- Signature
- Schedule

Practical question

1. What are the typical questions on a property claim form that have to be answered and why it is important to answer it?

Typical questions on a property claim form and their reason for insurers asking them include:

- Name, address and policy number - enables insurers to locate the underwriting file
- Date of Loss - to check if the loss occurred during the insurance policy period.
- Cause of Loss – to ascertain if the peril is insured
- Details of damaged property – to check that the policy insures it
- Insured's relationship to the property – check on policy cover and insurable interest
- Value of the property – to check the sum insured and for average.
- Cost of repairs or replacement – the basis of the insured's claim
- Details of any other party involved – checking for possible recovery through subrogation
- Other insurances – to check for double insurance

A liability claim form will ask for details of the incident and extent of injuries or property damage to third party as a guide to the size of the claim expected.

Chapter Four

Insurance products

Introduction

We have previously stated that insurance companies are main participants in the insurance market in Saudi Arabia as providers of various insurance services, including the provision of different products to meet the insurance needs of individuals, companies and others.

4.1 Insurance Products

This chapter will talk about the most prominent insurance products known in the Saudi market. But before that, we will talk about the most significant characteristics of these products:

Learning objective

Illustrating the most prominent characteristics of the insurance products known and availability in the Saudi market.

- **Miscellaneous products:** One of the most prominent characteristics of insurance products is that they are diversified to meet insurance needs of the various insurance applicants.
- **Standard products:** Standard products will be similar to insurance products in other insurance markets if prepared by experts in the insurance industry according to the risks that individuals and companies might face.
- **Flexible products:** In the sense that an insurance applicant can choose the insurance coverage that suits the nature of the risks he might face, or add some coverages to the standard coverage.
- **Licensed products:** Each insurance company must license any product they offer through the Saudi Arabian Monetary Authority(SAMA). Thus, insurance company cannot market or sell any insurance product without licensing it. The licensing process goes through several stages by preparing a special file with all the required information for licensing the product, and SAMA either grants a temporary license or a permanent license to the product.
- **Cooperative products:** As mentioned above, using a cooperative insurance system is one of the insurance market advantages in Saudi Arabia, and it does not allow any insurance company to operate differently, so we will find in the policy of any product a clause that relates to cooperative insurance.
- **Products that keep up with technology:** In the sense that applicants can buy some insurance products through insurance company's websites without visiting insurance companies.

Classifying insurance products in the Saudi insurance market:

Those who work in the insurance industry outline several categories of insurance products. Some of these categories are classified according to risks, such as fire or theft insurance products, and others are categorized according to the insurance applicant, such as individual insurance and corporate insurance. Others are categorized according to insurance subject matter such as property insurance and motor insurance. Here we will discuss the most prominent insurance products known in the Saudi market depending on the insurance applicant.

4.2 Individual Products:

Learning objective

Identifying available individual products in Saudi market and their extent of coverage.

A. Comprehensive insurance for motor vehicles:

This product covers the damage to individual and family vehicles (individual ownership). All vehicle insurance plans may look similar in their coverage, usually consisting of several sections:

Section 1:

Damage to the body of the vehicle as a result of a fortuitous accident or any other deliberate damage by others. It also covers damage caused by collision, overturning, fire, theft, and natural hazards.

Section 2:

it covers civil liability to third parties. The owner of the vehicle or driver may have civil liability to compensate the third party as a result of an accident caused by the insured vehicle. In this case, the insurance company shall pay compensation for such liability up to a maximum of 10 million SR per incident during the period of validity of the policy for the damage to property, death or bodily injury, including legal expenses.

Section 3:

The optional section, usually called additional covers or optional covers, e.g.:

- **Personal Accidents Extension:**
  This extension offers a coverage to personal injuries to the driver and / or passengers for an additional premium, so the insurer will compensate the insured for the death, and partial or total disability of the driver or passengers because of an insured accident.

- **Geographical Extension:**
  It is one of the advantages that individuals can benefit from when purchasing vehicle insurance policies. The geographical extension of the policy covers some countries such as GCC countries, Jordan or Egypt.

There is some additional coverage that the reader can see in motor vehicle insurance.

B. Motor Insurance Third Party Liability:

This cover is one of the most common forms of motor insurance in the insurance market in Saudi Arabia. It is a compulsory insurance through a unified insurance policy issued by SAMA.

This cover has been prepared by insurance industry experts to compensate third party who is a person that is not a party in the insurance contract but his interests may be affected by the terms and conditions of the insurance contract through third party liability coverage.

Everyone is responsible before the law for damages caused to others in their persons and property. The law therefore requires the party that causes a harm to others as a result of negligence to compensate them because it is legally liable for such damages. The civil third party liability is the responsibility of causing harm to the person who is not a party in the insurance contract, so that the insurance company is the first party, the insured is the second party, and the aggrieved person here is the third party.

The amount of compensation for third-party liability is determined in light of the damage value, taking into account the terms, conditions and exclusions of the insurance policy. Therefore, this cover compensates the aggrieved person as a result of an accident or risk to third parties by insured vehicles in one of the following cases:

- Physical damages to third parties inside or outside the vehicle
- Financial damages to third parties outside the vehicle
- Expenses

Of course, this cover includes liability limits for insurers up to 10 million SR to cover damage to property or death and physical injury.

C. Medical insurance for individuals:

We have already mentioned the Council of Cooperative Health Insurance, which approved a unified insurance policy for medical insurance. Medical insurance is mandatory for all private sector employees either Saudis or residents and their families.

Benefits of the program

- Treatment services in outpatient clinic and in-hospital including in-hospital accommodation and living expenses.
- Dental and vision treatment and hearing aids.
- Expenses of pregnancy and childbirth, including natural and Caesarean births and abortion.
- Pre-existing medical conditions prior to the insurance.
- Vaccinations for children according to the schedule of the Ministry of Health.
- Coverage up to five hundred thousand SR.

Individuals can buy this coverage by purchasing the policy for themselves and their families directly from any licensed insurance company.

D. Medical Malpractice insurance:

The medical malpractice insurance policy provides protection to any medical practitioner against the responsibilities as a result of negligence or omission during his work. In this respect, it is taken into consideration that the coverage is not limited to doctors or surgeons, but also includes paramedics, medical technicians, nurses and pharmacists, etc.

It is possible to choose the limitation of the coverage from among the options available in the policy. Also, insurance coverage can be obtained through a single policy for up to 5 years. Thus, the policy ensures peace of mind and full protection for a long period, which will positively reflect the work performance in an atmosphere of tranquility.

This cover is a mandatory cover for doctors as a condition for obtaining a license from the Health Affairs Authority in the Kingdom of Saudi Arabia.

E. Homeowners insurance for individuals:

The homeowner's insurance policy provides peace of mind, by ensuring the protection of buildings and their contents against fire, natural disasters, explosions, earthquakes, riots, strikes, intentional damage, storms and pipe explosions.

This policy covers: A) buildings B) or their contents only, consisting of other personal effects, or (c) the buildings and their contents.

The policy also covers loss caused by looting or theft or attempted burglary or burglary for theft of contents, including jewelry, alloys, gold or silver jewelry or other precious metals.

There are also options for covering, as an example, liability to servants and third parties, etc.

F. International Travel insurance:

This policy provides insurance coverage for the insured while traveling abroad against any losses he may suffer due to a series of common accidents ranging from cancellation or changing of itinerary, missed departure, emergency medical expenses, personal accidents, lost baggage in travel or delayed arrival. The policy is designed to provide comprehensive protection for travelers with travel-related risks.

The standard policy covers emergency medical expenses outside Saudi Arabia. The insured person can also obtain medical emergency services in most parts of the world twenty four hours a day by contacting service providers appointed by the insurance company.

The international travel policy provides two types of coverage:

- Short-term insurance covering individual trips within a period not exceeding six months.
- Annual travel insurance covering any number of trips during the entire year.

This coverage is important as it is one of the mandatory documents for obtaining a travel visa for some countries.

G. Personal Accident insurance for individuals:

The personal accident policy is designed to physically compensate the insured person (or his legal heirs) in case of an accident that results in an injury, a permanent or temporary disability or death during the period of insurance. It provides coverage throughout the insurance period worldwide.

This coverage is optional, but some embassies require some families to enable drivers or servants to obtain this coverage as a prerequisite for work.

4.3 Corporate Insurance products:

Learning objective

Identifying insurance products provided to companies in the Saudi insurance market and the benefit of each product

Insurance coverage is designed by insurance companies to meet companies' insurance needs of different categories. Despite the multiplicity of these covers, the following covers are the most common in the Saudi market:

A. Motor Vehicle insurance:

This product offers flexible insurance solutions and various coverage for fleets of different size, and provides coverage options that can be tailored to commercial requirements of different types of vehicles:

- Types of vehicles insured
- Leased vehicles (rent-to-own method).
- Rental vehicles.
- Light transport vehicles (not exceeding 3.5 tons).
- Medium transport vehicles (not exceeding 5 tons).
- Heavy transport vehicles (over 5 tons and / or more than 16 seats).
- Commercial vehicles used in domestic and international transport.
- High-risk commercial vehicles as gas and fuel trucks.
- Vehicles of diplomatic nature.

Coverages that fall under this product:

This product allows you to choose between one or more motor insurance products:

Motor vehicle own damage and third-party liability insurance (comprehensive)

- Providing coverage for the loss or damage to the insured vehicle within the declared value.
- Choosing comprehensive vehicle insurance with some additional coverage such as personal accident insurance for driver and passengers, etc.
- In the event of an accident resulting in the payment of compensation in accordance with the provisions of this policy, the maximum liability of the company per incident and during the validity period of the policy for physical damage, expenses, and material damage together shall not exceed the total amount of 10,000,000 SR (10 million SR).

Third Party Liability insurance:

- In the event of an accident resulting in the payment in accordance with the provisions of this policy, the maximum liability of the company per incident and during the validity period of the policy for physical damage, expenses and material damage together will not exceed the total amount of 10,000,000 (ten million SR), which is the maximum liability of the insurance company.

B. Medical insurance for companies:

It includes all coverages, conditions, and limitations of the standard policy issued by the Council of Cooperative Health Insurance and in the Implementing Regulations of the Cooperative Health Insurance Law. The coverage includes outpatient clinics and in-patient in a shared hospital room with an annual maximum of 500,000 SR, in addition to birth coverage, dental expenses, and hearing aids up to SR 2,000. Coverage is also available outside Saudi Arabia in case of emergency during leave or business trip not exceeding 90 days. The beneficiary is required to obtain a prior approval of the company for the expenses of in-patient and outpatient services starting from 500 SR and more, and pays %20 of the treatment cost in outpatient clinics up to a maximum of one hundred SR.

C. Protection and Savings insurance:

When individuals are exposed to death or total permanent disability that prevents them from doing their jobs, many problems arise for employers, their dependents or their financial institutions that have contracts or credit programs with them. Thinking about the future and preparing for its volatility also requires the necessity of managing a saving and investment program that provides a financial resource that will help the beneficiaries to face difficult living conditions in case of death or disability of the breadwinner. A number of needed protection and saving programs has been designed for individuals, employers, financial institutions and banks that operate on the basis of the principle of Islamic Takaful:

- **Credit Life insurance program (Credit):**

  This program targets customers for banks and credit companies, as borrowers are insured in favor of a bank or credit company as beneficiaries. Under this program, the insurance company pays the remaining balance of the loan that has to be paid to the bank or credit company in case the borrower is exposed to death or permanent disability.

- **Group Term Life insurance for employees:**

  This program targets employers who have a number of employees working for them, and the policy pays the benefit (the agreed amount of insurance) if any of the covered employees is exposed to death or permanent disability.

D. Personal Accidents insurance for companies:

The personal accidents policy is designed to provide monetary compensation to an insured person (or his legal heirs) if, during the term of the insurance, he has been exposed to an accident that has resulted in an injury, permanent disability, temporary incapacity or death. It provides worldwide coverage throughout the insurance period.

E. Property insurance for companies:

This product is divided into a number of sub-covers:

Property insurance: against fire and allied perils:
This insurance compensates insured for accidental damage to property which may be the result of multiple perils such as fire, lightning, explosion on the ground or underground, collision damage, aircraft damage, water tank rift, explosion of pipes or appliances, leakage of sprays and storms, Cyclones, tropical or tropical cyclones, floods, waterlogging, riots, strikes, intentional damage, earthquakes, looting, violent theft or forcible entry to or exit from insured premises.

Property insurance: against fire and lightning:
This policy covers accidental damage caused by fire or lightning.

Property insurance: against all risks:
This policy provides comprehensive and integrated coverage for industrial units or commercial property, etc. against all risks (including accidental damages) except for what is specifically excluded under the policy. There are two kinds of coverages: the first is the accidental damage insurance policy, which is mainly related to commercial property, and the second is the insurance of industrial property «against all risks», which is primarily related to industrial units. Of course, both policies specifically exclude consequential losses.

Property insurance: for shop owners:
Stores are one of the most important selling points in today›s world. They open round the clock to compete and gain customers, so they are exposed to a lot of risks, including dealing with employees and business management, which requires thinking about managing all those risks. For this purpose, this product is designed to meet the needs of stores owners.

This policy provides insurance coverage for all types of shops except for certain specific activities. Coverage under the policy includes standard coverage such as fire, lightning, and violent theft (robbery), as well as the possibility of covering compensation for rent of an alternative unit in case the insured shop is damaged.

This integrated policy also provides multiple optional covers such as damage to refrigerated inventories, fixed glass panels, cash, goods in transit, civil liability, subsequent loss, workers ' compensation, personal accidents and employee fidelity insurance.

Property insurance: for Consequential Loss:
This policy covers loss of profits due to the decrease in the normal volume of trading resulting from the interruption of work or irregularity due to loss or damage covered under any of the property

insurance policies mentioned above. The coverage under this insurance includes the increase in the cost of post-loss business as well as fixed expenses for work, and expand insurance coverage to include additional risks.

F. Engineering insurance:

This product includes a number of covered items:

Engineering insurance: Contractor's All Risks:
Contractor's all risk policy is designed "against all risks " especially for engineering projects such as construction of buildings, construction of bridges, road works, etc., providing comprehensive protection for contractors and entrepreneurs as well as subcontractors against all risks they may be exposed to, except what is specifically excluded. Insurance coverage can be extended to include additional risks such as third party liability insurance.

Engineering insurance: Erection All Risks:
This insurance covers risks associated with storage, collecting, or erection, as well as the period of machine testing and factory operation. The policy provides comprehensive coverage against all risks unless specifically excluded. Insurance coverage can be extended to include additional risks such as third party liability insurance.

Engineering insurance: Contractor's Equipment and Machinery:
This insurance covers sudden or unexpected loss or damage to the construction machinery and equipment used by the contractor in the workplace either by repair or replacement, whether the machinery or equipment is operating, parked or being dismantled for the purpose of cleaning, packaging or repair, or in the context of any of these mentioned operations, or in the context of subsequent installation after their operation has been successfully tested.

Engineering insurance: Electronic Devices and Computers:
The policy covers all types of computers and electronic devices, including microprocessors, electronic information processing, communication devices, medical devices, film equipment, studios, electronic boards, etc. This insurance also covers unexpected financial damage caused by electronic devices. The policy also covers external information means, cost increase, and work related expenses.

Engineering insurance: Steam Boilers and Pressure Vessels:
This insurance shall indemnify the insured for loss or damage to boilers and pressure vessels by explosion or collapse in the ordinary course of business. Insurance coverage can be extended to cover the insured›s surrounding property as well as the liability that the insured may be legally held for like any bodily injury or damage to the property of third parties.

Engineering insurance: Machinery Breakdown:
This policy covers unexpected loss or unexpected financial damage to the insured machines that require repair or replacement (depends on the case) for defects in casting, defective materials, design errors, fabrication defect, faulty installation and operation, lack of skills, lack of water inside boilers, natural explosion, rupture due to centrifugal force, circuit breakage, storms or other not specifically excluded causes.

Engineering insurance: Inventory Corruption in Warehouses:
This insurance is a form of subsequent loss coverage designed specifically to provide insurance coverage of inventory in refrigerated warehouses. This insurance covers loss or damage to the goods or commodity declared in the insurance application if they are damaged or corrupted.

Engineering insurance: Loss of Profits:
This policy covers loss of profits resulting from interruption or irregularity due to an unexpected accident resulting from the interruption of machinery such as fire or technical fault.

G. Public Liability Insurance:

Here comes under this product a large number of covers and policies, including:

Burglary and Theft Insurance:
This insurance provides coverage for loss or damage to the stock, furniture, equipment, extensions, and all other contents in any store or business establishment and extends coverage to damage to work premises.

Professional Liability Insurance:
Professionals are considered to have high technical expertise in their field of work or profession, so they must pay special attention to the services provided to their clients. However, human error cannot be ignored at all times. The omission or error we may encounter in many cases result from negligence or unintentional negligence, but ultimately leads to a claim against those professionals and craftsmen as a result of causing their clients to suffer material losses.

In that sense, professionals such as architects, civil engineers, consultants, brokerage firms, financial consulting firms, lawyers, law firms, accountants, brokers and insurance agents are advised to provide their clients with the following insurance products:

Civil Public Liability Insurance:
This policy covers legal liability for which the insured is legally held responsible for paying a compensation to others for causing any accidental bodily injury to others (including death or illness), as well as, any loss or damages to the property of third parties arising in performing his work, career, or activities.

Product Liability Insurance:
The manufacturers, producers, distributors or sellers of a tangible product or commodity traded over a long period of time may always be liable for the risk of legal liability. Thus, they will have to pay financial compensations to consumers or third parties as a result of causing bodily injury or damage to third parties› property due to an error or defect in the product sold with their knowledge. Usually every product (especially electrical goods, vehicles, automobiles, pharmaceuticals, foodstuffs such as food, drinks, etc.) is often exposed to such risks.

Product liability insurance covers the legal liability that the insured may be required to compensate for.

The insurance coverage under this section of the policy includes any costs or expenses incurred in defending any legal action in court.

Work Accidents Insurance:
Jobs related to accidents are part of every occupation, business or industry activity especially when this activity involves manual labor. Under the Saudi Labor Law, every employer is liable to pay compensation to his employees upon death, injury, illness or disability due to work accidents. The law determines the amount of compensation payable in each of the compensable cases as in cases of death or disability, etc.

This policy provides protection for the institution or any activity against all those responsibilities

towards users through two main benefits:

The first relates to insurance coverage according to the benefits that have to be paid under the Saudi Labor Law or the provisions of Islamic Sharia

The second relates to the coverage according to the benefits that have to be paid under the Saudi Labor Law and / or the provisions of the Islamic Sharia in excess of or more than the compensation available under the benefits stipulated under the General Organization for Social Insurance Regulations.

Money Insurance:
This policy covers the loss of money, remittances, checks, securities, etc. while on the job site or institution.

- While in transit (excluding postage) between pre-agreed destinations.
- While in the properties of the insured specified in the policy schedule.
- While in the residence of the employer or any manager or employee working for the insured.
- While kept o night in closed vaults inside the bank until it is transferred by a bank official.

Fidelity Insurance:
This type of insurance covers the financial losses that may be incurred by the insured as a result of any act of fraud or dishonesty committed by any employee in the course of his work with the insured. This policy is suitable for covering dishonesty especially for some categories of users such as cashiers, financial accountants, Stores, etc. because of their job responsibilities to deal with money or inventory.

Director's Liability Insurance:
The directors and administrative managers liability policy provides insurance coverage for each member or administrative director against liability for which may be legally held due to an unintentional or intentional error or negligence committed or alleged to have been committed, in the course of managing the affairs of the company in his capacity as director.

H. Marine Insurance:

This type of insurance covers the loss or damage for the goods during maritime, air, or road transport whether within the Kingdom of Saudi Arabia or for those goods destined for export or import to and from Saudi Arabia. Companies in Saudi Arabia provide two types of cargo insurance coverage: "all risks" or specific and named risks.

I. Energy Insurance:

It is a specialized type of insurance related to petrochemical and hydrocarbon energy and oil installations and other important energy resources such as oil, gas and electricity. It covers all risks that may be exposed too such as fire, damage, destruction and explosion. The coverage extends to include liability, consequential losses and operating expenses, the removal of debris and environmental protection insurance.

I-A. Aircraft Hull Liability Insurance:

This policy covers loss or accidental damage to the aircraft on the basis of either replacement or repair of the damaged aircraft, as well as legal liability for accidental bodily injury (whether or not fatal) and any accidental damage that may affect third party property due to the aircraft itself, any passengers on board, or any objects or materials falling from it.

I-B. Airport Owners and Operators Liability Insurance:

A branch of aviation insurance provides full protection to aircraft owner, or bodies in charge of its management, or observers of aircraft hangars, or contractors by compensating them for their legal liability to third parties such as passengers and airlines companies.

I-C. Aircraft Hull War & Allied Perils Insurance:

This policy covers the loss or damage to the aircraft due to the risks excluded from insurance coverage under the Aircraft hull insurance policy "against all risks", which are caused by war and allied perils, including extortion as well as costs or expenses incurred in the event of hijacking.

I-D. Pilot Loss of License Insurance:

This insurance compensates any crewmember against the risk of withdrawing his license (temporarily or permanently) due to medical unsuitability resulting from an accident or illness.

I-E. Aviation Personal Accident Insurance

This insurance pays for injuries that an aircraft crewmember or any of the passengers suffers, whether on aircraft board or on their way to enter it or when leaving the aircraft, as a result of an accident to the insured aircraft.

Thus, after referring to the insurance products offered by the insurance companies in Saudi Arabia, we would like to say that these products are standard products as mentioned above. They may be available in some companies and not available in others.

What is mentioned here is an overall idea, and there are many details for each product. Further, the reader can refer to the specialized references for each of the product.

J. Aviation Insurance:

The aviation insurance product provides a basic guarantee that gives local airlines the protection they need to operate and continue their services to serve the passengers and to support the movement of local and international trade.

Chapter Four
Revision questions:

1. State the coverage sections in the policy of comprehensive motor insurance:
2. State the type of coverages available in the property insurance:
3. What is the scope of insurance coverage for fidelity insurance?
4. What is the coverage offered in the Aircraft hull liability insurance?

Practical question

1. What is the importance of the aviation Insurance product? What is the benefit of insuring Aircraft hull and liability?

Chapter Four
Answers of Chapter Four Revision questions:

1. State the coverage sections in the policy of comprehensive motor insurance:

This product covers the damage to individual and family vehicles (individual ownership). All vehicle insurance plans may look similar in their coverage, usually consisting of several sections:

Section 1:
Damage to the body of the vehicle as a result of a fortuitous accident or any other deliberate damage by others. It also covers damage caused by collision, overturning, fire, theft, and natural hazards.

Section 2:
it covers civil liability to third parties. The owner of the vehicle or driver may have civil liability to compensate the third party as a result of an accident caused by the insured vehicle. In this case, the insurance company shall pay compensation for such liability up to a maximum of 10 million SR per incident during the period of validity of the policy for the damage to property, death or bodily injury, including legal expenses.

Section 3:
The optional section, usually called additional covers or optional covers, e.g.:

- **Personal Accidents Extension:**
  This extension offers a coverage to personal injuries to the driver and / or passengers for an additional premium, so the insurer will compensate the insured for the death, and partial or total disability of the driver or passengers because of an insured accident.

- **Geographical Extension:**
  It is one of the advantages that individuals can benefit from when purchasing vehicle insurance policies. The geographical extension of the policy covers some countries such as GCC countries, Jordan or Egypt.

2. State the types of coverage available in property insurance:

Property insurance: against fire and allied perils:
This insurance compensates insured for accidental damage to property which may be the result of multiple perils such as fire, lightning, explosion on the ground or underground, collision damage, aircraft damage, water tank rift, explosion of pipes or appliances, leakage of sprays and storms, Cyclones, tropical or tropical cyclones, floods, waterlogging, riots, strikes, intentional damage, earthquakes, looting, violent theft or forcible entry to or exit from insured premises.

Property insurance: against fire and lightning:
This policy covers accidental damage caused by fire or lightning.

Property insurance: against all risks:

This policy provides comprehensive and integrated coverage for industrial units or commercial property, etc. against all risks (including accidental damages) except for what is specifically excluded under the policy. There are two kinds of coverages: the first is the accidental damage insurance policy, which is mainly related to commercial property, and the second is the insurance of industrial property «against all risks», which is primarily related to industrial units. Of course, both policies specifically exclude consequential losses.

Property insurance: for shop owners:
Stores are one of the most important selling points in today›s world. They open round the clock to compete and gain customers, so they are exposed to a lot of risks, including dealing with employees and business management, which requires thinking about managing all those risks. For this purpose, this product is designed to meet the needs of stores owners.

This policy provides insurance coverage for all types of shops except for certain specific activities. Coverage under the policy includes standard coverage such as fire, lightning, and violent theft (robbery), as well as the possibility of covering compensation for rent of an alternative unit in case the insured shop is damaged.

This integrated policy also provides multiple optional covers such as damage to refrigerated inventories, fixed glass panels, cash, goods in transit, civil liability, subsequent loss, workers ' compensation, personal accidents and employee fidelity insurance.

Property insurance: for Consequential Loss:
This policy covers loss of profits due to the decrease in the normal volume of trading resulting from the interruption of work or irregularity due to loss or damage covered under any of the property insurance policies mentioned above. The coverage under this insurance includes the increase in the cost of post-loss business as well as fixed expenses for work, and expand insurance coverage to include additional risks.

This policy covers loss of profits due to the decrease in the normal volume of trading resulting from the interruption of work or irregularity due to loss or damage covered under any of the property insurance policies mentioned above. The coverage under this insurance includes the increase in the cost of post-loss business as well as fixed expenses for work, and expand insurance

3. What is the coverage offered in Aircraft hull and liability insurance?

This policy covers loss or accidental damage to the aircraft by the risks covered on the basis of either replacement or repair of the damaged aircraft, as well as legal liability for accidental bodily injury (whether or not fatal) and any accidental damage that may affect third party property due to the aircraft itself, any passengers on board, or any objects or materials falling from it.

4. What is the importance of aviation Insurance? What is the benefit of insuring aircraft hull and liability?

The importance of this insurance is due to the high frequency of air traffic around the world and the associated risks. The insurance subject matter here is not a risk that is easily dealt with because of the large sums of insurance involved (the aircraft cost) and the liability towards passengers for any accidents that may occur, as well as for any damage that may occur at airports and arrival terminals in the countries of destination.

Chapter Five

Procedures and Policies of the Insurance Operation

Introduction

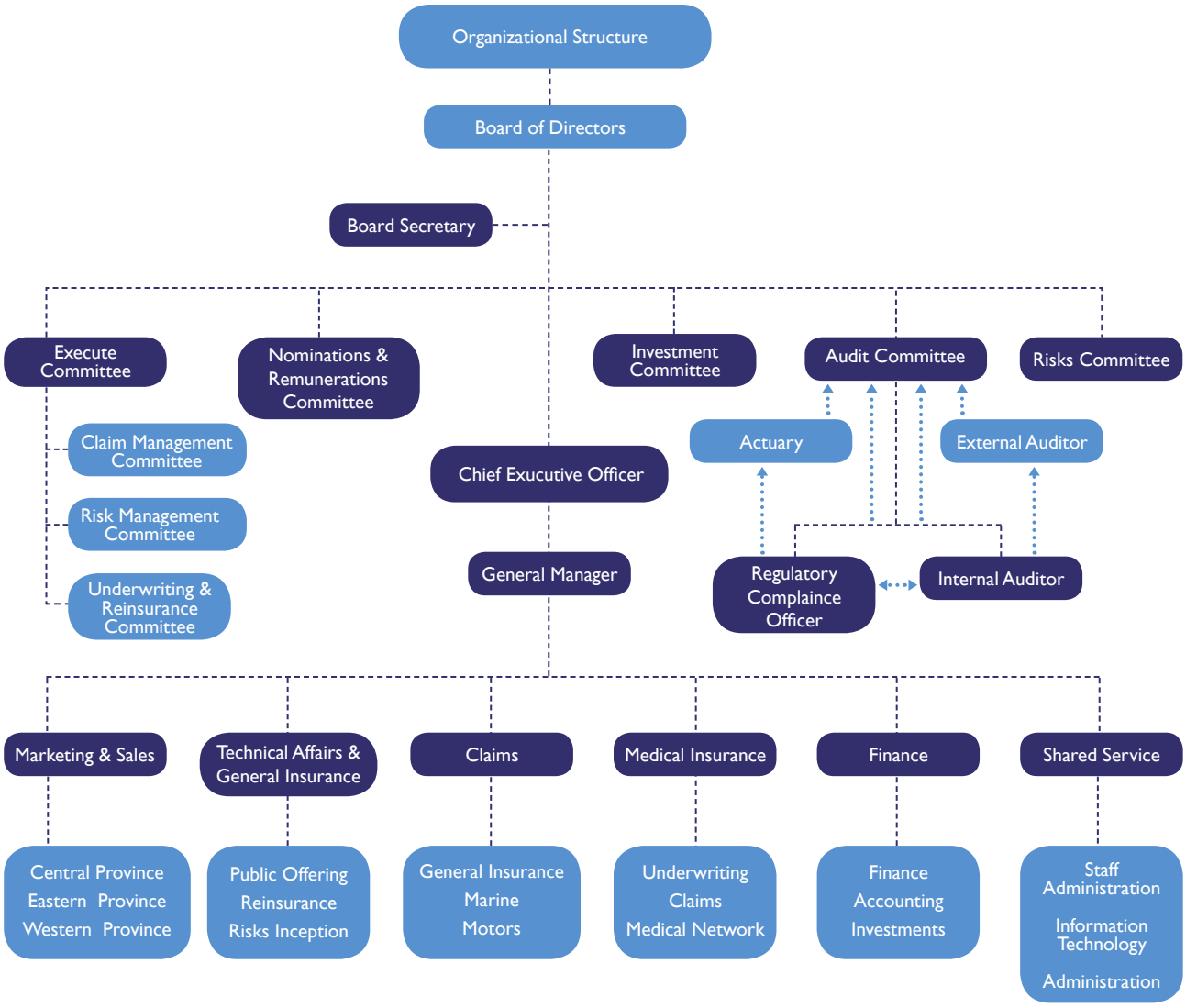
This chapter will tackle procedures, tasks and functions of insurance companies as part of their daily work in providing insurance services to the insured, including insurance products that suit the insurance needs of individuals and institutions, and provide after-sales services like managing the insurance policies and settling claims and dealing with accidents.

In this chapter, we will address the following:

- The default organizational structure of insurance companies.
- The main insurance functions and procedures.

As mentioned in the previous chapter, insurance companies and reinsurance companies are going through stages and steps to obtain licenses from the Saudi Arabian Monetary Authority(SAMA). The licensing process includes the construction of the organizational, administrative, and functional structure of the company in order to work on managing the company and its day by day operations.

Here we review the organizational structure and senior management of an insurance company as follows:



5.1 The default organizational structure of insurance companies

Learning objective

Introduce trainee to the default organizational structure of the insurance companies, its management and work plan

In reviewing this structure, we notice the following:

The management of the insurance companies consists of different administrative and functional levels as follows:

Learning objective

Introduce trainee to the board of directors and its functions and affiliated committees

5.1.1 Board of Directors

Any insurance company must have a board of directors, and it is characterized by the following:

A. The Board of Directors shall be representative of the main partners with elected members representing the shareholders.
B. The previous structure is a standard organizational structure, in the sense that it is the same to some extent in the companies, but there are some differences due to the particularities of each company, in addition to the size of the company›s work, which calls for expansion in some areas of functionality.
C. The board of directors of any company must be approved by the supervisory and regulatory authorities in order to maintain the selection of departments with high professional and ethical standards.
D. The board of directors shall be representative of the largest number of shareholders and must be approved by most members through election or agreement.
E. There are conditions that must be met in each candidate to take up a position in the board of directors or senior management, such as educational level and professional experience and good reputation.

The main functions and responsibilities of the board of directors are:

- Laying down criteria for membership in the board of directors and implementing it after having the approval of the general assembly.
- Adopting a comprehensive strategy and main work plans for the company and supervising their implementation.
- Setting, reviewing, and guiding an overall corporate strategy, main work plans, and risk management policy.
- Ensuring the integrity of financial and accounting systems, including relevant financial reporting systems.
- Identifying the optimal capital structure of the company, its strategies, and financial objectives and approving annual budgets and capital expenditures.
- Setting performance objectives and monitoring implementation and overall performance in the company.
- Reviewing and approving the organizational and functional structure of the company.
- Setting a written policy to regulate conflicts of interest and addressing possible

conflicts of interest for the members of the Board of Directors, the Executive Management and the Shareholders.
- Approving the Company›s Corporate Governance policy, including internal control policies and regulations, overall supervision, control its effectiveness, and modify it when necessary.
- Adopting professional codes of conduct for managers and employees to conform to the professional and ethical standards and regulating the relationship between them and stakeholders, including settling complaints or emerging disputes and protecting relevant confidential information.

Board of directors Committees:

Learning objective

Clarify the roles of the Board of Directors committees and functions of each committee

The Board of Directors consists of a number of committees that specialize in a variety of tasks according to the role of each committee. The following are the committees and the functions of each one of them:

A. Executive Committee:

The main functions and responsibilities of the executive committee are:

- Review the company›s strategy, decide objectives with management of the company, and submit them to the Board of Directors for approval.
- Monitor the work and ensure that the financial results are in line with the objectives approved by the Board of Directors.
- Inform the board of directors about any significant differences in results and recommend changes to achieve improvements.
- Review the annual budget and submit it to the Board of Director for approval.
- Recommend the Board of Directors to delegate the powers related to the day-to-day work, as agreed with the Administration.
- Review and approve the appointment of senior officials as requested by the Nominations and Remuneration Committee.

B. Investment Committee:

The main functions and responsibilities of the Investment Committee are:

- Determine the investment objectives of the company.
- Form an investment policy for the company.
- Ensure that the management has obtained regulator's approval for the investment strategy.
- Choose between managing investments internally or externally.
- Ensure that all investments comply with regulatory restrictions.
- Approve certain investments.
- Delegate authorities when necessary.
- Review investment performance.

C. Audit Committee:

The main functions and responsibilities of the Audit Committee are:

- Ensuring compliance with applicable laws and regulations through the regulatory compliance officer and internal and external auditors.

- Reviewing annual and initial financial statements and considering whether they are complete and consistent with the information known to the members of the Committee and reflect the appropriate accounting principles.
- Making a practical periodic review of financial and accounting policies, and providing recommendations regarding these policies to the Board of Directors.
- Reviewing the adequacy and integrity of internal control systems.
- Reviewing internal audit plans and development reports, discussing reports arising from internal audit reviews, management response, and assessing the implementation of the agreed work plans.
- Making recommendations to the Board of Directors regarding appointment, reappointment, and acceptance of resignation or dismissal of external auditors.
- Reviewing the results of the external auditor›s reports to ensure that immediate corrective action is taken in all deficiencies.
- Reviewing the effectiveness of the system of compliance with the laws and regulations and the findings of the investigation and the follow-up by the management (including disciplinary actions) in any case of non-compliance.
- Providing regular reports to the Board of Directors about the Committee›s activities, issues and relevant recommendations.

D. The Nominations and Remunerations Committee:

The main tasks and responsibilities of the Nominations and Remunerations Committee are:

- Recommend to the Board of Directors to nominate for Board membership in accordance with approved policies and standards.
- Annual review of the appropriate skills required for membership of the Board of Directors and preparation of the capabilities and competencies description required for such membership, including: determining the time that a member should devote to the work of the Board of Directors.
- Review the structure of the Board and recommend any changes.
- Identify weaknesses and strengths in the board of directors, and propose to address them in line with the company›s interest.
- Ensure the independence of independent members annually and the absence of any conflict of interest if the member is a board member of another company.
- Establish clear compensation and remuneration policies for board members and senior executives, and take into account the use of criteria related to performance when setting such policies.

After clarifying the role of the Board of Directors, we will move on to talk about the most important senior positions in the insurance companies:

Learning objective

Introduce the trainee to the senior positions in the insurance companies their role and function.

5.1.2 Compliance Officer:

It is one of the senior positions in the insurance companies. The compliance officer directly reports to the Audit Committee of the Board of Directors. He may be directly reporting to the Saudi Arabian Monetary Authority (SAMA). He is responsible for the insurance company›s compliance with the laws and regulations issued by the Saudi Arabian Monetary Authority and the Capital Market Authority (CMA) and other regulations issued by any supervisory and regulatory body. The compliance officer is also responsible for submitting a report to the Internal Audit Committee on any compensation or

claims falling under the criteria of technical claims.

Compliance Officer Responsibilities:

- Follow-up external risks and ensure SAMA›s prior approval.
- Follow-up the development of a new product and ensure SAMA›s prior approval.
- Provide copies of reinsurance agreements and submit them to SAMA.
- Maintain internal control procedures, and in a written form.
- Follow-up with the quarterly payment to SAMA.
- Follow-up with the establishment of new branches and ensure the approval of SAMA.
- Continue to maintain a minimum level of reinsurance at %30 of premiums.
- Follow-up with reinsurance companies and confirm the minimum rating of BBB.
- Registration and follow-up of all claims and maximum settlement period.
- Provide and follow up the registration of complaints and submit a semi-annual report to the Audit Committee.
- Provide a quarterly report about the company›s business to SAMA.
- Register and follow up on the transactions of the parties related to the company as shareholders and submit it to SAMA.
- Commit to submit the annual report to SAMA and confirm the composition of the Board of Directors and job Saudization ratios.
- Receive auditors› report within 60 days as of the end of the year before publication.
- Deliver accurate financial statements to SAMA within 90 days as of the end of the year.
- Ensure that SAMA approves the appointment of the External Auditor.
- Ensure that financial statements are published in accordance with the regulations within three months as of the end of the year.
- Submit the audited financial statements to the Capital Market Authority at a minimum, 10 days prior to the general assembly meeting.

5.1.3 Internal Auditor:

Each insurance company must have an independent internal auditor, so that the audit's responsibility is limited to one or several internal auditors. The responsibility of the internal auditor is to provide reasonable assurances that are keys to compliance with the laws and procedures.

The internal auditor submits his report to the Audit Committee referred to earlier. The report must include an evaluation of the effectiveness and efficiency of the internal controls policies and procedures, the reporting mechanism of the company, compliance with it, and recommendations for improvement.

5.1.4 Actuarial Expert

It is one of the important professions in the insurance industry. The appointed actuary will perform tasks stipulated in Article twenty of the Implementing Regulations of the Cooperative Insurance companies Control Law, which relate to the following:

- Obtaining information and data required from the former actuary.
- Reviewing the financial standing of the company.
- Assessing the Company›s ability to meet its future obligations.
- Determining retention ratios.
- Pricing the insurance products of the company.
- Identifying and approving the technical provisions of the company.
- Reviewing the investment policy of the company and giving recommendations thereon.
- Any other actuarial recommendations.
- The actuarial expert, should he note any current or future risks for the company, is

required to submit an urgent report to the company›s board of directors directly. The Board of Directors reviews the report, indicates his views thereon and submit them to SAMA within 15 days.

5.1.5 Senior management of the company:

After talking about the Board of Directors, we refer to the senior management of the company, which usually consists of the following functions as reflected in the organizational structure described above:

A. The Chief Executive Officer
B. The General Manager

The General Manager oversees a number of departments that are often similar among insurance companies:

- Marketing and Sales Manager
- Technical Affairs Manager
- Accidents and Claims Manager
- Medical Insurance Manager
- Financial Manager
- Support Services Manager

The senior management is responsible for supervising the company›s daily activities, and is responsible for performing these responsibilities without prejudice to any other supervisory or regulatory requirements. The duties of senior management include, but are not limited to:

- Implementing the companys strategic plans.
- Managing the company daily activities.
- Setting procedures for risk identification, prevention and control.
- Developing policies and procedures to ensure the efficiency and effectiveness of the internal control system.
- Keeping documents and accounting audits
- Working according to the directives of the Board of Directors and reporting to it.
- Ensure that all regulatory and supervisory requirements are met to the possible maximum extent.

We would like to point out that the senior management functions must have a documented and detailed job description that defines the roles, responsibilities, powers and sections under it according to the policy of each company. The sections that fall under these departments are similar in content but differ in names among companies.

5.2 The most important procedures of insurance operations in the Saudi market

We have learned that after obtaining any insurance company the license in the Saudi market, it begins with the formation of the organizational and functional structure. These departments start daily work in order to provide the insurance service to insurance applicants through a number of insurance products for individuals or institutions.

This service is provided through a number of standard functions including:
Learning objective

Introduce trainee to marketing and sales channels of the insurance products

A. Marketing for the insurance products of each company (marketing channels):

The insurance companies operating in Saudi market promote their various products to individuals and institutions through a number of marketing channels, and this function and its procedures are

related to the Marketing Manager:

- Marketing through television and radio advertising.
- Marketing through newspaper ads.
- Marketing through distributing brochures that show the characteristics of each product.
- Marketing through direct contact with prospective insurance seekers through specialized visits from marketing teams.
- Marketing through popular websites.
- Marketing through the company›s website.
- Marketing through telephone call centers.
- Marketing through fax by sending a promotion of a specific product to potential customers.
- Participating in specialized exhibitions.
- Participating in specialized conferences.
- Holding training courses to raise awareness of insurance for some private and governmental entities.
- Promoting corporate social responsibility in local communities.
- Supporting research related to product development.
- Developing new products to meet changing insurance needs.
- Sponsoring some community activities.
- Distributing promotional gifts to insurance applicants.
- Developing an institutional identity characterized by the development and modernity.

B. Selling insurance products (insurance sales channels):

After the insurance company markets and promotes its insurance products through its marketing system and in a number of channels that are very similar among the insurance companies, the other standard function of insurance companies is to reach the insurance applicants in order to complete the sale through several channels to sell insurance products. We will mention some of it:

- **Direct sale:**

This channel is a mean of selling insurance products through the insurance company, either directly through the direct contact with the insurance applicants or through sales representatives of the insurance company. The sales representative represents the company before potential customers, and therefore he is the mirror that reflects the image of the company he represents. He must meet certain conditions that qualify him to achieve the objectives of the company such as efficiency, training and having sufficient knowledge about the market conditions and insurance legislation in force.

- **Sales through call centers:**

Some insurance companies train some employees to sell insurance products through telephone contact with customers and meet their insurance needs and complete the sale in a professional manner.

- **Selling through websites (online sale):**

The trend towards increasing reliance on modern technology is one of the most important features of the modern era. The world has recently witnessed tremendous progress in information and communications technology and the increasing role of e-commerce in the marketing of goods and services through the internet network, which is one of the most important manifestations of globalization. The term e-commerce refers to all sales, purchases or services between commercial companies, individuals, governments and other public and private organizations that depend on the electronic processing of data through computer

networks.

The rapid technological developments that we are witnessing are expected to affect the infrastructure of the various economy sectors, including the insurance sector. Therefore, the failure of the insurance companies - especially in developing countries - to make such developments will put them in a weak competitive position comparing to foreign companies that rely in their strategy on the concepts of modern technology. In this context, we note the disparity in the dependence on e-commerce and the use of the Internet in e-marketing among developed and developing countries; developing countries still lack the material, human, and technological resources necessary to accommodate technological developments and new techniques in different sectors compared to developed countries.

- **Selling through insurance intermediaries:**

SAMA has licensed a number of intermediaries; the broker is a legal entity who, in exchange for a fee, negotiates with the company to complete the insurance process for the benefit of the insured.
The insured may obtain independent advice or consultation about a large number of insurance types from the broker without paying a direct salary. For example, the broker may give advice on the insured›s insurance needs, the best types of coverage and its limits, the best market and procedures for claims and documentation requirements, and informing him of any changes in the market. Most business insurance operations are carried out in most developed insurance markets through registered and licensed intermediaries.

- **Sale through insurance agents:**

SAMA has licensed a number of agents who, for a fee, represent insurance companies, market and sell insurance policies to one insurance company, and all the acts usually performed by the agent for the company or on its behalf. The agent is: a legal entity who, for a fee, represents the company, market and sell the insurance policies and all the acts that he normally undertakes for the company or on its behalf.

- **Sale through banks:**

Bancassurance is one of the important channels and important strategies that all the insurance markets in the world seek to implement it in order to increase their insurance premiums and market share, as well as reduce cost of marketing, sales and insurance products prices. This is done by taking advantage of the banks networks branches across each country as one of the alternative distribution channels that supports traditional marketing channels.

Selling insurance products through banks has many positives aspects; the most important one is developing the insurance culture and spread it in the society. There is no doubt that this development has a positive effect on the insurance sector as a whole, and then insurance companies have a definite interest in establishing this alliance with banks to reach large base of the bank customers.

Insurance is carried out through banks in the Kingdom by obtaining the appropriate license from SAMA.

After the sales channels succeed in marketing and selling any insurance product to the insurance applicants whether they are individuals or institutions, the important function of the companies will start, which is the underwriting process. It is done by the insurance companies after collecting the documents for each product, in order to make a specific offer including the price, conditions, and provisions:

C. Underwriting:

Underwriting is a primary function of any insurance company. It is the process by which the underwriter decides to accept or not to accept the insurance offer and sets the necessary conditions, price and premium.

In other words, underwriting is the selection and pricing of risks, depending on the pricing tables and actuarial data. The essence of the underwriter›s role in an insurance company is to determine the risk degree of the policyholders, and to determine the prices of the appropriate insurance policies covering that risk. The insurance company may lose customers and make its competitors gain them if the underwriter›s assessment of the risks is so severe that leads the premium to be excessive and unaffordable. It may also have to pay non-outstanding claims if the premiums received are not sufficient to pay compensation if the underwriting is unprofessional.

Now, with the help of a computer, underwriters can analyze information about insurance applications and determine whether the risk is acceptable and that it will not lead to loss. Insurance applications are often provided with loss adjuster's reports, risk management, medical reports, pricing offices reports, and actuarial studies. After that, underwriters must decide whether to issue the policy or not and the appropriate premium in the case of issuance. By adopting this decision, underwriters will be considered as the link between the applicants and the insurance channel sales. From time to time, underwriters of insurance companies and sales channel representatives can visit insurance applicants to clarify insurance coverage or policy terms.

Technology plays an important role in the underwriter›s job. Underwriters use applications and computer systems called "smart systems" to manage risks more effectively and more accurately. These systems automatically analyze and price insurance claims, suggest accepting or rejecting the risk, and adjust insurance price according to the risk. These systems improve underwriters› ability to make sound decisions and avoid unexpected losses.

Stages of underwriting process:

- Identifying the insurance applicant and the risk through the insurance form (in some types of insurance we may need supporting documents such as the report of the loss adjuster in the property insurance).
- The insurance application is submitted to the risk manager who analyzes it, clarifies its negativity and positivity, and sends a report to the underwriter.
- The underwriter, based on the Risk Manager›s report, makes one of the following decisions: risk rejection, conditional acceptance, or unconditional acceptance.
- The actuary is then asked to determine an appropriate insurance premium.
- The underwriter shall place the policy content and make the amendments that deems appropriate if the acceptance is conditional.
- The underwriter determines the percentage of risk he wishes to transfer to the reinsurer.

This does not represent the actual reality of the insurance market in terms of the roles that are currently existing:

D. Reinsurance:

It is the process by which the insured risk burden is transferred from the insurance company to a reinsurance company. The reinsurer compensates the insurance company for the compensation payment made to the insured if they suffered damage or loss in the event of an accident. Reinsurance is the main risk management tool, simply reinsurance is insurance for insurers. Insurers buy insurance to cover risks they cannot individually incur. Reinsurance helps the insurance industry to provide

protection for a large number of risks covered by insurance including large, concentrated, and complex risks.

Like insurance, reinsurance is essentially a promise to pay future claims in return for a premium currently paid. Most reinsurance operations purchased by insurers are to cover large individual losses and catastrophic events. Reinsurance companies need large capital to cover catastrophic events, using a sophisticated risk control system for the risks they cover, and reinsurers in particular have substantial capital that often leads to reinsurers being rated A or higher, According to the classification of famous measurement and classification companies.

The responsibility of the reinsurance department within the insurance company is to manage the reinsurance contracts of the company. This department monitors the claims with significant losses and determines the time at which they should be provided to their reinsurers. (Losses are always sent to reinsurers upon occurrence.) The Reinsurance Section is also responsible for negotiating a variety of reinsurance contracts and for nominating the best structure of reinsurance contracts to be presented to the company manager.

It is necessary to remember that there is no relationship between the insured and the reinsurer; there is an insurance contract between the insured and the insurance company. There is a similar arrangement between the insurance company and the reinsurer, but there is no legal or contractual relationship between the insured and the reinsurer. In most cases, the insured does not know that there is reinsurance.

* See chapter One

E. Receiving and processing claims:

All insurance companies licensed in the Kingdom of Saudi Arabia have departments to receive, process, and settle claims. Specific procedures are set up to receive, study, and settle insured›s claims. The company must also keep files related to the claims of the insured and divide them into paid claims, claims under consideration or settlement, and rejected claims, so that each file includes the following:

- Insurance application form and insurance offer if applicable.
- Copy of the insurance policy.
- Customer claim.
- Report of the loss adjuster, if any, and any documents necessary to substantiate the claim and determine the direct cause that eventually led to the loss.
- Documents or other insurance companies proportional share of compensation.
- Actions taken by the company and the claim status.
- A formal power of attorney given to the company by the insured to act on his behalf in the following cases:
    - Claim compensation from any third party for the loss it caused.
    - Defend the insured in the repudiation of liability or in determining the amount of compensation.
    - Final discharge signed by the customer for the paid claim.

From an insured's point of view, testing the insurance company›s reputation depends on how fast and fair it settle the claims made by its policyholders. The contract that binds the company and the insured is based on a promise that is only translated into action when a loss occurs to the insured.

If the insured submits a claim to the insurance company, it will be investigated by the claims representative who determines whether the loss is covered in the policy or excluded, especially for the insurance of individuals. However, if the claim is large and needs a technical experience, especially in the insurance of property, projects, energy, and aviation, loss adjuster and loss assessor are appointed to further investigation of the claim and calculation of the financial settlement.

The claims handling is the measure that shows the tangible benefit of insurance. The insured seeks to balance several elements in order to manage claims: satisfaction of the client on one hand, and on the other hand, reduction of administrative expenses, and avoidance of excessive compensation.

F. Financial operations:

Accounting and financial management of the company are considered as important operation and main functions of the insurance companies. This department has the following functions and operations:

- Providing periodic financial reports to the management and regulators as required.
- Cash flow management resulting from insurance operations premiums.
- Management of reserves and allocations for various risks.
- Follow up on the company›s receivables.
- Follow up on the company›s expenses.
- Follow up on employees› salaries.
- Follow up on the company›s balance in the banks.
- Follow up on payment of claims.
- Follow up on payment of reinsurance dues.
- Pay commissions to the beneficiaries of the sale channels.
- Preparation and maintenance of accounting records.

G. Investment Process:

Insurance companies gain their profits from two sources: underwriting profits and investment profits. The Investment Department plays a very important role for the insurance company, so each insurance company has to set an investment policy approved by the Board of Directors that manage the investment operations and methods of managing portfolios in accordance to the instructions of the Saudi Arabian Monetary Authority.

While insurance companies receive premiums, they usually do not expect to pay claims for a period of time as in the protection and savings insurance companies in particular. Therefore, the insurance company invests e premiums until any obligations has to be paid. The investment income has a double purpose: the first one: if they invest on a large-scale, this will make the insurance company gain the right profit. The second one: a good investment profit will allow the company to reduce the value of premiums paid by its customers, thus becoming more powerful to compete in the insurance market. For protection and savings companies, investments are a vital factor. Most protection and savings products have a role not only in income protection (as in life insurance) but also as a mean of investment.

K. Personnel and administrative processes:

As we know, the work of insurance companies is not based on machines or equipment but on the workers in this industry because they are the real capital of the company. Thus, insurance companies have to care about their staff.

It should be noted that the most important personnel and administrative operations are:

- Follow-up on staff management and their daily requirements.
- Set an employment policy.
- Set training and rehabilitation policy.
- Set and save employee files.
- Manage and protect the property of the company.
- Develop and improve job conditions.
- Develop and improve incentives and work environment.

Chapter Five
Revision questions:

1. List three characteristics that must be found in the Board of Directors in the insurance companies
2. State the functions and responsibilities of the Investment Committee
3. One of the important jobs in the insurance industry is the actuary. Mention 4 of his tasks
4. What is the underwriting function and how important it is to the insurance company?

Practical question

1. The department that the insured will communicate with when he has a claim is the claims department. To what extent this department is important to the company›s reputation and performance?

Chapter Five
Answers of Chapter Five Revision questions:

1. List three characteristics that characterize in the Board of Directors in the insurance companies

- The Board of Directors shall be representative of the main partners with elected members representing the shareholders.
- The previous structure is a standard organizational structure, in the sense that it is the same to some extent in the companies, but there are some differences due to the particularities of each company, in addition to the size of the company›s work, which calls for expansion in some areas of functionality.
- The board of directors of any company must be approved by the supervisory and regulatory authorities in order to preserve the selection of departments with High professional and ethical standards.

2. State functions and responsibilities of the Investment Committee

- Determine the investment objectives of the company.
- Form an investment policy for the company.
- Ensure that the management has obtained regulator's approval for the investment strategy.
- Choose between managing investments internally or externally.
- Ensure that all investments comply with regulatory restrictions.
- Have an approval for certain investments.
- Delegate power when necessary.
- Review investment performance.

3. One of the important jobs in the insurance industry is the actuary. Mention 4 of his tasks

- Obtaining information and data required from the former actuary.
- Reviewing the financial standing of the company.
- Assessing the Company›s ability to meet its future obligations.
- Determining retention ratios.

4. What is the underwriting function and how important it is to the insurance company

The underwriting is a primary function of any insurance company It is the process by which the underwriter decides to accept or not to accept the insurance offer and sets the necessary conditions, price, and premium.

In other words, underwriting is the selection and pricing of risks, depending on the pricing tables and actuarial data. The essence of the underwriter›s role in an insurance company is to determine the risk degree of the policyholders, and to determine the prices of the appropriate insurance policies covering that risk. The insurance company may lose work and make its competitors gain it

if the underwriter›s assessment of the risks is so severe that leads to make the premium excessive and the insurance applicants underwrite in the competitive companies. It may also have to pay non-outstanding claims if the premiums received are not sufficient to pay compensation if the underwriting is unprofessional.

Practical question

1. The department that the insured will communicate with when he has a claim is the claims department. To what extent this department is important to the company's reputation and performance

Insurance is to give a promise of compensation when the damage occurs, and the benefit of insurance is reflected when the claim for compensation is submitted.

Chapter Six

Risks and Obstacles of Insurance Companies' Operations

Introduction

A sound and developed insurance market is an essential element of any successful economy, and this can be confirmed by looking at the economies of many countries around the world. Not addressing insurance with the same momentum as other financial institutions (such as banks) does not reflect the real importance of the insurance industry. Many researchers who wrote in the history of economics and history of insurance have connected the existence of a good insurance market with the development of industry and other economic institutions. For example, Britain is one of the developed countries in the insurance market, where insurance accounts for 15% of GDP.

Despite the importance of the insurance industry in protecting individuals and institutions, it still has some obstacles that will be mentioned here, hoping that by time, they will end and become part of the history. Some of these obstacles and risks are:

Learning objective

Introducing the trainee to risks facing insurance companies at all levels.

6.1 Product development risk:

Product development risk is the risk associated with changes to an existing product in order to meet the needs of customers and make the product more marketable in a competitive environment. This will affect product coverage and liabilities, which leads to risk. When the company faces product development risk, it must:

- Conduct an actuarial review and obtain actuarial approval to sell the new product.
- Ensure the new product's compliance with the regulatory requirements for obtaining approval of any new product by the Saudi Arabian Monetary Authority(SAMA).
- Prepare a report on the changes in risks and the insured behavior from the date of launching the new product.

Note: development is not a problem as it is focused on developing an existing product and increasing its advantages, but the risk is in new products put on the market without testing.

6.2 Underwriting risk:

It is the risk associated with the assessment process of the risk that is presented to insurance companies for approval. When the company faces an underwriting risk, it must:

- Ensure that policies and phrases are clearly articulated leaving no room for interpretation.
- Ensure that the insured completes the insurance application.
- Ensure that premiums include the cost of policies, including indirect costs of marketing or any other charges.
- Set the guidelines for underwriting to determine the responsibilities of the departments related to the underwriting activities (for instance, but not limited to:

Sales Department, Claims Settlement Department, and Reinsurance Department).

- Reinsure part of the risk in accordance with the Regulation of Reinsurance Activities before selling any product to reduce and control overall risk and enhance risk tolerance.
- Conduct periodic and sufficient review of the appropriateness of the insurance policies, the underwriting guidelines, and the underwriting process to ensure the effective functioning of each department.

6.3 Pricing risk:

It is one of risks associated with the underwriting process, as it is one of its functions. It is a risk that arises from the process by which the company tries to determine the appropriate premium rate. The company facing pricing risk must do the following:

- Taking into consideration all potential risks using appropriate means to determine the price of the product.
- Evaluate profits and business losses to determine the effects associated with adjusting the premium rate in profits. In caste new patterns emerged, the company should launch the price assessment process (i.e. re-pricing)
- Engage actuarial experts in product pricing.

6.4 Claims settlement risk:

Risks associated with claims payment process for policyholders, each according to their coverage. The risk is that actual claims due to policyholders, in respect of the risks insured by an insurance company, will exceed the carrying amount of the insurance liabilities. The insurance risk is currently affected by the exceptional competitive nature of the market and the increased frequency and severity of claims, particularly motor claims and medical claims. Costs have increased sharply, which led to many losses in a number of companies that exceeded in some of them more than 50% of the company's capital.

The company facing claims settlement risk must do the following:

- Review decisions regarding claims settlement to ensure that they are taken in accordance with the coverage of the insurance policy, which would reduce the additional costs associated with making improper decisions in the future.
- Conduct periodic evaluation of claims settlement procedures and principles to enhance their effectiveness and quality.
- Identify and apply the claims settlement process with reinsurers in order to facilitate settlement of such claims.
- Identify and apply proper mechanisms for the development of appropriate precautions.

6.5 Solvency risk:

The solvency of cooperative insurance companies is one of the top priorities of authorities and organizations supervising the insurance sector around the world, as it is here in the Kingdom of Saudi Arabia. The Saudi Arabian Monetary Authority(SAMA) and the Capital Market Authority (CMA) are following this issue closely, and it gained more importance with the frequency of global financial crises. Generally, solvency means the ability to meet or pay obligations. In insurance, it is defined as "the ability of an insurance company or reinsurance company to permanently ensure its own resources to pay obligations arising from insurance or reinsurance business" i.e. "the ability to pay

obligations on maturity". The International Association of Insurance Supervisors has shown that any insurance company is solvent when it is able to meet its obligations for all contracts at any time (or at least in most circumstances).

Insurance companies' solvency means that they have permanent financial ability to pay back the disasters they may suffer, i.e., that they are able to meet their obligations to policyholders on time. The importance of solvency is that it represents protection for insurance policyholders' interests by meeting their dues on time, in addition to ensuring the success, survival, and continuity of insurance companies' operations because of its economic and social importance. Furthermore, the composition of the solvency margin varies according to the different regulations of countries, but generally consists of capital, reserves and retained earnings. Due to the importance of the margin of solvency, the regulators of the insurance sector impose a mandatory minimum solvency margin in line with their size and risk.

This problem is highlighted as one of the obstacles because:

- Companies are not meeting their obligations.
- Companies have stopped offering some types of insurance, causing a decrease in corporate revenues.
- Companies have stopped offering all types of insurance and hence a greater reduction in resources.

SAMA pays attention to this issue, therefore; many articles have been included in its Implementing Regulations to urge companies to control all their operations in order to ensure the continuity of their solvency, which is one of the tools to continue its operation.

6.6 Credit risk:

Risk associated with other party's inability to meet its obligations as evidenced by the insured's payment history and the general economic situation's effect on credit risk. These risks are one of the daily obstacles faced by some insurance companies, and when faced with credit risk, the company must do the following:

- Ask the insured to provide proper collateral or guarantee
- Implement a strict schedule for paying dues of premiums or other.
- Putting restrictions on granting credit in terms of quality and quantity.
- Conduct a periodic review of the credit granting policy adopted by the company in an attempt to identify areas of weakness in this policy and intervene in case of finding any.

6.7 Information technology risk:

Risk occurring because of error or failure to operate the business due to an error in information technology (which are the technical software used by the insurance companies in their day-to-day business). Each company is supposed to have a program used in daily operations to register the insured information, issue and manage policies and other insurance operations. When faced with such risk, the company must do the following:

- Provide an appropriate IT system for data security.
- Periodic review and regular update of the IT system and develop a disaster recovery plan.
- Use reliable and authentic software.
- Implementing a modern anti-virus system to be installed on all devices of the company.

- Keep all financial information and other information in a safe place.
- Save backup copies of all company information.
- Provide trained and qualified human resources.

6.8 Defrauding insurance companies' risk:

Learning objective

Introducing the trainee to insurance fraud, the risk resulting from it that companies face, and the sources of defrauding insurance companies

There is no doubt that the increase in fraud crimes suggests a lack of some cultural, social, and educational values among these fraudsters. The prevention of these crimes requires further research and study by specialized scientific bodies and institutions, considering that fraud is one of the obstacles impeding the progress of the cooperative insurance industry.

Defrauding insurance companies is not only a local phenomenon but is a global one, as fraud is practiced on most insurance companies.

Fraud in Insurance:

Insurance fraud is defined as any act or negligence intended to obtain dirty money or achieve illegal gain for the party who committed the fraud (which will be referred to in this research as "the fraudster") or for third parties. This can be achieved by, but not limited to, the following means:

- Deliberately present, conceal, withhold, or not disclose one or all of the material facts relating to a financial decision, process or perception of the insurance company›s status.
- Lack of responsibility, abuse of trust, and misuse of agency.
- Poor distribution of insured assets in order to submit claims later.

Fraud in insurance is creating a fake insurance claim or increasing insurance claim cost by increasing the damage cost or changing its nature by unlawful means to obtain undue gains. Fraud is divided into primary and secondary. Primary fraud is a person claiming an accident, injury, theft, or damage that does not exist, or claim that he has performed a service he has not performed, all for obtaining a legal gain from the insurance company. Secondary fraud is an honest and righteous person making a small lie or lies to maximize or increase his dues from the insurance company unduly.

Thus, we can summarize the types of defrauding insurance companies as follows:

- A false claim made by the insured or the injured party in the incident by making fake statements to serve his interest or personal benefit or to obtain undue indemnity.
- The use of fraudulent methods that would delude the insurance company that there is an accident, which is not true, to gain a profit.
- To claim a movable or immovable property knowing that he is not qualified to do so.
- Using a false name or having an incorrect status.

Fraudsters of Insurance Companies:

Far more difficult for the underwriter is the assessment of moral hazard; in individual risks, what matters is the conduct of the insured person. The dishonest person who may make a fraudulent or exaggerated claim clearly presents a greater moral hazard than the honest person does. However, recognizing this in advance can be difficult, and so is deciding whether an exaggerated claim is

dishonest or merely a negotiating tool.

In addition to the individual, social attitudes can be important. Some segments of the society do not consider insurance fraud as dishonest, perhaps because the victims of it are not people.

Fraud comes in all forms and sizes, and can be a simple act made by one person or a complex process involving a large number of people or sources from within and outside the insurance company. The International Association of Insurance Supervisors notes that the fraudsters of insurance companies include:

- Internal fraud: the chairman of the board, a manager, or an employee conspiring with others from within or outside the company to defraud it.
- Policyholder – insured fraud: defraud the insurance company by purchasing or/and developing a product insured by a person or persons through receiving false payment or coverage.
- Insurance brokers, insurance agents, or insurance professional fraud: insurance companies' brokers or agents defrauding the insurance company or the policyholders, or claims adjuster defrauding by changing the facts in claims adjusting reports.
- Providers of supplementary insurance services fraud: fraud by car maintenance centers, car agencies, medical centers such as hospitals, pharmacies, or doctors.
- Fraud by contractors or suppliers that do not have a role in settling insurance claims or do not represent main parties in the insurance contract.

Here are some details regarding fraud done by those persons:

Learning objective

Introducing the trainee to internal fraud and its evidence.

A. Internal Fraud:

As part of its management of all the risks faced by insurers, these insurance companies must consider the impact of internal fraud on staff morale as well as the possibility of financial losses. Internal fraud also poses a risk to the reputation of insurance companies, as serious cases can have a significant economic impact on these companies.

Factors making insurance companies become victims of internal fraud:

- Complex organizational structure: internal fraud is more likely to occur to insurance companies with complex organizational structure, where there is an increase of allocation of responsibilities or lack of identification of employees' duties.
- Inventions and technology speed: the speed of modern economics, product development, and computing all increase the opportunities of fraud.
- Rewards and promotions policies: the motivation for fraud may be greater if the employee›s status and salary depend on achieving certain objectives.
- Economic climate and trading status: stages of instability in an insurance company such as mergers and acquisitions or tenders may offer unexpected opportunities for fraud.
- Fraud is most likely to occur when the insurance company›s control systems are not very strong.
- The risk of internal fraud in centralized management systems is likely to increase, particularly in view of the geographical spread of the country.

In general, fraud occurs at all levels, including the level of the board of directors and management itself, and the higher the level at which fraud is committed, the greater the loss of money.

Employees who steal money or resources of insurance companies - such as equipment, stocks, or information - represent a traditional fraudulent behavior, but corrupt employees engage in costlier scheme. These schemes also include bribery behavior, which is typically "buying" something such as the influence of bribery recipient who make business decisions. Although commercial bribery is not as common as other types of fraud, it is usually costlier and involves conspiracy between employees and third parties. Usually, these conspiracies include the theft or charge of commissions from a supplier as a reward for awarding the contract. This type of fraud is difficult to detect, because bribery is paid directly from the supplier to the employee and does not pass through the insurance company›s books of account, unless disclosed by other employees, merchants or third parties.

Traditional indicators of Internal Fraud:

- An individual or a group of individuals conspiring to benefit from a particular financial operation and / or financial decision.
- The company›s strategy changes rapidly.
- The organizational structure is complex.
- Great number of executives.
- Conflict of interest between managers, team members, foreign companies and contractors.
- The commission structure is unusual.
- Training programs are weak.
- The times and places of making deals and the parties to it are unusual.
- Activities are not consistent with the stated policies of the insurance company.
- Employee rotation at the management level is high.
- Costs increase without justifications or are high compared to competitors.
- Morale is low within the insurance company or within some departments in this company.
- Managers or employees, who do not want take a vacation or seem to be under pressure, being late for work.
- Board of directors, managers, or employees who suddenly resign.
- Clear changes in the personality of directors, managers or employees.
- Sudden wealth of board members, managers, employees or living above the level of income.
- Sudden change in the lifestyle of board members, managers or employees.
- Managers or employees with considerable power and / or power without supervision or inspection by another person. It can also be by those who refuse or oppose an independent review of their performance.
- Relationships with board members, managers, or employees who has external trade interest or close relationships with third parties, which constitute a conflict of interest. For example, the unbalanced amount of work or other forms of «support» may be granted to third parties that are close to managers or employees.
- Customers' complaints.

B. Policyholders (insureds) fraud or from those who submit fraudulent claims to insurance companies:

Learning objective

Define policyholders' fraud, its characteristics, and its cases

Policyholders' fraud can occur upon the conclusion of the insurance contract, during the insurance contract, or when the request for payment or indemnity is made. Third parties involved in the settlement of the claim can also submit fraudulent financial claims. For instance, medical workers can claim reimbursement for medical services that were not provided or engineers can increase the cost of repairs.

Policyholder may deliberately conceal or provide incorrect information. For example, he may refrain from providing information about the denial of coverage by other insurance companies or provide false information about the claims. This poses a significant risk to Insurance companies, which may not have provided coverage or may have provided coverage under different circumstances (higher premiums or higher deductibles) if such information was known.

Fraudulent claims can have any of the following characteristics:

- Claim damages or losses that did not really occur.
- Exaggerate damages or losses covered by the insurance.
- Falsify the truth to make the accident appear as one that the insurance policy covers.
- Falsify damages.
- Fake an accident that caused damages or losses covered by the policy.
- Insured not doing any action to avoid or reduce the damage.
- The claimant makes inconsistent statements either to the police, experts or third parties.
- The claimant requests the payment in cash.
- The claimant accepts a low settlement to receive a quick settlement.

Fraud in insurance claims can be linked with other types of fraud such as identity fraud. For example, there have been cases of medical treatment provided to persons using the identity of other insured persons to cover the cost of medical treatment.

Cases of policyholders' fraud and fraudulent financial claims in insurance:

- Exaggerate damages or losses.
- Fake accidents.
- Report and claim indemnity of damages or losses that are not real.
- Fraudulent claims in the medical field.
- Fraudulent financial claims related to money-laundering.
- Fraudulent financial claims related to terrorism financing.

C. Insurance brokers fraud:

Learning objective

Identify cases of insurance brokers fraud and its indicators

Insurance brokers or insurance professionals – independent or others – are important for the distribution, payment and settlement of claims, and they may keep records of insurance companies' clients. Thus, insurance brokers are involved in the most important operations of insurance companies, and are important in managing the risk of fraud by insurers.

Examples of brokers involved in fraud:

- Withholding premiums paid by the policyholder until the claim is paid.
- Insuring factious policyholders and claiming to receive the first payment and collecting commission.
- Cancelling insurance by stopping further payment of premiums.
- Warning signs of brokers' fraud include:
- The broker requires paying an immediate commission or a commission in advance.
- The policyholder/insured lives outside of the broker's working area.
- The broker has a small portfolio with large sum insured.
- Premiums received or commissions paid are above or below the normal for the specified type of policies.
- Requiring the policyholder to make payments through the broker, which is an unusual method in this field.
- The insured and the broker are the same person.
- A personal or intimate relationship between the client and the broker.
- Unexpected developments or results such as:
- High claims rate.
- Increase production to be exceptional or for no clear reason.
- High rate of early cancellation or discontinuities.
- High number of unsettled claims.
- Relatively, the broker has many insurance policies:
- The commission is higher than the first premium.
- Late payments of premiums.
- Payment of a claim immediately after the conclusion of the insurance agreement (especially in life insurance cases).
- A large number of fraudulent cases.
- An unreasonable number of insureds who have a high-risk ratio such as the elderly.
- The broker changing his usual address or name.
- Continuous changes in the financial assets of the broker.
- A number of complaints or legal interrogations.
- Financial problems faced by the broker.
- Broker involvement in a third partly business.
- Continuous talk about operational procedures.
- The broker's insistence on using certain loss assessors and/or contractors to make repairs.

D. Fraud by services providers to insurance companies:

Learning objective

Identify fraud indicators committed by supplementary services providers

These providers include medical centers, hospitals, doctors and pharmacists. Some of these types of fraud are mentioned here:

- Health care provider: the health care provider inflates the bill as he knowingly provides incorrect numbers in the bill and distort the facts.
- Medical identity fraud: use of another person's identity to benefit from health care.
- Medical transference / illegal volunteerism: refers to situations in which people are used and given incentives to perform medical procedures, whether or not these procedures are actually carried out.
- Billing fraud: medical service provider knowingly provides incorrect bills to pay for services that have not been provided, bills for false medical procedures, or bills for a medical necessity when it is actually optimal or a cosmetic case not covered by the health insurance.
- Vaccinations fraud: false billing by health services providers for vaccinations that have not been given.
- Pharmacy: the pharmacy provides high bills or falsify facts.
- Surgery center fraud: any fraudulent activity (billing fraud…etc) related to the surgery center's patients.
- Disability: a disability claim provided within a disability policy, where the holder is in a permanent or temporary disability and receives ongoing privileges and / or professional privileges, and / or carries out an act or activity beyond his or her physical abilities.

Fraud cost in the insurance sector:

Learning objective

Identify the implications of fraud and what insurance companies will face from these operationsproviders

Insurance fraud, like most types of fraud, is a "hidden crime" and because much of it remains unknown, undisclosed or proven, it is difficult to set accurate figures. While most insurers believe that fraud is a problem, they find it difficult to agree on the extent of it.

The number of rejections of claims submitted to insurance companies as fraud is not that big. Additionally, insurers refrain from providing figures in this context. A number of senior insurance specialists have pointed out that the actual ratio of rejecting fraudulent financial claims is unclear, and this figure varies considerably according to the insurance company and the work being done. Most insurers consider rejections a serious matter, and so before rejecting the claim, a thorough investigation would have to be carried out. In general, the decision of rejection is in the hands of senior management.

Determining the negative effects of fraud on insurance companies:

Fraud is a mental effort translated into a form of an interactive behavior with the victim, and here it is

the insurance companies. As social life develops and changes, so are the mental abilities of fraudsters. This make them devote most of their attention and time to using these new data to serve their purposes in increasing the size and types of fraud on insurance companies and other fields, which results in a great number of negative effects on insurance companies:

Negative effects on insurance companies:

- Defrauding insurance companies lead to huge financial losses due to continuous payments of indemnities for insurance claims for accidents that are not true or genuine.
- Insurers are forced to increase insurance rates for individuals or institutions to compensate for losses and increase the proportion of financial reserves, which causes the loss of some customers due to losing competitive-based pricing.
- As a result of high indemnities cost, insurers have to stop issuing and selling certain types of insurance, which causes imbalance in the organizational form of the company in terms of the classes of insurances in which it operates.
- Insurers have to stop dealing with some insurance support services providers such as car maintenance centers or medical services including medical centers and pharmacies. This reduces the chances of expanding the service networks, competition with companies, or even having competitive prices. More service networks mean better preferential rates, which leads to breaking the monopoly by providers of the same service.
- Losses incurred by insurers in spending time searching for service providers who follow highly transparent and ethical professional and administrative systems to mitigate potential fraud. This requires experience and expertise in investigating supplier systems and expertise.
- Losses incurred by insurance companies due to reduced size and type of investments because of increased payments and lack of financial returns. It is known that insurance companies invest a large part of the premiums they receive in various projects in order to diversify their sources of income. The compensations for paying fraud claims are in fact part of the investment amounts.
- Losses incurred by insurance companies because of searching, investigating, and prosecuting fraudsters, as well as appointing lawyers to follow-up fraudsters in various judicial bodies.
- Losses incurred in the search for a way to reduce losses instead of increasing sales, meaning that decision-makers in insurance companies are concerned in finding a way to reduce these losses.
- Losses incurred by insurers in appointing accountants, auditors, and additional experts to disclose correct and incorrect amounts and claims, in order to submit the required reports to the board of directors.
- Losses incurred by insurance companies in estimating cost of assessing the loss resulting from property accidents such as fire accident, in addition to the indemnity itself, especially if we knew that the cost for appointing loss adjusters is high compared to other professions.
- Moral losses that will occur within the company itself because of doubt and blame, which will be directed to some employees. This will affect the employees' loyalty, ambitions, psychological well-being, and thus their productivity.
- Losses incurred by insurance companies because of amendments to reinsurance agreements renewed annually. It is known that insurance companies reinsure a large part

of the risk accepted with major international reinsurance companies according to the reinsurance agreements. These agreements depend on the company's results during the year, so the greater the losses, the more difficult the terms and the lesser the privileges.

- When fraudsters hack the company and its systems, the insureds' loyalty gets affected, which will prompt them to search for other insurance companies.
- Losses incurred by insurers because of the continuous training to detect fraud patterns and types resulting from the nature of fraudsters themselves who are using new methods of fraud.
- Losses incurred by insurance companies when installing and updating technical systems by using computers or any other devices to detect the means and methods of fraud used by fraudsters. (Zureikat, 70-80).

SAMA's role in fighting insurance fraud:

SAMA has developed an anti-fraud regulation that includes general principles and minimum standards to be complied with by insurance and reinsurance services companies to prevent or at least reduce fraudulent practices. The purpose of it, is to establish high standards for detecting and preventing fraud, and under this regulation, companies must set appropriate internal control procedures to ensure compliance with this regulation. Additionally, when contracting with other parties, they must ensure all parties compliance with this regulation, especially when there is a clear violation by one of the contracting parties.

For more information on SAMA's role, the reader can refer to SAMA's website to read all about the rules, regulations, and circulars of SAMA by clicking on the link below:

http://www.sama.gov.sa/ar-sa/Laws/Pages/Insurance.aspx

6.9 Lack of qualified human resources:

One of the obstacles facing insurance companies and insurance market generally in Saudi Arabia is the lack of qualified human resources in terms of knowledge of the insurance industry in all its functions. This problem is the main obstacle facing the insurance sector. It is undeniable that this shortage has a serious impact on the insurance market, especially that insurance activity is a high-risk activity. It requires professional and technical expertise to manage it, and the relative weight of technical expertise as a success factor of insurance activity is more important than the capital. This obstacle occurs due to the following reasons:

- Novelty of the insurance industry in the Kingdom of Saudi Arabia, which led to the lack of accumulated experience in terms of human resources.
- Lack of qualified educational institutions that work to qualify national human resources in the insurance industry.
- Lack of specialized training centers in the insurance industry.
- Insurance services companies compete to attract the few qualified personnel, which led to the instability of these personnel.
- Some qualified personnel with insurance knowledge moving to work in other fields due to the demand of their skills.
- Some social influences have led new generations to move away from working in the insurance industry.
- Increased demand for local labor in most of the other professions, making a differentiation between the insurance industry and other industries.
- Increase the size of insurance business in the Saudi insurance market in terms of insurance premiums, forcing companies to look for new workers.

- Increasing number of licenses issued for insurance services companies, which increased the demand for qualified personnel.

We would like to mention here that the Saudi Arabian Monetary Authority(SAMA) attaches a special importance to this issue. It requires insurance companies and insurance services companies to set out in their annual plans a training and qualification plan in order to raise the level of employees in the insurance industry.

6.10 Insurance awareness and education:

Despite the quantum leap in the insurance market in Saudi Arabia, insurance industry experts still have reservations about the penetration rate in the insurance market in the Kingdom compared to global market. This, of course, is due to the lack of insurance awareness and education in the Saudi society for the following reasons:

- The novelty of the insurance industry in the Kingdom of Saudi Arabia in its regular form, since it started almost after 2004 after the issuance of the Implementing Regulations and the beginning of establishing insurance companies and insurance services companies.
- Insurance products are still viewed as non-priority products with the exception of mandatory products such as third-party liability motor insurance and medical insurance.
- Lack of media activity that covers the advantages of the insurance industry in Saudi Arabia, as the media still focuses more on the disadvantages of the sector.
- Some of the social norms prevailing in Saudi society and the local communities' negative view, due to the delay in organizing this sector. However, we expect this view to disappear gradually.
- Educational institutions not participating in conducting studies and researches about the advantages of the insurance industry and its role in providing protection for individuals and properties, and drive the development.
- The impact of the pre-regulation insurance situation in Saudi Arabia and the negative effects of this phase.
- Lack of specialized training programs that work to educate individuals and institutions on the importance of the insurance industry.
- Delays in the application of some types of insurance products to become compulsory like other markets, such as homeowners insurance or motor insurance on a yearly basis.
- Insecurity of Saudi citizens in working at insurance companies and insurance services companies for continuous and long period for the desire to work in government sectors, despite the several incentives that insurance companies provide.
- The insurance companies' failure to hold conferences or meetings that indicate the nature of the insurance industry and its role in the economic development and the protection of individuals and institutions, or failure to carry out continuous public information and advertising programs targeting the largest possible segment of Saudi society to promote insurance awareness and education.
- Lack of clear social responsibility programs of insurance companies towards various social issues.

6.11 Reinsurance risk:

Risk associated with transferring part of the risk to another company. During the ordinary course of business, insurance companies reinsure with reinsurance companies to reduce their exposure to financial losses that may arise from large insurance claims. Although companies have reinsurance agreements, they are not exempted from their direct obligations to policyholders if reinsurers fail to meet their obligations.

In recent years, insurance companies suffered a number of losses. Changes occurred in some natural climate conditions such as flood, which made reinsurers reluctant to accept risks from some companies or to reject the renewal of some of the major reinsurance agreements with insurance companies.

6.12 Reputation risk:

Risk resulting from negative reviews made about the company by the public or competitors, which limit the company's ability to establish new relationships or services, or continue to serve existing clients. This may expose the company to financial losses or a lack of insured clients, therefore; the company's revenues and capital will be affected. When the company faces reputation risk, it must be careful when dealing with customers and the community.

Examples include, late payment of claims, medical approvals, or even third party administrators services.

6.13 Non-compliance risk:

When a company is faced with risks resulting from violating regulatory and corporate rules, regulations, and instructions, a company must do the following:

- Ensuring that the company complies with all rules and regulations governing its work.
- Adequate follow-up of all instructions governing insurance activities, as well as, payment policies and procedures.
- Ensure the seriousness and adequacy of contractual relations with the insured and other parties.

Violations that may be made by insurers include; not setting rules to deal with the insured, exceeding the time required to handle claims and accidents, or selling products that have not been approved by SAMA.

6.14 Changes in country risk:

Risk associated with changes in the work environment and investment within the country, which in turn affects the profitability of companies. In this situation risk will include macroeconomic mismanagement resulting from the misuse of ineffective fiscal and monetary policies, which may lead to inflation, inadequate interest rates, and recession. In addition to wars, political instability, or labor market instability leading to higher costs.

6.15 Money-laundering and terrorism financing risk:

Learning objective

Define money laundering, its stages, and indicators.

Money-laundering means committing an act or attempting to commit an act with the intention of concealing or disguising the origin of money obtained illegally and making it appear to have come from a legitimate source.

On the other hand, terrorism financing means financing terrorism operations, terrorists, and terrorist organizations.

Money laundering goes through three stages:

A. Placement
B. Layering
C. Integration

A. Placement:

Placement involves the actual entry of illegally or irregularly obtained money or funds into financial and non-financial institutions. This process is carried out through cash deposits, purchase of financial instruments in cash, foreign currency trading , purchase of insurance policies, purchase of gold, jewelry, precious metals, real estate, cars, and other commodities.

B. Layering:

At this point, the suspect seeks to separate the funds from their source through a number of complex transactions involving purchases, cancellation, early waivers of annual returns during the transitional period that appears to be out of control, loans secured by other loans, wire transfer. In addition to a number of fake documentary credits, fraudulent investment or commercial plans, huge deposit consisting of several smaller deposits in different locations, all with the aim of misleading the auditors and making the tracking process difficult for administrators.

C. Integration:

This stage includes a seemingly interpretation of the wealth of the person suspected with money-laundering provided through a variety of programs such as purchases of assets or securities, shell companies working as a front for it, legally protected companies, or investments in securities or other technical businesses etc. This is through a way that allows return of funds as legitimate gains, and then making it become part of other regular funds in the economy so that it is difficult to distinguish between legitimate funds and illegitimate funds.

Terrorism financing:

Terrorism, terrorist acts, and terrorist organizations financing are considered money-laundering crimes according to the anti-money laundering law, even if the funds used were legitimate. The anti-money laundering law and its implementing regulations have obliged financial and non-financial institutions, when suspecting a person or a commercial institution that directly or indirectly provides or collects funds knowing that it will be used for unlawful purposes, to notify the Financial Investigation Unit.

Methods and trends of money laundering:

Money laundering is carried out in various ways including retailing, i.e., splitting large amounts into smaller amounts that can be deposited, purchasing, or using this method in stock or bond trading or insurance operation without raising suspicion. Other methods include money transfers, purchase of cash instruments (such as traveler's check), deposit through ATMs or deposit of funds through shell companies. Finding an employee of a financial or a non-

financial institution to collude with, whether voluntarily or not will facilitate money laundering operation. Supervisory and regulatory bodies, including (Ministry of Commerce and Investment – SAMA – CMA), issue guidelines for anti-money laundering (AML) and combating financing terrorism (CFT). The Financial Action Task Force (FATF) issues an annual document regarding money laundering methods, which institutions must review and update their information and regulations accordingly.

Insurers should realize that the insurance industry is vulnerable to money laundering and terrorism financing. Including, but not limited to, the following:

- Money launderers insure for large sums of money and receive them after a specified period by purchasing an insurance policy and paying premiums using the money to be laundered. After a short period, the insurance policy is cancelled and the sum will be received by the insured (Money Launderer) after deducting the insurance expenses, in the form of a check issued by the insurance company.
- High sum insured on the savings insurance policy.
- Additional premiums paid in the portfolio of Protection & Savings policy.
- High sum insured on personal accidents insurance.

Money launderer also uses the following methods:

- Laundering by secured loans.
- Laundering by documentary credit.
- Laundering through financing and revenue.
- Laundering through capital market.
- Method of establishing shell companies.
- Laundering by fictitious jurisdictional disputes.
- Laundering by establishing interface projects.
- Laundering in contracts and large supplies.
- Laundering through touristic festivals and events.
- Licensed charities and associations.

Establishing an effective control system:

All financial and non-financial institutions should design and develop internal control systems for AML and CFT, taking into account the following points:

- Policies of the financial and non-financial institutions of AML and CFT should include
- self-evaluation procedures to ensure that the institution complies with those policies
- and procedures.
- Internal auditors of financial and non-financial institutions should include the AML and
- CFT compliance report within their inspection and audit programs.
- Financial and non-financial institutions should develop and constantly update indicators
- of suspected money laundering and terrorism financing.

Indicators of money laundering in insurance:

- Insured is late or hesitated in giving information to complete customer verification.
- An agent / broker identifying and insured through an unregulated or poorly regulated market.

- Insured pays the insurance premiums in advance unexpectedly.
- Insured requests the purchase of a large part of an agreement in a lump sum, while he usually pays small regular payments.
- Insured transfers the benefit of an insurance policy to a third party with no apparent connection to him.
- Insured replaces the first beneficiary by a third party with no apparent connection to it.
- Insured terminated a policy at an early stage in the event of a loss, and give the refund check to a third party.

Exercise due professional care:

All financial and non-financial institutions shall exercise due professional care and keep the required documents in their records on the identity of persons involved, and the nature and type of activity they exercise, as well as the documentation of the operations carried out. All institution shall exercise due professional care when:

- Building a business relation.
- There are reasons to suspect money laundering and terrorism financing.
- There is a slight doubt regarding the information provided by the clients and its adequacy.

The minimum of exercising due professional care includes the following:

- Verify the identity of the client,
- Verify the identity of the agents and their powers of attorney.
- Verify the purpose and nature of the activity practiced by the client.

To help insurance companies in the Kingdom of Saudi Arabia in AML and CFT, SAMA has established rules and implementing regulations for this, which insurance and reinsurance services companies shall comply with.

Chapter Six
Revision questions:

1. What are the stages of money laundering?
2. List four indicators for internal fraud.
3. What is pricing risk?

Practical question

1. Insurance companies face fraud in different methods. list these methods and their effect on insurance companies.

Chapter Six
Answers of Chapter Six Revision questions:

1. What are the stages of money laundering?

Money laundering goes through three stages:

A. Placement
B. Layering
C. Integration

A. Placement:

Placement involves the actual entry of illegally or irregularly obtained money or funds into financial and non-financial institutions. This process is carried out through cash deposits, purchase of financial instruments in cash, foreign currency trading , purchase of insurance policies, purchase of gold, jewelry, precious metals, real estate, cars, and other commodities.

B. Layering:

At this point, the suspect seeks to separate the funds from their source through a number of complex transactions involving purchases, cancellation, early waivers of annual returns during the transitional period that appears to be out of control, loans secured by other loans, wire transfer. In addition to a number of fake documentary credits, fraudulent investment or commercial plans, huge deposit consisting of several smaller deposits in different locations, all with the aim of misleading the auditors and making the tracking process difficult for administrators.

C. Integration:

This stage includes a seemingly interpretation of the wealth of the person suspected with money-laundering provided through a variety of programs such as purchases of assets or securities, shell companies working as a front for it, legally protected companies, or investments in securities or other technical businesses etc. This is through a way that allows return of funds as legitimate gains, and then making it become part of other regular funds in the economy so that it is difficult to distinguish between legitimate funds and illegitimate funds.

2. List four indicators for internal fraud.

- Morale is low within the insurance company or within some departments in the company.
- Managers or employees, who do not want take a vacation or seem to be under pressure, being late for work.
- Board of directors, managers, or employees who suddenly resign.
- Clear changes in the personality of directors, managers or employees.

3. What is pricing risk?

It is one of risks associated with the underwriting process, as it is one of its functions. It is a risk that arises from the process by which the company tries to determine the appropriate premium rate. The company facing pricing risk must do the following:

- Taking into consideration all potential risks using appropriate means to determine the price of the product.
- Evaluate profits and business loss to determine the effects associated with adjusting the premium rate in profits. In caste new patterns emerged, the company should launch the price assessment process (i.e. re-pricing)
- Engage actuarial experts in product pricing.

Practical question

1. Insurance companies face fraud in different methods. List these methods and their effect on insurance companies.

- Internal fraud: Chairman of the Board, a manager, or an employee conspiring with others from within or outside the company to defraud it.
- Policyholder – insured fraud: defraud the insurance company by purchasing or/and developing a product insured by a person or persons through receiving false payment or coverage.
- Insurance brokers, insurance agents, or insurance professional fraud: insurance companies' brokers or agents defrauding the insurance company or the policyholders, or claims adjuster defrauding by changing the facts in claims adjusting reports.
- Providers of supplementary insurance services fraud: fraud by car maintenance centers, car agencies, medical centers such as hospitals, pharmacies, or doctors.
- Fraud by contractors or suppliers that do not have a role in settling insurance claims or do not represent main parties in the insurance contract.

There is no doubt that the increase in fraud crimes suggests a lack of some cultural, social, and educational values among these fraudsters. The prevention of these crimes requires further research and study by specialized scientific bodies and institutions, considering that fraud is one of the obstacles impeding the progress of the cooperative insurance industry.

Defrauding insurance companies is not only a local phenomenon but is a global one, as fraud is practiced on most insurance companies.

Chapter Seven

Customer Service According to the Insurance Market Code of Conduct Regulations in the Kingdom of Saudi Arabia

Introduction

Customer service is a set of practices designed to improve customer satisfaction's level, i.e. the sense that the service or product provided by the company has achieved customer satisfaction. In a more precise definition, it is the process by which the needs of customers are met by providing a high quality service that results in customer satisfaction.

SAMA has issued the Insurance Market Code of Conduct Regulations in the Kingdom of Saudi Arabia as follows:

7.1 Section One: Introduction & Purpose

Learning objective

Introducing the trainee to the sections of the regulations and its role in regulating insurance operations in the Saudi market

Purpose:

1. This regulation includes general principles and minimum standards to be met by insurance companies, including branches of foreign insurance companies and insurance and reinsurance services companies authorized by SAMA to deal with their current and potential customers in the future.
2. The objective of these regulations is to establish high standards for working in the insurance field.
3. The instructions of these regulations must be accompanied by articles: 12, 15, 16, 19, 22, 24, 25, 26, 37, 43, 44, 45, 46, 49, 51, 52, 53, 54, 55, 65, 71,77, 78, 80

Definitions:

4. The terms used in these regulations shall be amended to the same meaning in accordance with Article 1 of the Implementing Regulations of the Cooperative Insurance Companies Control Law unless otherwise indicated.

Scope and Exclusions:

5. The term «Authorized Companies» in these regulations refers to both insurance companies and insurance and reinsurance services companies, including insurance brokers and agents, insurance claims settlement specialist, loss assessor, loss adjusters, and insurance advisors.
6. These regulations do not apply to reinsurance activities.
7. Authorized companies must establish appropriate internal controls to ensure compliance with these regulations and in the case of contracting with other companies, they shall ensure that all parties comply with these regulations.
8. Authorized companies must maintain adequate records to prove its compliance with these regulations including, but not limited to, reasons for early cancellations or non-renewal of insurance policies, claims registers, and complaints registers.

Compliance Control for Contracted Companies

9. Insurance companies are responsible for ensuring that all persons who deal with customers on their behalf, including their employees and authorized agents who sell

the company›s products and services, perform their duties in accordance with these regulations.

Non-compliance:

10. Non-compliance with the requirements set out in these regulations is contrary to the terms of the permit and the authorized company may face penal action.
11. Authorized companies shall promptly notify SAMA of any circumstances that may hinder them from complying with the requirements stipulated in these regulations.

Structure of the Regulations:

12. Sales and Marketing Code of Conduct Regulations requirements are set out in the second and third sections of these regulations.
    - ❖ Section two – General Requirements – Based on General Principles.
    - ❖ Section three – Sales and Marketing Code of Conduct Standards: requires the authorized companies to have minimum requirements and guidelines for sales and marketing, for as long as they have a relationship with the customer before, during, and after the sale.

7.2 Section Two: General Requirements

Learning objective

Clarifying to trainee the general requirements in Section Two of the regulations

Integrity:

13. Authorized companies shall act in an honest, fair, and transparent manner and fulfill all their obligations to the customers under SAMA's regulations and instructions. If the obligations of insurance principles and practices were not fully codified into these regulations or in the Cooperative Insurance Companies Control Law and its Implementing Regulations, authorized companies may follow best practices accepted internationally.

Skill, Care, and Diligence:

14. Authorized companies shall work within their area of competence in dealing with customers in accordance with necessary professional skills and with utmost care and diligence to increase their efficiency through training, experience, and working with experts in this area.
15. Authorized company and its employees shall maintain and develop its skills and knowledge in the insurance field, be aware of the products and services provided by the company or the companies it represents, and be aware of the intended use of these products and services.

Non-discrimination:

16. Authorized companies shall not discriminate against its current or potential customers in the future, and shall provide convincing reasons for rejecting, cancelling, or not renewing insurance policies.

Adequate Resources:

17. Authorized companies shall take reasonable care to maintain adequate administrative, financial, operational, and human resources to carry out their business and serve their customers.

Disclosure of Information to Customers:

18. Authorized companies shall notify customers of all relevant information in a timely manner so that they can take informed decision based on adequate information.

19. Authorized companies shall take reasonable procedures to ensure accuracy and clarity of the information provided to customers and making them available in writing.

Data Protection:

20. Authorized companies shall ensure at all times the protection of customer's personal data, meaning that the data:
    - ❖ Shall be obtained and used for specified and formal purposes.
    - ❖ Shall be kept in a safe place and be up-to-date.
    - ❖ Shall be given to the customer when he submits a request in writing to do so.
    - ❖ Shall not be disclosed to any third party without prior permission of SAMA, except for auditors of the companies and actuaries.

Protection of Customer Fund:

21. Authorized companies shall ensure the protection of customer funds they keep on their behalf. Any premium collected by the broker or the agent must be deposited in an independent bank account (premium account) created for this purpose or immediately deposited with the insurance company as required by the contractual arrangement with the insurance company. Payments that can be deducted from the premium account are as follows:
    - ❖ Premiums of the authorized insurance company.
    - ❖ Commission amounts when the insurance company delegates the broker or agent to deduct the commission directly from the premiums. Premium account must not be treated as a broker or agent's property in any case. Particularly, this account should not be used as a collateral for any loan and must be used by the broker or agents for any personal financial transaction.

Conflict of Interest:

22. Authorized companies shall take reasonable procedures to identify and address any conflict of interest to ensure fair dealing with all customers. When a conflict of interest arises, the authorized company must disclose it to the customer and must not put its interest before the customer's.

Contracting with other Companies:

23. When authorized companies conclude a contract internally or with other companies, it must be related to a valid contract that determines the terms and conditions of service delivery, the rights and responsibilities of each party, and each party's liability to the other.

7.3 Section Three: Market Conduct Standards

Learning objective

Introducing the trainee to Section Three of the regulations and the articles stipulated in it

Section A: Insurance (Policies) Samples and Pricing

Learning objective

Introducing the trainee to insurance policy parts, contents, and any subsequent amendments.

Insurance Policy Wording and Contents:

24. Insurance policy application wording and policy samples must adhere to the following minimum requirements:
    - ❖ They must be written in Arabic and can be provided in English.
    - ❖ The sentence structure and language used should be as simple as possible.
    - ❖ They should be printed in clear readable text and not in very small letters.

25. Printed insurance policy application and policy samples must adhere to the requirements stipulated in Article 52 of the Implementing Regulations of the Cooperative Insurance Companies Control Law, and must include: *Article (52): "The Insurance Policy shall be written in a clear way that can be read by the public at large, and shall contain the following:

    1. Policy contents should include:
        - A) Policy number, which must also be provided in all related documents to this policy.
        - B) Insured name and mail address.
        - C) Coverage period.
        - D) Coverage description and limits.
        - E) Deductible.
        - F) Additional coverage.
        - G) Conditions and Exclusions.
        - H) Insurance rates and premium amounts, basis of premium calculation and the amount of commission paid under the policy.
        - I) A list of insured properties and interests.

    2. The standard text of the policy shall contain the type of coverages, general terms, conditions, and exclusions.
    3. Attachments that indicate additional coverages, conditions, and exclusions not covered above and different from the original agreement.
    4. The Company's signature and seal shall be on the policy and its attachments.

Amendments to Insurance Policy:

27. Authorized companies must provide the terms of the cancellation of insurance policy to be fair, clear to customers, reasonable and appropriate for the product. The cancellation terms must be clearly stated in the insurance policy and including the following:
    - ❖ Conditions under which the insurer has the right to cancel the policy.
    - ❖ Conditions under which an insured can cancel the policy.
    - ❖ Requirements for notice of cancellation including notice period of cancellation. In any case, the authorized company shall give the insured a minimum period of 30 days prior to the effective date of cancellation (according to Article 54 of the Implementing Regulations of the Cooperative Insurance Companies Control Law).
    - ❖ A description of the method of refunding the premium payable to the insured on

cancellation and when it is payable.

- As for Protection & Savings Insurance, in addition to point (d) above, the cash surrender value should be stated and clarified if applicable for each year of the plan or the insurance program.

Free Look Period Provision (Protection & Savings Insurance):

28. A Free Look clause has to be incorporated in all Protection & Savings, which should provide a minimum of 21 days' period from the date of delivery of the policy to the insured to review it and evaluate its suitability and whether it provides the benefits stated by the agent or broker. The insurance policy will be considered fully valid, and this condition will be considered waived by the insurer if he fails to inform the insurance company during the specified period that the insurance policy will be returned. If the insured customer considered the insurance policy inappropriate, the insurance company must be notified in writing during the free look period. The premiums refunded and paid to the customer are subject to the following:

    - Deduction of the expenses incurred by the insurance company, such as, the medical examination of the client.
    - Deduction from the premium for the period of coverage before the cancellation or non-acceptance of the policy.
    - With respect to the investment part (Units invested in) of the protection and savings policy, the insurance company is entitled to make an appropriate adjustment to take in consideration the changes in the unit price during the lapsed period.

Pricing:

29. Authorized company must utilize the pricing that was approved by SAMA as part of the product approval process.

Discrimination:

30. The criteria and practices of authorized company's insurance underwriting must not be by unfairly discriminatory.

Section B: Advertising and Marketing:

Learning objective

Procedures that insurance companies must follow when advertising and marketing its products

Credibility

31. Authorized companies should not disseminate inaccurate, misleading, exaggerated, or deceptive data or advertisements, directly or indirectly, including but not limited the following information:

    - Name of the company issuing the insurance policy.
    - The financial situation of the insurance company issuing the insurance policy.
    - Insurance policy coverage.
    - Advantages or benefits granted by the insurance policy.
    - If the advertisement includes the price of the policy, it should be clarified whether the price is inclusive of all fees or not.

Misleading Data:

32. Authorized companies' advertisements should not contain any false or misleading information regarding other insurance companies.

Section C: Communication with the Customer during the Pre-sale Period:

Learning objective

The trainee will identify the duties of the insurance company when communicating with customers in the pre-sale stage

Information on Authorized Companies' Offerings:

33. Authorized companies must disclose some minimum pre-acceptance information to the customers:

- ❖ Whether they are insurers, working for an insurer, or working independently for the customer.
- ❖ If a financial relationship exists between the broker and the insurer other than regular commission agreements, particularly if there is a joint ownership or if the two parties had joint owners, the customer shall be notified.
- ❖ The nature and range of products and services they can offer.

Assess Customer's Needs:

34. Authorized companies are obliged to seek information from customers to assess their insurance needs depending on the products and services that they are interested in. Insurance companies shall not provide additional coverages that conflict with the customer's needs to obtain a higher premium, with the exception of Protection & Savings contracts (see Article 41 below).

35. Authorized companies have ensure that the advice given to clients adequately meets their needs.

36. Authorized companies should provide sufficient information to enable customers to make informed decisions when purchasing insurance products and services including:

- ❖ Clarify the appropriateness of the advice given to meet their needs.
- ❖ If different options are specified in the advice given, information regarding the difference in benefits, coverage, and cost of these options should be clearly given to the prospective insured.

Increase Expenses:

38. Unless it is fully justified, authorized companies should not recommend the customer to replace the Protection & Savings insurance policy with a new one, and should inform him that additional amounts will be incurred in addition to the initial expenses and that the insurer, agent, or broker will receive additional commission.

Insurance Companies Quotations:

39. Insurance brokers must make reasonable efforts to obtain quote offerings from several authorized insurance companies and indicate the reasons for recommending any particular insurance company. For general insurance and health insurance contracts, if the insurance company recommended by the broker did not offer the cheapest price to the

customer, the broker shall provide the customer with details of the cheaper price and a full justification of his recommendation. The justification should include a comparison of the terms and conditions offered by each insurance company, and if the broker would earn more commission on the recommended policy this must be explained to the customer.

Section D: Selling Insurance Products and Services:

Learning objective

Introducing the trainee to insurance company's requirements when selling its products to customers.

Disclosure to Customers:

40. Before accepting a request to obtain an insurance policy, authorized companies must provide customers with the basic terms and conditions of the product and service to be purchased such as, but not limited to:
    - ❖ The name of the insurance company that is providing coverage of the insurance policy.
    - ❖ Coverage period.
    - ❖ All related costs, including premiums and any other fees.
    - ❖ Terms of premium payment, grace period, implications of non-payment of the premium and any other related details.
    - ❖ Claims settlement procedures.
    - ❖ Complaints handling procedures.
    - ❖ Obligations of each party under the insurance policy.
    - ❖ Renewal rights and conditions.
    - ❖ Requirements for policy changes and amendments.
    - ❖ Any aspect of the policy where the insurance company has the right to change something once cover has commenced such as benefit charges, and Protection and Savings policy fees.
    - ❖ Insurance company mailing address, phone, fax, and email.

41. In addition to the above, authorized companies must provide the following information with regard to Protection and Savings insurance products:
    - ❖ Type of plan - Participating, non-participating, or investment linked.
    - ❖ Basis of participation in profit in case of a participating plan– cash bonus, deferred bonus, reversionary bonus, terminal bonus etc.
    - ❖ Plan illustration providing the sum insured, surrender value, and paid up value over the term of the plan. It should also indicate these sums at the end of each of the first five years of the policy term, and on the due date if appropriate.
    - ❖ If benefits or advantages were not fully guaranteed, the customer must be provided with three illustrations for the total return on investment (3%, 5% and 7% per annum).
    - ❖ The range of guarantee of any investment, or expenses charged must be clearly indicated to the customer, and the values shown are only for the purpose of clarification, unless the investment or expenses charged were fully guaranteed and set.
    - ❖ As for non-linked programs, when implemented, premiums and fees should be distributed according to main coverages, supplemental coverages, and any other coverages or services provided.

- ❖ When providing the customer with information relevant to past performance, that is the basis of the current performance measures provided, it should be made clear to the customer that past performance is not indicative of future performance and does not necessarily guarantee future returns.
- ❖ If the money allocated to the savings portion of the protection and savings policy of policyholders can be invested in different investment unit linked products (fund), these funds must be described and their descriptions should include at a minimum:
    1. Description of asset classes in which the fund may invested in.
    2. Classification of each fund in terms of risk and price fluctuation.
    3. Illustration of the risk standards, if the fund was measured based on a given standard.
    4. Geographical spread of investments.
    5. Indicate any concentration of investments in certain types of investment channels.
    6. The currency in which the fund is priced.
    7. Number of times the fund has been valued.
    8. Name of the fund manager, if the fund is not managed by the insurance company.
    9. The fund›s past performance, taking into account what is mentioned in point (8) above.

42. Authorized companies that sell Protection and Savings insurance policies shall complete a customer Fact-finding Form that contains sufficient information to support the recommended product. The Fact-finding Form must be signed by the customer and kept in the customers' file. In case of any dispute regarding the appropriateness of the sold policy, the contents of the Fact-finding Form will be taken into account. If the Fact-finding Form was not in the file or has been poorly or improperly filled out, it is likely to settle the dispute in the customer's favor.

43. When selling, insurance brokers shall disclose to the customer all commissions / fees charged in return for the services provided to this customer from all sources.

44. Authorized companies, representing the insurance company in preparing the insurance policy, shall disclose to the customer all commissions, fees, and any other indemnity charged for preparing the insurance policy.

45. Insurance coverage cannot be dated prior to any insurance product. Additionally, an insurance company or its employee cannot provide evidence of product coverage unless the customer has obtained an annual insurance policy that meets the minimum standards specified for that policy.

Customers Responsibilities:

46. Before the insurance policy is concluded, authorized companies must inform customers of their key obligations under the insurance policy to pay premiums in time and provide full and fair disclosure of all relevant information necessary to determine the insurance needs and cover the risk. It is expected that the customer will disclose to the authorized company all material facts and relevant information necessary to the best of knowledge.

Confirmation of Coverage:

47. As soon as the insurance policy is concluded, authorized companies must provide

customers with an official written confirmation of the insurance coverage. If complete policies were not available, the authorized company must issue a temporary evidence of coverage confirmation that can be legally used as proof of coverage.

48. When receiving an application for a compulsory insurance product – Vehicle or Health Insurance – with a first premium payment in advance, a receipt must be provided to the customer indicating that coverage will commence from the date the application is completed.

49. When an application for insurance is taken without a premium payment, the Insurer should provide a receipt to the customer indicating that coverage will commence the date the policy is issued and the first premium is paid.

Policy Documentations:

50. Authorized companies are obliged to provide the full insurance policy documentation to customers promptly after entering into an insurance contract. They must also obtain the customer's signature confirming reading, understanding, and receiving of the all insurance policy documentations.

Related Parties:

51. Authorized insurance company shall not issue or renew an insurance policy to any of its owners, Board of Directors, senior executives, or related parties until the full premium is paid (in accordance with Article 49 of the Implementing Regulations of the Cooperative Insurance Companies Control Law). Related parties means family members including wives, husbands, children, parents, brothers and sisters.

Premium Collection:

52. Authorized companies shall not receive premiums or fees for services they do not provide or future services not yet provided.

53. Insurance companies are considered to have received the premiums once the agents or brokers receive the payment.

Section E: Post-sale Customer Services:

Learning objective

Illustrating to the trainee, the insurance company's duties after the issuance of the policy

Post-sale Services:

54. Authorized companies must provide timely and appropriate post- sale services to customers, including response to their queries, administrative requests, and requests to amend insurance policies. In particular, they must do the following:

- Provide coverage certificates when requested by the customer.
- Provide written confirmation of any amendments to the insurance policy and any additional amounts due.
- Issue receipts for any amounts received unless payment is made by credit card or other automatic bank transfer methods (in this case the electronic transaction record shall be sufficient.
- Pay amounts due for refund or any other charges due to the customer.

55. Authorized companies must immediately notify customers of any changes in disclosure or conditions to customers when the policy is in force, including changes in the authorized company's contact data and changes in claim submission procedures.

Claims Settlement:

56. To settle claims, authorized companies must do the following:
    - ❖ Respond to claims received in a prompt manner.
    - ❖ Provide claims forms showing all the information or steps required by the customer (including the beneficiary for a Protection and Savings policy) to file the claim.
    - ❖ Acknowledge to the customer the receipt of the claim and any missing information within (7) days from receiving the claim's application form.
    - ❖ Inform customers of the progress of filed claims, at least every (15) days (as per article 44 of the Implementing Regulations). Insurance company are obliged to settle the individuals' claims within (15) days from the date of receiving the claim and necessary documents, and the period may be extended for a further (15) days provided that the regulatory compliance officer is given a notice. The period of settling companies' claims must not exceed (45) days after receiving all necessary documents and loss assessor's report, which should be adjusted by the company within a week from the date of the incident report. If the more time is needed, the regulatory compliance officer shall be notified of such delay.
    - ❖ Settle claims in a fair manner and with no discrimination.
    - ❖ Appoint a loss assessor or a loss adjuster when necessary, and notify the customer of such an appointment within (3) working days.
    - ❖ Conduct a reasonable investigation of claims within (15) days for individuals claims and (30) days maximum for companies' claims.
    - ❖ Notify the customer in writing of the claim acceptance or refusal promptly after completing the investigation, stating the following:

First: for accepted claims (full or partial acceptance):	Second: for denied claims:
• Settlement amount. • How the settlement amount is reached? • Justification if reduced settlement is offered. • Justification in case any part of the claim is not accepted.	• Written reason for denying the submitted claim. • Copies of documents or information used in reaching the decision, if requested.

    - ❖ Explain the complaints process if the customer does not agree with the settlement.
    - ❖ Pay the claims amount without undue delay upon receiving all required information anddocumentations.

Claims Settlement Period:

57. Insurance companies shall settle claims within a period indicated in Article 44 of the Implementing Regulations of the Cooperative Insurance Companies Control Law, and when that is not possible, provide an explanation with reasons for such delay.

Credit Control:

58. Authorized companies should not give excessive credit to customers. Upon signing the insurance policy, the mechanism for premiums payment must be clearly agreed upon, and noted in the policy. Additionally, the insurance company should promptly cancel a policy, after appropriate warnings, (30) days' notice, if payments are not made. Premiums must be paid separately without offsetting claims payments.

Complaints Handling:

59. Authorized companies have to put in place a fair and transparent process for handling complaints, and inform customers with complaints filing procedures.

60. Upon receipt of a complaint, the authorized companies must:
    - ❖ Acknowledge receiving a complaint.
    - ❖ Provide a time estimate for complaints handling.
    - ❖ Provide the customer with contact information to follow-up on the filed complaint.
    - ❖ Inform customers on the progress of a filed complaint.
    - ❖ Settle claims promptly and fairly within (10) working days from receiving the complaint.
    - ❖ Notify the customer in writing of the complaint acceptance or refusal and the reasons for it, and any indemnity offered for the customer.
    - ❖ Explain complaints filing process to the dispute committees formed under Article (20) of the Cooperative Insurance Companies Control Law.

Cancellation:

61. Cancellation of policies must conform to the cancellation conditions specified in the policy terms and conditions. Cancellations by the insurance company must be notified to customers in writing, including a reference to the relevant contractual cancellation condition and explanation of the underlying reasons for the cancellation.

62. When cancelling an insurance policy, amounts due to customers must be paid without undue delay. Such amounts must be calculated in accordance with the provisions of Article (54) of the Implementing Regulations of the Cooperative Insurance Companies Control Law.

Renewal and Expiry:

63. Authorized companies must inform customers of the policy renewal or expiry date ahead of time to allow customers to renew or obtain coverage from another company.

64. For all Protection and Savings contracts, insurance companies should provide an annual statement to their customers which include the following information:
    A. Projected due cash value or cash value at age (85) related to the insurance policy.
    B. Current sum insured on main and supplementary benefits.
    C. Total premiums paid in the previous year.
    D. Policies linked to investment funds should show the value of the units in each fund.

Distribution of Surplus::

Insurers have to determine the mechanism for distribution of premium in compliance with Article (70) of the Implementing Regulations of the Cooperative Insurance Companies Control Law, and submit this mechanism to SAMA for approval. This mechanism should be available to customers and to the public.

Chapter Seven
Revision questions:

1. List the key points of general requirements.
2. What elements should be included in the Insurance Policy?
3. When disclosing information, what are the information that insurance company should provide to customers?
4. What should the insurance companies do upon renewal and expiry?

Practical question

1. When accepting (fully or partially) or denying a claim, how does the company handle the claim and respond to the claimant?

Chapter Seven
Answers of Chapter Seven Revision questions:

1. List the key points of general requirements.

- Integrity.
- Skill, Care, and Diligence.
- Non-discrimination.
- Adequate Resources.
- Disclosure of Information to Customers.
- Data Protection.
- Protection of Customer Funds.
- Conflict of Interest.
- Contracting with other companies.

2. What elements should be included in the Insurance Policy?

Insurance policy application wording and policy samples must adhere to the following minimum requirements:

- ❖ They must be written in Arabic and can be provided in English.
- ❖ The sentence structure and language used should be as simple as possible.
- ❖ They should be printed in clear readable text and not in very small letters.

Printed insurance policy application and policy samples must adhere to the requirements stipulated in Article 52 of the Implementing Regulations of the Cooperative Insurance Companies Control Law, and must include: *Article (52): "The Insurance Policy shall be written in a clear way that can be read by the public at large, and shall contain the following:

1. Policy contents should include:
   - A) Policy number, which must also be provided in all related documents to this policy.
   - B) Insured name and mail address.
   - C) Coverage period.
   - D) Coverage description and limits.
   - E) Deductible.
   - F) Additional coverage.
   - G) Conditions and Exclusions.
   - H) Insurance rates and premium amounts, basis of premium calculation and the amount of commission paid under the policy.
   - I) A list of insured properties and interests.
2. The standard text of the policy shall contain the type of coverages, general terms, conditions, and exclusions.
3. Attachments that indicate additional coverages, conditions, and exclusions not covered above and different from the original agreement.

4. The Company's signature and seal shall be on the policy and its attachments.

Amendments to Insurance Policy:

27. Authorized companies must provide the terms of the cancellation of insurance policy to be fair, clear to customers, reasonable and appropriate for the product. The cancellation terms must be clearly stated in the insurance policy and including the following:

- ❖ Conditions under which the insurer has the right to cancel the policy.
- ❖ Conditions under which an insured can cancel the policy.
- ❖ Requirements for notice of cancellation including notice period of cancellation. In any case, the authorized company shall give the insured a minimum period of 30 days prior to the effective date of cancellation (according to Article 54 of the Implementing Regulations of the Cooperative Insurance Companies Control Law).
- ❖ A description of the method of refunding the premium payable to the insured on cancellation and when it is payable.
- ❖ As for Protection & Savings Insurance, in addition to point (d) above, the cash surrender value should be stated and clarified if applicable for each year of the plan or the insurance program.

3. When disclosing information, what are the information that insurance company should provide to customers?

1. Authorized companies shall notify customers of all relevant information in a timely manner so that they can take informed decision based on adequate information.
2. Authorized companies shall take reasonable procedures to ensure accuracy and clarity of the information provided to customers and making them available in writing.

Practical question

1. When accepting (fully or partially) or denying a claim, how does the company handle the claim and respond to the claimant?

- ❖ Notify the customer in writing of the claim acceptance or refusal promptly after completing the investigation, stating the following:

First: for accepted claims (full or partial acceptance):	Second: for denied claims:
• Settlement amount. • How the settlement amount is reached? • Justification if reduced settlement is offered. • Justification in case any part of the claim is not accepted.	• Written reason for denying the submitted claim. • Copies of documents or information used in reaching the decision, if requested.

- ❖ Explain the complaints process if the customer does not agree with the settlement.
- ❖ Pay the claims amount without undue delay upon receiving all required information and documentations.

Claim management in an insurance company is responsible for compensation when damage occurs, and this is when the purpose of purchasing an insurance is achieved, as well as the benefit for customers gained from the protection of insured property with different types of coverage and liability to third parties in the insurance covering it.

Chapter Eight

The Main Participants in the Insurance Industry in the Kingdom of Saudi Arabia.

Introduction

National economies vary from free market to state controlled nationalized economies. However, even in the freest of free market economies, governments find it necessary to control and regulate their insurance industry. Insurance companies are entrusted with huge amounts of money ranging from $50 Billion to $200 Billion. The insurers are thus custodians of public funds and they have to be regulated in an effort to ensure that the public and its funds are dealt with honestly, and to prevent the insurers from taking unwarranted risks while investing these entrusted funds.

8.1 The Purpose of Insurance Industry Control and Regulation:

Learning objective

Introducing the trainee to the purpose of regulating insurance industry and its need for control and opening the insurance market for investors.

Purpose:

1. To maintain the insurers' financial solvency and capacity so they can carry out their long-term obligations to policyholders and pay claimsThe objective of these regulations is to establish high standards for working in the insurance field.
2. To guarantee a fair treatment of current and prospective policyholders and beneficiaries by both insurers and the insurance brokers.
3. The need to make certain types of insurance compulsory as a way of achieving broad protection to the general population.

In this chapter, we will start by looking at the historical background of the insurance law in the Kingdom of Saudi Arabia, why government control over insurance industry is necessary, why certain types of insurance are compulsory, and how these issues are dealt with in the Kingdom.

Insurance Industry's Need for Regulation and Control:

Consumers buy insurance to protect themselves against what is generally a small probability of a catastrophic loss, effectively transferring the risk of any loss to an insurance company. In turn, the insurance company spreads the risk it assumes over a large pool of policyholders, using capital reserves to shoulder any compensation costs to policyholders who may incur an unexpected loss.

The Historical Background of the Insurance Industry in the Kingdom:

The Control of Cooperative Insurance Companies Regulation, which was enacted as Royal Decree No M/32 on 1 August 2003, is the first Saudi Arabian legislation regulating insurance. Prior to insurance regulations, over 75 insurance operators were writing business estimated in excess of SR 7.2 Billion in the Kingdom, they were able to do so without any regulation at all. Now, this has been completely transformed. What used to be an unregulated free-for-all Saudi insurance market, has become one of the most closely regulated insurance markets in the region.

The lack of regulations in the past, does not mean that the Saudi Arabian government took a non-interventionist approach to the insurance industry. Rather, its past reluctance to legislate and regulate insurance arose from the uncertain status of insurance under Islamic Law. While, for example, the prohibition of charging or paying interest is based on clear statements in the primary sources of Islamic Law, there is no reference to insurance in the Islamic Law texts, which are regarded as

authoritative in Saudi Arabia. This is not surprising, since these texts were compiled in the period from the 13th to 17th centuries of the Gregorian calendar, that is, at a time when insurance was just evolving as a business in Europe.

In Saudi Arabia, the debate of whether or not contracts of insurance are legitimate under Islamic law was narrowed down to the key issue that to profit from an insurance transaction runs counter to Islamic law, while collective risk sharing is acceptable and in the community's interest. This is based on Decision No 51 of 23 March 1977 (2/4/1397H) of the Council of Senior Ulema, a Saudi Arabian government body of religious scholars. They ruled that cooperative (or mutual) insurance is "a form of contract of donation", and, because no one is supposed to profit from cooperative insurance transactions, the Senior Ulema considered insurance in this form to be acceptable under Islamic Law.

In 1985 (1405H), the state-owned National Company for Cooperative Insurance (NCCI) was formed by Royal Decree as a Saudi Arabian joint stock company, with the Public Investment Fund, the Pension Fund and the General Organization for Social Insurance as its shareholders. This was done in response to the Senior Ulema's recommendations that a cooperative insurance company should be established in the Kingdom of Saudi Arabia to offer an alternative to commercial insurance.

In keeping with NCCI's articles of association, the company maintains separate accounts for both its policyholders and for its shareholders. Therefore, it is actually a hybrid between a true mutual insurance, which is wholly owned by its policyholders and not traded on a stock market, and a commercial insurance. Nevertheless, it is sufficiently mutual to meet the Senior Ulema's recommendation that it should conduct its business on a cooperative basis.

Although there was never a statutory prohibition of commercial insurance in the Kingdom, the Saudi Arabian Ministry of Commerce did not issue commercial registrations to any person or company, other than NCCI, to conduct insurance business in the country. Yet, a fair number of foreign-registered insurance organizations operated in Saudi Arabia. The majority of these were Bahraini-exempt companies, that is, companies registered in Bahrain with the express purpose of not conducting business there. The companies' day-to-day business in Saudi Arabia, such as writing policies and settling claims, was done through a local agent. In other words, the majority of insurance operators in Saudi Arabia were foreign-based, but they work on marketing and underwriting risks within the Kingdom.

In accordance with the strict letter of the law, conducting any kind of business in Saudi Arabia without holding the requisite commercial registration is unlawful. Notwithstanding this, the Ministry of Commerce exercised a loose supervisory function over foreign insurers who conducted business in the country. Certainly, nothing was clandestine in how those organizations operated.

For example, all government construction contracts contain a provision that the contractor must have Contractor's All-Risks Insurance with an insurer who is represented in Saudi Arabia, and it was quite acceptable to insure such risks with Bahrain-based, Saudi-operating insurers other than NCCI. Despite this pragmatic approach to an insurance issue created by an interpretation of the Islamic Law principles relevant in this context, having an insurance industry which is essentially offshore and not subject to direct Saudi supervision naturally created problems.

While a handful of the foreign insurers who wrote business in Saudi Arabia were of a blue-chip background, there were many who were financially unsound and sometimes unscrupulous. Not surprisingly, there were incidents of insurers collecting premiums and disappearing overnight. Furthermore, because the business was essentially foreign, local retention of risk and reinsurance within the Saudi market was low, with over 70 per cent of the premiums generated in Saudi Arabia leaving the country. Nevertheless, until quite recently, no serious effort was made to impose real control on the Kingdom's insurance market. The current insurance industry reforms were driven by two important changes that were taking place within the Kingdom.

Since insurance was an unrecognized business in the Kingdom, how did insurers get around the problem to enable them to write business in Saudi Arabia?

The Two main reasons for regulating insurance sector are:

1. The compulsory medical Insurance.
2. Joining the World Trade Organization.

For many years, before regulating the insurance sector, all health-care in Saudi Arabia has been free to citizens and foreign residents alike. Since there were an estimated six million foreign workers and their dependents in Saudi Arabia, this clearly imposed a considerable burden on the kingdom's healthcare system and on the economy as a whole. To alleviate the problem, the government introduced the Cooperative Health Insurance Act, Royal Decree No (71) of 13th August 1999 (27/4/1420H), which makes it mandatory for employers to take out private medical insurance for their foreign employees and their dependents. Article 1 of the Act stipulates that "This Law aims at providing health care and organizing it to non-Saudi residents of the Kingdom. It may be applied to Saudi citizens on the basis of a resolution by the Council of Ministers". Article 2 provides for insurance coverage "to include all of those to whom such Act applies and their families". Article 3; however, stipulates that no residence permit shall be granted or renewed unless the applicant holds the cooperative health insurance policy, which covers the length of the residence permit.

The expansion of state owned industry is not in line with the overall government policy. Rather, the Saudi government has been working to encourage an increase in the private sector's role in the economy as a whole not to decrease it. Additionally, setting up the provision of health insurance to an estimated four to six million persons within a relatively short period would have been a logistical exercise well beyond the capacity of any single entity.

The second key driver to the introduction of insurance regulation in the Kingdom was King Abdullah's determination to have Saudi Arabia accede to the World Trade Organization (WTO). A part of the Kingdom's agreement to join the WTO was the opening up of its insurance sector to foreign interests. In truth, this is a paradox, because in its past unregulated state the Saudi insurance market was open to all comers, albeit not in any official basis. If one viewed the opening up of the Saudi insurance market solely from the perspective of being able to establish a licensed Saudi Arabian insurer, it was closed to both foreigners and Saudis alike, since there was no framework for the setting up of such entities, other than NCCI, of course.

Consequently, the Cooperative Insurance Companies Control Law, by Royal Decree No M/32, came into force on 20th of November 2003 (2/6/1424H). With the issue of the Implementing Regulations made by the Minister of Finance on 20th of April 2004 (1/3/1425H), a new industry in the Kingdom was born.

Regulation of Insurance in the Kingdom of Saudi Arabia:

When the decision was made for Saudi Arabia to open its doors to insurance, it was done based on improving the service to all people, it being in the public interest. Additionally, to enable the nation to deal with its healthcare insurance problem, and to bring about an open market, fairness, and a level-playing field between foreign and domestic insurance companies in line with WTO agreements. On 30th of July 2003 (1/6/1424H), the Saudi Council of Ministers passed historic legislation opening the Kingdom's insurance sector to foreign investment and the Cooperative Insurance Companies Control Law came into force on 20 November 2003 (2/6/1424H). Therefore, because much of the detail of the legislation is contained in the Implementing Regulations, the new regulatory scheme did not become effective until the publishing date of the Implementing Regulations.

The objective of the Law and the Implementing Regulations were expressed in Article 2 of the Implementing Regulations:

"Article 2"

Objectives of the Law and its Implementing Regulations:

1. Protection of insured and shareholders rights
2. Encouraging fair and effective competition, and providing better insurance services with suitable prices and coverage
3. Enhancing the stability of the insurance market
4. Enhancing the insurance sector in the Kingdom and provide training and employment opportunity to Saudis

The government regulator of the Saudi insurance sector is the Saudi Arabian Monetary Authority(SAMA), which, since its formation in 1957 (1376H), has proven to be a successful and stringent regulator of the Saudi banking sector. Indeed, SAMA has brought this Saudi monetary system well within modern standards.

The insurance industry provides insurance services through a number of products designed by experts in providing coverage that protects individuals and organizations from collaborative and interactive industries. Meaning that it starts relationships with many government and private bodies responsible of various tasks, roles, and jobs. Below is an illustration of these relationships:

8.2 Regulators and Supervisors:

Learning objective

Introducing the trainee to the regulators and supervisors of the insurance market and its role and tasks related to the insurance sector

A - Saudi Arabian Monetary Authority:

Established in 1952 and known as (SAMA), Saudi Arabian Monetary Authority is considered as the central bank of the Kingdom of Saudi Arabia and the most significant authority in the region in banking and insurance sector.

Under a number of laws and instructions, SAMA has many duties such as the safety of banking system and its effectiveness in fulfilling its obligation to users of banking system services and its shareholders. What matter is the role of this Authority in the insurance industry with respect to the professional functions of SAMA related to the insurance activity, since it controls cooperative insurance companies in the Kingdom by doing the following:

- Preparing the Implementing Regulations of the Cooperative Insurance Companies Control Law in the Kingdom.
- Regulating the establishment of insurance and reinsurance companies in the Kingdom.
- Supervising the technical aspects of insurance and reinsurance companies' operations.
- Issuing licenses for insurance companies wishing to operate in the Kingdom.
- Regulating the distribution of surplus funds to shareholders and policyholders.
- Determining the capital and solvency requirements for each class of insurance business required by companies.
- Regulating the companies' investments both inside and outside of the Kingdom.
- Determining education and qualification requirements of insurance company personnel, brokers and agents.
- Setting Code of Conduct, insurance sales, and information disclosure.
- Approving insurance products of insurance companies.

- Interpreting and implementing the contracts.
- Regulating compulsory purchase of insurance coverage.
- Regulating and controlling cooperative insurance companies, insurance and reinsurance services companies, loss adjusters, and actuaries.

Timeline

Developing the task force of Insurance Control Department

The Cooperative Insurance Companies Control Law was enacted as Royal Decree No M/32 on 2/6/1424H. Subsequently, the Implementing Regulations of the Law was published by the Minister of Finance resolution No 1/596 on 1/3/1425H, and the main objective of this Law and its Implementing Regulations is to regulate the insurance sector in the Kingdom.

Once they have been published, SAMA formed a professional staff of supervisors to perform the regulatory and supervisory functions on the insurance sector. This team currently works in a general department affiliated with SAMA and addresses these functions.

Ever since its establishment, the Insurance Control Department protects the insured and develops the market. Insurance Control Department has the authority to:

- Protect insured from unjustified financial losses, and people with dishonest conduct in the insurance sector.
- Promote the market transparency by requiring insurance companies to publish reliable and validated data to the persons dealing with this sector's companies.
- Promote and develop insurance market growth in the Kingdom of Saudi Arabia through innovating the required tools and spreading insurance awareness in the market
- Ensure insurance sector stability to encourage investment in this sector and the financial sector in general.
- Promote and develop human resources skills in the insurance sector, including specialists and supervisors of the insurance field in the Kingdom.

History of SAMA's Insurance Control Department

After reviewing the information above, we can notice the development in the scope of activities of the Insurance Control Department under SAMA, which is considered one of the main effective partner in the insurance industry history in the Kingdom. We would also like to remind the reader that until the preparation of this book, a great number of rules, regulations, and resolutions that regulates the sector have been published. We will state the regulations here, but for further clarifications visit www.sama.gov.sa :

- Implementing Regulations of the Cooperative Insurance Companies Control Law.
- Principles to be implemented to regulate foreign insurance companies in the Kingdom of Saudi Arabia.
- The withdrawal plan that must be followed by unlicensed insurance companies working in the Kingdom.
- Insurance Market Code of conduct Regulations
- Anti-money Laundering & Combating Terrorism Financing Rules
- Anti-Fraud Regulation for the insurance companies
- Risk Management regulation.
- Regulations for Supervision and Inspection Costs.
- The Regulation of Reinsurance Activities
- Actuarial work regulation for insurance and reinsurance companies.
- Insurance Intermediaries Regulation
- Online Insurance Activities Regulation.
- The Unified Compulsory Motor Insurance Policy.
- Investment Regulation.
- Outsourcing Regulation for Insurance and Reinsurance Companies and Insurance Service Providers
- Anti-money Laundering & Combating Terrorism Financing Rules (update).
- Surplus Distribution Policy
- Insurance corporate governance regulation.
- Audit committee regulation in insurance and reinsurance companies.

These regulations were listed respectively according to the dates it has been published. All of them regulate most of the work areas of insurance and insurance and reinsurance services companies that will be mentioned later.

B - Council of Cooperative Health Insurance:

Council of Cooperative Health Insurance is an independent Saudi government body enacted by the decision of the Cabinet of ministers No. 71 and a date 11/ 8/1999 (27/4/1420 H) to supervise the implementation of Cooperative Health Insurance Law that aims to provide and regulate health-care for all private sector employees and their dependents. The Minister of Health is the chairman of the board, and includes as members, some government ministries representatives.

General Secretariat of the Council of Cooperative Health Insurance:

It is the executive body of the council. Its duties include; preparation and execution of the executive policies and procedures, direct supervision over the health insurance industry including continuous technical and medical follow-up over all those concerned with the law, and the ongoing efforts to preserve the insureds' rights.

The General Secretariat has made significant and several efforts in the cooperative health insurance industry, which focus on achieving the objectives of the law with the main partners in the insurance relationship including accredited health service providers, qualified insurance companies, and insureds. Some of these efforts are:

- Accredit health-care services providers: health-care services providers are one of the three parties of the insurance relationship mandated to provide health-care services for the insureds who have a contract with the insurance companies qualified by the council. Health-care services providers are classified as: hospitals, single day surgery center, clinics compound, dispensaries, single doctor clinic, diagnostic center, physical therapy center, analysis laboratory, pharmacies, artificial devices and limbs stores, and eyeglasses stores. The General Secretariat of the Council accredits health-care institutions, willing to work under the cooperative health insurance umbrella, of both private and public sector after ensuring that they fulfill accreditation requirements and has qualified human resources as well as appropriate administrative and technical resources to professionally deal with qualified insurance companies. Thus, the nature of this relationship makes it a necessity for the service provider or the health facility to fulfill a number of required standards to play its role as it should be in this insurance relationship.
- Renew accreditation of health facilities: a control step with a regulatory role and one of the primary tools to maintain quality levels of health facilities to ensure it is doing its role fully. Accreditation of health-care providers is renewed annually or every two or three years for some of them, after fulfilling accreditation renewal requirements that are an extension of the previous accreditation.
- Qualifying health insurance companies: to enter the health insurance market, insurers must obtain a license from SAMA and must be qualified by the Council of Cooperative Health Insurance to practice cooperative health insurance business. Consequently, health insurance companies will manage the benefits covered in the cooperative health insurance policy, and the General Secretariat of the Council will prepare the necessary work plans to qualify and follow-up these companies works based on implementation stages, coordination with relevant authorities, and formation of committees and task forces that serve implementation purposes.

Main obligations of health insurance companies:

- Carry out its functions for the clients to provide proper insurance coverage, since it is directly accountable to policyholder (employer) since the inception of insurance policy signed with the client.
- Upload the insureds names on the Cooperative Health Insurance network system within (48) hours.
- Issue insurance cards for insureds within (5) working days' maximum from the date of policy inception and its delivery to client. Insurance company must remain responsible of any claims occurring from the beginning of policy issuance.
- Quickly give approvals for service providers to provide treatment for beneficiaries within (60) minutes.
- Quickly settle service providers' claims within (60) days, so they can provide treatment services properly and effectively for the insurance company clients.
- Provide health-care services for insureds by concluding health services contracts with service providers accredited by the Council.
- Provide guides that include the policy, insurance coverage scope and limits, and accredited service providers network for beneficiaries when starting insurance coverage.
- Inform accredited service providers with the joining of policyholder to the insurance coverage to suit beneficiaries' needs and work places so they do not have to receive

service from a service provider outside the network.
- Establish a unit to accept and address beneficiaries' complaints.
- Adhere to minimum benefits of the standard cooperative health insurance policy.
- A Qualifying Department exists. It qualifies insurance companies to participate in the cooperative health insurance business, and health insurance claims management companies to handle cooperative health insurance claims. The Department also supervises and regulates companies' performance to ensure business is conducted based on Cooperative Health Insurance law, implementing regulations, and standard policy.

C - Capital Market Authority:

All insurance companies under the law must be public joint stock companies, they must offer part of their shares to the public (40% of the capital value of the company). Since the authority responsible for this issue is the Capital Market Authority, the reader must be introduced to it as one of the main participant in the insurance market in Saudi Arabia.
The Capital Market Authority in Saudi Arabia began unofficially in the early fifties of the last century, and the situation continued until the government established the basic regulations of the market in the eighties. Under the "Capital Market Law" issued by Royal Decree No. (M / 30) on 2/6/1424H, the Capital Market Authority (CMA), a governmental body with financial and administrative independence and is directly linked to the Prime Minister, has been established.

CMA Tasks

The Authority shall supervise the organization and development of the capital market and issue the regulations, rules and instructions necessary to implement the provisions of the Capital Market Law. It aims to provide an appropriate environment for investment in the market, increase confidence in it, ensure adequate disclosure and transparency of the listed companies, and protect investors and securities dealers from illegal acts in the market.

CMA's Main Activities:

- Send a reminder of the deadline for applying by e-mail.
- Receive financial forms monthly, quarterly, and annually.
- Ensure the accuracy and integrity of the data collected.
- Calculate the relevant ratios for the study of performance and trends.
- Issuing market reports at the sector and corporate level.
- Checking the solvency problems of companies (this is of course an important activity for the insurance industry; since solvency is an important issue for insurers).

CMA's Powers:

CMA's powers include the following:

- Regulating and developing Capital Markets, as well as developing the methods of agencies and bodies working in securities trading.
- Protecting investors from unfair and improper practices including fraud, deception, manipulation, or trading based on insider information.
- Working on achieving justice, efficiency, and transparency in securities transactions.
- Developing controls that limit risks associated with securities transactions.
- Developing, regulating, and controlling securities issuing and trading.
- Regulating and controlling the activities of CMA-supervised bodies.
- Regulating and controlling disclosure of information related to securities and its issuers.

- CMA seeks to protect investors and achieve justice, efficiency, and transparency in trading by detecting businesses and actions considered manipulative and misleading. The market rise and fall on the other hand is governed by the supply and demand only.
- CMA sets the controls and instructions regulating advertisements of insurance companies listed on Saudi Stock Exchange (Tadawul), which these companies must comply with when posting any advertisement on Tadawul's website. The company is responsible for the advertisement and its content. The management also undertakes the work and the tasks of investigating the cases of electronic violations, summoning the violators and questioning them, and hearing the witnesses of securities practices violations via websites and forums, mobile phone messages, or audiovisual media such as advising investors on issuing recommendations or managing investment portfolios without obtaining a license from CMA. The management tasks are as follows:
- Investigate the cases of electronic violations referred to it by the Electronic Control Unit after the Unit has taken the necessary procedures for adjustment and collecting evidences.
- Requesting information or records that the management deems necessary to complete the procedures for investigating electronic violations of relevant authorities. – Calling and questioning the violators, and hearing witnesses' statements.
- Coordinate with relevant authorities to limit those violations.
- CMA also monitors the publication of financial statements and reports issued by the listed companies to ensure that they comply with CMA requirements and regulations in terms of the timing of publication and the information it covers.
- CMA has also determined the periods during which the company must publish its financial statements and these are:
- The announcement of the annual financial statements as soon as they are adopted within a period not exceeding forty working days from the end of the annual fiscal period covered by those statements. - The announcement of the quarterly financial statements as soon as they are adopted within a period not exceeding fifteen working days from the end of the fiscal period covered by those statements.

Corporate Governance:

It is a working mechanism for controlling and directing all activities of the corporation to protect the rights of shareholders and stakeholders (such as employees, clients, and suppliers). The Governance is a coherent set of organizational procedures and arrangements that govern the relationship between shareholders and board of directors as well as executive management to achieve long-term strategic objectives to meet the needs of shareholders, stakeholders, and regulators through the role of corporates' departments in performing their business with integrity, credibility, and accountability. Thus, there is a regulatory relationship exercised by the Capital Market Authority on insurance companies as one of the main components of the capital market.

D - Ministry of Commerce and Investment:

The Ministry of Commerce and Investment is looking forward to serving the public and companies, including insurance companies, and simplifying the service procedures by the different means available. Therefore, the Ministry worked on implementing a range of its services in electronic form and providing integrated interactive services that facilitate for the final beneficiary completing his application completely and from any city without having to come to the Ministry. In addition to providing verification services directed to the business sector and government agencies, and follow-up services that help the client to follow his request through the easiest and fastest ways such as mobile phones, along with some inquiry services.

Each e-service provided at the portal has a time of delivery that the ministry is committed to, and is clearly mentioned in the e-service page. In case of delay in delivery, the applicant can contact the customer service center for objection.
The commercial registration of any insurance company or even the insurance and reinsurance services is one of the services provided by the Ministry of Commerce and Investment to the insurance company. That is because the acquisition of a commercial registration for the company is a major requirement for obtaining the insurance work permits by the Saudi Arabian Monetary Authority.
Therefore, any licensed insurance company must be subject to the Companies Law issued by the Ministry of Commerce and Investment, which regulates the relationship between all shareholders as a joint stock company first before they are an insurance company. Of course, obtaining a commercial registration goes through regular procedures.
The commercial registration indicates the trade name of the company, the names of the members of the board of directors and the general manager, the capital of the company, and the nature of the activity to be exercised. It is a noted that the commercial registration is a reference number for many private transactions and with the official authorities, and its entry of force is an important evidence of the continuity of the company's business. The company must inform the Ministry of any adjustments to the partnership contract that may substantially alter this contract.
A new law was issued for companies in 2015 (1437H), which includes many articles related to joint stock companies in the capital market. As all insurance companies in the Kingdom of Saudi Arabia are public shareholding companies, they must adhere to these articles.

E - General Investment Authority:

On the 10th of April 2000, the Saudi government has established the General Investment Authority (SAGIA), which is responsible for managing the investment environment in the Kingdom of Saudi Arabia. It operates under the directives of the Kingdom's government and provides services and facilities to the investors to improve the investment climate and promote economic development in Saudi Arabia. It serves as a catalyst to promote inward investment and to facilitate exchange of best practices between the public and private sectors and with regard to the insurance sector, and play the role of mediator between the global business community and the Saudi government, ministries and agencies. It also aims to participate in the development of a sophisticated economic policy based on study and strategic research.
SAGIA is the body responsible for managing and supervising the investment environment for foreign investors in the Kingdom of Saudi Arabia, and controlling insurance companies whose investors are non-Saudi.

The role of the General Investment Authority is to:

- Operate as an investment portal for the Kingdom and a first stop to start the investment.
- Provide efficient, effective, and appropriate support to investors, including assistance on arrival in the Kingdom, visa issuance, freight forwarding, and customs clearance.
- Work with government partners such as the National Industrial Clusters Development Program.
- Coordinate with other government institutions, relevant authorities and suppliers such as law firms, banks, analysts, and insurance companies.
- Monitor the Kingdom's ability to attract investors and improve it to higher levels through the National Competitiveness Center.
- SAGIA's main tasks in the insurance fields and activities:
- Protect the rights of insurance policyholders, and its beneficiaries (investors).

- Ensure the achievement of the economic and social objectives of the insurance activity and maintaining national savings.
- Ensure safety of the financial centers of the insurance market units and coordinate between them to prevent conflicts.
- Participate in the development of insurance awareness in the country.
- Support insurance market and work on its development.
- Improve the insurance profession and contribute effectively to the provision of expertise.
- SAGIA's role in supervising and controlling the insurance activity:
- Register non-Saudi enterprises and persons engaged in insurance activity.
- To carry out any insurance activity, the law requires registering with the Insurance Control Department.

These activities relates to the following:

- ❖ Insurance or reinsurance companies.
- ❖ Insurance brokers companies.
- ❖ Insurance actuaries.
- ❖ Insurance consultants.
- ❖ Loss adjusters and loss assessors
- ❖ Insurance companies' auditors through the quality control unit of the work of auditors registered in the Authority records.
- ❖ Determine the capital requirements required to register and license the insurance company to carry out the activity.
- ❖ It is necessary to invest in the legally specified investment aspects of companies.
- ❖ The necessity to satisfy certain conditions for those who lead the departments of the insurance companies on behalf of the investors.

Thus, we see the importance of the General Investment Authority, as it is one of the main portals for foreign investors in the insurance sector. The role of it remains on controlling and supervising these investors as long as they are in the Kingdom.

F - Chamber of Commerce and Industry:

Each registered and licensed insurance company must join the Chamber of Commerce in the city where it is licensed. The Chamber of Commerce and Industry is a non-governmental organization that organizes private sector support, supervision and follow-up, including insurance companies and insurance and reinsurance services companies, since it is the main representative of this sector in the Saudi economy. Through its various activities, the Saudi Chambers work to support the private sector, provide its requirements, and establish the elements of developing its role in the economic activity, either directly or indirectly through coordination with relevant authorities. The Saudi private sector is dominated by small and medium-sized enterprises (this activity includes the activity of most of the insurance and insurance professions companies), which is evident when looking at the proportion of the number of these establishments, ranging from 80% - 90% of the total employees of each chamber. Because of that, it was essential that each chamber seek to provide all possible support to these enterprises. However, following up on the size and diversity of this support, there is variation from chamber to another depending on the capabilities and expertise of each. Interest in these enterprises has increased in the three main chambers (Riyadh, Jeddah, and eastern province) to the extent/point of establishing specialized centers for small and medium-sized enterprises to crystalize and coordinate efforts in each chamber and between chambers to implement all successful means to support and develop these enterprises. Other chambers seek to keep pace with these trends in order to unify and coordinate the areas of support for these enterprises, while some chambers are still looking for the areas of support they can provide for them.

The following are the major efforts exerted by the Saudi Chambers of Commerce and Industry to support and develop the role of small and medium enterprises in the national economy, based on the data provided in this regard by the regular coordination meetings of the Council of Chambers.

Competencies of Chambers of Commerce and Industry:

Chambers of Commerce and Industry are competent in the following:

- Collecting and disseminate all information and statistics related to commerce and industry.
- Preparing studies and researches related to commerce, industry, and insurance.
- Providing government bodies and companies with data and information on commercial and industrial issues.
- Providing suggestions on the protection of national commerce and industry from foreign competition.
- Informing traders and manufacturers of regulations, decisions, and instructions affecting commercial and industrial matters.
- Guiding traders and manufacturers to key countries for importing and exporting, and to the road of commerce and industry development.
- Limiting and discussing traders and manufacturers issues in preparation for submission to the competent government bodies.
- Settling commercial and industrial disputes by arbitration if the parties to the dispute agree to refer them to it.
- Enlighten traders and manufacturers of new investment opportunities in the commercial and industrial fields through coordination with the competent bodies.
- Encourage traders and manufacturers and urge them to benefit from local and foreign expertise houses, and encourage investments in joint ventures to contribute to development.

Among the important articles related to the work of insurance companies within the competencies of the Chamber of Commerce:

Article (8): The Chambers of Commerce and Industry shall issue and validate certificates, papers, and documents specified by the Minister of Commerce by his decision, in return for a fee determined by the Minister of Commerce.

G - Ministry of Labor and Social Development:

The overall objective of the Ministry is to regulate the use of the labor force through the implementation of the Labor Law, human resource planning and development, and labor disputes settlement in the private sector including the insurance sector.

The Ministry of Labor stresses that all private sector institutions and companies must apply cooperative health insurance for its Saudi employees and their families. The Ministry also confirms the activation of the regulatory role of the labor offices to control the violators, and to submit immediate reports on the extent of these companies and institutions' commitment to the Ministry's decisions. This is concerning the activation of the cooperative health insurance implementation to all Saudis working in the private sector and their families. Additionally, The Ministry of Labor stresses that private companies and institutions are obliged to conclude health insurance contracts for all their Saudi employees and not to tolerate that, and inform all labor offices to follow-up and monitor any facility that does not go in line with this approach.

The Ministry of Labor also call for citizens working in the private sector to go to the nearest labor office to report on companies and institutions that have not cover them under the Cooperative Health Insurance Law, so that the office can take action against violators and compel the company to apply it.

Under Article (14) of the Health Insurance Law in the Kingdom, if the employer does not participate or pay the cooperative health insurance premiums for his employee along with his family, whom this Law applies on and are included in the cooperative health insurance policy, he shall be obliged to pay all premiums due. Additionally, it will pay a fee not exceeding the annual subscription cost, and may be deprived of employees' recruitment for a permanent or a temporarily period.

The Ministry's General Tasks:

- Develop the general policy of labor affairs in the Kingdom within the scope of the general policy of the country in accordance with Islamic principles and social justice to achieve full employment, stable, and rewarding employment opportunities for citizens, creating conditions and working relations to increase production, improve living standards, and strengthen human relations among employers.
- Research and study the labor issues within the plans and projects of economic and social development framework in partnership with the competent bodies in the Kingdom.
- Set plans and develop policies related to the employment of Saudis and the Saudization of jobs in private sector facilities in light of what is stated in the Labor Law, the Council of Ministers Decree No (50) on 1416/4/21H, and other resolutions and instructions in this regard.
- Supervise the recruitment and transfer of services, and the use of labor force and giving it license to work in private sector facilities. In addition to the issuance of licenses for private recruitment offices.
- Develop policies concerning labor inspection, monitoring Labor Law implementation and direct employers about the requirements of its acts.
- Create a database for the labor market in the Kingdom that includes data of private sector employees, whether Saudis or non-Saudis.
- Discuss and propose the means to create and coordinate the distribution of social services to employees, supervise its implementation, disseminate its means, and prepare rules, regulations, services, and resolutions for their implementation.
- Follow up the implementation of projects and programs related to labor affairs and pursue common objectives in this regard in cooperation with the competent country bodies, taking into account the competencies and powers vested in each.
- Prepare and implement labor statistical research and publish its results in agreement with the Central Department of Statistics and Information.
- Track and evaluate the plans, projects, and programs implemented in relation to labor affairs and prepare reports and data related to it.
- Discuss means of organizing relations with Arab and foreign countries, international organizations, and Arab and international regional authorities in relation to labor affairs, including exchange of experience, information, and specialized experts, dispatch of missions, and taking procedures for concluding agreements serving this purpose within the scope of the country's general policy after referring to the competent bodies.
- Organize participation in regional, Arab, and international conferences and seminars related to its fields of competence, and prepare for holding such international conferences in agreement with the competent bodies.

H - Other Regulatory and Government Bodies:

As mentioned above, the insurance sector is part of an integrated institutional and economic system that intersects its work with many of the regulatory, supervisory and government bodies. We have mentioned above the most important ones of these bodies. However, there are some bodies related with the insurance sector but with less roles such as the General Department of Traffic, Civil Defense, municipalities, and some specialized committees like the transport committee etc.

8.3 Cooperative Insurance and Reinsurance Companies

Learning objective

Introducing the trainee to the licensed insurance and reinsurance companies in the Saudi market and the requirements for obtaining a license.

Insurance and reinsurance companies are major participants in the insurance industry and the insurance market in Saudi Arabia. As part of the functions and competencies of the regulatory and supervisory bodies, especially the Saudi Arabian Monetary Authority(SAMA), have set out the rules and regulations that show how to license and establish insurance and reinsurance companies. A number of insurance companies have been licensed after taking the steps below:
Submit a license application to SAMA including the following:

- Application or license application form.
- Memorandum of Association.
- Articles of Association.
- Organizational structure.
- Economic feasibility study.

Submit a five-year work plan that includes:

- Classes of insurance that will be undertaken by the Company.
- Ability to cede reinsurance treaties for the classes the company intends to reinsure.
- Products marketing plan.
- Projected costs and financing to start the Company's operation.
- Projected growth rate of the business taking into consideration the margin of solvency.
- Expected number of employees and a Saudization plan for training and employment.
- Annual cost based on projected growth rate of the business.
- Projected financial statements related to the growth rate.
- Technical Provisions statement for the proposed growth of the insurance operation certified by a qualified Actuary.
- Branching distribution plan in the Kingdom.
- An irrevocable bank guarantee issued by one of the local banks for the capital required, such guarantee must be renewed until the capital is paid up.

Submitting these requirements to SAMA shall result in licensing the insurance company after going through the licensing steps as required.
As of the date of preparing this book, the following insurance companies have been licensed:

Cooperative Insurance Companies:

1. The Company for Cooperative Insurance (Tawuniya)
2. The Mediterranean and Gulf Cooperative Insurance and Reinsurance Company (MEDGULF)
3. Malath Cooperative Insurance and Reinsurance Company
4. Saudi Arabian Cooperative Insurance Company (SAICO)
5. AlAhli Takaful Company
6. SABB Takaful Company
7. Arabian Shield Insurance Company
8. Salama Cooperative Insurance Company
9. Gulf Union Cooperative Insurance Company
10. Allianz Saudi Fransi Cooperative Insurance Company
11. Trade Union Cooperative Insurance Company
12. Al Sagr Cooperative Insruance Company
13. Saudi Indian Company for Cooperative Insurance (Wafa)
14. Arabia Insurance Cooperative Company
15. Walaa Cooperative Insurance Company
16. Bupa Arabia for Cooperative Insurance Company
17. Saudi Cooperative Reinsurance Company (Saudi RE)
18. United Cooperative Assurance Company
19. Al Ahlia for Cooperative Insurance Company
20. Allied Cooperative Insurance Group Company (ACIG)
21. Al Rajhi Cooperative Insurance Company (Al Rajhi Takaful)
22. Chubb Arabia Cooperative Insurance Company
23. Al Alamiya Cooperative Insurance Company
24. Axa Cooperative Insurance Company
25. Gulf General Cooperative Insurance Company
26. Buruj Cooperative Insurance Company
27. Wataniya Insurance Company
28. Amana Cooperative Insurance Company
29. Saudi Takaful Company (Solidarity)
30. Alinma Tokio Marine Company
31. Aljazira Takaful Cooperative Company
32. MetLife AIG ANB Cooperative Insurance Company
33. Saudi Enaya Cooperative Insurance Company

Cooperative Reinsurance Companies:

1. Saudi Cooperative Reinsurance Company (Saudi RE)

Features of Insurance Companies in the Kingdom of Saudi Arabia:

Here are some notes to the reader about the insurance companies that have been licensed as the key focus in the insurance industry in the Kingdom of Saudi Arabia:

- All these companies are licensed by SAMA and are therefore allowed to subscribe to insurance products that provide insurance needs for individuals and institutions.
- All these companies are registered with the Ministry of Commerce and Investment and the Companies Law has been satisfied to guarantee shareholders' rights.
- All these companies operate in a cooperative system. No licensed insurance company is allowed otherwise.
- All these companies adhere to the minimum capital of the insurance companies allowed which is one hundred million SR.
- All these companies are public shareholding companies and a large part of Saudi Arabia's citizens are shareholders in these companies.
- All these companies are subject to control and supervision by SAMA, which provides protection to insurance companies and their insureds.
- All these companies are subject to the so-called good governance, which requires disclosure of what has to do with the financial results and decisions or any decisions that may affect the company›s legal or financial status.
- All these companies are committed to contracting with reinsurers that are classified to guarantee the rights of the insured and maintain the company›s position in terms of the subscribed risk management.
- Some companies have non-Saudi shareholders, and therefore the terms and conditions of the General Investment Authority are applied.

8.4 Insurance and Reinsurance Services Companies and Insurance Professionals

Learning objective

Introducing the trainee to the insurance and reinsurance services available in the insurance sector and the currently licensed entities to carry out these businesses

They are among the main participants in the insurance industry in the Kingdom of Saudi Arabia. After officially applying and fulfilling all requirements of each insurance and reinsurance services, SAMA grants a license to practice any of the insurance and reinsurance services related to insurance or reinsurance.
Of course, many persons or companies providing insurance and reinsurance services will obtain a license after going through the following licensing stages:
Submit the application form for the insurance and reinsurance services accompanied by:

- Memorandum of Association.
- Articles of Association.
- Organizational structure.
- Economic feasibility study.

A three-year work plan that includes:

- Classes of insurance that will be undertaken by the insurance and reinsurance services provider.
- Projected costs and financing to start the Company's operation.
- Projected growth rate of the business

- Expected number of employees and a Saudization plan for training and employment.
- Annual cost based on projected growth rate of the business.
- Projected financial statements related to the growth rate.
- Branching distribution plan in the Kingdom.
- An irrevocable bank guarantee issued by one of the local banks for the capital required, such guarantee must be renewed until the capital is paid up.

Individuals providing insurance and reinsurance services are natural persons licensed to practice any of the insurance and reinsurance services and are employed by the owner of insurance professions. They must fulfill the requirements below to obtain a license from SAMA:

- Obtaining a university degree with at least five years of experience in insurance or a specialized insurance certificate.
- Passing the required examination for the desired profession or obtain an equivalent qualification.

After going through these stages and requirement, a number of insurance and reinsurance services companies has been licensed as follows:

First- Insurance and Reinsurance Service: Insurance Brokers Companies

The insurance broker is the legal person who, in return for payment, negotiates with the insurance companies to complete the insurance process for the insured. We would like to add here that the minimum capital of the company required for licensing the insurance broker is SR3 Million. The insurance law has warned the insurance companies not to deal with any unlicensed broker. This of course applies on the other insurance and reinsurance services.
The following brokerage companies have been licensed:

1. National Insurance Brokers Company
2. First Insurance & Reinsurance Brokers Company
3. Solutions Insurance & Reinsurance Broker Company
4. Insurance House Company-Insurance & Re-Insurance Broker
5. Global United Insurance and Reinsurance Broker Company
6. ACE Insurance Brokers and Reinsurance Company Ltd.
7. Green Shield Insurance and Reinsurance Broker Company
8. Hazards Protection for Insurance Broker Company
9. AON Saudi Arabia Insurance and Reinsurance Brokerage Company
10. Willis Saudi Arabia Company Ltd. Insurance and Reinsurance Brokers
11. Al-Thanyan Company for Insurance Brokerage
12. Saudi Brokers Company Ltd. for Insurance and Reinsurance Brokerage
13. Saudi Marsh Insurance and Reinsurance Broker Company
14. Brokerage House Company Ltd. for Insurance and Reinsurance Broker
15. Trust Insurance Brokers Company
16. Daman Insurance and Reinsurance Brokers Company
17. Ittihad Insurance Brokers – Insurance and Reinsurance Company
18. Al Mamoon Overseas Insurance Broker Company Ltd.
19. Elite Insurance & Reinsurance Broker
20. NASCO Saudi Arabia Insurance and Reinsurance Company
21. UIB Saudi for Insurance and Reinsurance Broking Company Ltd.
22. Lonsdale and Associates Insurance Brokers
23. Al Yamama Insurance Brokers Company
24. Trust Brokers Company for Insurance and Reinsurance Broker
25. Aims Gulf Insurance Brokers Company

26. WAKEN Insurance Brokers Company
27. Chedid Re Company Ltd.
28. Masarat Insurance Broker Company
29. Isam Kabbani Insurance and Reinsurance Broker Company
30. Authorized Policy Insurance Broker Company
31. Fenchurch Faris Insurance and Reinsurance Brokers Company
32. Gulf Coverage Insurance and Reinsurance Brokers Company
33. RFIB Saudi Arabia Ltd. for Insurance and Reinsurance Brokerage
34. Yasser Mohammad Ahmad Bugshan Insurance Broker Company
35. Marina Insurance & Reinsurance Brokers Company
36. International Saudi Insurance Broker Company
37. Deraya Insurance Brokers Company
38. Arkan Insurance Brokers Company
39. Esnad Insurance Brokers Company
40. Al-Falwids Insurance and Reinsurance Brokers
41. Izar Insurance Brokerage Company
42. Comprehensive Policy Insurance and Reinsurance Brokers Company Ltd.
43. Kingdom Brokerage Insurance & Reinsurance Company
44. Chedid & Associates Saudi Arabia Insurance Brokerage Company
45. Al Afaq Insurance and Reinsurance Brokers Company
46. FAL Cooperative Insurance and Reinsurance Brokers Company
47. Modern Insurance and Reinsurance Broker Company
48. Orbits for Insurance Brokerage Company
49. Golden Nouran Insurance Brokerage Company
50. Prime Risks for Insurance and Reinsurance Brokers Company
51. GroupMed Insurance Brokers Company
52. Broker Care Insurance Brokers Company
53. Diamond Policy Company Ltd.
54. Al Sabil Asia Insurance and Reinsurance Brokerage Company
55. Star Care Insurance Brokers Company
56. Namar Insurance Brokers & Reinsurance Company
57. Golden Broker Insurance Brokerage Company
58. Tawafuq Alwostaa Company Ltd.
59. Best Insurance Broker Company
60. Ballorat Insurance Brokers Company
61. ARTKOM International Insurance Brokers Company
62. Al Mustashar for Insurance Brokerage Services Company
63. Commercial Arabia Services Insurance Brokers Company
64. Gulf Insurance & reinsurance Brokers Company
65. Independent Company for Insurance Brokerage Services
66. Future Vision Insurance & Reinsurance Brokerage Company
67. Al Bassami Insurance Broker Company Ltd.
68. Afq Insurance Broker Company
69. DAAM Cooperative Insurance and Reinsurance Brokers Company
70. Global Accreditation Insurance Broker Company Ltd.
71. Alamen Insurance Broker Company
72. Tawkol Insurance Brokers Company
73. Andalusia Brokerage Company
74. Arabian Marketing Services Company - Insurance & Reinsurance Brokers
75. Wajeef Insurance Brokerage Services Company
76. Al Tayyar Insurance Broker Company

77. Al Aman Insurance & Reinsurance Broking Company
78. Broker Vision Insurance Broker Company
79. Excellence Insurance Broker Company
80. Laval Insurance Broker Company
81. Dar Maiar Insurance Broker Company
82. Wasl Insurance Broker Company
83. Abdul Latif Jameel Insurance Brokerage Company
84. Aman Insurance & Reinsurance Broker Company
85. Dhamin Cooperative Insurance Company
86. Saudi Alliance Insurance Brokers Company
87. Wathiqa Cooperative Insurance Broker Company
88. Takaful Emarat Insurance Services Company

Second- Insurance and Reinsurance Service: Insurance Agents Companies

An insurance agent is a legal person who, in return for payment, represents the insurance company, markets and sells insurance policies, on behalf of the insurance company.
The agent can be an agent for one insurance company or one insurance product, and the minimum that is required to license an insurance agency is five hundred thousand SR.
As of the date of preparing this book, the following insurance agencies have been licensed:

1. AlOula Insruance Services Company Ltd.
2. Re-Communication Insurance Agent Company
3. Riyadh Insurance Company Ltd.
4. Saudi Agents for the Cooperative Insurance Agency Company
5. Arabia Insurance Agent Company
6. Insurance Management Co. Insurance Agency
7. Safe Cover Agency Insurance Company
8. Takaful Amana Company Ltd. for Cooperative Insurance Agency
9. Alinma Cooperative Insurance Agency
10. Arabian Shield Insurance Agency
11. Kafalh Insurance Agency Company
12. Shariqa Corner for Insurance Services Company Ltd.
13. Sanad Agency Company Ltd.
14. Foundation Insurance Agency Company
15. Moatamadah Insurance Agency Company
16. Elite Panorama Cooperative Insurance Agency Company
17. Bader Cooperative Insurance Agency Company
18. Kayan Middle East Co. for Cooperative Insurance Agencies
19. Tadamon for Cooperative Insurance Agency Company
20. Alhadaa for Cooperative Insurance Agency Company
21. Tamayuoz Insurance for Cooperative Insurance Agency Company
22. Motamadoun Insurance Agency Company
23. Insurance House Company for Insurance Agency
24. Professional Group Insurance Agency Company
25. Insurance Operations Agency Company for Insurance Services
26. Alfa Insurance Agency Company Ltd.
27. Tuba Insurance Agency Company
28. Ahd Al Saudia Insurance Agency Company
29. Majal Alwefaq Insurance Agency Company
30. Del Cooperative Insurance Agency Company

31. United Compliance Insurance Agency Company
32. Fursan Insurance Agency Company Ltd.
33. Husun Al Aman for Cooperative Insurance Agency Services Company
34. Takaful of the Middle East for Insurance Agency
35. Ace Insurance Agency Company
36. National Takaful Insurance Agents Company
37. Waad Insurance Agency Company
38. Easy Solutions Cooperative Insurance Agency Company
39. Abdul Latif Jameel Insurance Agency Company
40. The Ocean Modern Insurance Agency Company Ltd.
41. Etemad Insurance Agency Company
42. Saudi Takaful Insurance Agents Company
43. AlMayazeen Insurance Agency Company
44. Al Areen Insurance Agency Company
45. Tawun United Insurance Agency Company
46. Al Tawun Al Oula Insurance Agency Company
47. Madad Al Aman Insurance Agency Company
48. Al Tazeezat for Insurance Agency Company
49. Alawwal Insurance Agency Company
50. Fajr Insurance Agency Company
51. Wattad National Insurance Agency Company
52. Saudi Anadel Insurance Agency Company
53. AlAhli for Marking Insurance Services
54. SABB Insurance Agency Company Ltd.
55. AlArid Insurance Agency Company
56. Future Insurance Agency Company
57. Allianz Saudi Fransi Insurance Agent Company
58. Rand Insurance Agency Company
59. Medad Al Thiqah Insurance Agency Company
60. Tkatof Cooperative Insurance Agency Company
61. Al Babtain Cooperative Insurance Agency Company
62. Al Rajhi Takaful Agency Company
63. Theatel Insurance Agency Company
64. Tamkeen Al Raida Insurance Agency Company
65. Isdar Cooperative Insurance Agency Company
66. Roaa Insurance Agency Company
67. Madar Insurance Agency Company
68. Integrated Protection Company for Insurance Agency
69. AlMaros Company for Insurance Services

Third- Insurance and Reinsurance Service: Actuaries

The actuary is the person applying the probability theory and statistics under which services are priced, and obligations and allocations are made. Each insurance company must appoint an actuary in accordance with the instructions of the Saudi Arabian Monetary Authority.
The minimum required capital of the actuary company is SR150,000. As of the date of preparing this book: the following actuarial compamies have been licensed:

1. AlKhwarizmi Actuarial Services Company
2. Nitaq Actuarial Services Company
3. Manar Sigma Actuarial Services Company

Forth- Insurance and Reinsurance Service: Surveyors and Loss Adjusters

The loss assessor and loss adjuster is the legal person who inspects and surveys the insured risk of prior to insurance, surveys the damage after its occurrence to find out the causes of loss, adjust its value, and determine liability.
The minimum capital of the loss assessors and loss adjusters companies is SR500 thousands. As of the date of preparing this book. The following companies have been licensed:

1. Najm for Insurance Services Company
2. Gulf International Surveyors Company Ltd. for Surveying and Adjusting Losses
3. Saudi McLarens Company for Surveying and Adjusting Losses
4. Saudi Inspection, Survey & Loss Adjusting Company
5. Ahmad Omar Badhidouh & Partners Trading Co. Ltd. for Inspection, Survey & Loss Adjusting Company
6. Ocean Breeze for Inspection and Surveys Company Ltd.
7. Al Bollour Company for Inspection & Survey
8. Soulat Loss Adjusting & Survey Co. Ltd.
9. Matthews Daniel Loss Adjusting & Survey Co. Ltd.
10. Middle East International Loss Adjusting & Survey Company
11. Charles Taylor Adjusting Saudi Arabia Company
12. International Arab Surveyors for Surveying and Adjusting Losses
13. Saudi Cunningham Lindsey Company for Surveying and Adjusting Losses
14. Al Barrak Inspection and Survey Services Company

Fifth- Insurance and Reinsurance Service: Claims Settlement Specialists

The insurance claims settlement specialist is the legal person who manages, reviews, and settles insurance claims on behalf of the insurance company.
The minimum capital of the insurance claims settlement specialists company is SR3 Million. The following companies have been licensed:

1. GlobeMed Saudi Company for Medical Claims Settlement
2. Next Care Saudi Company for Insurance Claims Settlement
3. Saudi Comprehensive Care Company for Insurance Claims Settlement
4. Mednet Saudi Arabia Company for Insurance Claims Settlement
5. MedVisa Company for Medical Claims Settlement
6. GAPCORP Saudi Company Ltd. for Insurance Claims Settlement
7. Gulf Warranties Company for Insurance Services
8. BMCare Company Ltd. for Insurance Claims Settlement
9. Health LaBas Company for Managing Claims
10. Enaya Company for Insurance Claim

Sixth- Insurance and Reinsurance Service: Insurance Advisors

An insurance advisor is a person who provides insurance consultative services and receives a fee from the person who consulted him.
The minimum capital of the insurance consultant company is SR150,000. The following companies have been licensed:

1. Ace Insurance Consulting Company
2. Tawuniya Insurance Consulting Company Ltd.
3. Al Tafakr Insurance Consultants

Chapter Eight
Revision questions:

1. SAMA controls cooperative insurance companies in the Kingdom by taking on different roles. Mention five of them.
2. Mention three of the main obligations of health insurance companies.
3. What are the requirements for submitting a license application to SAMA?
4. Identify insurance broker and what is the minimum capital required for licensing?

Practical question

1. An insurance advisor provides his services to the entity that will pay his fee – What are the benefits of having an insurance advisor in the sector?

Chapter Eight
Answers of Chapter Eight Revision questions:

1. SAMA controls cooperative insurance companies in the Kingdom by taking on different roles. Mention five of them.

- Preparing the Implementing Regulations of the Cooperative Insurance Control law in the Kingdom.
- Regulating the establishment of insurance and reinsurance companies in the Kingdom.
- Supervising the technical aspects of insurance and reinsurance companies' operations.
- Issuing licenses for insurance companies wishing to operate in the Kingdom.
- Regulating the distribution of surplus funds to shareholders and policyholders.
- Determining the capital and solvency requirements for each class of insurance business required by companies.
- Regulating the companies' investments both inside and outside of the Kingdom.
- Determining education and qualification requirements of insurance company personnel, brokers and agents.
- Setting Code of Conduct, insurance sales, and information disclosure.
- Approving insurance products of insurance companies.
- Interpreting and implementing the contracts.
- Regulating purchase of compulsory insurance coverage.
- Regulating and controlling cooperative insurance companies, insurance and reinsurance services companies, loss adjusters, and actuaries.

2. Mention three of the main obligations of health insurance companies.

- Carry out their tasks for the clients to provide proper insurance coverage for them, since they are directly accountable to policyholder (employer) since the inception of insurance policy signed with the client.
- Upload the insureds names on the Cooperative Health Insurance network system within (48) hours.
- Issue insurance cards for insureds within (5) working days maximum from the date of policy inception and its delivery to client. Insurance company must remain responsible of any claims occurring from the beginning of policy issuance.

3. What are the requirements for submitting a license application to SAMA?

A number of insurance companies have been licensed after taking the steps below:
Submit a license application to SAMA including the following:

- Application or license application form.
- Memorandum of Association.
- Articles of Association.
- Organizational structure.
- Economic feasibility study.

Submit a five-year work plan that includes:

- Classes of insurance that will be undertaken by the Company.
- Ability to obtain reinsurance treaties for the classes the company intend to reinsure.
- Marketing plan.
- Projected costs and financing to start the Company's operation.
- Projected growth rate of the business taking into consideration the margin of solvency.
- Expected number of employees and a Saudization plan for training and employment.
- Annual cost based on projected growth rate of the business.
- Projected financial statements related to the growth rate.
- Technical Provisions statement for the proposed growth of the insurance operation certified by a qualified Actuary.
- Branching distribution plan in the Kingdom.
- An irrevocable bank guarantee issued by one of the local banks for the capital required, such guarantee must be renewed until the capital is paid up.

Submitting these requirements to SAMA means that the insurance company has obtained the license after going through the licensing steps as required.

4. Identify insurance broker and what is the minimum capital required for licensing?

The insurance broker is the legal person who, in return for payment, negotiates with the insurance companies to complete the insurance process for the insured. We would like to add here that the minimum capital of the company required for licensing the insurance broker is SR3 Million. The insurance law has warned the insurance companies not to deal with any unlicensed broker. This of course applies on other insurance and reinsurance services.

Practical question

1. The insurance advisor provides his services to the entity that will pay his fee – What are the benefits of having an insurance advisor in the sector?

Advisory is an important point especially for large risks that contain multiple overlapping risks. The role of the advisor is to determine the types of risk to be covered and whether the insurance applicant needs a policy covering all the risks or specific risks based on their type and occurrence level. In addition to whether there were protection means and whether they were efficient in preventing and reducing the severity of the risk when it occurs. Moreover, giving the insurance applicant tips on the methods of compensation required for those risks. For example, does he need a value-specific policy since the subject matter of insurance has a value that may change such as (marine insurance – artwork) or needs to cover the first loss only such as large industrial enterprises or heavy equipment. When the damage occurs here, its results will be confined for a certain part of the subject matter of insurance.

Insurance Terminologies

Assessor: An expert appointed to estimate the cost of the claim for compensation and approval of adjustment under the insurance policy. In the fire insurance branch, an expert appointed by the insured is known as an assessor, and an expert appointed by the insurer is known as claims adjustment expert.

Average clause: This condition is included in all types of conditions for insurance of goods issued by the Institute of London Underwriters. It includes applying a deduction of a percentage (Franchise) on the losses. It has another meaning in the general insurance where it addresses the issue of the decrease in the insurance amount and the application of the principle of proportional Compensation.

Bill of lading: A document that the carrier shall release and deliver to the owner of the goods to be shipped. Under this document, the carrier company shall acknowledge receipt of these goods. The bill of lading contains a description of the goods and considered as a contract between the owner of the goods and the carrier company. This contract has to contain all the clauses related to goods shipment and delivery.

Claims document: A number of documents provided by the insured to the insurer or the underwriter to be able to prove his right to claim compensation. These documents vary from one branch to another. However, it mostly focuses on matters, such as proving the existence of a valid insurance policy, proving the actual value of the damage, justifying the claim amount, and proving that the insured took all steps to allow recovery from third parties

Mandatory excess: The insurance policy sometimes states that the insured must bear the first amount or a certain percentage of the loss value. This amount or percentage is called excess. The excess helps the insured averting from paying the inspection fees and other administrative expenses, which must be spent in order to remedy and settle minor losses. It can also minimize minor claims that may be made up by the insured, as sometimes happens in health insurance.

Condition: The insurance contract is considered to be adhesion contract. Therefore, the stronger party, the insurer, imposes the terms of the contract. The insured must obediently accept these conditions and any breach may lead to contract termination by the insurer.

Contract: A written agreement intended to establish a legal relationship between two or more persons, or introduce an amendment to this relationship if it is existing, or break it off. The following elements must be available to ensure the validity or legality of the contract, which are, the mutual consent, the consideration, and the purpose.

Contribution clause: it stipulates that if the insured has insured the same risk with more than one insurer, each insurer has to pay a share of the compensation amount that commensurate with his share of the insurance amount shown in the policy schedule. This problem can be solved in different ways depending on the situation: 1 - If the total amount of the sum insured in the policies does not exceed the value of the subject matter of insurance, each insurer contributes when the insured risk occurred by a percentage of compensation equal to the amount of insurance in the policy. The insured cannot receive a compensation equal to the value of loss, but shall receive one compensation, which

will be a contribution by all the insurers according to their share in the insurance amount. 2 - If the total amount of the sum insured exceeds the value of insurance - assuming good faith - the insured cannot obtain more than the value of the actual loss as it is an exploitation of insurance and means of illicit gain. The way of compensation adjustment differs from one legislation to another in this case.

Cover note (Temporary Note): The document that includes the temporary cover given by the insurer to the insurance applicant until the completion of the procedures related to the policy.

Deductible: a specified amount deducted from the amount of compensation. If it does not exceed the value of loss, the compensation does not exist at all. The purpose of the deductible is to encourage the insured to avoid the loss as he contributes in its cost, by paying the deductible amount. On the other hand, it aims to reduce the administrative expenses by excluding small claims that require administrative effort to adjust it. It also leads to reduce the price of insurance. It can be a proportion of the sum insured or a fixed amount deducted from the claim of the insured. This type of occurrence differs from the deducted proportion (Franchise).

Depreciation: the efficiency of something is decreased in value due to depreciation. In marine insurance, it specifically means the decreased of the goods value as a result of the damage, so this defect is determined by a certain percentage of the insurance value of the goods. In the hull insurance, the insurance value on the ship is reduced upon renewal if there are some damages that have not fixed, and the reduction shall be equivalent to the cost of repairing these damages at, or immediately after, the occurrence of such damages.

Fraud: The insurance contract becomes void if the acts of the insured involve cheating or forgery and the premium is not refunded in this case

General agent: An agent appointed by the principle to represent him in all transactions authorized by the principle or an agent appointed by the insurance company in a specific area to obtain insurance for it.

Indemnity: The insurer shall indemnify the insured for the losses incurred by the latter due to an insured risk stated in the insurance policy. The insured shall not make a profit from the compensation, as the indemnity is intended to return the aggrieved person to the same financial condition prior to the loss. Sometimes the indemnity may contain a profit as in the agreed value insurance policy, which is a document in which the sum insured is determined when issued, and the sum insured of this policy includes the expected value of profit obtained after the arrival of the goods.

Insured: A person whose life is insured in a life (Protection and Savings) insurance policy or a person who has an insurance interest in the subject matter in other types of insurance.

Insured value: Value of insured property.

Subrogation: The right of the insurer to act on behalf of the insured in claiming third parties for

compensating of a loss (these parties are liable totally or partially) that the insurer compensated the insured for. The maximum value to which the insured is entitled shall not exceed the value of the claim paid to the insured under the principle of subrogation. If the insurer received an amount that exceeds the value of the claim paid on behalf of the insured, it must be returned. The rule does not apply on the total loss remnants / salvage that the insurer obtains, so the insurer can keep it in addition to what he receives under the principle of subrogation.

Accident: An unexpected event that results in negative consequences that was not intended by the insured or in his determination to achieve.

Adjuster: The adjustment expert may be an individual or a body specializing in the settlement of claims of a specific type or several types of insurance losses. Its core tasks are to detect or inspect the loss, and to ensure that the policy covers the damage of the claim, and then calculates the accurate compensation.

Agreed value policy: An insurance policy where the insurer agrees with the insured ahead to consider the amounts mentioned in the schedule of the policy as a final amount. Thus, it can be used in the case of total loss provided that these amounts do not involve any fraud or exaggeration in the assessment for the purpose of enrichment at the expense of the insurer.

Benefit: The right to receive cash returns or to take advantage of the services under the insurance contract as in the case of personal accident insurance and health insurance.

Beneficiary: The party to whom a benefit is allocated, such as the benefit of the insurance policy or the interest determined for the beneficiary under a will.

Insurance broker: a person or a specialized entity in insurance that acts as a broker on behalf of the insurance applicant against a fee. The fee is usually a percentage of the insurance company premium. In addition, large brokerage companies practice mediation between insurance companies and reinsurers to arrange agreements or distribute shares. It is known that Lloyds Underwriters receive insurance only through brokers, and these brokers must be registered and recognized at Lloyds. The broker is responsible before the insurer or the reinsurer to pay the premium even if the insured did not pay. By virtue of the law of Agency, the broker is held liable in the event of failure to perform his duty that may lead to harm his client.

Notice of cancellation:

Offer note of the re-insurance application: A document prepared by the insurer stating the details of the risk to be presented to the reinsurers in order to be reinsured by agreement. It may be submitted to the reinsurer directly or through the insurance broker.

Partial loss of goods: Loss of the insured goods as a result of a risk that has been insured and not considered as a total loss

Loss ratio: The total paid and outstanding amount of compensation during a certain period to net premium income during the same period

Named peril: risk stated in the insurance policy. For example, the typical fire policy states that the insurer is obligated to indemnify the insured for the physical damage to the insured item due to fire or lightning. If the damage is caused by any other unnamed peril in the policy, the insurer is not obliged to compensate for it. The concept of named peril is different from the concept of all risks. Writing of the insurance policy on the basis of all risks means not naming the risks to which the insurer is responsible, while in named perils policies the insurer only names the risks that it wishes to insure.

Renewal notice: Notice of renewal sent by the insurer before the end of the insurance period to the insured informing him about the termination date of insurance. The insurer also asks the insured to notify him of his consent to renew the insurance under the same conditions or according to any other amendment entered to the policy by the insurer or the insured. Furthermore, sending a renewal notice to the insured is not considered a legal obligation that the insurer must do. Therefore, sending a notice is only a procedure performed by the insurer to ensure the continuation of the renewal of the insurance policies in force and to preserve the insured interests that are at risk.

Surveyor/Loss adjustor: A person who has the knowledge and experience necessary to inspect the property or the insured objects and prepare a report. In marine insurance, usually when inspecting goods outside the country of underwriting, the insurer issues instructions through the insurance broker to the nearest Lloyd's agent to conduct the inspection. The agent's selection of the surveyor is deemed accepted by the insurer. In some marine insurance policy, the insurer insists on designating by name the person to be entrusted with the task of inspecting the goods if necessary.

General average account: An account opened by the ship owner to receive deposits or initial payments from the sharing parties of the general average (loss).

Gross net premium: the total premium after subtracting the total returned premiums and before deducting commission of the insurance broker and other discounts.

Gross premium: the total premium before deducting brokerage commission and other deductions such as tax, supervision fees, etc.

Hazard: A characteristic related to the subject matter of insurance that leads to cause the loss or increase the probability of loss. For example, if the subject matter of insurance in the fire policy is made of inflammable materials, or is related to the insured acts as poor management and negligence for moral hazard.

Hull insurance: Insurance of the ship's body, its machinery and equipment. The expression may also refer to insure aircraft hulls.

Implied condition: A condition not expressly written in the policy, but is implied and considered

part of the insurance contract and is binding on the contract parties as if the policy has expressly stated it. The journey begins after a reasonable period from receiving the insurer risk acceptance is an example of implicit condition in the marine insurance policy. It is known that any breach of an implied condition by the insured gives the insurer the legal right to invalidate the Insurance Policy from the date of its inception.

Inception of the policy: The starting date of the policy.

Incurred loss ratio: rate of actual loss during a period (incurred loss) to the earned premiums.

Incurred losses: Losses occurred during the insurance period irrespective of whether the claims incurred were paid or not.

Insured: A person whose life is insured in a life insurance policy (Protection and Savings) or a person who has an insurable interest in the subject matter of insurance as in other types of insurance.

Insured against: When the insurer insures a certain risk/risks, so he is liable for the loss, which the direct cause of its occurrence is the insured risk.

Insured peril: risk stated in the policy or named risk. The insurer undertakes to compensate the insured for the loss, which the direct cause of its occurrence is an insured risk in the policy provided that the value of this loss should be higher than the value of the deductible/excess, if stipulated in the policy.

Intermediary: An agent or broker whose task is to join two parties in the negotiation of a commercial transaction. This term may sometimes be used as an alternative of broker.

Invoice: A document proving the contract of sale and the price of the goods sold.

Invoice value: The value of the goods according to the invoice.

Jetsam: Shipments of goods casted away in the sea from the ship for the purpose of achieving public safety for marine adventure/voyage.

Knot: Nautical velocity knots are equal to one nautical mile per hour and equal to the sea mileage of 6080 feet.

Moral hazard effect: the risk effect related to the insured character, which may increase the probability of loss due to negligence, mismanagement or lack of responsibility.

Named policy: A term rarely used in the marine insurance market, but is used in the shipping field to mean a marine cargo insurance policy - specifying the name of the ship. In practice, the cargo insurance policy (except the open policy) is often issued after identifying the ship's name which is included in the insurance policy. However, insurance companies in developing countries often

face difficulties in obtaining the name of the ship prior to issuing the policy due to the difficulty of communication and the irregularity of procedures.

Named risk: risk identified in the insurance policy that does not differ from the term "named peril". Some of insurance policies name the insured risk such as the fire policy and theft policy. Some insurance policies may tend to define the risk, while policies that do not name the insured risk are known as all risk policies or comprehensive policies.

Negligence: Negligence in the performance of a work, service or duty or improper execution of a particular work, duty or service which any reasonable and prudent person is presumed to perform in an event where the default or negligence occurred.

Insurance agent: A representative of the insurer who is an employee or an independent agent authorized by the insurer to market, discuss, and conclude insurance contracts on his behalf under an official power of attorney.

Risk:The risk can be defined as an accident that is possible to occur which means the risk occurrence is not inevitable.The accident that is inevitable is not a risk from an insurance point of view.

Self Assessment Questions

Chapter One
Self-Assessment Questions

Choose the best answer to each question.

1. Which of the following examples is speculative risk?

A. A situation that has three possible outcomes, either loss, break-even or gain.
B. A widespread natural disaster
C. A situation which has only two possible outcomes, loss or break-even
D. A loss which affects only a few people

2. Insurance deals with risk on the basis of:

A. Risk prevention
B. Risk avoidance
C. Risk transfer
D. Risk removal

3. The law of large numbers assists insurers because:

A. It helps make reliable claim predictions
B. It helps determine overheads
C. It helps make reliable income predictions
D. It helps forecast the level of new production

4. For risk to be insured, it must be:

A. Speculative and fortuitous
B. Pure and fortuitous
C. Inevitable and pure
D. Speculative and inevitable

5. One of the physical hazard factors for buildings:

A. Type of building
B. The age of the insurance applicant
C. Number of insurance policies for the applicant
D. The insurance applicant has bank account

Chapter One
Self-Assessment Questions

6. Public interest can be defined as:

A. The financial relation with the subject matter insured
B. The conditions in the policy
C. The laws of the country
D. The exclusions in the policy

7. What is meant by "a peril"?

A. Increase the damage
B. Decrease the damage
C. Cause the damage
D. Has no effect on the damage

8. What is meant by "a hazard"?

A. Affect the extent of damage
B. Cause the damage
C. Decrease the damage
D. Does not affect the damage

9. The difference between moral and behavior hazards is that:

A. Moral is intentional while behavior can be seen
B. Moral is intentional while behavior is unintentional
C. Moral is unintentional while behavior is intentional
D. All of the above

10. Why is it necessary for a risk to be financially measured in order to be insured?

A. To be indemnified
B. To have insurable interest
C. To be pure risk
D. All of the above

Chapter Two
Self-Assessment Questions

Choose the best answer to each question.

1. Utmost good faith principle can be defined as:

A. Financial relation between the insured and the subject matter of insurance
B. The right to claim from the third party
C. Duty of disclosure of all material facts
D. All of the above

2. Utmost good faith principle applies on:

A. Insurance applicant
B. Insurance company only
C. Both the insurance applicant and the insurer
D. None of the above

3. Material fact is a fact that:

A. Must not be disclosed
B. Affect the premium
C. Affect the conditions
D. Influence the decision of the underwriter in accepting or declining the risk

4. The age of the insured is a material fact in:

A. Fire insurance
B. Theft insurance
C. Private motor insurance
D. All contractors risk

5. A comprehensive vehicle insurance includes some material facts to help the underwriter evaluate the moral hazard effect:

A. Vehicle type
B. Vehicle use
C. Age of the insured
D. Previous losses

Chapter Two
Self-Assessment Questions

6. Insurable interest can be defined as:

A. Financial relation between the insured and the subject matter of insurance
B. The right to claim from the third party
C. Duty of disclosure of all material facts
D. D. All of the above

7. When insurable interest in the general insurance should be present?

A. At policy inception
B. During the policy validity
C. When loss occurs
D. All of the above

8. What are the available options for providing indemnity?

A. Monetary payment
B. Repair
C. Reinstatement
D. All of the above

9. Who has the power to choose indemnity method?

A. Policyholder
B. Third party
C. Insurance company
D. None of the above

10. What is the principle supported by the Contribution Principle and the Subrogation Principle?

A. Insurable interest
B. Indemnity
C. Proximate cause principle
D. Utmost good faith

Chapter Three
Self-Assessment Questions

Choose the best answer to each question.

1. One feature of the insurance contract is mandatory, and this obligation is:

A. Binding on the insurance company only
B. Binding only on the insured
C. Binding on both parties of the contract
D. Not binding on any party

2. The comprehensive definition of the insurance contract must include:

A. The legal aspect only
B. Theoretical aspect only
C. Legal and theoretical aspects
D. Defining any correct aspect

3. In order for the insurance contract to be entered into, it must have:

A. Acceptance only
B. Offer only
C. Printing is clear
D. An offer and acceptance

4. The consent element of the insurance contract concerns:

A. The Insured
B. The insurance company
C. The Insured and insurance company
D. The Consent is not an element of the insurance contract

5. Insurance contract parties are:

A. The Insured and insurance company
B. The Insurance application and insurance contract
C. The Insurance application and insurance offer
D. The Insurance offer and insurance contract

Chapter Three
Self-Assessment Questions

6. One of the following is considered a defect of will in the insurance contract

A. The high cost of the insurance premium
B. Insuring the insured's property in one policy
C. The existence of consent with error and fraud
D. The insurance company refuses the insurance application

7. The subject matter of insurance must be:

A. Acceptable to the insured
B. Acceptable to the insurance broker
C. Any property may be insured therein
D. Legally acceptable and known to both parties

8. The purpose element in the insurance contract is:

A. The direct purpose of insurance
B. Insurance parties
C. Contract consideration
D. Mutual Consent

9. One of the characteristics of the insurance contract is that it is an indemnity contract, this means:

A. The insured receives compensation only
B. The official institutions receive their fees
C. Insurance companies receive the premium only
D. Each party receives a reward for what is given

10. Probability in the insurance contract means:

A. Insured person is exposed to a real risk
B. The insurance company bears a potential risk
C. The insurance company bears pre- insurance risks
D. The insurance company bears potential and pre-insurance risks

Chapter Four
Self-Assessment Questions

Choose the best answer to each question.

1. One of the following is considered a standard product to insured individuals:

A. Contractor's all risk
B. Factory insurance
C. Commercial vehicle insurance
D. Home insurance

2. One of the standard coverage for corporate insurance:

A. Doctor's professional liability insurance
B. Reinsurance treaty
C. Contractor's equipment insurance
D. Private vehicle insurance

3. Marine insurance is one of the insurance coverage for companies that covers:

A. A. Travel insurance
B. B. Emergency diseases affecting
C. C. Insurance covering personal accidents of seafarers during vacation
D. D. Insurance of goods during transport

4. Fidelity insurance compensates the insured in case:

A. A. Embezzlement of fund by an insured employee
B. B. Robbery of funds during transport
C. C. Damage to the Insured's safe
D. D. stealing contents of the insured's warehouse

5. Limits in motor insurance third party liability in Saudi Arabia:

A. A. Three hundred thousand SR for one incident and total accidents
B. B. Five hundred thousand SR for one incident and total accidents
C. C. One million SR for one incident and total accidents
D. D. Ten million SR for one incident and total accidents

Chapter Four
Self-Assessment Questions

6. Insurance of contractors' all risk is within the insurance products covering:

A. A. Motor insurance
B. B. Medical insurance
C. C. Money insurance
D. D. Engineering insurance

7. Additional coverage on motor insurance:

A. A. Medical insurance for the driver
B. B. professional liability insurance for the driver as a doctor
C. C. Personal accidents insurance for the driver
D. D. Insurance of the driver's home

8. Damage to contractor's equipment can be covered within:

A. A. Motor insurance
B. B. General liability of contractors insurance
C. C. Machinery breakdown and inventory corruption insurance
D. D. Contractors' machinery and equipment insurance

9. One of the main coverages of aviation risks:

A. A. Diseases affecting pilots
B. B. Damage to the aircraft hulls
C. C. Damage to the houses of pilots
D. D. Damage to pilots' vehicles

10. In order to make insurance companies accept the insurance of inventory corruption in the cooling equipment, the following insurance coverage must be available

A. A. Fire insurance
B. B. Boilers insurance
C. C. domestic workers insurance
D. D. Machinery breakdown insurance

Chapter Five
Self-Assessment Questions

Choose the best answer to each question.

1. The main committee that reports to the Board of Directors of the insurance company is:

A. Insurance Brokers Committee
B. Audit Committee
C. Insurance Agents Committee
D. Sales Representatives Committee

2. One of the major operations in the insurance companies is the underwriting process, which means:

A. Claims acceptance process
B. Distribution of insurance operations surplus
C. Acceptance of insuring the risk
D. The Company's underwriting process in the financial market

3. The regulatory compliance officer in the insurance company is responsible for:

A. Observes employees work attendance
B. Applying probability and statistics theory used in pricing insurance products
C. Provision of advisory services related to insurance activity
D. Ensure compliance with applicable regulations and relevant directives

4. The process of reinsurance in insurance companies means:

A. Return the insurance premiums to the insured
B. The process of accepting the risk offered by the insured
C. Transfer of the insured risk burden from the insurance company to the reinsurance company
D. The investment process of collected insurance premiums

5. One of the following is considered a major selling channel in insurance companies:

A. Newspaper advertisements
B. Reinsurance treaty
C. Social Responsibility of the company
D. Insurance Brokers

Chapter Five
Self-Assessment Questions

6. The department that relates to the principle of compensation in insurance companies is:

A. Information Technology department
B. Investment department
C. Actuarial expert
D. Accidents and Claims department

7. One of the functions of reinsurance department in insurance companies is:

A. Investment in collected premiums
B. Transfer of risk from insurance companies to reinsurers
C. Direct compensation for vehicle accidents
D. Direct compensation for property accidents

8. Selling through an insurance agent is an example of:

A. Sale through insurance brokers
B. Sale through direct salespersons
C. Sale through call centers
D. Sale through a major sales channel which is the a channel of insurance agents

9. The process of identifying the insurance applicant is known as:

A. Claims adjustment
B. Receiving claims
C. Customer Service
D. Underwriting

10. The minimum permitted rating of reinsurance companies to which insurance companies must comply with in accordance of the instructions of the Saudi Arabian Monetary Authority:

A. AAA
B. BBB
C. CCC
D. DDD

Chapter Six
Self-Assessment Questions

Choose the best answer to each question.

1. Insurance fraud is defined as:

A. Inability of a party to meet his obligations regarding a financial contract
B. Falsifying an insurance claim or increasing the insurance claim cost by increasing the damage cost
C. Rejecting the renewal of some of the major reinsurance treaty\ies of insurance companies
D. Failure to increase the penetration rate in the insurance market

2. Solvency of insurance companies means:

A. The financial director's inability to fill the position
B. Actual claims in insurance companies exceeding the carrying amount of the insurance liabilities
C. Companies are able to meet their obligations to policyholders
D. Lack of specialized training programs working on raising the awareness of individuals

3. External fraudsters on insurance companies can be:

A. Employees on a vacation
B. Board of directors
C. Insurance brokers
D. Insurance representatives

4. Reasons why Saudi employees of insurance companies are unstable and move to work in other fields:

A. High demand and low supply
B. Scholarship to study abroad
C. Lack of incentives in insurance companies
D. Non-Saudi employees cost is cheap

5. One of the following is a negative effect of solvency:

A. Companies inability to continue with social responsibility programs
B. Companies stopping to underwrite new insurance business.
C. Not giving incentives to employees
D. Increase of fraud from several sources

Chapter Six
Self-Assessment Questions

6. One of the following is a product development risk that insurance companies face:

A. Not following the actuary's instructions for selling a new product
B. Ensure the new product's compliance with the regulatory requirements
C. Prepare a report identifying the changes in risks and the insured behavior at th of the new product.
D. Increase in insurance rates

7. One of the following is a procedure followed by insurance companies to face underwriting risk:underwriting risk:

A. Not articulating policies and phrases clearly
B. Not giving importance to the completion of the insurance application by the insured
C. Ensure that insurance premiums include all costs
D. Not conducting periodic and sufficient review of the appropriateness of the insurance policies

8. Identifying and applying proper mechanisms for the development of appropriate precautions; is one of the procedures undertaken by insurance companies to face:

A. Product development risk
B. Underwriting risk
C. Information technology risk
D. Claim settlement risk

9. To prepare for countering insurance risk, insurance companies do one of the following:

A. Monitoring the high rate of policy cancellation
B. Using sound practices to manage company's assets
C. Implement a strict schedule for paying dues
D. Not putting restrictions on granting credit

10. One of the risks related to changes occurring in countries and affecting insurance companies' performance:

A. Increase in car accidents
B. Wars and political instability
C. Floods and storms
D. Increase of fraud from several sources

Chapter Seven
Self-Assessment Questions

Choose the best answer to each question.

1. The main purpose of these regulations:

A. These regulations include the general principles and minimum standards to be met by the insurance companies, including the branches of foreign insurance companies and insurance and reinsurance services companies authorized by SAMA to deal with their current and potential customers in the future.
B. The objective of these regulations is to establish high standards for working in the insurance field, regardless of insurance companies' performance.
C. These regulations set out general principles, and full compliance is not a necessity for insurance companies.
D. These regulations do not apply on foreign companies working in the market.

2. Integrity is one of the general requirements in the regulations and it states:

A. Authorized companies shall work within their area of competence in dealing with customers in accordance with the necessary professional skills and with utmost care and diligence to increase its efficiency through training, experience, and working with experts in this area.
B. Authorized companies shall discriminate unfairly against its current or potential customers in the future, and shall provide convincing reasons for rejecting, cancelling, or not renewing insurance policies.
C. Authorized companies shall not take reasonable procedures to ensure accuracy and clarity of the information provided to customers and making them available in writing.
D. Taking care of junior clients. This does not apply on senior clients.

3. Article 52 stipulates that (The Insurance Policy shall be written in a clear way that can be read by the public at large, and shall contain the following):

A. Policy number, which must also be provided in all related documents to this policy
B. Insured name and mail address, and the national address is not required from some clients
C. Coverage period for specific policies only
D. Coverage description without determining the coverage scope

4. Free Look period provision:

A. 15 days
B. 20 days
C. 21 days
D. 18 days

Chapter Seven
Self-Assessment Questions

5. Authorized companies should not give inaccurate, misleading, exaggerated, or deceptive data or advertisements, directly or indirectly, including but not limited to information about:

A. Name of the company issuing the insurance policy
B. The financial situation of the insurance company issuing the insurance policy, which is not important to clients
C. Property insurance policy coverage
D. Indicating the price without clarifying whether it is inclusive of all fees or not

6. One of the information that insurance companies must disclose before accepting the customer's request to obtain an insurance policy:

A. Whether it is an insurance company, working for an insurance company, or working independently for profit
B. If a financial relationship exists between the broker and the insurer other than regular commission agreements, particularly if there is a joint ownership or if the two parties had joint owners, the customer shall be notified
C. The nature and range of products and services they can offer or receive from reinsurers
D. Giving advices and recommendations according to the company's interest

7. Insurance companies must disclose the following when a customer requests to obtain an insurance policy:

A. Claims settlement procedures, only the ones that he can withdraw
B. Complaints handling procedures
C. Obligations and duties of the insured under the insurance policy
D. Renewal conditions of companies' policies

8. If the funds of policyholders can be invested in a set of investment funds associated with a unit, the investment funds must be described and their description should include at a minimum:

A. Assets classes that the fund may invest in only in the Kingdom
B. Classification of each fund in terms of risk and volatility of the external units
C. The criteria must be clarified if the fund is measured based on some criteria
D. The currency in which the fund is priced locally, and foreign currencies are not accepted

Chapter Seven
Self-Assessment Questions

9. Authorized companies must provide timely and appropriate post-sale service to customers post-sale, including response to their queries, administrative requests, and requests to amend insurance policies. In particular, they must do the following:

A. Provide coverage certificates when requested by the customer
B. Provide written confirmation of any amendments to the insurance policy and any additional amounts due only after the insured pays the premium and if he does not pay, he will not receive it.
C. Issue receipts for any amounts received by any payment method, whether it is via credit card or any other automatic bank transfer method
D. Pay amounts due for refund or any other charges due to the customer according to the company's interest

10. To settle claims, authorized companies must do the following:

A. Respond to claims received according to the days specified by the insurance company
B. Provide claims forms showing all the information or steps required by the customer (including the beneficiary under a Protection and Savings policy) to file the claim or the company will have the right to refuse if the forms were not completed
C. Acknowledge to the customer the receipt of the claim and any missing information within (7) days from receiving the claim's application form
D. Notify the customer verbally of the claim refusal and in writing of the claim acceptance

Chapter Eight
Self-Assessment Questions

Choose the best answer to each question.

1. One of the following is an insurance and reinsurance services provider:

A. Cooperative insurance company
B. Cooperative reinsurance company
C. Insurance brokers
D. Council of Cooperative Health Insurance

2. Council of Cooperative Health Insurance is a body that supervises and regulates insurance companies. One of the following is a main task of the council:

A. Grant license for insurance brokers
B. Selling medical insurance documents to those who request the insurance
C. Investing the cumulative premiums of insurance companies
D. Qualifying medical services providers

3. The body that grants license for the actuary:

A. Saudi Arabian Monetary Authority(SAMA)
B. Ministry of Commerce and Investment
C. Chamber of Commerce
D. General Secretariat of the Committees for Resolution of Insurance Disputes &Violations

4. Claim settlement specialist is an insurance and reinsurance services provider that do the following:

A. Providing insurance consultative services
B. Concluding documents with insurance companies
C. Check and inspect what is requested to be insured before it is actually insured
D. Managing, reviewing, and settling insurance claims

5. The sum insured of the medical insurance policy set by the Council of Cooperative Health Insurance is:

A. Unlimited. The insured can receive treatment at any cost.
B. One million SR.
C. Five hundred thousand SR.
D. Ten million SR.

Chapter Eight
Self-Assessment Questions

6. One of the Implementing Regulations issued by Saudi Arabian Monetary Authority and is related to risks faced by insurance companies:

A. Supervision, inspection, licensing, and accreditation costs regulations
B. Regulations of reinsurance business only within the Kingdom
C. Anti-Money Laundering (AML) and Combating the Financing of Terrorism (CFT) rules
D. Foreign investment regulations

7. One of the functions of the General Secretariat of the Council of Cooperative Health Insurance:

A. A. Prepare and establish implementing policies and procedures
B. B. Licensing insurance companies
C. C. Licensing hospitals and medical centers
D. D. Renewing non-Saudi's residence permit (Iqama)

8. One of the main obligations of health insurance companies:

A. Providing medicines and treatments
B. Medical examination for patients
C. Licensing doctors and medical practitioner
D. Giving approval for providing medical treatments

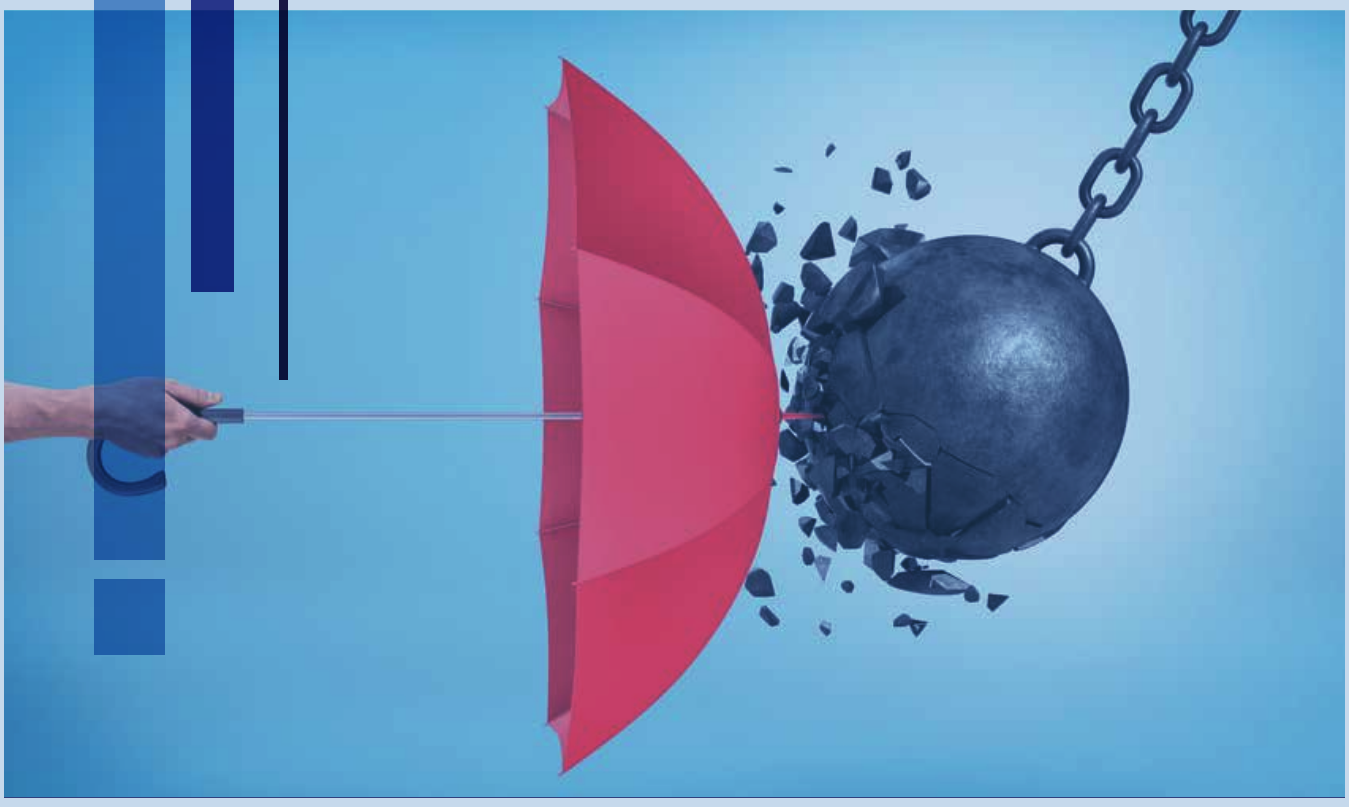
9. Under the Law and with Capital Market Authority (CMA)'s Supervision, insurance companies are required to offer shares to the public for trading by:

A. 100% of the insurance companies' capital
B. 60% of the insurance companies' capital
C. 50% of the insurance companies' capital
D. 40% of the insurance companies' capital

10. When there is a non-Saudi company partner to any insurance company, it must obtain the license from

A. General Investment Authority (SAGIA)
B. Saudi Arabian Monetary Authority(SAMA)
C. Ministry of Commerce and Investment
D. Ministry of Labor and Social Development

Answers to Self Assessment Questions



Chapter One Answers to Self-Assessment Questions

1. **Which of the following examples is speculative risk?**

   Answer: A – P.7 - uninsurable risks

2. **Insurance deals with risk on the basis of:**

   Answer: C – P.9 - Insurance as a tool of transferring risk

3. **The law of large numbers assists insurers because:**

   Answer: A – P.7 - Law of large number

4. **For risk to be insured, it must be:**

   Answer: B – P.6 - insurable risks

5. **One of the physical hazard factors for buildings:**

   Answer: A – P.12 - Hazards

6. **Public interest can be defined as:**

   Answer: A – P.8 - General interest

7. **What is meant by "a peril"?**

   Answer: C – P.12 - Main causes of perils and hazard

8. **What is meant by "a hazard"?**

   Answer: A – P.13 - Main causes of perils and hazard

9. **The difference between moral and behavior hazards is that:**

   Answer: B – P.13 - Main causes of perils and hazard

10. **Why is it necessary for a risk to be financially measured in order to be insured?**

    Answer: A – P.5 - Financial risk

Chapter Two Answers to Self-Assessment Questions

1. **Utmost good faith principle can be defined as:**

   Answer: C – P. 26 - Utmost Good Faith Principle

2. **Utmost good faith principle applies on:**

   Answer: C – P. 26 - Utmost Good Faith Principle

3. **Material fact is a fact that:**

   Answer: D – P. 27 - Facts to be disclosed

4. **The age of the insured is a material fact in:**

   Answer: C – P. 27 - Facts to be disclosed

5. **A comprehensive vehicle insurance includes some material facts to help the underwriter evaluate the moral hazard effect:**

   Answer: D – P. 27 - Application on Material Facts

6. **Insurable interest can be defined as:**

   Answer: A – P. 28 - Insurable Interest Principle

7. **When insurable interest in the general insurance should be present?**

   Answer: D – P. 29 - When Insurable Interest is available

8. **What are the available options for providing indemnity?**

   Answer: D – P. 30 - Indemnity Principle – Indemnity methods

9. **Who has the power to choose indemnity method?**

   Answer: C – P. 31 – Indemnity Principle

10. **What is the principle supported by the Contribution Principle and the Subrogation Principle?**

    Answer: B – P. 34 - Subrogation Principle

Chapter Three Answers to Self-Assessment Questions

1. **One feature of the insurance contract is mandatory, and this obligation is:**

   Answer: C- P.54 - insurance contract characteristics

2. **The comprehensive definition of the insurance contract must include:**

   Answer: C – P.48 - defining the insurance contract

3. **In order for the insurance contract to be entered into, it must have:**

   Answer: D – P.50 - Insurance contract elements – insurance contract parties

4. **The consent element of the insurance contract concerns:**

   Answer: D - P.51 - Insurance contract elements - consent

5. **Insurance contract parties are:**

   Answer: A – P.51 - Insurance contract elements – insurance contract parties

6. **One of the following is considered a defect of will in the insurance contract:**

   Answer: C – P.52 - second element – Will of defect

7. **The subject matter of insurance must be:**

   Answer: D – P.52 - third element – contract consideration

8. **The purpose element in the insurance contract is:**

   Answer: A - P.53 - fourth element – contract purpose

9. **One of the characteristics of the insurance contract is that it is an indemnity contract, this means:**

   Answer: D – P.53 - Fifth element – insurance contract characteristics – indemnity contract

10. **Probability in the insurance contract means:**

    Answer: A – P.54 - insurance contract characteristics – Fortuitous contract

Chapter Four Answers to Self-Assessment Questions

1. **One of the following is considered a standard product to insured individuals:**

   Answer: D – P.72 - Individual insurance – housing insurance

2. **One of the standard coverage for corporate insurance:**

   Answer: C – P.76 - corporate insurance – engineering insurance

3. **Marine insurance is one of the insurance coverage for companies that covers:**

   Answer: D – P.78 - corporate insurance – marine

4. **Fidelity insurance compensates the insured in case:**

   Answer: A – P.73 - corporate insurance product - Insuring trust

5. **Limits in motor insurance third party liability in Saudi Arabia:**

   Answer: D – P.71 - insuring liability to the third party

6. **Insurance of contractors' all risk is within the insurance products covering:**

   Answer: D – P.70 - engineering insurance

7. **Additional coverage on motor insurance:**

   Answer: C – P.71 - individual product – comprehensive insurance for motors

8. **Damage to contractor's equipment can be covered within:**

   Answer: D – P.76 - corporate insurance – engineering methods

9. **One of the main coverages of aviation risks:**

   Answer: B – P.78 - corporate insurance- Aviation insurance

10. **In order to make insurance companies accept the insurance of inventory corruption in the cooling equipment, the following insurance coverage must be available**

    Answer: D – P.76 - corporate insurance - engineering insurance

Chapter Five Answers to Self-Assessment Questions

1. **The main committee that reports to the Board of Directors of the insurance company is:**

   Answer: B – P.86 - Board of Director Committee – Audit committee

2. **One of the major operations in the insurance companies is the underwriting process, which means:**

   Answer: C – P.92 - underwriting process

3. **The regulatory compliance officer in the insurance company is responsible for:**

   Answer: D – P.86 - Audit committee

4. **The process of reinsurance in insurance companies means:**

   Answer: C – P. 92 - Reinsurance

5. **One of the following is considered a major selling channel in insurance companies:**

   Answer: D- P.91 - channels of selling insurance – Sale through brokers

6. **The department that relates to the principle of compensation in insurance companies is:**

   Answer: D – P. 93 - Receiving and processing claims

7. **One of the functions of reinsurance department in insurance companies is:**

   Answer: B – 92 - Reinsurance

8. **Selling through an insurance agent is an example of:**

   Answer: D – P.91 - channels of selling insurance – sale through agents

9. **The process of identifying the insurance applicant is known as:**

   Answer: D – P.92 - underwriting stages

10. **The minimum permitted rating of reinsurance companies to which insurance companies must comply with in accordance of the instructions of the Saudi Arabian Monetary Authority:**

    Answer: B – P.92 - reinsurance

Chapter Six Answers to Self-Assessment Questions

1. **Insurance fraud is defined as:**

   Answer: B – P. 103 – Defrauding insurance companies' risk

2. **Solvency of insurance companies means:**

   Answer: C – P. 101 – Solvency

3. **External fraudsters on insurance companies can be:**

   Answer: C – P. 107 - Insurance brokers fraud

4. **Reasons why Saudi employees of insurance companies are unstable and move to work in other fields:**

   Answer: A – P. 110 – Lack of qualified human resources

5. **One of the following is a negative effect of solvency:**

   Answer: B – P. 101 - Solvency

6. **One of the following is a product development risk that insurance companies face:**

   Answer: C – P. 100 – Product development

7. **One of the following is a procedure followed by insurance companies to face underwriting risk:underwriting risk:**

   Answer: C – P. 100 – Underwriting risk

8. **Identifying and applying proper mechanisms for the development of appropriate precautions; is one of the procedures undertaken by insurance companies to face:**

   Answer: D – P. 101 – Claim settlement risk

9. **To prepare for countering insurance risk, insurance companies do one of the following:**

   Answer: C – P. 102 – Credit risk

10. **One of the risks related to changes occurring in countries and affecting insurance companies' performance:**

    Answer: B – P. 112 – Changes in country risk

Chapter Seven Answers to Self-Assessment Questions

1. **The main purpose of these regulations:**

   Answer: A – P. 120 – Purpose of the Regulations

2. **Integrity is one of the general requirements in the regulations and it states:**

   Answer: A – P. 121 - General Requirements – Integrity

3. **Article 52 stipulates that (The Insurance Policy shall be written in a clear way that can be read by the public at large, and shall contain the following):**

   Answer: A – P. 124 – Insurance (Policies) Samples and Pricing

4. **Free Look period provision:**

   Answer: C – P. 124 – Free Look Period Provision

5. **Authorized companies should not give inaccurate, misleading, exaggerated, or deceptive data or advertisements, directly or indirectly, including but not limited to information about:**

   Answer: A – P. 124 – Marketing – Credibility

6. **One of the information that insurance companies must disclose before accepting the customer's request to obtain an insurance policy:**

   Answer: B – P. 125 – Communication with the Customer during the Pre-sale Period

7. **Insurance companies must disclose the following when a customer requests to obtain an insurance policy:**

   Answer: B – P. 126 – Selling Insurance Products and Services – Disclosure to Customers

8. **If the funds of policyholders can be invested in a set of investment funds associated with a unit, the investment funds must be described and their description should include at a minimum:**

   Answer: C – P. 126 – Selling Insurance Products and Services – Disclosure to Customers

9. **Authorized companies must provide timely and appropriate post-sale service to customers post-sale, including response to their queries, administrative requests, and requests to amend insurance policies. In particular, they must do the following:**

   Answer: A – P. 128 – Post-sale Customer Services – Post-sale Services

10. **To settle claims, authorized companies must do the following:**

    Answer: C – P. 128 – Post-sale Customer Services

Chapter Eight Answers to Self-Assessment Questions

1. **One of the following is an insurance and reinsurance services provider:**

   Answer: C – P. 156 – Insurance and Reinsurance Services – Insurance Brokers Companies

2. **Council of Cooperative Health Insurance is a body that supervises and regulates insurance companies. One of the following is a main task of the council:**

   Answer: D – P. 140 – General Secretariat of the Council of Cooperative Health Insurance

3. **The body that grants license for the actuary:**

   Answer: A – P. 155 - Actuaries

4. **Claim settlement specialist is an insurance and reinsurance services provider that do the following:**

   Answer: D – P. 155 – Claims Settlement Specialistss

5. **The sum insured of the medical insurance policy set by the Council of Cooperative Health Insurance is:**

   Answer: C – P. 140 – Council of Health Insurance

6. **One of the Implementing Regulations issued by Saudi Arabian Monetary Authority and is related to risks faced by insurance companies:**

   Answer: C – P. 138 – History of Saudi Arabian Monetary Authority(SAMA)'s General Department of Insurance Control

7. **One of the functions of the General Secretariat of the Council of Cooperative Health Insurance:**

   Answer: C – P. 140 - General Secretariat

8. **One of the main obligations of health insurance companies:**

   Answer: D – P. 141 – Main obligations of health insurance companies

9. **Under the Law and with Capital Market Authority (CMA)'s Supervision, insurance companies are required to offer shares to the public for trading by:**

   Answer: D – P. 142 – Capital Market Authority (CMA)

10. **When there is a non-Saudi company partner to any insurance company, it must obtain the license from**

    Answer: A – P. 144 – General Investment Authority (SAGIA)

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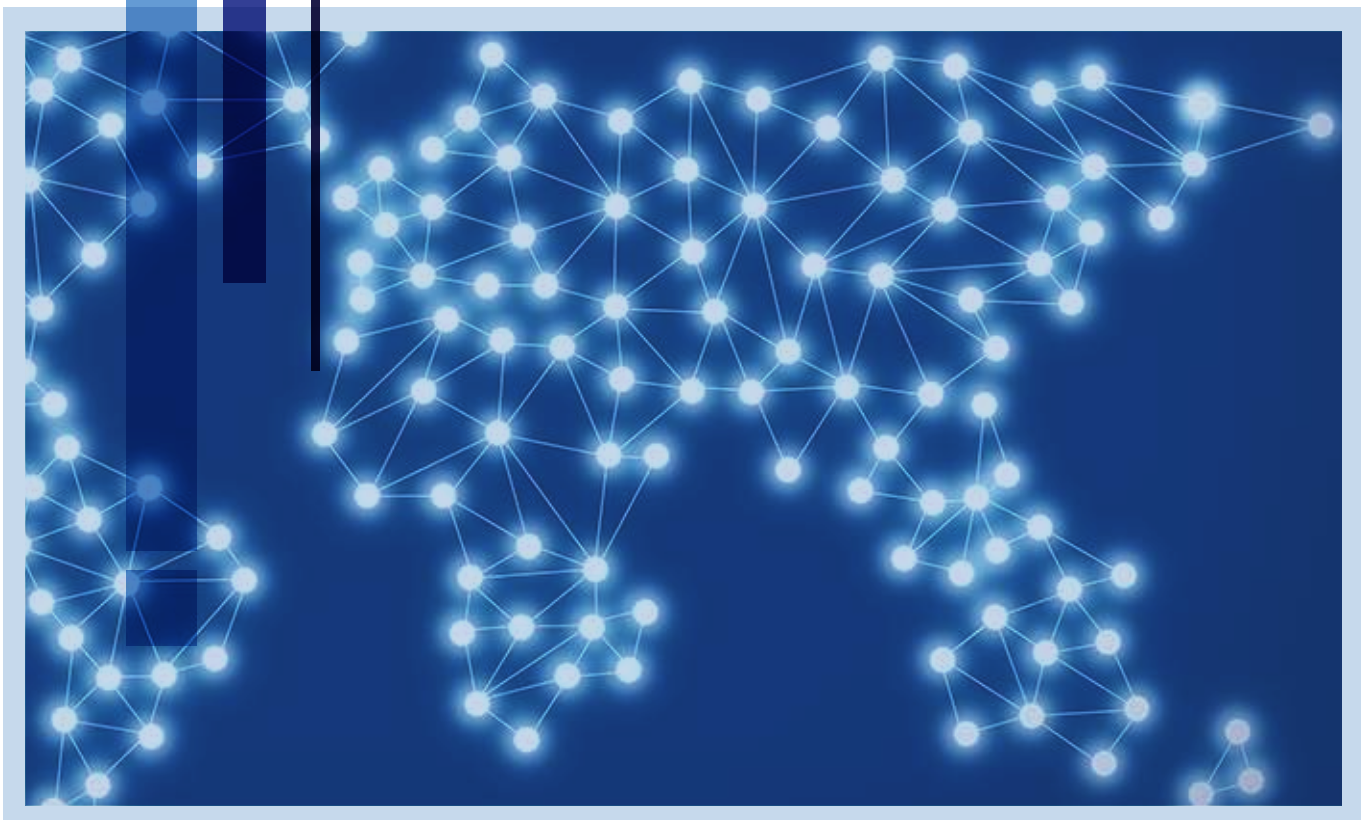

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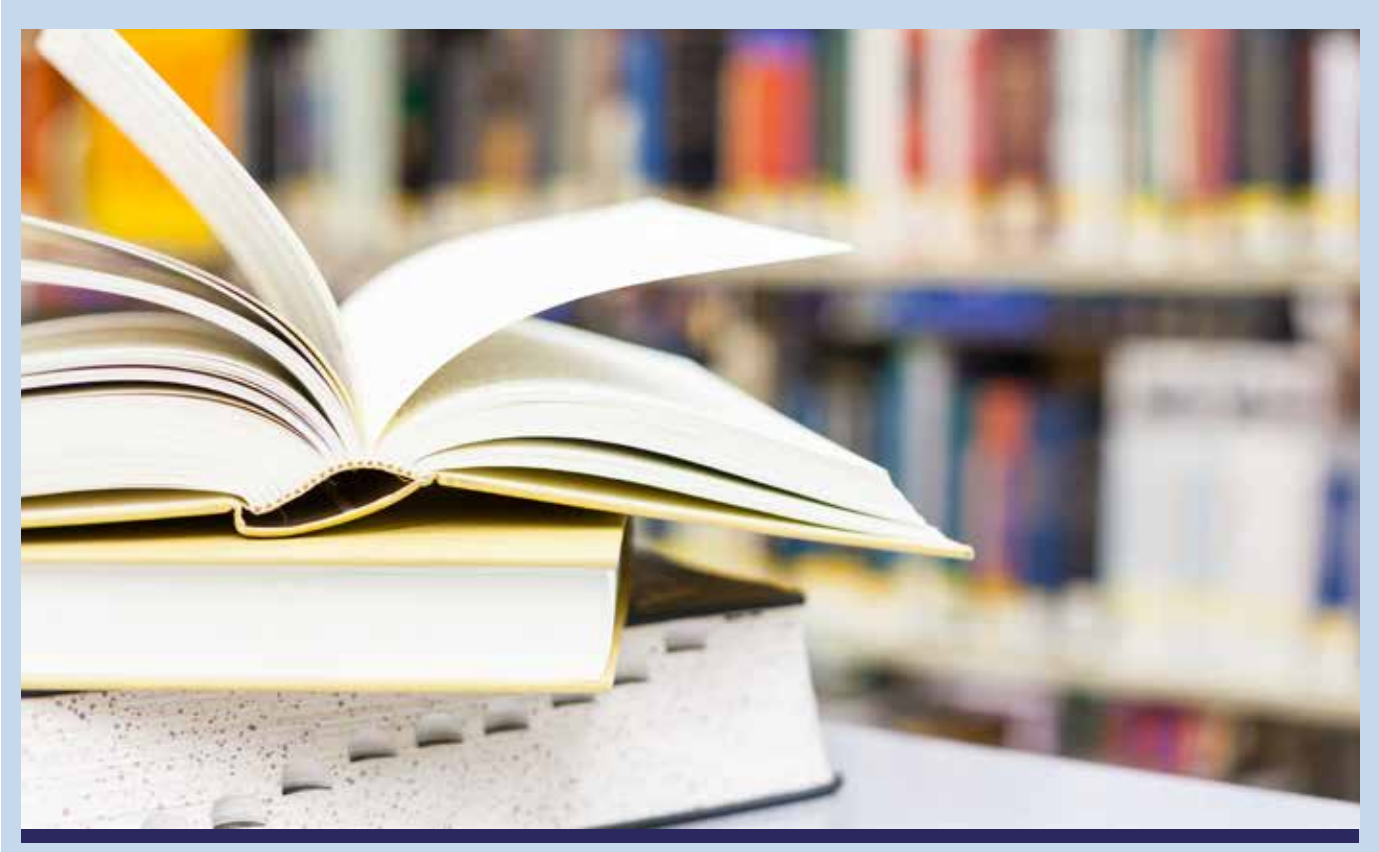

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