STUDY PACK

ON

INSURANCE, PENSIONS AND RISK MANAGEMENT

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FOREWORD

This fourth edition of the CIPM study pack is one of the learning resources recommended to persons preparing for certification through professional examinations. It is uniquely prepared to meet the knowledge standards of HR certification bodies and/or degree awarding institutions. The study pack is highly recommended to researchers, people managers and organisations responsible for human capital development in its entirety.

Each chapter in the text has been logically arranged to sufficiently cover all the various sections of this subject as itemised in the CIPM examination syllabus. This is to enhance systematic learning and understanding of the users. The document, a product of in-depth study and research, is practical and original. We have ensured that topics and sub-topics are based on the syllabus and on contemporary HR best practices.

Although concerted effort has been made to ensure that the text is up to date in matters relating to theories and practices of contemporary issues in HR, nevertheless, we advise and encourage students to complement the study text with other study materials recommended in the syllabus. This is to ensure total coverage of the elastic scope and dynamics of the HR profession.

Thank you and do have a productive preparation as you navigate through the process of becoming a seasoned Human Resources Management professional.

Olusegun Mojeed, FCIPM, fnli
President & Chairman of the Governing Council

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Oluwatoyin Naiwo, FCIPM
Registrar/Chief Executive

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CHAPTER ONE

COMPREHENSIVE OVERVIEW OF RISK

1.0 LEARNING OBJECTIVES

1. To provide a deeper understanding of risk
2. To understand the classifications of risk
3. To understand the sources of risks
4. To understand the terminologies in risk and their application to insurance

1.1 NATURE AND CONCEPT OF RISK

Risk is an inherent aspect of almost every human endeavor. From the beginning to the end of each day, individuals and organizations are exposed to varying degrees of risk. This implies that risk is not limited to specific activities but rather present in all facets of human life, and everyone is expected to encounter risk at some point, whether consciously or unconsciously. In essence, taking risks can be voluntary or involuntary. Therefore, the need to understand the risk attached to each activity we set out to do becomes an important exercise in the process of decision-making in business both public and private.

Given that risk permeates the intersection of humans and society, it is crucial to emphasize the need for a comprehensive understanding of risk. Our society is fraught with risks, including terrorism, robbery attacks, war, insurgency, accidents involving boats and vehicles, plane crashes, epidemics, liquidation events, and natural disasters like earthquakes. Within the domain of human resources management, employers and employees confront risk factors such as job loss, death, and occupational health hazards within their workspaces. It is noteworthy that even human resources managers are not exempt from these earlier-mentioned risk factors.

In this vein, risk can be defined as the uncertainty of future outcomes. It should however be noted that various authors and researchers have defined risks and these definitions are dependent on the perspective from which these authors view risks. Rejda (1998) defines risk as uncertainty concerning the occurrence of loss. To Dickson (1984), risk is uncertainty or lack of predictability of outcome in a given situation. Also, in ISO Guide 73 (2009), risk was decribed as the effect of uncertainty on objectives. Risk has also been defined as the possibility of deviation of the actual outcome from the expected outcome. Risk therefore, is uncertainty of outcome which could be negative or positive.

1.2 RISK AND ITS RELATED TERMS

1. **Uncertainty:** Uncertainty is defined as the state of mind characterized by doubt about what will or will not happen in the future. The difference between risk and uncertainty is that under a risky situation, there exist probability estimates, records, or data that could assist in predicting future outcomes. While, uncertainty deals with situations where there is the absence of probability estimates, data, or records to assist in predicting future outcomes.
2. **Chance:** The term chance refers to situations that may lead to the occurrence of a positive outcome. Thus, the term chance is not often used for situations that may result in loss or physical damage.
3. **Loss:** This is the actual diminishing in or outright elimination of value. Loss comes in various ways and forms. It could be in the form of a house razed by fire or the depreciation of an asset.
4. **Peril:** This is the actual cause of loss. Examples of perils include fire, flood, earthquake, and so on.
5. **Probability:** This is the measure of the likelihood of the occurrence of an event.
6. **Hazard:** This refers to the situation or condition that may increase the frequency and severity of loss. It is a condition that increases the possibility of a loss arising from a peril. There are four major categories of hazards. These are:
   i. **Physical Hazard:** These are the physical characteristics or physical qualities of an item, asset, property, or any subject matter that may increase the frequency and severity of a loss. For example, the frequency and severity of a fire accident may be increased when a petrol station is located beside a welder's workshop.
   ii. **Moral Hazard:** This refers to the attitude and conduct of an individual which may increase the frequency and severity of loss that they suffer. An example of this is the dishonesty or fraudulent character of an individual.
   iii. **Morale Hazard:** This is an extension of moral hazard. It refers to indifference to loss or reduced concern about the potential consequences of risk because individuals know they are protected by insurance. Unlike moral hazard, morale hazard is not driven by conscious intent but rather arises due to a lack of motivation or care resulting from the knowledge that insurance will cover any

losses. Individuals may become less cautious or neglectful in protecting their belongings or assets, assuming that insurance will compensate for any damage or loss.

iv. **Legal Hazard:** This refers to situations that increase the frequency and severity of loss to an entity as a result of a change in regulation, government policy, or change in laws of a country or state.

7. **Frequency and Severity:** Frequency of risk measures the number of times which loss may occur while severity on the hand refers to the potential impact or consequences that can arise from a specific event or loss.

1.3 CLASSIFICATION AND TYPES OF RISK

Risk can be classified into four major dichotomies. These are:

1. **Risk classified based on effect or consequences:**
   a. **Fundamental Risk:** These are risks that their causes and effects cannot be traced to any particular individual or group. Its effect is usually on a large number of people. Thus, it can be said to be impersonal in nature. Examples of such risks include earthquakes, erosion, war, economic depression, flood, famine, and other natural disasters. Insurers do not always cover these risks but government and charitable organizations provide compensation or assistance to those who suffer losses as a result of the occurrence of the risk.
   b. **Particular Risk:** These are risks that their causes and effects are traceable to an identifiable particular individual. This type of risk can be said to be personal in nature. Examples include theft of an item, include injury at work, fire damage, motor accident, and death of a breadwinner. Particular risks are risks within the purview of insurance.
2. **Risk classified based on outcome or result:**
   a. **Pure Risks:** These are risks that have only the element of loss or no loss that is, without the possibility of financial gain. In other words, they are risks with breakeven elements. Pure risks always come into existence naturally and do not form any part of our daily lives and activities. Examples of these risks include injury at the workplace, flood damage; fire damage, motor accidents, earthquake, volcanic eruption, theft, and so on.

b. **Speculative Risks:** These types of risks, on the other hand, are risks that would not have existed but for the action of man based on speculation. These risks have the elements of loss, no loss, or gain. When a person speculates that certain transactions may bring about some gain and embarks on it, such transaction may yield the speculated gain or result in a loss or may yield neither a gain nor a loss (breakeven). Examples of speculative risks include investment in equities and/or real properties, business diversification, mergers and acquisitions, and so on.

3. **Risk classified based on nature:**

   a. Static Risks: These are risks that are not capable of changing their forms. An example of a static risk is the risk that a property will be destroyed by fire. If the causes of fire are considered over a long period, it will always be from cooking, heating, and lighting, or from a malicious act. Other examples include the risk of theft, death, sickness, or accident.

   b. Dynamic Risks: Dynamic risks on the other hand are risks that may change their form as a result of economic or social changes. Examples include the risk of unemployment, technological changes, and consumers' tastes.

4. **Risks classified based on the capability of financial measurement:**

   a. **Financial Risks:** These are risks that are capable of financial measurement and are therefore insurable. examples include material damage to property; theft of property; fire loss; employee liability/litigation cases and so on.

   b. **Non-financial Risks:** This means that the outcome of risk cannot be measured in financial terms, though the affected party may attach financial sum in terms of their subjective considered financial value. Examples include the emotional and sentimental values of items owned by an individual, the reputation of an organization, and so on.

1.4 SOURCES AND ENVIRONMENT OF RISK

There are various sources through which risk may emanate and these are:

i. **Physical environment:** This refers to the geological and climatic conditions that can give rise to risks. Examples include earthquakes, windstorms, floods, landslides, and other risks emanating from nature.

ii. **Social environment:** This refers to factors and influences stemming from the community and the society that can give rise to risks. It includes social unrest, insurgency, militancy, terrorism, and religious upheaval. All these could be sources of loss or damage to lives and property.

iii. **Political environment:** This refers to the influence and impact of political factors on an individual or organization's activities. It includes government regulation and policies like tax policies that could be discriminatory or punitive, confiscation of property by a host government; Political instability such as civil unrest, and so on.

iv. **Legal environment:** This refers to the set of laws, regulations, statutes, and legal precedents that govern the activities of individuals or organizations and can give rise to risks. These risks include compliance and regulatory risks, contractual obligations, intellectual property rights, employment laws, data privacy and security, environmental and health regulations as well as litigation and legal disputes.

v. **Operating environment:** This refers to the specific conditions and factors in which an organization operates, including its industry, market, customers, competitors, suppliers and technology. Examples of risks in the operating environment include the entry of new competitors, shifting customer preferences, price volatility, loss of market share, and so on.

vi. **Economic environment**: This refers to the conditions and factors related to the overall economy in which an organization operates. It includes inflation, recession, interest rate, exchange rates, fiscal and monetary policies, depression and so on that hampers the organization from achieving its set objectives.

SUMMARY

Risks constitute the background for the study of insurance. The concept of risk is that which is worth studying as it is present in all human endeavors. An understanding of this concept will be useful in decision-making to determine how risk can be managed; whether by insurance or non-insurance means. Understanding risk therefore enables the individual or organization to achieve its set out objectives.

REVIEW QUESTIONS

1. Explain with examples the difference between fundamental and pure risk?
2. What are the sources of risk to an organization engaged in the manufacturing of plastic products?
3. The degree of hazard is considered by insurance companies in helping them to fix their premium, explain with examples the various types of hazards that the insurance companies can consider in order to fix their premium.
4. Explain five risks that an organization may be faced with in carrying out its daily activities.
5. Differentiate between risk and chance
6. Differentiate between risk and uncertainty

7. Case Study

Imagine you are a risk management consultant for a small manufacturing company that specializes in producing electronic components. The company has been experiencing rapid growth in recent years and is now considering expanding its operations into a new market overseas. They are excited about the potential for increased revenue and market share but are also aware that entering a new market carries various risks.

Discuss the concept of risk in the context of this company's expansion plans. Identify and analyze at least three specific types of risks they might face when entering a new overseas market. Provide recommendations on how the company can effectively manage and mitigate these risks to ensure a successful expansion.

In your response, consider factors such as market volatility, regulatory compliance, cultural differences, economic stability, and any other relevant risk factors. Additionally, discuss the importance of risk assessment and risk mitigation strategies in the decision-making process for this expansion.

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CHAPTER TWO

RISK MANAGEMENT

2.0 LEARNING OBJECTIVES

i. To understand the meaning of risk management
ii. To understand the risk management process
iii. To identify the techniques used in risk identification
iv. To understand the difference between risk management and risk control
v. To understand the approaches to risk management
vi. To understand crisis management, business continuity risk management, and Data and information risk management

2.1 INTRODUCTION

The first chapter of this study pack has explained the concept of risk and its various classifications. As explained earlier, risk is ever present; as one is being addressed, others may emerge. Therefore, it is important to regularly review risks, as this will help to determine whether the desired objective is attained. The following objectives could be achieved if risks are managed properly:

i. Reduce their frequency of occurrence.
ii. Reduce their severity if they eventually occur.
iii. Reduce the social and economic cost in terms of pains and sufferings that will be associated with the occurrence.

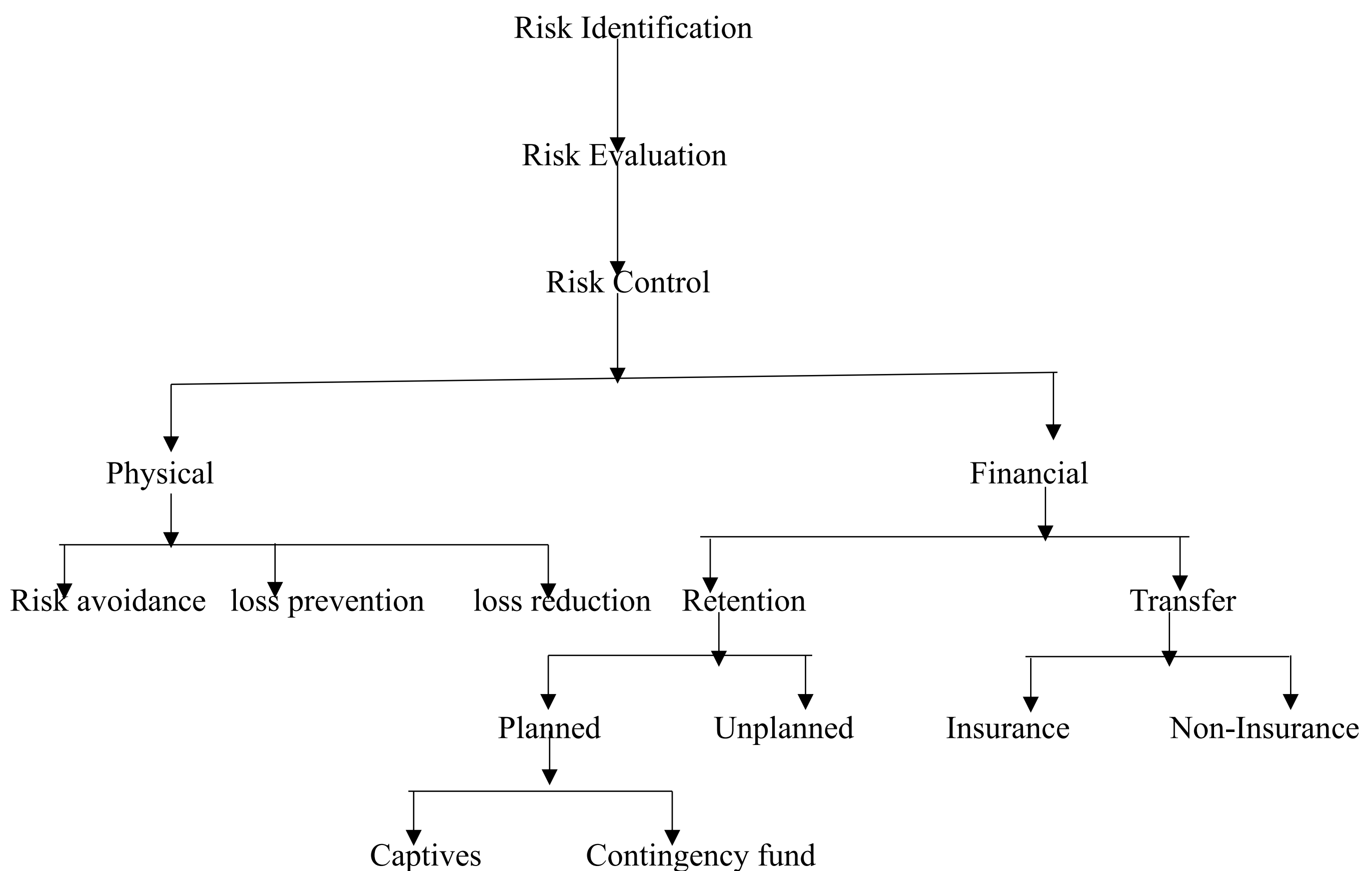
2.1.1 THE CONCEPT OF RISK MANAGEMENT

The concept of risk management is an intrinsic part of human nature and as such, most people naturally avoid tasks that are considered potentially dangerous. For example, nobody will normally play with exposed electric wire; or run across a road when a fast-moving car is approaching. This is because of the high risk of danger associated with it; for example, some organizations will not venture into certain businesses or employ certain categories of people who pose certain kinds of risk. Since its appearance in the business lexicon in the 1950s and 1960s, several authors have defined risk management from perspectives relating to their disciplines and professions. However, for this course, our definition will focus on risk management processes under which other activities are embedded. To a layman, risk management is seen as the process of controlling risk. This is just a step in the overall process of managing risk.

Risk management is the identification, analysis, and control of those risks which could threaten the operations, assets, and other responsibilities of an organization (Kaye, 2001). The Chartered Insurance Institute of London defines the term as the "identification, evaluation and economic control of those risks which threaten the access or earning capability of an organization." Risk management is a scientific and systematic process of identifying, evaluating, controlling, and financing loss exposures on risks that threaten the economy, earning capacity as well as survival and continuity of an organization or an individual.

2.2 RISK MANAGEMENT PROCESS

The risk management process involves three major steps that are systematically and scientifically linked to one another. This process is illustrated below:



2.2.1 RISK IDENTIFICATION

Risk identification is the first and most crucial step in the risk management process. It involves the identification and recognition of loss exposures, hazards, and risk factors that may affect or threaten the operations or activities of an entity. Risk identification is vital to the effective and efficient management of risk because failure to identify risk and loss exposures could bring about serious problems or threats that

may prevent or halt the smooth operations of an entity. To identify risks, some vital techniques and strategies have been devised over the years. These techniques include:

i. **Physical Inspection:** This involves visiting the organization's premises, to ascertain the risks that the organization may face and suggest ways by which there can be improvement. Physical inspection will include the inspection of the factory, workshop, training shed, offices, and production (manufacturing) processes. This helps to highlight the current situation of the organization, their attitude towards risk, loss control in place, health, safety, and general housekeeping of the organization's handlers. It also exposes how the premises and plants co-habit with their surroundings.

ii. **Organization Chart:** This provides an overview of the structure of the company and can reveal areas of risk concentration or possible dependencies between different business areas. The organization's chart will also show the analysis of the risk exposures of a business for several reasons that include:

    a. To reveal crucial information about the nature and scope of the organization's activities

    b. To reveal the interrelationships and interdependences among various parts of the organization

    c. They also show the breakdown of the organization into various profit and loss centers, which are facts to be considered when decisions on risk financing are being made.

    d. Organizational charts also reveal crucial authority pervading the organization.

    e. Structural defects in the organization, which affect loss exposures, may also be identified through analysis of these charts.

iii. **Flowchart:** This is a pictorial representation of production stages or distribution in a place of business such as an organization's relations with suppliers, customers, utilities, and modes of transportation. Flowchart enables the organization to discover areas of potential risk.

iv. **Contract Terms**: This includes a purchase agreement, sales agreement, lease agreement, mortgage agreement and other form of contract entered into which may expose the individual or organization to risk.

v. **Accounting Records** (including balance sheets, profit and loss statements, and analysis of sources and application of funds): These provide the needed data on which assets and other resources are valued. A good inspection of these documents may reveal some frauds that were

perpetrated in the past and other intended ones that may be attempted or perpetrated in the future.

vi. **Checklist:** This is used where the person identifying the risk is not based at the premises, a checklist can be produced for completion by someone on–site. Drafting a checklist should be carried out with utmost care if it is to capture all the information that is required.

vii. **Hazard and Operability studies (HAZOP):** This is an extremely detailed examination of a plant or process. Commonly used in high-risk industries where areas of general risk are already known, but specialized risk analysis needs to be undertaken.

viii. **Fault Tree Analysis and Event Tree Analysis:** This starts from potential risks and traces backward the range of events and sequences of events that could result in risk occurring.

ix. **Delphi technique:** Here, a group technique for aggregating the opinion of several experts is used. Copies of the questionnaire may be completed independently, and these are circulated anonymously between the panel members. This process is repeated several times to achieve a convergence of opinion.

x. **Failure Mode and Effect Analysis:** This involves an analysis of all the components of an activity to discover what effect there may be if any of the components fail in the process of carrying out such activity. Under failure mode and effect analysis, for each component of a system, the effect of its failure is identified together with the consequential failure on the rest of the system. The likelihood and consequence of failure can then be estimated. Failure mode and effect analysis and fault tree/event tree analysis are used in complex manufacturing industries such as automobiles.

xi. **Human Reliability Analysis (HRA):** This aims at identifying failures due to humans. Processes are broken down into decision points at which correct or incorrect performance can result.

xii. **Decision Trees:** This is the use of a graph or model of decisions and their possible consequences, including chance event outcomes and resource costs. A decision tree is used to identify the strategy most likely to reach a goal.

2.2.2 RISK EVALUATION

This is the second major step in risk management. After the identification of risk, a risk identifier needs to ascertain or measure the frequency and severity of the risk. Whist frequency refers to the number of times a risk event occurs, severity refers to the economic loss or financial impact of a risk event when it does occur. With the evaluation of risk, it becomes possible for an organization to determine the level of risk

faced by the organization. Mathematically, the level of risk can be ascertained by multiplying the frequency of a risk event by its severity. For example, if an organization experiences the risk of theft 10 times in a year and on average, they make losses amounting to N20,000 every time the risk occurs, then the level of risk of the firm will be given as:

Frequency f(x) X Severity S(x)

Therefore, level of risk = 10 X N20,000

=N200,000

The frequency and severity of risk identified are then measured and classified into high, moderate, and low. Consequently, a risk of fire can be classified as having low frequency, high severity to an organization while risk of larceny while have high frequency with low severity. All the identified risks should be classified in like manner. The frequency and severity level of risk also helps the organization determines a suitable risk control mechanism to adopt in managing the risk. Risks profiles that exhibit high severity and low frequency can be retained by some organization while most companies usually decide to transfer risks with high frequency and moderate severity.

2.2.3 RISK CONTROL

As earlier stated, risk control is often confused with risk management whereas risk control is just a step in the risk management process. Risk control entails all efforts geared towards preventing the occurrence of a loss as well as minimizing the loss before it occurs (pre-loss control) and all efforts geared towards minimizing the loss after they have occurred (post-loss control). Therefore, pre-loss control activities are efforts taken towards reducing the frequency of the loss, and post-lost control efforts are geared towards reducing the severity of loss, that is, the financial impact of a loss after the loss has occurred.

i. Physical Risk Control

Physical risk control involves all physical techniques that can be applied by a risk manager to handle risks. It includes:

a. **Risk Avoidance:** This is a technique of physical risk control that involves giving up or abandoning any activity leading to a loss. It is also known as risk elimination and helps to eliminate the possibility of the occurrence of a loss. However, it is important to note that risk avoidance is impossible in some situations since some risks cannot be avoided. Also, where risk is abandoned, potential opportunities will be abandoned.

Therefore, the cost has to be weighed against the benefit to adopt risk avoidance as a risk control method.

b. **Loss Prevention:** This is a technique of physical risk control that involves the reduction of the occurrence of loss, that is, it involves the reduction of the frequency of a loss. Examples of these activities include the use of locks and bolts, the use of screen guards for phones, and the use of burglary-proof doors.

c. **Loss Reduction:** This involves the reduction of the severity of a loss. Examples of these techniques include smoke detectors, fire extinguishers, automatic water sprinklers, and so on.

ii. Financial Risk Control

Financial risk control is a method of risk control that deals with the financing of loss after its occurrence. Financial risk control helps to answer the question of who bears the cost of loss and whether the cost of loss will be borne by the entity itself or transferred to another party. Therefore, financial risk control can be subdivided into retention and transfer:

a. Risk Retention: This is a technique of financial risk control whereby an individual or organization bears the cost of a loss or risk event by itself. Risk-retention can be further subdivided into planned and unplanned risk retention:

Planned Risk Retention: This is a strategy in risk retention whereby the organization is aware that there is a risk or loss exposure inherent in its activity and decides to retain the risk. Examples include:

- **Captives:** These are organizations that provide insurance and risk management services to their parent company (and other organizations). Captives can be opened or closed. Oen captives are insurance companies that render services to both the parent body and other organizations and closed where it renders services only to the parent company.
- **Risk or Contingency Funds:** These are funds set aside by an organization to draw on whenever there is a loss. On the part of the individual, personal savings are made from regular personal income so that funds can be drawn from such savings to pay for such losses as they occur.

Unplanned Risk Retention: For unplanned risk retention, an organization is not aware of the existence of a loss exposure and consequently does not attempt to handle it. By default, therefore, the organization has elected to retain the risk associated with the loss exposure.

b. **Risk Transfer:** This is a financial risk control technique that involves shifting the responsibilities for meeting one's losses to another party. It is divided into insurance and non-insurance.

- **Insurance:** Insurance is a system by which one party called the insured transfers risk to another party called the insurer, for a certain amount (premium) and the other party agrees to reimburse the former upon the occurrence of an insured contingency. The concept of insurance is further discussed in great detail in chapter five of this book.
- **Non-insurance:** This involves the transfer of the financial consequences of risk by one party to another by means other than insurance. Examples of non-insurance risk transfers are:
    - **Disclaimer Notice:** This includes signs that are displayed conspicuously in buildings. Examples of this are the "cars are parked at owner's risk" usually displayed in the parking garages of several companies.
    - **Hold-Harmless Clause:** This can also be called an agreement to waive. It is an agreement whereby one party agrees to waive or relinquish rights that are ordinarily accrued to him under a contract.
    - **Contract:** This involves a party shifting the burden of loss to another party through contractual agreements. This method is most common in tenancy agreements, whereby landlords shift the cost of repairing damaged property to the tenant.
    - **Alternative Risk Transfer (ART):** This is a broad term used to describe techniques used to protect one's assets or for covering the financing of risk through a non-conventional insurance market. They are tailor-made solutions for risks that the conventional insurance market would regard as uninsurable or cannot absorb. An example of this is the use of derivatives and securitization.

2.3 TRADITIONAL VERSUS ENTERPRISE RISK MANAGEMENT

Traditional risk management is faced with certain limitations. Under traditional risk management, risk management is practiced in isolation such that risks are not handled centrally in an organization. Also, not

all risks are considered within the traditional risk management framework. Traditional risk management typically addresses risks related to financial, operational, and project-specific areas, thereby ignoring the need to manage all other types of risks capable of leading a business to bankruptcy. Enterprise risk management was therefore developed to address the weakness of traditional risk management. Also known as Enterprise-wide risk management, Holistic risk management, corporate risk management, and Integrated risk management, Enterprise risk management incorporates the management of all types of risks confronting an organization. Enterprise risk management is anchored on the need to integrate rules and regulations guiding corporate governance, internal control, and risk management into a single managerial framework.

In this vein, Enterprise risk management is defined as a systematic discipline and an integrated method directed at managing organizational risks to create and maximize value for stakeholders. Enterprise risk management (ERM) does not isolate risk since it considers all organizational risks as critical to their survival and therefore adopts a holistic rather than a silo approach to the treatment of risks. Some of the features of Enterprise risk management are as follows:

i. The integration of all risks faced by an organization
ii. It identifies potential events capable of affecting the enterprise and manages them to ensure that they fall within the organization's risk appetite
iii. All organization members are involved in the design and implementation of the risk management process.
iv. It is embedded in the company's strategy
v. It is applied at all levels and sections across the enterprise
vi. It is an ongoing/continuous process within the organization
vii. It addresses risks holistically

The main difference between Traditional Risk Management (TRM) and Enterprise Risk Management (ERM) are as follows:

i. TRM focuses primarily on managing risks within specific departments or functions of an organization. It typically addresses risks related to financial, operational, and project-specific areas. On the other hand, ERM takes a broader view of risks and considers them across the entire organization. It encompasses strategic, operational, financial, and other risks that could impact the achievement of organizational objectives.

ii. TRM operates in silos, with different departments or functions managing risks independently. Each department identifies and addresses risks within its area of responsibility while ERM integrates risk management into the organization's overall strategic planning and decision-making processes. It aligns risk management with the organization's mission, vision, and values.

iii. TRM is often reactive in nature, focusing on identifying and mitigating risks after they occur. It may not proactively anticipate and plan for potential risks while ERM emphasizes proactive risk identification and assessment. It aims to anticipate potential risks and opportunities and develop strategies to mitigate risks and capitalize on opportunities.

iv. TRM may rely on risk transfer mechanisms such as insurance policies to mitigate the impact of identified risks while ERM promotes a culture of risk ownership throughout the organization. It encourages employees at all levels to identify and manage risks within their areas of responsibility.

v. TRM may have limited integration with the overall strategic objectives of the organization. It may not have a holistic view of risks that could affect the entire organization while ERM fully integrates with the overall strategic objectives of the organization by viewing risks that could affect the entire organization holistically.

2.4 RISK MANAGEMENT APPROACHES

There are two main approaches to risk management. These are the top-down and the bottom-up approach.

i. **Top-down approach:** The top-down approach to risk management involves starting from a high-level perspective and cascading down to the specific risk's areas within an organization. In this approach, senior management and executives play a significant role. Some key aspects of this approach are as follows:

   a. **Strategic Focus:** The top-down approach aligns risk management with the organization's strategic objectives. It considers risks that could impact the achievement of these objectives and focuses on identifying and managing risks at the enterprise level.

   b. **Executive Involvement:** Senior management takes the lead in setting the risk appetite and defining the risk management framework. They establish risk

management policies, provide guidance, and allocate resources for risk management activities.

c. **Risk Identification and Assessment:** The top-down approach typically involves interviewing key stakeholders, executives, and subject matter experts to gather insights on potential risks. Risk assessments are often conducted at a high level, focusing on broad categories of risks that could impact the organization's strategic goals.

d. **Risk Prioritization:** Identified risks are prioritized based on their potential impact on the organization's objectives and the likelihood of occurrence. This prioritization helps allocate resources and attention to the most critical risks.

e. **Integration with Decision-Making:** The top-down approach aims to integrate risk management into decision-making processes. It involves considering risks when making strategic choices, investments, and resource allocations, ensuring that risks are managed in the context of organizational priorities.

ii. **The bottom-up approach:** The bottom-up approach to risk management starts at the operational level and involves the active participation of individuals and departments throughout the organization. Some key aspects of this approach are as follows:

a. **Operational Focus:** The bottom-up approach emphasizes identifying and managing risks at the operational level. It aims to capture risks specific to departments, processes, projects, and day-to-day activities.

b. **Employee Involvement:** In this approach, individuals and teams on the ground play a critical role in identifying and reporting risks. Employees are encouraged to be proactive in identifying risks within their areas of responsibility.

c. **Risk Identification and Assessment:** The bottom-up approach relies on surveys, workshops, and collaborative discussions to identify risks. It encourages employees to provide insights and observations on potential risks, leveraging their expertise and knowledge of operational activities.

d. **Risk Aggregation:** Risks identified at the operational level are aggregated and analyzed to provide a holistic view of risks across the organization. This helps identify emerging risks, trends, and patterns that may not be apparent at the individual level.

e. **Risk Communication:** The bottom-up approach emphasizes open communication channels to report and share information about risks. It encourages a culture of transparency, where employees feel comfortable reporting risks and raising concerns.

Both top-down and bottom-up approaches have their strengths and weaknesses. To achieve a comprehensive and effective risk management strategy, organizations often integrate both approaches. This integration allows for a balanced view of risks, considering both strategic and operational perspectives. It ensures that risks at all levels are identified, assessed, and managed appropriately. By combining the top-down approach for strategic alignment and decision-making with the bottom-up approach for operational insights and employee engagement, organizations can enhance their risk management capabilities and create a risk-aware culture throughout the organization.

2.5 IMPLEMENTING ENTERPRISE RISK MANAGEMENT

Implementing enterprise risk management (ERM) involves a systematic and comprehensive approach to identifying, assessing, and managing risks across an organization. The steps involved in the implementation of enterprise risk management are as follows:

i. **Establishing a Foundation:** The first step in implementing enterprise risk management is to develop a clear understanding of the organization's objectives, risk appetite, and risk management philosophy. This includes defining the scope of the ERM program and aligning it with the organization's strategic goals and culture.

ii. **Selecting an ERM Framework:** This involves choosing an ERM framework that suits the organization's size, industry, and risk management needs. Common frameworks include the Committee of Sponsoring Organizations of the Treadway Commission (COSO) framework, the International Organization for Standardization (ISO) 31000 framework, and customized internal frameworks.

iii. **Identifying and Assessing Risks:** This involves conducting a comprehensive risk assessment to identify and evaluate risks across the organization. Here, key stakeholders and subject matter experts are engaged in other to gain insights into potential risks and their potential impact on business objectives. Use risk assessment techniques such as workshops, surveys, and interviews to gather information.

iv. **Establishing Risk Ownership and Accountability:** This step involves clearly defining roles and responsibilities for risk management throughout the organization.

The organization will assign risk owners who will be responsible for identifying, monitoring, and mitigating risks in their respective areas and must also promote a culture of risk awareness and accountability across all levels of the organization.

v. **Developing Risk Response Strategies:** Once risks are identified and assessed, appropriate risk response strategies must be developed. This may involve accepting, avoiding, transferring, or mitigating risks. Risk mitigation measures, such as control activities, policies, and procedures, are also implemented in other to reduce the likelihood or impact of identified risks.

vi. **Integrating ERM into Decision-Making Processes:** Here, risk management is embedded into the organization's decision-making processes. Risks and potential mitigation strategies are considered when making strategic, operational, and financial decisions. It must also be ensured that risk information is communicated effectively to decision-makers.

vii. **Monitoring and Reviewing:** This involves implementing mechanisms to monitor and review risks on an ongoing basis. This includes establishing key risk indicators (KRIs) and performance indicators to track the effectiveness of risk mitigation efforts. Also, risk assessments are regularly assessed and updated to reflect changes in the business environment and emerging risks.

viii. **Fostering Risk Culture and Awareness:** This involves promoting a risk-aware culture throughout the organization and encouraging employees to identify and report risks while providing training on risk management principles and practices to employees, and recognizing and rewarding risk-aware behaviors.

ix. **Communication and Reporting:** Here, effective communication channels are established for sharing risk information across the organization. Each operational unit and department keep a risk register to document risk event. Regular reporting mechanisms are developed to provide updates on risk management activities and the status of risk mitigation efforts to relevant stakeholders, including senior management and the board of directors.

x. **Continuous Improvement:** ERM is an iterative process that requires continuous improvement. It is important that a regular review and refining of the ERM program based on lessons learned, feedback from stakeholders, and changes in the business

environment are carried out. Risk management strategies should be adapted and enhanced in other to address emerging risks and evolving business needs.

2.6 BUSINESS CONTINUITY RISK MANAGEMENT

Business Continuity Risk Management (BCRM) is a proactive approach to identifying and mitigating risks that could disrupt or threaten the continuity of business operations. It focuses on developing strategies and plans to ensure the organization can continue its critical functions and recover quickly in the event of a disruptive incident. In some ways, business continuity shares most of the same characteristics as enterprise risk management but it focuses mainly on risks that threaten the existence of an organization. It can therefore be said that business continuity management focuses on efforts to meet the organization's post-loss goals of survival and continuity of operations.

By implementing BCRM, organizations can minimize the impact of disruptions, maintain essential functions, protect their reputation, and enhance their overall resilience in the face of unforeseen events. BCRM provides a framework to systematically identify, assess, and manage risks, ensuring the continuity of business operations and safeguarding the interests of employees, customers, and other stakeholders. The key aspects of business continuity risk management include:

i. **Risk Assessment:** BCRM begins with a comprehensive risk assessment to identify potential threats and vulnerabilities that could impact business operations. This includes natural disasters, technological failures, cyber-attacks, supply chain disruptions, pandemics, and other unforeseen events.

ii. **Business Impact Analysis (BIA):** A BIA evaluates the potential consequences of a disruptive incident on various aspects of the organization, such as operations, finances, reputation, and customer satisfaction. It helps prioritize critical functions and determine recovery time objectives (RTO) and recovery point objectives (RPO) for each function.

iii. **Risk Mitigation:** BCRM involves implementing risk mitigation strategies to reduce the likelihood and impact of potential disruptions. This may include measures such as redundancy in critical systems, backup and recovery solutions, implementing cybersecurity controls, diversifying supply chains, and establishing alternate work locations.

iv. **Business Continuity Plans (BCPs):** BCPs are the documented procedures and guidelines that outline how the organization will respond and recover in the face of

a disruptive incident. They provide step-by-step instructions to restore critical operations, manage communications, activate emergency response teams, and coordinate with external stakeholders.

v. **Training and Testing:** BCRM emphasizes the importance of training employees on their roles and responsibilities during a crisis and conducting regular testing and exercises to validate the effectiveness of the BCPs. This helps identify gaps, improve response capabilities, and ensure readiness for potential disruptions.

vi. **Continuous Improvement:** BCRM is an ongoing process that requires regular review and updates. Lessons learned from real incidents or exercises should be incorporated into the risk management strategy and plans. This ensures that the organization remains resilient and adaptable to changing threats and circumstances.

vii. **Coordination and Communication:** BCRM emphasizes effective coordination and communication both internally and externally. This includes establishing clear lines of communication during a crisis, maintaining relationships with key stakeholders, and establishing protocols for sharing information and updates.

2.7 COMPLIANCE MANAGEMENT

Compliance management refers to the processes, systems, and practices implemented by organizations to ensure adherence to laws, regulations, industry standards, and internal policies. It involves identifying applicable requirements, establishing controls, monitoring compliance, and taking corrective actions when necessary. Effective compliance management helps organizations mitigate legal and reputational risks, safeguard their stakeholders' interests, and foster a culture of integrity and ethics. By implementing robust compliance programs, organizations can demonstrate their commitment to responsible business practices and ensure compliance with applicable laws and regulations. Some key aspects of compliance management are as follows:

i. **Regulatory Landscape:** Organizations operate within a complex regulatory landscape, which may include local, national, and international laws and regulations. Compliance management involves staying updated on relevant requirements that apply to the organization's industry, geography, and operations.

ii. **Compliance Framework:** Establishing a compliance framework involves developing policies, procedures, and controls that address specific regulatory requirements including corporate governance principles. This includes designing

internal controls, creating documentation, and establishing reporting mechanisms to ensure compliance.

iii. **Risk Assessment:** Compliance management involves conducting risk assessments to identify areas of potential non-compliance. This assessment evaluates the likelihood and impact of compliance failures, allowing organizations to prioritize resources and efforts accordingly.

iv. **Policies and Procedures:** Developing and communicating comprehensive policies and procedures is essential for compliance management. These documents outline the expected behavior, responsibilities, and actions necessary to comply with applicable laws and regulations.

v. **Training and Awareness:** Organizations must provide training and awareness programs to ensure employees understand their obligations and the importance of compliance. Training programs may cover topics such as anti-corruption, countering money laundering & terrorism financing, data privacy, workplace safety, and ethical conduct.

vi. **Monitoring and Auditing:** Compliance management includes monitoring and auditing activities to assess adherence to established policies and procedures. This may involve conducting internal audits, requiring all department to periodically give reports on key compliance requirements, performing compliance checks, and utilizing technology solutions to monitor and track compliance activities.

vii. **Reporting and Documentation:** Compliance management requires maintaining accurate and up-to-date records of compliance efforts. This includes documenting compliance activities, maintaining records of training sessions, and preparing reports for regulatory authorities when necessary.

viii. **Corrective Actions:** When non-compliance is identified, compliance management involves taking appropriate corrective actions. This may involve implementing remedial measures, updating policies and procedures, retraining employees, or initiating disciplinary actions as needed.

ix. **Continuous Improvement:** Compliance management is an ongoing process that requires continuous improvement. Organizations should regularly review and update their compliance programs to address changing regulatory requirements and evolving risks.

x. **External Relationships:** Compliance management often involves engaging with external stakeholders, such as regulatory bodies, auditors, and industry associations. Building and maintaining positive relationships with these stakeholders can help organizations stay informed, build trust and receive guidance on compliance matters.

2.8 CRISIS MANAGEMENT

Crisis management is the process of preparing for, responding to, recovering from, and learning from a crisis or emergency that poses a significant threat to an organization's operations, reputation, or stakeholders. It involves proactive planning, effective coordination, and swift decision-making to mitigate the impact of the crisis. Effective crisis management helps organizations minimize the impact of crises, protect their reputation, and recover quickly. By being prepared, having clear communication strategies, and maintaining a proactive and adaptive approach, organizations can navigate through crises more effectively and emerge stronger. The basic features of crisis management are as follows:

i. **Risk Assessment and Planning:** Crisis management begins with identifying potential risks and conducting risk assessments to understand the likelihood and potential impact of various crisis scenarios. This enables organizations to develop crisis management plans and establish protocols for different types of crises.

ii. **Crisis Response Team:** Establishing a crisis response team is crucial. This team typically includes senior executives and representatives from relevant departments. They are responsible for decision-making, communication, and coordination during a crisis. Roles and responsibilities should be clearly defined.

iii. **Crisis Communication:** Effective communication is essential during a crisis. Organizations should develop a crisis communication plan that outlines how information will be shared internally and externally. Clear, timely, and transparent communication helps manage stakeholders' expectations and maintain trust.

iv. **Incident Response and Recovery:** Crisis management involves activating the crisis response plan when a crisis occurs. This includes implementing immediate actions to address the crisis, safeguard employees and assets, and mitigate further damage. Once the crisis is contained, efforts focus on recovering and restoring normal operations.

v. **Stakeholder Management:** Crisis management requires organizations to manage relationships with various stakeholders, such as employees, customers, suppliers,

investors, regulators, and the media. Understanding stakeholders' concerns and providing timely and accurate information helps maintain trust and credibility.

vi. **Adaptive Decision-making:** Crises often require quick and adaptive decision-making. The crisis management team must assess the situation, consider the available information, and make informed decisions under pressure. Flexibility and agility are critical in adapting strategies as the crisis evolves.

vii. **Post-Crisis Evaluation and Learning:** After the crisis is resolved, it's important to conduct a thorough evaluation to assess the effectiveness of the crisis management response. This includes identifying areas for improvement, updating crisis management plans, and integrating lessons learned into future crisis preparedness.

viii. **Training and Drills:** Regular training and drills are essential to ensure that employees are prepared to respond to a crisis. Simulating crisis scenarios through tabletop exercises or simulations helps familiarize the crisis response team with their roles, test communication protocols, and identify areas for improvement.

ix. **Continuous Improvement:** Crisis management is an iterative process. Organizations should continuously review and update their crisis management strategies and plan to address emerging risks, technological advancements, and lessons learned from previous crises.

x. **Collaboration and External Resources:** Crisis management often requires collaboration with external entities, such as emergency services, industry associations, and crisis management consultants. Establishing relationships and agreements with these resources in advance can enhance response capabilities.

2.9 DATA AND INFORMATION RISK MANAGEMENT

Data and information management involves the processes, systems, and strategies implemented by organizations to effectively capture, store, organize, analyze, and utilize data and information assets. It encompasses activities such as data governance, data quality management, data integration, data security, and information lifecycle management. Effective data and information management enables organizations to harness the value of their data assets, make informed decisions, improve operational efficiency, and maintain data integrity and security.

Thus, data and information risk management is the process of identifying, assessing, and mitigating risks associated with data and information assets within an organization. It involves protecting the confidentiality,

integrity, and availability of data while ensuring compliance with relevant regulations. Data and information risk management requires a combination of technical controls, well-defined processes, skilled professionals, and a culture of data security awareness throughout the organization.

By implementing effective data and information risk management practices, organizations can protect their valuable data assets, reduce the likelihood of data breaches, ensure compliance with regulations, and maintain the trust of customers and stakeholders. Various activities are involved in data and information risk management. These activities include:

i. **Risk Identification:** The first step in data and information risk management is to identify potential risks. This includes assessing internal and external threats, vulnerabilities, and the potential impact on data assets. Risks can arise from various sources, such as cyberattacks, data breaches, unauthorized access, human error, natural disasters, or system failures.

ii. **Risk Assessment:** Once risks are identified, they need to be assessed to determine their likelihood of occurrence and potential impact. This involves evaluating the sensitivity and criticality of the data, as well as the effectiveness of existing controls and safeguards in place to mitigate those risks. Risk assessment helps prioritize risks based on their significance, allowing organizations to allocate resources and implement appropriate mitigation strategies.

iii. **Risk Mitigation:** Risk mitigation involves implementing controls and measures to reduce the likelihood and impact of identified risks. This includes implementing technical safeguards like encryption, access controls, and network security, as well as administrative controls such as policies, procedures, and employee training. Regular monitoring, testing, and updating of controls are essential to ensure their effectiveness.

iv. **Compliance Management**: Data and information risk management also involves ensuring compliance with relevant laws, regulations, and industry standards related to data protection and privacy. Organizations need to understand and comply with data protection laws such as the General Data Protection Regulation (GDPR), the Nigeria Data Protection Act, or industry-specific regulations like the Payment Card Industry Data Security Standard (PCI DSS).

v. **Incident Response and Recovery:** Despite preventive measures, incidents and breaches may still occur. Therefore, organizations need to have a robust incident response plan in place. This includes processes for detecting, containing, investigating, and recovering from security incidents or data breaches. Timely response and effective communication are crucial to mitigate the impact and prevent further damage.

vi. **Data Governance:** Data governance plays a vital role in data and information risk management. It involves establishing policies, procedures, and controls for data management throughout its lifecycle. This includes data classification, data access and sharing, data retention, and data disposal. Proper data governance ensures that data is handled and protected appropriately, minimizing the risk of unauthorized access or misuse.

vii. **Continuous Monitoring and Improvement:** Data and information risk management is an ongoing process that requires continuous monitoring, assessment, and improvement. Organizations should regularly review and update their risk management strategies to adapt to changing threats and technological landscapes. It is important to stay informed about emerging risks and trends in data security and incorporate best practices accordingly.

SUMMARY

This chapter provides an overview of risk management, covering its definition, process, approaches, and various aspects. It also explores the importance of risk management in mitigating potential threats to businesses. The concept of enterprise risk management, as well as the difference between ERM and TRM, were also discussed. The chapter also delves into crisis management emphasizing the need to prepare for and effectively respond to unexpected events. Additionally, it discusses the significance of data and information systems management in risk management efforts. Lastly, the chapter touches on business continuity management, highlighting its role in ensuring the uninterrupted operation of business during disruptive events. Overall, the chapter provides a comprehensive understanding of risk management and its related components.

REVIEW QUESTIONS

1. Differentiate between risk management and risk control
2. What are the key aspects of business continuity management?
3. Discuss the major types of risk control and give two examples of risk transfer
4. Highlight five techniques of risk identification
5. Discuss enterprise risk management and differentiate between it and traditional risk management.
6. Case Study

   You are the HR manager of a medium-sized manufacturing company that has recently experienced a significant increase in workplace accidents and injuries. The company is concerned about the rising costs of workers' compensation claims, the impact on employee morale, and the potential regulatory compliance issues related to workplace safety.

   Discuss the concept of risk management in the context of HRM for your manufacturing company. Identify and analyze the specific workplace safety risks and challenges the company is facing, taking into consideration factors such as the nature of the manufacturing processes, employee training, and regulatory requirements.

   In your response, outline a comprehensive risk management strategy for addressing these workplace safety risks. This should include risk assessment, risk mitigation measures, safety training programs, incident reporting and investigation protocols, and communication strategies for promoting a culture of safety within the organization. Emphasize the importance of proactive safety measures and how they align with the company's HRM objectives and overall risk management framework. Additionally, discuss how effective risk management in HRM can contribute to improved employee well-being, reduced operational costs, and enhanced compliance with workplace safety regulations.

   This case study question requires you to apply the principles of risk management to the specific domain of Human Resource Management (HRM) in the context of workplace safety. You should demonstrate your ability to identify and assess risks related to employee safety, develop strategies for risk mitigation and prevention, and emphasize the importance of fostering a culture of safety within the organization.

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CHAPTER THREE

HUMAN RESOURCE RISK MANAGEMENT

3.0 LEARNING OBJECTIVES

i. To understand the meaning of HR risk management
ii. To understand the nature and sources of HR risks
iii. To identify the strategy to manage HR risks
iv. To understand the importance of HR risk management

3.1 INTRODUCTION

In today's dynamic business environment, organizations face numerous challenges in managing their human resources effectively. Human resource risk management is a crucial aspect of organizational strategy that focuses on identifying, assessing, and mitigating risks associated with the human capital. By implementing robust risk management practices, businesses can safeguard their talent pool, optimize workforce performance, and maintain a competitive edge in the market.

Human Resources Risk Management is the process of identifying, assessing, and mitigating potential risks and challenges related to human resources within an organization. It involves adopting strategies and practices to safeguard the organization's workforce, reputation, and overall effectiveness in achieving its goals. It involves the application of risk management principles and strategies to the various aspects of human resources, including recruitment, talent management employee relations, compliance with employment laws, data protection and more. The main objective of Human Resources Risk Management is to proactively address and minimize risks that could impact the organisation’s workforce, reputation, operational efficiency, and overall success. By effectively managing Human Resources Risks, organizations can create a safe and productive work environment, maintain legal compliance, enhance employee engagement, and protect their reputation in the marketplace.

3.1.1 NATURE OF HUMAN RESOURCE RISKS

The nature of human resources risks is diverse and can vary from one organization to another. These risks arise from various factors related to the management and interactions of the workforce within the organization. Human resource risks encompass a wide range of potential threats and vulnerabilities that can impact an organization's workforce and overall business performance. These risks can arise from both

internal and external factors and they affect different aspects of the employee lifecycle, including recruitment, retention, training and development, performance management, and employee relations.

Understanding the nature of these human resource risks and developing proactive risk management strategies is vital for organizations to maintain a competitive advantage and achieve long-term success. By effectively addressing these risks, human resource professionals can contribute significantly to the organization's overall performance and sustainability. Below are some common aspects that define the nature of human resources risks:

i. **Workforce Availability and Skills Gap:** One of the significant human resource risks is the availability of skilled talent in the job market. Skill shortages can arise due to rapid technological advancements, changes in industry demands, or a lack of qualified candidates in specific regions or industries. Failure to address this risk can lead to difficulties in recruiting and retaining talent with the required expertise, impacting the organization's ability to stay competitive.

ii. **Employee Turnover:** High employee turnover rates can have significant adverse effects on an organization. Losing valuable employees can result in a loss of institutional knowledge, reduced productivity, increased recruitment costs, and disrupted team dynamics. Addressing turnover risk requires strategies to enhance employee engagement, improve job satisfaction, and provide opportunities for career growth and development.

iii. **Compliance and Legal Risks:** Non-compliance with labor laws, employment regulations, and industry standards can lead to legal disputes, penalties, and damage to the organization's reputation. Human resource professionals must ensure that the organization adheres to all relevant laws and regulations, including those related to employee rights, working conditions, wages, and benefits.

iv. **Workplace Safety and Health:** Ensuring a safe and healthy work environment is crucial for minimizing workplace accidents and injuries. Failure to address workplace safety risks can result in employee harm, increased workers' compensation claims, and potential legal liabilities for the organization.

v. **Employee Relations and Conflict:** Poor employee relations, conflicts among team members, or strained relationships with management can negatively impact

workplace morale and productivity. It is essential to address employee relations risks proactively, promoting open communication, conflict resolution, and a positive work culture.

vi. **Succession Planning and Talent Development:** Not having a robust succession plan in place can lead to leadership gaps and hinder the organization's ability to retain and develop key talent. Identifying and nurturing future leaders through talent development programs is essential for ensuring continuity and organizational growth.

vii. **Technological Disruptions:** As technology continues to evolve, organizations face the risk of technological disruptions impacting job roles and workforce requirements. This may result in the need for re-skilling or upskilling employees to adapt to changing job demands.

viii. **Workforce Diversity and Inclusion:** Inadequate focus on workforce diversity and inclusion can lead to reduced innovation, diminished employee engagement, and potential discrimination-related legal risks. Organizations must embrace diversity and foster an inclusive work culture to mitigate these risks.

ix. **Economic and Global Market Conditions:** Economic fluctuations and changes in global market conditions can impact workforce demand and supply, leading to challenges in talent acquisition, retention, and compensation.

x. **Reputation and Branding:** Negative employer branding, such as poor online reviews from current or former employees, can deter potential candidates from applying to the organization. Maintaining a positive reputation is crucial for attracting top talent and retaining existing employees.

3.2 SOURCES OF HUMAN RESOURCES RISKS

Human resources risks can arise from various sources within an organization and its external environment. Identifying these sources is essential for effective risk management. Here are the primary sources of human resources risks:

i. **Internal Sources:** The internal sources of human resource risks are as follows:

a. **Workforce Management:** These include:

- **Employee Performance:** Inconsistent or poor performance of employees can impact overall productivity and organizational success.

- **Employee Morale:** Low morale can lead to reduced engagement, increased absenteeism, and higher turnover rates.
- **Employee Turnover:** Frequent turnover can disrupt operations, increase recruitment costs, and cause knowledge loss.
- **Succession Planning:** Failure to identify and groom potential successors for key positions can create leadership gaps.

b. **Compliance and Legal Issues:** These include:

- **Labor Laws:** Non-compliance with employment laws and regulations can result in legal actions and penalties.
- **Contractual Obligations:** Breach of employment contracts or collective bargaining agreements can lead to disputes.
- **Discrimination and Harassment:** Failure to address discrimination or harassment claims can result in legal liabilities.
- **Data Protection:** Mishandling of employee data can lead to data breaches and legal consequences.

c. **Work Environment:** These include:

- **Workplace Safety:** Inadequate safety measures can lead to accidents and injuries.
- **Work-Life Balance:** Poor work-life balance can cause burnout and decreased productivity.
- **Ethical Culture:** Lack of an ethical work culture may result in misconduct and reputational damage.

d. **Human Resource Practices:** These include:

- **Recruitment and Selection:** Ineffective hiring processes can lead to a mismatch of skills and organizational needs.
- Training and Development: Inadequate training can result in skills gaps and hinder employee growth.
- **Performance Management:** Flawed performance evaluation practices can lead to biased decisions.

ii. External Sources: The external sources of human resource risks are as follows:

a. **Economic Factors:** These include:

- **Economic Downturn:** Economic challenges can impact business operations and lead to workforce reductions.
- **Inflation:** Rising inflation may affect wage demands and compensation-related issues.

b. **Market and Industry Trends:** These include:

- **Talent Availability:** Changes in the job market can affect talent acquisition and retention.
- **Technological Advancements:** Automation and technological disruptions may alter job roles and skill requirements.

c. **Regulatory Environment:** These include:

- **Changing Employment Laws:** Evolving labor laws and regulations may require adjustments in HR practices.
- **Global Regulations:** International operations can be subject to varying labor laws and compliance requirements.

d. **Social and Political Factors:** These include:

- **Diversity and Inclusion:** Societal expectations for diversity and inclusion can influence HR practices.
- **Geopolitical Risks:** Political instability in certain regions can impact workforce availability and operations.

e. **Technological Risks:** These include:

- **Cybersecurity:** Increasing reliance on technology exposes organizations to data breaches and cyber threats.
- **Automation:** Automation and artificial intelligence may displace jobs and create skill gaps.

f. **Natural and Environmental Risks:** These include:

- **Natural Disasters:** Events like earthquakes or floods can disrupt operations and workforce availability.
- **Climate Change:** Environmental concerns may impact organizational practices and workforce planning.

3.3 ORGANISATIONAL PRACTICES THAT MINIMIZE HUMAN RESOURCES RISK

Organizational practices that minimize human resources risks include:

i. **Employment Practices and Compliance:** Theses includes:

a. **Discrimination and Harassment:** Ensuring a workplace free from discrimination based on race, gender, age, religion, etc.

b. **Wage and Hour Compliance:** Adhering to wage and hour laws, including overtime, minimum wage, and employee classification.

c. **Employee Contracts and Agreements:** Properly documenting employment terms and conditions to avoid disputes.

d. **Workplace Safety:** Implementing safety protocols to prevent accidents and maintain a safe work environment.

ii. Talent Management: This include:

a. **Recruitment and Selection:** Ensuring fair and objective hiring practices while attracting skilled candidates.

b. **Succession Planning:** Identifying and developing employees for future leadership roles.

c. **Training and Development:** Providing employees with necessary training to enhance skills and performance

iii. Employee Relations: This include:

a. **Grievance Handling:** Establishing effective procedures to address and resolve employee complaints.

b. **Employee Engagement:** Promoting a positive work culture to enhance employee satisfaction and retention.

c. **Employee Discipline:** Implementing fair disciplinary actions when necessary.

iv. Data Protection and Information Security: This include:

a. **Confidentiality:** Safeguarding sensitive employee information and preventing data breaches.

b. **Compliance with Data Protection Laws:** Adhering to data protection and privacy regulations.

v. Organizational Culture and Ethics: This include:

a. **Ethical Conduct:** Promoting ethical behavior at all levels of the organization.

b. **Diversity and Inclusion:** Fostering an inclusive workplace that embraces diversity

3.4 STRATEGIES FOR HUMAN RESOURCES RISK MANAGEMENT

i. **Risk Identification and Assessment:** Conducting a comprehensive risk assessment is the foundation of effective human resource risk management. HR professionals should identify potential risks through data analysis, employee surveys, feedback mechanisms,

and industry benchmarking. This enables them to prioritize risks based on their potential impact and likelihood of occurrence.

ii. **Proactive Workforce Planning:** Proactive workforce planning involves anticipating future talent needs and developing strategies to address skill gaps. By conducting regular workforce planning exercises, organizations can identify potential risks related to talent shortages, retirement waves, or emerging skill requirements. This enables them to implement targeted recruitment, training, and development initiatives to mitigate these risks.

iii. **Robust Policies and Procedures:** Implementing clear and comprehensive policies and procedures is crucial for mitigating human resource risks. These should cover areas such as recruitment and selection, employee onboarding, performance management, workplace safety, and employee relations. Regularly reviewing and updating these policies ensures their alignment with changing legal requirements and industry best practices.

iv. **Training and Development:** Investing in employee training and development programs is essential for mitigating risks associated with skills gaps, low employee engagement, and inadequate performance. By providing employees with the necessary skills and knowledge, organizations can enhance workforce capabilities, improve job satisfaction, and reduce turnover rates.

v. **Effective Communication and Employee Engagement**: Open and transparent communication is vital for mitigating human resource risks such as low employee morale, resistance to change, or misunderstandings. Organizations should foster a culture of open communication, encourage feedback, and ensure employees have access to appropriate channels for raising concerns or reporting grievances.

3.5 IMPORTANCE OF HUMAN RESOURCES RISK MANAGEMENT

Human resources risk management is a critical aspect of overall risk management for organizations. By proactively identifying and mitigating HR-related risks, organizations can safeguard their employees, reputation, and business operations, leading to long-term success and sustainability. Human Resources Risk Management is of paramount importance to organizations for several reasons. It goes beyond the traditional HR functions of recruitment and talent management and focuses on identifying and mitigating potential

risks related to the workforce and HR practices. Some key reasons for the importance of human resources risk management include:

i. **Legal Compliance**: HR risk management ensures that the organization complies with employment laws and regulations, reducing the risk of costly lawsuits, fines, and penalties associated with non-compliance.

ii. **Protecting Employees**: By proactively managing risks related to workplace safety, harassment, discrimination, and other HR issues, organizations can ensure the well-being and safety of their employees, fostering a positive work environment.

iii. **Reputation Management**: A strong HR risk management strategy helps protect the organization's reputation by promoting fair and ethical practices, diversity and inclusion, and employee well-being. A positive reputation can attract top talent and enhance the organization's image in the marketplace.

iv. **Business Continuity**: Addressing HR risks, such as succession planning and talent management, ensures a stable and skilled workforce, reducing disruptions to business operations during times of change or crisis.

v. **Cost Reduction**: Effective HR risk management can lead to cost savings. By preventing legal actions, employee turnover, and workplace accidents, organizations can save on litigation expenses, recruitment costs, and productivity losses.

vi. **Enhanced Decision-Making**: With HR risk management practices in place, organizations can make informed and data-driven decisions about workforce planning, performance management, and talent development.

vii. **Improved Employee Engagement and Productivity**: Addressing HR risks positively impacts employee morale and engagement, leading to higher productivity and performance levels within the organization.

viii. **Adapting to Change**: HR risk management helps organizations adapt to changing circumstances, such as technological advancements, shifts in the labor market, and evolving regulatory requirements.

ix. **Preventing Talent Shortages**: By identifying and addressing talent gaps in the organization, HR risk management ensures that the right skills and expertise are available to meet current and future business needs.

x. **Crisis Preparedness**: A well-designed HR risk management plan includes contingency measures for potential HR crises, such as handling layoffs, natural disasters, or unexpected workforce challenges.

xi. **Supporting Organizational Goals**: Human resources risk management aligns HR practices with the organization's overall strategic objectives, enabling the HR department to contribute effectively to the organization's success.

xii. **Employee Retention and Loyalty**: Addressing HR risks fosters a positive work environment and supportive culture, leading to higher employee satisfaction, retention, and loyalty.

SUMMARY

Human resource risk management is a critical component of organizational success in today's complex business landscape. It is crucial for organizations to regularly assess these sources of human resources risks, develop risk mitigation strategies, and integrate risk management into their overall business strategy. By proactively identifying and mitigating risks associated with human capital, organizations can optimize workforce performance, attract and retain top talent, ensure compliance with legal requirements, and maintain a positive organizational reputation. By implementing robust risk management strategies, HR professionals can navigate the ever-changing human resource landscape and contribute to the long-term success of their organizations.

REVIEW QUESTIONS

1. Discuss five organizational practices that can help to minimize Human Resource risks.
2. What are the key sources of Human Resource risks?
3. Discuss the major types of HR risks and give two examples of each
4. Highlight five importance of HR risk management
5. Identify and Explain the Strategies for managing Human Resource risks in a manufacturing organization
6. Case Study

   You are the Human Resources Director of a global technology company with offices in multiple countries. The company has recently experienced a series of challenges related to human resource management. These include issues like high employee turnover, cultural clashes in the international teams, and compliance concerns in different regions.

   Discuss the concept of Human Resource Risk Management in the context of your global technology company. Identify and analyze at least three specific HR-related risks and challenges your company is currently facing, considering factors such as talent retention, cross-cultural management, and legal compliance.

   In your response, outline a comprehensive HR risk management strategy to address these challenges. This should include risk assessment, risk mitigation measures, talent development initiatives, diversity and inclusion programs, and legal compliance strategies tailored to the different regions in which your company operates. Emphasize the importance of aligning HR risk management with the company's overall strategic goals and the global nature of the business.

   Additionally, discuss how effective HR risk management can positively impact the company's performance, employee satisfaction, and its ability to navigate the complexities of a global workforce.

   This case study question requires you to apply the principles of Human Resource Risk Management to a real-world scenario, considering the challenges and risks associated with managing a global workforce. You should demonstrate your understanding of HR-related risks and your ability to develop strategies to mitigate these risks while aligning HR practices with the company's broader objectives.

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CHAPTER FOUR

ORIGIN OF INSURANCE

4.0 LEARNING OBJECTIVES

i. To understand the origin of insurance
ii. To understand the history of insurance in Nigeria

4.1 INTRODUCTION

From when history recorded the existence of human society; there have been situations when adverse situations have affected them with no solution other than to resort to self-help, or if the situation can be avoided, this is chosen as an option. Insurance as a concept came into existence when individuals decided to come together to share the responsibility of catering for losses that may arise from their daily living.

4.1.1 HISTORICAL DEVELOPMENT OF INSURANCE

Marine insurance is the earliest type of insurance. It evolved with the development of the bottomry bond, credit systems, and interest laws, which were based on a sound understanding of the risks involved in maritime ventures and methods to protect against them. If a ship was lost, the loan and interest were forfeited. The insurance contract was incorporated into the carriage contract. Sea and land travelers were highly susceptible to losing their merchandise and vessels due to widespread piracy at sea and caravan robberies. Additionally, maritime adventures faced other risks, such as capture by the King's enemies. Shipowners faced immense risks, and to protect them, marine traders created a way to distribute financial losses that individual victims could not bear easily. Initially, this cooperative method was voluntary, but it has since transformed into a modern premium system.

In the 14th century, the current form of marine policies emerged, with the Brugians leading the way. In 1310, the Count of Flanders allowed the establishment of a Charter of Assurance in the town, enabling merchants to insure their goods against maritime risks. Later in the 14th century, the Lombards introduced marine insurance to the United Kingdom. Merchants who underwrote marine risks gathered in Edward Lloyd's coffeehouse in Tower Street, London. This coffeehouse specialized in catering to insurance needs and eventually became the first insurance market, known today as Lloyds.

It was not until 1575 that the need for formalizing marine insurance policy provisions arose, resulting in the establishment of the Chambers of Assurances. Every policy had to be registered. The Marine Insurance Act of 1745 was later enacted, nullifying contracts where neither party had an interest in the outcome of a potential maritime loss. The Marine Insurance Act of 1906 repealed the 1745 Act and made wagering contracts null and void, requiring marine contracts to be documented in a policy to be admissible as evidence.
The liberation of motor car use came with the passing of the Locomotive on Highway Acts 1896 in the UK. Before that, motor vehicles faced restrictive legislation. The use of motor transport boomed during and after World War I, increasing the demand for insurance. In the early 1920s, many motorists could not afford insurance due to high vehicle purchase costs, leading to hardships for road accident victims, who often lacked compensation from negligent, financially strapped motorists. This caused serious injuries and fatalities, prompting the realization of motor insurance as a social necessity and the enactment of the Road Traffic Act of 1930. This legislation mandated compulsory insurance for liabilities related to death or injury to others and spurred increased demand for motor insurance. Following World War II, motor vehicle ownership and usage skyrocketed in the UK, including among young people, and along with commercial motoring, this contributed to the growth of the motor insurance industry.

After marine insurance, fire insurance took shape in its present form. Initially observed in the Anglo-Section Guild, fire insurance provided personal assistance to fire victims by supplying life essentials. Fire insurance gained traction in England after the great fire in 1666. The first fire insurance office was established in 1681, and as colonies expanded, fire insurance spread worldwide.

Life insurance first emerged in England during the 16th century, with the earliest known policy insuring the life of William Gybbons on June 18, 1653. While life insurance policies originated in late 16th-century England, they lacked a scientific foundation. The Society of Assurance for Widows and Orphans, founded in 1699 as the first mutual life insurance company, did not achieve significant success. Subsequently, the Amicable Society for a Perpetual Assurance Office began operations in 1706, followed by the London Insurance Corporation and the Royal Exchange Assurance Corporation. These companies restricted membership to those under 45 years of age and charged uniform annual premiums, regardless of age or health status.

Before 1582, early funeral and burial societies did not operate on sound mathematical principles due to the lack of vital statistics. Records of births and deaths were non-existent, so there was no accurate understanding of a person's life expectancy. The first attempt to address this issue was made by London's parish clerks, who began collecting baptism and burial records around 1582. These records were later published as Bills of Mortality. In 1662, London merchant John Graunt examined the Bills of Mortality and used them to create the first mortality table. Though imprecise, this table was utilized by Rev. Dr. Assheton, who established the Life Assurance and Annuity Association in 1699. Unfortunately, the endeavor failed due to insufficient premium rates. During the following years, several scientists began investigating mortality rates. In 1756, James Dodson demonstrated the feasibility of scientifically-based life insurance by proposing age-based level premium rates derived from a mortality table.

Early mortality tables, such as the Northampton Table and Carlisle Table, were based on 18th-century death records and used by life insurance companies for many years. In the 19th century, the development of accurate mortality tables became possible with the introduction of government-mandated decennial censuses in England starting in 1801. These censuses provided more reliable data from across the country rather than from a single town. The first English Life Table was based on the 1841 census, and subsequent tables were derived from later censuses. With each iteration, the tables became increasingly comprehensive and reliable.

However, the English Life Tables were based on the general population and not specifically on insured lives. This discrepancy led to the development of the British Life Tables in 1903, which utilized data from 48 insurance companies between 1863 and 1893. Since then, life insurance tables have been continually refined and improved. The Continuous Mortality Investigation, launched in 1921, further contributed to the development of increasingly accurate and specialized tables. Today, the most widely used tables are the Assured Life Tables (AM00 and AF00).

4.2 THE HISTORICAL DEVELOPMENT OF INSURANCE IN NIGERIA

Various forms of social insurance existed before the influence of Western civilization and contemporary insurance in Nigeria. These systems are developed through extended family networks and social groups, such as periodic contributions among age groups and other associations. However, it wasn't until the early 20th century that British merchants who established trade posts along the West African coast introduced modern commercial insurance to Nigeria. These merchants began insuring with established London-based

insurance companies, some of which later appointed agents to represent their interests in Nigeria. The Royal Exchange Assurance Company was the first to open a full branch office in Nigeria in 1921, located in Lagos.

In 1945, the Motor Vehicle (Third Party Insurance) Ordinance No. 53 was enacted, taking effect on April 1, 1950, to protect against third-party risks related to motor vehicle usage. Royal Exchange Assurance held a near-monopoly on Nigeria's insurance business for about 30 years until 1949, when three other British-owned insurance companies entered the market: Norwich Union Fire Insurance Society, Tobacco Insurance Company Limited, and the Legal and General Assurance Society.

During the early years of Nigeria's insurance industry, there was minimal government oversight. The Nigerian government allowed insurance companies to operate freely, as long as they complied with the country's commercial laws. However, after gaining independence, the Nigerian government recognized the potential for abuse under this laissez-faire approach and took measures to protect policyholders and third parties, following the example of other modern nations. The Insurance Companies Act of 1961 was the first legislation to introduce government supervision of insurance in Nigeria.

In 1958, the first indigenous company called the African Insurance Company Limited was established Post-independence, the Nigerian government, and some regional political subdivisions also established their own insurance companies, such as NICON Insurance Plc., Great Nigeria Insurance Co. Ltd., Nigeria General Insurance Co. Ltd., LASACO Assurance Plc., and others. In 1997, the National Insurance Commission (NAICOM) Act established the National Insurance Commission to administer and enforce the Insurance Act, oversee the regulation and control of the insurance business in Nigeria, and protect insurance policyholders, beneficiaries, and third parties.

In 2003, the Insurance Act of 2003 was enacted as a consolidated act, incorporating appropriate amendments and additions from previous insurance legislation to regulate the insurance business in Nigeria. The 2005 insurance industry reform aimed to restore public confidence, increase capacity, and enhance the international competitiveness of Nigerian insurance companies, leading to a significant reduction in the number of insurance companies operating in the country. While some companies merged, others shifted from reinsurance to pure underwriting, and some remained independent without merging.

The Insurance Act of 2003 provided that insurance companies in Nigeria must have the following paid-up share capital:

a. Life Assurance Company - ₦150million
b. Non-Life (General Business) Insurance Company - ₦200million
c. For composite company - ₦350million
d. For reinsurance companies - ₦350million

However, this has been further increased by an amendment to the 2003 Act in 2005. By the amendment, the required share capitals have been raised to:

a. Life Assurance Business - ₦2billion
b. Non-life (General) Insurance Business - ₦3billion
c. Reinsurance Company - ₦10billion

This amendment made no provision for a composite insurer. Therefore, any insurer that wishes to transact business as a composite insurer must register two separate companies-one to transact life assurance business and the other to transact non-life insurance business.

SUMMARY

History has shown that before the introduction of insurance, in many societies there existed various methods by which citizens assisted one another in the event of adversity. This could be by drawing from contributions made by members or assisting through labor to mitigate losses suffered by any member. Therefore, this chapter has addressed the historical development of insurance focusing on its introduction as a means to assist others. The chapter explains the reason behind the introduction of some classes of insurance, emphasizing its role in managing and transferring risks. Furthermore, it delves into the historical development of insurance in Nigeria, providing insights into how the industry has evolved within the country.

REVIEW QUESTIONS

1. Discuss the rationale behind the introduction of Motor Insurance
2. Discuss the significance of the 2005 insurance industry reform in Nigeria
3. Explain the evolution of Marine Insurance as the first form of insurance
4. Discuss the rationale behind government intervention in the insurance industry in Nigeria, post-independence.
5. **Case Study:** The insurance industry in Nigeria has grown significantly over the years, but its origins can be traced back to a relatively distant past. Analyze the historical development and origin of the insurance industry in Nigeria.

    a) Begin by providing a historical overview of Nigeria, focusing on the socio-economic factors that contributed to the emergence of insurance as a financial service.

    b) Discuss the earliest forms of insurance or risk-sharing practices that existed in Nigeria before the formal insurance industry was established. Explore how traditional practices may have influenced modern insurance.

    c) Examine the role of colonial powers in introducing formal insurance institutions to Nigeria during the colonial period. Highlight any key milestones or developments during this time.

    d) Describe the growth and evolution of the insurance industry in Nigeria after gaining independence. Include factors such as regulatory frameworks, market competition, and the expansion of insurance products and services.

    e) Discuss the challenges faced by the Nigerian insurance industry today and identify opportunities for further growth and development.

    f) Analyze the impact of insurance on Nigerian society and the economy, considering aspects like risk management, financial inclusion, and economic stability.

    g) Briefly outline the regulatory framework governing insurance in Nigeria and its role in shaping the industry.

In your response, provide historical context and relevant data to support your analysis. Additionally, consider the unique cultural and economic factors that have influenced the development of the insurance sector in Nigeria.

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CHAPTER FIVE

CONCEPT OF INSURANCE

5.0 LEARNING OBJECTIVES

i. To understand the concept of insurance
ii. To understand the elements of a valid insurance contract
iii. To recognize the categories of persons who cannot enter into a valid insurance contract
iv. To identify the types of insurance companies
v. To understand the primary and secondary functions of insurance

5.1 INTRODUCTION

Insurance is a fundamental concept that plays a crucial role in managing and mitigating risks in various aspects of life. Whether it is protecting properties, safeguarding health, or securing businesses, insurance provides a valuable safety net that offers peace of mind and financial security. This chapter delves into the concept of insurance, exploring its functions, characteristics, as well as types. By gaining a deep understanding of insurance, human resource managers can appreciate its significance in safeguarding against unforeseen events in their organizations and personal lives and ensuring a resilient and protected future.

5.1.1 CONCEPT AND MEANING OF INSURANCE

One of the definitions of risk is that it is the uncertainty of loss. Risk can also be defined as uncertainty concerning the occurrence of loss. Insurance in this vein, is a risk transfer mechanism used for the transfer of risk from the individual or organizational risk bearer to another entity. The availability of insurance itself does not however cancel out risk but allows the provision of financial assistance to those who suffer the effect of risk. The definition of insurance varies and is dependent on the discipline of the person defining it. The definition of insurance based on different professions is illustrated below:

The Economists: According to the economist, insurance is a device for the transfer of some risk of economic loss from the insured who otherwise would have borne the risk, to an insurer in return for a premium.

Lawyers: Lawyers see insurance as a contract whereby a person called the insurer or assurer agrees in consideration of money paid to him, called the premium, by another person called the insured or assured to indemnify the latter against loss resulting to him on the happening of certain events.

Sociologists: The sociologists define insurance as a device whereby the participants provide financial compensation or succor to those among them encountering the many misfortunes or contingencies that befall humanity often from the accumulated contributions of all those participating in the insurance system.

Insurers: Oyetayo (2001) defines insurance as a provision of a system of compensation for loss, damage, sickness, death, and other unforeseeable circumstances in return for regular payments of a predetermined premium. Banjo (2003) also defines insurance as an arrangement by which one party (the insurer) promises to pay another party (the insured or policyholder) a sum of money if something should happen which causes the insured to suffer a financial loss.

5.2 INSURANCE CONTRACT

A contract is a legally binding agreement between two or more parties to do or not to do something. They intend to create a legal relation and not merely to exchange mutual promises. The relationship between an insured and an insurer is contractual. Hence, an insurance contract is an agreement enforceable by law between the insurer and the insured whereby the insured agrees to pay a particular amount called the premium to the insurer and abide by the terms and conditions of the policy. In return, the insurer agrees to pay the insured a sum of money or something of monetary value on the happening of a specified event. To ensure that an insurance contract is valid and enforceable, the following elements must be present:

i. **Offer:** An offer is a firm, unambiguous statement made by one person called the offeror to another person called the offeree embodying the terms under which the offeror is prepared to enter into the contract. Such an offer may be in writing or given verbally. It is important to distinguish between an offer and statements which are made when negotiations are still in progress. These are known as "invitations to treat" which are in effect invitations to make an offer. Circulars and advertisements fall under this category. For example, a prospectus published by an insurance company that contains details of covers and standard rates of premium is likely to be regarded as merely an invitation to treat. Sometimes, the proposal form which is submitted to the insurer serves as an offer that the insurer will accept by confirming coverage or issuing the policy. In other cases, the insurer may quote a premium based on the information supplied in the proposal form and in so doing make an offer which the proposer may then accept or decline.

ii. **Acceptance:** A contract comes into existence when one party makes an offer that the other party accepts unconditionally. There is an acceptance when the insured or insurer accepts the proposal

made by the other party without attaching any condition. If new terms are introduced into the offer, the acceptance becomes a counter offer which is open to be accepted or rejected by the person who made the original offer. An acceptance can be made by word of mouth, by writing delivered by hand, through the post, by telephone, by email, or by conduct. In insurance, an offer may emanate either from a prospective insured or from the insurer. Thus, whether a particular statement is an offer or an acceptance depends on the nature of the statement and not necessarily on what the parties to the transaction call it.

iii. **Consideration:** Consideration has been described as some rights, interest, profit, benefit accruing to one party or some forbearance, detriments, loss, or responsibility given, suffered, or undertaken by another party. A contract must be supported by consideration to be valid. It is therefore the exchange element in a bargain. In insurance, both parties provide consideration as follows:

   a. Consideration from the insured to the insurer (this is the premium)
   b. Consideration from the insurer to the insured (indemnity). This is the promise to compensate the insured or to make certain payments in the event of certain occurrences taking place. This promise is applicable whether a claim arises during the period of insurance or not.

iv. **Consensus ad idem (meeting of minds):** This is a fundamental requirement of any agreement that could be legally enforceable. It means the meeting of the minds of the insured and the insurer as evidenced by a valid offer and acceptance. In an insurance contract, "meeting of minds" refers to the mutual agreement of the parties involved regarding the terms and conditions of the policy. Both parties must have a clear and shared understanding of the policy's contents for the contract to be legally binding. Any ambiguity or disagreement about the terms of the contract can lead to legal disputes in an insurance contract.

v. **Intention to create legal relations:** For an insurance contract to be enforceable, both parties must intend for it to be binding under the law. There must be an intention to create legal relations. With many informal and social agreements, there is never an intention of legal consequences should the agreement for some reason not be carried out. This point seldom gives rise to any difficulty in insurance, where it is usually quite evident that the parties intend the agreement to be legally binding.

vi. **Capacity:** For a contract of insurance to be valid, both the insured and the insurer must have the legal capacity to enter into the contract. In Nigeria, those who carry out the business of insurance are usually limited liability companies. Section 3 of the Insurance Act, 2003 makes provision for persons who may commence or carry on insurance business in Nigeria. These are:

   a. A company duly incorporated as a limited liability company under the Companies and Allied Matters Act or;

   b. A body duly established by or under any other enactment to transact the business of insurance or reinsurance.

Generally, any person can be insured under the contract of insurance, provided such a person has insurable interest except in some cases where the law grants exceptions. These cases include:

a. **Minor/Infant:** In Nigeria, a person below the age of 18 is a minor. He does not have the full contractual capacity as other persons to enter into a contract of insurance. However, he can do so if it is for his benefit (necessaries or contract of apprenticeship). If however the contract is not for his benefit, it is not binding on him and he is likely to avoid it.

b. **Drunken and Insane persons**: A certified drunk or someone suffering from mental infirmity is incapable of entering into a contract of insurance. A contract involving a mentally infirmed or drunk person may be voidable but not void. To avoid the contract such a person must be able to prove that his infirmity or drunkenness makes him incapable of understanding what he is doing and the other party is aware of this infirmity while contracting with him.

c. **Enemy Aliens:** An alien is a person who is resident in one state but he is the subject of a foreign state. In peacetime, an alien has the same contractual capacity as a citizen of the country he is residing but in wartime, an enemy alien cannot enter into a contractual agreement in his resident country, and all existing contracts with such enemy aliens are dissolved or suspended.

d. **Corporation:** a corporation or society which is incorporated in Nigeria is a legal person and has an existence distinct from its owners and employees. The capacity of a corporation to enter into an insurance contract depends on what business the company is set up to carry on as evidenced in the memorandum of association. If a company enters into an insurance contract outside its scope, such contracts are ultra vires and void.

5.3 FORMAL REQUIREMENT OF AN INSURANCE CONTRACT

Insurance cover may be given orally and although a written policy is eventually issued in almost every case, a claim may well happen before the policy is prepared. A few exceptional cases where some formality may be required in an insurance contract under the law are addressed below:

a. **Contract by deed:** There is no legal requirement for any type of insurance contract to be in the form of a deed.

b. **A contract that must be in writing: the** only type of insurance required to be in writing is the Marine Insurance Policy. This is subject to the provision of Section 22 of the Marine Insurance Act, of 1906. However, a marine insurance contract may be formed without the existence of the policy but to be able to claim against the insurer, the insured must hold a policy.

c. **Contract which must be evidenced in writing:** A contract of guarantee must be evidenced in writing according to Section 4 of the Statute of Frauds Act 1677. This provision may apply to some fidelity guarantee insurance but not all of them. This is because some modern fidelity policies are often contracts of insurance only and not contracts of guarantee.

d. **Other insurance contracts where some form of documentation is required:** Section 2 of the Life Assurance Act, 1774 provides that the life insurance policy shall contain the name of the person interested in it. This implies that a form of policy must be present in life assurance.

5.4 DEFECTIVE CONTRACTS

a. **Void contract:** A void contract is one which legally does not exist. It is an apparent agreement that is devoid of legal effect. Such a contract would arise in insurance where some essential element of an insurance contract is missing.

b. **Voidable contract:** A contract is voidable if it can be voided. Where either party is in breach of a vital contractual term, the other party has a right to consider the contract void (set the contract aside). The contract is said to be voidable at their option. This may arise under an insurance policy, where the insured is in breach of a policy condition that places a continuing agreement upon them. On the other hand, the aggrieved party may decide to overlook the breach in which event the contract is unaffected and remains in full force.

c. **Unenforceable contract:** an unenforceable contract is neither void nor voidable but which cannot be enforced through the court. For example, a marine insurance contract that is not in writing.

5.5 THE BASIC FUNCTIONS OF INSURANCE

The functions of insurance can be broadly categorized into two. These are:

a. Primary functions
b. Secondary functions

Primary Functions: Primary functions are functions performed by the very nature of insurance. These functions include:

i. **Risk Transfer:** The original reason insurance was established is to transfer risk from the would-be-insured to the insurer. Insurance as a risk transfer mechanism is one whereby, a person in exchange for a price called the premium transfers risk to another person/entity (insurer). The insurers being experts in risk-bearing accepts all insurable risks of individuals and organizations.

ii. **Charging of Equitable Premium:** Insurers charge the risk owners for the risks that have been transferred to them. The premium is the price paid for the relief that the insured enjoys by shifting the burden of carrying risks to the insurer. However, since risks are different and of different values, and present different degrees of hazards, they attract different amounts of premium payable. Thus, the premium payable is determined by the insurer and commensurate to the value of the risks and level of hazards.

iii. **Creation of Common Pool:** Insurance put various risks of similar nature into the same class and also put the premiums paid for them into this same class so that losses that arise from a particular class of risks are paid for from the pool of funds created from the premiums paid for the risk of that class. This is based on the law of large numbers which connotes that for large risks of identical risk, the risk that actual losses per person are greater than predicted decreases as the size of the pool increases.

Secondary functions: Other functions which are not primary but flow along the primary functions are secondary functions. These functions include:

i. **Investment of Funds:** Premiums charged by insurers are not exhausted in the cost of carrying out the insurance contract. These excesses accumulate into large sums and are invested in other sectors of the economy. The government regulates the investment of such insurance funds.

ii. **Basis for Credit:** Banks and other loan-providing institutions demand insurance policies on the lives and collateral of the lenders. Such policies may be either bought by the lender or on the lender's behalf by the bank from the insurance companies before the loan is granted.

iii. **Reduction of Anxiety:** The anxiety suffered by people following a loss incident is reduced or removed if insurance cover is in place for the item that was lost.

iv. **Peace of Mind:** the owner of properties experiences a good deal of peace of mind when there are insurance covers on such properties or life. This is because of the realization that if a loss occurs to the insured properties/lives, he will be compensated by the insurer.

v. **Savings:** life assurance policy (endowment) is a good means of savings for people especially those who find it difficult to save. It is a way of providing for the future.

vi. **Generate Foreign Exchange:** Insurance is a form of service suitable for export to generate foreign exchange for a company. Here, risk is transferred to other insurance companies in other countries. The transfer of such risk requires the payment of foreign exchange as a premium.

vii. **Loss Prevention:** Insurance encourages the insured to take steps that might prevent the occurrence of the loss or reduce the extent of losses if they occur. Insurance achieve this by granting discount at reducing premium rate chargeable on reduced risk, distributing items for safety like a helmet for construction workers, automatic fire extinguisher for homes/offices, and so on.

viii. **Stimulation of Business Enterprise:** The major stimulant of a business idea or investment funds. However, entrepreneurs would not ordinarily want to invest all or better part of their money in a business, without a good amount/reserve to fall back on, in the event of the occurrence of a loss, but with the available insurance cover, such entrepreneur can invest their money in a business venture.

ix. **Promotion of Executive Efficiency:** Executive and management staff members of an organization can perform their duties of managing the organization with more efficiency without any worries about their lives, properties, and future if they are assured of the existence of insurance covers on such lives, properties, and future.

x. **Sustenance of Unity:** By making funds available through the claims paid by the insurer in the event of the death of a breadwinner whose life was assured, the family unit or even business enterprise can survive as a unit even after the death of such breadwinner.

5.6 CHARACTERISTICS/FEATURES OF INSURABLE RISK

The characteristics of insurable risks include:

a. **Pure risk:** Because insurance does not seek to make the insured richer, speculative risks are not insurable due to the elements of gain present in such risks. Only pure risks can be insurable against losses that may happen.

b. **Particular risk:** The risk must arise from an individual cause and affect the same in that position rather than from a large group of people. All particular risks are insurable. It should be noted however that in some countries nowadays, some fundamental risks such as earthquakes in Asia, tornadoes, and so on are insurable.

c. **Fortuitous (accidental):** The cause of the loss must be accidental in nature during the normal course of that individual or organization's activity. In other words, the event leading to loss must not be pre-planned.

d. **Financial Measurement**: The object (subject matter of insurance) must be capable of being assigned a monetary value so that in the event of a loss, such value will form the basis for the receipt of compensation from the insurance company. Emotional and sentimental value (losses) cannot form the object of an insurance contract.

e. **Insurable Interest**: The party buying insurance must have a legally recognizable financial relationship with the subject matter of insurance. Meaning that the loss of or damage ofthe subject matter will create a direct financial loss which the insured will be requiredto meet from their pocket.

f. **Homogenous Exposure**: There must be a sufficient number of exposures to similar risks for the insurance company to be able to forecast the expected extent of the loss.

g. **Public Policy:** Insuring the risk by the insurance company must not be against public policy and the laws of the land e.g. insuring the proceeds of a criminal activity or insuring the fines that will be imposed for committing a traffic offence.

h. **Low frequency and High Severity:** Risks that occur once in a long while but which result in high-valued losses are best for insurance unlike risks that happen very often and bring about little losses.

i. **Legality:** The insurance business operates within the provision of the law; therefore, the subject matter of insurance is not insurable if it is illegal.

j. **Market Agreement:** The insurers in a country constitute a market. When insurers in a country agree that a risk is not insurable or acceptable to them, none of their members will accept such risks.

5.7 TYPES OF INSURANCE COMPANIES

The types of insurance companies include:

a. **Proprietary Companies:** These are insurance companies that are formed by registration under the Companies and Allied Matters Act with authorized share capital; shareholders' liability is limited to their shares and profits made belonging to these shareholders

b. **Mutual Companies**: These are registered by the companies act but with a feature that it is owned by the policyholders who also share any profit that is made.

c. **Specialist Companies:** These are registered insurance companies that underwrite only one class of insurance; they can be proprietary or mutual companies.

d. **Captive Insurance Companies**: These are set up as subsidiaries by parent companies tounderwrite the risks of their parent companies. A captive is a special-purpose insurance or reinsurance company established primarily to finance risks arising from its parent group or groups and thereby contributing to a reduction in the parent's total cost of risk. Captive insurance companies can take several different forms as follows:

i. **Pure Captive:** A pure captive is owned and controlled by a single-parent organization and is formed as a subsidiary of that organization. The captive insures the parent organization or other subsidiaries of the parent. Subject to regulatory approval, it may also insure the risks of controlled third parties.

ii. **Group Captive:** A group captive is owned and controlled by multiple non-related organizations. It is formed asan independent entity and insures the risks of its owners.

iii. **Association Captives:** An association captive is owned by members of a common industry or trade association and is designed to insure the risks of that industry among its members. Participation in the captive program is limited to members of the association. They exist to deliver services to their members.

iv. **Risk Retention Groups:** A risk retention group is an entity licensed under the Federal Liability Risk Retention Act. In the United States of America. It is owned by its insureds and is authorized to underwrite the liability risks of its owners only. Owners must be from a similar industry group.

v. **Reciprocal Insurer:** A reciprocal insurer is an unincorporated association of subscribers operating individually and collectively through an attorney-in-fact to provide reciprocal insurance among themselves. This type of captive refers to the organizational structure. It is an alternative to a stock or mutual form. Most domiciles allow for group captives, association captives or risk retention groups to be formed as reciprocal insurers.

vi. **Rent-a-Captive:** A rent-a-captive is an insurance company that rents its capital and services to insureds who wish to create a captive program but do not want to invest in and own an insurance company. The owners of rent-a-captive facilities will usually require collateral from insureds to protect aggregate participation in the captive program.

vii. **Sponsored Captives, Segregated Cells, and Protected Cells:** These entities are all forms of rent-a-captives. Their distinguishing feature is that the assets and liabilities of one captive program (cell) are legally separated from the assets and liabilities of other captive programs. Traditional rent-a-captive structures have no such legal separation but require indemnification from their insureds for liabilities from their captive programs.

viii. **Agency Captive:** An agency captive is owned by insurance agents and typically allows the agency to share in theunderwriting profits and investment income of its book of business. It also demonstrates to insurers and reinsurers that the agent is committed to the profitable underwriting of that business.

e. **Lloyds syndicate:** These are associations of individuals and, nowadays, corporate members ofLloyds, who provide capital for insurance. The underwriting is managed on their behalf by managing agents. There has however been a change in Lloyds in recent years as corporate members have been admitted to join syndicates who used to be private individuals with wealth. These corporate members now provide the majority of the capital used at Lloyds.

f. **Reinsurance companies:** These are companies that provide cover for direct insurance companies for risks that are beyond their carrying capacity or which they lack the needed experience to cover.

SUMMARY

This chapter provides a comprehensive overview of the concept of insurance, covering its meaning, the elements of a valid insurance contract, its functions, types, and its features. It highlights the importance of insurance in managing risks and protecting individuals, businesses, and assets from potential financial losses. Understanding the concept of insurance is essential for every human resource practitioner in other to allow efficient navigation of the insurance landscape.

REVIEW QUESTIONS

1. What are the risks that a human resource manager may have to deal with in the course of their carrying out their job?
2. The board of your organization has directed that all the risks faced by your organization should be insured as the officer in charge of administration explain to them the features of insurable risk.
3. What are the benefits available to an organization from the purchase of insurance?
4. Explain the features of risk to which the insurance company will not be willing to sell insurance?
5. Discuss the possibility of an organization setting up a captive and the types of captives available.
6. Case Study: Imagine you are an insurance consultant tasked with advising a family-owned restaurant business. The restaurant has been operating successfully for several years but is now considering whether to purchase various insurance policies to protect its assets and mitigate risks. The owners are unsure about the types of insurance they need and how insurance works. Discuss the fundamental concepts of insurance in the context of this family-owned restaurant business. Address the following points:

    a) Explain the importance of identifying and assessing the specific risks that the restaurant faces. Consider potential risks such as property damage, liability claims, employee injuries, and business interruption due to unforeseen events.

    b) Provide an overview of the types of insurance policies that may be relevant to the restaurant's needs. Discuss policies such as property insurance, liability insurance, workers' compensation, and business interruption insurance.

    c) Explain the relationship between insurance premiums and coverage. Discuss how the cost of insurance is determined and the factors that influence premium rates. Offer recommendations on the appropriate level of coverage for the restaurant.

    d) Describe the concepts of deductibles and policy limits. Explain how they impact the cost of insurance and the level of protection provided.

    e) Outline the general claims process that the restaurant should follow in the event of a covered loss. Emphasize the importance of prompt reporting and documentation.

    f) Discuss how insurance is just one component of an overall risk management strategy. Recommend additional risk mitigation measures that the restaurant can implement alongside insurance coverage.

    g) Explain the importance of complying with local and national insurance regulations. Discuss how non-compliance can affect the restaurant's ability to file claims and maintain coverage.

In your response, provide practical advice and examples to help the restaurant owners understand the concepts of insurance and make informed decisions regarding their insurance needs. Consider the specific risks and challenges that the restaurant industry faces and how insurance can be a valuable tool for protecting the business.

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CHAPTER SIX

INSURANCE BUSINESS PRACTICE

6.0 LEARNING OBJECTIVES

i. To understand the meaning of underwriting
ii. To understand the factors commonly considered in major classes of insurance
iii. To identify underwriting terms and conditions
iv. To understand the basis for ex-gratia payments
v. To understand claims processing and documentation required for claims processing

6.1 INTRODUCTION

Insurance underwriting is a crucial process that forms the backbone of the insurance industry. It involves assessing risks, determining appropriate terms and conditions, setting premiums, and managing claims. This chapter delves into the world of insurance underwriting, exploring the various aspects and intricacies involved. We will delve into underwriting terms and conditions, which define the coverage and limitations of insurance policies. Additionally, we will examine the rating process, which determines the premiums charged based on risk assessment. The chapter also explores the crucial task of claims processing, ensuring that policyholders receive fair and timely compensation. Furthermore, we will discuss ex gratia payments, which go beyond the scope of the policy to provide compassionate assistance to policyholders. We will touch upon payments made by mistake and the important role of loss adjusting in assessing and settling claims accurately. By delving into these facets of insurance underwriting, we aim to provide a comprehensive understanding of the processes involved and their significance in ensuring a fair and efficient insurance system.

6.1.1 INSURANCE UNDERWRITING

Underwriting is broadly defined as the process of accessing, pricing and accepting insurance risk. Insurance underwriting is defined as the process of determining whether or not a risk would be accepted and where such risk is accepted, the terms and conditions, and the rate of premium that should be charged on such risk. The word underwriting evolved from Marine Insurance where wealthy merchants/businessmen provide cover for maritime risks. This contract involves a negotiation between a merchant and the cargo owner agreeing on the items of the subject matter to be covered and the perils they are covered against. After full negotiation, an agreement is reached and the contract is fully consummated as the merchant signs or appends his signature ‘under’ the risk covered. Hence, the term “UNDERWRITING”.

6.1.2 UNDERWRITING FACTORS COMMONLY CONSIDERED IN MAJOR CLASSES OF INSURANCE

a. Life Insurance:

i. Age

ii. State of Health

iii. Financial Status

iv. Family/Personal medical history or background

b. Burglary and Theft Insurance:

i. Use of protective gadgets or tools

ii. Location of premises

iii. Nature of construction of the building

iv. The attitude of the insured

v. Use of subject matter

vi. Attitude of the insured

vii. Proximity of fire-fighting services

c. Fire Insurance

i. Nature of the construction

ii. Use of subject matter

iii. Attitude of the insured

iv. Use of protective gadgets

v. Proximity of fire-fighting services

d. Motor Insurance

i. Age of the driver

ii. Value of the vehicle

iii. Experience of the driver

iv. Purpose of the vehicle

v. Roadworthiness of the vehicle

vi. Safety gadgets installed in the vehicle

6.1.2 UNDERWRITING TERMS AND CONDITIONS

i. **Under-insurance:** Underinsurance occurs when an insured declares a lower value than the actual value of the subject matter of insurance. For instance, if the value of the subject matter is One Million Naira (N1,000,000) and the insured declares five Hundred Thousand Naira (N500,000), the value of the subject matter has been underinsured for N500,000. In this

situation, if a loss occurs, the insurer would not pay the full value of the loss. The amount of claim that would be paid to the insured would be determined through the application of average:

$$\text{Average} = \frac{\text{Amount Declared (Sum Insured)}}{\text{The amount which should have been declared (Value at Risk)}} \times \text{Value of the loss}$$

From the example above, if the loss is N800,000, then the average will be calculated as follows:

$$\text{Average} = \frac{\text{N500,000}}{\text{N1,000,000}} \times \text{N800,000} = \text{N400,000}$$

ii. **Excess and Deductibles:** Excess and Deductible clauses are clauses that provide that the insured must bear the first amount of any loss. They are expressed either as a sum of money or a percentage of the loss. These clauses are common in many types of policy, including household, motor, and various non-consumer (business) insurances. Excess and Deductibles are important in claims as they eliminate the need for the insurer to process small losses thereby reducing the insurer's loss costs and loss adjustment expenses. However, there is a major difference between excess and deductible. An excess is an amount a policyholder must bear before the liability passes to the insurer (subject to the sum insured) while a deductible is an amount withheld by the insurer from the claim amount paid to the policyholder. For example:

a. A policy has a sum assured of N1,000 and an excess of N100. If the loss to the insured is N500, then the insurer will pay N500-N100= N400. If the loss to the insured is N1,500, then the insurer will pay N1,000 (as it is the maximum amount that the insurer can pay)
b. If a policy has a sum-insured of N1,000 and deductible of N100 and a loss of N500 occurs to the insured, the insurer will pay; N500-N100 = N400

If the loss to the insured is N1,500, then the insurer will pay N1,000 – N100= N900.

This means, the deductible reduces the maximum payout but the excess does not.

iii. **Franchise:** Franchise is a benchmark fixed below which, all losses are borne by the insured alone and above which, all losses are paid by the insurer. For example: If a policy is subject

to N1,000 franchise and a loss of N2,000 occurs, the insurer will be liable for the whole N2,000 but if the loss that occurs is N900, the insured will bear the full loss.

iv. **Sum Insured:** Sum insured refers to the specific amount of coverage provided by an insurance policy. The sum insured represents the maximum limit or value that an insurer will pay out in the event of a covered loss or claim. It acts as a financial safeguard for the policyholder or insured individual, providing them with a certain level of protection against potential risks. The concept of the sum insured can vary depending on the type of insurance policy.

   a. **Sum Insured in Property Insurance:** In property insurance, the sum insured represents the value assigned to the insured property

   b. **Sum Assured in Life Insurance:** In the context of life insurance, sum assured refers to the fixed amount guaranteed by the insurance company to the policyholder or their beneficiaries upon the occurrence of the insured event. It represents the coverage level of the life insurance policy.

v. **Warranties and conditions:** Warranties and conditions play significant roles in the underwriting of insurance policies, defining the rights and obligations of the parties involved. A **warranty**, in the context of insurance, refers to a specific statement or promise made by the policyholder to the insurer. It acts as a condition precedent, meaning it must be strictly complied with for the insurance contract to remain valid. If the warranty is breached, the insurer may have the right to deny a claim or void the policy. Warranties can be categorized into two types:

   a. **Affirmative Warranties:** These are statements made by the policyholder regarding specific facts or conditions related to the insured property or risk. For example, in property insurance, the policyholder may warrant that the premises are equipped with fire alarms and security systems.

   b. **Promissory Warranties:** These are promises made by the policyholder regarding future conduct or actions. For instance, a policyholder may warrant that they will maintain a certain level of security measures throughout the policy period.

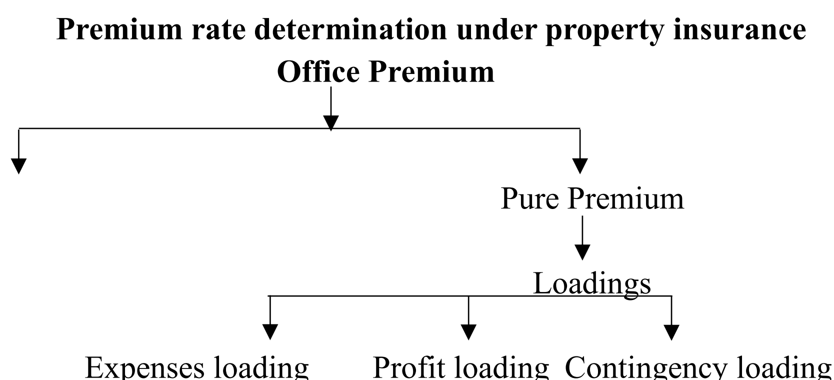
If a warranty is breached, the insurer may choose from various remedies, including denying a claim, reducing the amount payable, or even canceling the policy ab initio (from the beginning). Policyholders must understand and comply with the warranties stated in their insurance contracts to ensure coverage.

Conditions in insurance policies, on the other hand, outline the obligations and responsibilities of both the insurer and the policyholder. Unlike absolute warranties, conditions are considered less crucial to the essence of the contract. Breaching a condition may lead to certain consequences, but it does not automatically invalidate the entire policy. Conditions typically relate to matters such as premium payment, notice of loss, cooperation during the claims process, and adherence to safety measures. Failure to comply with a condition may result in consequences such as policy cancellation or reduction in claim settlement.

Policyholders need to be aware of the conditions stated in their insurance policies and fulfill their obligations accordingly. Non-compliance with conditions may affect the coverage provided and the insurer's response in the event of a claim. The distinction between warranties and conditions lies in their importance to the contract. Warranties are considered essential terms, compliance with which is fundamental to the validity of the insurance contract. On the other hand, conditions are obligations that, if breached, may have consequences but do not automatically render the entire contract void.

6.2 RATING

Rating is the process or method of determining the premium to be charged on a policy based on the class of insurance. Premium rate determination varies depending on the class of insurance.



Pure Premium: This refers to the insurer's cost of expected claims or loss. It is the average estimated amount that the insurer would incur in paying claims. It is the component of the total premium that the insured pays for the risk presented to the insurer.

Loadings: This refers to all other allowances usually added to the pure premium to arrive at the office or total premium. Loading can be categorized into three major groups:

i. **Profit Loading:** This refers to the fraction or percentage of the pure premium that is charged by the insurer to make allowance for their profit

ii. **Expenses Loading:** These are allowances made by insurers to cover their operating, administrative, and other expenses including wages and salary, electricity, rent and rates, and so on.

iii. **Contingency Loading:** These are usually in the form of reserves. They are charged to premium to make provision for fluctuations in claim experience.

6.2.1 PREMIUM RATE DETERMINED UNDER LIFE INSURANCE

Premiums in life insurance are usually determined by considering three major factors or elements:

i. **Mortality/Death Component:** The mortality component of life insurance premium is that part of the life insurance premium that covers the actual risk of death. It is the cost of expected claims that a life insurer is meant to pay in respect of death claims.

ii. **Interest Rate Component:** Investment of premium is a major feature of the life insurance contract. Life insurance is usually in the long term, so money gotten as a premium is usually invested. When life insurers receive premiums, they invest a large fraction of those premiums. It is expected that the average premium to be paid by the life assured would be reduced by the amount of average income earned on investments.

iii. **Loadings:** This refers to all other allowances usually added to the pure premium to arrive at the office or total premium.

6.3 CLAIMS PROCESSING

A claim is a formal request made by a policyholder to an insurance company for compensation or reimbursement for a covered loss or damage. Claims are made when a policyholder experiences a loss or damage to their insured property, or when they suffer an injury or illness that is covered under their policy. A claim typically involves providing documentation and evidence to the insurer to support the claim, such as medical reports, police records, or photographs. The insurer then evaluates the claim to determine whether the loss or damage is covered under the policy, and if so, the appropriate amount of compensation to be paid.

Claims processing in insurance refers to the procedures and activities that an insurer undertakes to evaluate and settle claims made by policyholders. When a policyholder experiences a loss covered by their insurance policy, they can file a claim with their insurer to receive compensation for the loss. The claims processing procedure typically involves the following steps:

i. **Notification:** The policyholder notifies the insurer of the loss by filing a claim. This can be done through various means, such as phone, email, or online through the insurance company's website.
ii. **Documentation:** The policyholder provides documentation supporting their claims, such as police reports, photographs, or medical records.
iii. **Evaluation:** The insurer evaluates the claim to determine whether the loss is covered by the policy and the amount of compensation that the policyholder is entitled to receive. The insurer may also investigate the claim to verify the accuracy of the information provided by the policyholder.
iv. **Approval or denial:** The insurer either approves or denies the claim based on the evaluation. If the claim is approved, the insurer will issue payment to the policyholder.
v. **Payment:** The insurer issues payment to the policyholder once the claim is approved. The payment may be in the form of a lump sum or installments, depending on the policy terms.
vi. **Closure:** The claim is closed once the policyholder receives payment, and the insurer records the results of the claim. Claims processing is a critical function of insurance, and insurers must handle claims fairly and efficiently to maintain the trust of policyholders.

There are various documentation requirements in the processing of claims. Though these documents vary depending on the type of policy and class of insurance for which the claim is sought, certain documents are required for all claims processing irrespective of the type of policy or class of insurance business. These documents include:

i. **Claim Form:** A duly and fully completed claim form is required for all claims. The form contains questions to be answered by the insured or claimant on the circumstances of the loss. A blank claim form is provided by the insurance company's claims office or other representatives to the insured or claimant for completion upon the notification of the claim by the insured/claimant. The insured/claimant then goes ahead to complete the form and submit it to the insurer's representative.
ii. **Discharge Voucher:** Upon adjustment of the claim by the claims officer after submission of all substantiating documents by the insured/claimant, an offer is made to the claimant/insured stating the amount to be paid to them as a claim and a breakdown of the said amount. A discharge voucher is sent along with the settlement offer, which must be completed and signed by the insured/claimant if the settlement offer sent to them is accepted. The discharge

voucher releases the insurer from any further liability on the claim as soon as payment is made. When a discharge voucher is completed by the insured it becomes an executed discharge voucher.

6.4 DOCUMENTATION PER CLASS OF INSURANCE

The documentation required for certain classes of insurance other than the completed claim form and discharge voucher includes:

i. **Motor Insurance**

Accidental Damage to Insured's Vehicle

a. Detailed Estimate of Repairs
b. Photographs of the accident (damaged vehicle and scene)
c. Receipt for towing services
d. Police report (Where third–party death or bodily injury is involved.

Theft of Motor Vehicle

a. Vehicle Keys (In duplicate)
b. Original Insurance certificate
c. Original Vehicle License and Proof of Ownership
d. Police report (Interim and final)
e. Original purchase receipt and invoice
f. Where any of the items above other than the police report was stolen along with the vehicle, an affidavit will be required by the insurance company.

Third-Party claims

a. All correspondence received from third parties
b. Details of the third party's insurance cover
c. Police report.

ii. **Burglary (Theft) Insurance**

a. Police Reports (Interim and final)
b. Purchase invoice or receipt of the stolen or damaged items
c. Estimate of repairs for damaged property
d. Photograph of damaged properties

iii. Fire and Special Perils

a. Purchase invoices and receipts of the damaged or destroyed items
b. Estimate of repairs to damaged property or premises
c. Fire brigade report (if the brigade attended the fire)
d. Eyewitness account(s) of the incident (where obtainable)
e. Photograph of the damaged property (if photographs were taken)

iv. Fidelity Guarantee

a. Proof of the nature and amount of loss (the documentation required will vary according to the nature of the defalcations).
b. Police reports (Interim and final)
c. Character reference
d. Internal Audit Report
e. Profile of the Culprits and their entitlements.

v. Group or Personal Accident

Bodily Injury

a. Doctor's report showing the percentage of disability.
b. Medical bill, where medical expenses are covered by the policy.
c. A note of the last salary or earnings of the injured person (or pay slip), where the benefit payable is a multiple of salary or earnings.
d. Pictures of the injured person.

Death

a. Death certificate or warrant to bury, indicating the cause of death.
b. Police Report (This will usually be required for claims of death resulting from motor accidents)
c. Postmortem Report (usually required where there has been a coroner's inquest)
d. A note of the last salary/earnings of the deceased if the benefit payable is a multiple of the annual salary or earnings.

vi. Life policies (Group or Individual)

a. A duly stamped medical certificate of Cause of Death
b. A completed proof of death form filled by the Medical Personnel that attended to the deceased before his/her demise
c. National Population Commission Certificate of Death
d. Valid means of identification of the beneficiary(ies)
e. Marriage certificate with the deceased (if the spouse is the beneficiary/trustee on the policy)
f. Police report (If death is as a result of auto-accident)
g. Policy document
h. Loan/Bank account statement (if the policy is a credit life policy)

6.5 EX-GRATIA PAYMENTS

Ex-gratia is a Latin word which means "by favor". It is a voluntary payment made by the insurer in response to a loss for which it is not technically liable under the terms of its policy. Ex-gratia claim payments are made for different reasons which include:

i. To maintain good relations between insurance companies and policyholders
ii. It can serve as an alternative to resolving disputes between the insured and the insurer
iii. To create a positive public image for potential clients

6.6 PAYMENTS BY MISTAKE

As insurance companies make a series of payments in a year, some errors are bound to occur. One of these is the mistaken payment of a sum of money to an insured. Mistaken payments include:

i. Mistakes about entitlement, such as payments to the wrong person
ii. Payment on a policy that has lapsed for non-payment of premium
iii. Payment in the mistaken belief that the loss was covered by the insurance
iv. that the insured has an insurable interest
v. That the insured event has occurred
vi. Mistakes about the extent of loss and in calculating the benefit payable

If a payment is made to an insured by mistake and the policy terms contain a clause that provides insurers with a contractual right to recover any mistaken payments to an insured, the insurer can show that this

contractual right exists and pursue an action against the insured to recover any mistaken payment. Such a contractual clause is however unusual. In most cases, an insurer's claim to recover any mistaken payment would have to be based on the law of unjust enrichment. If successful, the insurer's remedy would be restitution of the overpaid amount. To succeed with a claim for unjust enrichment, the insurer would have to show the following:

a. That there has been a mistaken payment to the insured.
b. That the overpayment was made by mistake
c. That the mistake was one of fact and not law
d. That the mistake was essential
e. That the mistake was excusable

6.7 LOSS ADJUSTING

Loss adjusting is the process of assessing and investigating insurance claims made by policyholders who have suffered a loss or damage to their property. The purpose of loss adjusting is to determine the extent of the loss or damage and to ensure that the policyholder receives the appropriate compensation under the terms of their insurance policy. Loss adjusting is typically carried out by the loss adjuster. The major responsibilities of the loss adjuster are discussed in chapter 8 of this book.

SUMMARY

This chapter delves into the realm of insurance underwriting, covering key aspects such as underwriting terms and conditions, rating, claims processing, ex gratia payments, payments made by mistake, and loss adjusting. It emphasizes the significance of insurance underwriting in assessing risks, determining coverage, setting premiums, and managing claims in the insurance industry. The discussion explores the importance of underwriting terms and conditions in defining the scope and limitations of insurance policies. It also sheds light on the rating process, which establishes premium rates based on risk assessment. The chapter further emphasizes the critical role of efficient claims processing to ensure policyholders receive fair and timely compensation. Additionally, it examines ex gratia payments that extend beyond the policy's coverage to provide compassionate assistance to policyholders in certain circumstances. The note touches upon payments made by mistake and highlights the role of loss adjusting in accurately assessing and settling claims. Overall, this chapter provides a comprehensive understanding of the multifaceted nature of insurance underwriting and its integral role in ensuring a fair and efficient insurance system.

REVIEW QUESTIONS

1. What is the role of underwriting terms and conditions in insurance policies? How do they define the coverage and limitations of an insurance policy?
2. Explain methods of premium rate determination in the underwriting process?
3. Discuss the importance of efficient claims processing in insurance underwriting. How does it ensure fair and timely compensation for policyholders?
4. What are ex gratia payments in insurance? How do they go beyond the policy's coverage to provide compassionate assistance to policyholders?
5. Describe the role of loss adjusting in insurance underwriting. How does it contribute to the accurate assessment and settlement of claims?
6. **Case Study:** You are the Chief Underwriting Officer (CUO) of a regional insurance company that specializes in providing property and liability insurance coverage to small and medium-sized businesses. The company has experienced an increase in claims related to property damage and liability issues, which has raised concerns about underwriting standards and claims management processes. Discuss the concepts of insurance underwriting and claims management in the context of your regional insurance company. Analyze the following aspects:

a) Identify and analyze the underwriting challenges your company may be facing, considering factors such as risk assessment, pricing, and policy selection. Discuss how these challenges may contribute to an increase in claims.

b) Examine the recent claims trends and patterns in your company's portfolio. Identify the types of claims that have been most prevalent and their potential causes.

c) Provide recommendations for improving the underwriting process to minimize future claims. This may include enhancements to risk assessment methods, policy pricing strategies, and policy issuance procedures

d) Describe the current claims management process in your company, from the initial claim report to the resolution. Evaluate the efficiency and effectiveness of this process.

e) Recommend best practices for claims handling that can help reduce claims costs and improve customer satisfaction. Discuss the importance of timely claims investigation, communication with policyholders, and dispute resolution.

f) Discuss the role of technology, such as data analytics and claims management software, in streamlining underwriting and claims processes. Highlight any potential technological solutions to address the challenges identified.

g) Explain how effective underwriting and claims management contribute to a positive customer experience and retention. Discuss the impact of poor claims handling on the company's reputation.

In your response, provide concrete examples and strategies for enhancing the underwriting and claims management functions within your regional insurance company. Consider the balance between risk assessment and risk pricing, the importance of proactive claims management, and the overall impact on the company's profitability and customer satisfaction.

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CHAPTER SEVEN

CLASSIFICATION OF INSURANCE BUSINESS

7.0 LEARNING OBJECTIVES

i. To identify the classification of insurance business

ii. To understand the classes of insurance businesses under each classification

7.1 INTRODUCTION

The insurance industry plays a critical role in providing financial protection and security to individuals, businesses, and society as a whole. To effectively understand and navigate the diverse landscape of insurance products, it is essential to delve into the classification of the insurance business.

7.1.1 CLASSIFICATION OF INSURANCE BUSINESS

Section 2 of the Insurance Act 2003, classifies insurance businesses into two. These are:

a. General/Non-Life Insurance Business; and

b. Life Insurance Business

7.1.2 GENERAL/NON-LIFE INSURANCE BUSINESS

i. Property Insurance: This is a type of insurance coverage that is designed to protect against financial losses or damages that may occur to physical property, such as buildings, equipment, inventory, or other assets. Property insurance includes:

- **Fire & special perils policies:** The term fire is defined in insurance as the actual ignition of something which should not be on fire. Fire policy in its pure or standard form covers Fire, lightning, and explosion of boilers or gas used for domestic purposes. However, with additional premiums, some other perils, known as special perils can be added to the standard fire policy to make it a Fire and Special perils policy. These additional perils include; storm, flood, burst pipe and overflowing of water tanks, malicious damage, earthquake, aircraft damage, riot and strike, tornado and cyclone, etc. are issued to cover material property such as buildings, contents, and stock. In practice, insurers issue the fire & special perils policy as one product. Even when a different rate is quoted for fire and another rate for special perils on the placement slip, this policy is always sold as a single product in the Nigerian insurance market.

- **Burglary/Theft:** This covers loss of or damage to property caused by theft, the word theft in insurance terms refers to forcible entry to or exit from the premises.
- **Engineering Insurance:** This covers explosion, breakdown, or accidental damage to the plant, equipment and machineries which is generally grouped under the following headings:
    1. boilers and pressure plant;
    2. engine plant;
    3. electrical plant;
    4. lifting machinery;
    5. miscellaneous plant; and
    6. computers.

Many of these items need to be inspected regularly by a competent person as a legal requirement. Consequently, inspection contracts often accompany these covers.

- **Agriculture:** Insurance of agriculture produce (animal and crops) against loss or/and damage caused by perils stated in the policy which could include death, fire, disease, accident, flood etc. Agricultural animals include fish, poultry, livestock, snail, etc.
- **Money:** This covers all risks of loss or destruction of or damage to money in transit, on the insured's premises during business hours (and for modest amounts out of safe outside business hours), in a bank night safe, etc. The term 'money' is defined widely. Cover may include fixed payments if staff members suffer injury or damage to their clothing when a robbery occurs.

ii. **Pecuniary insurance:** Pecuniary means 'relating to money' and pecuniary insurance covers intangibles such as income, revenue, or value. Some classifications will include 'money insurance' under this heading. Examples are as follows:

- **Fidelity Guarantee:** The word 'fidelity' implies the 'faithful or loyal performance of a duty. The financial results of a lack of fidelity, arising from the dishonesty or disloyalty of a company's employee(s), can be insured against. Therefore, such insurance covers the risk of losing money or stock, by the fraud or dishonesty of a person holding a position of trust.
- **Legal Expenses:** Insurance for individuals, families, and businesses to enable them to meet the cost of seeking legal advice for pursuing/defending civil actions.

- **Credit:** Credit is the system of buying or selling goods or services without immediate payment being made. Credit insurance covers businesses against the risk of non-payment, whereby the seller ensures that if their debtors (buyers) fail to meet their obligations, the seller can recoup their losses.
- **Business interruption:** Insurance against losses due to an interruption in business occurring immediately after, and in consequence of, material damage to property. The cover is in respect of the actual loss of earnings of the business, adjusted for business trends, plus the increased costs associated with the business recovery.
- **Political risk:** Insurance that can be taken out by businesses against the risk that revolution or other political conditions will result in a loss.

iii. **Motor Insurance:** This is the insurance of motor vehicles and liabilities arising out of their use. Motor insurance is the most significant compulsory insurance in Nigeria. The principal types of motor insurance are Third party only policy; Act only policy; Third party, fire, and theft policy; and Comprehensive motor policy.

iv. **Liability Insurance:** This is the insurance of the legal liability to pay compensation and costs awarded against the insured in favor of another party, in respect of death, injury, disease, loss, or damage sustained by that party. Examples are as follows:

- **Employers' Liability:** Insurance to compensate the insured in respect of their legal liability to pay damages to any employee arising out of bodily injury, disease, illness, or death arising out of or in the course of employment by the insured. Like motor insurance, this is made compulsory by law.
- **Public Liability:** Insurance to compensate the insured in respect of claims from third parties (i.e. members of the public or companies) for accidental bodily injury or damage to their property due to the insured's negligence or that of their employees.
- **Products Liability:** Covers legal liability for third-party bodily injury or property damage caused by products, goods, or services sold or supplied
- **Directors' and Officers' liability:** Covers personal legal liability incurred by individual directors and officers for financial loss resulting from their negligence or failure to fulfill statutory responsibilities.
- **Professional Indemnity:** This protects a person acting in their professional capacity against claims that might be made alleging that injury or loss has resulted from their negligent actions or advice. Professional Indemnity Insurances are compulsory for

healthcare providers and mandatory registration requirement in some industries like Insurance Broking.

v. Marine and Aviation Insurance

- **Marine Insurance:** Marine insurance covers three main areas: physical damage to ships or goods, cargo liabilities incurred to other parties, and loss of income. Marine hull insurance covers physical damage to the ship, its machinery and equipment, and some limited liability insurance in case of contact with other vessels, and marine cargo insurance covers loss or damage to goods, The liabilities of the ship/carrier are often covered with mutual insurers who cover mainly liabilities to people, cargo and the environment. The loss of income can take the form of loss of hire or freight (the price paid for using the ship) or loss of passage money (the price paid by passengers).

  The term freight can also be used to mean the goods being carried and it is in this context insurers offer goods in transit/freight liability insurance which covers the liability of the carrier (often a land-based carrier rather than a sea carrier) for damage to the goods during the journey.
- **Aviation Insurance:** Aviation insurance covers both loss of or damage to the aircraft (hull) and legal liability to parties and passengers (liability). Specialist covers such as aviation products and personal accident policies for aircrew are also insured in the aviation market. However, aviation cargo is covered under a marine policy. Satellite insurance is a specialized branch of aviation insurance. Lloyds of London provided the first policy to cover the Intelsat satellite in 1965 and since that time a specialist market for providing aerospace and satellite products has developed. This type of business is yet to find its root in the Nigerian market.

For purpose of financial reporting, The Insurance Act 2003 categories General Insurance into the following eight (8) categories:

(a) **Fire insurance business:** This contains the following sub categories:

i. Fire & Special Perils Insurance
ii. Combined Fire & Burglary Insurance
iii. Industrial All Risk Insurance
iv. Business Interruption Insurance

v. Fire Householder/ Houseowner Insurance

(b) **General accident insurance business**: this includes:

1. Public & Product Liability,
2. Fidelity Guarantees,
3. Money Insurance
4. Burglary & Housebreaking Insurance
5. Goods in Transit Insurance
6. Employer's Liability
7. Group Personal Accident/ Personal Accident Insurance
8. Professional Indemnity etc.

(c) **Motor vehicle insurance business**

(d) **Marine and Aviation insurance business**

(e) **Oil and Gas insurance business**: This category offers various insurance covers for the industry upstream and down-stream operations.

(f) **Engineering insurance business**

(g) **Bonds Credit Guarantee and Suretyship** insurance business: Bonds are usually taken up by contractors/ suppliers to provide financial security to their principals in the event of non-fulfillment of contract terms. The policy is usually purchased are the instance of the principal who makes the insurance policy a mandatory requirement under the contract terms to protect his interest in the contract.

(h) **Miscellaneous insurance business**: Legal, travel and credit insurance are included under this category.

These are the main categories of non-life insurances under the Act and other classes are recognized as sub-categories under them.

7.1.3 LIFE INSURANCE BUSINESS

There are three basic classifications of life assurance policy:

a. Individual Life Insurance
b. Group Life Insurance
c. Health Insurance

a. **Individual Life Insurance:** The basic types of life assurance are:

   i. Term assurance

   ii. Whole life assurance and,

   iii. Endowment assurance.

      i. **Term assurance:** Term assurance policies just provide cover against death within a specified period. The cover is pure protection with no investment element. A payout is possible but not certain, i.e., the life assured may not die during the term of the policy. During the term of the policy, if the life assured survives no payment is made and the policy expires There are several different forms of term assurance, and some of these are explained below:

         - **Level Term Assurance:** The simplest form of term assurance is level term assurance. This contract provides that the life office will pay the sum assured only if the life assured dies during the term of the policy, that is, before the expiry date. The sum assured does not vary during the term of the policy and once it has expired the policy has no value. This is the cheapest form of life assurance.
         - **Renewable Term Assurance:** Some term assurances are 'renewable'. This means that on the expiry date, there is an option to take out a further term assurance at ordinary rates without further evidence of health, as long as the expiry date is not beyond an earlier specified age, say, the age of 65 years. Each subsequent policy will have the same option. Renewable term assurances are used when there is a definite initial need for cover but it is not known how long the need will last. The policy can then be renewed as many times as required.
         - **Convertible Term Assurance:** This is a level term assurance with an option that enables the assured to convert at any time during its existence, to a whole life or endowment assurance, without further evidence of health. The premium for the new policy will be that normally applicable to a whole life or endowment assurance policy for a person of the life assured's age at the time of conversion. The premiums charged for convertible term assurance will be slightly higher than for the ordinary-level term assurance to allow for the cost of the conversion option.
         - **Decreasing Term Assurance:** Term assurance of this type has a sum assured which reduces each year (or possibly each month) by a stated amount, decreasing to nil at the end of the term. It is normally used to cover a reducing debt, such as the capital

outstanding on a house purchase mortgage, with the sum assured being linked to the reduction in the capital outstanding under the loan. Although the cover decreases each year, the premium remains constant and these premiums are sometimes payable for a shorter period than the policy term itself.

- **Increasing Term Assurance:** À term assurance with a level sum assured gives a reducing amount of real cover as the value of money declines year by year due to inflation. Consequently, attempts have been made to combat this by introducing term assurance policies with some form of increasing sum assured. Some offices offer policies where the sum assured can be increased each year by a set percentage (often 10%) of the original sum assured. Other offices have short-term policies which can be renewed at the end of the term for a higher amount.

ii. **Whole Life Policies:** Whole life and endowment policies are different in that a payout is certain. Thus, there is an investment element in these policies and most have a surrender (cash-in) value. For this reason, they are sometimes called substantive policies. A whole life policy is a very simple policy that pays out a sum assured whenever the life assured dies. Unlike term assurance, it is a permanent policy not limited to an expiry date and since a claim is certain, premiums will be more expensive than for a term assurance where a claim is merely possible or at worst probable. Whole-life policies can often be used as security for a loan (collateral) either from the life office or from another lender.

- **Non-Profit Whole Life Policies:** A non-profit whole life policy has a level premium, payable throughout life. Some policies offer cessation of premiums at a certain age, often 70 years. It pays only a fixed sum assured, whenever death occurs. The sum assured is a fixed sum with no bonus or unit linking. However, it is common for the sum assured only to be payable if death occurs more than two years after the start of the policy, with only a refund of premiums payable on death before that period. There will usually be no surrender value.
- **With-Profits Whole Life Policies:** These policies are almost the same as non-profit whole-life assurances, the only difference being that the amount payable on death is the sum assured plus whatever profits have been allocated up to the date of death. Again, premiums can be payable throughout life or can cease at, for example, 80 or 85 years. They are used for family protection and inheritance tax funding.

iii. **Endowment Policies:** The third basic type of policy is endowment assurance. An endowment policy will pay out on the maturity date of the policy, or earlier death. Here, the sum assured is payable. on a fixed date - either on the maturity date or the life assured's earlier death. Since there will be a payout at some stage, endowment assurances are substantive contracts and can be used as security for loans either from the life office itself or from other lenders. Level premiums are payable for the duration of the contract. Premiums for endowments are generally more expensive than for whole-life assurances because claim payments are generally made earlier. The types of endowment policies include:

- **Non-Profit Endowments:** These are the most basic form of endowment, with level premiums and a payout of only a fixed guaranteed sum assured on maturity or earlier death. They are very rarely sold these days.
- **With-Profits Endowments:** Here the amount payable on maturity or earlier death will be the guaranteed sum assured plus the bonuses. If the policy runs to maturity, bonuses will be higher than if it becomes a death claim because they will have been added for a longer period. As with whole-life assurances, it is not possible to guarantee what the eventual payout will be because of the variable nature of future bonuses. Premiums are higher than for non-profit endowments, to reflect the greater benefits that are payable. With-profit contracts are the basic element in many savings and house purchase arrangements.

b. Group Life Assurance

Group life assurance schemes were developed to enable employers to make provisions for the dependents of employees who died while in their service. They are usually arranged in conjunction with an occupational pension scheme. In principle, a group life assurance scheme is a collective term assurance, where a large group of lives is insured, often at a low premium and with simplified underwriting. The insurer will have to pay out each time one of the insured groups dies. The insured group will change frequently as new employees join and older employees leave or retire. Recently, life offices have offered employers more flexible packages incorporating other benefits such as income protection insurance (IPI) and critical illness coverage. The aim is to enable a company to offer its employees a very good remuneration and benefits package. With the enactment of the

Pension Reform Act of 2004 (as amended by the 2014 Act), Group Life was made compulsory for employers in Nigeria (Section 9 of the Pension Reform Act 2004).

c. **Health Insurance:** There are several different types of insurance related to personal health:

i. **Personal Accident:** Provides payments in the event of accidental death or bodily injury.

ii. **Sickness:** Provides payments for inability to work due to sickness.

iii. **Private Medical Insurance**: Provides cover for individuals who seek medical treatment outside the National Health Service (NHS) or Health Management Organizations (HMOs) when they are ill.

iv. **Payment Protection Indemnity:** Provides fixed benefits for individuals who suffer an accident, are ill, or lose their jobs. Benefits are usually geared to known outgoings such as mortgage repayments, but may include more general expenses.

v. **Critical Illness:** Provides payment in the event of the diagnosis of a defined range of serious illnesses.

SUMMARY

In this chapter, we explore the classification of insurance business, which is primarily categorized into two main types: life insurance and general insurance. These classifications are established based on the Insurance Act of 2003, which serves as a regulatory framework for the insurance industry.

The first classification we delve into is life insurance. Life insurance is a type of insurance that provides financial protection and support to individuals and their families in the event of unfortunate circumstances, such as death, disability, or critical illness. It is designed to safeguard the insured's life and ensure the well-being of their loved ones. Under the classification of life insurance, various classes of business can be identified, such as term life insurance, whole life insurance, and endowment policies. Each of these classes caters to specific needs and objectives, offering different benefits and coverage options.

Moving on to the second classification, we explore general insurance. Unlike life insurance, general insurance covers a wide range of non-life aspects and protects against various risks that do not involve human life. General insurance encompasses numerous classes of business, including property insurance, motor insurance, health insurance, liability insurance, marine insurance, and more. Each class of business within general insurance addresses distinct areas of risk and offers financial security against specific perils or contingencies.

By understanding the classification of the insurance business, human resource practitioners can effectively understand and identify different types of insurance product needs of their respective organizations.

REVIEW QUESTIONS

1. What are the two main classifications of insurance business, as per the Insurance Act of 2003?
2. Explain the concept of life insurance and its primary purpose.
3. Provide examples of different classes of business under the classification of life insurance.
4. What distinguishes general insurance from life insurance?
5. Name at least three classes of business within general insurance and briefly describe each.
6. How does understanding the classification of insurance business benefit human resource practitioners in their operations and decision-making processes?
7. **Case Study:** You are an insurance expert tasked with advising a startup that is about to launch a new online platform for selling handmade artisanal products. The startup's founders are interested in understanding the different types of insurance they might need to protect their business and their customers. Discuss the classification of insurance and provide recommendations for the startup in terms of the types of insurance coverage they should consider. Consider the following points:

a) Explain the fundamental classification of insurance into two main categories: life insurance and non-life insurance (also known as general insurance). Clarify the primary differences between these categories.

b) Within the realm of non-life insurance, break down the various types of coverage relevant to the startup's online platform. Include explanations of property insurance, liability insurance, and business interruption insurance. Discuss why each of these types may be important for the startup.

c) Emphasize the importance of liability insurance for the startup. Discuss the potential liability risks they may face, such as product liability and cyber liability, and recommend suitable policies to mitigate these risks.

d) Explain the need for property insurance, particularly for safeguarding the startup's physical assets like office equipment and inventory. Discuss coverage options such as fire insurance and theft insurance.

e) Highlight the significance of business interruption insurance in the event of unforeseen disruptions (e.g., natural disasters or cyberattacks). Discuss how this type of insurance can help cover lost income and ongoing expenses during downtime.

f) Recommend insurance coverage that ensures customer protection. This may include discussing insurance policies that safeguard customer data, protect against financial loss related to product defects, or provide coverage in case of delivery issues.

g) Mention any legal or regulatory requirements related to insurance for the startup, such as workers' compensation insurance or compliance with e-commerce regulations.

h) Explain the importance of conducting a thorough risk assessment specific to the startup's industry and operations. Encourage the startup to work with an insurance broker or agent who can tailor coverage to their unique needs.

In your response, provide practical guidance on the types of insurance coverage the startup should consider, take into account the nature of their business and potential risks. Help the founders understand how insurance can protect their business, assets, and reputation while ensuring compliance with relevant regulations.

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CHAPTER EIGHT

OVERVIEW OF THE NIGERIAN INSURANCE MARKET

8.0 LEARNING OBJECTIVES

i. To understand the parties in the insurance market
ii. To recognize the difference between an insurance agent and a broker
iii. To identify the role of various support staff in the insurance industry
iv. To understand the need for regulatory bodies in the insurance industry
v. To identify the market associations in the insurance market

8.1 INTRODUCTION

The Nigerian insurance market is a dynamic and crucial component of the country's financial landscape. In this chapter, we delve into the intricacies of this market, exploring its key parties, the roles they play, and the various support services that contribute to its functioning. By understanding the structure and stakeholders within the Nigerian insurance market, human resource practitioners will gain valuable insights into the landscape in which insurance transactions take place and understand its effect on their organization. The insurance marketplace provides financial services that are supportive of other industries producing goods and services. The parties involved in the insurance market will be discussed below:

8.2 SELLERS

The sellers of insurance are the various insurance companies that sell insurance products to individuals, corporate bodies, and the government. It also includes reinsurance companies and Lloyds in the United Kingdom. They come by different names such as insurance companies, assurance companies, and reinsurance companies. They could be life-only companies, general business or non–life companies, specialist companies, mutual companies, etc., irrespective of the name that is used, they all have a common goal which is to render insurance service to their clients or subscribers.

8.3 BUYERS

The buyers of insurance are the various parties that purchase insurance policies that are offered for sale by the sellers. The policies could be life or non-life policies. While it is not easy to ascertain the number of buyers that are in the Nigerian insurance market, with increased awareness, a good economy, and market practice, these numbers will increase.

8.4 INTERMEDIARIES

These groups come into perspective when the party wanting to purchase insurance does not approach the insurance company directly. They include insurance brokers, Lloyds brokers, reinsurance brokers, and insurance agents. Their primary role is to assist clients in identifying their insurance needs, comparing available insurance options, and facilitating the purchase of insurance policies that best meet their requirements. For all categories of intermediaries, a commission is paid to them for any business that comes through them to the insurance company.

8.4.1 DIFFERENCE BETWEEN INSURANCE AGENTS AND INSURANCE BROKERS

Though agents and brokers are both regarded as intermediaries in the insurance industry, there are clear differences between the two as follows:

a. An insurance agent or the person running the agency must possess in his personal name at least a certificate of proficiency before the agency can be registered by the National Insurance Commission. The Certificate of Proficiency is to be based on an examination conducted by the Chartered Insurance Institute of Nigeria. A brokerage firm is to operate as a company – whether a partnership or limited liability.

b. The license issued to an agency or agent is restricted to an insurer or a number of insurers. It is not permitted to deal with any insurer not stated on its license. A broker, literally speaking, deals with all insurers in the market.

c. An insurance broker may handle reinsurance broking – based on the right experience. An insurance agent or agency is not so permitted.

d. An insurance agent or agency acts as a go-between (post office) between the insured or insurers. An insurance broker holds himself out as an expert on insurance matters and is expected to display a far higher level of competence than an agent.

e. A brokerage firm is statutorily required to maintain at all times a professional indemnity cover for at least a limit of ₦10million.The insured relies only on the integrity of the agent as a form of security.

f. An insurance agency or agent must pay immediately to the insurer any premium collected in order not to invalidate the client’s policies. An insurance firm has a grace period of 30 days from policy inception or renewal.

g. An insurance brokerage firm is statutorily required to establish and maintain at all times a client's accounts for all monies, premiums, claims and recoveries relating to clients, insurers and reinsurers. This does not apply to an agency or agent.

h. The books and accounts of an agency or agent need not be audited. It is a statutory requirement that the books and accounts of a brokerage firm should be audited annually and a certificate issued to confirm payment of all premium collected by the broker to the insurers concerned. False declaration of income or premium remittance and even failure of premium remittance by the brokerage firm are grounds for cancellation of its registration certificate by National Insurance Commission.

i. An insurance brokerage firm must have on its senior management level at least one person with a professional insurance qualification or possessing at least seven years' experience at senior management level with an insurance company or insurance broking firm.

j. An insurance agent or agency is entitled to only 50% of the comparable commission payable to an insurance brokerage firm in respect of any line of business.

k. An insurance brokerage firm is statutorily required to keep the record of all insurance business that it handles. In particular, separate records are to be kept in respect of transaction with insurers based in Nigeria and those overseas.

l. An insurance brokerage firm is statutorily required to submit annually to National Insurance Commission audited statement of account (comprising Revenue Account, Profit and Loss Account and Balance Sheet).

8.5 SUPPORT SERVICES

These are individuals or organizations that provide technical support services to parties in an insurance contract. They include:

a. **Loss Assessors:** A loss assessor, also known as a public insurance adjuster, is a professional who assists policyholders in managing and navigating the insurance claims process. Their primary role is to represent the policyholder's interests and help them obtain a fair and maximum compensation from their insurance company for a covered loss or damage. The responsibilities of a loss assessor include:

i. **Claim Assistance:** Loss assessors help policyholders in understanding the insurance

policy terms and conditions, as well as the claims process itself. They guide and advise policyholders on the necessary steps to take when filing a claim and ensure that all required documentation is prepared accurately and submitted on time.

ii. **Loss Assessment:** Loss assessors evaluate the extent of the loss or damage suffered by the policyholder. They assess the value of the items lost or damaged, analyze the cause of the claim, and review the policy coverage to determine the scope of the claim.

iii. **Negotiation:** Loss assessors negotiate with the insurance company on behalf of the policyholder to achieve a fair settlement. They use their knowledge of insurance policies and claim procedures to advocate for the policyholder's best interests and aim to obtain the maximum compensation possible.

iv. **Documentation and Evidence:** Loss assessors assist in gathering and documenting the necessary evidence to support the claim. This may involve assessing property damage, interviewing witnesses, and working with experts or contractors to determine repair or replacement costs.

v. **Loss Assessment Report:** Loss assessors prepare a comprehensive loss assessment report that outlines the details of the claim, including the cause of the loss, the extent of the damage, and the recommended compensation amount. This report serves as a basis for negotiation with the insurance company.

vi. **Claim Settlement:** Loss assessors help policyholders understand the settlement offers made by the insurance company and provide advice on whether the offers are fair and reasonable. They strive to ensure that the policyholder receives the full and fair compensation they are entitled to under their insurance policy.

It is important to note that a loss assessor works on behalf of the policyholder and represents their interests, unlike a loss adjuster who represents the insurance company. Loss adjusters are appointed by the insurance company to assess claims and determine the compensation amount from the insurer's perspective. Loss assessors, on the other hand, are independent professionals hired by the policyholder to advocate for their rights and maximize their claim amount. Loss assessors can be particularly helpful in complex or disputed claims, where their expertise and experience in dealing with insurance companies can make a significant difference in the outcome of the claim.

a. **Risk Surveyor:** The role of a risk surveyor as a support service provider for insurance companies involves assessing and evaluating the potential financial risks associated with offering insurance cover for properties or sites. Their primary responsibility is to provide insurance underwriters with information and recommendations on how to reduce risk or determine whether insurance coverage should be offered. Here are the key aspects of their role:

i. **Site Surveys and Assessments:** Risk surveyors visit properties or sites to conduct thorough evaluations of potential risks. They assess and evaluate risks related to buildings, employees, customers, and other aspects by undertaking research, collecting data, and using templates to record assessments. They may also collect photographic evidence to support their findings.

ii. **Risk Reporting and Recommendations:** Based on their assessments, risk surveyors prepare detailed valuation and risk survey reports and presentations for insurance underwriters. These reports identify and analyze risks, propose risk reduction measures, and make recommendations on risk quality, rating, and classification. They also provide advice to clients on-site and discuss opportunities for reducing future insurance claims.

iii. **Collaboration and Communication:** Risk surveyors work collaboratively with various stakeholders, including underwriters, brokers, clients' representatives, health and safety inspectors, and fire officers. They share their knowledge and expertise across the business and maintain effective communication channels to ensure that risk management practices are aligned with the organization's goals and standards.

iv. **Risk Improvement and Quality Assessment:** After recommended improvements have been made to mitigate risks, risk surveyors allocate quality grades to assess the effectiveness of the implemented measures. They accompany underwriters on site visits to help them understand the practical aspects of the property or site and validate the risk management strategies.

v. **Technical Knowledge and Compliance:** Risk surveyors stay up-to-date with technical aspects affecting risks, such as trade processes, health and safety legislation, codes of practice, and industry standards. They handle technical referrals from brokers, clients, and colleagues, ensuring compliance with

regulatory requirements and industry best practices.

vi. **Risk Improvement and Quality Assessment:** After recommended improvements have been made to mitigate risks, risk surveyors allocate quality grades to assess the effectiveness of the implemented measures. They accompany underwriters on site visits to help them understand the practical aspects of the property or site and validate the risk management strategies.

vii. **Training and Development:** Risk surveyors contribute to the development of the business by maintaining technical knowledge and standards within the organization. They provide training on risk management to enhance the skills and capabilities of teams across the organization.

b. **Claims Investigator:** The role of a claim's investigator as a support service provider for insurance companies is to conduct thorough investigations into insurance claims to determine their validity and accuracy. Claims investigators play a crucial role in verifying the legitimacy of claims, detecting potential fraud, and providing essential information to insurance companies. The key role of a claim's investigator are as follows:

i. **Investigation of Claims:** Claims investigators are responsible for investigating insurance claims filed by policyholders. They gather relevant information, such as documentation, statements, and evidence related to the claim, to assess its validity. This may involve conducting interviews with the claimant, witnesses, and other involved parties.

ii. **Fraud Detection:** One of the primary functions of claims investigators is to identify potentially fraudulent activities. They scrutinize claim details, inconsistencies, and patterns to detect any signs of fraudulent behavior, such as staged accidents, falsified documents, or exaggerated damages. By identifying fraud, investigators help protect the interests of insurance companies and maintain the integrity of the claims process.

iii. **Documentation and Reporting:** Claims investigators meticulously document their findings, observations, and evidence during the investigation process. They prepare detailed reports that outline the investigation process, summarize their findings, and provide recommendations to insurance companies. These reports assist insurers in making informed decisions regarding claim settlements and potential legal actions.

iv. **Collaboration and Communication:** Claims investigators work closely with various stakeholders, including insurance adjusters, legal teams, law enforcement agencies, and external experts. They may collaborate with these professionals to gather additional information, validate findings, or seek specialized expertise in complex cases. Effective communication and collaboration ensure a comprehensive investigation and facilitate prompt claim resolution.

v. **Legal and Ethical Compliance:** Claims investigators adhere to legal and ethical standards while conducting investigations. They ensure compliance with relevant laws, regulations, and industry guidelines. They also maintain confidentiality and handle sensitive information with professionalism and discretion.

vi. **Surveillance and Fieldwork:** In some cases, claims investigators may need to perform surveillance activities to gather evidence or validate claim information. This may involve conducting site visits, inspecting damaged property, or monitoring claimants' activities. Fieldwork provides investigators with firsthand information and strengthens the accuracy of their findings.

vii. **Continuous Learning and Development:** Claims investigators stay updated on the latest industry trends, investigative techniques, and legal developments related to insurance claims. They engage in continuous learning and professional development activities to enhance their skills and knowledge, ensuring their investigations remain effective and aligned with industry best practices.

c. **Repair garages:** Repair garages play a crucial role as support service providers for insurance companies in the context of motor insurance claims. Their primary role is to provide repair services for vehicles involved in accidents or covered by insurance policies. Their responsibilities include:

i. **Vehicle Assessments:** Repair garages perform detailed assessments of damaged vehicles to determine the extent of repairs required. They evaluate the damage, provide cost estimates, and create repair plans based on industry standards and insurance guidelines. These assessments help insurance companies determine the appropriate coverage and claim settlement amounts.

ii. **Repair Services:** Repair garages are responsible for repairing vehicles according to the established repair plans. They have skilled technicians and mechanics who perform necessary repairs, replace damaged parts, and restore vehicles to their pre-accident condition. The repairs may include bodywork, painting, mechanical repairs, electrical repairs, and other necessary services.

iii. **Parts Procurement:** Repair garages manage the procurement of parts required for vehicle repairs. They source genuine or approved parts based on insurance company guidelines, ensuring the quality and compatibility of the replacements. Effective parts management helps streamline the repair process and ensure the timely completion of repairs.

iv. **Timely and Efficient Service:** Repair garages strive to provide prompt and efficient repair services to minimize vehicle downtime and inconvenience for policyholders. They aim to complete repairs within reasonable timeframes while maintaining high-quality workmanship. Timely repairs also contribute to the overall customer satisfaction and smooth claims processing for insurance companies.

v. **Quality Assurance:** Repair garages ensure the quality of their repair work by adhering to industry standards, manufacturer specifications, and safety regulations. They employ skilled technicians who are trained in the latest repair techniques and use advanced equipment and tools. Quality assurance measures help deliver repairs that meet or exceed the expectations of both insurance companies and policyholders.

vi. **Communication and Documentation:** Repair garages maintain effective communication with insurance companies throughout the repair process. They provide regular updates on repair progress, any additional work required, and estimated completion timelines. They also document the details of repairs, including the scope of work, parts used, and any relevant warranty information. Clear communication and comprehensive documentation facilitate efficient claims handling and ensure transparency between all parties involved.

vii. **Coordination with Insurance Companies:** Repair garages work closely with insurance companies to ensure alignment with the claims process. They

may coordinate inspections, share repair estimates and supporting documentation, and address any queries or concerns raised by insurance adjusters. Collaboration and cooperation between repair garages and insurance companies streamline the claims settlement process and help resolve any potential issues or disputes.

d. **Loss Adjusters:** A loss adjuster is an independent professional who is hired by an insurance company to assess and investigate a claim made by a policyholder. The loss adjuster is responsible for evaluating the extent of the loss or damage and determining the appropriate amount of compensation that the policyholder is entitled to receive under the terms of their policy. Loss adjusters typically have extensive knowledge and experience in various areas, such as insurance policies, construction, engineering, and law, which allows them to evaluate and investigate claims effectively. Loss adjusters are specialized professionals who work in the insurance industry and are engaged by insurance companies to handle claims on their behalf. The major responsibilities of the loss adjuster are as follows:

   i. **Assessing Liability:** Loss adjusters evaluate whether the insurance company is liable for the claim or not. They thoroughly examine the circumstances surrounding the claim to determine if it falls within the coverage provided by the insurance policy.

   ii. **Investigating Claims:** Loss adjusters conduct detailed investigations to gather information and evidence related to the claim. This involves interviewing the claimant, witnesses, and any other relevant parties. They may also review records such as police reports, medical records, and property damage assessments to assess the validity and extent of the claim.

   iii. **Evaluating Damages:** Loss adjusters inspect the damaged property or assess the extent of personal injuries to determine the scope and value of the damages. They analyze the information gathered during the investigation process and use their expertise to assess the appropriate settlement amount.

   iv. **Negotiating Settlements:** Loss adjusters work with claimants, policyholders, and other involved parties to negotiate and settle claims. They consider the insurance policy terms and conditions, the extent of damages, and other relevant factors to arrive at a fair and reasonable settlement.

v. **Documentation and Reporting:** Loss adjusters prepare detailed reports documenting their findings, assessments, and recommendations regarding the claim. These reports are submitted to the insurance company for review and decision-making purposes.

vi. **Collaboration with Professionals:** Loss-adjusting firms may employ professionals from various disciplines, such as accountants, engineers, and legal officers, to provide a comprehensive and specialized approach to claims handling. These professionals may assist the loss adjuster in evaluating complex claims and providing expert opinions.

In Nigeria, loss adjusters must adhere to a strict code of conduct and are members of professional institutes, such as the Institutes of Loss Adjusters of Nigeria (ILAN) and the Chartered Institute of Loss Adjusters. They are expected to maintain impartiality in their assessments, even though their fees are paid by the insurance company. However, claimants also have the option to engage their own loss assessors, although they would need to bear the charges themselves.

8.5 MARKET ASSOCIATION/SELF-REGULATORY BODIES

There are various bodies that are set up by insurance operators with the primary responsibility of overseeing the activities of their members to ensure that best practices are maintained and the interest of operators are protected. They include the Nigerian Insurers Association (NIA) for insurance companies; the Nigerian Council of registered insurance brokers (NCRIB) for insurance brokers; the Institute of loss adjusters (ILAN) for loss adjusters; the Association of registered insurance agents of Nigeria (ARIAN) for insurance agents and Professional reinsurers association of Nigeria (PRAN).

a. Nigerian Insurers Association (NIA): This is the principal organization that regulates the practices of insurance companies in Nigeria. The association was founded in 1971 as a body comprising insurance companiesand reinsurance companies that are registered to carry out insurance business in Nigeria. The body has as its objectives the following:

i. Prescription and enforcement of self-regulation and code of ethics.

ii. The protection and advancement of the common interest of insurers transactinginsurance business in Nigeria.

iii. The creation of a better understanding of insurance by the community.

iv. To consult and co-operate with other associations or similar bodies in matters of mutual interest and to obtain affiliation with such associations whether within or outside theterritory of Nigeria.

b. The Nigerian Council of Registered Insurance Brokers (NCRIB): Before the passing of the 1976 Insurance Act, anyone could set up the business of offering insurance advice to the public. There were no statutory stipulations as to the experience and qualifications of such persons parading themselves as insurance brokers, agents, advisers or consultants. The insurance brokers and agents are the intermediaries between the members of the public and insurers. Following discussions with the National Insurance Commission of Nigeria (NAICOM) and the Chartered Insurance Institute of Nigeria (CIIN), a bill entitled "The Nigerian Council of Registered Insurance Brokers Bill" was presented in year 2001 to the Nigerian national assembly by the then Nigerian Corporation of Insurance Brokers. This led to the passing of the Nigerian Council of Registered Insurance Brokers Act which became effective on June 6th 2003. The main features or sections of the Act are as follows:

i. **Section 1** (Establishment of the Council): This gives legal backing to the establishment of a body known as the Nigerian Council of Registered Insurance Brokers as a body corporate. It is to be referred to as "the Council".

ii. **Section 2** (Duties of the Council): These include;

- Establishment and maintenance of a central organization for insurance brokers,
- Establishment and maintenance of a library,
- Arbitration and settlement of disputes or questions between the members andother parties and disciplining of members,
- Enrolment of insurance broking corporate body,
- Establishment and maintenance of a register of Insurance Brokers indicating names, addresses, qualifications and other particulars of all persons who apply to beregarded as insurance brokers. This list of persons is to be published periodically.

c. **Institute of Loss Adjusters of Nigeria:** The loss adjusters are experts in dealing with claims. They usually will follow a claim through from the moment it is reported to the insurance company to the point of settlement. As employees of insurance companies' loss adjusters perform the duty of minimizing further losses by promptly informing insurance companies about insurers' losses, ascertain the premium at the time of loss, investigate any unusual circumstances and determine the rate of indemnity. The loss adjuster can also be of help to the insured by providing advice and guidance on steps that are to be taken after a loss has occurred.

In carrying out their duties to the insurance company, the loss adjuster will write reports for the insurance company. In this report the following information will be contained:

i. Description of premises and the type of business carried on in it.
ii. Cause and extent of damage.
iii. Safety measures taken to protect the premises.
iv. Whether the insured has complied with all the warranties that are contained in the contract.
v. Possible rights of recovery against any third party (subrogation).
vi. Recommended amount insurers should reserve for settlement of the claim.
vii. Details of the claim and any adjustments made.
viii. Adequacy of the sum insured.
ix. Salvage.
x. The existence of other insurances so that the principle of contribution can apply.
xi. Payment details.

d. **Association of Registered Insurance Agents of Nigeria:** The Association of Registered Insurance Agents of Nigeria (ARIAN) is an umbrella organization that covers all insurance sales agents in Nigeria. It was founded on June 1, 2000. The association aims to promote professionalism, integrity, and financial independence among insurance agents and to enhance the overall growth and development of the insurance industry in Nigeria. The vision of ARIAN is to position agents towards professional excellence in insurance, while

its mission is to promote, protect, and defend the integrity of its members and their profession, as well as the success of its businesses for the benefit of consumers. The association achieves this through education, information, and networking services. ARIAN strives to form a common front for all insurance agents in Nigeria, build integrity and honesty among agents, and ensure their financial independence. It also works towards increasing the number of registered members, publicizing the Nigerian insurance agency business, and eradicating fraud in the industry.

ARIAN collaborates and partners with various stakeholders, including its regulatory body, the National Insurance Commission (NAICOM), and other industry bodies, to foster unity among all insurance agents in the country. The association conducts seminars, training, and symposiums for its members, promotes and protects their interests and welfare, and establishes appropriate training associations to encourage education in the principles and practice of insurance selling. Regulator: in Nigeria, this is the National Insurance Commission, whose broad role is to regulate the activities of all insurance practitioners. They also sanction erring practitioners.

e. **Professional Reinsurers Association of Nigeria (PRAN):** Even though professional reinsurance practice was introduced into Nigeria in 1977, with the establishment of the Nigerian Reinsurance Corporation, the need for self-regulation led to the formation of the Professional Reinsurers Association of Nigeria. It has among others the following objectives:

i. Fostering cooperation and understanding among members.
ii. Assisting ceding companies (insurers) on technical matters and to offer training programmes.
iii. To reducing outflow of foreign exchange by ensuring maximum retention of business written in Nigeria.
iv. Encouraging members to maintain the highest professional standards.

8.6 REGULATORY BODIES

Regulatory bodies are organizations or government agencies that are responsible for overseeing and regulating insurance activities to ensure compliance with laws, protect policyholders' interests, promote fair

market practices, and maintain the stability and integrity of the insurance industry. These regulatory bodies establish and enforce rules, regulations, and standards that insurance companies, intermediaries, and other market participants must follow. Regulatory bodies include:

a. **Nigerian Insurance Commission Act (NAICOM):** In 1997, the Federal Government passed two major pieces of legislation relating to insurance businesses, one of which is the **Nigerian Insurance Commission Act of 1997** which created the National Insurance Commission and which is now saddled with all regulatory functions and authorities carried out previously by various bodies. The Board is made of four part time members. (Chairman and three persons to represent the interest of the public) and seven full time members (the Commissioner for Insurance, his two deputies and one representative each from the Federal Ministry of Finance, Central Bank of Nigeria, Chartered Insurance Institute of Nigeria and the Federal Ministry of Commerce). As stated in the Act, its functions and scope among others include:

    i. Approving rates of insurance premium to be paid for tariff-based insurance business
    ii. Establishing standards for conduct of insurance business in Nigeria
    iii. Approving standards, conditions and warranties applicable to all classes of insurance business
    iv. Protecting insurance policy-holders, beneficiaries and third parties to insurance contracts
    v. Publishing for sale and distribution to the public, annual reports and statistics on the insurance industry
    vi. Contributing to the educational programmes of the Chartered Insurance Institute of Nigeria and the West African Insurance Institute
    vii. Acting as adviser to the Federal Government on all insurance related matters. In order to finance its activities, the commission derives funds from Federal Government allocation, and the one percent levy on turnover of insurance institutions, apart from investment incomes and penalties payable by insurance institutions.

The commission also has the power of registration, administration, supervision and

winding-up over all insurance institutions. For registration purpose, an application is to be made to this Board in a prescribed form and this application may be (I) granted; (ii) granted subject to conditions and (iii) rejected (though appeal could be made to the Minister for Finance within 30 days of refusal).

b. **The Chartered Insurance Institute of Nigeria (CIIN):** Historically, what is now known as the Chartered Insurance Institute of Nigeria was founded in 1959, as the Insurance Institute of Nigeria. However, it became a chartered body in 1993 through the passing of The Chartered Insurance Institute of Nigeria Act of the same year. The Chartered Insurance Institute of Nigeria is the overall professional and educational body for the entire industry and draws membership from all individual practitioners working in the different sections of the industry. The membership is categorized into four namely: (i) Fellows; (ii) Associates; (iii) Ordinary and (iv) Students. The duties of the body are as follows:

   i. Determining the standard of knowledge and skill to be attained by persons seeking to become registered members of the Insurance Profession.
   ii. Reviewing the set standards from time to time as circumstance may permit.
   iii. Conducting examinations and setting the entry requirements.
   iv. Creating insurance awareness through seminars, training, conferences, etc.

SUMMARY

This chapter begins by introducing the various parties involved in the Nigerian insurance market. These include insurance companies, insurance intermediaries, policyholders, and regulatory bodies. Each party plays a distinct role, contributing to the overall functioning and growth of the market. Understanding the responsibilities and interactions of these entities is crucial to gaining insights into the Nigerian insurance sector.

A significant focus of the chapter is the differentiation between insurance agents and insurance brokers. While both agents and brokers facilitate insurance transactions, they have distinct contractual relationships with insurers and legal responsibilities. Agents primarily represent the insurer, while brokers act on behalf of the insured. Understanding the roles and differences between these two entities provides a clear understanding of their contributions to the Nigerian insurance market.

The chapter also explores the support services that are integral to the insurance industry. These services include loss assessors, loss adjusters, repair garages, market associations, and regulatory bodies. Loss assessors and loss adjusters play critical roles in the claims process, assessing and adjusting losses to ensure fair and accurate settlements. Repair garages provide necessary repair and maintenance services for insured assets, aiding in the restoration process after a loss event. Market associations foster collaboration and promote industry-wide initiatives, while regulatory bodies ensure compliance and oversee the Nigerian insurance market.

REVIEW QUESTIONS

1. Who are the key parties involved in the Nigerian insurance market, as discussed in the chapter?
2. Explain the difference between an insurance agent and an insurance broker in the Nigerian insurance market.
3. What roles do loss assessors and loss adjusters play in the insurance industry, specifically within the Nigerian insurance market?
4. How do repair garages contribute to the functioning of the Nigerian insurance market?
5. Discuss the significance of market associations in the Nigerian insurance industry.
6. What is the role of regulatory bodies in the Nigerian insurance market, and why are they important?
7. **Case Study:** The Nigerian insurance market has experienced notable growth and changes over the past decade. Analyze the dynamics and challenges of the Nigerian insurance market and provide recommendations for a foreign insurance company considering entering this market:

a) Begin by providing an overview of the Nigerian insurance market, including its size, key players, and recent growth trends. Discuss the economic factors that have contributed to the expansion of the insurance sector in Nigeria.

b) Explain the regulatory framework governing the insurance industry in Nigeria. Discuss the roles of regulatory bodies such as the National Insurance Commission (NAICOM) and how they impact market entry and operations.

c) Identify and analyze the challenges and obstacles that foreign insurance companies may face when entering the Nigerian market. Consider factors such as competition, market saturation, and consumer awareness.

d) Describe the different segments of the Nigerian insurance market, including life insurance, non-life insurance (general insurance), and microinsurance. Analyze the opportunities and challenges associated with each segment.

e) Discuss consumer behavior and preferences in the Nigerian insurance market. Explore factors that influence insurance purchasing decisions, including cultural aspects and awareness of insurance products.

f) Explain the distribution channels commonly used in the Nigerian insurance market, including brokers, agents, and bancassurance. Evaluate the effectiveness of these channels and their relevance to foreign insurers.

g) Provide recommendations for a foreign insurance company considering entry into the Nigerian market. Discuss potential market entry strategies, such as partnerships with local insurers or setting up a wholly-owned subsidiary.

h) Emphasize the importance of risk management for insurers operating in Nigeria. Discuss the specific risks associated with this market, such as currency fluctuations and regulatory changes, and recommend risk mitigation strategies.

i) Assess the growth potential of the Nigerian insurance market in the coming years. Consider factors like rising middle-class income, infrastructure development, and increasing awareness of insurance products.

In your response, draw on current data and industry insights to support your analysis and recommendations. Highlight the opportunities and challenges that foreign insurance companies should be aware of when considering entry into the Nigerian insurance market, and stress the importance of a well-informed market entry strategy.

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CHAPTER NINE

PRINCIPLES OF INSURANCE

9.0 LEARNING OBJECTIVES

i. To understand the various principles of insurance
ii. To understand the need for the requirement of insurable interest in a general insurance business transaction
iii. To identify the proximate cause in an insurance contract claim
iv. To understand the meaning and effect of subrogation
v. To understand the meaning and reason for contribution to the insurance business

9.1 INTRODUCTION

The principles of insurance form the bedrock of the insurance industry, guiding its practices, policies, and operations. In this chapter, we delve into the fundamental principles that underpin the concept of insurance and drive its functioning. By exploring these principles, readers will gain a comprehensive understanding of the key concepts and considerations that shape the insurance landscape. Insurance, at its core, is a mechanism designed to mitigate financial risks and uncertainties. The principles of insurance provide a framework for evaluating and managing these risks effectively. They govern the relationship between the insured and the insurer, ensuring fairness, transparency, and stability within the insurance ecosystem.

9.2 INSURABLE INTEREST

The principle of insurable interest forms the basis of all insurance contracts because, without it, there will not be insurance as an insurance contract can only be legally enforced when the proposer/insured has an insurable interest in the subject matter of insurance. To have such interest, there must be a legally recognized financial relationship between the proposer for insurance and the property or event for which insurance is sought. Such that the proposer would suffer financial loss if the property were destroyed or the insured event happened or would benefit by the continuing safety of the property or non-occurrence of the event.

Therefore, Insurable interest is the legal right to insure arising out of a financial relationship recognized at law, between the insured and the subject matter of insurance. Based on this definition, the following terms should be understood:

i. **Subject Matter:** Subject matter in the context of insurable interest are in two ways: the subject matter of insurance and the subject matter of contract. The item or event to be insured is the subject matter of insurance. It may be any type of property or any event which may result in a loss of legal right or the creation of a legal liability. On the other hand, the financial interest a person has in the subject matter of insurance is the subject matter of the contract. This was established in Castellain v Preston (1883).

ii. **Legal Relationship:** The relationship between the insured and the subject matter of insurance must be one recognized by law. Examples of a legal relationship include ownership and marriage.

iii. **Financial Value:** The insurable interest in the subject matter of insurance must be one which is financially measurable.

9.2.1 TIMING OF INSURABLE INTEREST

The requirement of the time when insurable interest must be present depends on the class of insurance business in question. For instance:

i. General Insurance

a. Marine Insurance: Section 6(1) of the Marine Insurance Act, 1906 states that any marine insurance contract is void in the absence of insurable at the time of loss. The Marine Insurance (Gambling Policies) Act 1909 also made it a criminal offence to effect a marine policy where either there is no insurable interest, or where there is no reasonable expectation of such an interest.

b. Non-Marine Insurance: The Gaming Act 1845 made all contracts of gambling or wagering null and void. The effect of this legislation on a general, non-marine insurance is taken out without insurable interest is to treat such contract as gamble and therefore of no effect. In this vein, insurable interest in non-marine insurance policies must be present at the inception of the contract.

ii. Life Insurance: Prior to the enactment of the Life Assurance Act 1774, people could effect life insurance policies on another person's life without insurable interest, simply as a form of wager. Upon the enactment of the Life Assurance Act 1774, insurable

interest must exist between the insured and the life assured at the inception of a life policy.

9.2.2 CREATION OF INSURABLE INTEREST

Insurable interest in the subject matter of an insurance policy may arise in the following ways:

i. **At common law:** In some cases, insurable interest is automatically presumed to exist. These cases include:
   a. **Ownership:** The ownership of a property gives a person an automatic interest in such property. This is because one stand to lose financially, if such property is lost or damaged.
   b. **Life:** Everyone is presumed to have an unlimited interest in their own life. Also, a husband and wife have an unlimited insurable interest in the life of each other.

ii. **In contract:** In some cases, a person will agree to accept responsibility for something for which they would ordinarily not be liable. An example of this is tenancy agreement, whereby a landlord shifts the cost of repairing damaged property to the tenant.

iii. **By Statute:** Certain statutes impose duties on, or grant some benefit to an individual or some group of individuals. Such imposition creates insurable interest for these individuals or group.

9.2.3 APPLICATION OF INSURABLE INTEREST

The application of insurable interest shall be considered under the following categories:

i. **Life Insurance:** Application of insurable interest in life insurance falls under two broad categories:
   a. **Family Relationships:** These are the relationships where a precise financial interest might be difficult to establish, but is nevertheless presumed to exist due to the natural tie of love and affection between the parties. Just as every individual is presumed to have an unlimited insurable interest in his or her own life, husband and wife also have an insurable interest in each other’s lives.
   b. **Business Relationships:** There are several business relationships that could give rise to an insurable interest. The main examples include;

- **Partners:** Partners have insurable interest in each other up to the amount of any expense that may arise from the death of the other.
- **Employer and Employee:** An employee can insure the life of his employer strictly to a sum representing their wage or salary for the minimum period of notice under the contract of employment, or the remaining portion of a fixed term contract. An employer on the other hand has an insurable interest in the life of their employee up to an amount representing the value of the work to which the employer is entitled.
- **Creditor and Debtor:** A creditor has an insurable interest in the life of their debtor up to the amount of the debt plus interest payable in such debt. A debtor however has no corresponding interest in the life of their creditor.

ii. **Property Insurance:** Insurable interest in property insurance generally arises out of ownership of the subject-matter of insurance; certain instances where the insured is not the full owner but a part owner of the subject matter, and instances when the insured is not the owner of the subject matter but such property is in his custody. These instances are explained below:

a. **Part or Joint Owners:** A person who is a part or a joint owner of a property has insurable interest in the property up to the limit of their financial interest.

b. Agents: An agent of a principal can insure the property of the principal who has insurable interest in such property on their behalf.

c. **Bailees:** Someone who holds property on a temporary basis for another has an insurable interest in that property while the property is in their custody. They have an insurable interest in the property since if it is damaged or stolen, they may have to replace it.

d. **Landlord and Tenants:** A landlord has an insurable interest in the property that they own and their tenant also have insurable interest in such property since they may be legally liable for the repairs of the property if it is damaged or destroyed and may have to pay rent even when the premises are unhabitable.

e. **Finders and people in possession:** A person who finds a property have a right to insure it since he is in possession of the property at that moment. Possession

of a property gives a better right to the property than any other person other than the owner of the property.

9.3 UTMOST GOOD FAITH

The principle of utmost good faith is a fundamental principle in insurance contracts. It can be defined as “a positive duty to voluntarily disclose accurately and fully all facts material to the risk for which the proposer is seeking to purchase insurance to cover” It requires both the insured and the insurer to act honestly, provide complete and accurate information, and disclose all relevant facts to each other. The principle of utmost good faith is also known as *uberrimae fidei*, a Latin term meaning "utmost faith." The principle of utmost good faith helps to maintain the balance of information between the insured and the insurer. It ensures that the insurer has access to all relevant information needed to accurately assess the risk and set appropriate premiums. By providing full disclosure, the insured helps the insurer make an informed decision and avoids potential disputes in the future. The principle of utmost good faith imposes certain duties on both parties involved in an insurance contract:

i. **Duty of Disclosure:** The insured has a duty to disclose all material facts that could influence the insurer's decision to accept or reject the risk. Material facts are those that would be considered important to the insurer in determining the terms and conditions of the policy. The insured must provide accurate and complete information, even if not specifically asked by the insurer. The duty of disclosure was explained by the court in the case of Carter V Boehm (1766). Material facts are defined by Section 18(2) of the Marine Insurance Act 1906 as follows: “every circumstance is material which would influence the judgment of a prudent insurer in fixing the premium or determining whether he will take the risk.”

   The insurer also has a duty of disclosure to the insured. They must ensure that the statements made to the insured are true and must not mislead the insured about the policy. Section 54 of the Insurance Act in Nigeria further explains the duty of the insurer as regards the disclosure of material facts. Subject to the provision of the Consumer Insurance (Disclosure and Representation) Act (CIDRA) 2012, the common law duty of disclosure of material facts by consumers to insurers has been replaced by the duty to take reasonable care not to make a misrepresentation. Under the CIDRA, a consumer is someone who takes out insurance wholly or mainly for a purpose unrelated

to the individual's trade, business, or profession. The Insurance Act, 2015 on the other hand changes the obligations of the parties to a non-consumer insurance contract at the inception of the contract as a duty of fair presentation of the risk. A fair presentation of the risk is defined as one which makes disclosure of every material circumstance that the insured knows or ought to know, or disclosure that gives insurers sufficient information to put a prudent insurer on notice that it needs to make further inquiries for the purpose of revealing these material circumstances.

Facts that need not be disclosed

The duty of the proposer (would-be insured) to disclose material facts to the insurer imposes an obligation on the proposer. However, there are some facts that need not be disclosed by the would-be insured in the course of the contract. These facts include:

i. Facts of law
ii. Facts of public knowledge
iii. Facts that lessen the risk
iv. Facts where the insurer has waived its right to the information
v. Facts that a survey carried out by the insurer should have revealed
vi. Facts that the insured does not know
vii. Facts outside the scope of specific questions
viii. Spent convictions

Consequences of Non-disclosure: The general rule is that if the insured is in breach of the duty of disclosure, the insurer may avoid the contract entirely, *ab initio*. The insurer must set the whole contract aside and where the non-disclosure is fraudulent, the insurer may keep the premium and also sue for damages. The insurer also has the right to ignore the breach and leave the policy in force. Where there is a claim and the insurer set the whole contract aside, the claims become unpayable but where he ignores the breach, he must pay any claim that arise under the policy.

ii. **Duty to Avoid Misrepresentation:** The insured must not make any false statements or misrepresentations regarding the risk of being insured. A representation is a written or oral statement made during the negotiations for a contract. Therefore, a misrepresentation is a

false statement of fact that induces the other party to enter into the contract. To affect the validity of the agreement, the false statement must:

a. Be one of fact (rather than a statement of law, or of opinion or belief)
b. Be made by a party to the contract
c. Be material
d. Induce the contract
e. Cause some loss or disadvantage to the person who relied upon it.

Where a person makes a false statement with the deliberate intention of misleading another and putting them at a disadvantage there is a fraudulent misrepresentation. If the statement is false but there is no intention to mislead the other party, it can be described as an innocent misrepresentation. The rules that apply to misrepresentation is similar to those for non-disclosure.

Consequences of Misrepresentation: The rules that apply to misrepresentation is similar to those for non-disclosure. When a proposer deliberately or recklessly answers wrongly, the insurer will be entitled to avoid the policy ab initio. The misrepresentation must however concern a fact not an opinion. Under the CIDRA, misrepresentation is a qualifying misrepresentation, that is, if it was either deliberate, reckless or careless, the insurer may avoid the contract and refuse to pay all claims and can keep any premiums paid for the risk unless it will be unfair to the consumer to retain the premium. If, however, the qualifying misrepresentation is careless but not deliberate and reckless, then the insurer will only be able to apply compensatory remedy such as proportionately reducing the amount to be paid as claim to the careless policyholder, or increasing the amount to be paid as premium by the policyholder/insured.

9.3.1 Warranties

Warranties means a guarantee or promise made by one party in other to provide assurance to another party that specific acts or conditions are true or will be met. Warranties can relate to present, past and future situations. The types of warranties are:

a. **Expressed:** These are specified in the policy and place a responsibility on the insured to do or not to do a thing; e.g. in a fire policy it could include a requirement that

inflammable materials are not kept at home or that all lights and electrical appliances are switched off when a person is not at home.

b. **Implied:** These are not written into the policy but would be understood by both parties to apply to the contract. They are only encountered in marine insurance where the seaworthiness of the vessel to be insured is an implied warranty in any marine adventure.

c. **Continuing warranties**: These are warranties that relate to past, present and future situations.

The Marine Insurance Act, 1906 provides that a warranty must be exactly complied with whether material to the risk or not and a breach of a warranty results in the immediate termination of the contract. However, immediate termination of the contract of insurance for breach of warranty has been widely considered to be unduly harsh. Thus, the Insurance Act, 2015 provides that a breach of warranty will no longer automatically cause an insurance contract to terminate. Instead, an insurer's liability will be suspended from the time of the breach. The insurer will have no liability for losses occurring during the time of suspension, but will be liable for losses occurring after the breach has been remedied. Also, the insurance company the Insurance Act 2015 prevents the insurance company from repudiating a contract wholly or in part or a claim brought on the grounds of the breach unless the breach amounts to a fraud and it is a breach of a fundamental term of the contract.

9.4 INDEMNITY

Indemnity is the restoration of an insured to the position they were before the occurrence of a loss. It is a mechanism by which insurers provide financial compensation to the insured after the occurrence of a loss in an attempt to place the insured in the same position they were in before the occurrence of the loss. This principle is central to insurance because it is the basis for which a party enters into an insurance contract. i.e., being compensated if he suffers a loss or the event insured against occurs.

In the ruling of Lord Justice Brett, in the case of Castellan V Preston(1883) he said that indemnity is the controlling principle in insurance law and defined this principle as "the very foundation in my opinion of every rule which has been applied to insurance law is this, namely, that the contract of insurance contained in a marine or fire policy is a contract of indemnity and of indemnity only,……………if ever a proposition is brought forward which is at variance with it, that is to say, which either will prevent the assured from

obtaining a full indemnity or which gives the assured more than a full indemnity, that proposition must certainly be wrong."

Essentially, it means that following a loss, the insured should be returned to the exact same financial position as he or she was in before the loss occurred. However, the interpretation of what constitutes indemnity is not as easy as many would expect as it is the insured's financial interest in the subject matter of insurance that is insured.

However, it can be observed from the above explanation of indemnity that not all insurance contracts are contracts of indemnity. These policies are policies that provide fixed benefits to the insured mainly for the life of a person, accident, or sickness. It is impossible to place a price on the loss of a limb, sight, or life of a person. Hence, the principle of indemnity cannot apply. In this vein, Life, Health, and personal accident insurance policies are called contracts of benefits and not contracts of indemnity in that in the event of a claim, a defined amount or benefit will be paid.

9.4.1 METHODS OF PROVIDING INDEMNITY

i. **Cash payment:** This is the most commonly used method of indemnifying policyholders and it simply involves payment of cash, payment by cheque, transfers to a bank account, and any other related means
ii. **Repair:** This is the repair of the subject matter in question. This is commonly used in property and motor insurance whereby some motor workshops are accredited to repair the vehicles of clients if they are not totally damaged.
iii. **Replacement:** This is most common in glass insurance or insurance of jewelry where the window and other items are replaced by companies in that field for insurance companies or part of jewelry (like pendants) are replaced by jewelers if that part of the jewelry is lost or damaged. Insurance companies also use this method in motor insurance.
iv. **Reinstatement:** This form of indemnity is rarely used. It involves the restoration or rebuilding of property that has been damaged. Insurers rarely use this option because if they decide to reinstate, they become responsible for any problems that arise in the reconstruction process. If the insurer chooses to reinstate, and the restored property is defective or in any way inferior to the old property, or there is an unreasonable delay in handing it over, the insurers may have to pay compensation to the policyholder for breach of contract.

9.4.2 FACTORS LIMITING THE PAYMENT OF INDEMNITY

There are factors that can limit the amount of indemnity that an insured can receive in the event of a loss and these are:

i. **Sum insured:** The sum insured is the amount stated in the policy which represent the financial interest of the insured in the item or event insured. This sum should reflect the actual replacement cost of the insured property. It is therefore the maximum amount payable in the event of a claim. If a policy has a sum insured specified, then indemnity cannot exceed this sum insured even if the insured's loss is greater. That is why it is important to review sums insured regularly especially at times of significant inflation, to ensure that the compensation received reflects the full value of the property.

ii. **Average:** If a loss occurs and the insured is found not to insure the full value of the property, then the insurer's liability will be reduced in the same proportion as the underinsurance because the insurer only received a premium for a proportion of the entire value at risk. This concept was discussed in chapter six.

iii. **Excess:** This is an amount of each and every claim which is not covered by the policy. This is common in most insurance (except the 'fire only' section of the Fire & special perils policy), where there is an excess clause in an insurance contract, the insured is his own insurer for the value of the excess and thus does not receive full indemnity from the insurance company.

iv. **Franchise:** This is a fixed amount which is to be paid by the insured in the event of a claim. However, once the amount of the franchise is exceeded, the insurer pays the whole of the loss, including the value of the franchise.

v. **Limits**: These are placed by the wording of the contract as the maximum amount that the insurance company will pay on any policy irrespective of the amount of loss.

Just as the insured can receive less than the value of their loss, they can also under certain circumstance receive more than indemnity under the following situations:

i. **Reinstatement**: The insured can request that his policy be subject to the reinstatement memorandum and as a result the method of settlement will provide the insured with an amount that has been calculated without deduction of wear, tear and depreciation. The insurer agrees to pay the full cost of the reinstatement.

At the time of reinstatement, sum payable includes indemnity, plus wear, tear and depreciation plus the effects of inflation between the date of loss and eventual date of reinstatement.

ii. **Agreed Value Policies**: In agreed value policies the value of the subject-matter of the insurance is agreed at the start of the contract and the sum insured is fixed accordingly. This value will be reviewed at each renewal and in the event of a claim, the value need not be proved to the insurer. Agreed value or valued policies are common in marine insurance. They are also sometimes used when insuring works of art and other objects, such as vintage motor case, whose true value may be of dispute at the time of a claim.

iii. **First Loss Policies**: There are occasions when the insured believes that the full value of the insured property is not really at risk, that is, a total loss or even a very substantial loss seems impossible. In this case, the insured may request that their policy has a sum insured that is less than the full value of the property.

iv. **New for old cover**: This type of cover applies to household content policies. It is an attempt to replace a property at the current cost. Here, the insurers agree to pay the full replacement cost of any insured item which is lost or destroyed without the deduction of wear and tear and/or depreciation.

9.5 SUBROGATION

The whole essence of insurance is to restore the insured to their pre-loss position and insurance contracts for non-life business are contracts of indemnity which means that a person can only recover the exact amount of their loss and no more nor less. Indemnity thus rules out a person from recovering twice for the same loss. To understand the principle of subrogation, the following example will be helpful:

Ade was driving to work and is hit from behind by Chike who was not paying attention to see that the traffic light had changed to red (stop sign), Ade's car is severely damaged but because Ade have an insurance policy the insurance company pays for the repair of his car. Clearly, it can be seen that legally Ade has a case against Chike for being the cause of the accident and so can institute a case for compensation. But the principle of subrogation forbids this as receiving money from the insurance company and from Chike will mean receiving more than the loss amount which is contrary to the

principle of indemnity that forbids receiving more than one's loss if an event occurs.

The principle of subrogation is thus a corollary of the principle of indemnity and premised upon that of equity in law by providing that when an insurance company has paid a claim to their policyholder, and another party outside of the contract is in law liable for the cause of the loss; such third party should not avoid his or her financial responsibilities as doing so will be unjust to the insurance company who is only managing the premium fund of various insured with it and which must be protected to avoid not having money to meet the primary obligation of paying compensation to those that have insurance policies with it.

Subrogation can therefore be defined as the right of an insurer, having indemnified the insured, to stand in the place of the insured in other to avail himself of all the rights and remedies that the insured has against a third party responsible for the loss. Subrogation applies when the contract is one of indemnity and this is decided in the case of Castellian V Preston (1883) where Preston was in the course of selling his house to Rayner when it was damaged by fire, he recovered from his insurers, Liverpool, London and Globe, and when the conveyance of the property was completed, which was prior to repairs being carried out, Preston also received the full purchase price from Rayner, the insurer sued in the name of their chairman, Castellian, and were successful in recovering their outlay.

The contract of sale placed an obligation on Rayner to pay the full contracted price of £3100 even though the building had been damaged and not repaired. In accepting that figure, Preston had enforced his rights against Rayner, the recovery of £330 from Preston being the cost of repair. This is an example of an insurer availing himself of rights which had already been enforced. It should be noted however, that life contracts are not subject to the doctrine of subrogation because they are not contract of indemnity meaning that if death was caused by the negligence of another person, then the deceased's representative may be able to recover from the third party as well as from his insurance policy.

The duty of subrogation is a reciprocal one, in that just as the insured cannot receive more than their loss from the insurance company, the insurers must not make any profit for exercising their subrogation right. The case of Yorkshire Insurance Co. Ltd V Nisbet Shipping Company Limited (1961) is a case law in

this regard. Here, settlement had been made at £72,000 by the insurer but due to the lapse of time between the claim payment and the recovery from the third party and due to the fact that the pound sterling had been devalued in the interval, the insured was paid £127,000. It was held that the insurers were only entitled to £72,000. So, the insurance company can only subrogate to the extent that they have provided indemnity. Other points that need to be taken notice of concerning subrogation are as follows:

i. Where the insured has been considered his own insurer for part of the risk, as in the case of an excess or the application of average; such insured will be entitled to retain an amount equal to that share of the risk out of the money recovered.
ii. Where the insurer makes an ex-gratia payment to the insured, then the insurer will not be entitled to subrogation rights should that insured also recover from another source. Since ex-gratia payment is not indemnity and so subrogation cannot apply.

9.5.1 HOW SUBROGATION RIGHTS MAY ARISE

Subrogation rights may arise in any of the following three ways:

i. **Tort:** The law of tort refers to a body of laws that govern civil wrongs and provide a legal framework for individuals to seek compensation for injuries or harm caused by the actions or omissions of others. A tort occurs when one party's conduct leads to harm or injury to another party, resulting in legal liability. Tort law aims to provide remedies to injured parties, hold wrongdoers accountable, and deter future harmful acts. Subrogation typically occurs in tort when an insured individual or entity suffers harm or incurs expenses due to the negligence or wrongdoing of another party.
ii. **Contract:** Subrogation rights may arise in contracts. This arises in situations where the insured has an alternative contractual right of recovery, in addition to that provided by the insurer. The insurer can enforce this right for their own benefit.
iii. **Statute:** Subrogation may also arise in the form of a statutory right belonging to the insured. The most common example of this is the statutory right of property owners to recover damages from the police authority if their property is damaged in the course of a riot. This right arises under the Riot Compensation Act 2016 (RCA).

9.6 CONTRIBUTION

Like subrogation, contribution is a corollary of the principle of indemnity which effectively prevents the insured from 'making a profit from his loss". The possibility of making a profit arises from the existence of double insurance. Contribution is the right of an insurer to call upon others, similarly, but not necessarily equally liable to the same insured, to share the cost of an indemnity payment. The rule is that if an insurer has paid a full indemnity, he can recoup an equitable proportion from the other insurers of the risk. But where full indemnity has not been paid, then the insured will wish to claim from the others also to receive an indemnity. Contribution will apply under the following conditions:

i. Two or more policies of indemnity exist
ii. The policies cover a common interest.
iii. The policies cover a common peril which gives rise to the loss.
iv. The policies cover a common subject matter.
v. Each policy must be liable for the loss.

Examples of contribution in practice are: a policy covering the insured's stock in their Lagos warehouse will contribute with one covering his stock in all their warehouses; also, a policy insuring Ade's interest will contribute with another policy insuring Ade's and Chike's interest in the same property.

The leading case on contribution is that of North British & Mercantile V Liverpool & London & Globe (1877) here merchants Rodocanachi had deposited grain at the granary owned by Barnett. Barnett had a strict liability for the (safety of the) grain according to the custom of the trade in London and had therefore insured it. The owner had also insured to cover his interest as owner. When the grain was damaged by fire, Bennett's insurers paid and sought to recover from Rodocanachi's insurer. Because the interests were different, one as a bailee and the other as owner. The court held that contribution should not apply.

i. **Common peril:** the perils insured by each policy do not have to be identical under each contract example in the case of American Surety Co. of New York V Wrightson (1910), an insurance covering dishonesty of employees was held to be in contribution with one covering dishonesty of employees, fire and burglary, the dishonesty was the common peril.
ii. **Common subject matter:** If the object of insurance is the same in two insurance

policies, both will contribute towards the settlement of any claim that may arise. As an example, if policy A covers motor vehicle and stock in a warehouse, against fire and Policy B covers motor vehicle and building. In the event of fire damage to the vehicle; both will contribute to settle the insured; with motor vehicle being the common subject in both policies of insurance.

9.6.1 METHODS OF CALCULATING CONTRIBUTION

There are two main methods of calculating the ratio of contribution. These are:

i. **Maximum Liability Method:** Here, the loss is shared by the insurers in proportion to the maximum amount of cover that is available under each policy which, in the case of property insurance, is usually equivalent to the sum-insured. For example:

If a property is insured for N10,000 with insurer A and for N30,000 with insurer B and a loss of N25,000 occurs;

Insurer A will pay:

$$\frac{\text{N10,000}}{\text{N40,000N (10,000 +N30,000)}} \times \text{N25,000} = \text{N6,250}$$

Insurer B will pay:

$$\frac{\text{N30,000}}{\text{N40,000}} \times \text{N25,000} = \text{N18,750}$$

However, there are cases whether this method will not operate fairly or will not workout at all. These could be:

a. Where terms and conditions of the policies are not the same.
b. Where the range of the two policies is different.

For example, Policy B may cover stock in buildings X, Y, and Z while policy A may cover stock in building X alone.

ii. **Independent Liability Method:** Here, the liability of each insurer for the particular loss which has occurred is assessed as though its policy were the only one in force. The figure that results in each case represents the independent liability of the insurer for the loss. The loss is then shared in the proportion to the independent liabilities

of the two insurers. For example:

Scenario 1 Policy A: Sum Assured N10,000

Policy B: Sum Assured N20,000

Loss N6,000

First calculate independent liabilities:

Policy A= N6,000

Policy B= N6,000

A + B = N12,000

Therefore; Policy A pays;

$$\frac{N6,000}{N12,000} \times N6,000 = N3,000$$

And Policy B pays:

$$\frac{N6,000}{N12,000} \times N6,000 = N3,000$$

Whether the maximum liability method or independent method is used will depend on the circumstances and the class of business concerned.

For property insurance, there is little legal authority on the basis of contribution and the choice of method will usually depend on market price. Where the subject matter of insurance is identical and policy is not subject to average or excess, the maximum liability method is normally used. Where a lower limit applies within a greater sum insured or excess applies, the independent liability method will be applied. For liability insurance, it is established in law, that the independent liability method is the proper basis of calculation.

Furthermore, in some cases, market agreements between insurers will modify the application of contribution itself. This can happen in two ways:

a. Insurers may agree to share losses in cases where, strictly speaking, contribution does not arise in law
b. They may sometimes agree to waive rights of contribution in cases where such a right clearly exists, so that the whole of the loss is borne by one insurer.

9.7 PROXIMATE CAUSE (CAUSA PROXIMA)

This is another important principle of insurance, because in every insurance contract, it is necessary to state without ambiguity the perils against which the insurance company is giving cover; e.g., fire, theft, employer's liability, business interruption e.t.c. so that the intention of the parties to the contract is clearly defined and there won't be unneeded dispute when a loss occurs. This is because whether or not a policy will provide cover will depend upon the actual cause of the loss.

In certain types of losses, this may be straight forward and easy to find out, while in others it may not be easy and the insurance company will need to take decision on whether the insured is entitled to receive compensation or not. Example, a shop losing its wares following a break in will be a clear case of theft. Suppose on the other hand, that same shop losses it wares by the operation of a sprinkler system which is used to extinguish a fire outbreak and the policy the shop owner bought is a fire policy what will be the cause of loss here? Will it be fire or water that is used to extinguish the fire? This is just some of the dilemma which insurance companies face because if they are wrong in determining the true cause of a loss, they will either be paying money to someone who does not deserve it or they will be facing litigation from a party who thinks that he is entitled to receive compensation. However, case laws over time have assisted the insurance companies in overcoming this challenge.

The legal case that defined this principle was that of **Pawsey V Scottish Union and National (1907**), proximate cause was defined in this case as "the active, efficient cause that sets in motion a train of events which brings about a result, without the intervention of any force started and working actively to form a new and independent source."

This means that the proximate cause of a loss is the dominant cause from which a direct chain of events can be seen to lead to the loss. To simplify all this, "proximate" means "nearest" and may not be the first cause nor the last cause but rather the dominant cause. In **Leyland Shipping Co. V Norwich Union (1918),** proximate cause was said to be the efficient or operative cause. The following example, may assist in illustrating the principle of proximate cause:

There are ten houses in line on a street and there is a fire outbreak in house one and this extends to house six, the dominant cause of the fire in house six could be traceable to that in house one. However, if there is an interruption by someone say arsonist who in the course of the fire sets house number nine on fire and

this affects house ten, the course of the fire in house ten will no longer be traceable to that in house one because the arsonist has become a new and intervening force that caused the fire in house ten. And will therefore be referred to as the dominant cause.

To find the intention of the parties the perils relating to the risks must be determined. These perils are:

i. **Insured perils:** These are perils that are named as covered by the policy.
ii. **Excepted/excluded perils:** These are named as not covered by the policy.
iii. **Uninsured perils:** These are not named or mentioned in the policy.

If all the events leading to a loss are insured, then it is not important to identify the proximate cause of such loss as the policy cover will automatically operate. But where one of the events leading to loss is an uninsured or excluded peril, then finding the proximate cause becomes important. As a rule:

i. If the proximate cause is found out to be an excluded peril, then the insurer is not liable for the loss.
ii. If the proximate cause is an insured peril, then the insurer is liable for the loss even if the actual loss is caused by an uninsured peril.
iii. If both an insured peril and an excluded peril led to the loss, it is essential to establish which came first. If the insured peril follows the excluded in unbroken sequence, the insurers have no liability.
iv. If the excluded peril follows the insured peril, insurers are liable for damage consequent upon the operation of the insured peril, but only that incurred before the intervention of the excluded peril.

SUMMARY

The chapter outlines the fundamental concepts that shape the insurance industry. Utmost good faith, insurable interest, indemnity, subrogation, and contribution form the cornerstone of insurance practices, ensuring trust, fairness, and stability in the insurance ecosystem. A clear understanding of these principles empowers stakeholders to navigate insurance contracts, assess risks accurately, and participate effectively in the insurance marketplace.

REVIEW QUESTIONS

1. What is the principle of utmost good faith, and why is it important in insurance transactions?
2. Define the concept of insurable interest and explain its significance in insurance contracts
3. What does the principle of indemnity entail, and how does it prevent the insured from profiting from an insurance claim?
4. Discuss the principle of subrogation and its role in the insurance industry.
5. Explain the principle of contribution and how it ensures a fair sharing of the burden of loss among multiple insurers.
6. Why is it essential for insurance professionals and policyholders to understand and apply the principles of insurance?
7. **Case Study:** A family-owned construction business is planning to expand its operations and take on larger projects. As part of this growth strategy, they are considering various insurance options to protect their business interests and manage risks. As their insurance consultant, explain the fundamental principles of insurance to help them make informed decisions:

a) Explain the principle of utmost good faith in insurance contracts. Discuss how both the insurer and the insured are expected to act in good faith during the underwriting and claims processes. Provide examples of how this principle applies to the construction business.

b) Describe the concept of insurable interest and why it's essential in insurance. Discuss how the construction business can demonstrate insurable interest when insuring its projects, equipment, and liabilities.

c) Explain the principle of indemnity, emphasizing that insurance aims to restore the insured to the same financial position they were in before a loss occurred. Discuss how this principle influences the valuation of insured assets and the settlement of claims for the construction company.

d) Discuss the principle of contribution, which states that when multiple insurance policies cover the same risk, each insurer shares the liability proportionally. Provide examples of how this principle might apply to a construction project involving various subcontractors.

e) Explain the principle of subrogation, which allows insurers to step into the shoes of the insured to recover their losses from third parties responsible for a loss. Discuss how this principle can be relevant to the construction business in cases of liability claims.

f) Describe the principle of proximate cause, which determines which cause is the primary reason for a loss and whether it's covered by insurance. Provide examples of how this principle can affect claims related to construction accidents or property damage.

Based on the principles discussed, provide recommendations for the types of insurance coverage the construction business should consider as they expand their operations. Highlight the importance of aligning their insurance choices with their specific risks and business objectives.

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CHAPTER TEN

REINSURANCE

10.0 LEARNING OBJECTIVES

i. To understand the meaning and purpose of reinsurance
ii. To identify the difference between the types of reinsurance
iii. To understand the benefit of reinsurance
iv. To identify the methods of reinsurance

10.1 INTRODUCTION

Reinsurance is a crucial aspect of the insurance industry, serving as a mechanism for insurers to transfer a portion of their risks to other parties. In this chapter, we delve into the world of reinsurance, exploring its purpose, mechanisms, and significance within the insurance ecosystem. By understanding the fundamentals of reinsurance, readers will gain valuable insights into this essential component of the industry.

10.2 MEANING AND PURPOSE OF REINSURANCE

Reinsurance is the act of transferring risk assumed by an insurance company to another insurer or a company set up for that purpose called a reinsurer. In other words, reinsurance is the "insurance of insurers". It is a transaction through which an insurance company or insurer transfers a part or the whole of the risk it has assumed to another company (reinsurance company or reinsurer) to spread the risk and reduce the effect of any potential loss on its financial strength. The insurance company in a reinsurance transaction is also known as the reinsured, the ceding company, the primary insurer, or the cedant.

In a reinsurance transaction, the insuring public has no direct relationship with the reinsurance company. Rather they deal with the direct insurance companies who in turn deal with the reinsurance companies. It is worthy of being mentioned here that reinsurers too may reinsure the same risk (s) that they accepted from the direct office with other reinsurance companies through a process known as retrocession.

Reinsurance should not be confused with co–insurance which is when an insurance company shares the risks brought before it with other insurance companies with the main insurance company being referred to as the lead insurer. Under this arrangement, each participant receives a percentage of the premium

proportionate to the percentage of risk given it and will be required to contribute the same as the claim if a loss occurs.

The purpose of reinsurance is to provide insurance companies, known as ceding companies or reinsured, with a means to reduce the financial consequences resulting from the risks they have accepted as insurers. Reinsurance allows insurers to spread their risks and protect themselves from catastrophic losses or aggregations of liability.

10.3 BENEFIT OF REINSURANCE

Reinsurance has several benefits for the insurance company. These benefits include:

i. **Spreading of Risk:** Reinsurance allows insurers to spread their potential losses by transferring a portion of the risks they have assumed to reinsurers. By doing so, insurers can avoid centralization of liability for specific types of risks, business lines, or geographic areas. Reinsurance acts as a cushion, protecting insurers against the financial strain that could arise from large or multiple losses.

ii. **Increasing Capacity:** Reinsurance enables insurers to increase their capacity to underwrite policies and offer higher coverage limits. Insurers have a gross capacity, which represents the limit of coverage they can provide before considering reinsurance. By ceding a portion of their liability to reinsurers, insurers can increase their gross capacity and write more business without exposing their net account to excessive risk. Reinsurance helps insurers compete in markets where the ability to accept large risks is crucial.

iii. **Accessing Technical Expertise**: Reinsurance companies often have specialized knowledge and expertise in managing specific types of risks. By partnering with reinsurers, insurers can benefit from their experience and insights, which can help improve underwriting practices and risk management strategies. Reinsurers can provide valuable guidance and support to insurers in assessing and pricing risks effectively.

iv. **Catastrophe Protection:** Reinsurance plays a crucial role in protecting insurance companies against losses arising from natural disasters and catastrophic events. Insurers operating in high-risk areas, such as regions prone to wildfires, hurricanes, or flooding, face the potential for significant financial strain due to a sudden influx of high-value claims. Reinsurance provides a safety net and helps mitigate the financial impact of such events.

v. **Financial Stability:** Reinsurance can help stabilize the financial losses of insurance companies. Even if an insurer has the financial capacity to pay a large number of high-value claims, reinsurance can smooth the financial impact, preventing substantial losses and ensuring the insurer's financial stability.

vi. **Stability of underwriting (or technical) results:** By indemnifying the ceding company, reinsurance helps to reduce the ceding company's claims fluctuation and thereby reduces the volatility of underwriting results over the years.

vii. **Facilitates Company Growth:** Reinsurance supports company expansion by relieving the burden of unearned payment reserve requirements. By transferring risks to reinsurers, insurance companies can focus on growing their business, acquiring new clients, and expanding their operations.

viii. **Protection against Insolvency:** Reinsurance safeguards insurance companies against insolvency by ensuring that they can fulfill their obligations and pay claims, even in the event of unexpected high-value claims or major disasters. It provides a safety net and enhances the financial security of insurers.

10.4 TYPES OF REINSURANCE ARRANGEMENT

The basic types of reinsurance are as follows:

i. **Facultative Reinsurance:** This is the original and oldest form of reinsurance with the characteristic that the risks brought before the reinsurance company are assessed individually with the ceding office having the choice to decide whether to buy

reinsurance and the reinsurer also having the power to decide whether to provide reinsurance cover. Facultative reinsurance provides coverage for individual or specified risks or contracts. It is typically used for high-value or hazardous risks that are not covered under a treaty agreement. Each risk or contract is negotiated separately between the ceding insurer and the reinsurer, and the reinsurer has the right to accept or reject each proposal individually.

ii. **Treaty or Obligatory Reinsurance:** This is a type of reinsurance that is arranged between the ceding company and the reinsurer. Both parties agree that every risk of a particular class of insurance that is covered by the ceding company must have a proportion of it ceded (transferred) to the reinsurer. Here, the direct insurer is obliged to cede a contractually agreed share of the risks, and the reinsurer is obliged to accept that share. Treaty reinsurance is a long-term contract that is in effect for a set period, rather than on a per-risk basis. Once the terms of the treaty agreement are established, all policies falling within those terms are automatically covered by the reinsurer.

iii. **Facultative Obligatory Reinsurance:** A facultative obligatory reinsurance arrangement combines some of the principles of both facultative and treaty reinsurance arrangements. Here, the details of the contract are agreed in advance but the insurers have the option whether to cede the risk to the reinsurer or not. The obligatory element rests on the reinsurer who must accept such cession whenever the insurer decides to cede.

10.5 METHODS OF REINSURANCE

There are two methods of reinsurance:

i. **Proportional Reinsurance:** This is a method of reinsurance based on risks. Here, the reinsurer will receive the premium and will have to pay the losses in proportion to its participation in the sum insured of the original risk. Under proportional reinsurance, the reinsurer receives a prorated share of all policy premiums sold by the insurer. In the event of a claim, the reinsurer bears a portion of the losses based

on a pre-negotiated percentage. This type of reinsurance allows for the sharing of both premiums and losses between the ceding insurer and the reinsurer.

a. **Facultative Proportional Reinsurance**: By effecting facultative proportional reinsurance, an insurer is able to transfer a share of a risk it has accepted to the reinsurance company. The result is that the insurance company will pay the reinsurer, a share of the premium proportionate to the amount of risk it has transferred to them, and in the event of a loss, the insurer or ceding company can recover the same share of the claim from the reinsurer.

b. **Proportional Treaty Reinsurance:** There are two types of proportional treaty reinsurance. These are:

   - **Quota Share Treaty:** In this type of treaty, the gross retention of the ceding company is shared with the reinsurer. This means that an arrangement is made whereby the primary insurer cedes a certain percentage of every risk insured by it to its quota share reinsurer provided that the risk falls into the class of risks under the quota share treaty; and in an event of a loss resulting in claim payment, the claim is shared in the same proportion at which the risk had been shared between the primary insurer and its reinsurer.
   - **Surplus Treaty:** In this type of treaty, the ceding company after retaining up to its retention capacity cedes the surplus amount to its reinsurers. This means that the ceding company accepts the risk that is above its gross retention capacity and passes the surplus on to its surplus treaty reinsurers. The retention capacity of the ceding company in a surplus treaty is referred to as lines. Unlike quota share reinsurance, the reinsurer does not participate in all risks but only takes on the risks above the amount retained by the insurer. The total capacity of the reinsurance treaty is typically expressed as a multiple of the insurer's lines. The surplus treaty reinsurer settles claims in the same proportion at which the risk was covered between the ceding company and its surplus treaty reinsurers.

ii. **Non-Proportional Reinsurance:** Non-proportional reinsurance involves the reinsurer assuming liability for losses that exceed a specified amount, known as the priority or retention limit. It is based on the size of the loss rather than the reinsurer's

share in the risk. Here, the reinsurer will have to pay only if an actual loss for a risk or number of risks exceeds the deductible, and then only up to the cover limit as contractually agreed. As the price for the cover, the reinsurer gets a negotiated portion of the original premium. Non-proportional reinsurance is further divided into:

a. **Excess of Loss Reinsurance:** Under this type of non-proportional reinsurance, the insurance company and reinsurance company agree on the amount that the insurance company is to retain. If losses under the policy remain within this limit, the reinsurance company does not become involved. But if the loss exceeds the amount agreed, the reinsurance company is liable to pay the balance up to an agreed limit.

   Excess of loss reinsurance is usually arranged on a 'per-risk' basis or 'an event or occurrence' basis also known as catastrophe excess of loss.

   - **Per-risk Excess of Loss:** Under a per-risk excess of loss basis, protection is provided for the insurer should a loss occur on an individual original policy that is greater than the amount retained by the insurer.
   - **Catastrophe or Per-event Excess of Loss:** Here, protection by the reinsurer is dependent on the accumulation of losses to an insurer's net retained account due to the occurrence of an insured event.

   Excess of loss reinsurance is arranged in layers, with different layers being called upon as a claim moves from one layer into the next. The first layer, which is most likely to be called upon, is known as the working layer; and it also happens to be the costliest to put in place.

b. **Stop Loss Reinsurance:** Stop loss reinsurance is a type of non-proportional reinsurance that provides coverage to the ceding insurance company for losses that exceed a specified threshold over a given period, typically a year. It covers a whole portfolio of risks or even the whole account of a ceding company. The purpose of stop-loss reinsurance is to protect the ceding company from unfavorable outcomes and stabilize its financial results.

   In stop loss reinsurance, the reinsurer becomes liable for losses incurred by the ceding company once the total amount of claims exceeds a predetermined limit.

This limit can be defined in various ways, such as a loss ratio or a specific amount. For example, a stop-loss reinsurance contract with a 75% stop-loss provision would mean that the reinsurer would start covering losses once the ceding company's total losses reach or exceed 75% of the earned premiums.

SUMMARY

The chapter on reinsurance explores the purpose, mechanisms, and significance of reinsurance within the insurance industry. Reinsurance serves as a vital tool for insurers to manage and transfer risks, safeguarding their financial stability. It enables insurers to spread their risks across multiple reinsurers, reducing exposure to large-scale losses and catastrophic events. The chapter delves into the various types of reinsurance arrangements, including facultative reinsurance and treaty reinsurance, and discusses the benefits and considerations of implementing reinsurance programs. Overall, a comprehensive understanding of reinsurance equips readers with valuable insights into its crucial role in the insurance industry.

REVIEW QUESTIONS

1. What is the purpose of reinsurance in the insurance industry?
2. Differentiate between facultative reinsurance and treaty reinsurance.
3. Discuss the benefits of implementing reinsurance programs for insurers.
4. What factors should insurers consider when assessing the cost-effectiveness of reinsurance arrangements?
5. **Case Study:** You are a reinsurance expert advising a large insurance company that operates in multiple countries. The company is evaluating its reinsurance strategy and considering various options to optimize its risk management and capital allocation. Analyze the concepts of reinsurance and provide recommendations for the insurance company's reinsurance strategy.

a) Begin by providing an overview of reinsurance, explaining its purpose and role in the insurance industry. Describe how reinsurance helps insurance companies manage risk and improve their financial stability.

b) Discuss the different types of reinsurance arrangements, including proportional (quota share) and non-proportional (excess of loss) reinsurance. Explain the key differences between these types and their potential applications for the insurance company.

c) Explain the factors that influence reinsurance pricing, including the level of risk transferred, the reinsurer's financial strength, and market conditions. Discuss strategies for negotiating favorable reinsurance terms and pricing.

d) Analyze the international aspects of reinsurance, considering how the insurance company's global operations may affect its reinsurance needs. Discuss the importance of selecting reinsurers with a strong international presence.

e) Explain how reinsurance impacts claims management for the insurance company. Discuss the process of filing claims with reinsurers and how reinsurers may participate in claims settlements.

f) Based on the analysis, provide recommendations for the insurance company's reinsurance strategy. Discuss specific reinsurance arrangements, including the appropriate mix of proportional and non-proportional reinsurance, and the selection of reinsurers. Consider the company's risk profile, market conditions, and growth objectives.

In your response, use relevant industry examples and data to support your analysis and recommendations. Emphasize the strategic importance of reinsurance in the insurance company's risk management and financial stability.

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CHAPTER ELEVEN

PENSIONS

11.0 LEARNING OBJECTIVES

1. To understand the need for pensions
2. To understand the reason government and private employers provide pension
3. To understand the type of pension scheme available
4. To determine the effect of the Pension Act 2004 and 2018 on pension schemes in Nigeria
5. To understand the government's role in pension regulation

11.1 INTRODUCTION

The concept of pension is of paramount importance in the realm of personal finance and retirement planning. In this chapter, we delve into the multifaceted world of pensions, exploring their significance, structure, and role in providing financial security during retirement. By understanding the intricacies of pensions, human resource practitioners will gain valuable insights into this critical aspect of long-term financial planning.

11.2 MEANING AND DEFINITION OF PENSION

A pension refers to a fixed amount of money paid at regular intervals, typically after retirement, to a person or their surviving dependents as consideration for past services, age, merit, poverty, injury, or loss sustained. It is a form of financial support provided to individuals who have worked and contributed to a pension plan during their working years. The pension payments are intended to provide a stable income during retirement and ensure financial security for retirees. Pension plans are often offered by employers as part of an employee's benefits package. Pensions are funded by the employer, the employee, or both.

11.3 WHY GOVERNMENT AND PRIVATE EMPLOYERS PROVIDE PENSION

There are several reasons why governments and private employers provide pensions. These reasons include:

i. **Attract and retain employees:** Offering a pension plan is an effective way for employers to attract and retain talented employees. A pension plan is a valuable benefit that can help employers attract and retain employees who are looking for long-term job security and financial stability.

ii. **Social responsibility:** Governments and private employers have a social responsibility to ensure that their employees are financially secure during their retirement years. Providing a pension plan is a way to fulfill this responsibility.

iii. **Tax benefits:** Governments provide tax incentives to encourage employers to offer pension plans. For example, contributions made by employers to a pension plan are tax-deductible, and the investment earnings on the plan are tax-free until the funds are withdrawn.

iv. **Employee morale:** Providing a pension plan can improve employee morale and job satisfaction. It demonstrates that the employer is committed to the long-term financial well-being of its employees. The fund that individuals, employers, or groups of employees contribute to during their active working life towards their pension is known as the pension fund. There are two stages of a pension fund. These stages are:

   i. **Accumulation stage:** The accumulation stage of a pension fund refers to the period when a person is actively contributing to their pension plan. During this stage, a portion of the employee's salary is deducted and paid into the pension fund. The main objective of the accumulation stage is to accumulate savings over time, which will be used to provide retirement benefits to the employee when they retire. The accumulation stage typically lasts for several decades, depending on the age of the employee and the terms of their pension plan. During this period, the contributions made by the employee, as well as any contributions made by the employer, are invested in various financial instruments, such as stocks, bonds, and mutual funds, to generate investment earnings. The accumulation stage is a critical component of a pension plan, as it determines the amount of savings that will be available to the employee at retirement. The more contributions made and the higher the investment earnings generated during the accumulation stage, the greater the retirement benefits that the employee will receive.

   ii. **Income Stage:** The income stage starts from the retirement date and lasts throughout the life, or beyond the life of a pensioner. It may start with a lump sum payment to the retiree immediately on retirement, and thereafter earning regular, periodic income.

11.4 TYPES OF PENSION SCHEME

Pension schemes can be generally classified into four broad categories. These are:

i. **By funding method**

a. **Pay-As-You-Go (PAYG):** The pay-as-you-go method is an employer-provided scheme. Here, the employer has no specific fund reserved for the payment of pension upon the retirement of their employees. When benefit fall due, employers pay from the organization's current income. This was the practice of the Nigerian government for the payment of public service pensions before the enactment of the Pension Reform Act, of 2004. The adoption of this system was possible because of the continuing nature of the government and its power to harness the resources of the country through tax. The government can also borrow funds at its rates to cater to pension liabilities.

b. **Advanced Funded Schemes:** Under the advanced pension scheme, employers set up funds before when the need for benefit payment falls due. Here, there is a complete separation of the funds from the fund of the business organization. The management of the fund is entrusted to an independent entity usually a board of trustees. The board is responsible for paying benefits out of the fund to retiring employees. This method of funding was common among private-sector employers before the enactment of the Pension Reform Act of 2004.

ii. **By Financing Method**

a. **Non-Contributory Scheme:** A non-contributory scheme is one that the employer bears responsibility for meeting all the obligations associated with the pension scheme. Employees do not contribute to the funding of the scheme.

b. **Contributory Scheme:** Under a contributory scheme, the employers and the employees jointly finance the scheme. Contributions may be at fixed rates or a balance of cost basis, with a fixed rate for employees. The employer pays the balance in such a situation and the employee's contribution varies according to the needs of the fund.

iii. **By Benefit Basis**

a. **Defined Benefit Scheme:** A defined benefit scheme is an employer-sponsored retirement plan in which the employee's benefits are determined based on a pre-established formula that considers factors such as length of employment and salary history. In a defined benefit plan, the employer assumes the responsibility

for managing the plan's investments and risks. The company typically hires an outside investment manager to handle the investment aspect of the plan. The employer is also responsible for ensuring that there are sufficient funds to meet the future benefit obligations to the employees.

The benefits provided by a defined benefit plan are usually paid out as a lifetime annuity or, in some cases, as a lump sum, depending on the rules of the specific plan. The benefits are paid out based on the predetermined formula defined by the plan. One key characteristic of a defined benefit plan is that both the employees and the employers know the formula for calculating retirement benefits in advance. This formula is used to define and set the benefit paid out to the employees. The benefit amounts are not dependent on investment returns, unlike retirement savings accounts where the payouts can vary based on market performance.

However, poor investment returns or miscalculations can lead to a funding shortfall in a defined benefit plan. In such cases, employers are legally obligated to make up the difference by contributing additional funds to cover the shortfall. The distribution of benefits in a defined benefit plan can be in various forms. It may involve fixed monthly payments, similar to an annuity, that continue throughout the employee's lifetime. Alternatively, it can be a one-time lump sum payment after retirement or a combination of periodic payments and a lump sum. If the employee passes away, the surviving spouse is often entitled to receive the benefits.

Defined benefit plans are managed and funded by the employer, and they assume all the investment and planning risks associated with the plan. The employer's responsibility includes making investment decisions, managing the plan's investments, and ensuring the availability of funds to meet future benefit obligations. The amount of pension to be paid under a defined benefit scheme is usually expressed in the form of:

Accrual rate(K) X Final Earnings (FS) X Number of years of Service(N)

It should be noted that final earnings may be the final basic salary, final total emoluments, or the average of some years' final earnings.

In the public service in Nigeria, before the introduction of the Pension Reform Act, of 2004, the defined benefit scheme was in the form of the payment of gratuity as a lump sum payment upon retirement which is usually dependent on the number of years of service and the subsequent payment of the annual pension.

b. **Defined Contributory Scheme:** Employers and employees jointly finance the defined contributory schemes. Benefits due to an employee depend on the joint contributions of the employer and the employees and the returns on investment. The risk present in a defined contributory scheme is borne by the members of the scheme rather than by the scheme itself, or by the employer. The defined contributory pension scheme operates on a money-purchase basis. Each employee has an account and the contribution by the employer and the employee goes into the employee's account. Employees bear the cost of administering the fund as well as the risks of investment, reinvestment, longevity, and inflation.

   Members(employees) of a defined contributory scheme get flexibility in benefit form and may be able to choose whether or not to provide a pension for dependents, take a tax-free cash sum or have annual increases to the pension once in payment.

c. **Hybrid Pension Scheme**: A hybrid pension scheme is a type of retirement savings plan that combines elements of both defined benefit and defined contribution plans. In a hybrid pension scheme, the employer guarantees a minimum level of retirement benefits to the employee, similar to a defined benefit plan. However, the employee also has the opportunity to contribute to their pension fund, similar to a defined contribution plan. The most common type of hybrid pension scheme is the cash balance plan. In a cash balance plan, the employer credits the employee's pension account with a specific amount of money each year, based on a percentage of the employee's salary. The employee is guaranteed a minimum level of retirement benefits, which is based on the amount of money in their pension account. Unlike a traditional defined benefit plan, in which the employer bears the

investment risk, a hybrid pension scheme places the investment risk on the employee. This means that if the investments do not perform as expected, the employee may receive lower benefits than what they expected. Hybrid pension schemes offer some of the benefits of both defined benefit and defined contribution plans. The employer provides a guaranteed minimum level of retirement benefits, and the employee has the opportunity to accumulate additional savings through contributions to their pension account. However, hybrid pension schemes are more complex than other types of pension plans and can be difficult for employees to understand.

iv. **By Benefit Payment Method**

a. **Pure Pension Scheme:** A pure pension scheme pays the benefits due on retirement to the pensioner as regular periodic income (pension) throughout the lifetime of the pensioner. Part of the pension may however be commuted to cash. This may be subject to a limit of 25%. The cash commutation may be tax-free while the pension may be subject to tax.

b. **Provident-Fund Scheme:** Here, employees take their benefits as a lump on retirement. The lump sum cash is tax-free, provided the scheme has the approval of the tax authorities. The major advantage of a provident fund is the benefit of the exemption from tax. Its main disadvantage is the possibility that retirees may suffer from money illusion. They may spend or invest the lump sum payment wrongly leading to a loss of the investment, and outliving their financial resources.

11.5 PENSION REFORMS ACT

Before the Pension Reform Act, of 2004, employers who operated advanced funded pension schemes had two methods of administering and managing their pension schemes. These methods are:

i. **Self-Administered Scheme:** A self-administered scheme is one that the employer manages in-house. The employer appoints a board of Trustees that is responsible for managing the scheme, investing the fund, and paying benefits to members or their beneficiaries. The board of trustees is also responsible for preparing and submitting returns to the tax authorities. The self-administered scheme also has some

drawbacks. Investment risks and mortality risks can affect fund solvency. Employers may have access to the fund, especially at a time when they have financial challenges. Also, the fund may become insufficient to pay future benefits if an employer borrowed it, not at an arm's length transaction but at a non-commercial rate of interest. For the government, on the other hand, public budgeting is carried out. Here, the budget is set aside for pension liabilities. Actuaries are made used to advise on pension liabilities.

ii. **Insured Scheme:** An insured scheme is one in which the trustee of an employer-sponsored pension scheme will insure the scheme with a life insurance company. The trustees pay the joint contribution as premiums to secure benefits for employees under a group pension policy. The trustees and the life insurer are the parties to the contract. The life insurer bears the associated risks (investment and mortality risk), keeps the records, and pays benefits to the trustees who pay to members or their beneficiaries. Employers cannot easily assess an insured pension fund.

The type of pension fund scheme based on benefit type before the Pension Reform Act was the Defined Benefit Scheme. The features of the defined benefit scheme operated before the 2004 Reform Act are as follows:

i. Non-uniformity of pension and gratuity rules/formulae in the public service;
ii. Non –contribution by the employees
iii. Basis of payment was the terminal salary or gross pay of the employee
iv. Combination of gratuity, pension, disability, and survivor benefits
v. Retirement on reaching age 60 or serving for 35 years in the public service, whichever camefirst
vi. Reduced pension benefits option for voluntary disengagement after serving between 10 and34 years;
vii. Limitation of statutory backing for pension/gratuity benefits to only public servants andmembers of the armed forces/ Paramilitary
viii. Payment of gratuity as a lump sum payment at retirement or resignation after severalyears
ix. Funding of schemes as operating expenses from provisions in the annual budgets

i.e., Pay-As-You-Go (PAYG) basis

x. Utilization of gratuity and pension left to the individual retiree.

xi. Diversion of budgetary provisions for pension/gratuities by government and /or officials who had access to such funds.

xii. No formal method of channeling savings from pension and gratuities for the economic development of the country.

xiii. Granting of permission (in 1997) to parastatals under Federal Ministries to make individual pension arrangements – maintain a self-administered pension scheme; transfer scheme to a third-party fund manager or place the risk with an insurance company

xiv. Fixing the minimum number of years to be served before eligibility to join a pension scheme

xv. Theoretically, pension was to be paid for life but practically serious challenges in continuing five years after retirement

xvi. Non- portability of pension/gratuity even within the public service and with the private sector.

xvii. A lot of bureaucracy in setting up Trustees and obtaining permission from the Joint Tax Board.

11.6 PENSION REFORM ACT 2004 AND 2014

The Nigerian pension system changed in 2004 with the enactment of the Pension Reform Act of 2004. The Act became effective for public sector employees from July 1, 2004, and January 1, 2005, for private sector employees. The 2004 Pension Reform Act introduced significant changes to the pension system in Nigeria, transitioning from a defined benefits scheme to a defined contribution scheme. The reform aimed to address issues such as inadequate funding, delays in pension payments, and mismanagement of pension assets. It established the National Pension Commission (PENCOM) as the regulatory body responsible for overseeing the new pension system.

The Act made pension compulsory for both public and private sector employees. It introduced a contributory pension scheme (CPS), and a single system of administration. Employers and employees jointly finance the scheme. Private companies specifically established for managing pensions (Pension Fund Administrator

(PFA)), are responsible for administering the scheme. Employers have no responsibility in administering the scheme and employees have the choice of PFAs to manage their fund, the fund type, and the benefit type on retirement. Employees bear all associated risks. Although the funds are managed by the PFAs, the custody of these funds is vested in another set of private companies known as the Pension Fund Custodians.

The Nigerian contributory pension scheme based on the 2004 Act is compulsory for all employers with at least three employees. Employers are also required by the Act to insure the lives of their employees to guarantee death-in-service benefit for employees who die before retirement. After a revision in 2014, the Act became the Pension Reform Act, 2014. The objectives of the Pension Reform Act 2014 are as follows:

i. Ensure that every person who worked in either the Public Service of the Federation, Federal Capital Territory, states and local government, or private sector receives his or her retirement benefits as and when due.
ii. Assist improvident individuals by ensuring that they save to cater to their livelihood during old age.
iii. Establish a uniform set of rules, regulations, and standards for the administration and payments of retirement benefits for the public service of the federation, public service of the Federal capital territory, the public service of the states and local government, and the private sector.
iv. Make provision for the smooth operations of the contributory pension scheme.

The provisions of the Pension Reform Act 2014 are as follows:

i. The scheme shall apply to employees who are in the employment of an organization in which there are 3 or more employees.
ii. Employees of organizations with less than 3 employees as well as self-employed persons may enroll under the micro-pension scheme
iii. The contribution for any employees to which the act applies shall be made in the following rates relating to their monthly emolument.
    a. a minimum of 10% by the employer; and
    b. a minimum of 8% by the employee.
iv. The rates of contribution may upon agreement between an employer and employee be revised upward from time to time with the commission being

notified of such revision.

v. Any employee to whom the act applies can also make voluntary contributions to his retirement savings account.

vi. The employer may agree on the payment of additional benefits to the employee upon retirement.

vii. The employer can elect to bear the full responsibility of the scheme provided that in such case, the employer's contribution shall not be less than 20% of the monthly emolument of the employee.

viii. Every employer shall maintain a group life insurance policy in favor of each employee for a minimum of 3 times the annual emolument of the employee.

ix. Where an employer failed, refused, or omitted to make payment as and when due, the employer shall make arrangements to effect the payment of claims arising from the death of any staff in its employment during such period.

x. In the case of professors covered under the Universities (miscellaneous provisions) (Amendment) Act 2012 and the category of political appointees entitled, by their terms and conditions of employment to retire with full benefits, the commission shall issue guidelines to regulate the administration of their retirement benefits provided that any shortfall shall be funded from the budgetary allocations by the employer.

xi. The retirement savings account of the employees is portable, they can be moved from one pension fund administrator to another or when the employee changes jobs, such an employee only needs to inform the new employer of his retirement savings account details.

xii. It empowered the national pension commission subject to the fiat of the attorney general of the federation, to institute criminal proceedings against employers who persistently fail to deduct or remit pension contributions of their employees within the stipulated time.

xiii. It empowered the national pension commission subject to the fiat of the attorney general of the federation, to institute criminal proceedings against employers who persistently fail to deduct or remit pension contributions of their employees within the stipulated time.

xiv. The law reduced the waiting period for accessing benefits in the event of loss of a jobfrom six months to four months.

xv. It exempted the personnel of the military and security agencies from the contributory pension scheme.

xvi. It vested the jurisdiction in pension matters in the national industrial court.

xvii. It provided for an employer to be compelled to open a temporary retirement savings account on behalf of an employee who fails to open a retirement savings account withinthree months of assumption of duty.

Certain persons are however exempted from the contributory pension scheme. These members of the armed forces, the intelligence, and secret services of the federation, and any employee who is entitled to retirement benefits under any pension scheme existing before the 25th day of June 2004.

11.7 RETIREMENT BENEFITS UNDER THE 2014 ACT

The act provides that a holder of a retirement savings account shall, upon retirement or attaining age 50 years whichever is later, utilize the amount credited to his retirement savings account for the following benefits:

i. Withdrawal of a lump sum from the total amount credited to his retirement savings account provided that the amount left after the lump sum withdrawal shall be sufficient to procure programmed fund withdrawals or annuity for life by guidelines issued by the commission.

ii. Programmed monthly or quarterly withdrawals calculated based on an expected life span.

iii. Annuity for life purchased from a life insurance company that is licensed by the national insurance commission.

iv. Professors covered by the Universities (miscellaneous provisions (Amendment) Act 2012 shallretire with full benefits according to the university act.

v. Other categories of employees entitled, by their terms and conditions of employment, to retire with full retirement benefits shall still apply.

vi. Where an employee voluntarily retires, disengages, or is disengaged from employment. The employee may with the approval of the commission, withdraw an amount not exceeding 25%of the total amount credited to his retirement

savings account. Provided that such withdrawals shall only be made after 4 months of such retirement or cessation of employment and the employee does not secure another employment.

11.8 PARTICIPANTS IN THE PENSION INDUSTRY AND PENSION INVESTMENTS

The pension industry involves several key participants who play different roles in the management and administration of pension plans. The main participants in the pension industry include:

i. **Pension Fund Administrator:** A pension fund administrator is a company that manages and administers pension funds on behalf of employers or the government. They handle the day-to-day management of the pension fund, including investing the funds, processing contributions and payments, and ensuring compliance with laws and regulations. The goal of a pension fund administrator is to protect and grow the assets of the pension fund so that it can provide retirement benefits to employees or retirees in the future.

   Pension Fund Administrators (PFAs) are a key component of the pension system in many countries. Typically, PFAs are private or public companies that are licensed by the regulatory agency responsible for overseeing the pension system. They play a critical role in managing retirement savings for workers who participate in a defined contribution pension plan.

   Based on the Pension Reform Act 2014, the functions of the Pension Fund Administrator are as follows:

   a. open Retirement Savings Account for all employees with a Personal Identity Number (PIN) attached;
   b. invest and manage pension funds and assets by the provisions of this Act;
   c. maintain books of account on all transactions relating to pension funds managed by it;
   d. provide regular information on investment strategy, market returns, and other performance indicators to the Commission and employees beneficiaries of the retirement savings accounts;

e. provide customer service support to employees including access to employees' account balances and statements on demand;

f. cause to be paid retirement benefits to holders of retirement savings accounts by the provisions of this Act;

g. be responsible for all calculations about retirement benefits; and

h. carry out other functions as may be directed, from time to time, by the Commission.

ii. **Pension Fund Custodian:** A Pension Fund Custodian (PFC) is a financial institution that is responsible for holding and safeguarding the pension fund assets of a pension plan. In many countries, including Nigeria, PFCs are licensed by the regulatory agency responsible for overseeing the pension system. The primary function of a PFC is to ensure the safety and security of pension fund assets. The Pension Fund Custodian has the following functions:

i. receive the total contributions remitted by the employer under section 11 of this Act on behalf of the Pension Fund Administrator and credit the account of the pension funds administrator immediately;

ii. notify the Pension Fund Administrator within 24 hours of the receipt of contributions from any employer

iii. hold pension funds and assets in safe custody on trust for the employee and beneficiaries of the retirement savings account;

iv. on behalf of the Pension Fund Administrator, settle transactions and undertake activities relating to the administration of pension fund investments including the collection of dividends, bonuses, rental income, commissions, and related activities;

v. report to the Commission on matters relating to the assets being held by it on behalf of any Pension Fund Administrator at such intervals as may be determined, from time to time, by the Commission;

vi. undertake statistical analysis on the investments and returns on investments concerning pension funds in its custody and provide data and information to the Pension Fund Administrator and the Commission;

vii. execute in favor of the Pension Fund Administrator's relevant proxy for voting about the investments; and

viii. carry out other functions as may be prescribed by regulations and guidelines issued by the Commission, from time to time.

iii. **Pension Transitional Arrangement Directorate:** The Pension Transitional Arrangement Directorate (PTAD) is a Nigerian government agency that was established in August 2013 to oversee the management of pension benefits for retirees under the Defined Benefit Scheme (DBS) in Nigeria. Based on the guidelines for the operation and supervision of the Pension Transitional Arrangement Department, the general functions of PTAD are as follows:

a. Carry out the functions of the relevant Pension Boards or Offices in the Public Service of the Federation;

b. Make budgetary estimates for all Federal Government pensioners under the Defined Benefit Scheme (DBS);

c. Maintain a robust database of all Federal Government pensioners under the DBS.

d. Carry out regular verification exercises to determine the live status of pensioners under the DBS and update the pensioner's payroll accordingly.

e. Ascertain deficits in pension payments, if any;

f. Ensure the payment of pension and outstanding retirement benefits to FGN pensioners under the DBS;

g. Carry out such other functions aimed at ensuring the welfare of pensioners as the Commission may, from time to time, direct; and

h. Render returns on its activities to the Commission, in line with the provisions of the PRA 2004.

iv. **Employers:** Employers are the primary sponsors of pension plans. They establish and contribute to the pension funds on behalf of their employees.

v. **Employees/Plan Participants:** Employees are the individuals who contribute to the pension plans and are the intended beneficiaries of the plans upon retirement. They may contribute a portion of their income to the pension fund, either voluntarily or as a mandatory requirement.

vi. **Regulators:** Regulatory bodies, such as government agencies or supervisory authorities, oversee and regulate the pension industry. They establish rules and guidelines to protect the interests of plan participants and ensure the stability and integrity of pension plans.

11.9 INVESTMENT FUND TYPES UNDER THE PENSION REFORM

The retirement savings account multi-fund structure became effective on the 2nd of July, 2018. The National Pension Commission (PENCOM) designed the structure as a life-cycle investment structure to suit the risk appetite of account holders. There are four types of funds under the pension scheme:

Fund I: This fund type is for contributors who have an appetite for high-risk. The fund carries the highest risk among the four funds. It has a higher proportion of its investments in financial instruments with unpredictable but potential for high returns on a long-term basis. A substantial proportion of the fund's investments will be in equities of public limited liability companies listed on the securities exchange like the Nigerian Stock Exchange. Contributors below 49 years are free to choose it. Returns under the fund can be high and in the event of loss in a downward market, there is hope of recovery before retirement age.

Fund II: This is the default fund type for contributors who are 49 years and below. Any contributor within the age bracket who did not choose Fund I, because they are risk averse, will automatically be in Fund II. The underlying financial instruments in Fund II are less risky than Fund I. The maximum investment in variable income securities like equities is 55% of the fund. Most will be in fixed-income securities like the Federal and State Government bonds to minimize the potential loss.

Fund III: This is for contributors who are 50 years and above. They can move to Fund II only. Fund III has a higher proportion of its investments in fixed-income securities than Fund II. Fund III ensures that contributors will not suffer the loss of value of their retirement savings account balance very close to retirement age when it will be very difficult to recover in the event of a loss.

Fund IV: This is the retiree fund. Retirees cannot choose any of funds I to III. This is to minimize their exposure to investment risks in old age. The investment of the fund is highly skewed towards fixed-income securities, especially government bonds.

Fund V (Micro Pension Plan): This is an innovation introduced by PENCOM in its guidelines for micro pension plans in 2018 to extend the scope of pensions to the informal sector. Though not compulsory, it enables people operating in the informal sector and self-employed individuals to provide pensions for their old age. Micro-pension plan contributors must be at least 18 years old. They are free to select and register formally with PFAs. Their contribution mode is flexible in terms of frequency, amount, and payment method. There is also flexibility in payment-daily, weekly, or monthly. They can pay any amount that they can afford. They can also exercise their right to move their RSA from one PFA to another. Micro-pension plan contribution has two components:

a. 40% for contingent withdrawal, and
b. 60% for retirement benefits.

Contributors are free to make contingent withdrawals before retirement. PFAs are expected to maintain a separate Fund for the micro-pension plan.

11.10 GOVERNMENT ROLES IN PENSION REGULATIONS AND REGULATORS OF PENSION

There were three regulators in the pension industry before the enactment of the pension reform act 2004. These are:

i. Securities and Exchange Commission (SEC),
ii. National Insurance Commission (NAICOM), and
iii. The Joint Tax Board (JTB).

While the Securities and Exchange Commission licensed Pension Fund Managers; National Insurance Commission was and is still responsible for licensing and regulating insurance companies while the Joint Tax Board approved and monitored all private pension schemes with enabling powers from schedule 3 of the personal income tax decree 1993.

11.11 NATIONAL PENSION COMMISSION (PENCOM)

The Pension Reform Act 2004 re-enacted in 2014 is the most recent legislation of the government of Nigeria at reforming the pension system in the country. It established a uniform pension system for both the public and private sectors and also established a single authority to regulate all pension matters and this is the

National Pension Commission (PENCOM). The National Pension Commission has the following objectives:

i. Enforce and administer the provisions of the act.
ii. Coordinate and enforce all other laws on pension and retirement benefits.
iii. Regulate, supervise, and ensure the effective administration of pension matters and retirement benefits in Nigeria.

While the functions of the commission are as follows:

i. Regulate and supervise the scheme established under the act and other pension schemes in Nigeria.
ii. Issue guidelines, rules, and regulations for the investment and administration of pension funds.
iii. Approve, license, regulate and supervise pension fund administrators, custodians, and other institutions relating to pension matters as the commission may from time to time determine.
iv. Establish standards, benchmarks, guidelines, procedures, rules, and regulations for the management of pension funds under the act.
v. Ensure the maintenance of a national data bank on pension matters.
vi. Carry out public awareness, enlightenment, and education on the establishment, operations, and management of the scheme.
vii. Promote capacity building and institutional strengthening of pension fund administrators and pension fund custodians.
viii. Receive, investigate, and mitigate complaints of impropriety made against any pension fund administrator, custodian, employer, staff, or agent.
ix. Promote and offer technical assistance in the application of the contributory pension scheme by the states and local government councils by the objectives of the act.
x. Perform such other duties which, in the opinion of the commission, are necessary or expedient for the discharge of its functions under the act.

SUMMARY

This chapter provides a comprehensive overview of this essential aspect of pension. It discusses the reasons for pension provision by governments and private employers, the types of pension schemes available, and the legislative reforms that have shaped the pension landscape in Nigeria. The chapter also highlights the roles of pension fund administrators, pension fund custodians, and the Pension Commission in managing and regulating the pension industry. By understanding the complexities of pensions, human resource practitioners are equipped to make informed decisions on their various organizations' pension responsibilities.

REVIEW QUESTIONS

1. What are the reasons why both government and private employers provide pensions?
2. Explain the difference between defined benefit (DB) and defined contribution (DC) pension schemes.
3. Discuss the significance of the Pension Reform Acts of 2004 and 2014 in Nigeria and their impact on the pension system.
4. What role do pension fund administrators (PFAs) play in the management of pension funds?
5. Define the responsibilities of pension fund custodians (PFCs) about pension funds.
6. What is the role of the Pension Commission (PenCom) and why is it important in the regulation of the pension industry in Nigeria?
7. **Case Study:** You are a pension fund manager at a financial institution, and you have been approached by a mid-sized company looking to revamp its employee retirement benefits program. The company is concerned about attracting and retaining top talent and wants to offer a competitive pension plan. Analyze the concepts of pensions and provide recommendations for designing an effective pension plan for the company.

a) Begin by providing an overview of pension funds, explaining their purpose and the role they play in retirement planning. Discuss the importance of pension funds in ensuring financial security for retirees.

b) Discuss the different types of pensions plans available, including defined benefit (DB) and defined contribution (DC) plans. Explain the key features and advantages of each plan type.

c) Analyze the retirement age and benefit options that should be considered for the company's pension plan. Discuss how early retirement, normal retirement, and deferred retirement options can impact plan design.

d) Explain how pension plans are funded, including contributions from both the employer and employees. Discuss the importance of regular contributions and the potential impact of contribution levels on plan sustainability.

e) Discuss the regulatory framework governing pension plans in the company's jurisdiction. Highlight the importance of compliance with pension laws and regulations.

f) Recommend strategies for effectively communicating the pension plan to employees and providing educational resources to help them make informed decisions about their retirement benefits.

g) Analyze the cost implications of the proposed pension plan, including administrative expenses and actuarial calculations. Provide strategies for managing costs while delivering competitive benefits.

h) Emphasize the importance of designing a pension plan that is sustainable in the long term, considering factors such as changing demographics and economic conditions.

i) Based on your analysis, provide recommendations for designing the company's pension plan. Discuss the most suitable plan type, contribution levels, investment options, and communication strategies to meet the company's talent retention and retirement security objectives.

In your response, draw upon industry best practices and considerations relevant to the company's specific needs and goals. Highlight the strategic importance of a well-designed pension plan in attracting and retaining employees and ensuring their financial well-being in retirement.

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CHAPTER TWELVE

SOCIAL INSURANCE

12.0 LEARNING OBJECTIVES

i. To understand what social insurance is

ii. To understand social insurance schemes in Nigeria.

iii. To understand regulation of insurance with reference to social insurance schemes.

12.1 INTRODUCTION

Social Insurance is a protective mechanism against social risks sponsored by the government with focus on protecting workers from lower consumption in post-retirement life, thereby averting old age crisis or poverty. It is a public insurance scheme, that is either mandated by the government as compulsory or directly sponsored and managed by it. Social Insurance can also be defined as an insurance programme required by law for substantial number of the general population, administered and closely monitored by the government and supported primarily by ear-marked contribution with a benefit structure that usually redistributes income to achieve some social objective, not private equity. Social insurance is a government sponsored insurance program that is defined by law, serves a defined population and is funded through premium or taxes paid by or on behalf of the participants.

Social security on the other hand, is defined as the protection which the society provides for its members, through series of public measures against economic and social distress that could have been caused by stoppage of earnings resulting in sickness, maternity, employment injury, old age, unemployment, invalidity and death. It involves all measure designed by government to protect citizens against perils such as: death, poor health and other contingencies against which individuals of little earning cannot effectively provide for by themselves. Social security encompasses social insurance and public assistance where public assistance are programmes that gives benefits to those who happen to have an unfortunate loss, from government revenue into which they have not contributed.

12.2 NIGERIAN SOCIAL INSURANCE TRUST FUND(NSITF)

The Nigerian Social Insurance Trust Fund was established through decree number 73 of 1993 and was meant to replace the National Provident Fund with effect from 1st July 1994.The decree creating the

fund provided that contributions would be made for the provision of social insurance for workers in the private sector to cover against loss of employment income in old age, invalidity or death. Though the rate of contribution by employers and employees was not specified in the decree, but the regulations to thedecree provided for contributions to be fixed at 6.5% for the employer and 3.5% from the employee based on the employee's basic salaries to be contributed monthly. With the effective date for this contribution to be from the 1st of July, 1994. Different sections of the NSITF decree provided for varying needs and requirements as follows:

i. This Act shall apply in respect of every person who
   (a) Is employed by a company,
   (b) Is employed by a partnership irrespective of the number of persons employed by the company or partnership; or
   (c) In any other case, where the number of persons employed is not less than five
ii. All employers and employees to which this Act applies shall be registered with the Board in such manner as may be prescribed by regulations made under this Act.
iii. The existence of a private pension scheme in respect of workers to whom this Act applies, shall not exempt an employer or employees referred to in subsection (I) of this section from the provisions of this Act.

12.2.1 PERSONS EXEMPTED FROM THE NIGERIAN SOCIAL INSURANCE TRUST FUND

The following persons are exempted from the provisions of this Act:

i. A person employed in the public service of the Federation or a State or Local Government who is entitled to the benefit of any scheme or pension on terms substantially similar to those prescribed by the Pensions Act; or
ii. A person who is entitled to diplomatic or equivalent status under the Diplomatic Privileges and Immunities Act; or
iii. A person not being a citizen of Nigeria who is employed in Nigeria for a period less than six years at a time, if the employee is liable to contribute to or is prospectively entitled to benefits from social security scheme of any country other than Nigeria or any benefit scheme by virtue of his employment which would provide the

employee with benefits substantially not less favourable than the like benefits to which he would have been entitled to under this act; or

iv. A minister of religion who is engaged in the propagation of his faith.

12.2.2 CATEGORIES OF CONTRIBUTIONS UNDER THE NIGERIAN SOCIAL INSURANCE TRUST FUND

Subject to the provisions of this Act, an employee referred to in section 10 of this Act shall be required to make the following contributions to the Fund established by section I of this Act, that is:

i. Contributions of the first category, being contributions payable by or on behalf of the employees against the contingencies of retirement, pension, death, invalidity and emigration; or

ii. Contributions of the second category, being contributions payable on behalf of the employeeby the employer against the contingency of employment injury.

Contribution to be paid monthly: Contributions of the various categories shall be paid on a monthly basis at the rate prescribed by regulations made under section 40 of this Act which shall be computed by reference to the wages of the employee concerned. The contributions payable in respect of each month shall fall due on the last day of the month concerned.

12.2.3 CATEGORIES OF BENEFITS UNDER THE NIGERIAN SOCIAL INSURANCE TRUST FUND

Subject to this act, the following benefits shall be payable to or in respect of a contributor whohas satisfied the applicable conditions prescribed by regulations made under this act, that is:

i. Retirement pension benefit.
ii. Retirement grant
iii. Survivor’s benefit.
iv. Death grant.
v. Invalidity benefit
vi. Invalidity grant.
vii. Such other benefit as may be approved from time to time by the Board.

12.2.4 OTHER BENEFIT METHODS UNDER THE NIGERIAN SOCIAL INSURANCE TRUST FUND ACT

A further provision of this act is that a contributor or contributors can chose to have their benefits converted to credits to meet specific need such as the purchase of a residentialbuilding for personal or family use. Additionally, this method can also be used to purchase equity holdings in the company where such employee is employed. The approval of the board will be sought before an employee can be compensated using this method. The act further provides for the following with respect to the Nigerian social insurance trust fund:

i. The funds contributed to them by any person before the registration of a pension fund administrator including any attributable income thereof not required for the purpose of administering minimum pension as determined by the commission shall be computed and credited into the respective retirement savings accounts opened under the act by each contributor or beneficiary of contributions made under the Nigerian social insurance trust fund act.

ii. Where a person who contributed any fund under the Nigerian social insurance trust fund act has retired before the commencement of the act, the funds due to him shall be paid to him in accordance with section 7 of the act. i.e., by programmed withdrawal, annuity and other provisions under this section.

iii. Where a person who contributed any fund under the Nigerian social insurance trust fund act has died before the commencement of the act, the estate or beneficiary of the deceased shall be paid the entitlement of such deceased person subject to the provisions of the Nigerian socialinsurance trust fund act.

iv. All pension funds and assets held and managed by the Nigerian social insurance trust fund shall be transferred to a pension fund custodian or administrator.

12.3 EMPLOYEE COMPENSATION ACT 2010

12.3.1 HISTORY OF EMPLOYEE COMPENSATION

The first formalized social security legislation in Nigeria began with the passage of the Workmen's Compensation Act of 1942 while still under colonial rule. It was meant for both public and private sector

employees and further amended in 1957 and 1987 (Workmen'sCompensation Decree). The immediate past Workmen's Compensation Act 2004 was deemed to:

i. Have insufficient and inequitable provisions for workmen who got injured in the course ofemployment;
ii. Have been operated more in the breach as most employers did not set aside funds asprescribed by law to take care of employees injured in the course of employment;
iii. Have failed as the alternative insurance machinery in the act was not activated by theminister with such powers;
iv. Lack of acceptance among the workers due to the general negative impression of Insuranceby Nigerians.
v. In order to address these flaws, the Workmen's Compensation 2004 was repealed andreplaced with the Employees Compensation Act 2010.

The Employee Compensation Act 2010 is basically the outcome of the agitations by organized labour (Trade Union Congress and Nigeria Labour Congress – TUC and NLC) against the employers (Local, State and Federal Governments as well as Nigerian Employers Consultative Association – NECA) for improved welfare of Nigerian workers. The Act reflects broadly the interests of all the parties (Nigerian Social Insurance Trust Fund for government; Nigerian Employers Consultative Association for employers and both the Trade Union Congress and Nigerian Labour Congress for workers) that were involved in the negotiations leading to its passage by the National Assembly. The Nigerian Social Insurance Trust Fund was mandated to run the scheme and have in their board representatives of the government (Federal), employer (Nigerian Employers Consultative Association) and workers (Trade Union Congress and Nigerian Labour Congress) appointees.

12.3.2 OBJECTIVES OF THE EMPLOYEE COMPENSATION ACT, 2010

The objectives of the act are to:

i. Provide for an open and fair system of guaranteed and adequate compensation for all employees or their dependents for any death, injury, disease or disability

arising out of or in thecourse of employment.

ii. Provide rehabilitation to employees with work-related disabilities.
iii. Establish and maintain a solvent compensation fund managed in the interest of employeesand employers.
iv. Provide for fair and adequate assessments for employers.
v. Provide an appeal procedure that is simple, fair and accessible, with minimal delays.
vi. Combine efforts and resources of relevant stakeholders for the prevention of workplacedisabilities, including the enforcement of occupational safety and health standards.

The Employee Compensation Act defines an "employee" as "a person employed by anemployer under oral or written contract of employment whether on a continuous, part-time, temporary, apprenticeship or casual basis and includes a domestic servant who is not a member of the family of the employer including any person employed in the Federal, State and Local Governments, and any of the government agencies and in the formal and informal sectorsof the economy."

The Employee's Compensation Act, 2010 is a social security/welfare scheme that provides comprehensive compensation to employees who suffer from occupational diseases or sustain injuries arising from accidents at workplace or in the course of employment. The basis or justification for 'compensation' is the employer's duty of care. The idea of compensation suggests that someone has suffered a wrong for which he has to be compensated monetarily. This implies that another person has a duty to prevent the occurrence of the wrong suffered.

Payment of compensation by the employer to the employee is rooted in the accepted principle that the employer has a duty of care, a duty to protect the health, welfare and safety of workers at work. Where the worker sustains injuries, gets ill or dies in work-related circumstances, the employer is liable to pay compensation to the worker or to his dependents, in the event of death. The Employee Compensation Act (ECA). The ECA is an act that directs employers to contribute 1% of their total emolument cost to the NSITF (Nigerian Social Insurance Trust Fund). where Total emoluments were defined as the summation of basic salary, transport and housing allowances based on a clarification meeting with

Nigerian Social Insurance Trust Fund by Nigerian Employers Consultative Association on what constitutes total emoluments which the 1% will be applied to. The amount is set aside as insurance to employees with compensation for injury in work place, mental stress, occupational hazard, and even death.

The act allows the board to prescribe different contribution and assessment rates to be madeby each employer based on the categorization of the risk factors of the particular class or sub- class of industry to which the employer belongs.

The act also defined injury to include "bodily injury or disease resulting from an accident or exposure to critical agents and conditions in the workplace". All employees suffering from mental stress, occupational injuries and diseases, as well as the dependents of a deceased employee, whose death is due to occupational injuries, are entitled to compensation under the act. In addition, the act empowers the Board to provide health care and disability support to affected employees. It is should be noted that "mental stress" was not included as part of" occupational injury" under the repealed Workmen's Compensation Act.

The Employee Compensation Act also provides for the compensation of an employee who suffers mental stress not resulting from an injury for which the employee is otherwise entitled to compensation, only if such mental stress is an acute reaction to a sudden and unexpected traumatic event arising out of or in the course of the employee's employment, or where such mental stress is diagnosed by an accredited medical practitioner to have arisen out of the nature of the work, or the occurrence of any event in the course of the employee's employment.

12.3.3 OTHER BENEFITS PROVIDED BY THE EMPLOYEES COMPENSATION ACT

Other benefits provided by the employees' compensation act include:

i. Compensation for injuries sustained where the nature of the business of the employer extends beyond the usual workplace i.e., where the employee is required to work both in and out of the workplace or where the employee has the permission of the employer to work outside the normal work place.
ii. An employee will also be entitled to payment of compensation with respect to any accident sustained while on the way between the place of work and;
    a. The employee's principal or secondary residence;

b. The place where the employee usually takes meals; or

c. The place where he usually receives remuneration, provided that the Employer has prior notification of such place.

iii. Where an employee suffers from hearing impairment of non- traumatic origin, but arising out of or in the course of employment under this act, the employee shall be entitled to compensation under this Act.

12.3.4 SCALE OF COMPENSATION UNDER THE EMPLOYEE COMPENSATION ACT

Where death results from the injury of an employee, compensation shall be paid to the dependents of the deceased:

1. Where the deceased employee leaves dependents wholly dependent on his earnings a widowor widower:

   i. and two or more children, a monthly payment of a sum equal to 90 per cent of the totalmonthly remuneration of the employee as at the date of death,

   ii. and one child, a monthly payment of a sum equal to 85 per cent of the total monthly remuneration of the deceased employee as at the date of death,

   iii. without a child who, at the date of death of the employee, is 50 years of age or above, or is an invalid spouse, a monthly payment of a sum equal to 60 per cent of the total monthly remuneration of the deceased employee, and

   iv. who, on the date of the death of the employee is not an invalid spouse, is under theage of 50 years and has no dependent children; a monthly payment of a sum that is equal to the product of the percentage determined by subtracting 1 per cent from 60 per cent foreach year for which the age of the dependent, at the date of death of the employee, is under the age of 50 years, and provided that the total percentage shall not be less than 30 per cent;

2. Where there is no surviving spouse eligible for monthly payments under this section, and the:

   i. Dependent is a child**,** a monthly payment of a sum equal to 40 percent of the total monthly rate of compensation under this Act that would have been payable if the deceased employee had, at the date of death, sustained a

permanent total disability,

ii. Dependents are 2 children, a monthly payment of a sum equal to 60 per cent of the monthly rate or compensation under this Act that would have been payable if the deceased employee had, at the date of death, sustained a permanent total disability, or

iii. Dependents are 3 or more children, a monthly payment of a sum equal to 80 per centof the total monthly rate of compensation under this act that would have been payable if the deceased had, at the date of death, sustained a permanent total disability.

3. Monthly payments to eligible children under this Act shall be made to children up to theage of 21 or until they complete undergraduate studies, whichever comes first.
4. Where the surviving child is disabled, the Board shall determine the period of the monthly payment for such time as the board believes that the disabled child would not have been dependent on the deceased employee.
5. Where the deceased employee does not leave a dependent spouse or child entitled to compensation under this section, but leaves other dependents or next of kin who were wholly dependent on him or her, the board shall determine a sum reasonable and proportionate to the pecuniary loss suffered by such dependents or next of kin by reason of death of the employee.
6. Where
   i. No compensation is payable under subsection (1) (*a*)-(*e*) of thissection; or
   ii. The compensation is payable only to a spouse, a child or children or a parent or parents; but the employee leaves a spouse, child or parent who, though not dependent on theremuneration of the employee at the time of the death of the employee, had a reasonableexpectation of pecuniary benefit from the continuation of the life of the employee, the Board shall make monthly payment of an amount to be determined by the Board to suchspouse, child or children, parent or parents; and

7. Where the employee leaves no dependent widow or widower, or the widow or widower subsequently dies, and the Board considers it desirable to continue the existing household, and when a suitable person acts as a foster parent or an administrator of the estate of the deceased employee in keeping up the household and taking care of and maintaining the children entitled to compensation, in a manner satisfactory to the Board, the same allowance shall be payable to the foster parent or administrator and on behalf of the children as would have been payable to a widow or widower and children, and shall be continued as long as those conditions continue.
8. Where a disabled spouse ceases to be disabled, or a widow or widower with dependent children no longer has dependent children or there is a reduction in the number of dependent children, the spouse, widow, widower or children shall be entitled to the same category of benefits as would have been payable if the death of the employee had occurred on the date the disabled spouse ceases to be disabled or the widow or widower no longer has dependent children or the number of dependent children is reduced, as the case may be.
9. Where there is a widow or widower and a child or children, and the widow or widower subsequently dies, the allowances to the children shall, if they are in other respects eligible, continue and be calculated in the same manner as if the employee had died leaving no dependent spouse.
10. Where at the date of death a spouse is not disabled, but is suffering from a disability that results in a substantial impairment of work ability and earning capacity, the Board may, having regard to the degree of disability or the extent of impairment of work ability or earning capacity, pay the spouse a proportion of the compensation that would have been payable if the spouse had been disabled.
11. For the purpose of this Act, where 2 employees in a workplace are married to each other and both are contributing to the support of a common household, each is deemed to be a dependent of the other.
12. Where 2 parents contribute to the support of a common household in which their children also reside, the children are deemed to be dependents of the parent whose death is compensable under this Act.
13. Where compensation is payable as the result of the death of an employee, or of injury

resulting in death, and where at the date of death the employee and dependent spouse were living separate and apart and there was in force at the date of death a court order or separation agreement providing periodic payments for support of the dependent spouse or children living with that spouse, no compensation under sub-section (1) of this section shall be payable to the spouse or children living with the spouse, but monthlypayments shall be made in respect of that spouse and those children equal to the periodic payments due under the order or agreement ; or no court order or separation agreement in force at the date of death providing periodic payments for support of the dependent spouse, or children living with that spouse, and the employee and dependent spouse were

i. living separate and apart for a period of less than 3 months preceding the date of death of the employee, compensation shall be payable in accordance with the provisions of sub-section (1) of this section, or
ii. separated with the intention of living separate and apart for a period of 3 months or longer preceding the death of the employee, monthly payments shall be made up to the level of support which the Board believes the spouse and those children would have been likely to receive from the employee if the death had not occurred.

14. The compensation payable under sub-section (7) of this section shall not exceed the compensation that would have been payable under sub-section 1 of this section had there been no separation.
15. Where an employee has lived with and contributed to the support and maintenance of a wife or husband and the employee and the wife or husband have no children, for a period of 3 years; or children, for a period of one year, immediately preceding the death of the employee, and where the employee does not leave a dependent widow or widower, the Board may pay the compensation to which a dependent widow or widower would have been entitled under this Act to the wife or husband.
16. Where an employee has lived with and contributed to the support and maintenance of a wife or husband for the period set out in sub-section (9) of this section ; an employee also left, surviving, a dependent widow or widower from whom, at the date of death,

the employee was living separate and apart ; and there is a difference in the amount of compensation payable to the widow or widower by reason of the separation and the amount of compensation that would have been payable to that spouse if that spouse and the employee had not been living separate and apart, the Board may pay compensation to the wife or husband up to the amount of the difference.

17. Where in any situation there is a need to apportion allowances payable to dependents among those dependents, the formula for apportionment shall be determined by the Board, unless the Board has grounds for a different apportionment, the sharing formula shall be where there is a dependent spouse and one child, two-thirds to the dependent spouse and one-third to the child ; is a dependent spouse and more than one child, half to the dependent spouse and half among the children in equal shares; and are children but no dependent spouse, among the children in equal shares.
18. If a dependent is entitled to receive compensation as a result of the death of an employee; and subsequent death of another employee, the total compensation payable for the dependant as a result of those deaths shall be an amount that the Board has reasonable grounds to believe is appropriate, provided that the compensation payable to a dependant shall not be less than the highest of the amounts that would otherwise be payable in respect of the death of any of the employees; and more than 90 per cent of the average remuneration of an employee.
19. Where a situation arises that is not expressly covered by this section, or where some special additional facts are present that would, in the opinion of the Board, make the strict application of this section inappropriate, the Board may make rules and take decisions it considers fair in the circumstances.

This piece of legislation is credited with the following features:

i. Comprehensive provisions for compensation to employees or their estates for death, injury, illness or any disability arising out of or in the course of employment;
ii. A very open and fair system of guaranteed and adequate compensation for all employees or their dependents for any death, injury, disease or disability of any kind arising out of or in the course of employment;
iii. A solvent compensation fund which will be managed in the interest of the employees

and employers;

iv. Provision for rehabilitation of employees affected by work -related disabilities including mental illnesses;

v. A fair, equitable and adequate assessment in terms of contribution to the fund by the employers and compensation from the same fund due to injured employees;

vi. Establishment of an appeal procedure which is simple, fair and accessible to both employers and employees;

vii. With the exception of members of the Armed Forces (not engaged in civilian capacity) it is applicable to all employees in both the public and private sectors whether permanent, temporary or casual including privately engaged domestic hands;

viii. There are statutory procedures by employers for reporting and making claims in respect of work place incidents resulting in death, injury, disability and illness. Failure to comply is an offence which attracts a penalty;

ix. Clearly stated procedures for paying compensation to any employee in respect of any injury, disease or death arising in the course of employment. Failure to comply might lead to forfeiture of benefits;

x. Making the Nigerian Social Insurance Trust Fund (NSITF) regulator on all matters pertaining to Employee Compensation due to accident resulting in to death, disability, injury or disease while in the course of employment. And the National Industrial Court the court where employees can launch their appeal if need be.

xi. Prohibition of any employee from waiving his compensation or any employer to make mandatory contributions to the Nigerian Social Insurance Trust Fund. Any infringement attracts criminal conviction and fine.

xii. Unfettered discretionary powers of the Nigerian Social Insurance Trust Fund Board in respect of accepting and assessing compliance with procedures for making compensation to injured employees or their estates;

xiii. Unfettered discretionary powers of the Nigerian Social Insurance Trust Fund Board in respect of accepting and assessing compliance by employers with procedures for reporting and making claims;

xiv. The enormous power of the Nigerian Social Insurance Trust Fund Board to increase the assessment of any employer to any percentage from the statutorily imposed one

per centum (1%) of the total annual payroll after the initial two years commencement of theact;

xv. Creation of statutory liability for every employer to make its contribution of one percent of payroll to the Fund even where the Nigerian Social Insurance Trust Fund Board has not raised any assessment;

xvi. Regarding an insolvent individual employer as a debtor to the Nigerian Social Insurance Trust Fund in respect of his contribution for a period of five years commencing from the end of the calendar year when the outstanding contribution was levied. This lien of the Board ranks far and above any other liens, charges or mortgages however created onthe employer's property;

xvii. Where the insolvent employer is a corporate body, unpaid contributions to the Nigerian Social Insurance Trust Fund is a lien on its property which includes the property of any director, manager, secretary or other officer of the organisation used in connection withits business;

xviii. Granting of power to any injured employee or the dependants (in case of death) to opt for litigation against the employer instead of compensation from the Fund. In this case negligence need to be proved against the employer;

xix. Where the accident resulting in to death, injury, disability or disease in the course of employment is caused by any other party apart from the employer, the employee is entitled to compensation from both the Nigerian Social Insurance Trust Fund and the negligent third party.

12.3.5 RECEIVING COMPENSATION UNDER THE EMPLOYEE'S COMPENSATION ACT

Every case of injury, disabling occupational disease or death shall be notified to theemployer within 14 days of the occurrence or receiving information of the occurrencestating:

i. The name of the employee,
ii. The time and place of occurrence, and
iii. In ordinary language, the nature and cause of the disease or injury, if known.

a. In the case of disabling occupational disease, the employer to be informed of the death or disability is the one who last employed the workman in the employment

to the nature of which the disease was due;(employee, on the request of the employer, and if fit to do so, provide to the employer particularsof the injury or occupational disease on a form prescribed by the Board and supplied to the employee or dependents of the employee;

b. Failure to comply with sub-section (1) means forfeiture of benefits or compensation under the Act, except the Board is satisfied that:

   i. Information, although imperfect in some respects, is sufficient to describe the disease or injury suffered;
   ii. Employer or its representative has no knowledge of it; or
   iii. Employer has not been prejudiced and the Board considers that the interest of justice requires that the claim be allowed.

a. Additionally, employers are to report to the Board and the nearest office of the National Council for Occupational Health in the state within 7 days of its occurrence, every injury to an employee that is or is claimed to be one arising out of and in the course of employment;
b. As well as report to the Board within seven days of receiving information about every disabling occupational disease or claim for or allegation of an occupational disease; and death of an employee arising out of and in the course of employment to the Board and its local representative;
c. The report on injury, occupational disabling disease and death must be in the form and manner prescribed by the Board stating:

   i. Name and address of employer;

   ii. Time and place of the disease, injury or death;

   iii. Nature of injury or alleged injury

   iv. Name and address of any specialist or accredited medical practitioner who attendedto the employee; and any other particular required by the Board under this Act or any regulation made under it. Report may be made by mailing the

copies of the form addressed to the Board at the address prescribed by it. And Failure to make a report as required under this section, unless allowed by the Board on the ground that the report for some sufficient reason could not have been made constitutes an offence under this Act.

The Board may by regulation, define and prescribe category of minor injuries not to be reported under this section. The Board, prior to the settlement of any claim, shall verify if the injury or disease for which a claim had been reported to the National Council for Occupational Safety and Health Office in the state where the accident or disease occurred are as required by theOccupational Safety and Health Act 2005.

The Board may also make rules of procedures for making claims for compensation under thisAct, and these are:

a. The application for compensation (different from reporting) shall be made on the form prescribed by the Board and shall be signed by the employee or the deceased employee's dependent;
b. Application not filed or determined within one year after date of death, injury or disability arising from an occupational accident or disease shall not attract any compensation;

c The Board, if satisfied about the existence of special circumstances concerning application for compensation, may pay the compensation if the application is made within three years;

d Compensation made shall only be for the period commencing on the date the Board received application for compensation

e The time limits of 1 and 3 years are not applicable to compensation for an occupational disease under this act if the application is re-filed and sufficient or scientific evidence was not available on those dates for the Board to recognize the disease as an occupational disease and this evidence became available at a later date.

12.3.6 POWERS TO RECOVER FROM ANOTHER PARTY THAT IS RESPONSIBLE FOR THE DEATH OR INJURY OF THE EMPLOYEE

The Board is at liberty to subrogate to the rights of an employee against any party liable for injury to a workman:

i. Employer of an injured or deceased employee is at liberty to maintain an action upon contract or indemnity agreement against another employer or independent contractor in respect of personal injury or death of an employee.
ii. Where the Board has the opinion that another employer or independent contractor caused the injury or death of another employer's worker, it may order that the compensation be charged in whole or in part to the negligent employer or independent contractor.

12.4 THE NATIONAL HEALTH INSURANCE SCHEME (NHIS)

This is a form of social security system with the aim of providing good and adequate health services to Nigerians based on the payment of small contributions in advance to selected or nominated health services providers on a regular basis. The scheme was established by the National Health Insurance Scheme Act of 1999 which states the benefits; sets out the general rules; and specifies the guidelines for its operations.

12.4.1 PARTICIPANTS

These are:

i. Government as the regulator through the NHIS determines the standard and guidelines aimed at protecting the rights of the contributors as well as enforcing the obligations of all thestakeholders;
ii. Employees in both the private and public sectors who must contribute 5% of their basic salary monthly to the scheme;
iii. Employers in both private and public sectors with at least 10 employees who must pay 10% of the employees' monthly basic salaries; while the employee

will contribute 5% of their monthly basic salary to enjoy health benefits.

iv. Health Maintenance Organizations (HMO) which are limited liability companies formed byprivate or public establishments or individuals solely for participating in the NHIS as regards contributors in the Formal Sector Social Health Insurance Programmed.

v. Health Care Providers – These are licensed government or private health care practitioners or facility (including in-house health facilities of employers) registered under the scheme for the provision of prescribed health benefits to the contributors and their dependents. Health care providers are categorized in to two as follows:

   1. Primary Health Care Providers who will serve as the first contact in the system. These are mainly private clinics/ hospitals, primary health care centres, nursing/maternity homes, outpatient departments of the Armed Forces/Police/other uniformed services, University medical centres and Federal Staff clinics.
   2. Secondary/Tertiary Health Care Providers which are for referral cases. These include general hospitals, pharmacies, laboratories, dental Clinics, physiotherapy clinics, and radiography clinicsetc.
   3. Other Contributors include the self-employed, retirees, any child over the age of 18 years and extra-dependents of family already covered by the scheme.

12.4.2 PROGRAMMES

These are designed to cover various segments of the society and are mainly:

i. Formal Sector Social Insurance Programme;
ii. Urban Self-Employed Social Health Insurance;
iii. Rural Community Social Health Insurance;
iv. Children under Five Social Health Insurance;
v. Permanently Disabled Persons Social Health Insurance;
vi. Prison Inmates Social Health Insurance;

vii. Tertiary Institutions and Voluntary Participants Social Health Insurance;
viii. Armed Forces, Police and Uniformed Services Social Health Insurance;
ix. Diaspora Family and Friends;
x. International Travel Health Insurance

12.4.3 BENEFITS

i. Outpatient care including consumables and prescribed drugs (as contained in the EssentialDrugs List)
ii. Antenatal Care;
iii. Maternity Care for up to four (4) live births for every insured person;
iv. Post- Natal Care;
v. Routine immunization as contained in the National Programme on Immunization;
vi. Family Planning;
vii. Consultations with a defined range of specialists i.e., surgeons, physicians etc;
viii. Care in a public or private hospital in a standard ward for a specified duration in respect ofphysical or mental disorders;
ix. Eye examination and care but excluding prescription glasses/spectacles and contact lenses;
x. Dental care.

12.4.4 METHOD OF OPERATION

i. Employer to register itself and the employees under the scheme;
ii. Employer to choose a National Health insurance Scheme -approved Health Maintenance Organisation that will provide a list of National Health Insurance Scheme approved Health Care Providers in order to make choices;
iii. Employees to be registered by National Health Insurance Scheme/Health Maintenance Organisation and issued with personal identification number (PIN) as a contributor within 30 days. However, only the contributor, the spouse and four biological children are covered. If the contributor is single, the relations cannot benefit from the scheme;

iv. When sick the contributor presents the card to the chosen Primary Health Care provider for treatment. All diseases are covered except AIDS;
v. Contributor may change primary health care provider after three months if not satisfied with the quality of services being rendered. In this case the Health Maintenance Organisation must be contacted;
vi. Health Maintenance Organisation will make payment for services to health care provider for services rendered to a contributor. There is no limit to the medical bills that National Health Insurance Scheme will pay as long as the treatment is within the provisions of the benefit package. Payment to Primary Health Care provider is by capitation i.e., a certain amount is paid monthly in advance whether the services are utilized or not.

12.4.5 NHIS Voluntary Contributors' Scheme

This is designed for:

i. Employers with less than ten (10) employees;
ii. Interested individuals;
iii. Interested families;
iv. Actively self-employed persons;
v. Retirees not currently covered by any of the NHIS prepaid programmes;
vi. Political office holders;
vii. Foreigners to Nigeria or persons with temporary residency status;
viii. Nigerians in diaspora
ix. Those not currently covered by any NHIS programmes but wish to enjoy the FormalSector benefit package.

The benefit package comprises:

i. Outpatient care including necessary consumables;
ii. Prescribed drugs, pharmaceutical care and diagnostics tests as contained in the NationalEssential Drugs List and Diagnostics Test List;
iii. Maternity care and delivery;

iv. Preventive care including immunization;
v. Consultation with specialists;
vi. Hospital care in a standard ward for a stay limited to cumulative 15 days per year;
vii. Eye examination and care excluding provision of spectacles and contact lenses;
viii. Provision of prostheses i.e., Nigerian produced artificial limbs;
ix. Preventive dental care and pain relief (including consultation, amalgam filling andsimple extraction.

12.5 OTHER SOCIAL INSURANCE PROVISION IN NIGERIA

12.5.1 MOTOR THIRD PARTY LIABILITY

a. The Motor Vehicle (Third Party) Insurance Ordinance 1946 makes itunlawful for any person to drive or permit another person to drive a vehicle on the public road without any form of insurance cover on it. The minimum requirement is that the insurance should cover the vehicle owneragainst liability for death and bodily injury caused to third parties while using the vehicle. This is a piece of legislation meant to enhance social welfare of Nigerians by compelling insurance companies to provide financial succor to victims of automobile accidents and their dependents. Even where there are breaches of policy conditions by vehicle owners, insurance companies are under legal obligation to compensate victims of road accidents and thereafter seek reimbursement from their policyholders.
b. The Insurance Act 2003, makes it is compulsory for every motor vehicle to have insurance cover for a minimum of ₦1m (One Million Naira) only against any damage to property of any person apart from the vehicle owner and/or the driver. This sum has been reviewed to N 3,000,000 for private vehicles, N 5,000,000 for commercial vehicles, N 2,000,000 for tricycles and N 1,000,000 for motorcycle riders as from 1st January, 2023.
c. In order to take care of victims that are permanently disabled or killed by uninsured or unidentified drivers, the Act has also compelled the setting up of ‘‘The Security and Development’’ fund by the insurance industry. Thefund is to be managed by the National Insurance Commission of Nigeria (NAICOM).
d. The benefits provided for by the motor third party insurance policy for bodily injury

and disability is an unlimited amount; this also goes for death. The amount payable can be determined by a court of law or and out of court settlement.

e. Additional benefits such as claim for loss of use of damaged vehicle used for business and the cost of towing and medical expenses are also providedfor.

12.5.2 Victims of Collapsed Structures

The Insurance Act 2003 has also provided that compensation is paid to victims ofcollapsed building whether completed or not. This is a form of social insurance for victims of such circumstances. It further made it compulsory for owners of buildings or structures under construction (with more than two floors) to effect an insurance policy against liability arising from the:

i. Death of any employee, workman or member of the public;
ii. Damage to the property of any employee, workman or member of the public, due to construction risks of every description at the size of the project. This also applies for owners of completed and inhabited buildings, schools, churches, offices etc. to have in place an insurance policy against any liability due to:

a. Death or injury to any person who is not residing within the premises;
b. Damage, loss or destruction of property belonging to third parties or members of the publicresulting from the following perils to the building:

- Collapse
- Fire
- Earthquake
- Storm
- Flood

Benefits provided for by this policy include:

A. Non- pay roll site workers or members of the public

a. Death ₦2, 000,000
b. Permanent disability ₦2, 000,000

c. Other level of injury depending on level of disability a % of ₦2, 000,000
d. Medical expenses (local maximum) ₦2, 000,00
e. Medical expenses (foreign maximum) ₦5, 000,000

B. property damage

a. site worker,3rd party or surrounding properties
₦50,000,000maximum in total legal cost and expenses
b. reimbursement for defense cost to the contractor in case the matter goes to court ₦1, 000,000

Note: the building contractor pays the premium.

12.5.3 VICTIMS OF MEDICAL PROFESSIONAL NEGLIGENCE

The National Health Insurance Scheme (NHIS) 1999 stipulates that medical professional (medical centers, instructors etc.) running and managing Health Management Organisations (HMO) must have Professional Indemnity cover against:

Negligence: failure of practitioner to exercise the required standard of care for the protection of the patient;

i. Errors i.e., healthcare intervention not carried out as they ought to have been;
ii. Mistakes i.e., errors in judgment or the misunderstanding of a diagnosis;
iii. Omissions i.e., oversight in the clinical management of a patient.

This is to further protect the public from damage that may be caused to them by the activitiesof these medical professionals. The amounts of benefit payable by this policy by an injured patient are:

a. Death ₦2, 000,000
b. Permanent disability ₦2, 000,000
c. Other level of injury depending on level of disability a % of ₦2, 000,000
d. Medical expenses (local maximum) ₦2, 000,000
e. Medical expenses (foreign maximum) ₦5, 000,000

Note: the hospital pays the premium

12.5.4 VICTIMS OF PLANE CRASHES

It is compulsory to have in place an insurance policy for every type of non-militaryplane before it can be permitted to be airborne. In respect of the death of passengers there is a strict liability (i.e., negligence on the part of the airline owner or operator, airport owner, plane manufacturer, aircrew etc. need not to be proved) for a minimum of the equivalent of $100,000.00 (One Hundred Thousand United States of America Dollars per seat in case of air crash. There is no financial limit in case of permanent or partial disablement and medical expenses to passengers due to the air crash. All these direct compensations are without prejudice to the rights of the dependants ofthe deceased or the injured passengers to approach the courts for additional compensation where negligence is established against the airline, its crew members, the airport operator, the manufacturer or any other third party.

12.5.5 Work-Related Disabilities

The Employees Compensation Act 2010 is very elaborate in its attempts to provide for the social welfare and rehabilitation of employees who get disabled while in the courseof employment. The scales of benefits include:

i. The payment of compensation and rehabilitation of employees suffering mental stress that is not due to visible, external and violent means;
ii. The payment of compensation in respect of hearing impairment;
iii. The provision of monthly compensation for a very long time to the dependants of employees after his death in the course of employment;
iv. The provision of healthcare such as medical, surgical, hospital, nursing, crutches, apparatus etc. should be provided in case of disability.

SUMMARY

Social security schemes are put in place by countries to cater for citizens who cannotpay for the cost of insurance because of their financial state. The cost associated with this scheme is paid for by the country's annual budget. However, in contrast, social insurance scheme is to be paid for by the individual, their employer or other organizations. This chapter explained and establishes the availability of these schemes.

REVIEW QUESTIONS

1. As part of government efforts to encourage citizens to be part financiers for the costs that are associated with their health care, the National Health Insurance Scheme (NHIS) Act 1999 was promulgated. Explain five categories of persons for whom the voluntary NHIS contributors' scheme is designed for.

2 (a) Explain the concept of Social Insurance Scheme

(b) Explain 5 types social insurance scheme legislation that have being undertaken to improve the welfare of citizens in Nigeria

3. The tripartite agreement between employers (NECA), Labour (NLC and TUC) and the government in Nigeria led to the enactment of the Employee Compensation Act 2010 tofurther improve the welfare of employees. Explain five benefits that are provided by thisAct.

4. The following is the total remuneration of an employee as captured in the accountsdepartment:

Basic	₦10, 000,000
Housing	₦5, 000,000
Transport	₦2, 000,000
Ward robe allowances	₦1, 500,000
Medicals	₦1, 000,000
Conferences	₦3, 500,000
Utilities	₦500, 000
Bonus	₦2, 000,000
Entertainment allowance	₦2, 000,000

Calculate the amount that the employer will contribute under the employeecompensation act to Nigerian social insurance trust fund.

5. Case Study: Nigeria, like many countries, faces various social and economic challenges. As a policy advisor, you have been tasked with analyzing the concept of social insurance in Nigeria and proposing recommendations for improving the social insurance system. Examine the existing social insurance landscape and provide recommendations for its enhancement.

a) Begin by providing an overview of social insurance and its significance in a developing country like Nigeria. Explain the fundamental principles of social insurance, including risk pooling and income redistribution.

b) Analyze the existing social insurance programs in Nigeria, such as the National Health Insurance Scheme (NHIS) and the Pension Reform Act (2014). Assess the coverage, effectiveness, and challenges of these programs.

c) Identify and discuss the key challenges and limitations of the current social insurance system in Nigeria. Consider issues related to coverage gaps, funding constraints, administrative efficiency, and the quality of services provided.

d) Examine Nigeria's population demographics and their implications for social insurance. Discuss the aging population, urbanization trends, and the impact of demographic shifts on the demand for social insurance services.

e) Propose strategies for expanding the coverage of social insurance programs to reach a larger portion of the population, especially vulnerable groups such as informal sector workers and rural communities.

f) Discuss options for sustainable funding mechanisms for social insurance programs. Explore possibilities for public-private partnerships, innovative financing models, and ways to reduce the financial burden on the government.

g) Address the quality of services provided under social insurance programs, particularly in healthcare and pensions. Recommend measures to enhance the accessibility, affordability, and effectiveness of services.

h) Analyze the regulatory framework governing social insurance in Nigeria. Discuss the role of regulatory bodies, such as the National Insurance Commission (NAICOM), and propose improvements to ensure transparency and accountability.

i) Emphasize the importance of public awareness and education about social insurance. Recommend strategies for improving awareness among the Nigerian population and educating them about the benefits and procedures of social insurance.

j) Emphasize the importance of public awareness and education about social insurance. Recommend strategies for improving awareness among the Nigerian population and educating them about the benefits and procedures of social insurance.

k) Highlight the need to ensure the long-term sustainability of social insurance programs. Discuss strategies for managing risks, adapting to changing circumstances, and achieving financial stability.

l) Draw upon international best practices in social insurance to provide insights and benchmarks for Nigeria's reform efforts.

m) Based on your analysis, propose a set of comprehensive recommendations for enhancing the social insurance system in Nigeria. Prioritize actionable steps and policy changes that can lead to improvements in coverage, effectiveness, and sustainability.

In your response, consider the unique socio-economic context of Nigeria and the importance of social insurance in addressing the country's development challenges. Emphasize the potential positive impact of an improved social insurance system on poverty reduction, healthcare access, and retirement security.

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ASSESSMENT QUESTIONS

1. A number of claim requests have been received by some insurance firms in Nigeria. This is connected to the recent fire incident at the popular Balogun Market in Lagos which resulted to loss of many lives and damage to properties worth billions of Naira. In insurance, the specific term that can be used to describe a loss event of this nature is:
    A. Total Loss
    B. Catastrophic Loss
    C. Pool of Loss
    D. Excess of Loss

2. The Management of Star Investment Ltd has observed a continuous decline in profit over the last three years. Investigation revealed that two senior employees in the accounting section have been committing fraudulent activities and they were immediately replaced by the Management. In order to control the effect of similar occurrence in future, advice the Management of Star Investment Ltd on the policy they should buy from the ones listed below:
    A. Fidelity Guarantee Insurance
    B. Money Insurance
    C. Fraud Insurance
    D. Theft Insurance

    (Use the following Short Case to answer Questions 3 to 4)
    Staysafe Insurance PLC. has agreed to grant insurance coverage to one of the biggest Construction firms in Nigeria. Considering the size of the risk, with the sum insured valued at 5.34 Million Naira, Staysafe Insurance PLC then approached Asorock Insurance Ltd. to cover 35% of the risk.

3. The term that best describes the above scenario is:
    A. Risk Retention
    B. Risk Pooling
    C. Coinsurance
    D. Reinsurance

4. Determine the amount of premium that will be retained by Staysafe Insurance PLC:
    A. ₦5,304,000
    B. ₦3,471,000
    C. ₦3,470,000
    D. ₦1,869,000

5. The Insurance policy required by the Pension Reform Act 2014 to be obtained by all Employers of Labour is:
    A. Group Life Insurance
    B. Employees Compensation Insurance

C. Employers Liability Insurance
D. Retirement Benefit Insurance

(Use the following Short Case to answer Questions 6 to 8)

In November last year, Mr Hassan ignorantly insured his newly built duplex with three different insurance companies. He purchased a policy to cover against Fire, Flood and Storm from Forefront Insurance Company at a sum insured of 1.327 Million Naira. Mr Hassan insured the building against Flood, Explosion and Burglary with Topmost Insurance Company and gave 1.369 Million Naira as the sum insured. He also insured the building with Giant Insurance Company against Storm, Burglary and Fire at a sum insured of 1.341 Million Naira. There was a heavy rainfall on June 8th of the current year. The windstorm that precedes the heavy rain blew off the roof of Mr Hassan's house and further caused damage to a section of the wall. The value of the loss is put at 0.870 million Naira.

6. Which among the insurers are liable to pay the claim?
   A. Forefront and Topmost Insurance Companies
   B. Topmost and Giant Insurance Companies
   C. Forefront and Giant Insurance Companies
   D. Forefront, Topmost and Giant Insurance Companies

7. Calculate the amount of claim that should be contributed by Giant Insurance Company:
   A. ₦437,717
   B. ₦437,283
   C. ₦288,994
   D. ₦285,977

8. Determine the contribution of Topmost Insurance Company to the total claim amount:
   A. ₦295,028
   B. ₦288,994
   C. ₦285,977
   D. None of the Options

9. Alhaji Danpsawa is an oil magnate in Nigeria but he is currently proposing to diversify into the insurance industry. As his consultant, tell him the minimum capital he is required to deposit with the Central Bank of Nigeria before the Regulator will approve his application for the establishment of a Non-Life Insurance company:
   A. ₦10 Billion
   B. ₦5 Billion
   C. ₦3 Billion
   D. ₦2 Billion

(Use the following Short Case to answer Questions 10 to 11)
Sweet life Assurance Ltd offered a Credit Bond Insurance cover to Late Mr Azubike who had obtained a loan of 12.5 Million Naira from All Purpose Financial Services. The loan was to be paid in 10 instalments over a period of 30 months. Before his death, Mr Azubike faithfully serviced the loan for one year and six months.

10. Mention the nature of relationship that All Purpose Financial Services has with Sweet Life Assurance Ltd:
    A. Creditor
    B. Insured
    C. Surety
    D. Third Party

11. Determine the actual liability of Sweet life Assurance Ltd:
    A. ₦12,500,000
    B. ₦1,250,000
    C. ₦5,000,000
    D. ₦416,667

12. If a franchise of ₦200 is placed on a policy and a loss valued at ₦500 occurred. How much will the insurer pay for the loss?
    A. ₦500
    B. ₦300
    C. ₦200
    D. None of the Options

(Use the following Short Case to answer Questions 13 to 15)
When completing the Proposal Form for his Comprehensive Motor Insurance Policy, Mr Idowu included his name as the only driver of the car. At the time of obtaining the policy, his son Bola, was three months away from his 18th birthday. On attaining 18 years of age, Mr Idowu in compliance with Nigerian law about age of persons allowed to drive, granted Bola the permission to drive his car.

13. What fundamental wrong do you think Mr Idowu committed which may not enable him to recover under the policy?
    A. Bola did not attend driving school
    B. Bola is not included in the policy as a driver of the vehicle
    C. Bola is not included as a party to the insurance contract
    D. Bola did not have insurable interest in the vehicle

14. As an expert, your advice to Mr Idowu would have been to:
    A. purchase another policy in Bola's name.

B. obtain driver's licence for Bola.
C. include Bola as a policyholder in the contract.
D. notify the insurer of his intention to allow Bola to drive the car.

15. In insurance practice, the basic requirement that underscores the above scenario is:
    A. Representation
    B. Need for Capacity
    C. Duty of Disclosure
    D. Legal requirement

(Use the following Short Case to answer Questions 16 to 18)

Emeka a business man who deals in importation of motor vehicle parts is presently expecting some goods worth 7.4 Million Naira from Germany. The goods are adequately insured by Rogson Insurance PLC. Prior to the arrival of the goods, there is an urgent need of capital for Emeka to embark on another business trip. Hence, Emeka transfer ownership of the goods to Chinedu who indicated his interest and make the necessary payments immediately. One week to the arrival of the goods, the vessel conveying the goods sinks resulting to a total destruction of the goods.

16. The principle of insurance that is most relevant to the above case is:
    A. Indemnity
    B. Utmost Good Faith
    C. Proximate Cause
    D. Insurable Interest

17. In your opinion liability for loss of the goods should be borne by:
    A. Chinedu
    B. Emeka
    C. Rogson Insurance
    D. None of the Options

18. The specific insurance policy purchased by Emeka from Rogson Insurance PLC is:
    A. Marine Goods Insurance
    B. Marine Hull Insurance
    C. Marine Cargo Insurance
    D. Marine Freight Insurance

19. Agricultural insurance falls under one of the following classifications:
    A. Property Insurance
    B. Miscellaneous Insurance
    C. Engineering Insurance
    D. Special Peril Insurance

20. Indemnity for a loss covered by property insurance policy personally arranged by an employee and also the liability insurance policy of the employer will be paid in:
    A. full value of the loss
    B. half the value of the loss
    C. partial Value of the loss
    D. no value of the loss

21. Parties to an insurance contract are obliged to disclose material facts. How would you verify the materiality of information submitted to an insurer?
    A. Information that can increase the chance of loss occurrence.
    B. Information that can increase the cost of insurer's business.
    C. Information that can influence the decision to accept a risk.
    D. Information that can make the proposer to change his decision.

22. Mr Bamidele purchased a fire insurance policy from Golden Gate insurance company to cover his residential apartment. In order to have his premium reduced, Mr Bamidele promised the underwriter to put automatic water sprinkler, fire alarm and fire extinguisher in place. What information would you use to describe Mr Bamidele's undertaking?
    A. Mr Bamidele agrees to a guaranty.
    B. Mr Bamidele has made a warranty.
    C. Mr Bamidele accepts to take excess.
    D. Mr Bamidele accepts to take franchise.

23. A storm blew down the wall of a timber building which, when it fell, broke electrical wiring. The broken wiring short-circuited and caused a fire in the timber building. The fire fighters were called and the water they used to put out the fire caused damage to the unburnt contents of the timber building. What in your opinion is the proximate cause of the water damage to the unburnt contents of the timber building?
    A. Broken Electrical Wiring
    B. Fire
    C. Storm
    D. Water used by Fire Fighters

24. There are many associations of practitioners operating in the Nigerian insurance market. With respect to this, which option is odd among the following?
    A. ARIAN
    B. CIIN
    C. ILAN
    D. NCRIB

25. What information would you use to determine the acceptability of a warehouse for a fire insurance policy?

A. Nature of ownership of the warehouse.
B. Owner of the items in the warehouse.
C. Size of the items in the warehouse.
D. Types of items in the warehouse.

26. One of the production plants of Igbinoba Confectionaries Limited has stopped working suddenly. As a result, production could not continue and hence, the company has started to record financial loss due to their inability to meet up with market demand. In order to forestall similar experience in future, you have been consulted to guide the company on the relevant insurance policy required to cover this kind of circumstance. Which policy would you suggest to them?
    A. Business continuation insurance policy.
    B. Business interruption insurance policy.
    C. Income recovery insurance policy.
    D. Plant breakdown insurance policy.

27. Brokage Nigerian Limited is a logistic company that takes the welfare of its employees very important. The company has put in place the group life insurance policy to provide benefits for the family deceased staff. Mr Duke, a staff of Brokage Nigerian Limited wishes to buy additional life insurance policy to complement his entitlement under the group life policy but he remains doubtful about the possibility to benefit from two different policies covering the same subject matter. What is your opinion about this?
    A. It will amount to an abuse of the principle of indemnity if Mr Duke is permitted to benefit under the two policies. Therefore, Mr Duke should not buy additional life insurance policy.
    B. Mr Duke may not be able to recover under the two policies because indemnity does not apply to life insurance policies. Therefore, he should not buy additional life insurance policy.
    C. Since the benefits under any of the two policies will be enjoyed by the dependants and not Mr Duke himself, it will be a waste of fund to purchase additional life insurance policy.
    D. Since there is no limit to the value one can place on his own life, Mr Duke has a right to buy additional life insurance policy and he will be entitled to benefits under the two policies.

28. One of your colleagues who is preparing for retirement has approached you to suggest a policy of insurance that he can purchase to take care of the cost of any physical or mental incapacitation as a result of old age. Which policy will you suggest to him?
    A. Long term care insurance.
    B. Old age weakness insurance.
    C. Personal accident insurance.
    D. Retirement benefits insurance.

29. In line with the provisions of the pension reform act 2014, what constitute the total annual emolument in an employee's income structure?
    A. Addition of the basic salary, housing allowance and medical allowance for a period of twelve months.

B. Addition of the basic salary, housing allowance and rent allowance for a period of twelve months.
C. Addition of the basic salary, housing allowance and transport allowance for a period of twelve months.
D. Addition of the basic salary, transport allowance and medical allowance for a period of twelve months.

30. The pension reform act 2014 provides that monthly contribution should be made to the retirement savings account of all employees. What percentage of an employee's monthly emolument should the employer contribute?
    A. Eight percent
    B. Eighteen percent
    C. Seven and a half percent
    D. Ten percent

31. Given that the pay slip of Mr Kuku shows thus; basic salary - ₦125,000; housing allowance - ₦70,000; transport allowance - ₦95,000 and medical allowance - ₦12,500. What do you think his monthly contribution to his retirement savings account will be?
    A. ₦23,200
    B. ₦24,200
    C. ₦29,000
    D. ₦52,200

32. If a peril is the primary cause of loss, how then is loss connected to risk?
    A. Loss does not exist in the event of risk.
    B. Loss has no relationship with risk.
    C. Loss is a possible outcome of risk.
    D. Loss is the uncertainty of risk.

33. Pureinsure, a non-life insurance company has approached Global Strength insurance PLC to accept a portion of a risk and its corresponding premium. What can you infer from this move of Pureinsure?
    A. Pureinsure has accepted a risk that is beyond its capacity and choose to reinsure part of it with Global Strength insurance PLC.
    B. Pureinsure is a subsidiary of a conglomerate called Global Strength insurance PLC.
    C. Pureinsure is in a partnership business with Global Strength insurance PLC.
    D. Pureinsure plays the role of intermediary between policyholders and Global Strength insurance PLC.

34. How would you interpret *Consensus ad idem* as an element of insurance contract?
    A. Parties to an insurance contract must abide by the wordings of the contract.
    B. Parties to an insurance contract must be of the same mind.
    C. Parties to an insurance contract must have mutual trust.

D. Parties to an insurance contract must know each other.

35. If all the events leading to a loss are insured by a policy, how do you think the insurer should handle claim payment?
    A. The insurer should confirm the nature of the peril before requesting for claim.
    B. The insurer should determine the proximate cause before paying the claim.
    C. The insurer should pay the claim without trying to determine the proximate cause.
    D. The insurer should reject the payment of the claim and notify the insured.

36. With respect to subrogation, which among the following statements do you consider invalid?
    A. The insurer can pursue any rights or remedies which the insured may possess.
    B. The insurer can recoup any profit the insured might make from the insured event.
    C. The insurer will call on other equally liable insurers to contribute the claim.
    D. The insurer will take possession of everything recovered from a liable third party.

37. What idea mostly validates the role of NAICOM in the Nigerian insurance market?
    A. Creating better understanding of insurance.
    B. Creating insurance awareness through seminars, training and conferences.
    C. Determining the standard of knowledge and skill for insurance professionals.
    D. Regulates the activities of all insurance practitioners.

38. Benefits in terms of tax relief are usually given to employers or employees for purchasing some types of insurance policies and social insurance schemes. Which among the following does NOT grant tax relief to the employer?
    A. Contributions under employees' compensation scheme.
    B. Contributions under the pension reform scheme.
    C. Premium under individual life assurance.
    D. Premium under the occupational group life.

39. What technique would you apply to treat a risk that is characterised by high severity and low frequency?
    A. Avoidance
    B. Hedging
    C. Insurance
    D. Retention

40. How would you make an offer in a contract of insurance?
    A. By completing the proposal form.
    B. By paying the first premium.
    C. By submitting an application letter.
    D. By talking to an insurance agent.

41. Which of the following is NOT a way to demonstrate the existence of insurable interest in a property?
    A. As a party in a mortgage.
    B. To be indebted to a bank.
    C. To hold an estate in trust.
    D. To inherit landed property.

42. What method would you engage to indemnify the loss of a partly collapsed building?
    A. Reinstatement
    B. Repair
    C. Replacement
    D. Rebuild

43. What underwriting decision would you make in respect of a risk that appears attractive but fall below the insurer's underwriting standard?
    A. Accept the risk
    B. Charge premium
    C. Increase the cover
    D. Reject the risk

44. As a representative of a registered pension fund administrator, from who among the following will you accept the proposer to participate in the contributory pension scheme?
    A. Accountant General of the Federation.
    B. Chief press secretary, Nigerian Navy.
    C. Director of protocol of the DSS.
    D. General officer Commanding, Dodan Baracks.

45. Under which of the following class of insurance business will you categorise agricultural insurance?
    A. Engineering Insurance.
    B. Miscellaneous Insurance.
    C. Property Insurance.
    D. Special peril Insurance.

46. If a franchise of ₦200 is placed on a policy and a loss valued at ₦500 occurred. How much will the insurer pay for the loss?
    A. ₦500
    B. ₦300
    C. ₦200
    D. ₦100

47. How would you describe the insurance policy required by the Pension Reform Act 2014 to be obtained by all Employers of Labour?

A. Employees' compensation insurance.
B. Group life insurance.
C. Pension insurance.
D. Retirement benefit insurance.

48. How would you define longevity risk to a group of employees preparing for retirement?
    A. Possibility that a retiree will die early into his retirement.
    B. Possibility that a retiree will outlive his income and financial resources.
    C. Tendency that a person will die at a very old age.
    D. Tendency that a retiree will not exhaust his income before his death.

49. Chief Goriola and two of his partners are currently proposing to establish an insurance firm. As his consultant, tell him the minimum amount they are required to deposit with the Central Bank of Nigeria before the Regulator can approve their application to establish a Non-Life Insurance company:
    A. ₦10 Billion
    B. ₦5 Billion
    C. ₦3 Billion
    D. ₦2 Billion

50. Which one of the following is a feature of facultative reinsurance method?
    A. Claims payment is based on agreed proportion.
    B. Transfer and acceptance of risks is based on agreed level of loss.
    C. Transfer and acceptance of risks is based on agreed proportion.
    D. Transfer and acceptance of risks is not based on agreed proportion.

51. While entering into the premises of Edible Foods Nigeria Ltd to meet up with his appointment in the HR Department, Mr Raji a job seeker was hit and injured by a window pane that broke away from the top floor of the Gate House. The appropriate insurance policy that will provide compensation for loss of this nature is:
    A. Workmen Compensation
    B. Professional Indemnity
    C. Group Personal Accident
    D. Public Liability

52. A storm blew down the wall of a timber building which, when it fell, broke electrical wiring. The broken wiring short-circuited and caused a fire in the timber building. The fire fighters were called and the water they used to put out the fire caused damage to the unburnt contents of the timber building. In your opinion, the Proximate Cause of the water damage to the unburnt contents of the timber building is:
    A. Fire
    B. Storm

C. Broken Electrical Wiring
D. Water used by Fire Fighters

(Use the following Short Case to answer Questions 53 to 55)
A building located at the centre of a popular market in Lagos was engulfed by fire. The building housed the branch office of Hope Bank on its ground floor. The first and second floors were occupied by a big supermarket and an IT office respectively. Preliminary investigation reveals that the fire resulted from electrical fault in the IT office and spread to the generator house located in front of the building before finding its way into the banking hall.

53. Compensation for the loss suffered by Hope Bank should be paid by the insurer of:
    A. the IT office.
    B. the Bank.
    C. the Building.
    D. the Generator House.

54. The specific insurance term that can be used to describe the fire that caused the loss is:
    A. Risk
    B. Hazard
    C. Peril
    D. Damage

55. In insurance, the proximity of the generator house to the bank can be described as:
    A. Peril
    B. Hazard
    C. Severity
    D. Subject Matter

(Use the following Short Case to answer Questions 56 to 58)
Mrs Nwogu insured her business premise against fire for 5 million Naira with an excess of 23%. Unfortunately, there is a loss and the claims amount is put at 2.8 million Naira,

56. Determine the liability of the insurer:
    A. ₦5,000,000
    B. ₦2,800,000
    C. ₦1,650,000
    D. ₦1,150,000

57. Assuming the report of an independent Claim Adjuster shows that the value of the loss is ₦987,430, how much will the insurer pay as indemnity?
    A. ₦4,012,570
    B. ₦1,812,570

C. ₦987,430
D. None of the Options

58. Calculate the liability of the insurer if the Excess of 23% is replaced with a Franchise of 63%:
    A. ₦5,000,000
    B. ₦3,150,000
    C. ₦1,850,000
    D. ₦987,430

59. Mr Gbade has just received the policy document in respect of the Theft and Burglary Insurance policy he purchased from Strongforce Insurance Ltd. He has approached you as a professional to help him locate the section that contains the actual cover provided by the policy. Which section will you tell him?
    A. Recital Clause
    B. Preamble
    C. Operative Clause
    D. Conditions

(Use the following Short Case to answer Questions 10 to 11)
Mr Bala, who has a Motor Insurance policy, had sent his driver to deliver some items to his mother-in-law. On his way, the vehicle collided with a tree by the road side and subsequently fell into a ditch. Although the driver was brought out unharmed, the vehicle was declare a total loss.

60. The type of Motor Insurance policy that will guarantee the payment of claim to Mr Bala under this circumstance is:
    A. Comprehensive
    B. Third Party, Fire and Theft
    C. Third Party Liability Only
    D. Road Traffic Act Only

61. The appropriate method of indemnity for a loss of this nature is:
    A. Cash
    B. Repair
    C. Reinstatement
    D. Replacement

62. In its Reinsurance arrangement, an insurer has decided on a particular amount as its deductible and a treaty of two layers once the claim is more than the deductible. The name given to this type of Reinsurance plan is:
    A. Excess of Loss
    B. Surplus Treaty
    C. Quota Share
    D. Facultative

63. If a limit of ₦500,000 is placed on a policy covering Gold jewelleries and a loss valued at ₦225,000 occurred, the maximum liability of the insurer will be:
   A. ₦725,000
   B. ₦500,000
   C. ₦275,000
   D. ₦225,000

(Use the following Short Case to answer Questions 64 to 65)
Joseph is a 17 years old undergraduate and a proud winner of a latest version of Toyota Corolla saloon car at the national competition for best undergraduate Research in Engineering. The vehicle has all the latest safety features and a free Comprehensive Motor Insurance Policy for one year. All these increases the confidence of Joseph who often over speed anytime he drives his new car on the highway.

64. The type of hazard Joseph constitutes on the highway is:
   A. Physical Hazard
   B. Morale Hazard
   C. Legal Hazard
   D. Moral Hazard

65. In case of an accident, all except one among the following will not be entitled to claim from the insurer:
   A. Joseph
   B. Sponsor of the competition
   C. A third party
   D. All of the Options

66. All the following except one is not an example of Speculative Risk:
   A. Investing in Stocks
   B. Soccer Betting
   C. Bank Savings
   D. Establishing a Small-Scale Business

(Use the following Short Case to answer Questions 67 to 69)
Ade receives a total of 1.5 million Naira from his insurer through his broker as indemnity for the total loss he suffered following an accident caused by another motorist, Moses. Ade believes that the value of his car as at the time of the accident was higher and he therefore sues Moses. The judge ruled that Moses should pay 2 million Naira as damages.

67. In insurance, Moses can best be described as:
   A. a Policyholder.
   B. an Insured.

C. a Liable Party.
D. a Third Party.

68. In accordance with insurance practice, who is eligible to take the 2 Million Naira damages from Moses should be paid to:
    A. the Insurer.
    B. Ade.
    C. the broker.
    D. the Court.

69. The principle of insurance that best explains this scenario:
    A. Indemnity
    B. Subrogation
    C. Contribution
    D. Proximate Cause

70. The Duty of Disclosure as enshrined in the principle of Utmost Good Faith is required to be observed by:
    A. the Insurer.
    B. the Policy holder.
    C. both the Insured and the Insurer.
    D. the Insured.

ANSWERS TO GENERAL MULTIPLE-CHOICE QUESTIONS

1. B
2. A
3. D
4. B
5. A
6. C
7. B
8. D
9. C
10. D
11. C
12. A
13. B
14. D
15. C
16. D
17. A
18. C
19. B
20. A
21. C
22. B
23. C
24. B
25. D
26. B
27. D
28. A
29. C
30. D
31. A
32. C
33. A
34. B
35. C
36. C
37. D
38. C
39. C
40. A

41. B
42. A
43. D
44. A
45. B
46. A
47. B
48. B
49. C
50. D
51. D
52. B
53. A
54. C
55. B
56. C
57. D
58. B
59. C
60. A
61. D
62. A
63. D
64. B
65. A
66. C
67. D
68. A
69. B
70. C