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The Financial Academy

“INSURANCE FOUNDATIONS” CERTIFICATE

Learning curriculum issued by the Financial Academy.
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This learning curriculum includes 6 chapters and is the main reference to pass the “Insurance Foundations Professional” Exam.

In the name of Allah,
the Most Gracious, the Most Merciful

Welcome to the learning curriculum issued by the Financial Academy. This book is designed to qualify candidates for Money Exchange and Transfer Professional Exam set in Financial Academy.

This book is a learning guide and FA made an enormous effort to ensure the accuracy of the content.

Curriculum mapping that is shown at the end of the book 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 Money Exchange and Transfer 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 different information of the curriculum and to promote deep learning of all chapters. 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 material may take up to 70 hours

Chapter One

Risk and Insurance Management Foundations

This part of book accounts for approximately 10 out of the 100 questions of the test.

1- 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 Insurance

Learning Objective

Introduce the beginning of 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 in the voyage to include; (cargo, 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 which later emerged in the form of institutions in the Islamic state in the Arabian Peninsula around 650 AD.

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, and form a fund to compensate those whose properties were damaged or if an accident occurred. 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 based on various insurance contracts, statistics, 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 after determining them by each according to the opportunities and size of the expected damage as a result of the realization of the insured risk. Then distribute premiums collected to a group of insured persons, in accordance with the terms and conditions of the insurance contract.

c. By having insurers as guarantors of the loss of the insured, regulating their responsibilities and the dues of each of them, 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.

1.2 The Risk

Learning Objective

Introduce the meaning of risk and when the term is used.

The risk is a more substantial component in insurance industry than any other industry. Assuming that the automotive industry is based on engines, then the insurance industry is based on the risk. In this part of the book, we will focus on understanding the risk.

1.2.1 Risk Definition

Several academics, researchers, and insurance industry practitioners have attempted to

define risk, for example

• Uncertainty of a loss occurring.

• The possibility of an outcome being different from the expected.

• The term RISK defined as “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 i.e. there is a state of suspicion about the occurrence of an event, or there is a probability that a loss will occur.

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. Accordingly, we can sum up the elements of risk as follows:

• 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.

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).

• Implied signals of having different levels of risk.

• Results may occur due to one or multiple reasons.

Since the definition of risk involves Uncertainty Term, it is important to differentiate between two types of risk, namely:

- Objective Risk

Objective Risk (also called degree of risk, or objectivity of risk). It is defined as the relative difference of the actual loss from the expected loss, for example: Suppose the car insurance company has 100,000 insured cars, and the company has statistics showing the volume of loss for these cars over a relatively long period (spanning several years). Now let’s assume that, on average, about 1% of these cars suffered a total loss each year (i.e. 1,000 cars), which is called the expected loss. In this case, it is very difficult to expect that 1000 cars will suffer a total loss during the next year, because they may increase to more to become 1100 or they may be less than that to become 900. So the loss in the future may be 1100, which is called the actual loss. The idea of insurance is based on reducing the gap between the expected loss and actual loss. Insurance companies

consider that this type of risk can be insured, because it can reduce the gap between the expected loss and actual loss by increasing the number of insurance subscribers.

- Subjective Risk

Subjective Risk (or what might be called the subjective sense of risk), is defined as the uncertainty resulting from an individual's personal judgment, or the belief that something is likely to happen without any evidence, which is called intuition. For example, suppose a person wants to travel to another country. As he was making his way to the airport, he came across someone he didn't like. Then, he thought that this was not a good sign and that something bad is going to happen to the plane. So he canceled the flight because of seeing this person, and not for any other logical reason. Here, we call this type of risk the subjective risk. Insurance companies cannot deal with this type of risk; Because it is not based on any scientific facts, but rather it varies from a person to another according to his judgment.

1.2.2 Risk and Insurance

We use the expression "risk" in insurance 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 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.

The best definition of risk: The possible financial loss to income or fortune because of certain incidents that harm individuals, properties or third parties. 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.

Question:

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:

As previously discussed, the risk has been defined as the circumstances that result in a loss inflicted on an individual or property. There is a number of risk classifications, these are:

A. Financial Risk and Non-Financial Risk

B. Pure Risks and Speculative Risks.

C. Fundamental Risks and Particular Risk

A. Financial Risk and Non-Financial Risk

- Financial Risk:

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. Damages caused by personal that can be identified by the courts can be identified and financially measured.

Financial risks are insurable and accepted by insurance companies.

- Non-Financial Risk:

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. Choosing when and 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. However, the same photograph may be not of the same value for somebody else.

Non-financial risk is a kind of risk that the insurance company does not accept to insure; Because it cannot rely on an accurate metric to measure loss size, which is a key component of the insurance industry.

Question:

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

B. Pure Risks and Speculative Risks.

- Pure Risk:

A situation that results in a loss or no loss. Its outcomes may be undesirable, or it may leave us in the same state we were in before that risk occurred. Examples of pure risks: the fall of a person on the ground might cause a wound or fracture or does not cause any injury, or a vehicle collision, which either causes a loss or does not cause any damage. 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., 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, shipwreck, illness or earthquakes. Therefore, pure risks are risks that insurance companies accept to insure.

Question:

Can you think of other examples of pure risk?

- Speculative Risks:

These risks may result in loss or gain such as equity investment in stocks. As these activities can bring financial gains or losses or nothing can happen.

Hence, the risk of speculation has three consequences:

- Loss
- No loss
- Profit

For example, if an individual buys 1,000 shares in a company, he will make a loss if the share prices fall. But he will make a profit in the event of price increase. Another example is a company introducing a new product to the market. In this case, the company may either yield profits, or the consumers may not like the product, and there will be a loss.

The distinction between pure risks and speculative risks is important for insurance. Because the risk of speculation is not insurable or is not insured by insurance companies. This is because there is an essential difference, namely that the speculative risks have a likelihood for making profit (they have three possible outcomes; loss, profit or breakeven), while pure risks have either loss or breakeven (there is no profit).

Question:

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

C. Fundamental Risks and Particular Risk

- 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, 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 fundamental.

Since 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 fundamental risks.

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

- Particular Risk:

Unlike 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 fundamental and particular risks. For example, a severe economic recession that causes public unemployment in a region is a 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 Characteristics of an Ideally Insurable Risk

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:

- There should be a large number of units to be insured: There should be a large number of units that are exposed to a similar risk.

- The loss should be measurable and identifiable: In the case of insurance on the loss of a car, it is easy to determine the extent of the damage caused to the car. While it is not possible to ensure the change in a person's judgment or psychological state, because there is no unit of measure by which we can know this loss, and also it is not possible to determine its size.

- The loss should not be general: I.e., the loss affects a large number of insurance units; so that many insurance units are exposed to the same loss (such as earthquakes and natural disasters).

- The risks are pure ones: Generally, the inability to foresee the future events, and whether there will be a loss or not. The risk has only two consequences, either a loss or no loss.

- If the loss is fortuitous: The term "fortuitous" loss essentially means "accidental" loss. In this context, this means that any event must be beyond the control of the insured, that is, it must be accidental for the insured.

- Realizing sufficient profit by the insurance company: In order for the insurance company to take a given risk as insurable, the total premiums must be higher than the total costs it expects to pay for future losses.

The Implementing Regulations of the Cooperative Insurance Companies Control Law define the "Risk" as "Situation involving the chance of loss or no loss, but no chance of gain."

- Insurable interest: 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 and its continued existence, and is affected if the risk is realized and this object or person is damaged or harmed".

Question

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: 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 fundamental and particular risks are but some are not. 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 fortuitous and be capable of financial measurement (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 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.

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 individuals, 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, or 6 times head and 4 times tail or other number. 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. 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.

General 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 for tuitous, 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.

Question

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 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, such as in some areas of natural disaster and the insurance premium becomes high and unaffordable.
We cannot be too inflexible concerning fundamental and particular risks. Generally, fundamental 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, at the level of society. 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.

1.3 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, If the event does not happen then no financial compensation is required. 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 a much larger 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 los, for the damages incurred, which can negatively affect 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.

- Insurance Pool: 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.

- Fair and just insurance premiums: 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.

Question:

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.
On what principle did homeowners rely when making this agreement?

Question

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? What would you advise them (given the magnitude 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 members 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 are the factors that should be considered in estimating premium to be paid?

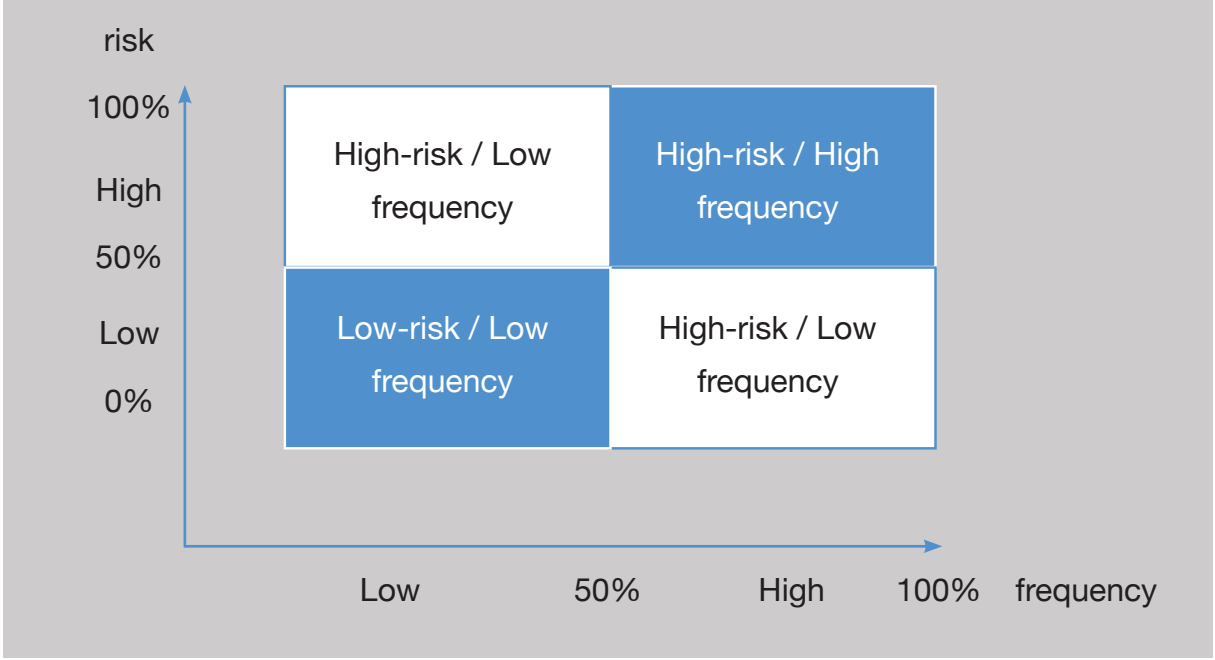
1.4 Risk Classification

1.4.1 High frequency/ low severity risks

Risks that occur often on an individual basis (not on a society basis) and are not financially severe. Most car accidents, thefts, or house fires would fall into this category.

1.4.2 Low frequency/ high severity risks

Risks 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



Question

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?

1.5 Main Perils and Hazard (contributing factors)

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. Peril:

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

Perils are divided 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 (for example, if a policy provides for the coverage of the loss or damage caused by the fire); It will compensate for damage caused by the fire. And the fire in this case 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. For example, if a policy provides an exception for coverage of loss or damage caused by an explosion; it will not compensate for what has been damaged by the explosion. And the explosion in this case is excluded peril.

• **Unnamed perils:** are perils not mentioned in the policy and usually they are not covered, for example, the risk that is not expressly written in the insurance policy.

Question:

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

1. Insuring a company building against fire
2. Insuring a storage of Television Company Limited against theft
3. Insuring imported goods from china shipped by sea

B. Hazard: Hazard

Hazard is a condition that may create or increase the chance of loss. For example, rain falling on the roads that causes the driver to be unable to see clearly. This increases the risk of collisions with other vehicles.

Hazards are divide into three kinds:

Physical, moral and behavioral hazards.

• **Physical hazards** are the triggers or the physical hazard contributing factors in insured item that cause the loss occurrence or increase its severity, such as: bad electrical extension cord or driving a car over a street full of oil. 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.

• **Moral hazards hazard** It is the influence of the risk related to the insurance applicant (individual or company), which may increase the possibility of a loss, due to his negligence, mismanagement, or lack of a sense of responsibility. And arise from the intentional or unintentional immoral, or illegal conduct of people. Usually the person insured and 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.

• **Attitudinal Hazard (Morale Hazard)** 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.

1.6 Reinsurance: Concept, Purpose, and Types:

Learning objective:

Introduce reinsurance, its types, how it works, and its benefits.

Reinsurance is a technical process between insurance and reinsurance companies under which the insurance company (the insurer) transfers liabilities completely or partially to the reinsurance company (reinsurer) for a premium (Fee). The insurance company will be in this situation as the insured regarding the reinsurance company. But it remains the insurer for policyholders. The reinsurer is the insurer for the insurance company. This process is practiced by insurance companies.

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".

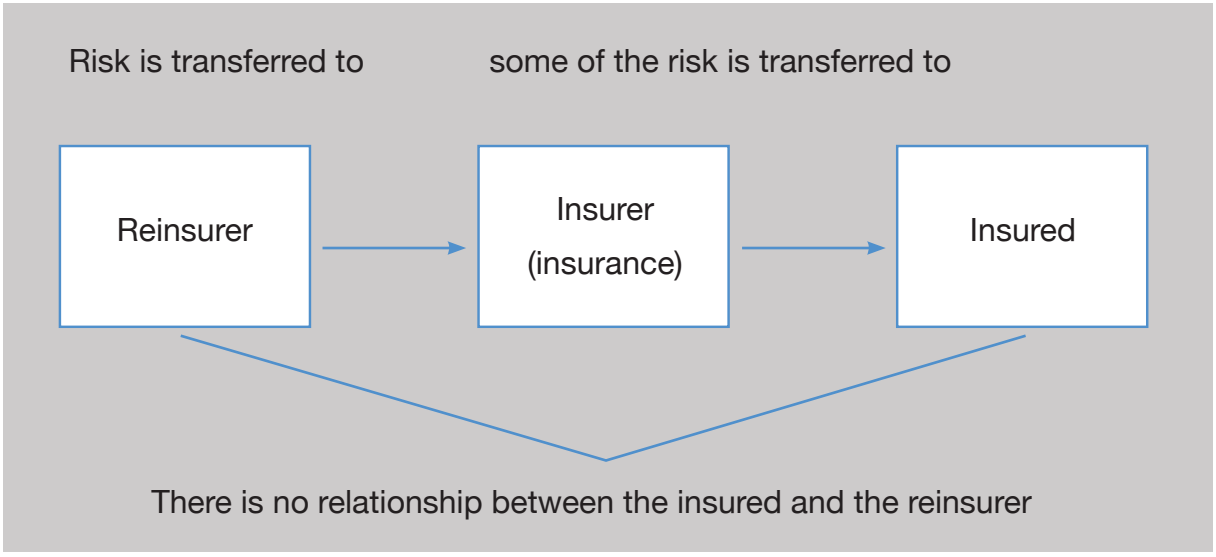
As for reinsurance, the Implementing Regulations define the term as "Transfer of the insured's risk from the insurer to the reinsurer. and to indemnify the insurer by the reinsurer for any payments made to the insured against damages or loss"

Question:

A client, who already has several large policies, offers an insurer to buy a new insurance. But it considers the risk too large or too hazardous to accept. So it decided to reject that insurance 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.



Question:

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

Reasons that cause insurance companies to seek reinsurance:

1) Capacity: Each insurer has a financially limited absorptive capacity in relation to the magnitude of risk it can accept, while the reinsurance helps to increase such capacity.

2) Stability: The reinsurance helps insurance companies to avoid extreme fluctuations in the cost and number of losses between one year and another and during the same year.

3) Reassurance and confidence: The insured eliminates uncertainty and enjoys psychological comfort and confidence, which motivates him/her to expand business and subscribe to new types of insurance.

4) Disaster Protection: When the insurance company suffers huge losses, it is exposed to financial problems, and the reinsurance helps it avoids such problems by transferring part of the risk to the reinsurer.

5) Apportionment of Risks: Reinsurance is a mechanism for transferring risk, where the

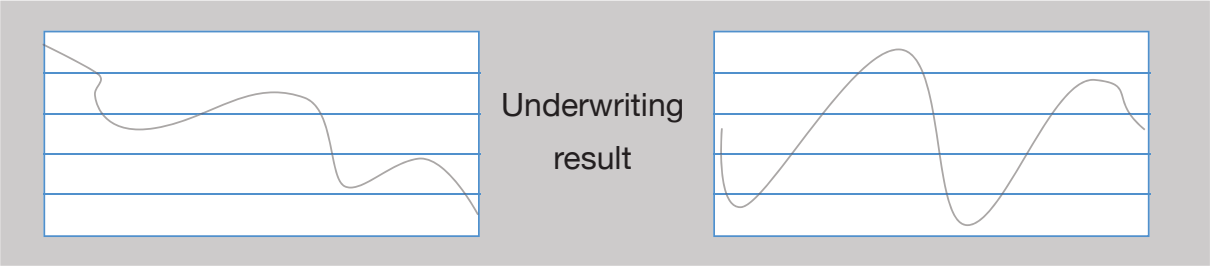
burden of losses that may be suffered by the country's economy is distributed to reinsurers in various regions of the world.

• **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 - claims equals underwriting result) and the loss ratio (claims + premium) are stable each year.



1.6.1 Types of Reinsurance

Reinsurance Contracts are divided into two types: Facultative Reinsurance and Treaty Reinsurance

A. Facultative Reinsurance:

This word is of French origin, meaning "optional", or "on request". In the Arabic language, it means voluntary choice, indicating that each party has the freedom and choice in discussing the terms of reinsurance policy in terms of the amount of risks it covers, the value of insurance premium, how losses are shared, and any conditions that each party wants to set. It is considered one of the best methods to be followed in certain areas of insurance (for example, aviation insurance) and any cases where the amount of insurance exceeds the capacity of the available agreements. This type of reinsurance is discussed separately for each reinsurance policy, and the reinsurer has the right to accept or reject any transaction. This means that the insurance company has to contact the reinsurer and give it details of the original risk (with all the substantial facts about the risk). If the reinsurer refuses, or if its conditions are unacceptable, the insurance company has to find another reinsurer. This type of agreements is used in the absence of many regular transactions that require making recurrent agreements with reinsurers.

The Implementing Regulations of the Cooperative Insurance Companies Control Law in the Kingdom define facultative reinsurance as "An optional case-by-case method of reinsurance. The reinsurer has the option to accept or neglect the offered risks".

Although a professional reinsurance broker could be helpful, it is still time consuming and the administrative cost is high, and there is always uncertainty that reinsurance is made on acceptable terms.

facultative reinsurance may be necessary when:

- There is no room in the agreement to add new risks.
- The risk is outside the terms of the agreement.
- The risk is unusual.

Question:

Why do you think that delays and uncertainty cause problems for the insurance company?

B.Treaty Reinsurance

Treaty reinsurance is an agreement between insurers and reinsurers. Under this agreement, reinsurers are obligated to accept all risks, within the limits specified in the agreement. The agreements are signed for one year, after which they can be renewed with the consent of both parties. Under such agreement, the reinsurers agree in advance to accept the reinsurance requested by the insurers. The main benefit to insurers is that they know they have reinsurance protection, and they know the cost of such protection once they accept the insurance applied for by the customer.

The Implementing Regulations of the Cooperative Insurance Companies Control Law in the Kingdom define treaty reinsurance as "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.

Question:

The insurance company has an agreement with the reinsurer, whereby the reinsurer agrees to accept 25% of all fire insurance policies issued by the insurance company, but the reinsurer notices that the insurance company has accepted insurance with a certain condition that the reinsurer did not accept, so can the reinsurer refuse to accept the reinsurance Insurance? Give reasons for your answer?

Treaty reinsurance agreements are divided into two types: proportional reinsurance and non-proportional reinsurance.

A. Proportional reinsurance:

It means the insurer and reinsurer share the risk, premiums and claims, usually on a percentage basis of the total risk accepted by the reinsurance company. 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" Reinsurance agreements are divided on a proportional basis into two main types:

- Quota share Agreements:

Under this agreement, the insurance company assigns a specific percentage of all its insurance transactions from a specific department or branch to the reinsurer, and accordingly the reinsurer is obligated to accept coverage of insurance policies. In return, the reinsurer receives its share of the total premiums for all transactions that were agreed upon in the agreement. In the event of a loss, it shall pay its share of the damages and any expenses related to the damages.

For example, an insurance company assigns a percentage (70%) of the insurance amount for each pre-determined risk to a reinsurer, and it keeps (30%) for itself, and in the same percentage, the insurance premiums and expected losses in the future are divided. If we assume that the insurance company insures a risk for a car worth SAR 100,000 and the insurance premium is SAR 3,000, then this car suffered an accident and the amount of loss was SAR 50,000, then the insurance amount, insurance premium and loss are distributed between the insurance company and the reinsurer as follows:

Each party's share of the insurance amount is as follows:

The retention limit for the insurance company is 30% of the insurance amount = (30% x 100,000) = 30,000

The reinsurer's share of the insurance amount = (70% x 100,000) = 70 ,000

Each party's share of the premiums is as follows:

Retention limit for the insurance company from the premiums = 30% x 3000 = 900

The reinsurer's share of the premiums= 70% x 3000 = 2100

Each party's share of the losses:

Retention limit for the insurance company from losses = 30% x 50000 = 15000

The reinsurer's share of the premiums= 70% x 50000 = 35000

- Surplus share Agreements:

Based on this type of agreement, the insurance company retains a specific amount for

each risk (called the retention limit, and is always a single limit) and transfers the rest to the reinsurer with an agreed maximum limit. This means that the insurance company reinsures only the risks that it does not want to keep for itself. This means that no part of any risk with an insurance amount that does not exceed the retention limit, is reinsured. For example, the reinsurance agreement extends to several times such limit(s), so the scope of surplus share agreement can be equal to 3 limits, i.e. the insurance company can reinsure the remaining portion of the sum insured that exceeds the retention limit with a maximum of 3 times such retention limit. In case the number of limits exceeds the agreement's scope, the insurance company solely bears the responsibility for such risks as well as any associated losses. Further, the company is entitled to premiums against such additional limits.

Example:

An insurance company has signed with a reinsurer a surplus share agreement of 5 limits (4+1) that covers a certain risk i.e. the amount of retention per limit is SAR 1 million. In such case, no insurance amount of more than SAR 5 million to be entrusted to the reinsurer, i.e. the insurance company can accept any risk whose maximum limit (insurance amount) equals SAR 5 million.

Suppose the insurance company insures a risk of SAR 1 million or less. In this case, the reinsurance company will not participate in any premiums or any losses that will occur in the future, because the value of the sum insured is less than the limit.

However, suppose that the sum insured amounted to SAR 4 million, the premium amounted to SAR 100,000, and a loss of SAR 800,000 occurred, then, the sum insured, premium and losses shall be distributed as follows:

The premium and loss shall be divided between the insurance company and the reinsurer in a ratio of 4:1

Insurance company's share (assigned company) = 1/4 = 25%

Reinsurer's share = 3/4 = 75%

Each party's share of the insurance amount is as follows:

The retention limit of the insurance company is 25% of the sum insured = (25% x 4,000,000) = 1,000,000

And the reinsurer's share of the sum insured = (75% x 4,000,000) = 3,000,000

Each party's share of the premiums is as follows:

Retention limit of the assigned company from the premiums = 25% x 100000 = 25000

And the reinsurer's share of the premium amount = 75% x 100,000 = 75,000

Each party's share of the losses:

Retention limit of the assigned company from losses = 25% x 800,000 = 200,000

And the reinsurer's share of the premium amount = 75% x 800,000 = 600,000

B. Non-Proportional Reinsurance:

This type of reinsurance is based on the insurance company determining its share of potential losses, not on the share it seeks to retain from insurance value. In addition, the reinsurance company bears any loss that exceeds the agreed limit. This type of agreement does not depend on a percentage for distribution of sums insured, premiums, and any future losses that occur. Therefore, it is called non-proportional reinsurance.

The premium that must be paid by the insurance company to the reinsurance company is determined to cover the expected losses and expenses paid. For example, a reinsurance policy issued with 10M SR excess only requires reinsurers to contribute when a loss exceeds this amount. and if the loss is less than SAR 10 million, the insurer will bear the entire loss.

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"

Question:

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?

Question:

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?

1.7 Co-Insurance and Self-Insurance:

Learning objective:

Introduce the conditions of co-insurance and how it differs from self-insurance.

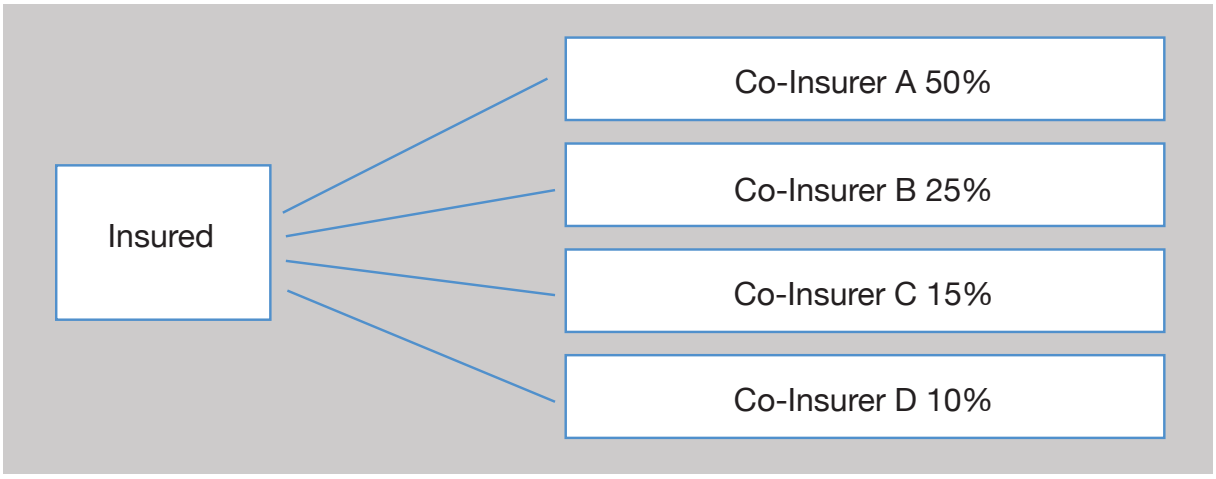
1.7.1 Co-Insurance:

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) 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).



Question:

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?

1.7.2 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 allocation of a regular balance, to meet the expected losses of the risk to be insured instead of serving 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.

Question:

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?

Question:

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

1.8 Insurance Benefits

Learning objective:

Introducing the importance of insurance industry, and its benefits at all fronts.

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 through insurable risks. Additional benefits regarding individual and society 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 Reduction:

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 of a business are usually the security for investors who would be reluctant to invest if insurance was not available (as it provides protection). A fire could easily make a business unprofitable due to the losses it may cause. 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, 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: Profits generated from tourism 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 insurance companies, insurance or reinsurance companies, or markets of the insurance industry: As insurance service providers in hospitals, medical centers, vehicle maintenance centers, or companies providing tools and public safety and other equipment.

Revision questions:

Answer the following questions, and check your answer in the corresponding section:

1. In order for the risk to be insurable, it has to have the following characteristics?
   Answer reference: Section 1.2.4

2. Causes that make the risk uninsurable?
   Answer reference: Section 1.2.5

3. What are the characteristics of insurable risks?
   Answer reference: Section 1.2.4

4. Law of large numbers helps the insurance companies in determining?
   Answer reference: Section 1.2.5

5. The purpose of reinsurance?
   Answer reference: Section 1.6

6. Types of insurance contract?
   Answer reference: Section 1.6.1

7. What is meant by co-insurance, and self-insurance?
   Answer reference: Section 1.7

Chapter Two

The Nature of the Insurance Sector in the Kingdom of Saudi Arabia

This part of book accounts for approximately 20 of the 100 questions of the exam..

2 - Introduction:

National economies vary, from free market economies, to command (state-controlled) economies. However, even in the most open free market economies, governments see it necessary to monitor and regulate their insurance industry.

Insurance companies attract huge sums of money (ranging from $50 billion to $200 billion), Such companies are entrusted with such funds. Therefore, it must be monitored and regulated to ensure that funds of shareholders and the insured are secured, as well as to prevent insurance companies from using funds at unsecured risks, under the pretext of investment.

Chapter Two

2.1 Objectives of Monitoring and Regulating the Insurance Industry:

Learning Objective

Understanding supervision and oversight of insurance industry, objectives of industry regulation, in addition to opening of market to investors.

The main objectives of insurance regulation throughout history are always as follows:

• Maintaining the financial solvency of insurance companies, and their ability to meet their long-term obligations towards their policyholders, and to pay claims.

• Ensuring fair dealing by insurance companies and brokers towards current and future policyholders and insurance beneficiaries.

• The need to make certain types of insurance compulsory as a means of achieving broad protection for all segments of society.

In this Module, we will begin by looking at the historical background of the insurance system in Saudi Arabia, the importance of government oversight of insurance industry, why certain types of insurance are required, and how such issues are dealt with in Saudi Arabia.

2.1.1 The Need for the Insurance Industry to be Regulated and Monitored:

Customers buy insurance to protect themselves against the generally small possibility of a heavy loss, so that the risk is actually transferred to the insurance company. The insurance company, in turn, distributes the risk attributed thereto to the large pool of its

policyholders, using capital reserves, so as to bear any compensatory costs for policyholders who may incur an unforeseen loss.

2.2 Historical Background of Insurance Industry in KSA:

The Cooperative Insurance Companies Control Law in KSA, issued by virtue of Royal Decree No. M/32, on August 01, 2003 is the first Saudi legislation regarding governmental supervision of insurance. Prior to the issuance of such Law, there were more than 75 insurance companies operating in KSA until the Saudi insurance market became the most regulated insurance market across the region.

In 1405 AH (1985 AD), the National Cooperative Insurance Company was established (Currently: Cooperative Insurance Company "Tawuniya") under Royal Decree as a joint stock company; At that time, the founding shareholders were the Public Investment Fund, the Pension Fund, and the General Organization for Social Insurance. Its establishment came in response to the urgent need for an insurance company in the Kingdom of Saudi Arabia, operating on the principle of cooperative insurance as alternative to commercial insurance.

In accordance with Tawuniya's AoA, the company had to manage two separate main accounts, the first for its policyholders, and the second for its stockholders. Accordingly, Tawuniya combines mutual insurance (which is fully owned by policyholders, and not traded in stock market), and commercial insurance.

2.3 Key Reasons behind Regulating Insurance Sector:

A. Mandatory Medical Insurance.

For several years prior to regulation of insurance sector, healthcare in Saudi Arabia was free for both Saudi citizens and foreign residents alike; and since there are about more than six million foreign workers and their dependents in Saudi Arabia, this clearly placed a significant burden on the healthcare sector in KSA, as well as its economy as a whole. In order to mitigate the issue, the government issued the Cooperative Health Insurance Law by virtue of Royal Decree No. (71) dated 27/04/1420 AH (August 13, 1999 AD), which obliges employers to provide private health insurance to their foreign employees and their families. Such Law stipulated in its first Article "This Law aims at providing and regulating health care to non-Saudi residents of the Kingdom. It may be applied to Saudi citizens and others pursuant to a resolution by the Council of Ministers.". The second Article also stipulates that "The cooperative health insurance coverage shall include all

individuals to whom this Law applies and their family members". Further, third Article indicated that "A residence permit may not be granted or renewed except after obtaining the cooperative health insurance policy, provided that said policy covers the duration of the residence permit".

The expansion of state-owned insurance industry does not commensurate with general government policy that aims to promote and not to limit the contribution of private sector in Saudi economy as a whole. In addition, providing health insurance to about four or six million people in a relatively short period could exceed the capacity of one company.

B. Accession to the World Trade Organization.

The second main motive for regulating insurance in KSA was its insistence on joining the World Trade Organization, as the WTO Accession Agreement indicated in a section thereof the opening of KSA to its insurance market for foreign investment. In fact, such organization contributed to clarifying and diversifying opportunities in terms of ability to establish insurance companies licensed to both foreigners and Saudis.

Therefore, the Cooperative Insurance Companies Control Law was promulgated by virtue of Royal Decree No. M/32, dated 02/06/1424 AH (20/11/2003 AD). In conjunction with the issuance of the Law's Implementing Regulations under Minister of Finance's Resolution No. 1/596 dated 01/03/1425 AH (20/04/2004 AD), a new industry dawned in the Kingdom.

2.4 Insurance Regulation in the Kingdom of Saudi Arabia:

When KSA decided to expand the scope of insurance, it basically aimed to improve the service for general public to serve public interest, and to enable the Kingdom to deal with health insurance issue, as well as to open the market and fair treatment and to create equal opportunities for both foreign and local insurance companies in accordance with WTO agreements.

On Jumada II 1424 AH (July 30, 2003 AD), the Saudi Council of Ministers approved a milestone legislation to open Saudi insurance sector to foreign investment. The Cooperative Insurance Companies Control Law was issued on 02/06/1424 AH (November 20, 2003 AD). Therefore, the new Law was not actually effective until issuance of the Implementing Regulations as many details of such new legislation included in the Regulations.

The objective of the Law and Implementing Regulations is stated in Article (2) of such Regulations:

"Article 2"

The objective of the Law and its Implementing Regulations:

• Protecting the rights of the insured and investors.

• Encouraging fair and effective competition and providing better insurance services at appropriate prices and coverage.
• Promoting the stability of insurance market.
• Developing insurance sector in the Kingdom, including training and job localization.

The governmental body responsible for regulating and monitoring the Saudi insurance sector is the Saudi Central Bank, which, since its inception in 1376 AH (1957 AD), has proven its success and strictness as a regulator and observer of the Saudi banking sector. It has really managed to push the Saudi monetary ecosystem forward within the framework of current standards.

Insurance industry is concerned with rendering insurance services through many products designed by experts in providing coverage that protect individuals and institutions from interactive and participatory industries, meaning that they enter into relationships with many government and private agencies that carry out many tasks, roles and functions. We will address such relationships below:

2.5 Regulatory and Supervisory Bodies:

Learning Objective

Introducing the regulatory and supervisory authorities on KSA insurance sector and the role of each entity as well as its main tasks related to insurance sector.

2.5.1 The Saudi Central Bank (SAMA):

Established in 1952, also known as (SAMA), and is considered one of the most important bodies for banking and insurance sector across the region. The responsibility for the integrity of the banking system and its effectiveness in carrying out its duties towards the country in general and users of the system's services and its shareholders rests with the Saudi Central Bank (SAMA) in accordance with SAMA's Law issued by virtue of Royal Decree No. (M/36) of 1442 AH.

What concerns us here is the role of SAMA with regard to insurance industry with regard to SAMA's technical functions related to insurance activity, as SAMA specializes in monitoring cooperative insurance companies in the Kingdom, by carrying out the following:

• Preparing the Implementing Regulations for the Insurance Law in the Kingdom.
• Regulating the establishment of insurance and reinsurance companies in the Kingdom.
• Supervising technical aspects of the operations of insurance and reinsurance

companies.

• Licensing insurance companies wishing to operate in the Kingdom.

• Organizing the distribution of surplus share funds to policyholders and shareholders.

• Determine capital requirements and financial solvency of each type of insurance activity that companies request to practice.

• Regulating investments of insurance companies inside and outside the Kingdom.

• Indicating educational requirements and qualifications for employees of insurance companies, brokers and agents.

• Determining behavior of dealing, insurance sales and disclosure of information.

• Approving insurance products for insurance companies.

• Interpreting and enforcing contracts.

• Regulating mandatory insurance coverage standards.

• Regulating and supervising cooperative insurance companies, insurance-related liberal professions, loss adjusters, and actuaries.

The Cooperative Insurance Companies Control Law was issued by virtue of Royal Decree No. M/32 dated 02/06/1424 AH, followed by the issuance of its Implementing Regulations by the Minister of Finance's Resolution No. 1/596 dated 01/03/1425 AH. The main objective of such Law and its Implementing Regulations is to regulate the insurance sector in the Kingdom.

Immediately after the issuance of such Law and its Implementing Regulations, SAMA formed a team of supervisors to perform duties of supervision and control over insurance sector. Such team is currently working within a general department affiliated to SAMA, concerned with carrying out supervisory and supervisory tasks on insurance sector, called Insurance Supervision Department.

Since its inception, the Insurance Supervision Department has been protecting the insured and developing the market. The powers of such Department are as follows:

• Protecting the insured from unjustified financial losses and dishonest behavior across insurance sector.

• Promoting market transparency by obligating insurance companies to publish reliable and audited data to the public dealing with companies in such sector.

• Fostering, developing and growing the KSA insurance market, through innovating tools to do so, and spreading insurance awareness across the market.

• Ensuring stability of insurance industry to encourage investments in such sector, as well as in investment sector as a whole.

• Promoting and developing skills of labor force in insurance sector companies, including insurance specialists and supervisors in KSA.

SAMA's Insurance Supervision Department:

Insurance Supervision Department is the government agency that greatly assists in regulating the work of insurance sector, as one of the main active partners in history of insurance industry in the Kingdom of Saudi Arabia. The Department's aims stem from the objectives of Cooperative Insurance Companies Control Law and its Implementing Regulations, which are:

- Protecting the rights of policyholders and shareholders.
- Encouraging fair and effective competition and providing better insurance services at appropriate prices and covers.
- Promoting the stability of insurance market.
- Developing insurance sector in the Kingdom, including training and job localization.

We remind our honorable readers that for the purpose of preparing this book, a large number of bylaws, regulations and decisions have been issued that regulate the work of sector. In addition, we will address such regulations here, and for further clarification visit SAMA's website at: www.sama.gov.sa.

We note from such regulations that they regulate most of work areas of insurance companies and free insurance professions as mentioned later.

2.5.2 Council of Cooperative Health Insurance (CCHI):

CCHI is a Saudi governmental body with an independent legal authority established under Article (4) of Cabinet Resolution No. (71) dated 27/04/1420 AH (11/08/1999 AD), which provides for the establishment of the Cooperative Health Insurance Council to oversee the implementation of the Cooperative Health Insurance Law, which aims to provide and organize healthcare for all workers in the private sector. CCHI's Board of Directors is chaired by His Excellency the Minister of Health and membered by some local government ministries.

2.5.3 The General Secretariat of the Council of Cooperative Health Insurance:

It represents CCHI's executive body. Its tasks are to prepare and implement policies and executive procedures and direct supervision of health insurance, including continuous technical and medical follow-up for all those concerned with the Law as well as to foster protection of policyholders' rights.

The General Secretariat is exerting great and multiple efforts in cooperative health insurance industry, with a view to achieving objectives of the Law with key partners in insurance relationship from approved health service providers, qualified insurance companies and policyholders, including:

• Accreditation of Healthcare Providers: Health care providers are one of the three parties to insurance relationship entrusted with providing health care services to policyholders who contract with insurance CCHI-qualified companies. Healthcare providers are classified into hospitals/ day surgery centers/ polyclinics/ clinics/ single-doctor clinics/ diagnostic center/ physiotherapy center/ labs/ pharmacies/ hardware and prosthetic stores/ eyeglasses stores. CCHI General Secretariat accredits health facilities in public and private sectors wishing to work under its umbrella after ensuring they meet accreditation requirements and have qualified staff as well as appropriate administrative and technical capabilities to deal professionally with qualified insurance companies. Therefore, the nature of such relationship necessitates that service providers or health facilities must meet a set of required criteria in order to handle its properly in such insurance relationship.

• Renewal of Accreditation of Healthcare Facilities: Renewing healthcare facility accreditation comes as a control step with a regulatory role, and is one of the basic tools for maintaining quality levels in healthcare facilities to ensure they perform the role entrusted thereto to the fullest extent. Accreditation of healthcare providers is renewed annually or every two or three years for some of categories, after they fulfill accreditation renewal requirements, as an extension of the previous accreditation.

- Qualification of Health Insurance Companies: To enter health insurance market, insurance companies must obtain a permit from SAMA, and then be qualified to practice cooperative health insurance by CCHI. Thus, health insurance companies manage benefits covered within cooperative health insurance policy. CCHI's General Secretariat prepares action plans necessary to rehabilitate and follow up the work of such companies according to implementation stages, activate coordination with concerned authorities, and form committees/work teams that serve purposes of implementation. CCHI has obligated insurance companies that provide health insurance to:

• Carrying out its duties towards its clients by providing appropriate insurance coverage; as it is directly responsible to policyholders (Employer) since entry into force of insurance policy signed with the client.

• Uploading names of policyholders to National Network of Cooperative Health Insurance System within 48 hours.

• Issuing insurance cards to policyholders within (5) working days at most from date of policy validity and handing it over to the client, while insurance company remains responsible for any claims that may arise since policy issuance. Starting from January 1, 2020, CCHI issued a decision stating that: Policyholders no longer need to present health insurance company's card when visiting healthcare providers, as the citizen's personal ID and the resident's permit are sufficient as basic IDs for policyholders.

• The insurance company must quickly grant approvals to provide treatment to beneficiaries to service providers within (60) minutes.

• Settling service provider claims as quickly as possible within (60) days, so that service provider can render appropriate and effective treatment services to insurance company's clients.

• Committing to provide healthcare services to policyholders by concluding health service contracts with CCHI-approved service providers.

• Providing beneficiaries at start of insurance coverage with explanatory brochures that include the policy, scope and limits of coverage, as well as network of approved service providers.

• Informing network of approved service providers that policyholder has joined insurance coverage in a way that suits needs of beneficiaries and their work locations, so that they do not have to receive service from a service provider outside such network.

• Committing to establish a unit to accept and handle complaints received from beneficiaries.

• Adhering to minimum benefits of Unified Cooperative Health Insurance Policy.

• There is a Qualification Department for insurance companies that qualifies such companies to engage in cooperative health insurance business, and qualifies health insurance claims management companies to engage in such insurance claims management. The Department supervises and monitors performance of companies to ensure they carry out their business in accordance with the Cooperative Health Insurance Law, its Implementing Regulations as well as its Unified Policy.

2.5.4 Capital Market Authority (CMA):

Since all insurance companies according to the Law must be public joint stock companies, they must offer part of their shares to public citizens at a rate of 40% of the company's capital value. Since the body responsible for such offering is CMA, the reader should be familiar with as CMA is one of the main participants in KSA insurance market.

KSA financial market arose with unofficial beginnings in 1950s of the last century, and such situation remained until the government laid down basic regulations of the market in 1980s. Further, in accordance with the "Capital Market Law" issued by virtue of Royal Decree No. (M/30) dated 02/06/1424 AH, CMA was established, a governmental body with financial and administrative independence and is directly reporting to the Council of Ministers.

• **CMA's Tasks**

CMA supervises the regulation and development of the financial market, and issue

necessary regulations, rules, and instructions for implementing the provisions of Capital Market Law so as to realize an appropriate climate for investment in the market, foster confidence therein, ensure appropriate disclosure and transparency of joint stock companies listed in the market, as well as to protect investors and securities dealers from illegitimate business in the market.

A. CMA's key responsibilities:

• Sending a deadline reminder for submitting application by e-mail.

• Receiving financial forms on a monthly, quarterly and annual basis.

• Ensuring accuracy and integrity of data collected.

• Calculating relevant ratios to study performance and trends.

• Issuing market reports at sector and corporate level.

• Checking solvency problems of companies (Definitely an important activity for insurance industry, since solvency is a key issue facing insurance companies).

B. CMA's Powers:

CMA has the following powers:

• Organizing and developing the financial market, and innovating and developing methods of bodies and entities working in trade of securities.

• Protecting investors from unfair and improper practices involving fraud, deception, scamming, manipulation, or insider trading.

• Working to achieve fairness, efficiency and transparency in securities transactions.

• Developing controls that limit risks associated with securities transactions.

• Fostering, organizing and monitoring issuance and trading of securities.

• Regulating and monitoring entities' activities subject to CMA supervision.

• Organizing and controlling disclosure of information related to securities and issuers thereof.

• CMA seeks to protect investors and achieve fairness, adequacy and transparency in trading by discovering actions and behaviors involving manipulation and deception. Regarding market rise and fall, it is a matter depend on supply and demand only.

• CMA sets controls and instructions regulating advertisements of insurance companies listed on Saudi Stock Exchange (Tadawul), by which such companies must abide when broadcasting any ads on Tadawul website. The responsibility of ads and its contents rests with the company. Further, CMA also investigates cases of electronic violations, calling and interrogating violators, and hearing statements of witnesses in violations of securities activities that occur through websites and forums, or through mobile phone messages, or through audio and visual media e.g. Providing advice to investors on issuance of recommendations or managing investment portfolios, without a CMA license.

CMA tasks can be summarized as follows:

• Investigating cases of e-violations referred to CMA by Electronic Control Unit (ECU) after taking control procedures and collecting necessary evidence by ECU.

• Requesting information or records that CMA deems necessary to complete investigation procedures in e-violations from relevant authorities. Calling and interrogating violators, and hearing statements of witnesses.

• Coordinating with relevant authorities to limit such violations.

• CMA also monitors publication of financial statements and reports issued by the listed companies to ensure their compliance with CMA's requirements and regulations in terms of timing of publication and information included therein.

• Further, CMA specified periods during which a company must publish its financial statements, which are:

• Announcing the annual financial statements as soon as they are approved within a period not exceeding forty working days from the end of the annual financial period covered by such statements. Announcing the quarterly financial statements as soon as they are approved within a period not exceeding fifteen working days from the end of the financial period covered by such statements.

2.5.5 Ministry of Commerce (MC):

MC is looking forward to serving the public and companies, including insurance companies, and simplifying service procedures by various available means. Therefore, MC managed to realize a set of e-services and render integrated interactive services that facilitate the way for final beneficiaries to complete their applications entirely from any city without visiting MC premises. Further, MC provides verification services directed to business sector and government agencies, as well as follow-up services that help track applications through the easiest and fastest means e.g. mobile phone, in addition to some inquiry services.

For every e-service available on the Portal, MC defines an approved time for its implementation. Such time is clearly mentioned on e-service page, and the applicant can, in case of delay in implementation, contact CRM center directly to object.

Commercial Register (CR) of any insurance company or even free insurance professions is one of the services provided by MC to insurance company. This is because obtaining a commercial register for a company is a prerequisite for obtaining insurance business licenses from SAMA.

Accordingly, any licensed insurance company must be subject to the Companies Law issued by MC, which regulates relationship between all shareholders constituting as a

joint stock company first before being an insurance company. In addition, obtaining a CR goes basically through legal procedures.

CR shows the company's trade name, names of Board members, general manager, company's capital, and nature of activity intended to be practiced. It is noteworthy that CR number is one of reference numbers for many private transactions especially with official authorities, and CR validity is an important evidence of the company's continuity of business. The company must inform MC of any amendments to the partnership contract that could fundamentally change such contract.

A new Companies Law was issued in 1437 AH/ 2015 AD that includes many articles related to joint stock companies in the financial market, and considering that all insurance companies in KSA are public joint stock companies, they must abide by the provisions of such Law.

2.5.6 Ministry of Investment (MISA):

MISA was established by the Saudi government on April 10, 2000 AD. MISA is responsible for managing investment environment in the Kingdom of Saudi Arabia. MISA works under directives of KSA's government and provides services and facilities to investors to improve investment climate and promote KSA's economic development as well. Further, MISA acts as key player for fostering local investments and facilitating the exchange of best practices between public and private sectors as well as insurance sector. MISA serves as a mediator between global business community and Saudi government, its ministries and departments, and also aims to contribute to realize an advanced economic policy based on study and strategic research.

MISA is the authority responsible for managing and supervising investment environment for foreign investors in KSA, as well as controlling insurance companies involving non-Saudi investors.

MISA's role is as follows:

• Act as an investment gateway to the Kingdom and a first channel for initiation of investment.

• Providing efficient, effective and appropriate support to investors, including assistance upon arrival to KSA, visa issuance, freight forwarding, and customs clearance.

• Work with government partners e.g. National Industrial Clusters Development Programme (NICDP).

• Coordinate with other government institutions, stakeholders and suppliers, e.g. law firms, banks, analysts, and insurance companies.

• Monitor the Kingdom's ability to attract investments to investors and raise such

activities to higher levels, through the National Competitiveness Center (NCC).

MISA Key Tasks in Insurance Fields and Activities:

• Protecting rights of policyholders and beneficiaries (for investors).

• Ensuring realization of insurance-related economic and social objectives and preservation of national savings.

• Ensuring integrity of financial positions of insurance market units, coordinating and preventing conflict between such units.

• Participating in development of insurance awareness across KSA.

• Supporting insurance market and driving its development.

• Promoting insurance professions and effectively contributing to provision of expertise.

MISA's Role in Supervising and Controlling Insurance Business:

• Registering non-Saudi establishments and persons practicing insurance business.

• To conduct any insurance-related business, the Law requires registration with MISA to monitor such business.

Such business include:

• Insurance or reinsurance companies.

• Insurance broker companies.

• Insurance actuaries.

• Insurance consultants.

• Inspection and damage assessment experts.

• Auditors of insurance companies' accounts through the unit controlling the work quality of auditors registered in MISA's records.

• Determining capital requirements necessary for registering and licensing insurance company to practice such business.

• Limiting investment to types of investment specified for companies under the Law.

• Fulfilling certain conditions in those leading management of insurance companies for investors.

Thus, we see how important MISA is; This is because MISA is one of the main gates for foreign investors in insurance sector. Further, MISA's role as always is to monitor and supervise such investors throughout their business journey.

2.5.7 Chamber of Commerce and Industry:

Every registered and licensed insurance company must be affiliated with the Chamber of Commerce in the city in which it is licensed, as the Chamber of Commerce and Industry is one of the non-governmental agencies that regulate support, supervision and follow-up of the private sector, including insurance companies and free insurance

professions, as such chambers is the main representative of this sector in the Saudi economy. Further, Saudi chambers, through their various activities, work to support the private sector, provide its requirements, and lay foundations for developing its role in economic activity, whether directly or indirectly, through coordination with the concerned authorities. Since the environment of Saudi private sector is dominated by small and medium enterprises (This activity falls under most insurance professions companies), which is illustrated by looking at the percentage of such establishments, which ranges between 80% - 90% of the total affiliates of each chamber, it was necessary for each chamber to provide all possible means of support to such facilities. However, by observing the size and diversity of such support, it becomes clear how big is the variation between such chambers according to capabilities and expertise of each chamber. Moreover, the three main chambers (Riyadh, Jeddah, Asharqia) have a greater interest in such facilities to the extent of establishing specialized centers for SMEs to embody and coordinate the efforts made in each chamber, and inter se, to utilize all successful means to support and develop such enterprises. Other chambers are seeking to keep pace with such trends to unify and coordinate the support pillars of such facilities, while we find that some chambers are still exploring areas of support they can provide to such facilities. We will shed some light on prominent efforts made by Saudi Chambers of Commerce and Industry to support and develop SMEs role in national economy, based on data presented in such regard in the periodic coordination meetings of the Council of Chambers.

A. Competence of Chambers of Commerce and Industry:

Such chambers are responsible for the following:

• Collecting and publishing all information and statistics related to trade and industry.

• Conducting studies and research related to trade, industry and insurance.

• Providing government agencies and companies with data and information on commercial and industrial matters.

• Providing suggestions on protecting national trade and industry from foreign competition.

• Informing traders and manufacturers of regulations, decisions and instructions that affect commercial and industrial matters.

• Guiding traders and manufacturers to key economies from which they import or export their goods, as well as the path of developing trade and industry.

• Gathering and discussing issues of traders and manufacturers in preparation for submission to the competent governmental authorities.

• Resolving commercial and industrial disputes by arbitration if parties to dispute agree to refer so to such bodies.

• Informing traders and manufacturers of new investment opportunities in commercial

and industrial fields through coordination with the competent authorities.

• Encouraging and urging merchants and manufacturers to benefit from local and foreign expertise houses, and foster investments in joint ventures to contribute to development realization.

Among key articles related to business of insurance companies within competencies of Chamber of Commerce:

Article (8): The Chambers of Commerce and Industry shall issue and certify the certificates, submissions and documents specified by resolution from the Minister of Commerce, in return for a fee to be determined by the Minister of Commerce.

2.5.8 Ministry of Human Resources and Social Development (HRSD):

HRSD's overall objective is to regulate the use of manpower through enforcing the Labor Law, planning and developing human resources, and settling labor disputes in the private sector, including insurance sector.

HRSD places emphasis on obligating all private sector-owned institutions and companies to apply cooperative health insurance to Saudis working for it as well as their families. HRSD also underlines the activation of labor offices' supervisory role to apprehend violators, submit immediate reports on compliance of such companies and institutions with HRSD's decisions regarding application of cooperative health insurance to all Saudis working in the private sector and their family members. Further, HRSD focus on obligating private companies and institutions to conclude health insurance contracts for all their Saudi employees. HRSD also informs all labor offices to follow up and monitor any facility not responding to such regulation.

HRSD also encourages citizens working in the private sector to visit the nearest labor office to report companies and institutions not considering their coverage within the Cooperative Health Insurance Law, so that such offices can take necessary action against violators and oblige such companies to adjust.

According to Article (14) of KSA's Cooperative Health Insurance Law, "If an employer does not subscribe to the cooperative health insurance, or fails to pay premiums for a worker, subject to this Law, and his family members who are covered by the cooperative health insurance policy, the employer shall be obligated to pay all due premiums, in addition to a fine not exceeding the amount of the annual subscription for each individual and the possibility of denying him, permanently or temporarily, the right to recruit expatriate workers."

A. HRSD General Tasks:

• Drawing up the general policy for labor affairs in KSA within the scope of KSA general policy subject to Islamic principles and social justice, so as to realize full employment, provide stable and remunerative job opportunities for citizens, establish conditions and labor relations to increase production, improve living standards, and consolidate human relations between employers.

• Researching and studying labor issues and problems within the framework of economic and social development plans and projects in partnership with the competent authorities in the Kingdom.

• Laying out plans and policies related to employment of Saudis and saudization of jobs in private sector establishments in light of the provisions of Labor Law, Cabinet Resolution No. (50) dated 04/21/1415 AH, and other decisions and instructions in such regard.

• Supervising recruitment and transfer of services and use of manpower, licensing them to work for private sector establishments, and issuing licenses for private recruitment offices.

• Developing policies related to labor inspection, monitoring implementation of Labor Law as well as guiding employers to requirements of the Law.

• Establishing a database for KSA labor market that includes data of workers in the private sector, whether Saudis or non-Saudis.

• Researching and proposing means leading to creation and coordination of distribution of social services to workers, supervising their implementation, publishing their means, and preparing laws, regulations, services and decisions for implementation thereof.

• Following up implementation of projects and programs related to labor affairs, and striving to realize common objectives in this regard, in cooperation with the competent state agencies, taking into account the competencies and powers vested in each body.

• Preparing and implementing labor statistical research and publishing its results in agreement with the General Authority for Statistics.

• Tracking and evaluating implemented plans, projects and programs in relation to labor affairs and preparing reports and data related thereto.

• Examining means of regulating relations with Arab and foreign countries, international organizations, and Arab and international regional bodies with regard to labor affairs, including exchanging expertise, information and specialized experts, sending missions and taking procedures for concluding agreements achieved for such purpose within the scope of KSA's general policy after referring to the competent authorities.

•Organizing participation in regional, Arab and international conferences and seminars related to its fields of competence, and preparing for holding such international conferences in agreement with the competent authorities.

2.5.9 Other Governmental and Regulatory Bodies:

As mentioned above, insurance sector is part of an integrated institutional and economic system whose work intersects with many regulatory, supervisory and governmental authorities. We have previously mentioned the most important of these bodies, but there are some parties related to insurance sector, but with fewer roles, including: The General Department of Traffic, Civil Defense, municipalities, some specialized committees e.g. the Public Transport Authority and others.

2.6 Cooperative Insurance and Reinsurance Companies:

Learning Objective:

Introducing to licensed insurance and reinsurance companies operating in Saudi market and requirements for obtaining a license

Insurance and reinsurance companies are among the key players in insurance industry in the Kingdom of Saudi Arabia. Since regulatory and supervisory authorities, especially SAMA, within their tasks and competencies, have set bylaws and regulations for how to license and establish insurance and reinsurance companies, a number of insurance companies have been licensed after going through the following steps:

Submit a license application to SAMA, including the following:

- Application or form for license application.
- Articles of Association.
- Bylaws
- Organizational structure
- Economic feasibility study.

Submit a five-year business plan that includes the following:

- Branches of insurance in which the company intends to operate.
- Ability to reinsure products to be reinsured.
- Product marketing plan.
- Expected expenses to start activity and financial sources needed for financing.
- Expected growth rates of activity, taking into account solvency margin.
- Expected number of employees, and plan for hiring and qualifying Saudis.
- Annual costs based on projected growth rates.
- Estimated financial statements linked to growth forecasts.
- A statement of technical bases of insurance operations and a certificate from actuaries.

• Company's branch opening plan.

• An irrevocable bank guarantee in an amount equal to the required capital issued in favor of the institution by a local bank, automatically renewed until the company's capital is fully paid.

Since insurance companies fulfilled such requirements for SAMA, companies have been legally licensed after going through such steps.

As of the date of preparing this Book, the following insurance companies have been licensed:

2.6.1 The following cooperative insurance companies have been licensed (Until the date of editing this material):

Sr.	Company Name
1	The Company for Cooperative Insurance (Tawuniya)
2	The Mediterranean and Gulf Cooperative Insurance and Reinsurance Company (MEDGULF)
3	Malath Cooperative Insurance Co.
4	Saudi Arabian Cooperative Insurance Company (SAICO)
5	Al-Ahli Takaful Company (ATC)
6	SABB Takaful Co.
7	Arabian Shield Cooperative Insurance Company
8	Salama Cooperative Insurance Company
9	Gulf Union National Cooperative Insurance Co.
10	Allianz Saudi Fransi Cooperative Insurance Company
11	Trade Union Cooperative Insurance & Reinsurance Company (TUCI)
12	Al Sagr Cooperative Insurance Company
13	Arabia Insurance Cooperative Company (AICC)
14	Walaa Cooperative Insurance Company
15	Bupa Arabia for Cooperative Insurance Company (Bupa Arabia)
16	United Cooperative Assurance Co.
17	Allied Cooperative Insurance Group (ACIG)
18	Al-Rajhi Company for Cooperative Insurance (Al-Rajhi Takaful)
19	Chubb Arabia Cooperative Insurance Company
20	Al Alamiya for Cooperative Insurance Co.
21	AXA Cooperative Insurance Company
22	Gulf General Cooperative Insurance Company

23	Buruj Cooperative Insurance Co.
24	Wataniya Insurance Co.
25	Amana Cooperative Insurance Company (Amanah)
26	Alinma Tokio Marine Company (ATMC)
27	Aljazira Takaful Ta'awuni Company
28	Saudi Enaya Cooperative Insurance Company

2.6.2 Saudi Reinsurance Company (Saudi Re):

There is only one company engaged in cooperative reinsurance business (Until the date of this material), namely the Saudi Reinsurance Company (Saudi Re).

2.7 Advantages of Insurance Companies in KSA:

Learning objective

Introducing characteristics and privileges of insurance companies in the Kingdom of Saudi Arabia.

Here, we provide some notes to the reader about licensed insurance companies as the main pillar in KSA:

• All of such companies are licensed by SAMA, therefore, they are allowed to subscribe to insurance products that provide insurance needs of individuals and institutions.

• All of such companies are registered with the Ministry of Commerce, subject to the Companies Law to guarantee shareholders' rights.

• All of such companies operate under cooperative system, and no licensed insurance company is allowed to operate except in cooperative insurance.

• All such companies adhere to the minimum permissible capital of insurance companies, which is SAR 100 million.

• All of such companies are public joint-stock companies, and a large part of Saudis are shareholders therein.

• All such companies are under SAMA's oversight and supervision, which provides protection for insurance companies and policyholders.

• All of such companies are subject to the so-called good governance, which requires disclosure of any data related to results and financial decisions or any decisions that may affect the company's legal or financial position.

• All of such companies are obligated to contract with rated reinsurance companies to guarantee policyholders' rights and maintain the company's position in terms of managing underwritten risks.

There are certain companies involving non-Saudi shareholders, therefore, they operate subject to MISA terms and conditions.

2 .8 Insurance Profession Companies and Practitioners:

Learning objective:

Introducing professions in insurance sector and licensees in Saudi market.

They are the main participants in insurance industry in KSA insurance market; This is because such professions are licensed by SAMA after involved practitioners submit an official application and fulfill all requirements for each insurance profession, so that they are licensed to practice any of such professions related to insurance or reinsurance business.

Surely, many insurance profession companies and practitioners obtained such license after going through the following licensing procedures:

Submit the license application form for insurance profession, accompanied by:

• Articles of Association
• Bylaws
• Organizational Structure
• Economic Feasibility Study

A three-year business plan that includes:

• Branches of insurance in which practitioner intend to conduct business.
• Expected expenses to start activity and financial sources needed for financing.
• Expected growth rates of business.
• Expected number of employees, and plan for hiring and qualifying Saudis.
• Estimated financial statements linked to growth forecasts.
• Branch opening plan.
• An irrevocable bank guarantee in an amount equal to the required capital issued in favor of the institution by a local bank, automatically renewed until the company's capital is fully paid.

As for insurance practitioner, i.e. natural persons licensed to practice any profession related to insurance or reinsurance business and work for self-employed professionals,

they must meet the following requirements to obtain SAMA's license:

• Holding a university degree with at least five years of insurance experience or a specialized insurance certification.

Passing the approved exam for required profession, or obtaining an equivalent qualification. After completing such stages and requirements, the self-employed professional must obtain an insurance policy that covers risks of professional liability for negligence, omission and fault.

2.8.1 First Insurance Profession: Insurance Brokers

An insurance broker is defined as a legal person who, in return for a fee, negotiates with insurance companies to complete insurance process for the benefit of policyholders. It is noteworthy that a company's minimum capital required to license an insurance broker is SAR 3 million. The Cooperative Insurance Companies Control Law prohibited insurance companies from dealing with any unlicensed broker, and this of course applies to all insurance self-employment professions.

The following insurance brokerage companies have been licensed (Until the date of editing this material):

Sr.	Company Name
1	National Insurance Brokers Company
2	Wajeef Insurance Brokerage Services Company
3	Solutions Insurance Broker Company
4	Insurance House Company
5	Global United Insurance Company
6	Ace Insurance & Reinsurance Brokers Ltd.
7	Green shield National Brokers Insurance and Reinsurance Ltd.
8	First Insurance Brokers Company
9	Al-Thunayan Insurance Brokers Company
10	Saudi Brokers
11	Arabian Marketing Services Company (AMS) Insurance & Reinsurance Brokers Company
12	Hazards Protection Insurance & Reinsurance Brokers (HPIB) Company
13	Al Aman Insurance & Reinsurance Brokers Company
14	Aon SpA Insurance & Reinsurance Brokers
15	Almostashar Insurance Broker Company
16	Marsh Insurance & Reinsurance Brokers Company

17	Insurance Brokerage House
18	Trust Insurance Brokers Company
19	Daman Insurance Company
20	ITTIHAD Insurance Brokers SA
21	Wasl Insurance Brokers Company
22	Al Mamoon Overseas Insurance Brokers Co. Ltd.
23	Elite Insurance & Reinsurance Brokers
24	Alkhadamat Altijaria Alarabia - Insurance Brokerage Company
25	NASCO Saudi Arabia - Insurance and Reinsurance Brokerage Company
26	Lonsdale & Associates - Insurance and Reinsurance Brokerage Company
27	Gulf Insurance Brokerage Company
28	Al Tayyar Insurance Broker Company
29	Al Yamama Insurance Brokers Company
30	Trust Brokers Insurance & Re-Insurance Brokerage
31	Aims Gulf Insurance Brokers
32	Waken Insurance Brokers
33	Independent Insurance Brokers
34	Al Bassami Insurance Broker Co.
35	Masarat Altameen for Insurance Brokerage
36	Authorized Policy Insurance Brokers
37	Broker Vision Insurance Company
38	Fenchurch Faris Insurance and Reinsurance Brokerage Company
39	Excellence Insurance Broker
40	Gulf Coverage Insurance Brokers Company
41	Yasser Mohamed Ahmad Bugshan Insurance Brokers Company
42	Marina Insurance and Reinsurance Brokerage Company
43	Saudi International Insurance Brokerage Company
44	Deraya Insurance Brokers Company
45	Arkan Insurance Brokers Company
46	Tawkol Insurance Broker Company
47	Esnad Insurance Brokerage Company
48	Alpha Lloyds Insurance Brokers LLC
49	Izar Insurance Brokerage Company
50	Grand Policy for Insurance & reinsurance Brokerage
51	Kingdom Brokerage for Insurance and Reinsurance
52	Chedid & Associates Saudi Arabia Insurance Brokerage Limited

53	Daam Insurance Brokerage Company
54	FAL insurance brokers company
55	Modern Insurance and Reinsurance Broker Company
56	Madarat Insurance Brokerage Company
57	Golden Nouran Insurance Brokerage Company
58	Prime Risk Insurance Brokerage Company
59	Future Vision Insurance & Reinsurance Brokerage Company
60	Mediterranean Insurance Brokers Company
61	Broker Care Insurance and Reinsurance Brokers Company
62	Etemad Insurance Brokerage Company
63	Diamond Policy Insurance Broker Company
64	Asian way Insurance Brokers and Reinsurance
65	Ameen Altameen Insurance Brokerage Company
66	StarCare Insurance Brokers Company
67	Namar Insurance Brokers Company
68	Laval Insurance Brokers Company
69	Alwasit Aldhahabi - Insurance Brokerage Company
70	Concord Insurance & Reinsurance Brokerage
71	Best Insurance Broker Company
72	Alballorat Company for Insurance Brokerage Services
73	Ofoq Insurance Broker Company
74	Andalusia Arabia Brokerage Company
75	ARTKOM International Insurance Brokers
76	Abdul Latif Jameel Insurance Brokerage Company Limited
77	Amin Insurance Brokerage Company
78	Takaful Emarat Insurance – Insurance Brokerage
79	Saudi Alliance Insurance Broker
80	Wathiqa Broker for Cooperative Insurance
81	Damin Insurance Broker Company
82	Jadara Alalamia - Insurance Brokerage Company
83	Kayan Middle East Insurance Brokerage Company
84	Yader Insurance Brokerage Company

2.8.2 Second Insurance Profession: Insurance Agents

Insurance agent is defined as the legal person who, for a fee, represents an insurance company, markets and sells insurance policies, and all works it usually carries out for or on behalf of the insurance company. An agent can be assigned for one insurance company/product, and the minimum required for an insurance agency license is SAR 500 thousand.

The following insurance agency companies have been licensed (Until the date of editing this material):

Sr.	Company Name
1	Modern Ocean Insurance Agency Company
2	Saudi Takaful Insurance Agency Company
3	Al Marooz - Insurance Agency Company
4	Al Areen - Insurance Agency Company
5	National Takaful Insurance Agency Company
6	Waad Company for Insurance Agency Services
7	AlAhli Company for Insurance Marketing Services (Insurance Agency Company)
8	Saab Insurance Agent Company
9	Alaried Insurance Agency Company
10	Saudi Fransi Insurance Agency Company
11	Rand Insurance Agent Company
12	Midad Altheqah Insurance Agency Company
13	Tadamun Insurance Agency Company
14	Albabtin Insurance Agency Company
15	Al Rajhi Takaful Insurance Agent Company
16	Theatel Insurance Agency Company
17	Altazeezt Insurance Agency Company
18	Fajr Insurance Agency Company
19	Wattad Alwatania Insurance Agency Company
20	Bawabat Alaman Insurance Agency Company
21	Ahad Alsaudia Insurance Company
22	Fursan Insurance Agency Company
23	Amaliat Altaamin Insurance Agent Company
24	Altawun Almutahida - Insurance Agency Company
25	Altawun Aloula Insurance Agency Company

26	Madad Alaman Insurance Agency Company
27	Dar Alttameen Insurance Agency Company
28	Aletemad Insurance Agency Company
29	Toba Insurance Agency Company
30	Almihania Group Insurance Agency Company
31	Tkatof Altaamin Insurance Agency Company
32	Husun Alaman Insurance Agency Company
33	Alhada Insurance Agency Company
34	Essdaar Insurance Agency Company
35	Saudi Agents Insurance Agency Company
36	Shadow Insurance Agency Company
37	Tamayouz Insurance Agency Company
38	Roaa Insurance Agency Company
39	Madar Altaamin Insurance Agency Company
40	Elite Panorama Insurance Agency Company
41	Takaful Alsharq Alawsat Insurance Agency Company
42	Almotamadoun Insurance Agency Company
43	Osous Insurance Agency Company
44	Almuetameda Insurance Agency Company
45	Integrated Protection Insurance Agency Company
46	First Company for insurance services (Insurance Agency Company)
47	Alriyad Insurance Agency Company
48	Majal Alwefaq Insurance Agency Company
49	Insurance Management Insurance Agency Company
50	Safe Cover Insurance Agency Company
51	Takaful Amanah Insurance Agency Company
52	Alinma Insurance Agent Company
53	Aldera Alsaudi Insurance Agency Company
54	Kafalah Insurance Agency Company
56	Alpha Insurance Agency Company
57	Aman Insurance Agency Company
58	Taqdeer Alealamia Insurance Agency Company

2.8.3 Third Insurance Profession: Actuaries:

Actuary is defined as the person who applies theory of probability and statistics according to which services are priced, obligations are established and provisions are made.

Each insurance company must have an actuary according to SAMA's instructions. The minimum required capital of actuarial company is SAR 150 thousand. The following actuarial service companies have been licensed (until the date of editing this material):

Sr.	Company Name
1	Alkhwarizmi Actuarial Services Company
2	Nitaq for Actuarial Services
3	Manar Sigma Financial Consulting
4	Saudi Milliman for Actuarial Services
5	United Co. for Actuarial Services (CAIS)

2.8.4 Fourth Insurance Profession: Surveyors and Loss Adjusters:

Surveyor and loss adjuster is defined as the legal person who examines and inspects the to-be-insured asset before being insured, and inspects damages after their occurrence to know causes of loss, estimate its value and determine liability. The minimum capital of surveyors and loss adjusters is SAR 500 thousand. The following surveyors and loss adjusters have been licensed (Until the date of editing this material):

Sr.	Company Name
1	Najm for Insurance Services
2	Arab Loss Adjusters (ALA)
3	McLarens Young Saudi Co. Ltd.
4	Saudi Inspection, Survey & Loss Adjusting Co. (SISLA)
5	Ahmad Omar Mohamed Badahidouh - Assessing & loss Adjusting Company
6	Naseem Ocean Inspection & Survey Co. Ltd.
7	Crystal Inspection Services (CIS)
8	Soulat Loss Adjusting & Survey Co. Ltd.
9	Matthews Daniel - Assessing & loss Adjusting Company
10	Middle East International Survey and Loss Adjusting Co.
11	Charles Taylor Adjusting Saudi Arabia - Assessing & loss Adjusting Company
12	Almueayinun Alkhalijiuwn - Assessing & loss Adjusting Company
13	Cunningham Lindsey Saudi - Assessing & loss Adjusting Company

2.8.5 Fifth Insurance Profession: Insurance Claim Adjusters:

Insurance claims adjuster is defined as the legal person who manages, reviews and settles insurance claims on behalf of an insurance company.

The minimum capital of insurance claim adjusting company is SAR 3 million. The following companies have been licensed:

Sr.	Company Name
1	GlobeMed Saudi - TPA Company
2	Saudi Next Care - TPA Company
3	Aleinaya Alshamila - TPA Company
4	MedNet Saudi Arabia - TPA Company
5	Medivisa - TPA Company
6	Gapcorp Saudi Arabia - TPA Company
7	PM Care Saudi - TPA Company
8	Damanat Alkhalij - TPA Company
9	La Bas - TPA Company
10	Enayat Almutalaba - TPA Company
11	Madarat Alwatania -TPA Company

2.8.6 Sixth Insurance Profession: Insurance Consultants:

Insurance consultant is defined as the person who provides consulting services in insurance business, so that its fees are collected from the entity to which the advice is provided.

The minimum capital of an insurance consultant company is SAR 150,000. The following insurance consulting companies have been licensed (until the date of editing this material):

Sr.	Company Name
1	ACE - Insurance Consulting Company
2	Marsh Saudi - Insurance Consulting Company
3	Altawuniya - Insurance Consulting Company
4	Dar Altafakr - Insurance Consulting Company

Revision questions:

Answer the following questions, and check your answer in the corresponding section:

1 What are SAMA's roles in monitoring cooperative insurance companies in the Kingdom (Mention five roles)?
Answer reference: Section 2.5.1

2 What are the main reasons that led to regulation of insurance sector?
Answer reference: Section 2.3

3 What are the most important obligations of healthcare insurance companies (Mention three)?
Answer reference: Section 2.5.4

4 What are the requirements that must be met when submitting an insurance company license application?
Answer reference: Section 2.6

5 Mention three of CMA powers?
Answer reference 2.5.4

6 Mention four elements that must be included in the submitted business plan in order to obtain a license for an insurance company?
Answer reference 2.6

7 What are the requirements for licensing self-employment insurance professions?
Answer reference: Section 2.8

8 Who are insurance brokers?
Answer reference: Section 2.8.1

9 What is the minimum capital for insurance brokerage companies?
Answer reference: Section 2.8.1

Chapter Three

Insurance Products and related services

This part of book accounts for approximately 20 of the 100 questions of the exam.

3 - Introduction:

This chapter will talk about the most prominent insurance products known in the Saudi market, which are provided by insurance companies in the Saudi market as providers of various insurance services, including the provision of different products to meet the insurance needs of individuals, companies and others.

In this link, we can access the Regulations issued by SAMA that shows controls related to insurance product approval:

Rules of Insurance Products Approval (sama.gov.sa)

Besides talking about customer services in KSA insurance market, which aims to foster customer satisfaction, i.e. the feeling that service or product provided by a company meets customers' needs by providing a high quality service that lead to customer satisfaction.

3.1 Most prominent characteristics of the insurance products:

Learning Objective

Illustrating the most prominent characteristics of the insurance products licensed in the Saudi market.

A. 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.

B. 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.

C. 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.

D. Licensed products: Each insurance company must license any product they offer through the Saudi Central Bank (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 prod

uct, and SAMA either grants a temporary license or a permanent license to the product.

E. 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.

3.2 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 ...etc. Here we will discuss the most prominent insurance products known in the Saudi market depending on the insurance applicant.

3.2.1 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.

- **Rules for Comprehensive Insurance of Motor Vehicles Financially Leased to Individuals**

SAMA issued Rules for Comprehensive Insurance of Motor Vehicles Financially Leased

to Individuals, as such policy is similar in its coverage of risks in comprehensive insurance policy. Such Rules included the relationship between the lessor and the lessee in comprehensive insurance of vehicles financially leased to individuals. It included several provisions, the most important of which are:

• The Lessor must include the name of the Lessee in the "vehicle registration" as the "actual user" of the Motor Vehicle.

The Lessor shall insure the Motor Vehicle annually throughout the finance leasing contract.

• The Lessor shall obtain insurance offers from at least three Insurers, and chose the best offer and lower price and provide it to the Lessee.

Mechanism for Calculating the Insurance Premium for Comprehensive Insurance on Motor Vehicles Financially Leased to Individuals:

• The Insurance Premium shall be calculated annually by the Insurer based on the changes on the Sum Insured and the pricing factors for the Lessee. The Lessor shall provide the Insurer with the Lessee's information in the Insurance Form which is required for pricing; after obtaining the Lessee's approval. The Sum Insured is determined in the first year following registration of the Motor Vehicle at the authorized authority based on the retail price offered by the certified dealership for the insured Motor Vehicle (excluding finance amounts or any other future services), provided that the value will be subject to the annually depreciation percentage, as specified in the Insurance Form as to reflect its real value at the time of renewal.

• At the end of the insurance year, the Lessor shall calculate the balance amount of what have been paid to the Insurer, and what have been paid by the Lessee, and keep it in the Lessee Insurance Account, and provide the lessee with a copy of the Lessee Insurance Account.

• At the end of the finance contract between the Lessee and the Lessor, the Lessor shall pay back the Lessee the extra amount of Premiums paid by the Lessee, or shall ask the Lessee to pay the extra amount paid by the Lessor to the Insurer for the insurance Policy.

• The accounts settlement related to the insurance Policy shall be made within (30) days from the termination date of the agreement between the Lessor and the Lessee.

Example: A person requested a financing lease for a vehicle worth SAR 200,000, and accordingly the value of insurance premium for the first year was determined at SAR 8,000, which represents 4% of the vehicle's basic value. Further, the insurance company gave a discount of 30% due to absence of previous claims, where the discount amounted SAR 2,400, so the insurance premium becomes SAR 5,600. In this case, the financing institution (Lessor) calculates the basic premium of SAR 8,000 and saves discount value and

an amount of SAR 2,400 in lessee insurance account.

In the second year, the vehicle's market value decreases based on a 20% decrease, so it becomes SAR 160,000. Then, the premium is calculated to be 4% of the vehicle value after applying such decrease and the premium becomes SAR 6,400. Assume that a discount of 40% is given, thus, the premium after applying discounts becomes SAR 3,840. Thus, the discount (SAR 2,560) is added to the lessee insurance account to the discount value in the first year, so that the lessee insurance account includes (SAR 2,400 + 2,560). Suppose that in the third year the actual amount of premium was SAR 4,200 and no discounts are made.

At the end of the last year of the financial lease contract, a liquidation is made between what was paid to the insurance company and the amounts paid by the lessee.

What was paid by the lessee = 8,000 + 6,400 + 4,200 = 18,600

What was paid to the insurance company from the lessor = 13,640

What is paid to the lessee by the financial leasing company at the end of the contract = 18,600 -13,640 = 4,960

In the first and second sections, vehicle damage and civil liability are covered, and in the third section: 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 incurred by third parties due to the accident, including expenses of towing or transporting the vehicle.

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

According to SAMA's circular, which obliges all insurance companies working in vehicle insurance to send a mobile text message to all their customers whose insurance policies for their vehicles have expired, or with 30 days or less until their expiration. The text of such message is "Our dear customer, to protect your rights and rights of others, renew the motor vehicle insurance policy through e-channels or Call Center (No.) #INSURE_TO_BE_SAFE".

C. Medical insurance for individuals:

We have already mentioned the Council of Cooperative Health Insurance, which approved a unified insurance policy for medical insurance, whereby individuals are entitled to optionally subscribe for themselves 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.
- Preventive measures e.g. vaccinations including seasonal vaccinations, and maternal and child care.
- Acute and non-acute psychological cases, Alzheimer's cases, autism cases.
- Infectious disease cases that require isolation in hospital, as determined by the Ministry of Health.
- Acquired cases of damage to heart valves.

- National Newborn Screening Program to Eliminate Disabilities
- Covering the Newborn Screening for Hearing-Loss and CCHD Program for all newborns.
- Costs of organ harvesting process from donors.
- Disability cases.
- Psoriasis treatment costs.
- Costs of infant formula for infants who need it medically until the age of 24 months per the regulations governing the coverage of infant formula milk
- Costs of covering the vaccination program for Respiratory Syncytial Virus (RSV) for children per the standard vaccination schedule issued by the Ministry of health.
- Costs of covering procedures treating extreme obesity by the gastric sleeve surgery only, in cases of BMI above 45.
- Costs of preparation and repatriation of the corpse of an insured individual to the home country specified in the employment contract.

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. 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, as required by the applicant, 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. 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 during the insurance period worldwide.

H. Hajj Insurance

It is an insurance to financially compensate the pilgrim in the event of losses suffered by him during his travel and during the period of stay for performing Hajj. Hajj insurance covers several risks, including but not limited to: Medical care due to an accident or illness, transportation costs to the medical center in Saudi Arabia, or to the pilgrim's country if he is from outside Saudi Arabia, dental treatment costs, repatriation costs in case of the pilgrim's illness where the insurance company assumes the costs of flight. Moreover, the insurance may include travel and accommodation costs incurred by the pilgrim during his illness, costs of delaying or canceling the flight, and costs of returning the body in the event of death.

I. Umrah Insurance

The Umrah insurance is very similar to Hajj insurance, as this policy covers the costs of health insurance and costs of flight delays. The insurance against the risks of Covid-19 has been added. The insurance covers the costs of infection with Covid-19 and this insurance includes: Treatment due to infection with Covid-19, the daily cost of staying in quarantine, the costs of transporting the body in case of death to the country of residence, and medical evacuation in case of infection.

J. Domestic Labor Insurance:

An insurance policy that covers some of the risks that the employer and domestic workers may be exposed to. This insurance policy includes the following insurance benefits, for example, but not limited to:

• Repatriation costs in the following cases: Escape, as the insurance company covers the cost of returning domestic workers to their country during the insurance period in case the sponsor reports that the insured has fled. It also covers the costs incurred when the domestic worker opts to cancel the employment contract, where the insurance company compensates the sponsor for the actual costs of returning the insured to his country if the insured decides to cancel the contract after the end of the first three months of the contract. Also, the insurance company may cover the costs of the death of a domestic worker, where the company bears the costs of returning the body of the insured to his country.

• Costs of permanent total disability or temporary partial disability due to accidents: The insurance company compensates the insured if he is injured during his work, and also bears the actual cost of the flight ticket to return the insured to his country.

• Replacement costs: The insurance company compensates the sponsor for the costs of replacing workers in the following cases:

o Personal reasons for domestic labor: The insurance company pays the basic expenses for replacing domestic workers in the event that the domestic workers refuse to perform the work assigned to them according to the employment contract for special reasons.

o Health issues for domestic labor: In the event of a medical condition that prevents the domestic worker from continuing to work according to the terms of the contract and based on a medical report.

o Escape of Domestic Workers In case the sponsor reported that the insured domestic worker has escaped during the insurance period, the insurance company compensates the sponsor for the costs of replacing the domestic worker

• Health Insurance Obtain health insurance coverage that covers the costs of treatment in approved medical facilities

F. Protection and Saving Insurance

An insurance policy, whereby the insurance company pays a certain insurance amount if something bad happens to the insured or at the end of the agreed period according to the insurance contract. In return, the insured pays the insurance subscription applicable in this type of insurance.

Insurance companies in Saudi Arabia offer two types of protection and saving insurance:

1- Protection Insurance: The insurance company pays the insurance amount to the beneficiaries named in the insurance policy in case of death or total, partial or temporary disability of the insured for the individual and groups, in return for payment of the monthly premiums agreed upon in the insurance contract until the end of the contract term.

2- Protection and Saving Insurance: The insurance company pay an amount/s, including the proceeds of savings on a future date, in return for payment of the monthly premiums agreed upon in the contract.

3.2.2 Corporate Insurance products:

Learning objective:

Identifying insurance products provided to companies in the Saudi insurance market.

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 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:

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.

Third Party Liability insurance:

• In the event of an accident resulting in the payment in accordance with the provisions of this policy as 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.

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, as mentioned in this educational material in section C of Part 3.2.1.The coverage includes outpatient clinics and in-patient in a shared hospital room with an annual maximum of 500,000 SR, in addition to pregnancy and birth coverage up to SR 15,000, dental expenses up to SR 2000. Coverage is also available outside Saudi Arabia in case of emergency during leave or business trip not exceeding 90 days. An amount of %20 of the treatment cost in outpatient clinics up to a maximum of one hundred SR shall be paid.

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 policyholder. 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.

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 and lightning. The policy can be extended to include the following perils: 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 all risks::**

This policy provides comprehensive and integrated coverage for industrial units or commercial property, etc. against all risks except for what is specifically excluded under the policy. There are two kinds of coverages: the first is the accidental damage insurance

policy, (such as: fires
Lightning and explosions (and the second is the insurance of industrial property «against all risks», which is primarily related to commercial and industrial property. Of course, both policies specifically exclude subsequent losses, which are covered in a separate endorsement, provided that there is material damage resulting from a risk covered under the policy.

• Hospitality Insurance, Merchant Insurance, Manufacturers Insurance and Contractors Insurance

This insurance covers the risks related to the property, buildings and premises of an organization, and the risks that threaten the safety and health of workers while performing their work. It covers the legal liability that may be incurred by the project owner, the risks posed to machinery and equipment, protection and transfer of funds and the goods in warehouses. It covers all business needs and provides insurance coverage commensurate with the nature of business and the enterprises that run the business, and their means, objectives and assets.

Examples of the risks covered by this type of insurance are physical losses of property due to perils such as fire, lightning, explosions, collapses, collision, and the damage, explosions and fall of aircraft, water tank flooding, water leakage, storms, hurricanes, theft and armed robbery, in addition to coverage for secured funds, and the general liability legally incurred by the insured as a result of accidents, death or injury of third parties or the damage inflicting on their property arising from accidents related to the insured's business or work.

• 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. Additional coverage may also be made for material losses resulting from the risk covered by the insurance policy.

F. Engineering insurance:

This product includes a number of covered items:

- Contractors Insurance including against Civil Liability:

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.

- 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. Insurance coverage can be extended to include additional risks such as third party liability 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.

- 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.

- 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.

-Deterioration of Stock Insurance

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.

• Inherent Defect Insurance

This policy covers the minimum mandatory insurance against hidden defects that are discovered in buildings and constructions after their use in non-governmental sector

projects. Inherent structural defects have been defined for the purposes of this type of insurance as "Any defect in the Structural Works or the Envelope weakening the strength and steadiness or stability of the Premises and attributable to a fault, error or omission in design, materials, geological investigation or construction which was undiscovered at the date of issue of the Occupancy Certificate. This type of insurance includes the following risks:

• Premises It is all the works at the address stated in the schedule, and includes the premises:

- Structural Works All internal and external load-bearing structures essential to the stability or strength of the Premises including but not limited to foundations, columns, walls, floors, beams.

- Envelope Building envelope that contains all the works forming part of external walls and roofing of the Premises but excluding: Movable elements of external windows and doors, external cladding unless it is essential for the stability of the building, and the equipment, fixtures and fittings.

- Non-structural Works All non-load bearing parts of the Premises, including but not limited to, floor coverings, ceilings, interior walls, windows and interior doors.

- Equipment, Fixtures and Fittings All non-loading bearing parts of the Premises, including but not limited to: Electrical wiring and connections, all fixtures and fittings, all equipment and fixtures for the collection and distribution of gas, water, heating and ventilation, all permanent mechanical and electrical apparatus including boilers and similar plant included in the Building Contract irrespective of whether such equipment, fixtures and fittings are fixed to or incorporated in any part of the Structural Works.

-External Works All external non-structural works owned by the Insured and the subject to the Building Contract, including but not limited to Pavement and cross-over

The term of insurance coverage is ten years.

G. Public Liability Insurance:

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

• **Burglary and Theft Insurance:**

This policy provides coverage against theft or burglary using violence and force. The compensation is for losses and damages that inflict on the contents of the insured building as a result of, for example, theft or attempted theft that occur by breaking into the insured building/s by breaking their windows, walls, ceilings or floors

• **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. How

ever, 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. Examples of professional professions include: Architects, civil engineers, consultants, financial consulting firms, lawyers, law firms and accountants.

• **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 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. This policy covers the liability for third party bodily injury/death and property damage. In addition, it can cover loading and unloading liability. It is suitable for transportation companies. 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 as stated above.

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 Organi

zation 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 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 on 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 courseof 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.

• **Clinical Trials Insurance**

Clinical trial insurance is coverage against the liability that may be incurred as a result of clinical trials. Clinical trials include any tests conducted on patients or any new treatments that are tried on people to measure their effectiveness and potency. Coverage against such treatments includes legal and financial compensation for any harm sustained by the patients participating in these trials as a result of any accident that has caused such harm This type of insurance also covers the medical equipment and tools used, where any damage to these equipment is compensated.

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 an environmental. protection insurance

J. Aviation Product Insurance::

The aviation product insurance provides a main guarantee that gives local airlines the cover of protection they need to run their activities and continue operating their flights to serve passengers and support the movement of local and international trade.

• **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.

• **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.

• **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.

• **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.

• **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. This

is of course due to the companies obtaining licenses for these products or some of them, or due to the particular underwriting interests of each company.

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.

• **Insurance coverage against the risks posed by drones**

This type of insurance covers the risks resulting from drones licensed by official authorities for use in aerial surveys and geographic information systems related to architectural and engineering activities and associated consultancy services, or those used in inspections of communication towers, power lines, industrial facilities, and renewable energy for the purposes of technical testing and analysis, or those used for the purposes of aerial photography in the authorized places.

k. Aquaculture insurance

In the past years, the world's need for fish and aquatic organisms has increased significantly, which triggered the establishment of fish farms to meet that demand and produce fish commercially. Despite its economic feasibility and financial returns, it comes with risks posed by predators, errors in the design of aquaculture ponds, risks resulting from climate change such as high temperature, hurricanes, diseases, and pests that affect them, in addition to the risks posed by humans such as theft and sabotage, or environmental risks such as water pollution. Therefore, the aquaculture insurance was approved for aquaculture projects, which covers losses resulting from the deaths of fish due to diseases and intoxication, losses resulting from climatic changes, losses resulting from various accidents such as collision and theft, and changes that occur to water such as contamination and other threats.

L. Event cancellation insurance

An insurance policy that provides insurance coverage to the insured against the risks of canceling the licensed events by the official authorities, not completing them, postponing them, stopping them or relocating them, for reasons outside the control of the organizer, such as weather conditions or cases of non-appearance in the event that this is agreed upon. The insurance company covers the financial loss resulting from the cancellation of a certain event (such as conferences, festivals and mega sporting events), due to certain risks, agreed upon between the insurer and the insured.

3.3 Basic principles of effective customer service

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.

Learning objective:

Introducing the sections of the regulations and its role in regulating insurance operations in the Saudi insurance market

3.3.2 Insurance Market Code of Conduct Regulations

SAMA has issued the Insurance Market Code of Conduct Regulations in the Kingdom of Saudi Arabia. The purpose of it is to establish high standards for working in the insurance field and 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. 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 with the requirements set out in these regulations is contrary to the terms of the permit and the authorized company may face penal action. Authorized companies shall promptly notify SAMA of any circumstances that may hinder them from complying with the requirements stipulated in these regulations.

3.3.3 General requirements of Insurance Market Code of Conduct Regulation

Learning objective:

Clarifying the general requirements

There are general requirements that the insurance companies and self-employed persons must adhere to in order to realize the objectives of this regulation, which are as follows:

A. Integrity:

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.

B. Skill, Care, and Diligence:

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.

C. Development

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.

D. Non-discrimination:

Authorized companies shall not unfairly discriminate against its current or potential customers in the future, and shall provide convincing reasons for rejecting, cancelling, or not renewing insurance policies.

The Saudi Central Bank has stressed the non-discrimination in providing insurance services to persons with disabilities. These instructions are available on the following link: People_with_disabilities.pdf (sama.gov.sa)

E. Adequate Resources:

Authorized companies shall take reasonable care to maintain adequate administrative, financial, operational, and human resources to carry out their business and serve their customers.

F. Disclosure of Information to Customers:

- Authorized companies shall notify customers of all relevant information in a timely manner so that they can take informed decision based on adequate information.
- Authorized companies shall take reasonable procedures to ensure accuracy and clarity of the information provided to customers and making them available in writing.

G. Data Protection:

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.

H. Protection of Customer Fund:

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.

I. Conflict of Interest:

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.

J. Contracting with other Companies:

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.

3.3.4 Market Conduct Standards

Learning objective:

Introducing insurance policy parts, contents, and any subsequent amendments.

The insurance policy, which is the contract concluded between the insurance company and the customer is a fundamental document that is relied upon to know the rights and duties of each party. Therefore, it is considered one of the most important matters that the company must make clear to the customers. The regulation included the key elements that the insurance policy must include, which are as follows:

A. Insurance Policy Wording and Contents:

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:

"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.

B. Amendments to Insurance Policy:

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: 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.

C. Free Look Period Provision (Protection & Savings Insurance):

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.

* With respect to the investment part (Units invested in), the insurance company is entitled to make an appropriate adjustment to take in consideration the changes in the unit price.

D. Pricing:

- Authorized company must utilize the pricing that was approved by SAMA as part of the product approval process.

E. Discrimination:

- The criteria and practices of authorized company's insurance underwriting must not be by unfairly discriminatory.

The Saudi Central Bank has stressed the non-discrimination in providing insurance services to persons with disabilities. These instructions are available on the following link: People_with_disabilities.pdf (sama.gov.sa)

3.3.5 Advertising and Marketing:

Learning objective:

Procedures that insurance companies must follow when advertising and marketing its products

Credibility

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:**

Authorized companies' advertisements should not contain any false or misleading information regarding other insurance companies.

3.3.6 Communication with the Customer during the Pre-sale Period: Authorized

Learning objective:

- Identify the duties of the insurance company when communicating with customers in the pre-sale stage

• **Information on Authorized Companies' Offerings:**

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:**

- 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).

- Authorized companies have ensure that the advice given to clients adequately meets their needs.

- 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.

• **Increase Expenses:**

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:**

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.

• **Disclosure to Customers:**

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.
- In addition to the above, authorized companies must provide the following information with regard to Protection and Savings insurance products:
* Indicate whether the protection and saving programs is a profit-sharing program, a non-profit-sharing program, or a unit-linked investment program.
* Basis of participation in profit in case of a participating plan– cash bonus, deferred bonus, reversionary bonus, terminal bonus etc.
* An explanation of the program that shows the insured amount, redemption value and amount paid during the program period. 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 or, if not, up to 85 years.
* 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 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.

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.

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.

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.

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:**

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:**

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. 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.

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:**

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:**

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 mean family members including wives, husbands, children, parents, brothers and sisters.

• **Premium Collection:**

Authorized companies shall not receive premiums or fees for services they do not provide or future services not yet provided.

Insurance companies are considered to have received the premiums once the agents or brokers receive the payment.

3.3.7 : Post-sale Customer Services:

Learning objective:

Illustrating insurance company's duties after the issuance of the policy

• **Post-sale Services:**

- 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.

- 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:**

- 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 (10) 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.

• **Claims Settlement Period:**

- 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:

- 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:**

- Authorized companies have to put in place a fair and transparent process for handling complaints, and inform customers with complaints filing procedures.

- 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:

- 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.

- 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:**

- 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. According to SAMA's circular, which obliges all insurance companies working in vehicle insurance to send a mobile text message to all their customers whose insurance policies for their vehicles have expired, or with 30 days or less until their expiration. The text of such message is "Our dear customer, to protect your rights and rights of others, renew the motor vehicle insurance policy through e-channels or Call Center (No.) #INSURE_TO_BE_SAFE".

- 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.

Revision questions:

Answer the following questions, and check your answer in the corresponding section:

1 What are the coverage sections in the comprehensive car insurance policy?
Reference 3.2.1

2 What are the types of coverage available in property insurance?
Reference 3.2.1

3 What is the scope of breach of trust insurance coverage?
Reference 3.2.2

4 What is the coverage for aviation structures and liabilities?
Reference 3.2.2

5 What are the most important risks covered by Hajj insurance?
Reference 3.2.1

6 Explain what is meant by protection and saving insurance?
Reference 3.2.2

7 Explain the risks covered by the medical malpractice insurance?
Reference 3.2.1

8 How important is aviation product insurance and what is the importance of aviation structures and liability insurance?
Reference 3.2.2

Revision questions:

Answer the following questions, and check your answer in the corresponding section:

9 A person applied for a finance lease for a vehicle worth SAR 200,000, and then the value of insurance premium for the first year was set at SAR 7,000, and the value of discount amounted to SAR 3,000, whereby the insurance premium becomes.
In the second year, SAR 5000. After the discount, the premium became 2700. In the third year, the insurance premium became SAR 4000. After the discount, the premium became 2400.
Calculate the following:
A. The amount charged to the lessee
B. The amount paid to the insurance company from the lessor
C. The amount paid to the lessee by the finance leasing company at the end of contract?
Reference 3.2.1

10 What is the purpose of the Insurance Market Code of Conduct Regulation in the Kingdom of Saudi Arabia?
Reference: 3.3.2

Chapter Four

Technical and Legal Principles in Insurance

This Chapter includes about 20 out of 100 questions of the exam.

4 - Introduction:

Interdependence and cooperation is the basis on which the insurance system was built, and in order for this system to be able to persist and for all stakeholders to benefit from it, the need for the foundations on which it is based has emerged. Therefore, this chapter aims to identify these foundations and try to explain them making them understandable for the reader.

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:

4.1 legal principles of insurance contract

They determine the substance of insurance relationship, regulates the responsibilities and obligations of both parties, and provides the necessary guarantees for the success of contractual relationship and for each party to enjoy his rights without unfairness or injustice

1- Principle of insurable interest
2- Utmost good faith principle

→ applicable to all types of insurance such as property insurance, civil liability and life insurance.

3- Proximate cause principle

4- Indemnity principle
5- Contribution principle
6- Subrogation principle

→ applicable to property insurance, civil liability insurance only.

Utmost good faith principle

Learning Objective

Introducing the first principle of utmost good faith

In this principle, both the insurance company and the insured must not provide invalid or misleadinginformation. 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 insurer 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.

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.

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 are blank or inadequate answers on a proposal that insurers do not follow up the assumption, then 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 re-ferred 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.

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

Motor insurance: purpose of using the vehicle or the age of the insurance applicant.

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.

A. Insurance Interest Principle:

Learning objective:

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

Insurable Interest "the legal right to insurance arising from a legal financial relationship between the person and the insured item. "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 exists by creating a contract between the insured and any other organization as an insurance company.

Conditions required in insurable interest:

- Interest must be financial: meaning that emotion is not enough to create a financial interest.

- 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:

• Full or partial partnership in properties.

• Consigned goods and property restitution contracts of mortgagor and mortgagee.

• Trustee of properties.

• Guarantor for the insured's properties.

• 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 of his family.

• 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.

• 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.

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

- When the insurance interest is available:

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 of goods on the ship, and the insurance of the ship's body shall be the same insurance interest as the insured person.

Protection and Saving Insurance: 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.

C. Indemnity Principle

Learning objective:

Introducing the indemnity principle and the main benefit thereof.

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:

- Cash 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.

- 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.

- 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.

- 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 samefinancial 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 SR 300,000. 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).

Question:

- 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? Give reasons for your answer.

B. First Loss Insurance

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.

Question:

(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 answer.
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 Rule (Average Condition)

If the value of insurance subject at the time of the accident is greater than the insurance amount, then the insured is deemed to have born the difference, and therefore the loss is shared between the insurer and the insured on a proportional basis as the insurance in this case is not sufficient.

The value of payable compensation by the insurance company is calculated using the following equation:

Payable Compensation = Actual Loss Amount x (Insurance Amount) / (value of insurance subject)

To calculate the payable compensation, we should differentiate between three cases:

First case: Over insured status:

In this case, we find that the insurance density is greater than one. The insurance density means the ratio of insurance amount to the value of insurance subject. In this case, the insured will receive compensation equal to the actual loss that occurred.

payable compensation = actual loss

Example (4.1):

A person procured an insurance coverage for his factory in the amount of SAR 1,000,000 from an insurance company against the risk of fire. A fire then broke out in the factory inflicting losses in the amount of SAR 600,000. How much is the compensation that the insured is entitled to receive from the insurance company, knowing that the factory worth at the time of fire SAR 800,000?

Insurance density = (insurance amount) / (value of insurance subject) = (1,000,000) / (800,000) = 1.25

Note that the insurance density is greater than one, and this means that the factory is

over insured.

In this case, the payable compensation = actual loss = SAR 600,000.

Second case: Underinsured status:

In this case, we find that the insurance density is less than one. This means that the amount of insurance is less than the value of insurance subject. In this case, the insured will not receive the full loss, but rather a percentage of the actual loss suffered as per to the following equation.

In this case, the insurance policy is referred to in order to check whether it contains the Average Clause or not:

A - The insurance policy contains an average Clause.

Insurance density = (insurance amount) / (value of insurance subject)

b - The insurance policy does not contain an average Clause.

payable compensation = actual loss

Example (4.2):

A person procured an insurance coverage for his factory in the amount of SAR 3,000,000 from an insurance company against the risk of fire. A fire then broke out in the factory inflicting a loss of SAR 500,000. At the date of fire, the factory was valued at SAR 4,000,000. How much is the compensation that the factory owner is entitled to if:

A - The insurance policy contains an Average Clause.

b - The insurance policy doesn't contain an Average Clause

Solution:

A- The insurance policy contains an Average Clause:

Insurance density = (insurance amount) / (value of insurance subject) = (3,000,000) / (4,000,000) = 0.75

Payable compensation = 500,000 x 0.75 = SAR 375,000.

B - The insurance policy doesn't contain an Average Clause

Payable compensation = actual loss = SAR 500,000.

Example (4.3):

In the previous example, how much is the compensation that the factory owner is entitled to if the loss is estimated at SAR 3,100,000, if:

A- The insurance policy contains an Average Clause:

b- The insurance policy doesn't contain an Average Clause

Solution:

A - payable compensation = actual loss x insurance density

= 3,000,000 x 0.75

= SAR 2,250,000

Note that when applying the formula, the insurance amount is substituted for the actual loss because the insurance amount is less than the actual loss.

payable compensation = actual loss (with maximum of the insurance amount) = SAR 3,000,000

Third case: Right insurance amount status:

In this case, we find that the insurance density is equal to one. This means that the insurance amount is equal to the value of insurance subject, and therefore the payable compensation is equal to the actual loss. (payable compensation = actual loss)

Example (4.4):

A person procured an insurance coverage for his factory in the amount of SAR 10,000,000 from an insurance company against the risk of fire. A fire broke out in the factory, where losses were estimated at SAR 700,000. At that time, the factory was valued at SAR 10,000,000 How much is the compensation that the factory owner is entitled to?

Solution:

We note that the amount of insurance is equal to the value of factory at the time of fire. This means that the insurance is just right and in this case:

payable compensation = actual loss = SAR 700,000.

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 incase 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.

G. Subrogation Principle

Learning objective:

Introducing the subrogation principle as it is applied in insurance.

Subrogation Principle: The right of insurance company (insurer) to replace the insured in pursuing a third party responsible for a loss suffered by the insured after the insurer compensates the insured.

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:

• Third party Liability for the Loss.

• 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:

• Fidelity Guarantee 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.

• Mortgage 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 insured 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.

H. Contribution Principle

Learning objective:

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

Contribution principle is "In cases of multiple insurances, the insurer may request the other insurers to pay their shares in the compensation payable to the insured. Meaning that the insurance company is entitled to require the other insurance companies (which have insured the same insurance subject) to participate in compensating the insured

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.

Insurers allow for dual insurance by a contribution condition in their policies, which states that in the event of more than one policy (covering the same risk or part thereof) 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. What is the meaning of "rateable proportion"?

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

First Method: Sums Insured Method: (Maximum Liability)

In this method, the contribution to be paid by each insurer is calculated by apportioning it according to the sums insured. This can be illustrated by an example:

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?

$$\text{Insurer's compensation} = \text{actual loss} * \frac{\text{Sum insured under individual policy}}{\text{Total Sum Insured}}$$

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.

All insurance companies share payment of the payable damages in the event of loss suffered by the insured. The share of each insurance company of the damages is commensurate with its share of the insurance amount it receives. Based on the following formula:

The insurer’s share in compensation = (the insurance amount held with that insurer) / (the total insurance amount held with all insurers) x actual loss

The contribution principle aims to avoid that the insured is overpaid in amounts exceeding the actual loss through multiple insurances. This principle applies to general insurances and does not apply to income and personal insurance.

• Applications of the contribution principle:

- Over insured or having the right insurance amount

We can tell if we have over insurance or the right insurance amount if the sum of insurance amounts held with more than one insurer equals or greater than the value

of insurance subject at the time of occurrence of insured risk.

Example (4.5):

A person procured insurance coverage for his house against fire in the amount of SAR 1,000,000 with three insurers, A, B, and C, divided into SAR 500,000, SAR 300,000, and SAR 200,000, respectively. If a fire broke out in that house and the damages were estimated at SAR 800,000, while the value of house at the time of fire was SAR 1,000,000 How much is the insurance that the house owner is entitled to and how will it be distributed to the three insurers.

Solution:

Insurance density = (insurance amount) / (value of insurance subject) = (1,000,000) / (1,000,000) = 1

Here we find that the insurance density is equal to one, and this means that the insurance is just right, and therefore the house owner will receive compensation equal to the actual loss.

Accordingly, the payable compensation = SAR 800,000.

This compensation will be distributed to the three insurers, each as per its share of the insurance amount, as follows:

Insurer A's share of the payable compensation = (the insurance amount held with insurer A) / (the total insurance amount of the three insurers) x actual loss

Company A's share of the payable compensation = 500.00/1,000,000 x 800,000 = 400,000 riyals

Insurer B's share of the payable compensation = (the insurance amount held with insurer B) / (the total insurance amount of the three insurers) x actual loss

Insurer B's share of the payable compensation = 300,000/1,000,000 x 800,000 = 240,000 riyals

insurer C's share of the payable compensation = (the insurance amount held with insurer C) / (the total insurance amount of the three insurers) x actual loss

Insurer C's share of the payable compensation = (200,000) / (1,000,000) x 800,000 = 160,000 riyals

- Underinsured status:

Under insurance is when the total insurance amounts held with more than one insurer is less than the value of insurance subject when the insured risk occurs.

Example (4.6):

A person procured insurance coverage for his car against the risk of collision in the amount of SAR 1,500,000 with three insurers A, B, and C, as follows:

SAR 700,000 with Insurer A

SAR 600,000 with Insurer B

SAR 200,000 with Insurer C

Then a collision accident occurred and the damages were estimated at SAR 600,000, while the value of car at the time of collision was estimated at SAR 1,700,000. how much is the insurance that the car owner is entitled to if:

1- The insurance policy contains an Average Clause.

2- The insurance policy doesn't contain an Average Clause.

Solution:

Insurance density = (insurance amount) / (value of insurance subject) = (1,500,000) / (1,700,000) = 0.88<1

This means that the car is under insured and therefore the car owner will not get the full amount of loss in case the insurance policy contains an Average Clause, and therefore:

payable compensation = actual loss x insurance density

= 600,000 x 0.88 = 528,000 riyals.

If the insurance policy doesn't contain an Average Clause, then the payable compensation = actual loss = 600,000 riyals.

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 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 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.

f. Proximate Cause Principle Proximate Cause Principle

Learning objective:

Introducing 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: "It is the direct cause that leads to the occurrence of the insurance loss detailed in the insurance policy." **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 insures 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:

4.2 Insurance Contract

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.

4.2.1 Defining the insurance contract

Learning objective:

Introducing 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, 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 personal accidents insurance, theft insurance, medical profession insurance,

death 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).

The Saudi Central Bank defined cooperative insurance as "It is a cooperative system aiming at protecting individuals and corporates from potential financial losses resulting from unanticipated coverable incidents by bringing back the insured persons to their financial position before the incident and sharing the earned surplus from insurance activities with them. The Supervision of Cooperative Insurance Companies Law and its Implementing Regulations stipulate that insurance companies shall share with the insured persons the profits generated by insurance operations by distributing a share of 10 percent to the insured persons or reducing their premiums for the next year and adding 90 percent to the shareholders' income.

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".

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".

4.2.2 Insurance Contract Elements:

Learning objective:

Introduce 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.

4.2.3 Insurance contract elements

Learning objective:

Introduce 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:

A. Availability of its elements and conditions of validity

B. The availability of these elements by mutual consent.

C. Consent does not exist unless the right will is manifested

D. This manifestation of will must stem from the contracted parties

E. A legitimate subject of insurance and a legitimate purpose.

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

A. 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)

B. 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.

• 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:

o 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 is voidable and cannot perform any contract (Alanbiki, 48).

o 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).

C. Third element: The subject matter of insurance (contracted)

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.

The insurance subject must be available upon contracting. 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.

D. 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. No insurance is permitted for anything that contradicts Islamic Sharia and public morals.

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

E. 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.

4.2.4 Stages of the insurance contract until conclusion:

Learning objective:

Stages of the insurance contract until final conclusion

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)

4.2.5 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:

• 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.

• Record Keeping:

Insurers need to know their potential liabilities, reinsurance requirements etc.

• Discrepancies:

The documents clarify discussions and agreements and ensure that insurers satisfy the policyholder's requirements.

• 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.

4.2.6 Proposal Forms and policy structure:

Learning objective:

Introduce 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.

4.2.7 Insurance Policy Forms

Learning objective:

Introduce 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 "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 size of the policy depends on the type of insurance, size of risk, additional conditions, requirements and risks covered. 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. etc.

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 motor policy?

D. Exclusions: 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. The most common of which are sonic bangs, radioactive contamination and war risks.

- 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.

Question:

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 by reducing Three 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 seven 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

4.2.8 The Importance of 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.

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.

4.2.9 Cover Notes and Certificates of Insurance:

Learning objective:

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.

• 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 Riyadh

• 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?

4.2.10 The Importance and the Content of Claim Forms:

Learning objective:

Introduce 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.
- 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?

4.2.11 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. Article 59 of 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 or obtain coverage from other insurer".

Also, a circular issued by the Saudi Central Bank requires all insurance companies operating in motor vehicle insurance to send SMSs to their customers whose insurance policies have expired, or there is 30 days or less left until their expiry date. The SMS reads "Our dear customer, to preserve your rights and the rights of others, renew your vehicle insurance policy via the electronic channels or through the call center number (.....) #Insure_to_be_safe

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?

4.2.12 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. Grace period shall not be considered an extension of the insurance coverage unless expressly stated in the terms of the policy.

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.

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 remain unchanged.

Revision questions:

Answer the following questions, and check your answer in the corresponding section:

1 What are the legal principles of insurance policy?
Reference 4-1

2 What is the material fact?
Reference 4-1

3 What is the period during which the principle of utmost goodwill must be observed?
Reference 4-1

4 when must the insurance interest be available for the different types of insurance?
Reference 4-1

5 What does the reinstatement method under the indemnity principle relate to?
Reference 4-1

6 There are methods governing the contribution principle, what are these methods and how does each method work?
Reference 4-1

7 Problem
If a store owner insures his goods for an amount of SAR 50,000, but at the time of loss the total value of goods was SAR 100,000, and the value of loss was SAR 15,000/- how much insurance shall he receive?
Reference 4-1

8 what are the element of insurance policy?
Reference 4-2-3

Revision questions:

Answer the following questions, and check your answer in the corresponding section:

9 What is the capacity to rights and obligations for a natural or legal person?
Reference 4-2-3

10 Where do the defects of will appear?

11 What is meant by the purpose of insurance contract?
Reference 4-2-3

12 What does “Indemnity” mean in insurance?
Reference 4-2-3

13 What are the stages of concluding an insurance contract in practice?
Reference 4-2-4

Chapter Five

Procedures and Policies of the Insurance Process

This part of book accounts for approximately 20 of the 100 questions of the exam.

5 - 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.

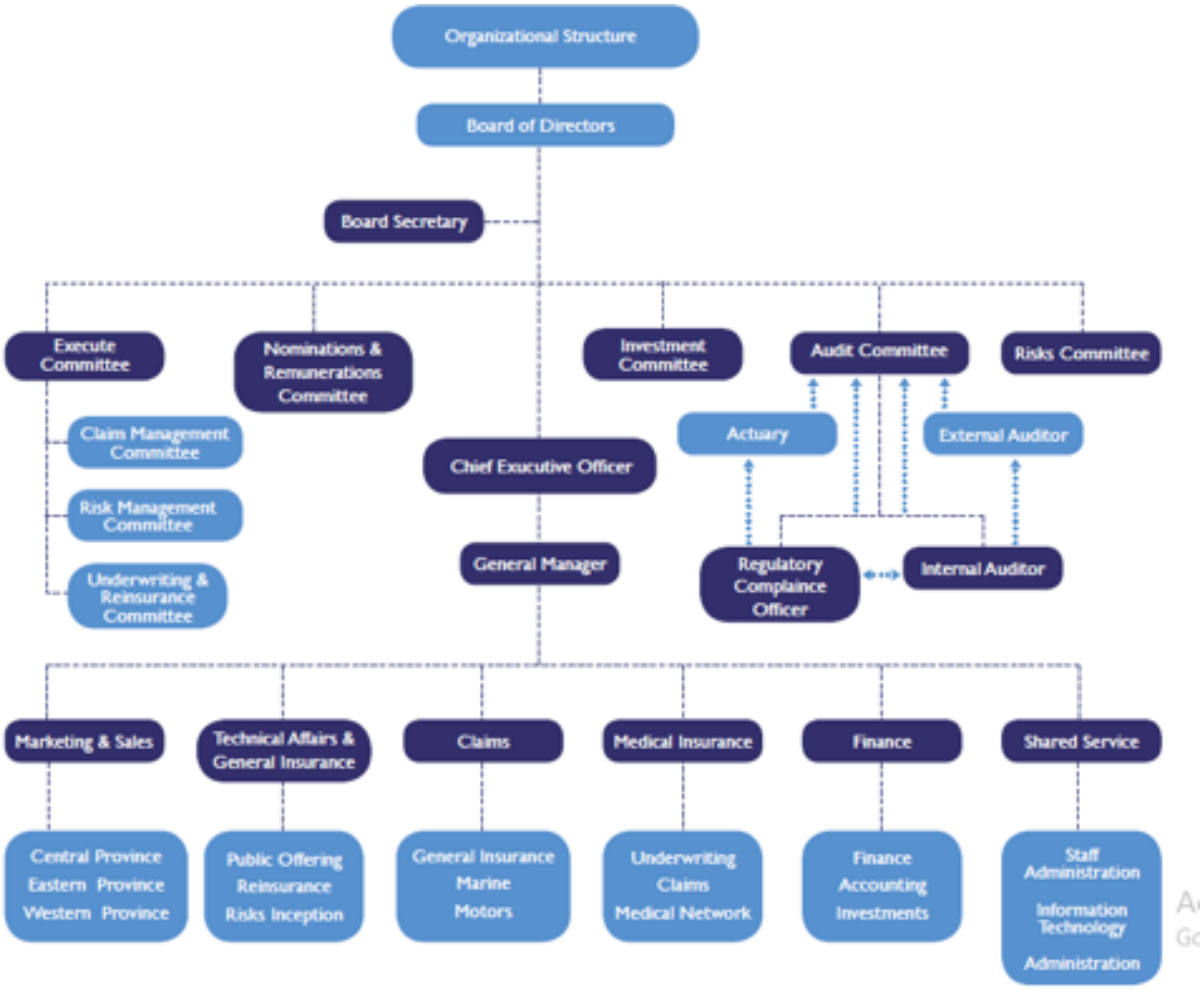
In this chapter, we will address the following:

• 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 Central Bank (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 the default organizational structure of insurance companies.

IIn reviewing this structure, we notice the following:

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

5.1.1 Board of Directors

Learning objective:

Introduce the board of directors and its functions

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 and supervising implementation of the company's key guidelines and objectives.

• 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.
• Ensure that the interests of the insured are protected at all times.

5.1.2 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

5.1.3 the most important senior positions in the insurance companies:

Learning objective:

Introduce the senior positions in the insurance companies
their role and function

A. 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 Central Bank (SAMA). He is responsible for the insurance company›s compliance with the laws and regulations issued by the Saudi Central Bank 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.

B. 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 a 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.

C. 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.

D. Senior management of the company:

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

• Risk 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 company's strategic plans.

• Managing the company's 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 document 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:

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

Learning Objective

Introduce marketing and sales channels of the insurance products

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.

- 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

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:

5.2.2 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.

5.2.3 Reinsurance: 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.

5.2.4 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

From an insured's point of view, testing the insurance company's reputation depends on how fast and fair it settles 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.

5.2.5 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

5.2.6 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 Central Bank.

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.

5.2.7 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

The risk management department in insurance companies is a main and critical function for its success and for achieving its objectives. Therefore, the risk management is an essential part of the strategic management of insurance companies. Its mission is to identify, measure, and manage the risks that insurance companies are exposed to in an organized manner in order to face these risks. Risk is the central element on which the insurance industry is based. Insurance companies must pay utmost attention to their risk management department. The risk management department adds value to the organization and to all stakeholders by assuming the following responsibilities:

- Identifying the key risks to which the organization is exposed
- Knowing how these risks affect the organization's activities and objectives
- Providing the necessary level of awareness for insurance company employees about the risks to which the company is exposed and how to face them
- Ensuring that the risk management procedures and activities are implemented effectively
- Developing appropriate tools for managing the risks that face the organization
- Issuing a well-articulated and understandable risk management policy that covers the risk management objectives and responsibilities
- Setting performance indicators that enable the company to monitor its main, financial and underwriting activities

Revision questions:

Answer the following questions, and check your answer in the corresponding section:

1 List three characteristics that must be found in the Board of Directors in the insurance companies?
Reference 5-1-1

2 Name four of the main duties and responsibilities of the board of directors in insurance companies?
Reference 5-1-1

3 Name three duties and responsibilities of the Executive Committee of the Board of Directors?
Reference 5-1-2

4 Name four of the duties and responsibilities of the investment committee?
Reference 5-1-2

5 Name four of the duties and responsibilities of the audit committee?
Reference 5-1-2

6 A key position in the insurance industry is the compliance officer, what is the purpose of this position?
Reference 5-1-3

7 A key position in the insurance industry is an actuary. Name four of his duties?
Reference 5-1-3

8 What is the underwriting process and how important is it to the insurance company?
Reference 5-2-2

Revision questions:

Answer the following questions, and check your answer in the corresponding section:

9 Explain the mechanism of selling through insurance agents?
Reference: 5-2-1

10 The department that the insured contacts when a claim arises is the claims department. How important is this department to the company's reputation and performance?
Reference 5-2-4

Chapter Six

Risks and Obstacles of Insurance Companies

This part of book accounts for approximately 20 of the 100 questions of the exam.

6 - 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. In KSA, insurance contributes by 1.48% 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 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 Central Bank (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.

6-1-1 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.

6-1-2 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.

6-1-3 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.

6-1-4 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 Central Bank (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.

6-1-5 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.

6-1-6 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.

6.2 Defrauding insurance companies' risk:

Learning objective:

Introducing insurance fraud, its risk and sources.

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 academic 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.

6.2.1 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 or for third parties. This can be achieved by, but not limited to, the following means:

• Misuse of Assets

• 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.

• Abuse of power, a position of trust or fiduciary relationship

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.

6.2.2 Fraudulent acts against 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.

• **Fraud Prevention**

- Companies should draft their insurance policies in the manner that eliminates fraud. Based on the annual reports prepared by the internal auditors and under the supervision of the Board of Directors, senior managers must apply new measures, policies and procedures to combat fraud, and improve the existing ones.
- Companies must clearly define and document customer choice policies, and set necessary conditions for accepting insurance for new customers, for each insurance category and product. Such terms shall be subject to Board approval to be reviewed annually.
- For each insurance product, companies must define clear and comprehensive procedures for evaluating claims, in particular detailing steps necessary to verify facts and credibility of claims and to verify indications of fraud activity (See Table 3).

- Companies must inform policyholders of the company's anti-fraud policies and consequences of providing false or inaccurate information. In addition, an information paragraph can be included into the policy itself to ensure that policyholders read and agree to measures taken.
- Since the drivers of insurance sector's flourish and customer relationship requirements conflict with the requirements to reduce fraud, therefore, companies must realize a proper balance between development goals, customer satisfaction, and detection of fraudulent practices. Therefore, operational objectives must be combined with objectives to reduce fraud and must be approved by the Board of Directors each year.

Here are some details regarding fraud done by those persons:

A. Internal fraud:

Learning objective:

Introducing internal fraud and its evidence

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:

• Complexity: 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

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:

Traditional indicators of Internal Fraud:

Typical Indicators of Internal Fraud	
Business Practices and Conditions	
Governance and Organizational Structure	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.
Operational Management	Training programs are weak.
	The times and places of making deals and the parties to it are un-usual.
	Activities are not consistent with the stated policies of the insur-ance company.
	Employee rotation at the management level is high.
	Staff turnover is frequent in finance and/or accounting de-part-ments.
	Absence or obsolescence of procedural evidence.
	Limited documentation of transactions, operations or expenses.
	Tasks and deals are complex and require special skills.
Accounting and Finance	Assets are restructured without justification.
	Weakness of accounting procedures
	Results and financial ratios are not correlated
	Value of stock changes without explanation
	Costs increase without justifications or are high compared to competitors.
	Financial problems emerge
Internal Control	Weakness of internal control structure.

Internal Audit	Information from previous investigations is insufficient
	Internal audits are weak or non-existent
Information Technology	Information and asset security system is weak
Claims for Compensation for Dam-age	Number of complaints from third parties is high
Others	Morale is low within the insurance company or within some departments in this company.
	Managers or employees, who do not want to 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.

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:

Typical Indicators of Fraud Practiced by Policyholders	
General Indications	
Claimant Behavior	
General Behavior	Claimant does nothing to avoid or limit damage
	Claimant dodges to avoid answering and does not cooperate when reenacting an incident
	The claimant makes inconsistent statements either to the police, experts or third parties.
	Claimant keeps claim details away from others (e.g. family, friends, neighbors, etc.)
	Claimant takes up work in person or over phone, and avoids written communication
	Claimant demonstrates in-depth knowledge of insurance terms and claims procedures
	Claimant verifies policy coverage shortly before the claimed incident

General Behavior	Claimant changes his/her address, bank details and phone number shortly before submitting the claim
	Claimant insists on using the services of certain contractors, engineers, or physicians without a valid reason
	Claimant avoids giving information about previous insurance refusal when applying for new insurance
Coverage	Policyholder owns several insurance policies for the same purpose with same coverage
	Policyholder often changes insurance companies
	Policyholder insists on conditions amendment
	Claimant raises claim in an impressive manner (including but not limited to seeking advice of her/his attorney or other professional advice in filing a claim)
Payment	The claimant requests the payment in cash.
	Claimant requests payment to be placed in different accounts
	Claimant requests payment to be made to a third party
	Claimant insists that payment exceeds the value of damaged items
Quick Settlement	Claimant insists on a quick settlement
	Claimant threatens to hire a lawyer if the settlement is not done quickly
	Claimant is constantly inquiring about the progress of settlement
	claimant accepts a low settlement to receive a quick settlement

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

Typical Indicators of Fraud Practiced by Insurance /Reinsurance Services Providers	
Finance	The broker is in financial trouble
Portfolio	The broker has a small portfolio with large sum insured
	Number of insurance policies, which requires a commission higher than the first premium, is high
	The portfolio contains delays of premium payments
	The portfolio contains a high number of fraud claims or a disproportionate number of policyholders and high-risk individuals (including but not limited to the disabled)
Processes	Broker works outside policyholder's area
	Broker asks for immediate or advance commission payment
	Broker requires policyholders to make payments by the broker itself, which is an uncommon practice in the field
	Premiums received or commissions paid are above or below the normal for the specified type of policies
	Broker has a relatively high claims ratio
	Broker is experiencing an exceptional increase in production for no apparent reason
	Broker has a high level of early cancellation of insurance policy
	Broker has a large number of settled claims
	Broker insists on seeking help of some loss adjusters and/ or some designated contractors for repairs
	Broker often changes control or ownership
Behavior	Broker has a personal or close relationship with the client
	Broker often changes his/her name and address
	Broker has a number of complaints or legal inquiries

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.

6.2.3 Fraud cost in the insurance sector:

Learning objective:

Identify the implications of fraud on insurance

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. For example, motor vehicle insurance fraud cases reached around 15,000 in 2019.

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).

6.3 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

6-4 Obstacles Facing Insurance Companies in KSA

6-4-1 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 se rvices companies, which increased the demand for qualified personnel.

We would like to mention here that the Saudi Central Bank (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.

6-4-2 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.

6-5 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

6-6 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 admin administrators' services.

6-7 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.

6-8 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.

6-9 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. There are also electronic transactions, which are the most widely used method by money launderers. 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 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.

Revision questions:

Answer the following questions, and check your answer in the corresponding section:

1. Q1: Explain what is meant by product development risk?
   Reference 6-1

2. Q-2 What should the company do in order to manage claim settlement risks?
   Reference 6-1-3

3. Q-3 Explain what is meant by solvency risk of insurance companies?
   Reference 6-4-1

4. Q4: What should the company do in order to face credit risk?
   Reference 6-1-5

5. Q-5 How do insurance companies face IT risks?
   Reference 6-1-6

6. Q-7 What are the stages of money laundering?
   Reference 6-9

7. Q-8 List four indicators for internal fraud.
   Reference 6-2-2

8. What is pricing risk?
   Reference 6-1-2

9. Q-10 Insurance companies face fraud in different methods. list these methods and their effect on insurance companies.
   Reference 6-1

Insurance Terminologies

Typical Indicators of Internal Fraud	
English	Arabic
Insurance	التأمين
Risk	الخطر
Objective Risk	الخطر الموضوعي
Subjective Risk	الخطر العشوائي
Financial Risk	الخطر المالي
Non-Financial Risk	الخطر غير المالي
Pure Risks	الأخطار البحتة (المحضة)
Speculative Risks	أخطار المضاربة
Fundamental Risks	الأخطار الاساسية (العامة)
Particular Risk	الأخطار الخاصة
Law of Large Number	قانون الأعداد الكبيرة
Peril	مسبب الخطر
Hazard	مؤثر الخطر
Physical Hazards	المؤثرات المادية
Moral Hazard	مؤثر الخطر المعنوي
Attitudinal Hazard (Morale Hazard)	مؤثر الخطر السلوكي
Reinsurance	إعادة التأمين
Facultative Reinsurance	إعادة التأمين الاختياري
Treaty Reinsurance	إعادة التأمين الاتفاقي
Utmost Good Faith Principle	مبدأ منتهى حسن النية
Insurance Interest Principle	مبدأ المصلحة التأمينية
Marine Insurance	التأمين البحري
Life (Protection and Savings)	تأمين الحماية والادخار
General Insurance	التأمين العام
Indemnity Principle	مبدأ التعويض
Depreciation	الاستهلاك
Agreed Value	القيمة المتفق عليها
First Loss Insurance	تأمين الخسارة الأولى
Average	النسبية (المعدل)
Underinsurance	الشيء موضوع التأمين
Sum Insured	مبلغ التأمين
Deductibles	مبلغ التحمل (الاقتطاع)
Reinstatement	جبر الضرر (الجديد بدل القديم)
Subrogation Principle	مبدأ الحلول
Contribution Principle	مبدأ المشاركة في التعويض
Proximate Cause Principle	مبدأ السبب المباشر
Warranties	الاشتراطات
Endorsement	الملاحق
Underwriting	الاكتتاب
Bancassurance	البيع عبر المصارف

Insurance Terms

Risk
A situation involving the chance of loss or no loss, but no chance of gain.

Objective Risk
The relative difference of actual loss from expected loss.

Subjective Risk
The state of uncertainty resulting from the mindset of an individual or belief that something happened without any evidence, which is called intuition.

Financial Risk
Situations that can be specified and measured financially; meaning that they are related to the outcome of the risk not to the risk itself.

Non-Financial Risk
Risks that are difficult to be identified and measured financially due to the psychological and moral effects that vary depending on persons and circumstances.

Pure Risks
The situation in which result is a loss or no loss, and its results may be undesirable or leave us in the same state as we were before it occurred.

Speculative Risks
Risks that may result in loss or profit, e.g. Stock investment, gambling and betting, as such activities can generate financial gains or losses, or none of them.

Fundamental Risks
Risks that affect large groups of individuals, i.e. basic hazards whose causes are beyond control of an individual/group of individuals and whose effects extend beyond an individual including whole community or a large segment thereof.

Particular Risk
Particular risks are, to a large extent, individual risks in their origins e.g. fire theft, disability and other risks that affect an individual or a group of individuals rather than the society as a whole.

Insurance Interest
The principle of insurance interest indicates that “there must be a legally valid interest between insurance applicant and thing or person subject to insurance, as it benefits from not being harmed and for its continued existence, and is harmed if a risk is realized and this thing or person suffers any damage.

Law of Large Number
It means that for a risk to be insurable, there must be a large number of similar risks.

Peril
Events and factors that cause/constitute the main cause of loss, e.g. accidents, earthquakes, storms, fires, explosions, and such causes are usually beyond control of an individual.

Hazard
Hazards are conditions that increase size of loss or increase the chance of a loss occurrence. For example, precipitation on roads leads the driver not being able to see clearly, and this increases possibility of a collision with other vehicles.

Physical Hazard
Triggers or physical factors in insured item that cause occurrence of loss or increase its severity.

Moral Hazard
Hazard related to insurance applicant, which may increase possibility of a loss, due to his negligence, mismanagement, or lack of a sense of responsibility. It arises from intentional or unintentional unethical and illegal behavior of individuals.

Attitudinal Hazard (Morale Hazard)
Involves the increase in likelihood of risk or size of loss as a result of policyholder's neglect due to existence of insurance, or in other words arising from the position of policyholders, which is different from moral hazard, as there is no underlying bad intention to cause the loss.

Reinsurance
Reinsurance is a technical process between insurance and reinsurance companies under which the insurance company transfers liabilities completely or partially to reinsurance company (reinsurer) for a premium (fee). Under such process, insurance company acts like the insured with respect to the reinsurer, but it remains insured toward policyholders, and the reinsurer acts as the insured with respect to the insurance company, and this process is practiced by insurance companies.

Utmost Good Faith Principle
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 any information material to the contract, and if one of the parties breached this principle, the contract will be void or voidable according to the reason for the breach.

Insurance Interest Principle
The legal right to insurance arising from a legal financial relationship between a person and thing insured. It means that the person benefits from an insurance policy must be the one to whom the financial loss occurred at the time such thing subject of insurance suffered loss or damage.

Indemnity Principle
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.

Deductibles
Also known as "deduction", first amounts paid by policyholders and are deducted from value of any claim and some voluntary deductions.

Reinstatement
Indemnity will be the full cost of replacement without any deductions for wear and tear, meaning that policyholder will receive the value of the damage incurred.

Subrogation Principle
The right of insurance company (insurer) to replace the insured in pursuing a third party responsible for a loss suffered by the insured after the insurer compensates the insured.

Contribution Principle
In cases of multiple insurances, the policyholder has the right to ask other policyholders to participate in policyholder's compensation, i.e. the insurance company has the right to ask other insurance companies (which have insured the same subject matter of insurance) to participate in compensation commission.

Proximate Cause Principle
The direct cause that leads to the occurrence of the insurance loss detailed in the insurance policy.

Insurance Contract
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.

Consent
The expression of will of each of the contracted parties, where such wills must meet.

Underwriting
It is the 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.

Direct sale
This channel is a way to sell insurance products through insurance company, directly, whether through direct communication with insurance applicants or through insurance company's sales representatives.

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.

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.

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.

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.

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.

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.

Multiple Choice Questions

The questions are developed to give students an overview sample of test questions. However, please note that they are not the actual approved exam questions for the Insurance Foundations Certificate:

Please choose one answer for each question. Then check the answers at the end of this section.

Chapter One Self-Assessment Questions

Choose the best answer to each question.

Q1: 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

Q2: Insurance deals with risk on the basis of:
A. Risk prevention
B. Risk avoidance
C. Risk transfer
D. Risk removal

Q3: 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

Q4: For risk to be insured, it must be:
A. Speculative and fortuitous
B. Pure and fortuitous
C. Inevitable and pure
D. Speculative and inevitable

Q5: 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

Q6: Public interest can be defined as:
A.The interests of the public or society as a whole.
B. The conditions in the policy

C. The laws of the country
D. The exclusions in the policy

Q7: 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

Q8: 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

Q9: 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

Q10: 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. To reduce the risk of loss

Q11: One of the following is considered a self-employment insurance profession
A. Cooperative insurance companies
B. Cooperative reinsurance companies
C. Insurance brokerage companies
D. Council of Cooperative Health Insurance (CCHI)

Q12: CCHI is one of the regulatory and supervisory authorities over insurance companies; CCHI main tasks are:
A. Granting a business license to insurance brokers
B. Selling medical insurance policies to insurance seekers
C. Investing accumulated premiums from insurance companies
D. Qualifying medical service providers

Q13: The entity that grants a license to actuarial firms is:
A. Saudi Central Bank (SAMA)
B. Ministry of Commerce
C. Chamber of Commerce
D. Insurance Dispute Resolution Committees

Q14: Insurance Claims Adjusters, an insurance profession that:
A. Provides advisory services related to insurance activity
B. Concludes documents with insurance companies
C. Examines and inspects the subject of insurance before being insured
D. Manages, reviews and settles insurance claims

Q15: The insurance amount in the medical insurance policy approved by CCHI:
A. Unlimited and policyholders can proceed with any value
B. SAR 1 million
C. SAR 500,000
D. SAR 10 million

Q16: The Implementing Regulations issued by SAMA and related to risks that insurance companies are exposed to:
A. Regulations for Supervision and Inspection Costs
B. Regulation of Reinsurance Activities
C. AML/CFT Introductory Course
D. Foreign Investment Regulation

Q17: Functions of General Secretariat of the Council of Cooperative Health Insurance include:
A. Developing and implementing the operational policies and procedures
B. Insurance companies
C. Licensing hospitals and medical centers
D. Renewing the residence of non-Saudi employees

Q18: One of the key obligations of health insurance companies is:
A. Providing medicines and treatments
B. Medical examination of patients
C. Licensing of physicians and medical practitioners
D. Giving approvals to provide medical treatment within 60 minutes

Q19: Subject to the law and under the supervision of the Capital Market Authority, insurance companies are required to offer shares to citizens to subscribe for at:
A. 100% of the insurance company's capital
B. 60% of the insurance company's capital
C. 50% of the insurance company's capital
D. 40% of the insurance company's capital

Q20: Where there is a non-Saudi partner in an insurance company, he must obtain the license from:
A. General Investment Authority
B. Saudi Central Bank only
C. Ministry of Commerce and Investment
D. Ministry of Human Resources and Social Development

Q21: One of the following is a standard personal insurance product
A. Contractors' All Risks
B. Factory Insurance
C. Commercial Auto Insurance
D. Home Insurance

Q22: Among the standard corporate insurance coverage
A. Physicians' professional liability insurance
B. Reinsurance Agreement
C. Contractors equipment insurance
D. Private Car Insurance

Q23: Among the insurance coverages for companies operating in the field of maritime transport:
A. Travel insurance
B. Emergency diseases affecting seamen
C. Insurance covering personal accidents affecting seamen during vacation
D. Securing goods during transportation

Q24: The Fidelity Guarantee Insurance policy compensates the insured in the event of:
A. Misappropriation of funds by an employee of the insured
B. Robbing money in transit
C. Damage to the insured's safe
D. Theft of the insured's warehouse

Q25: Limitations of Liability in Third Party Car Insurance in the Kingdom is:
A. Three hundred thousand riyals for an accident or total accidents
B. Five hundred thousand riyals for an accident or total accidents
C. Million riyals for an accident or total accidents
D. Ten million riyals for an accident or total accidents

Q26: Which of the following is an engineering insurance:
A. Motor insurance
B. Healthcare
C. Money insurance
D. Contractor all risk insurance

Q27: Additional motor insurance include
A. Driver medical insurance
B. Professional liability insurance for the driver as a physician
C. Driver's personal accident insurance
D. Driver's home insurance

Q28: Damage to contractor equipment can be covered under:
A. Motor insurance
B. Contractors General Liability Insurance

C. Machinery Breakdown and Deterioration of Stock (DoS) insurance
D. Contractor Plant and Equipment insurance

Q29: Among the main coverages for aviation hazards
A. Diseases that affect pilots
B. Damage to airport grounds
C. Damage to pilots' homes
D. Damage to pilots' vehicles

Q30: In order for insurance companies to accept insurance against deterioration of stock in refrigerators, the following insurance coverage must be available
A. Fire insurance
B. Boilers and digesters insurance
C. Domestic workers' insurance
D. Property insurance for shop owners.

Q31: Which of the following is one of the purposes of Implementing Regulations of the Cooperative Insurance Companies Control Law in the Kingdom of Saudi Arabia?
A. These regulations include the general principles and minimum standards that insurance companies must abide by, including branches of foreign insurance companies and insurance/re-insurance service providers licensed by the Saudi Central Bank in dealing with their current and potential customers
B. The objective of these regulations is to establish high standards for running insurance business regardless of the insurance companies' performance.
C. The regulations provide for general standards, the full compliance with which is not a strict requirement for insurance companies
D. The regulations do not apply to foreign companies operating in the Saudi market

Q32: A general requirement in the regulations is integrity, which provides that:
A. The licensed companies shall operate with integrity, transparently and fairly, and fulfill all of their obligations towards the customers in accordance with the regulations and instructions of the Saudi Central Bank.
B. The licensed companies shall discriminate between their customers, both current and future customers, and shall provide reasonable reasons for refusing, canceling, or not renewing insurance policies.
C. The licensed companies shall not take reasonable measures to ensure the validity and clarity of information provided to customers and to make such information available in written form.
D. The licensed companies shall exercise due diligence towards small-scale customers, but this does not apply to large-scale customers.

Q33: Article 52 of the Regulations provides that (the insurance policy shall be written clearly and in a language that is easily understood by the general public, and shall include the following)
A. The policy number, which shall be stated in all papers related to the policy.

B. The insured's name and mailing address. The address of specific customers is not requested.
C. Term of insurance for certain insurances only
D. The type of insurance coverage granted without specifying the scope of coverage

Q34: The period allowed for considering the P&S policy is
A. 15 days
B. 20 days
C. 21 days
D. 18 days

Q35: Licensed companies shall not directly or indirectly provide inaccurate, misleading, exaggerated or deceptive statements or announcements, including but not limited to information on:
A. Name of insurance company issuing the insurance policy
B. The financial position of the insurance company issuing the insurance policy, which is not important for customers
C. Property insurance coverage
D. The price of insurance policy without indicating any other related fees.

Q36: Information that the insurance company must disclose before a customer applies for insurance coverage
A. Whether it is an insurance company, works for an insurance company, or operates independently for a profit
B. If there is a financial relationship between the broker and the insurance company other than the regular commission agreements, and in particular if there is any joint ownership or if the parties have joint owners, which the customer must be informed of
C. The nature and scope of products and services that may be offered or obtained from re-insurers
D. Giving advice and recommendations in accordance with the insurance company's interests

Q37: The insurance company must disclose the following information when the customer applies for an insurance policy:
A. Claims settlement procedures that the company is entitled to initiate
B. Complaints processing procedures
C. The insured's obligations and duties under the insurance policy
D. Requirements related to renewal of corporate insurance policies

Q38: If the funds of insurance policy holders to be invested in a group of unit-linked funds, those funds must be specified, and such specification must include, at a minimum, the following:
A. Categories of assets in which the fund can invest in the Kingdom only
B. A rating for each fund in terms of risk and price volatility for offshore units
C. The criterion, if any, based on which the fund is measured
D. The currency in which the fund is priced locally, and no foreign currency is accepted.

Q39: After making the deal, licensed companies must provide services to customers in a timely and appropriate manner, including to answer their inquiries, administrative requests, and the requests to amend insurance policies. In particular, the licensed companies must:

A. Provide certificates of insurance when requested by the customer

B. Submit written confirmation of any amendments to the insurance policy and any additional charges, but subject to the insured having paid the premiums, otherwise the insured shall not be notified of the same.

C. Issue receipts for any amounts received by any payment method, credit card or other form of automated bank transfer.

D. Pay the refundable amounts or any other fees payable to the customer according to the company's interest

Q40: To settle the claims, the licensed companies must:

A. Respond to the claims received as per the days they specify for that purpose.

B. Provide the customer with the claim forms indicating all the information or procedures required to be filled in by the customer (including the beneficiary for the protection and saving insurance policy) in order to place the claim. Otherwise, the company may reject the claim

C. Acknowledge to the customer that the claims has been received and notify him of any missing information within (7) days of receiving the claim form.

D. Notify the customer orally in case of rejection and in writing upon acceptance of the claim

Q41: The insurance policy is binding, is this a binding force for:

A. The insurance company only

B. The insured only

C. Both parties to the policy

D. Not binding on any party

Q42: The comprehensive definition of an insurance policy must include:

A. The legal aspect only

B. The theoretical aspect only

C. The legal and theoretical aspects

D. Definition of any correct aspect

Q43: In order for an insurance policy to be a complete contract, it must have:

A. Offer only

B. Acceptance only

C. One party agrees to the terms of the contract

D. Both offer and acceptance

Q44: The consent under an insurance contract shall be of:

A. The insured, who is the person who contracts with an insurance company to insure himself against a specific risk

B. The Insurer, i.e. the insurance company

C. The insurer, i.e. the insurance company, and the second party (the insured), who contracts with the insurance company to procure an insurance
D. The reinsurer

Q45: The two parties to the insurance policy are:
A. The insured and insurance company
B. Insurance application and insurance policy
C. Insurance application and insurance offer
D. Insurance offer and insurance policy

Q46: One of the following is a defect of will in an insurance contract:
A. The high price of insurance premium
B. Insuring the Insured's property in one policy
C. Existence of consent with error and fraud
D. The insurance company rejects the insurance application

Q47: The subject matter of insurance policy must:
A. Be acceptable to the insured
B. Be acceptable to the insurance broker
C. Contain any property that can be insured
D. Be legally acceptable and known to both parties

Q48: The reason for the insurance contract is:
A. Direct purpose of insurance
B. Insurance parties
C. Subject matter of contract
D. The consent (offer & acceptance)

Q49: One of the characteristics of an insurance policy is that it is a netting contract, which means:
A. The insured receives compensation only
B. The competent authorities receive their fees
C. Insurance companies receive the premium only
D. Each party receives something in return for what he gives

Q50: Probability in an insurance policy means:
A. The insured is exposed to inevitable risk
B. The insurance company provides coverage for a risk that is unlikely to occur
C. The insurance company provides coverage for pre-insurance risks
D. The insurance company provides coverage for potential and pre-insurance risks

Q51: Utmost good faith principle can be defined as:
A. The insurance company provides coverage for pre-insurance risks
B. The insured does not cause an accident without intent
C. The insurance amount must be disclosed
D. The financial relationship between the insured and the insurance subject

Q52: Utmost good faith principle applies on:
A. Insured
B. Insurance company only
C. Both the insurance applicant and the insurer
D. There is no obligation on the parties to contract to show good faith

Q53: 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

Q54: The age of the insured is a material fact in:
A. Fire insurance
B. Store Robbery
C. Private motor insurance
D. All contractors risk

Q55: A comprehensive vehicle insurance includes some material facts to help the underwriter evaluate the moral hazard effect:
A. Vehicle type
B. Vehicle use
C. The age of the insurance applicant
D. Previous losses

Q56: 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. Any fact that increases the risk from the norm. For example, a car engine modified to make it go faster

Q57: When insurable interest in the general insurance should be present?
A. At policy inception
B. During the policy validity
C. When loss occurs
D. At the beginning of the coverage

Q58: What are the available options for providing indemnity?
A. Replacement with one of the insurance company's fixed assets
B. Giving a free insurance policy
C. Issuing a post-dated check for one year
D. Cash payment

Q59: Who has the power to choose indemnity method?
A. Policyholder

B. Third party
C. Insurance company
D. The party affected by the loss.

Q60: What is the principle supported by the Contribution Principle and the Subrogation Principle?
A. Insurable interest
B. Indemnity
C. Proximate cause
D. Utmost good faith

Q61: 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

Q62: 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

Q63: 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

Q64: 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

Q65: One of the following is considered a major selling channel in insurance companies:
A. Newspaper advertisements
B. Reinsurance Agreement
C. Social Responsibility of the company
D. Insurance Brokers

Q66: 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

Q67: 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

Q68: 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

Q69: The steps of identifying the insured applicant is known as:
A. Claims Settlement
B. Receiving claims
C. Customer Service
D. Underwriting

Q70: The body responsible for accounting and financial management for the administration and the regulatory authorities, as requested, are:
A. Financial operations
B. Underwrite
C. Marketing
D. Reinsurance

Q71: The minimum permitted rating of reinsurance companies to which insurance companies must comply with in accordance of the instructions of the Saudi Central Bank:
A. AAA
B. BBB
C. CCC
D. DDD

Q72: 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 treaties of insurance companies
D. Failure to increase the penetration rate in the insurance market

Q73: 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

Q74: External fraudsters on insurance companies can be:
A. Employees on a vacation
B. Board of directors
C. Insurance brokers
D. Insurance representatives

Q75: One of the following is a negative effect of solvency:
A. Stop performing its obligations
B. Ask the insured to provide proper collateral or guarantee
C. Implement a strict schedule for paying dues of premiums or other
D. Putting restrictions on granting credit in terms of quality and quantity

Q76: One of the following is a negative effect of insolvency:
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

Q77: 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 the launch of the new product
D. Increase in insurance rates

Q78: One of the following is a procedure followed by insurance companies to face 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

Q79: 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

Q80: To prepare for countering insurance risk, insurance companies do one of the following:
A. The high rate of policy cancellation
B. Using sound practices to manage company's assets
C. Implement a strict schedule for paying dues
D. putting restrictions on granting credit

Q81: 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

Q82: What are the risks arising from determining the right value of premium by the company?
A. Settlement risk
B. Pricing risk
C. Marketing risks
D. financial risks

Q83: When an insurance company faces pricing risk, it must:
A. Stop performing its obligations
B. Engage actuary to set prices for the product
C. Develop and implement appropriate mechanisms to set the appropriate precautions
D. Conduct a periodic evaluation of claims settlement procedures and principles to enhance their effectiveness and quality

Q84: Which of the following is not considered an obstacle to solvency risk:
A. Stop performing its obligations
B. Companies stop subscribing some types of insurance, causing reduction in the companies' revenues
C. Companies stop subscribing all types of insurance, and consequently the resources are substantially decreased
D. Placing restrictions on granting credit in terms of its quality and quantity

Q85: What are the risks posed by the inability of the other party to fulfill its obligations, which is inferred from the insured's history of default in payment of premiums?
A. Settlement risk
B. Credit risks
C. Marketing risks
D. Financial risks

Q86: When facing credit risk, the insurance company must:
A. Request the insured to provide the appropriate guarantee
B. Provide an appropriate information technology system to protect data security
C. Periodically review and continuously update the information technology system and develop disaster recovery plans
D. Use reliable and genuine software

Q87: To address the information technology risks, the insurance company should:
A. Request the insured to provide the appropriate guarantee
B. Set a strict schedule for payment of dues, i.e. the premiums and other duties
C. Keep all financial and other information in a safe place
D. Place restrictions over credit in terms of its quality and quantity

Q88: Which of the following is an example of fraud?
A. The insured discloses all facts to the insurance company
B. Demonstrating good faith in dealing with others
C. Buying shares in several insurance companies
D. Misallocation of the insured assets in order to submit claims at a later time

Q89: Which of the following is defined as fraud against an insurance company in the purchase and or execution of an insured product by a person (s) conspiring to receive payment or untrue coverage.
A. Internal fraud
B. Fraud of insurance policy holder
C. Fraud of brokers
D. External fraud

Q90: Which of the following is one of the factors that increase the chance of internal fraud?
A. Remuneration and promotions policies
B. Age of company
C. Number of insurance companies
D. Number of insureds.

Q91: Which of the following is an example of brokers involved in insurance company fraud:
A. The claimant makes inconsistent statements either to the police, experts or third parties
B. Fabrication of incidents causing damage or loss covered by the policy
C. The insured person does not take any action to avoid or limit damage
D. Withholding premiums paid by the policyholder until the claim is paid

Q92: SAMA controls cooperative insurance companies in the Kingdom by:
A. Approving insurance products of insurance companies
B. Determining the sale price of insurance policies to clients
C. Determining the number of employees in insurance companies

D. Determining the size of buildings owned by insurance companies

Q93: In order to obtain license, insurance and reinsurance service providers must meet several requirements, namely:
A. Obtaining an English proficiency certificate
B. Being over 30 years old
C. Having at least 10 years of experience in insurance companies
D. Obtaining a university degree with at least five years of insurance experience or a specialized insurance certificate

Q94: Which authority is responsible for managing and supervising the investment environment of foreign investors in KSA and controlling insurance companies in which there are non-Saudi investors?
A. Saudi Central Bank
B. General Investment Authority
C. Ministry of Finance
D. Capital Market Authority

Q95: Which of the following is considered one of CMA functions:
A. Regulate and control the disclosure of information related to securities and issuers
B. Provide beneficiaries with explanatory brochures containing the policy, the scope and limits of coverage and the network of accredited providers at the beginning of coverage
C. Protect insured persons against unjustified financial losses and dishonest behavior in the insurance sector
D. Promote, develop and grow the insurance market in KSA, by innovating the tools to do so, and raise insurance awareness in the market

Q96: Which of the following is considered one of functions of the General Secretariat of the Council of Cooperative Health Insurance:
A. Protecting insured persons against unjustified financial losses and dishonest behavior in the insurance sector
B. Promoting market transparency by requiring insurance companies to publish reliable and accurate data to the public of those dealing with companies of this sector
C. Promoting, developing and growing the insurance market in KSA, by innovating the tools to do so, in addition to raising insurance awareness in the market
D. Renewing the accreditation of health facilities

Q97: .....is the legal person who inspects and surveys the insured risk prior to insurance, surveys the damage after its occurrence to find out the causes of loss, adjust its value, and determine liability.
A. Actuarial Expert
B. b. Loss adjuster
C. Insurance Agents
D. Insurance Brokers

Q98: Najm for Insurance Services Company is an example of:
A. Actuarial Expert
B. Insurance Agents
C. Loss adjuster
D. Insurance Brokers

Q99: .....is the legal person who, in return for payment, negotiates with the insurance companies to complete the insurance process for the insured.
A. Actuarial Expert
B. Insurance Agents
C. Loss adjuster
D. Insurance Brokers

Q100: Which of the following is one of the reasons that led to the regulation of the insur-**ance sector in KSA:**
A. High costs of external insurance
B. Absence of an insurance regulatory authority
C. Accession to the World Trade Organization
D. Absence of reinsurance companies

Answers to Self-Assessment Questions

Q1: Answer: A – reference: 1.2.3
Risks that may give rise to loss or gain, such as investments in stocks, gambling and betting, as these activities can bring financial gains or losses or nothing can happen.

Q2: Answer: C – reference: 1.3
We can turn to the role of insurance in the face of 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 to transfer the risk from one party (insured) to another (insurer) (the insurance company).

Q3: Answer: A – reference: 1.3
Applying this principle to the insurance enables insurers to predict more accurately the future probability and volume of losses 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.

Q4: Answer: B – reference: 1.2.4
- The risks are pure ones: Generally, not knowing future events and whether there is a loss will occur, meaning that the risk has only two outcomes, either loss or no loss.
- If the loss is fortuitous: The term “fortuitous” loss essentially means “accidental” loss. In this context, this means that any event must be beyond the control of the insured, that is, it must be accidental for the insured.

Q5: Answer: A – reference: 1.5
• **Physical hazards:**
Are the triggers or the physical hazard contributing factors in insured item that cause the loss occurrence or increase its severity, such as: bad electrical extension cord or driving a car over a street full of oil. 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.

Q6: Answer: A – reference: 1.2.5
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.

Q7: Answer: C – reference: 1.5
Events and factors that cause/constitute the main cause of loss, e.g. accidents, earthquakes, storms, fires, explosions, and such causes are usually beyond control of an individual.

Q8: Answer: A – reference: 1.5
Hazards are conditions that increase size of loss or increase the chance of a loss occurrence. For example, precipitation on roads leads the driver not being able to see clearly, and this increases possibility of a collision with other vehicles.

Q9: Answer: B – reference: 1.5

• **Physical hazards:**

Are the triggers or the physical hazard contributing factors in insured item that cause the loss occurrence or increase its severity, such as: bad electrical extension cord or driving a car over a street full of oil. 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.

• **Moral Hazard** is hazard related to insurance applicant, which may increase possibility of a loss, due to his negligence, mismanagement, or lack of a sense of responsibility. It arises from intentional or unintentional unethical and illegal behavior of individuals. Usually the person insured and it could be the employees or management. Moral hazard is always more difficult to be detected because it is not physical or tangible and cannot be touched or seen, such as, 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.

• **Attitudinal Hazard (Morale Hazard)** Involves the increase in likelihood of risk or size of loss as a result of insured's neglect due to existence of insurance, or in other words arising from the position of insured, which is different from moral hazard, as there is no underlying bad intention to cause the 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,) 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.

Q10: Answer: A – reference: 1.2.4

The loss should be measurable and identifiable: In the case of insurance on the loss of a car, it is easy to determine the extent of the damage caused to the car. While it is not possible to insure the change in a person's psychological state, because there is no unit of measure by which we can know this loss, and also it is not possible to determine its size.

Q11: Answer: C – reference: 1.8.2

First- Insurance and Reinsurance Service: Insurance Brokers

Q12: Answer: D – reference: 2.5.2

Functions of General Secretariat of the Council of Cooperative Health Insurance
Accreditation of Healthcare Providers
Renewal of Accreditation of Healthcare Facilities
Qualification of Health Insurance Companies

Q13: Answer: A – reference: 2.8.3

The entity that grants a license to actuarial firms is Saudi Central Bank.

Q14: Answer: D – reference: 5.8.2
Insurance claims adjuster manages, reviews and settles insurance claims.

Q15: Answer: C – reference: 3.5.2
The insurance amount in the medical insurance policy approved by CCHI is SAR 5000.

Q16: Answer: C – reference: 2.5.1
The Implementing Regulations issued by SAMA and related to risks that insurance companies are exposed to: SAMA's Insurance Supervision Department develops rules of Anti-Money Laundering and Counter-Terrorism Financing.

Q17: Answer: C – reference: 2.5.2
One of the functions of General Secretariat of the Council of Cooperative Health Insurance is licensing hospitals and medical centers.

Q18: Answer: D – reference: 2.5.3
One of the key obligations of health insurance companies. The insurance company must quickly grant approvals to provide treatment to beneficiaries to service providers within (60) minutes.

Q19: Answer: D – reference: 2.4.5
Since all insurance companies according to the Law must be public joint stock companies, they must offer part of their shares to public citizens at a rate of 40% of the company's capital value.

Q20: Answer: A – reference: 2.5.6
When there is a non-Saudi partner company in any insurance company, the license must be obtained from the General Investment Authority.

Q21: Answer: D – reference: 3.2.1
Individuals insurance – House insurance

Q22: Answer: C – reference: 3.2.2
Company Insurance - Engineering Insurance

Q23: Answer: D – reference: 3.2.2
Company Insurance - Marine Insurance

Q24: Answer: A – reference: 3.2.2
Misappropriation of funds by an employee of the insured

Q-25: Answer: D – reference: 1.2.3
It covers civil liability to third parties. The owner of the vehicle or driver may have a 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.

Q26: Answer: D – reference: 3.2.2
Contractors risks insurance

Q27: Answer: C – reference: 1.2.3
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.

Q28: Answer: D – reference: 3.2.2
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.

Q29: Answer: B – reference: 3.2.2
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.

Q30: Answer: D – reference: 3.2.2
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.

Q31 Answer: A – reference: 3.3.2
Insurance Market Code of Conduct Regulations
SAMA has issued the Insurance Market Code of Conduct Regulations in the Kingdom of Saudi Arabia; the purpose of these Regulations is:

These regulations include 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.

Q32: Answer: A – reference: 3.3.4
Integrity is one of the general requirements in the regulations, which states: 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 the best practices recognized internationally.

Q33: Answer: A – reference: 3.3.4
Article 52 stipulates that the Insurance Policy shall be written in a clear way that can be read by the public at large.

Q-34: Answer: C – reference: 3.3.4
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 throughout 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 to consider the policy.

Q35: Answer: A – reference: 3.3.6
Authorized companies should not disseminate inaccurate, misleading, exaggerated, or deceptive data or advertisements, directly or indirectly, including but not limited the information: Name of insurance company issuing the insurance policy.

Q36: Answer: B – 3.3.5
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.

Q37: Answer: B – reference: 3.3.5
When a customer applies for an insurance policy, the insurance company must disclose the complaints handling procedures.

Q38: Answer: C – reference: 3.3.5
The standard must be Illustrated, if the fund was measured based on a given standard.

Q39: Answer: A – reference: 3.3.7
Authorized companies must provide timely and appropriate post sale services to customers,

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.

Q40: Answer: C – reference: 3.3.7
In accordance with claim settlement, authorized companies must do the following: Acknowledge to the customer that the claims have been received and notify him of any missing information within (7) days of receiving the claim form.

Q41: Answer: C – reference: 4.2.5
Accordingly, this contract has general characteristics and special characteristics, which we will review as follows:
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.

Q42: Answer: C – reference: 4.2
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.

Q43: Answer: D – reference: 4.2.3
Consent is the expression of the will of each of the contracted parties, where these wills must meet.

Q44: Answer: C – reference: 4.2.3
• Identifying the contracted parties:
The parties to the insurance contract are (the insurer), i.e. the insurance company, and the other party is the insured, who contracts with the insurance company to insure himself against a particular risk.

Q45: Answer: A – reference: 4.2.3
• Identifying the contracted parties:

The parties to the insurance contract are (the insurer), i.e. the insurance company, and the other party is the insured, who contracts with the insurance company to insure himself against a particular risk.

Q46: Answer: C – reference: 4.2.3
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

Q47: Answer: D – reference: 4.2.3
Third element: The subject matter of insurance (contracted)
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).

Q48: Answer: A – reference: 4.2.3
Fourth element: the purpose in insurance contract:
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.

Q49: Answer: D – reference: 4.2.3
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.

Q50: Answer: B – reference: 4.2.5
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.

Q51: Answer: C – reference: 4.2.5
Insurance contract is a contract of good faith:
This means that the insurance contract must be implemented in good faith. This char

acteristic 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.

Q52: Answer: C – reference: 4.2.5
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.

Q53: Answer: D – reference: 4.1
A material fact is any information 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.

Q54: Answer: C – reference: 4.1
Motor insurance: purpose of using the vehicle or the age of the insurance applicant.

Q55: Answer: D – reference: 4.1
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.

Q56: Answer: A – reference: 4.1

Insurable Interest "the legal right to insurance arising from a legal financial relationship between the person and the insured item. "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.

Q57: Answer: D – reference: 4.1

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.

Q58: Answer: D – reference: 4.1

Methods of providing indemnity:

A. Cash 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.

Q59: Answer: C – reference: 4.1

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.

Q60: Answer: B – reference: 4.1

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.
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.

Q61: Answer: B – reference: 5.1.1
Audit Committee

Q62: Answer: C – reference: 5.2.2
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.

Q63: Answer: D – reference: 5.1.1
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.

Q64: Answer: C – reference: 5.2.3
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.

Q65: Answer: D – reference: 1.2.5
• 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.

Q66: Answer: D – reference: 5.2.4
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.

Q67: Answer: B – reference: 5.2.3
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.

Q68: Answer: D – reference: 1.2.5
Channels of selling insurance – sale through agents

Q69: Answer: D – reference: 5.2.2
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).

Q70: Answer: A reference: 5.2.5
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.

Q71: Answer: B – reference: 5.1.2
Compliance Officer Responsibilities:
• Follow-up with reinsurance companies and confirm the minimum rating of BBB.

Q72: Answer: B – reference: 6.2
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.

Q73: Answer: C – reference: 6.1.4
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.

Q74: Answer: C – reference: 6.2.2
Insurance brokers fraud

Q75: Answer: A – reference: 6.1.4
• Companies are not meeting their obligations.

Q76: Answer: B – reference: 6.1.4
• Companies have stopped offering some types of insurance, causing a decrease in corporate revenues.

Q77: Answer: C – reference: 6.1
Prepare a report on the changes in risks and the insured behavior from the date of launching the new product.

Q78: Answer: C – reference: 1.1.6
• Ensure that premiums include the cost of policies, including indirect costs of marketing or any other charges.

Q79: Answer: D – reference: 6.1.3
Claim settlement risk

Q80: Answer: C – reference: 6.1.5
• Implement a strict schedule for paying dues of premiums or other.

Q81: Answer: B – reference: 8.6
Wars and political instability

Q82: Answer: B – reference: 6.1.2
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, and when the company faces pricing risk.

Q83: Answer: B – reference: 6.1.2
• Engage actuarial experts in product pricing.

Q84: Answer: D – reference: 6.1.4
The solvency 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.

Q85: Answer: B – reference: 6.1.5
Credit risk associated with other party's inability to meet its obligations as evidenced by the history of the insured's late payment of premiums.

Q86: Answer: A – reference: 6.1.5
Ask the insured to provide proper collateral or guarantee

Q87: Answer: A – reference: 6.1.6
• Keep all financial information and other information in a safe place.

Q88: Answer: D – reference: 6.2
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, including 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.

Q89: Answer: B – reference: 6.2.2
• 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.

Q90: Answer: A – reference: 6.2.2
• Rewards and promotions policies: the motivation for fraud may be greater if the

employee›s status and salary depend on achieving certain objectives.

Q91: Answer: D – reference: 6.2.2
• Withholding premiums paid by the policyholder until the claim is paid.

Q92 Answer: A – reference: 2.5.1
The Bank is responsible for monitoring Cooperative Insurance Companies in KSA through:
• Approving insurance products for insurance companies.

Q93: Answer: D – reference: 2.8
As for insurance practitioner, i.e. natural persons licensed to practice any profession related to insurance or reinsurance business and work for self-employed professionals, they must meet the following requirements to obtain SAMA's license:
• Holding a university degree with at least five years of insurance experience or a specialized insurance certification.
• Pass the approved examination for the required profession or obtain an equivalent qualification.

Q94: Answer: B – reference: 2.5.7
MISA is the authority responsible for managing and supervising investment environment for foreign investors in KSA, as well as controlling insurance companies involving non-Saudi investors.

Q95: Answer: A – reference: 2.5.4
Organizing and controlling disclosure of information related to securities and issuers thereof.

Q96: Answer: D – reference: 2.5.3
• Renewal of Accreditation of Healthcare Facilities: Renewing healthcare facility accreditation comes as a control step with a regulatory role, and is one of the basic tools for maintaining quality levels in healthcare facilities to ensure they perform the role entrusted thereto to the fullest extent. Accreditation of healthcare providers is renewed annually or every two or three years for some of categories, after they fulfill accreditation renewal requirements, as an extension of the previous accreditation.

Q97: Answer: B – reference: 2.8.4
The loss adjuster and loss assessor is the legal person who inspects and surveys the insured risk prior to insurance, surveys the damage after its occurrence to find out the causes of loss, adjust its value, and determine liability.

Q98: Answer: C – reference: 2.8.4
The following inspection and loss assessment companies have been licensed (up to the editing date of this academic material).

Q99: Answer: D – reference: 2.8.1
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.

Q100: Answer: C – reference: 2.3
Accession to the World Trade Organization.

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