Specimen coursework assignment

M85 – Claims practice

The following is a specimen coursework assignment including questions and indicative answers.

It provides guidance to the style and format of coursework questions that will be asked and indicates the length and breadth of answers sought by markers. The answers given are not intended to be the definitive answers; well-reasoned alternative answers will also gain marks.

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Coursework submission rules and important notes

Before you start your assignment, it is essential that you familiarise yourself with the information in the *Coursework Support Centre* available on www.revisionmate.com

Please note the following information:

- These questions must not be provided to, or discussed with, any other person regardless of whether they are another candidate or not. If you are found to have breached this rule, disciplinary action may be taken against you.
- Important rules relating to referencing all sources including the study text, regulations and citing statute and case law.
- Penalties for contravention of the rules relating to plagiarism and collaboration.
- Coursework marking criteria applied by markers to submitted answers.
- Deadlines for submission of coursework answers.
- You must not include your name or CII PIN anywhere in your answer.
- The total marks available are 200. You need to obtain 120 marks to pass this assignment.
- Your answer must be submitted on the correct answer template in Arial font, size 11.
- Answers to a coursework assignment should be a maximum of 10,000 words. The word count does not include diagrams however, it does include text contained within any tables you choose to use. The word count does not include referencing or supplementary material in appendices. **Please be aware that at the point an assignment exceeds the word count by more than 10% the examiner will stop marking.**

Top tips for answering coursework assignments

- Read the Learning Outcome(s) and related study text chapter for each question before answering it.
- Ensure your answer reflects the context of the question. Your answer must be based on the figures and/or information used in the question.
- Ensure you answer all questions.
- Address all the issues raised in each question.
- Do not group question parts together in your answer. If there are parts (a) and (b), answer them separately.
- Where a question requires you to address several items, the marks available for each item are equally weighted. For example, if 4 items are required and the question is worth 12 marks, each item is worth 3 marks.
- Ensure that the length and breadth of each answer matches the maximum marks available. For example, a 30 mark question requires more breadth than a 10 or 20 mark question.

M85 Specimen coursework assignment

The coursework questions link to the Learning Outcomes shown on the *M85 syllabus* as follows:

Question	Learning Outcome(s)	Chapter(s) in the Study Text	Maximum marks per answer
1	Learning Outcome 1	Chapter 1 to 5	30 marks
2	Learning Outcome 2	Chapter 6	10 marks
3	Learning Outcome 3	Chapters 7	10 marks
4	Learning Outcome 4	Chapters 8 to 10	20 marks
5	Across more than one Learning Outcome	Across more than one chapter	20 marks
6	Across more than one Learning Outcome	Across more than one chapter	20 marks
7	Across more than one Learning Outcome	Across more than one chapter	30 marks
8	Across more than one Learning Outcome	Across more than one chapter	20 marks
9	Across more than one Learning Outcome	Across more than one chapter	10 marks
10	Across more than one Learning Outcome	Across more than one chapter	30 marks

M85 specimen coursework questions and answers

Question 1 – Learning Outcome 1 (30 marks)

You are a claims handler for DB plc, a UK based insurer. A policyholder, Mr Jarvis, insures his private car with you on a comprehensive basis.

Mr Jarvis notifies you of a claim for damage to his vehicle that has been damaged whilst parked on a public road. You investigate the claim and discover the car did not have a valid certificate to demonstrate its roadworthiness. Mr Jarvis' motor policy wording excludes cover when the car does not have a current certificate of roadworthiness.

DB plc also discovers that Mr Jarvis has an unspent conviction for shoplifting. The shoplifting conviction occurred prior to the inception of the policy. The insurer voids the policy from inception, as they had not been advised of the shoplifting conviction. The insurer states that they would still not pay the damage claim, even if the policy voidance decision was unsuccessful, in view of the policy exclusion regarding roadworthiness.

Mr Jarvis complains to DB plc, indicating that the conviction question on the motor insurance proposal form only asked for details of motoring convictions. Additionally, he complains he was unaware of the roadworthiness exclusion in the policy.

(a) Discuss the policy voidance decision taken by the insurer. (20)

(b) Discuss the policy exclusion in relation to the roadworthiness exclusion, should the policy voidance decision be unsuccessful. (10)

Answer to question 1 (Learning Outcome 1)

(a) The insurer may consider a previous unspent conviction for shoplifting to be material information. A driver with a criminal record, depending on the nature of the conviction history, represents a moral hazard to the insurer and they would likely wish to either (i) decline to quote, or (ii) apply underwriting terms to reflect the moral hazard.

The insurer would be expected to include a question at insurance proposal stage that required Mr Jarvis to disclose the shoplifting conviction on a proposal form. In addition, Mr Jarvis could be provided, prior to policy inception, with a Statement of Facts by the insurer, that he would be expected to read and advise of any inaccuracies.

As per the Consumer Insurance (Disclosure and Representation) Act 2012 (CIDRA), Mr Jarvis is expected to take reasonable care to answer the insurer's questions fully and accurately (CII study text, M85 Claims practice, 2018).

The insurer's decision to void the policy would suggest that the non-disclosure was both relevant to the underwriting of the risk and a deliberate or reckless omission by Mr Jarvis. Under CIDRA, an insurer is entitled to avoid the contract where they consider the non-disclosure to be deliberate or reckless (CII study text, M85 Claims practice, 2018).

Mr Jarvis has challenged the insurer's policy avoidance on the basis that they did not ask for convictions, only 'motor convictions'. The insurer should review the insurance proposal process to consider the validity of the challenge. Mr Jarvis may have completed the proposal by telephone, internet, email or post but regardless of the medium, there should be evidence available to review.

If the review establishes that the question was clearly asked for all types of convictions and Mr Jarvis provided a negative response, then the insurer should maintain the policy avoidance. If the review establishes that there is ambiguity in the question then further consideration will be required. It could be argued that any ambiguity constitutes a breach of the Financial Conduct Authority (FCA) principle of treating customers fairly (CII study text, M85 Claims practice, 2018). In fact, the Association of British Insurers recommends that if insurers require details of motoring and non-motoring convictions, they should ask two specifically worded questions, relation to each type.

It may be that the non-disclosure was 'careless' with the question asking for 'convictions' with Mr Jarvis assuming that this applied to motoring convictions only. In the circumstances, the insurer may decide that the question was sufficient for Mr Jarvis to volunteer the shoplifting conviction even if he was unsure of its relevance. If the non-disclosure was careless, then the insurer would need to evidence that, had they been made aware of the shoplifting conviction, they would have declined to offer insurance (for a policy avoidance to be upheld).
If the policyholder is correct and he was only asked about motoring convictions, then the insurer would reinstate the policy. Mr Jarvis would be entitled, as a consumer, to

take his complaint to The Financial Ombudsman Service (FOS). The FOS will look unfavourably upon the insurer avoiding cover where there was no request for disclosure at proposal (CII study text, M85 Claims practice, 2018).

The FCA require under the Insurance: Conduct of Business Sourcebook (ICOBS) that an insurer must not unreasonably reject a claim except where there is evidence of fraud. Further, ICOBS state that a rejection of a consumer policyholder's claim is unreasonable if it is for breach of a warranty or condition unless the circumstances of the claim are connected to the breach (CII study text, M85 Claims practice, 2018).

(b) If the policy is reinstated then the claim will be considered on the strength of the policy exclusion only. It is noted here that Mr Jarvis suffered damage to his car whilst it was parked on a public road. Therefore, the circumstances of this claim in the absence of any other relevant facts would seem to be unconnected to the lack of a certificate demonstrating that his vehicle was roadworthy. It would then seem to fail the ICOBS requirement of reasonableness, as it will be unreasonable for the insurer to reject the claim given that the circumstances have no relationship to the roadworthiness or otherwise of the car.

This is specifically found in ICOBS 8.1.2. that states that a *'...rejection of a consumer policyholder's claim is unreasonable, except where there is evidence of fraud, if it is... for breach of warranty or condition unless the circumstances of the claim are connected to the breach.'* (CII study text, M85 Claims practice, 2018).

If Mr Jarvis had been driving the car at the moment of the accident then the outcome could be very different, would the lack of roadworthiness certificate mean that the accident was more severe? These influences on the total value of the claim would need to be considered.

It is unclear if Mr Jarvis' car is a total loss. If it is, and the policy has not been voided, then the insurer will be in a strong position to argue that the lack of a *certificate* of roadworthiness reduces the value of the car.

Question 2 – Learning Outcome 2 (10 marks)

You are a claims handler for a personal lines insurer. One of your policyholders, Mr Klein, reports a claim for damage to his vehicle. His vehicle has been damaged whilst it was parked.

Mr Klein believes that the value of the car prior to the accident was £17,000. The estimated cost of repair is £15,000. You indicate that you intend to treat the car as beyond economical repair, having valued it at £12,500 in its pre-damage state. Mr Klein disputes your valuation and is seeking payment at his pre-damage value.

Discuss how you would negotiate and settle the claim. (10)

Answer to question 2 (Learning Outcome 2)

The Insurance: Conduct of Business Sourcebook (ICOBS) contains specific rules regarding claims handling, which can be located in ICOBS 8 (CII study text, M85 Claims practice, 2018).

Central to the claim under consideration will be ICOBS 8.1.1, which states that an insurer must 'handle claims promptly and fairly' and must provide 'reasonable guidance to help a policyholder to make a claim'. The insurer will need to ensure that they are dealing with Mr Klein's claim in a fair and transparent manner. It will also be prudent to resolve the disputed valuation as promptly as possible. In doing so, the insurer will ensure that they are treating Mr Klein fairly. The principle of treating customers fairly (TCF) is a key requirement for the Financial Conduct Authority (FCA) (CII study text, M85 Claims practice, 2018).

Firstly, the insurer should outline precisely how they arrived at the valuation of £12,500 and provide copies of any guides or related evidence they used to justify this valuation. For example, it may be that the insurer is relying on an independent motor engineer's report. If so, it would be prudent to disclose either the report itself or the pertinent information to Mr Klein.

In addition, the insurer should state that they seek to arrive at the true valuation of the vehicle and, if it can be established that the vehicle was worth more than £12,500, then they will be able to consider an increased settlement offer. To assist Mr Klein, the insurer should describe the evidence they require to consider a higher valuation. For example, the insurer may request identification of similar cars and their current sale prices. The insurer could, if appropriate, seek a considered justification from Mr Klein as to why his vehicle was a unique or more expensive model when compared with the market average.

It is possible that the vehicle has been insured on an agreed value basis *at the figure of £17,000*, where the amount to be paid should a total loss occur, is agreed in advance. If Mr Klein has arranged the insurance policy on such a basis, then the value of the salvage may determine whether the vehicle is repairable and potentially trigger the agreed value option (CII study text, M85 Claims practice, 2018).

Question 3 - Learning Outcome 3 (10 marks)

You are the broker for MTG plc, a large retail organisation with an annual turnover of £30 million.

MTG plc has made a property claim to their insurer, but the settlement amount cannot be agreed. MTG plc is dissatisfied with the insurer's stance and the insurer's own complaints procedure has been exhausted. MTG plc wishes to pursue the claim further.

(a) Identify, with justification, **two** appropriate methods of resolution that MTG plc may pursue to resolve the claim. (4)

(b) Explain **one** advantage and **two** disadvantages for **each** of the methods you have identified in (a) above. (6)

Answer to Question 3 (Learning Outcome 3)

(a) Two methods that MTG plc could pursue to achieve potential resolution to their claim are mediation and litigation. Mediation would be a good next step as it is something insurers use frequently and it results in a fairly swift resolution. An alternative method to resolve the dispute would be litigation, which is likely to be the preferred option only if mediation fails. Litigation is useful when the claim is significant as it will be legally binding.

(b) Mediation has the advantage of being private and cost-effective, so no external party will know the outcome or that mediation has taken place. This is good when the insurer does not wish to set a precedent on a particular claim.

The disadvantage of mediation is that it is non-binding and does not determine legal liability. Therefore, even if an agreement is reached it is not legally binding and all the effort can be wasted. Also, if attempted at the wrong time it can simply add to overall costs (CII study text, M85 Claims practice, 2018).

Litigation has the advantage that legal liability will determined and the court's decision is binding, unless challenged through a further court case. Litigation is expensive both in terms of the preparation costs and the costs associated with hearing the case. It will generally take place in a court which is open to the public and press, so preventing any confidentiality.

Question 4 – Learning Outcome 4 (20 marks)

You are a claims handler for a liability insurer. One of your policyholders, KS Ltd, is a building contractor. KS Ltd have notified you of a claim which occurred on one of their building sites to John, a 27-year-old plumber. John fractured his hip and ankle after slipping on a wet floor following a spillage of liquid. John has made a claim against KS Ltd.

You have established that cover is applicable under KS Ltd's employers liability policy. It has been six months since the accident and John is still unable to return to work or carry out household tasks.

(a) Explain briefly **five** of the most common heads of claim which John is likely to pursue and the method of assessment of each by the insurer. (10)

(b) Describe **five** types of evidence the insurer may seek in order to assess the claim that may be presented by John. (10)

Answer to question 4 (Learning Outcome 4)

(a) John is likely to pursue the following heads of claim:

i) Pain, suffering and loss of amenity (sometimes known as PSLA). John has sustained a fractured hip and ankle and he is entitled to financial compensation to reflect the pain and suffering he has endured following the accident at work. Loss of amenity is the inability (whether in a physical or mental capacity) of John to do the things he was able to do prior to the accident. It is very hard to assess the pain and suffering as it is subjective and may vary from one claimant to the other. In contrast, loss of amenity is an objective test.

ii) Loss of earnings. Given his injuries, you would expect John to have been unable to work as a plumber whilst injured and to have suffered from a loss of income. John will be entitled to claim for the wages he has lost from the date of the accident. If John can be utilised in KS Ltd's business in any other form, wages paid for this work can be off-set against any claim. Assessment is evidenced based.

iii) Future loss of earning or handicap on the labour market. If John continues to suffer from a disability as a result of the accident then he will be entitled to claim for either an ongoing loss of earnings or a payment to reflect handicap on the labour market. The amount of the award will depend on whether John will be able to continue employment, if at all, and in what capacity. Assessment for this would come via the courts from an agreed formula which also takes into account receiving the money earlier than if you earnt it.

iv) Past care. It would be expect that John will have received care and assistance immediately following his accident and he will be entitled to recover a financial amount to reflect this care, whether it has been provided professionally or by family and friends. Care is calculated on an hourly rate and discounted for care provided gratuitously.

v) Future care and services. If John continues to suffer disability, which requires weekly personal assistance and reduces his capacity to undertake household tasks, then he will be entitled to claim an award to cover the costs of providing such services in the future (CII study text, M85 Claims practice, 2018). Again the assessment of this is made by the courts once all the relevant medical reports and costs are received.

(b) The insurer may seek the following evidence:

i) Obtain expert medical evidence. Evidence from independent medical experts will provide an assessment of the injuries, which will allow consideration of the financial value that the injuries will attract. The insurer would commonly use the Judicial Studies College's *Guidelines for the Assessment of General Damages in Personal Injury Cases* to value John's injuries. Kemp & Kemp – *The Quantum of Damages* - is one of a number of other sources of information for assisting in the valuation of personal injury claims.

ii) Past wage details. Commonly, the claims handler will ask for details of John's earnings for the 13 weeks pre-accident and details of all payments made post-accident. The earnings details for the 13 weeks pre-accident will provide the claims handler with average earnings from which to calculate loss of earnings post-accident. Any payments made by way of gratuitous pay, sick pay or government benefit will be reduced from the amount paid to John.

iii) Future loss of earnings or handicap on the labour market. If John is able to return to work, albeit with minor ongoing symptoms, then it may be appropriate to make a nominal sum to cover any handicap on the labour market. However, if John is unable to return in a full-time capacity (or even part-time) then the claims handler will wish to calculate an amount for future loss of earnings. The Ogden tables will be central to the calculation, which uses actuarial tables to calculate a lump sum award.

iv) Care and services. The claims handler will assess the past care requirement by primarily relying on any available commentary as to care requirements in the medical report(s) (CII study text, M85 Claims practice, 2018). At the time of assessment of the claim, the cost of care may have already been incurred, in which case receipts, payslips, etc, may be required.

v) In addition, the claims handler will consider whether there are any other services available to assist with the resolution of the case. For example, it is unclear whether John will recover fully from his injuries and so a report from a rehabilitation expert may be appropriate. The appointment of a rehabilitation firm will enable the claims handler to consider John's initial needs and recovery potential. The rehabilitation firm will also be able to assist with vocational training, which may enable John to train and enter a different profession, if he is unable to return to plumbing. Alternatively, if the handler considers that John may be exaggerating his injuries, then surveillance by investigators would be an option to consider (CII study text, M85 Claims practice, 2018).

Question 5 – Across more than one Learning Outcome (20 marks)

You are a claims handler for a household insurer. One of your policyholders, Mrs Griffiths has a policy covering buildings and contents.

Mrs Griffiths' property is damaged during a storm. Her property suffers water damage, which was as a result of a leaking roof. Shortly after the storm, Mrs Griffiths goes on holiday for a month and only notified you of the damage when she returns from holiday. Whilst Mrs Griffiths is on holiday, there are further storms and additional damage to the property occurs.

You have instructed a loss adjuster to meet Mrs Griffiths to discuss the claim for damage to her property.

(a) Explain the specific investigations that the loss adjuster will need to carry out. (10)

(b) Discuss the likely claim outcomes with reference to relevant policy terms. (10)

Answer to Question 5 (Across more than one Learning Outcome)

(a) Loss adjuster investigation

It may be that the investigation is being conducted under a reservation of policy rights. A reservation of rights will allow investigation of the claim but without confirming that any cover or payment in respect of the claim or claims will be made under the terms of the policy (CII study text, M85 Claims practice, 2018).

A standard insurance policy will contain a 'claim notification condition', which will outline the actions expected by Mrs Griffiths as to when and how to notify a claim. Commonly a claim notification condition will include words such as 'immediately' or 'as soon as reasonably practicable, others sometimes specify within a certain

number of days.' In the circumstances, the loss adjuster will wish to clarify precisely when and how Mrs Griffiths attempted to notify the claim (CII study text, M85 Claims practice, 2018). The loss adjuster is likely to ask why Mrs Griffiths was unable to notify the insurer either before or during the holiday.

The loss adjuster will also need to inspect the damage to the roof and consider whether or not the leak in the roof is a result of an insured peril, such as storm, or whether the leak has materialised over time, perhaps as a result of wear and tear. This is important, as the insurance policy will not cover the repair or replacement of the roof if it is has not been damaged by an insured peril (CII study text, M85 Claims practice, 2018).

The loss adjuster will also need to enquire of Mrs Griffiths if any action was taken to mitigate the loss, following the first storm. Mrs Griffiths' policy is likely to contain a requirement to take 'reasonable care' to prevent and mitigate losses.

Finally, the loss adjuster will need to consider the internal damage that has been caused by the ingress of storm water and will comment upon the likely extent of the damage from the first and subsequent incidents.

(b) Policy considerations

Much will depend upon the outcome of the loss adjuster's investigation. For example, the actions, if any, that Mrs Griffiths took to notify the insurer of the initial damage and any action taken to mitigate the loss. Mrs Griffiths may, for example, have engaged a local builder to effect emergency repairs, but who subsequently failed to complete the works.

If Mrs Griffiths has failed to maintain the roof, failed to immediately notify the storm claim to the insurer and then failed to take reasonable steps to mitigate loss, then the insurer may decide to decline cover under the terms and conditions of the policy.

It is unlikely that the insurer would decline the claim for any breach of notification condition alone. Even if the policy contained a strict notification condition, e.g. 30 days, the insurer would need to be aware of the requirement to treat the customer fairly (CII study text, M85 Claims practice, 2018) and to assist with the claim presentation. If the insurer were to decline the claim for the late notification they would need to demonstrate that they have been prejudiced by the late notification of the claim.

With regard to the roof, if the insurer determines that the roof has not been maintained and has failed as a result of wear and tear then it will not cover the cost of the repairs to the roof but may consider the internal damage caused by the water ingress.

There is a common law duty placed upon all policyholders to mitigate losses. If Mrs Griffiths took no actions to mitigate the damage and left a gaping hole in her roof whilst she was abroad on holiday, then insurers are likely to limit payment. In theory, it would be reasonable to restrict payment to the damage caused by the first storm and not for subsequent storm damage. In practice, it will be difficult to distinguish between the events and the insurer is likely to agree to pay a proportion of the rectification works.

Question 6 – Across more than one Learning Outcome (20 marks)

You are a claims handler for SRI plc, a commercial property insurer. GW plc, one of your policyholders, is a retailer of children's clothes.

GW plc's town centre retail premises and stock are destroyed in a fire. The stock consists of children's clothes, some of which are last season's.

GW plc submits claims for the destroyed building and stock, as well as business interruption. The buildings are insured for £300,000 on a reinstatement basis and the stock for £50,000. After investigation, the insurer establishes that the reinstatement value of the buildings is £500,000 and the stock is valued at £60,000.

(a) Explain, **showing all your workings**, how SRI plc would calculate the buildings and stock claims with reference to relevant policy terms. (10)

(b) Explain the actions that could be taken to mitigate the business interruption claim. (10)

Answer to Question 6 (Across more than one Learning Outcome)

(a) Underinsurance

The insurer is likely to have an underinsurance clause (CII study text, M85 Claims practice, 2018) within the policy.

The underinsurance clause used to deal with this matter is called the 'average clause'. An average clause provides that where the sum insured is less than the value at risk, the insured will be considered as their own insurer for the uninsured part of the risk and the claim payment for any loss will be scaled down proportionately (CII study text, M85 Claims practice, 2018).

Accordingly, the buildings and stock would be calculated as follows (assuming this is a total loss):

Buildings

Sum insured	=	£300,000
Value at risk	=	£500,000
Value lost	=	(£300,000 / £500,000) x £500,000 = £300,000

Stock

Sum insured	=	£50,000
Value at risk	=	£60,000
Value lost	=	(£50,000/£60,000) x £60,000 = £50,000

The above calculations are straightforward on a total loss basis and in this example the policyholder would be considered to be the insurer for £210,000 of the loss (£200,000 underinsurance on the buildings plus the £10,000 underinsurance on the stock).

This calculation has been made on the basis that a 100% pro-rata average clause applies to the buildings.

If you were considering a third-party stock claim you may approach the stock claim differently and seek a further deduction for the fact that the stock was last season's. However, in a first party claim, stock would be considered as the cost of replacing the stock (plus transportation costs).

(b) Business Interruption loss

Any successful business will want to return to trading as soon as possible after a loss to ensure that their customer base is not lost. The insurance policy will cover the loss of profits but this will be limited to a maximum indemnity period and it may take years to recover a lost customer base.

If the premises had been flooded, for example, it may have been possible for the policyholder to undertake emergency steps to mitigate the loss and be in a position to open the shop by working around the clock for a short period of time. The policy would often cover the 'increased cost of working' in this situation. This could include say, the additional overtime necessary to assist with the re-opening.

However, with fire damage the building is likely to be in a poor state and if stock has not been destroyed by fire, it will have been ruined by smoke.

To limit the business interruption loss, the insurer will look to secure alternative and suitable premises as close as possible to the existing premises. The existing retail premises are located in a town centre and it is possible that there may be another unit available to rent, which would suit the policyholder's business. A nearby, alternative premises would almost certainly mean that many, if not all, customers would be retained and the business would continue to trade at normal, or near normal, levels whilst the damaged premises are being reinstated.

In addition, the insurer will need to consider the availability and lead time to obtain replacement stock items. Given the relatively modest sum insured, you would expect stock to be available within a matter of weeks (CII study text, M85 Claims practice, 2018).

Question 7 Across more than one Learning Outcome (30 marks)

You are a claims handler for a commercial property insurer. A policyholder, CJB Ltd, suffers a fire at their premises, which results in the buildings being totally destroyed. Due to the size of the fire, a neighbouring building is also damaged.

Following an investigation by your team, it is found that waste bins had not been emptied by the policyholder's employees on the evening before the fire, contrary to the waste warranty.

(a) Discuss how settlement options differ for first party and third party claims. (15)

(b) Explain your position as the insurer, in relation to any property claims submitted. (15)

Answer to Question 7 (Across more than one Learning Outcome)

(a) First party policies contain terms and conditions that will assist with how claim will be valued. For example, many household insurance policies are written on a new for old basis, whereby if an item is damaged by an insured peril, then the policy will provide replacement with a new, comparable model. There may be limitations such as a reduction for wear and tear for specific items, such as clothing.

In commercial insurance policies the policy will often include conditions relating to how a claim will be dealt with, for example, a reinstatement basis. In these circumstances, any betterment resulting from the reinstatement will be deducted from the settlement amount. Generally speaking, first party claims are settled on an indemnity basis (with beneficial variations as mentioned). Given our scenario, CJB Ltd would seek a reinstatement basis for the claim they have experienced.

Third party claims are not subject to a contract of insurance and are brought against the policyholder via statute, tort or negligence. Any settlement is first subject to an assessment of legal liability to establish if liability exists. If liability attaches, it is then necessary to consider what payment would put the claimant back to the position they were in prior to the loss.

Like first party losses, a third-party claim will also be considered on an indemnity basis, which can lead to arguments as to what this means in practice. For example, a policyholder may be engaged in a contract at a third party residential property. Whilst undertaking the contract, the carpet is damaged at the property. Subject to liability, the correct basis for settlement would be on an indemnity basis. However, in practice this means that the claimant must pay an additional amount for a new carpet, which they may not have wanted to replace. The claimant can argue that the insurer should find a similar carpet of a similar age to fit into the property (which of course they could not do). In these circumstances, the insurer may find that they effectively settle the claim on a 'new for old' basis (CII study text, M85 Claims practice, 2018).

In general terms, policy clarity and the existence of a contractual relationship with the policyholder is likely to enable early settlement of a claim. In contrast, the third-party claimant may be more difficult to negotiate with as the claim is inherently 'not their fault' and is a nuisance to them that could have been avoided. Therefore, the neighbouring businesses claim may take a while to resolve. It may be that their own insurer settles the claim first and then seeks to recover their losses from you.

(b) A warranty is a requirement contained within the policy requiring the insured to maintain a state of affairs, such as the operation of an alarm. The insurer, by including an alarm warranty for example, is stating that they are willing to provide theft cover for the property but this is conditional upon an alarm being operational whilst the premises are unoccupied. An alarm acts to deter intruders and can notify third parties, including the police, to attend the premises immediately. Such actions can avoid or limit any loss. If the alarm is not working then the insurer may suffer significant loss. To avoid this, a warranty is added.

Similarly, a waste warranty operates to limit the insurer's exposure to a loss. Waste stored next to a building is a physical hazard, as waste often contains combustible materials. Further, waste can be a target for persons looking to start a fire, i.e. it provides material which may be easy to set alight.

In the circumstances under consideration, the insurer will wish to establish where the fire occurred. It may be, for example, that the fire was of electrical origin and occurred some distance from the waste bins and indeed within the building. Alternatively, the fire may have originated and spread from a fire that started where the waste material had been stored.

If the fire was of electrical origin (following the example above) then the insurer would most likely provide cover for the loss. However, if the fire started by the stored waste then the insurer would be entitled to rely upon the waste condition to decline any liability or payment in respect of the claim. The claim by the neighbour would be based on whether SJB Ltd are held responsible for the fire.

The Insurance Act 2015, which came into force in August 2016, states that an insurer can only avoid liability in certain circumstances, being that a loss occurred whilst a warranty was breached, but before it could be corrected. Additionally, the circumstances of the loss must be directly related to the breach. (CII study text, M85 Claims practice, 2018).

If the failure to empty the waste bins on the evening preceding the fire has no connection to the loss, then the insurer cannot avoid liability.

Question 8 – Across more than one Learning Outcome (20 marks)

You are a loss adjuster instructed by a commercial property insurer to investigate a claim made by one of their policyholders, Mr Wake.

Mr Wake is a landlord with one multi-occupancy property. He has been insured with the current property insurer for two years. Following a fire at the property, Mr Wake makes a claim for the damage to the property and loss of rent. Mr Wake exaggerates the loss of rent claim, basing it on the fifteen tenants who were all paying rent at the latest renewal of the policy. At the time of the fire there were only four tenants occupying space in the property.

There had been two fire losses at the property that were settled by the previous insurer, neither of which had been disclosed to the current insurer.

(a) Explain how the non-disclosures might impact upon the way that the claim may be considered by the insurer. (10)

(b) Explain the implications of the exaggeration of the loss of rent claim for the insurer. Refer to **two** relevant cases in support of your explanation. (10)

Answer to Question 8 (Across more than one Learning Outcome)

(a) Non-disclosure

The non-disclosure of the previous fire losses relates to the proposal for the insurance contract and subsequent renewal of the policy. The Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA) initially appears to be relevant here. CIDRA applies to 'consumers.

However, it is to be noted that Mr Wake is a landlord and thus working in a business (i.e. a non-consumer capacity) and therefore The Insurance Act 2015 is relevant here.

The Financial Ombudsman Service (FOS), would in the event of a complaint, be expected to consider the landlord to be a 'micro enterprise'. The FOS definition of "micro enterprise" includes small businesses with less than 10 employees and a turnover below two million Euros. The approach of the FOS and that generated by the Insurance Act 2015 (as well as CIDRA) are all influenced by each other.

Under the Insurance Act, a duty of fair presentation is placed upon the proposer/policyholder. The insurer must outline the information that they consider material and the proposer's material representations as matters of fact must be substantially correct. (CII study text, M85 Claims practice, 2018). If any matters are raised in the policyholder's response, which may be material, the insurer will need to make further enquiries.

It would be expected that the claims history of the policyholder would have been material to the underwriting of the risk and you expect the insurer to have asked a suitable specific question. Often the insurer will ask for information about all claims 'within the last 5 years'. It is not clear whether the two previous fires were in the five year period preceding inception of the policy or not. If they were within a five year period, then the non-disclosure may either be 'deliberate or reckless' or 'careless'.

If the non-disclosure was deliberate or reckless the insurer may avoid the contract and refuse the claim. The insurer may also retain the insurance premium, unless it would be unfair to do so. If the non-disclosure was careless then remedy is based upon what the insurer would have done had the claims been disclosed. If the insurer would not have offered cover then the insurer would be entitled to avoid the contract from inception. Further, if the insurer would have offered insurance but on different terms, then the policy would operate as if these different terms and conditions were in place at the time of the latest fire. Finally, if the insurer would have offered terms but would have charged an additional premium then the claim can be reduced proportionally based on the amount of additional premium that would have been charged.

Given that the policyholder has neither disclosed at inception or at renewal (or indeed during the contract itself) it is most likely that the insurer will consider this to be a deliberate or reckless non-disclosure.

(b) Fraud

The common law position is that if a claim is exaggerated, in full or part, the insurer is entitled to decline the claim in full (*Britton v Royal Insurance Company* 1866). The position with regard to whether the policy can be voided from inception or from the date of the fraud is less clear. For this reason, the insurer will often include a 'fraud condition' in the policy wording, which will outline clearly the insurer's remedy in the event of fraud by the policyholder.

From the circumstances provided, there is no reason to doubt that there were indeed fifteen tenants at renewal of the policy. Since renewal however there has been a significant reduction in the number of tenants. If the policyholder has submitted a claim for loss of rent for fifteen tenants then this would appear to be a clear attempt to defraud the insurer. The policyholder may argue that the claim was innocent and was based on a misunderstanding of policy cover. However, given that the policyholder has had two previous fires, with the likelihood of loss of rent claims, this is unlikely to be accepted.

The case is similar in nature to the case of *Orakpo v Barclays Insurance Services* (1995), which was decided in the insurer's favour. In this case, the court decided that the exaggeration was enough for the insurer to be discharged from all liability for the claim.

It would appear, therefore that the insurer would be entitled to void the policy from the date of the fraud and retain the premium. Notwithstanding that, the insurer was entitled in (a) to avoid the policy from inception of the risk. This may hinge on when the tenants actually ceased to pay rent.

The Insurance Act 2015 also comments on the remedies for an insurer when presented with a fraudulent claim. If a fraudulent claim is presented, then the insurer is not liable to pay the claim or if paid, the insurer may recover the claims sum paid. Additionally, the insurer may treat the contract as having been terminated from the time of the fraudulent act.

Additionally, should the insurer treat the contract as terminated, then it may refuse all liability in respect of any relevant event occurring after the fraudulent act and it is not obliged to return any premiums paid by the policyholder under the contract. (CII study text, M85 Claims practice, 2018).

However, the burden of proving fraud is an onerous one and this may be difficult to do.

Question 9 - Across more than one Learning Outcome (10 marks)

You are a claims handler for RW plc, an insurer. One of your policyholders, TJP Ltd, insures their risks on a commercial combined policy. You receive a telephone call from a senior manager working for an overseas subsidiary of TJP Ltd. The senior manager indicates that a liability claim is being made against the overseas subsidiary.

Identify, with justification, the steps you would take to determine whether this overseas subsidiary is covered under TJP Ltd's commercial combined policy and for this particular claim. (10)

Answer to Question 9 (Across more than one Learning Outcome)

To determine whether the overseas subsidiary is covered under the commercial combined policy, it would be prudent to:

i. Check the policy schedule to see if the subsidiary is listed as a named entity and is included in the insurance programme provided by RW plc's underwriter. If the policy schedule were 'silent' as to the subsidiary then you would ask the underwriter if they were aware of the subsidiary or whether the details of the subsidiary are contained within the underwriting file. Sometimes a business can contain so many subsidiaries that it is not practical to list each one separately on the policy schedule. (CII study text, M85 Claims practice, 2018).

ii. If there is ambiguity in the underwriting file as to whether or not the subsidiary is included then it would be good practice to review the original broker presentation, if there is one. The broker presentation will outline the risk being considered and will include turnover and the employee details for the business. Reviewing the turnover and employee figures that was used to calculate the premium may determine whether the premium charged accommodates the subsidiary being considered i.e. the subsidiary is not listed or named but a premium has been collected in consideration of the turnover and employees attached to the subsidiary.

iii. Check that the business activities for the subsidiary are consistent with the business description listed on the schedule and the type of trade expected from the broker presentation. If the trade is different from the business description then the underwriter would want to consider whether there has been material non-disclosure prior to policy inception.

iv. Consider whether the policy covers claims arising from the jurisdiction of the subsidiary. It is normal, for example, for policies to exclude claims from US jurisdictions. If the subsidiary was listed on the schedule but the jurisdiction was limited, there would need to be careful consideration with underwriters to establish the cover that was being provided.

v. Finally, consider whether the liability that arises is one that would be considered under the policy. For example, if the claim arises from professional negligence then it may be that the commercial combined policy only covers employers' and public liability.

Question 10 – Across more than one Learning Outcome (30 marks)

You are a claim handler for a household insurer. Your policyholders, Mr and Mrs Greenwood, insure their home buildings and contents with you. There is a burglary at their home and the Greenwoods report a claim to you.

Amongst the items stolen are five items of antique furniture. According to the household proposal form, each item of antique furniture was worth approximately £2,000. Additionally, one valuable earring (one of a pair) is taken by the thieves. The contents sum insured is £50,000. The burglars entered the Greenwood's home by breaking the locked patio door.

Investigation by your appointed loss adjuster identifies that three of the stolen antiques are undervalued and each is worth five times the declared value (i.e. £30,000 in all) although Mr Greenwood sincerely believes that the value was correctly stated at the time of policy inception. The other two stolen antique items are correctly valued.

The policy is subject to a security warranty and it is discovered that at the time of the burglary a skylight had been left on the latch, but this was not the method of entry.

(a) Explain the impact of possible undervaluation on the claim presented. (10)

(b) Explain how the insurer may settle the claim for the theft of one earring. (12)

(c) Explain the application of the security warranty in view of the method of entry. (8)

Answer to Question 10 (Across more than one Learning Outcome)

(a) Often a household policy will restrict the cover it provides on individual valuable items. The policy definition of a valuable item would include antiques. Often the policy will restrict cover for valuables to 5% of the total contents sum insured. In the case under consideration, Mr and Mrs Greenwood have a sum insured of £50,000; 5% would equate to a £2,500.

However, the insurer will provide a higher sum insured for antiques if they are specified with separate sums listed in the policy schedule, i.e. the limits can be increased beyond 5% of the contents sum insured. Mr and Mrs Greenwood may have requested that their antiques are specified so the 5% limit will not be applied by the insurer.

It is not clear if Mr and Mrs Greenwood have £50,000 contents sum insured plus £10,000 in specified valuable items or whether the £10,000 limit is within the £50,000. It may not make any material difference.

Mr and Mrs Greenwood are underinsured by £24,000 for the lost antiques. Against a total claim of £34,000 they have cover up to £10,000.

The policy will likely contain a sum insured of £2,000 per antique and will provide payment at the limit of the policy i.e. £10,000.

The policy may contain an underinsurance clause but again, the underinsurance would simply result in a payment of £10,000.

(b) The stolen earring is described as 'valuable' but we are not informed of its worth. Neither are we advised whether the sum insured is adequate but in the absence of any comment, must assume that the item is adequately covered.

It is unclear whether the policy contains a 'pairs and sets' clause or not, which would be directly relevant to the loss of an earring. Most insurers will include a pair and sets clause (or matching items) clause in their policies. This clause restricts the cover to replacing the damaged item only, even if it is part of a set.

However, the FOS has ruled more than once that if it is crucial to the policyholder's position that they have a complete new set of items, insurers should pay for the provision of a new complete set, notwithstanding this term of the policy, on grounds of fair and reasonable treatment.

Some insurers have in fact reversed the original meaning of a 'pair and sets' clause. They still have such a clause within their policy but in line with the FOS rulings now state that if one of a set is lost the insurer will specifically pay for both items. The insurer concerned may well take this approach upon consideration of the likely decision of the FOS. If this is the case, if a new set is purchased, the remaining earring becomes the property of the insurer. If the earring has sentimental value, it is possible to have the earring made into another piece of jewellery and a settlement figure just covering the other earring be given.

Further, given the limited cover provided under (a) the insurer would be prudent to consider paying for the replacement of both items if the policyholder requires this.

(c) The Insurance: Conduct of Business Sourcebook (ICOBS: 8.1.2) states that:
'A rejection of a consumer policyholder's claim is unreasonable, except where there is evidence of fraud… it if is for breach of warranty or condition unless the circumstances of the claim are connected to the breach'. (CII study text, M85 Claims practice, 2018).

ICOBS is directly relevant to the claim under consideration. The policyholder, it would appear, is technically in breach of the security warranty for leaving a skylight on a latch (although we are not told whether Mr and Mrs Greenwood were in the house at the time of the theft). Regardless, the burglars did not enter via the skylight but instead entered via the patio door. The insurer would not raise issue with the unsecured skylight as it is incidental to the means of access used by the burglars.

There may be a requirement under the Greenwood's household policy for there to be forcible and violent entry or exit from the property for cover for theft to operate. There is no evidence to suggest that the patio door was unlocked at the time of the theft. Entry was gained through a locked patio door and accordingly it would be reasonable to deduce, without the need for further information that forcible and violent entry was gained to the property.

Referencing must be completed before submission

All sources must be referenced in the body of your answer as well as in your reference list. See the *Specimen coursework assignment and answer* for examples of how to reference correctly in text and in your reference list.

References

CII study text, M85 Claims practice, 2018

Question deconstruction and answer planning

The following three plans are based on 10, 20 and 30 mark questions respectively.

Question 2 – Learning Outcome 2 (10 marks)

You are a claims handler for a personal lines insurer. One of your policyholders, Mr Klein, reports a claim for damage to his vehicle. His vehicle has been damaged whilst it was parked.

Mr Klein believes that the value of the car prior to the accident was £17,000. The estimated cost of repair is £15,000. You indicate that you intend to treat the car as beyond economical repair, having valued it at £12,500 in its pre-damage state. Mr Klein disputes your valuation and is seeking payment at his pre-damage value.

Discuss how you would negotiate and settle the claim. (10)

Question deconstruction

- Review learning outcome 2 in the course material and the relevant information in the study text.
- Highlight the instructions within the question (which are circled in red above).
- What is the context? The basis on which a motor claim is handled by an insurer is being disputed. Your discussion should be from the perspective of the insurer.
- The question is a discussion based question for ten marks. The perspective that the discussion should unfold is essential. That of the insurer only.

Answer plan

- What are the options for the insurer in negotiating settlement? What are the settlement options? A discussion means that the range of options should be considered and that some form of conclusion or recommendation should be made.
- As this is a 10 mark question, your answer should be shorter than the answers to either a 20 or 30 mark question.

Question 4 – Learning Outcome 4 (20 marks)

You are a claims handler for a liability insurer. One of your policyholders, KS Ltd, is a building contractor. KS Ltd have notified you of a claim which occurred on one of their building sites to John, a 27-year-old plumber. John fractured his hip and ankle after slipping on a wet floor following a spillage of liquid. John has made a claim against KS Ltd.

You have established that cover is applicable under KS Ltd.'s Employers liability policy. It has been six months since the accident and John is still unable to return to work or carry out household tasks.

(a) Explain briefly **five** of the most common heads of claim which John is likely to pursue and the method of assessment of each by the insurer. (10)

(b) Describe **five** types of evidence the insurer may seek in order to assess the claim that may be presented by John. (10)

Question deconstruction

- Review learning outcome 4 in the course material and the relevant information in the study text.
- Highlight the instructions within the question (which are circled in red above).
- Consider the context. Following an injury at work, an employers' liability claim is being made.
- There are two parts of the question, both worth 10 marks and both ask for an explanation. See the Glossary of key words at the end of this guide for detailed descriptions of this verb. This will guide you in relation to the level of detail required.

Answer plan

- In each part, the question asks for an explanation. An answer that correctly lists, states or identifies the five most common heads of claim, and all the steps taken to satisfactorily conclude the claim will be insufficient to gain all the marks. An explanation means that further justification is required. In part (a), the method of assessment should also be discussed. Both question parts carry equal marks and, therefore both should be similar in length and breadth of answer.
- As this is a 20 mark question, your answer should be longer than the answer to a 10 mark question but shorter than the answer to a 30 mark question.

Question 10 – Across more than one Learning Outcome (30 marks)

You are a claim handler for a household insurer. Your policyholders, Mr and Mrs Greenwood, insure their home buildings and contents with you. There is a burglary at their home and the Greenwoods report a claim to you.

Amongst the items stolen are five items of antique furniture. According to the household proposal form, each item of antique furniture was worth approximately £2,000. Additionally, one valuable earring (one of a pair) is taken by the thieves. The contents sum insured is £50,000. The burglars entered the Greenwood's home by breaking the locked patio door.

Investigation by your appointed loss adjuster identifies that three of the stolen antiques are undervalued and each is worth five times the declared value (i.e. £30,000 in all) although Mr Greenwood sincerely believes that the value was correctly stated at the time of policy inception. The other two stolen antique items are correctly valued.

The policy is subject to a security warranty and it is discovered that at the time of the burglary a skylight had been left on the latch, but this was not the method of entry.

(a) Explain the impact of possible undervaluation on the claim presented. (10)

(b) Explain how the insurer may settle the claim for the theft of one earring. (12)

(c) Explain the application of the security warranty in view of the method of entry. (8)

Question deconstruction

- Review the relevant learning outcomes in the course material and relevant information in the study text. Identify which learning outcomes relate to all parts of the question.
- Highlight the instructions within the question (which are circled in red above).
- Consideration of the context. A theft has taken place at a residential home and a loss adjuster has been appointed to investigate the theft.

Answer plan

- There are three parts to the question. Your answer should be divided into three parts and the number of words reflective of the number of marks.
- Each part is asking for an explanation of an aspect of the claim or how the claim might be handled. In part (a), the question also requires identification of the effect of undervaluation on the claim as well as an explanation.
- As this is a 30 mark question, your answer should be longer than the answers to 10 and 20 mark questions.

Glossary of key words

Analyse
Find the relevant facts and examine these in depth. Examine the relationship between various facts and make conclusions or recommendations.

Construct
To build or make something; construct a table.

Describe
Give an account in words (someone or something) including all relevant characteristics, qualities or events.

Devise
To plan or create a method, procedure or system.

Discuss
To consider something in detail; examining the different ideas and opinions about something, for example to weigh up alternative views.

Explain
To make something clear and easy to understand with reasoning and/or justification.

Identify
Recognise and name.

Justify
Support an argument or conclusion. Prove or show grounds for a decision.

Outline
Give a general description briefly showing the essential features.

Recommend with reasons
Provide reasons in favour.

State
Express main points in brief, clear form.