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LIFE ASSURANCE LAW AND PRACTICE IN ZAMBIA
(PROBLEMS OF THE ZAMBIA STATE INSURANCE CORPORATION LIMITED)

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SUPERVISOR
LIFE ASSURANCE LAW AND PRACTICE IN ZAMBIA
(PROBLEMS OF THE ZAMBIA STATE INSURANCE CORPORATION LIMITED)

By

ASWELL NIKOKO CHISANGA

An Obligatory Essay submitted to the University of Zambia in partial fulfillment of the requirements for the degree of Bachelor of Laws.

The University of Zambia
School of Law
P.O. Box 32379,
LUSAKA.

JUNE, 1989
DEDICATION

This work is dedicated to my late son and daughter Chama Musonko Chisanga and Chibuta Temfwe Chisanga, respectively (MTSRIP) who never lived to understand how much I and their mother loved them.

Thanks to my Darling Wife, Florence Bwalya Chisanga for bearing the loss of our most loved ones bravely and for her love and understanding. My pursuit of academic advancement at UNZA robbed her of me at the time she would have loved to have me present.

I also wish to thank my father and mother, Mr. and Mrs. Joshua Bikoko Chibwe Chisanga and Elesina Kaputo Chisanga for their sacrifice in my education.

I am grateful to all my friends and relatives too numerous to mention for the encouragement, moral and material support given at all times. I wish you all God's blessings.
ACKNOWLEDGEMENTS

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I also thank Dr. J.M. Mulwila under whose supervision this work was undertaken for his guidance and encouragement.

I salute Management of the ZSIC Ltd for financial and material assistance during my period of research.

Lastly, I thank Staff at the ZSIC Ltd Life Office, Ndola, Officials in the National Archives of Zambia and Ministry of Commerce and Industry, Lusaka, for all the data supplied to me during my research.

Aswell Bikoko Chisanga

UNZA, LUSAKA

JUNE, 1989
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ABSTRACT

The purpose of this essay is to build and probably extend the layman's knowledge of the general theory and practice of insurance as specifically applied to life assurance. Although reference will be made to practice in the United Kingdom, this is only for the sake of understanding those areas where there may be lack of material at home. By and large, this paper is concerned with the practice of life assurance and problems of administration of the same by the Zambia State Insurance Corporation Limited, being the sole insurance company in Zambia.

The author has been prompted to research into this particular field by two considerations. The first is simply that, having worked in the then Group Life and Pensions Department of the Corporation for close to seven years, he acquired an appreciation of the practical difficulties that a life office, especially one in a developing country like ours encounters from day to day and how these in turn affect the life assurance market.

The second and, perhaps, the more important reason why the author felt compelled to write on this topic is on account of the general outcry by the public who have complained about what they have often
called "shoddy services" rendered to them by their only insurance company. This can be seen from the number of letters written by members of the public to the press. Some of these have complained about delays by the Corporation in issuing policies or granting of policy loans.

One such letter purportedly written by a former employee of the Corporation and entitled "ZSIC Ignores Client's Approaches" appeared in the Sunday Times, 17th July 1988 and stated inter alia:

"---I resigned in frustration because the Corporation failed to recognise the importance of the client vis-a-vis policy servicing. The Corporation's management just has no regard for people's complaints and behave like they are masters and not servants of the client. The Corporation has become an exploiter both to the clients and to its own salesmen. No wonder ZSIC has failed to retain salesmen worth the profession."

Others have expressed the feeling that the only way to improve services offered by the Corporation to the public is to de-nationalise it by allowing some of its shares to be held by private hands. It has been asserted that the Corporation, like all other parastatal organisations, operates like a government department and the only good thing government departments are renowned for is inefficiency.

Extremists have gone beyond this by calling upon the government to reform the law and allow individuals with adequate finances to form insurance companies which
should compete with the Zambia State Insurance Corporation Limited which at present enjoys a monopoly in the insurance industry in Zambia.

The author believes that all these complaints are not for fun and neither are they baseless. There must be something wrong somewhere. After all, it is said; "There is no smoke without fire."

It is the Corporation's own Managing Director, Honourable Mweene Mwiinge, MCC, who capped it all when he, during the third ZSIC Life Production Club Convention at Baluba River Motel near Luanshya said:-/Times of Zambia, Saturday, 17th September 1987/

"We have been criticised by the public, and in particular the client, for not offering satisfactory service to them. We should admit that this criticism is real. We should not pretend that everything is well-----. Our attitude towards clients is shameful ------ We collect premiums from clients and after doing so, we dump them and do not bother to make a follow up------".

The following day's Sunday Times carried a comment stating that there had been too many futile complaints about the manner in which the Corporation had been handling its business with or for its clients.

Such are the reasons why the author desires to bring to light the difficulties the Corporation's Life Offices face in their administration of life assurance with a view that the public may become aware of how and why, sometimes, delays and shoddy services may be or are
inevitable. This must not be construed to mean that the author is an apologist of the Corporation's inefficiency. It is hoped that the understanding of such problems faced by the Corporation will foster the much needed confidence between the Corporation and its insureds for the benefit of both and also create a sense of responsibility in the Corporation's staff towards the insureds.

It is gratifying to learn that the Corporation, implicitly accepting that its customers are getting a raw deal from its services, and in a bid to improve its services to its clients, has formed the Customer Relations Committee whose primary function is to receive and deal with complaints and compliments relating to any of its operations. It is the hope of this author that the Committee will achieve its stated and noble objectives.

The essay consists of four Chapters. Chapter One is an introduction and will consider the history of insurance in The United Kingdom and Zambia. Chapter Two is devoted to principles of insurance law. Chapter Three will discuss the administration of life assurance in Zambia by looking at the personnel, procedures and operations in the Life Division of the Z.S.I.C. Limited. Chapter four is the conclusion and consists of an analysis of problems inherent in the administration of life assurance and the recommendations to ameliorate the same.
CHAPTER ONE

GENERAL HISTORY OF INSURANCE

Definition

In its modern form, an insurance contract may be defined as an agreement in which one party (the insurer) agrees or undertakes, in return for a stipulated amount of money (the premium) to be paid by another party (the insured/assured), to pay to such other party or his nominee a sum of money on the occurrence of a certain event or to indemnify against loss caused by the risk insured against.¹ Like any other contract, therefore, a contract of insurance is a promise or a set of promises for the breach of which the law gives a remedy, or the performance of which the law in some way recognises as a duty.²

Old Forms and Functions of Insurance

The concept of insurance as a risk transfer mechanism, whereby the individual or business enterprise can shift some of the uncertainties of life on the shoulders of others is not a new phenomenon. A form of "insurance" called Collegia Tenuiorum existed in Ancient Rome.³ A Collegia was a community of rather poor people who gathered together and contributed to
a common fund. When a member of the community died, a certain amount was paid to his family to meet burial costs.

Traditionally in Zambia, the extended family system provided a very effective means of "insurance" for the family of a deceased relative. When a husband and father died, his relatives would take over the responsibility of caring for his widow and children. Unfortunately, with the prevailing adverse economic conditions, the extended family system has broken down and people are becoming indifferent to the needs of relatives other than those of the immediate family.

In the Middle Ages in England, there existed the merchant guilds. A guild was basically an association of merchantmen following the same profession, for example goldsmiths. It was often stipulated in the articles of the guilds that the guild had to protect the commercial interests of its members and help them in case of fire, flood, theft or sickness and care for the widows and orphans of its members.4

Early Insurance 5

The earliest references to insurance in the modern sense occurred after the beginning of the 14th
century and appeared in the accounts of the Italian Merchant bankers who dominated the international trade of Europe at that time and whose practice naturally spread along the trade routes to other centres of commerce. A merchant who had to transport goods on a ship was given a loan. If the ship arrived safely at destination, he had to reimburse the loan together with a fairly high interest. If the vessel was lost together with the cargo, the loan did not have to be reimbursed nor had any interest to be paid. In 1230, Pope Gregory IX forbade this kind of loan, as according to Canon Law in the Middle Ages, the charging of interest was against Biblical teaching. With the papal decree the granting of such loans became very difficult. Of course there were always people who found ways and means in order to get a loan and in the course of time this loan was transformed into a kind of insurance proper, that is, the risk was separated from the loan.

As noted above, man has been fascinated by sea travel for purposes of trade and adventure since earliest times. It is not unusual, therefore, that man's first attempt at seeking protection was from the danger posed by the sea. It is generally believed that
the first known form of insurance protection was in marine where the first policy was issued in 1347 at Genoa in Italy. With this new kind of document, a new chapter of insurance in its modern form began. In Bruges (Italy), there is a record of a court judgment in an assurance matter in 1377, while an ordinance regulating marine insurance was issued in Barcelona in 1435. An ordinance issued in 1523 at Florence codified the practice of insurance in Italy. King Phillip II made marine insurance regulations for Spain in 1556 and for Antwerp in 1563. By this time, the importance of the Mediterranean trade was going low after the discovery of America. The town of Antwerp in Spain had now become the leading centre of the marine insurance market, though this position of supremacy was shortly taken over by London. It follows that marine insurance is the oldest branch of insurance in the United Kingdom.

**Marine Insurance in The United Kingdom**

Before the Royal Exchange was constructed, merchants met in the now Lombard Street (so named after the merchants from Lombardy), and it was there that marine insurances were effected. There is record to show that in 1563, an Antwerp merchant
insured three ships on a voyage from Havre to Central America. The policy was written in French and was endorsed by thirty-seven English underwriters who acknowledged that the insurance was, "After the use of Lombard Street in London and of the bourse of Antwerp".  

There were, however, disputes at times. Disputes on marine matters including marine insurance were, in London, referred to the Admiralty Court. But this was not very satisfactory for the court had no special knowledge of law merchant or Lombard Street assurance customs. This function of arbitrating over marine insurance disputes was therefore given to the Privy Council during Tudor times.

**Chamber of Assurances**  

The Tudors (1485-1603), particularly Elizabeth I, were very much interested in merchantile matters and the Privy Council from time to time received complaints from merchants who could not collect assurance moneys from the underwriters. A foreign money market (bourse) was therefore erected in London by Sir Thomas Gresham. This was named as the Royal Exchange by Elizabeth I in 1570. In 1575, the Chamber of Assurances was set up in the Royal Exchange with the main task of regis-
tering all policies effected in the city of London. This was intended at preventing abuses by evilly disposed people who might insure the same property twice over and seek to recover in the event of loss from more than one source. Registration was evidence of the contract and this was very useful if the policy was subsequently lost. Registration of policies also facilitated the settlement of disputes as it was evidence of the contract and its terms. The establishment of the Chamber of Assurances resulted in:

(a) The adoption of a standardised marine insurance policy,

(b) A reduction in the number of cases coming before the Admiralty Court, and

(c) The giving of permanence to the customs of merchants, at home and abroad in marine insurance.

Although the registration of policies proved a protection against fraud, disputes in marine insurance were still frequent and in 1601, the first enactment relating to marine insurance was passed which set up a Court of Arbitration for determining disputes on marine insurance. However, by the 18th century, disputes on Marine Insurance returned to the
jurisdiction of the ordinary law courts. Some of the greatest judgments Lord Mansfield (Lord Chief Justice of England on the bench from 1756 - 1788) is re-embered for were in insurance matters.

Chartered Companies

In 1720, The London Assurance and Royal Exchange Assurance obtained Royal Charters. The Bubble Act, 1720, which authorised the granting of charters also prohibited other corporations, partnerships and societies from engaging in marine insurance in competition with the two companies. Competition could therefore come only from individuals who continued to underwrite marine policies. Moreover, the growth of foreign trade combined with the prohibition of other associations gave individual underwriters their opportunity. Indeed, it was during the 18th century that marine underwriting became a specialised business with a developed market, and this led to the formation of Lloyd's as it is known today, which has competed successfully with the joint-stock insurance companies to the present time.

Lloyd's Underwriters

The individual merchants who underwrote marine risks met in the coffee-house of Edward Lloyd, opened
around 1680 in Blackfriars Street in London but moving in 1691 to a site on the corner of Lombard Street and Abchurch Lane. The coffee-houses of the late 17th and early 18th centuries were centres of much of the business life of the city of London. The coffee-house at Lloyd's attracted shipowners, merchants, sea-captains and underwriters interested in marine insurance. It became the centre for sales of ships and their cargoes and by 1712, it was possible for a broker to advertise and give no other address but the coffee-house itself.

Lloyd died in 1713 but the coffee-house was carried on by his family. About 1734, the then proprietor of the coffee-house began the publication of Lloyd's List, which gave the movements of ships and other matters of trading interest. Lloyd's grew in influence and strength and the underwriters eventually took a lease of premises in the Royal Exchange where they remained until their building in Leadenhall Street was opened in 1928.

Opposition to Monopoly

In the early part of the 19th century, various attempts were made to oppose the monopoly of the two chartered companies; The Royal Exchange Assurance and The London Assurance, and these efforts were success-
ful in 1824. The successful application was made by The Alliance Marine Insurance Company which had very strong banking interests. Since there was no real defence against Alliance's petition, the monopoly was withdrawn by an Act of Parliament which received Royal Assent on 24th June, 1824. The banning of monopoly did not operate to the detriment of the two chartered companies because expansion of trade at home and overseas provided enough business for all. Other companies gradually entered the marine insurance market until today when it comprises many companies operating as competitors and yet also as friendly collaborators.

Fire Insurance

The Industrial Revolution changed the face of the British Industrial Scene and engendered many more items which needed to be insured. Large factories were built which housed complicated machinery; volumes of goods were processed by these factories and transported to warehouses and customers around the country and shipped overseas. This mushrooming of industrial activity brought with it a growth in the demand for insurance protection. The Great Fire of London in 1666 drew attention to the absence of any co-ordinated form
of insurance against fire. Therefore, for all practical purposes, fire insurance began after 1666. In 1680, Dr. Nicholas Barbon, a London builder, in partnership with three others set up the Fire Office, later called Phenix, where brick houses would be insured at the rate of 6d. per annum and timber houses at double rate. The second scheme was that of the Corporation of London which became an abortive experiment in municipal insurance. In 1683, The Friendly Society became a competitor of the Fire Office. The Hand-In-Hand was formed in 1691, being absorbed by the Commercial Union in 1905. Other fire insurance companies which were later formed were The Sun Fire Office in 1710, The Union Fire Office in 1714 and the Westminster Fire Office in 1717.

Life Insurance

Life assurance can be traced back to the 16th century when short-term assurances at high rates were usually effected as collateral security for loans. The earliest recorded life insurance was one granted by sixteen individual underwriters on 18th June, 1583, for twelve months for £382 6s. 8d. on the Life of one William Gibbons. The policy concluded with the words:— "God send the said William Gibbons health and long
life. Gibbons died on 9th May, 1584 and the underwriters had to pay.

The short term form of policy taken out by William Gibbons was typical of the type of assurance issued in those early days. They were issued to cover the lives of persons who owed money when they were going on a voyage or to provide extra security for a loan. Such short-term policies, being from year to year, could be subscribed by individual underwriters, but life assurance as known today is usually a permanent contract renewable annually at the option of the policy-holder throughout the life of the person insured or at least for a long term of years. For such contracts to give acceptable security to policy-holders, the insurers need to be either a mutual society or a joint-stock company of unlimited duration.

The first such venture to make any real progress was the Amicable Society for A perpetual Assurance Office which received Royal Charter from Queen Anne in 1706. The Society operated on the simple principle of collecting contributions from its members and dividing these periodically among the estates of those who had died since the last division. The Society survived until 1866 when it was absorbed by the Norwich Union Life Insurance Society of 1808 which is still in existence today.
The year 1762 marks the birth of life insurance in its modern form. In that year was founded The Society For Equitable Assurance On Lives And Survivorships, which is still operating today as the Equitable Life Assurance Society. The Society was founded without share capital under a constitution known as a Deed of Settlement which provided that it should be a society of persons qualified and willing to become mutual contributors for life insurances upon payment of premiums proportionate to the chance of death attending the age of the life to be insured and to the duration of the insurance. It would be noted that this form of insurance was more gambling as policies of insurance were effected on the lives of public men with recklessness. In order to put an end to these practices, the Life Assurance Act of 1774 was passed which was entitled:

"An Act for regulating insurances upon lives and prohibiting all such insurances except in cases where persons insuring shall have an interest on the life or death of the person insured".

Before the end of the 18th century, two other life insurance offices were formed: The Westminster Society in 1792 and The Pelican in 1797. In 1806, The Rock, London Life and The Provident were formed
to transact life insurance business, followed by The Eagle in 1807 and The Scottish Widows Fund in 1815.

**HISTORY OF INSURANCE IN ZAMBIA BEFORE INDEPENDENCE**

There is hardly any recorded history of insurance in Zambia from the dawn of the present century to independence. However, the emergence of insurance companies in Northern Rhodesia, as then Zambia was, can be attributed to the advent of colonialism and the subsequent settlement of white settlers in the territory following the grant of Royal Charter to a company formed by Cecil Rhodes called the British South Africa Company on 29th October, 1889.

The company was given a mandate to conclude, on behalf of the British government, concessions with African tribal chiefs in the region lying immediately to the north of the British Bechuanaland, and to the north and west of the South African Republic, and to the West of the Portuguese Dominions. The concessions by the BSA Company on behalf of the British government bound the tribal chiefs who were to accept British rule and grant monopoly of the mineral rights to the Company. By 1891, the Company's representatives had concluded several concessions with some local
chiefs and on its behalf, the British government concluded treaties with Germany and Portugal, which effectively gave the Company the right of occupation and control over a specified area North of the Zambezi. However, from an economic point of view, the occupation of the territory by the Company was not economically viable and therefore the Company's stronghold still remained in Southern Rhodesia.

Following the construction of the railway line from Bulawayo across the Zambezi River in 1902, white immigrants, mainly Afrikaners from South Africa began to settle in Northern Rhodesia especially along the line of rail where they started farming. Most of the food produced was supplied to the mines in Katanga. The settler population in Northern Rhodesia rose from 1500 in 1911 to over 3500 by 1921. Due to a number of problems between the white settler population and the BSA Company, the British government took over administration of Northern Rhodesia in 1924. The colonial Office encouraged European immigration and settlement in Northern Rhodesia and set aside vast blocks of land which would be available for exclusive European use. This inducement saw a large number of whites coming to settle in the territory. The expansion of electrical and automobile industries after the
first World War increased the world demand for copper. This had the effect of bringing into Northern Rhodesia a large number of European mineral prospectors some of whom were accompanied by their families whose number on the Copperbelt was 4000 in 1931.11

The earliest insurance companies in Northern Rhodesia therefore were formed only after 1930 and these were simply intended to serve the economic interests of the European settlers. Records available indicate that among the earliest companies were the London and Lancashire Insurance Company registered in Northern Rhodesia on 15th February, 1939 to transact all classes of insurance business. All its directors were British and its head office was in London, with a local office at Livingstone. The Motor Union Insurance Company was registered in Northern Rhodesia on 3rd February 1939 to carry out fire, accident, motor and marine insurance. Like the London and Lancashire, it was incorporated in London and had its local office in Lusaka. The Yorkshire Insurance Company was registered in 1942, the Santam Insurance Company and Norwich Union Life Insurance Society in 1956. The American Insurance Company, the South African Fire and Accident Insurance Company and the Legal Insurance Company were
all registered in Northern Rhodesia in 1958. A few other insurance companies not enumerated above were also registered between 1930's and 1940's. In 1959, the Santam Insurance and American Insurance Companies wound up business in the territory followed by the Norwich and South African Fire in 1964. Between 1967 and 1968, the London and Lancashire, Legal, Yorkshire and Motor Union were among the many insurance companies which wound up business in the newly independent country of Zambia.
FOOTNOTES


CHAPTER TWO

LEGAL PRINCIPLES OF MODERN INSURANCE

As indicated in Chapter 1, a contract of insurance is a legal bargain between parties on terms to which they both agree and therefore the general principles of the law of contract apply with equal force to insurance contracts. This chapter therefore discusses legal principles of the modern insurance contract.

Offer

The offer usually comes from the person who desires to protect himself through insurance and it is ordinarily called a proposal. In order for the offer to be effective, it must be communicated to the other party, the insurers. The proposal may be made verbally, for example, over the counter of an insurance company, on the telephone, or to one of the insurers' representatives. It may also be made in writing through a letter, or as the practice is in Zambia, by the completion of an insurance proposal form.

In a proposal for life assurance, the proposer will be required to answer questions designed, inter alia, to disclose the name, address, occupation and
age of the proposer, his history of health, for example, what diseases he has suffered or suffers from. He must also state whether he takes intoxicating liquor or smokes and if so, in what quantities. In addition, a statement of family history of health and the proposer's medical doctor are required. The proposal form invariably ends with a declaration which must be signed by the proposer which is often couched as:

"I-----(name of proposer), the proposed assured, do hereby declare and warrant that all the answers to the foregoing questions are true, complete and correct in every respect, and I do hereby agree that this warranty shall be the basis of the contract of assurance between me and the ------company Ltd (name of insurance company)".

Acceptance

Acceptance is not effective until it is communicated to the other party who made the offer. The acceptance of the proposal may be signified by the insurers in one of the following ways:

1. By a formal acceptance, that is, where the insurers formally indicate to the proposer orally or in writing that the proposal has been accepted.

2. By issue of policy; The issue of the policy is conclusive intimation that the insurers have
accepted the proposal.

However, in the two instances above, where the insurer has intimated to the proposer that the insurance does not commence until the first premium is paid, then there will be no cover until such premiums is settled.

3. By acceptance of premium; "Where no policy has been issued to the proposer before the loss, the receipt of the premium and its retention by the insurers, though by no means conclusive, may raise a presumption, in the absence of any circumstances leading to a contrary conclusion, that the insurers have accepted the proposal".¹

Consideration

Consideration consists of some right, interest, profit or benefit accruing to one party or some forebearance, detriment, loss or responsibility given, suffered or undertaken by the other². In the case of insurance contracts, the consideration moving from the insured to the insurer is the premium and that from the insurer to the insured is the promise to indemnify.
Insurable Interest

Macgillirray defines insurable interest as:

"Where the assured is so situated that the happening of the event on which the insurance money is to become payable would, as a proximate result, involve the assured in the loss or diminution of any right recognised by law or in any legal liability, there is an insurable interest in the happening of that event to the extent of the possible loss or liability."

Insurable interest is necessary in every contract of insurance. It is the legal right to insure, and means that the insured must be in a legally recognised relationship to what is insured whereby he will suffer in a pecuniary sense by the happening of that event insured. It follows that the mere effecting of a policy of insurance carries with it no right to recover thereunder simply because of the happening of an insured event. The insured must have an insurable interest to be able to recover. Perhaps a better understanding of the principle of insurable interest may be had by reference to the leading case of Macaura v Northern Assurance Company. In that case:

"The plaintiff, a majority shareholder in a company owning some timber, was owed a large sum of money by the company. He therefore effected a policy to insure the timber belonging to the company against loss by fire. A fire occurred and he claimed
from the insurers who repudiated the liability on the ground that he had no insurable interest. The House of Lords, agreeing to the argument by the insurers, dismissed the plaintiff's claim stating that as a shareholder, the plaintiff had no insurable interest in the assets of the company).

The concept of Insurable Interest cannot be concluded without reference to three statutes, that is, The Life Assurance Act, 1774, The Gaming Act, 1845 and The Marine Insurance Act, 1906. The Life Assurance Act, 1774, provides, inter alia, that:

"No insurance shall be made by any person--- on the life or lives of any person or persons, or on any other event or events whatsoever, where- in the person or persons for whose use, benefit, or on whose account such policy or policies shall be made, shall have no interest, or by way of gaming or wagering."

The Life Assurance Act, 1774, did not extend to Insurances made by persons on ships goods or merchandise. Hence, the Gaming Act of 1845 was passed which covers the position as regards goods and merchandise. Section 18 of that Act provides:

"All contracts or agreements, whether by parole or in writing, by way of gaming or wagering shall be null and void, and no suit shall be brought--- for recovering any sum of money---alleged to be won upon any wager, or which shall have been deposited in the hands of any person to abide the event on which any wager shall have been made."

By the provisions of this Act, if A insured B's goods without an insurable interest in them, then such is a wager, and A cannot claim if the goods perish or are destroyed.
Section 4 of the Marine Insurance Act, 1906 states that:

"(1) Every contract of marine insurance by way of gaming or wagering is void

(2) A contract of Marine insurance is deemed to be a gaming or wagering contract,

(a) where the assured has not an insurable interest as defined by this Act, and the contract is entered into without expectation of acquiring such an interest."

As regards life insurance, a man is deemed to have an unlimited financial interest in his own life and he may therefore insure his life for any amount. Where the life of another is assured, it is essential for the person assuring to have a financial interest in the life of the other person being insured, as for instance, a creditor in the life of his debtor to the value of the debt.

Utmost Good Faith

Most commercial contracts are governed by the common law doctrine of CAVEAT EMPTOR (let the buyer beware). This doctrine means that a seller of goods does not need to reveal the defects inherent in the goods he is selling. Therefore, a buyer who buys such goods and discovers subsequently that they have serious defects has no right of action at common
law against the seller, unless the latter made representations or gave a warranty as to the non-existence of those defects. A prudent buyer must therefore inspect the goods or employ a person to carry out an examination on his behalf.

However, contracts of insurance are different because one party to the contract alone, the proposer, knows or ought to know all about the risk proposed for insurance, and the insurer has to rely upon the information given by the proposer in his assessment of that risk. For this reason, contracts of insurance are contracts **uberrimae fidei** (of the utmost good faith). The doctrine of utmost good faith therefore requires both parties to a contract of insurance to make a full disclosure of all material facts. A material fact for this purpose was defined by Brett, L.J. in the case of **Rivaz v Gerrussi** as:

"A fact which would affect the judgment of a rational underwriter in considering whether he would enter into a contract at all or enter into it at one rate or another".

In contracts of life assurance, for example, the proposer has a duty to disclose what type of diseases he has suffered or suffers from.
The necessity for the duty to disclose is clearly stated in the following extract from the judgment in the case of *Carter v Boehm* where Lord Mansfield said:

"Insurance is a contract upon speculation. The special facts upon which the contingent chance is to be computed lie most commonly in the knowledge of the insured only; the underwriter trusts to his representations, and proceeds upon confidence that he does not keep back any circumstance in his knowledge to mislead the underwriter into a belief that the circumstance does not exist, and to induce him to estimate the risk as if it did not exist. The keeping back of such a circumstance is a fraud, and therefore the policy is void. Although the suppression should happen through mistake, without any fraudulent intention, yet still the underwriter is deceived, and the policy is void; because the risk run is really different from the risk understood and intended to be run at the time of the agreement——Good faith forbids either party, by concealing what he privately knows, to draw the other into a bargain from his ignorance of fact and his believing the contrary.

The failure by one party to exercise the utmost good faith entitles the aggrieved party to repudiate the contract. It is important to note, however, that although the obligation is binding on both parties alike, it usually arises out of the conduct of the proposer or insured. An insurer must, on the other hand, disclose the precise terms of the contract he offers and must not take advantage of the
propounder's ignorance.

The principles of indemnity and subrogation which follow, though not applicable to life assurance contract are, however, important in the general law of insurance, and it would not be out of place to briefly consider each of them.

Indemnity

Almost all policies of insurance, with the exception of insurances of the person, are contracts of indemnity. A contract of indemnity is one whereby the amount payable under it is measured by the extent of the insured's pecuniary loss. This can be best explained by a quotation from the judgment in Castellain v Preston where Brett, L.J. said as follows:

"The very foundation, in my opinion, of every rule which has been applied to insurance contained in a marine or fire policy is a contract of indemnity and of indemnity only, and that this contract means that the insured, in a case of loss against which the policy has been made, shall be fully indemnified, but shall never be more than fully indemnified".

The object of indemnity is to place the insured, as nearly as possible, in the same financial position after a loss as that occupied immediately before the happening of the insured event. The principle
of indemnity, as noted earlier, has no application in life assurance contracts. Where a life assured dies, the full sum of assurance is settled and the contract is treated as discharged.

**Subrogation**

Subrogation is a corollary of the principle of indemnity and the right of subrogation, therefore, applies only to policies which are contracts of indemnity. Thus, it does not apply to life assurance contracts.

Subrogation is the right which one person has of standing in the place of another and availing himself of all rights and remedies of that other, whether already enforced or not. The right often arises to the insurers after payment has been made by them to the insured in settlement of his claim. The insurers are then entitled to receive the benefit of all rights of the insured against third parties which, if satisfied, will extinguish or diminish the ultimate loss sustained. Talking about the principle of subrogation in the already quoted case of *Castellain v Preston*, 8 Brett, L.J. had this to say:—

"In order to apply the doctrine of subrogation, the insurer must be placed in the position of the insured — as between the underwriter and the insured, the underwriter is entitled to every right of the insured."
On a policy of motor insurance, for example, the insurers have a right to recover from the third party the amount paid as a result of damage to the insured's vehicle if the accident had been caused by the third party's negligence.
FOOTNOTES

1. Per Lord MacLenan in McElroy v London Assurance Corporation (1897) 24 R (Court of Session) 287, 291.


4. (1925) AC 619.

5. (1880) 6 QBD 222, 229.


7. (1883), 11 QBD 380, 386.

8. Ibid, 388.
CHAPTER THREE
LIFE INSURANCE IN ZAMBIA

HISTORY OF INSURANCE IN ZAMBIA AFTER INDEPENDENCE

The administration of insurance in Zambia can never be understood without a proper appreciation of the historical and economic development of the nation. In particular, the present history of the Zambia State Insurance Corporation Limited could not have been the same if the Government of the Republic of Zambia had not taken steps to nationalise the insurance industry and create the corporation as the sole insurer in the country.

During the period of the Federation, the carrying on of insurance business was regulated by the provisions of the Insurance Act, 1956, which was administered by the Federal Registrar of Insurance. With the dissolution of the Federation with effect from 1st January 1964, responsibility for the administration of the Insurance Act in Northern Rhodesia, as it then was, passed to the Ministry of Finance. The transfer control was achieved by the Insurance Laws (Modifications and Adaptations) Regulations, 1964, published under Government Notice No. 35 of the 10th January, 1964. The First Registrar of Insurance was appointed on 22nd February 1964 and one of his first
tasks was to circularise the insurers previously registered under the Federal Law to ascertain whether they wished to continue to transact insurance business in Zambia. There were sixty-three companies that opted to continue transacting insurance business in Zambia at the end of 1964. However, of the number stated, only about half were operating in the country by the end of 1966. Most of those which wound up business believed that they could never carry on business successfully in a country under black government. The mass winding up of the companies spelled doom for the infant nation.

In 1967, the GRZ decided that a National Company should be formed to underwrite motor insurance business with the object of providing competitive rates within an open market comprising thirty foreign insurance companies then existing in the country. All these companies invested a very great proportion of the premiums collected from Zambia in their own countries of origin. A lot of insurance money was therefore being drained out of the young nation and little remained behind for investment. Towards the end of 1967, the GRZ decided that the Zambia State Insurance Corporation Limited should be incorporated as a limited liability company under the Companies Act and on 8th January 1968, the
corporation was registered although it did not transact any business until after the 26th March 1968, when it was duly licenced to carry out business of an insurer as required by Sections 6 and 7 of the Insurance Act. 5

The next major step in the development of the insurance industry in Zambia was taken on the 10th of November 1970, when the President of the Republic, Dr. Kenneth Kaunda announced that with effect from 1st January 1971, no company other than the Zambia State Insurance Corporation Limited would be allowed to write insurance in the country. Before the end of 1970, the Insurance Companies (Cessation and Transfer of Business) Act 5 was enacted giving effect to the President's announcement. By Section 4(1) of that Act:—

"No person other than the Corporation shall, after the end of the current year, enter into any new contract of insurance".

Current year has been defined as the year ended 31st December 1970. Sub-section (2) disallows persons, other than the Corporation to renew any contract of life insurance and sub-section (3) prohibits all persons, except the corporation, to carry on any insurance business, or enter into any contract of
insurance in Zambia. It is an offence for any person to contravene any of the provisions of the Act. Further, by terms of Section 5 of the Act, all contracts of insurance subsisting at the commencement of the Act, were to be transferred to the Corporation. Any contract of insurance not so transferred to the Corporation automatically got terminated.

Following the enactment of the Insurance Companies (Cessation and Transfer of Business) Act, the Corporation created the Life Division which was charged with the responsibility of marketing life assurance.

**Administration of Life Assurance in Zambia**

The Corporation consists of the Non-Life and Life Divisions, each of which is headed by a Divisional General Manager who reports to the Managing Director. The Non-Life Division, which has its headquarters at the Corporation's head office at Premium House in Lusaka, administers Marine, Aviation, Fire, Agricultural, Motor, Personal Accident and related insurances. The Life Division, whose headquarters is at the Corporation's Regional Office at Mpendwa House in Ndola, is responsible for Life and Group Life assurances. This essay is devoted to the practice of individual life assurance by the Corporation. The information con-
tained in the following pages is based on the author's interviews with the Corporation's staff and records available to him in various departments falling under the Life Division at Npondwa House in Ndola. The research was conducted between February and March 1989.

The Life Sales Representative

In Zambia, the life assurance contract is normally brought into effect through the medium of a life sales representative. He is an agent engaged by the Corporation to solicit and market insurance service to the public and ordinarily, like any other agent, is paid on commission which is calculated as a percentage of the premium paid on each policy. Presently, the Corporation engages two types of life sales representatives: (i) The full time life sales representatives and (ii) the Independent contractors. The distinction between them is simply that the full-time life sales representative, though paid by commission, is employed on pensionable terms and to that effect contributes to and is a member of the pension scheme run by The Employer and is entitled to loans from the Corporation. The independent contractor enjoys no pension and related benefits. His only entitlement is commission. Both categories of repro-
sentatives are however under the control of the Corporation in the manner in which they carry out their work and it is the Corporation which provides both of them with office accommodation and stationery.

The representative usually conducts his sale of insurance service after prospecting in a given community. He therefore moves about to identify the people who are most likely to take up insurance, ascertains whether such persons are insurable and whether their financial status is such as can allow them to pay the premium. The representative then makes an appointment with his targeted client.

At the consequent interview, he will discuss with the client life insurance products, such interview always being conducted with a view to persuading the client on the desirability of insuring one's life. Inevitably, the representative will also furnish the client with information on what amount of premium the client may have to pay for a stated sum assured and generally what benefits accrue once a person effects a life policy. The client, if not interested in effecting insurance, may outrightly refuse. But often many people ask for time to think about the idea and probably ask their spouses, children or parents. For the client who expresses interest in taking up a policy
of life assurance, a non-medical proposal form for life assurance will be given which the client will be required to complete. The author's interviews with a number of life sales representatives revealed that although the rule is that the proposal form must be completed by the proper, it is normal practice amongst salesmen to assist the proper in completing the form. This is done especially in cases of proposers who are illiterate or blind and in all such cases, the representative must read back to the proper what he, the representative, has written in the form. If the proper agrees that the answers written by the representative in the proposal form are correct, he will sign or thump print on the form. As stated earlier in Chapter Two, the questions in the proposal form are intended to have the proposer disclose facts which will help the insurer in assessing the risk proposed for insurance.

Medical Examinations

From the information supplied by the proposer in the proposal form, the life sales representative will ascertain whether the proposer must undergo insurance medical examinations or not. Below is indicated the current medical requirements for life
insurance:

<table>
<thead>
<tr>
<th>Amount of Sum Assured</th>
<th>Age 40 years and Below</th>
<th>Age over 40 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to K20000</td>
<td>Non Medical</td>
<td>AB</td>
</tr>
<tr>
<td>K20 001-K30 000</td>
<td>AB</td>
<td>ABC</td>
</tr>
<tr>
<td>K30 001-K45 000</td>
<td>ABC</td>
<td>ABCD</td>
</tr>
<tr>
<td>K45 001-K60 000</td>
<td>ABCD</td>
<td>ABCDE</td>
</tr>
<tr>
<td>K50 001-K80 000</td>
<td>ABDCE</td>
<td>ABCDEF</td>
</tr>
<tr>
<td>K80 001-K100 000</td>
<td>ABCDEF</td>
<td>ABCDEFG</td>
</tr>
<tr>
<td>K100 001 And Above</td>
<td>ABCDEFGH</td>
<td></td>
</tr>
</tbody>
</table>

**KEY**

A = Medical Report
B = Chemical Urinalysis
C = Microurinalysis
D = Chest X-Ray
E = 12 Lead ECG
F = Hematology Studies comprising; FBC with Differential and ESR
G = Blood Chemistry Studies Comprising; FBS, Triglycerider, Cholesterol, Creativa, SGOT and SGPT
H = Financial Reports

The meaning of the above table is that if the amount of insurance sought is below K20 000 and the proposer is aged 40 years or below, then unless there is something adverse to his health indicated in the non-medical proposal form, he will not undergo further medical examinations. Such cases are therefore called "Non-
medical cases". But if for example, Mr. Chair who is 50 years of age proposes insurance for K85 000, then he will be required to submit medical reports ABCDE and E.

In medical cases, that is, where the client needs to be medically examined, the representative arranges for the client to be examined by one of the Corporation's Insurance Medical Officers who operate in Lusaka, Kitwe and Ndola. In other towns, the representative must arrange for the client to be examined by a private medical officer at the expense of the Corporation.

In both non-medical and medical cases, the representative verifies the date and place of birth of the proposer indicated in the proposal form by asking the proposer to produce a means of identity. The National Registration Card or Passport is normally sufficient evidence of one's date and place of birth. In the absence of the NRC or Passport, the proposer will be requested to swear the Proof of Age Affidavit before a Commissioner of Oaths. The representative will copy the verified details and write them on the Extract Form which will be attached to the non-medical or medical forms. When the representative is convinced that all the required documents have been submitted, he will
request the proposer to pay stamp duty, and where the proposer desires, he may further pay the first premium. Upon payment of the same, the proposer will be issued with a receipt indicating the proposal number and the amount paid. It should be reiterated that mere collection of the premium by the representative on behalf of the Corporation does not constitute an acceptance of the offer from the proposer. The practice by the Corporation is that there must be a formal acceptance of the proposer's offer, that is, the Corporation will communicate to the proposer in writing indicating its acceptance of the offer after the Corporation's underwriters have assessed the risk. Therefore, where the proposal is declined or deferred, the premium together with stamp duty paid are refunded to the proposer.

After issuing the proposer with a receipt, the representative finally submits the proposal or medical form, Debit or Stop Orders Form, Extract copy of receipt and all money or cheques collected for premium and stamp duty and any relevant documents to the District Office.

District Office

At the District Office, the proposal or medical form together with all the accompanying documents are scrutinised to ensure that they contain all the required
information. Where omissions or ambiguities are discovered, the documents are referred back to the representative who will in turn get back to the proposer for clarification. Where all the documents are in order, a file is opened and premium calculation done. A letter of acknowledgement of receipt of the proposal for life assurance is then dispatched to the proposer who is informed that he will hear about the Corporation's decision on his proposal in due course. The District office then passes the file to the New Business Department.

New Business Department

When the Proposal Section in the New Business Department receives the file from the District Office, it will indicate the date when the file has been received by stamping the date of receipt on the front cover of the file. Staff in the Section will record, in respect of each proposal, the proposal number, name of proposer, sum assured and yearly premium in the appropriate register maintained for each of the 16 life district offices. When such information has been recorded on the appropriate register, the file is sent to the Registry Section where the Staff will verify whether the proposer has ever proposed life assurance before, and if he has, whether the same was accepted and on
what terms. If the Registry staff discover that the proposer has an existing policy, they will put the existing policy file on the new proposed file which will be sent to the Underwriting Department. Equally, where the proposer has no existing policy or has had his proposal declined, this will be indicated on the proposal file before it is sent to the Underwriting Department.

Underwriting

Underwriting is the process of assessing the risk and determining what terms and costs are to be applied to such risk. When the Underwriting Department receives the file, it will examine the submitted medical reports to see whether they satisfy the underwriting requirements. The underwriter in arriving at a decision whether to accept at ordinary rates of premium or loaded premium, decline or postpone the risk, takes into account a lot of factors which include the health record and occupational hazards of the proposer. For example, a person who is excessively overweight or underweight will have an extra-mortality premium loading which he will be required to pay in addition to his normal premium.

After the Underwriting Department has underwritten each proposal and made a decision whether to accept,
decline or postpone, it prepares letters of acceptance for all those proposals which have been accepted either with or without conditions. Cases accepted with conditions are those where the insurer has imposed certain terms which the proposer must abide by before the insurance becomes effective. All extra-premium cases are therefore conditional acceptances because they become effective only after the proposer has agreed to meet the stated term; that is, agreed to pay the required extra premium. In law, conditional acceptances constitute counter-offers. Cases accepted without conditions are those where the insurer is immediately bound by its obligation on the contract.

For deferred or decline cases, appropriate letters are also drafted. Deferred or postponed cases are those which the underwriter feels cannot be accepted immediately on account of one or more reasons, but which may be considered in future upon the expiry of a certain period of time and production of a favourable medical report. For example, a proposer whose medical report reveals that he is suffering from gonorrhea will usually have his case postponed for six months. Upon expiry of the period, he will be requested to submit a fresh micro-urinalysis which will reveal whether he has recovered from the malady or not. If he has, his
case will be reconsidered and if there are no
other impairments, his proposal may be accepted.
Declined cases are those in which the insurer out-
rightly refuses to accept the risk proposed for
insurance. In insurance practice, these are commonly
referred to as bad or poor risks. In life assurance,
this normally happens where the medical reports
submitted by the proposer indicate that his state of
health is very poor.

After the acceptance, deferment and declining
letters are finally typed, checked and signed, they
are sent to the New Business—Proposal Section who dis-
patch the letters to the proposers after updating the
proposal register in respect of each case by indicating
whether the case has been accepted, declined or post-
poned. It normally takes between 2 to 3 weeks between
submission of proposal or medical forms and the issue
of letters of acceptance, declinature or postponement.
Those proposers whose proposals have been accepted are
now called the assureds. For deferred and declined
cases, refunds will be processed if the proposer had
paid any money for stamp duty or first premium. Once
refunds have been remitted, the files are sent to the
Registry Section with a different series of numbers
allocated by the Policy Issuc Section and marked "NTU".
that is, Not Taken Up. In all cases of acceptance, deferment or postponement, four copies of the letter are prepared and signed. The first copy is dispatched to the client, second to the respective sales representative, third to the District Office and the fourth remain on the file. The author’s interview with personnel in the Underwriting Department revealed that for cases declined on medical grounds, the Corporation does not directly inform the proposer the reasons why his proposal for life assurance has been declined. Rather, the practice is that where the proposer is anxious to know why his proposal has been rejected, he is asked to provide the Corporation with the name and address of his personal physician whom the Corporation communicates to, giving such doctor the reasons why his client’s proposal for life assurance had been rejected.

In all accepted cases, where the first premium has been paid, a computer input form known as the MAT is immediately completed. Concurrent with the completion MAT is the allocation of a policy number for each accepted proposal. The MAT is completed in 5 copies. The first copy goes to the Technical Department for computer use, the second to Records for premium collection and calculation of the representatives' commission if the insured is paying his premium by cash over counter
(C.O.C), the third to Addressograph Section, fourth to the respective sales representative and the fifth to the District Office. Although the MAT forms are immediately completed for Stop Order cases, that is, those cases where an insured instructs his employer to deduct the premium and send it to the Corporation, the same are not distributed to the various departments as in C.O.C. cases. The MAT forms are kept on the file awaiting receipt of the first stop order premium from the employer. After the first stop order premium is received, the policy document will be typed. As for those cases where the first premium has already been paid, upon completion of the MAT forms by the New Business-Policy Issues Section; the file is immediately sent for the typing of the actual policy document. When the same is ready, it is sent to the Underwriting Department where it is checked and signed, after which it will be sent back to Policy Issues Section who will record in the Policy Register the policy number, name of client, sum assured and proposal number. From the Policy Issues Section, the file will go to the Proposal Section who will update the respective proposal register by indicating in the register the policy number and date of dispatch of the policy document. The section finally dispatches the policy document to the assured either through the representative or the District Office.
The file is then sent to the Technical Department for reinsurance purposes.

**Records Department**

One very important task of the Records Department is the collection of premiums. Premiums are normally paid in one of the following three ways.

1. **Cash Over Counter (C.O.C)**

   As said earlier, an insured may opt to be paying his premium by cash over counter. We noted that of the 5 copies, of the NLIC form prepared by the New Business Department, one goes to the Records Department. The department uses this copy to prepare three member's record cards, the first of which is sent to the respective district office where the insured is expected to be paying his premium over the counter, the second is retained by Head office and the third is sent to the Commission Section for the calculation of the representative's Commission which he receives, in respect of each policy, for three years. Payment of the commission to the representative is suspended where the policy has lapsed through failure by the insured to pay premiums. Payment of commission is resumed when the insured revives the policy by paying the outstanding premiums.
and in such cases, the representative receives his commission in arrears. If the policy lapses within the first four months, all commission paid to the representative on it is recovered. This is done to ensure that the representative encourages his client to pay his premium on time.

A client who pays his premium by C.O.C. will be issued with an original copy of the receipt for the payment showing the policy number, amount of premium, and date paid. The district office where the premium is paid will then indicate on the insured's record card the date on which the premium has been paid. The receipt counterfoil retained by the district office will be sent to head office where, upon receipt of the same, the Records Department will post the premium on the insured's record and maintained by them.

2. **Debit Order**

A Debit Order is a mandate by an insured account holder to his bankers directing the latter to pay to the Corporation a specified amount of money on a stated date in settlement of his insurance premium. Normally premiums are collected through the debit order system on a monthly basis. To effect a debit order, the Records Department dispatches to the insured's bank two computer-run copies of debit notes which indicate
the bank code, policy number, amount of premium and
the due date of the debit.

Upon receipt of the debit notes, the bank will
debit the insured account-holder's account and send
the premium deducted to the Corporation. In cases where
the account has been closed or does not have a suffi-
cient balance, the bank will send back the debit notes
to the Corporation with appropriate remarks. The Corpo-
ration currently pays 5 ngwee service charges for every
debit note sent to the bank. An additional fee of 0.25%
is paid to the bank on all gross amounts of premiums
expected in a particular month from any given bank.
During the time of the author's research, the Corpora-
tion and Barclays Bank (Z) Limited were negotiating for
a review of the stated rates of charges with a view
to increasing the same. It is anticipated that other
banks will soon follow the example by Barclays Bank in
demanding more commission from the corporation.

3. Stop Order

A Stop Order is simply an instruction by an
employee to his employer directing the latter to deduct
a specific amount of money from his earnings and send
the same to the Corporation in settlement of his insurance
premium. Employees of the GRZ and big employers like
like ZCCM, PTC, Zambia Railways, ZSIC and Defence Forces normally arrange to pay their premiums through the stop order system. The advantage of this method is that it reduces administrative expenses on the part of the Corporation which receives the premiums as lump sum payments. Employers who have agreed to maintain the stop order system are paid by the Corporation a commission of 2.5% of the gross amount of premium collected every month.

Unlike in C.O.C. cases, commission to representa-
tives on debit and stop order cases is calculated by the computer. The Records Department only receives the state-
ment of commission in respect of each representative. Such amount is added to commission due on C.O.C. cases to arrive at the representative's total commission.

When a death claim is intimated or when the insured applies for a policy loan, the Records Depart-
ment must first confirm whether the premiums on the policy have been paid to date before the claim can be settled or the loan granted.

Policy Lapse

Premiums payable over the counter must be paid one month in advance between the 1st and 15th of the month in which they are due. If the premium is not paid
within the stated period, it is the duty of the District Office to send the first reminder to the assured reminding him of the overdue premium. If between the 20th and 25th of the following month the assured does not pay the premium a second reminder will be dispatched to him stating that the premiums for the previous and current months are overdue. If by the end of the first week of the third month the premium is still unpaid, a letter of lapsation is sent. This letter informs the assured that on account of the unpaid premiums on his policy, the policy has become lapsed. However, the assured is instructed that should he wish to revive the policy, he must settle the amount of overdue premiums to which must be added the amount of one premium being advance payment. Overdue premiums are always paid with interest. Furthermore, the assured must complete a Declaration of Health form in which he must indicate whether there has been a change in his habits with regard to the consumption of alcohol, tobacco or drugs and whether he has changed his occupation or residence. The Corporation, if it finds fit, may even call for the assured's full medical report when considering whether to revive the policy or not. Revival of a lapsed policy is therefore not automatic and the Corporation reserves the discretion to refuse to revive the policy if there
are goods reasons even if the assured is willing to pay the outstanding premiums with interest. The author was however, informed that the Corporation does not normally cancel lapsed policies but allows assureds who are willing to pay outstanding premiums together with interest and who submit satisfactory Declaration of Health forms to revive their lapsed policies. Assureds paying by stop or debit order are not required to complete a Declaration of Health form even if the premiums have not been paid for more than three months.

Policy Services Department

This department is concerned with maintaining services on policies. Its primary functions include paying sums assured in the event of the death of the assured life or upon the policy maturing, paying out of policy loans, surrenders and making endorsements to policies.

Death Claims

In event of death of the policy-holder, the Corporation requests the claimant to submit the following documents before the claim can be considered:

(i) Death Certificate or Medical Certificate of The Cause of Death
(ii) Declaration of Identity (By a person who personally knew the deceased and who is not interested in the proceeds on the policy)

(iii) Policy document

(iv) Certificate of Medical Attendant

(v) Letter of Administration

All the above documents are required as a safeguard against fraudulent claims because evilly disposed persons may steal a policy document, forge a death certificate and lodge a claim. The Corporation's insistence on all the above documents discourages those with evil intentions from lodging fake claims. So far the Corporation is not aware of having paid a fake claim.

When all the documents are submitted, the Policy Services Department will underwrite the claim to see whether it is admissible or not. At the time of such underwriting, statements on personal health by the insured (now deceased) given in the original proposal form are compared with medical evidence contained in the Certificate of Medical Attendant. The latter will indicate cause of death and diseases which preceded or co-existed with the immediate cause of death. For example, Mr. Roof may die on 5th March, 1989 from anaemia. On the Certificate by Medical Attendant, the doctor will state that the cause of death was anaemia, but that such disease had been preceded by diabetes, which the deceased had suffered from since 1980. If Mr. Roof had taken up his policy in 1985, he will be expected to have disclosed
his diabetic state in his proposal form. If he had not, there will be a non-disclosure of a material fact for which the Corporation is entitled to repudiate the claim. In 1988, the Corporation repudiated 22 death claims, 19 on the grounds of non-disclosure and 3 for suicide.  

The amount payable on a death claim is the sum assured on the policy plus bonuses which have accrued up to the date of death. The current rate of bonuses is 3.5% of the sum assured per annum. Premiums paid on the policy after the death of the assured are also refundable. If the death claim is admitted, it will be paid. Ordinarily, it takes between 3 to 4 weeks to have a death claim cheque drawn where all the required documents are present. It takes longer periods where one or more of the required documents are not submitted. Where the policy document is lost, the claimant is requested to pay an advertising fee of K370.68 for the Corporation to issue a policy copy before settlement of the claim. In 1988, the Corporation settled 359 death claims amounting to K4,233,324.00.  

Policy Loans

A policy-holder whose policy has been in force for at least two years in certain types of insurance and three years for others, is entitled to a loan against his policy. In all circumstances, the amount of loan is limited to a maximum of 90% of the surrender value which is the sum payable under a life assurance contract which is terminated. It is usual for the amount to be paid as
surrender value to fall short of the aggregate sum remitted by way of premiums under the policy. There are a number of reasons for this difference, the most important of which are the following:

(i) Life assurance cover has been given for the time the policy has been in force and this must be paid for

(ii) Yearly overhead expenses, including renewal commission, and preliminary expenses, such as procuring commission, stamp and possibly doctor's fee, have been incurred and the company needs reimbursement.

The policy-holder applying for a policy loan must complete a loan application form and surrender his policy document which will be retained by the Corporation as a collateral security for the loan advanced. Before the loan is approved, staff in the Policy Services Department must verify with their counterparts in the Records Department whether premiums have been paid to date, and in case of second or subsequent loan, whether the previous loan has been repaid in full. The loan cheque will normally be drawn after 2 to 3 weeks from the date of submission of the application. Such cheque will normally be a crossed one, though negotiations can be made to have the same made open. All policy loans are repayable with an interest of 13% chargeable half-yearly. In 1988, there were an average of 400 policy loans approved and paid per month.
Surrenders

A surrender is simply a cancellation of the policy by the insured. This comes about for a number of reasons. The policy-holder may feel that he does not need insurance protection any more, or that the type of insurance he contracted for does not meet his present needs. However, in the majority of cases of surrender, the assureds state that they can no longer afford to pay the premium in view of the prevailing adverse economic conditions. A policy-holder who wants to surrender his policy will be requested to write a letter of cancellation. He must also complete a Discharge Form and surrender the policy document to the Corporation. A surrender value is then calculated and the cheque will normally be ready for collection within 2 to 3 weeks of the submission of the letter of surrender.

Maturities

When an endowment assurance has matured, that is, become payable, the Corporation has to pay the policy-holder, the sum assured plus bonuses due on the policy. About 3 months before the maturity date, the corporation writes to the policy-holder at his last known address advising him that his policy is due to mature. He is requested to submit to the Corporation the policy document, some form of identity like the NRC and complete a Discharge Form. When these documents are submitted, the maturity value is calculated and a cheque drawn to the assured. Policy-holders who have migrated to places outside Zambia are requested to complete a Currency Questio-
naire which will assist the Corporation in applying for foreign exchange to pay the policy-holder abroad. There are a good number of cases where the Corporation has not paid on the matured policies because the policy-holders cannot be traced even after sending many reminders to them through their last known addresses. The Corporation puts monies payable on such policies in a reserve fund hoping that one day the policy-holder will appear.


3. ZSIC op. cit p.9


8. Ibid.
CHAPTER FOUR

PROBLEMS OF ADMINISTRATION OF LIFE ASSURANCE

The first chapter of this essay looked at the history, forms and functions of insurance in the olden ages and the second chapter discussed legal principles of modern insurance law. The third chapter discussed the practice and administration of life assurance by the Zambia State Insurance Corporation Ltd, being the sole insurer in the country. This fourth and last chapter of the essay attempts to look at the problems related to the operations, personnel and procedures in the practice and administration of life assurance by the Zambia State Insurance Corporation Ltd, and the effects of the aforesaid problems on the public's image of the Corporation and the insurance industry as a whole. The chapter concludes that the operations, personnel and procedures in the Life Division of the Corporation are not satisfactory. Recommendations are then made which are intended to ameliorate the situation with a view to shaping the Corporation to serve the economic and social aspirations of its nation and customers.

The Sales Representative

We noted in Chapter 3 in respect to the independent sales representative, called the independent contractor, that although he is regarded as being an independent contractor, he nevertheless falls under the supervision of the Manager of the Corporation and works within the Corpora-
tion's official hours. He also uses equipment and stationery supplied to him by the Corporation.

The author doubts whether the Corporation's so called independent contractor is in fact and in the eyes of the law independent. It is the view of this writer that the so called independent contractor is nothing but an employee of Corporation and for whom the Corporation would be held vicariously liable in case of his committing a tort against a third party in the course of his duties. The writer is supported in this view by the following authorities. Selwyn \(^1\) postulates that the basic division between an employee and an independent contractor is that the former works under a contract of service whilst the latter is engaged under a contract for services. Several tests are applied to distinguish the two. In the 19th century, the determining factor was stated to be the control which was exercised by the employer over the employee in the manner in which the employee could do his work. Thus, if the employer could tell the employee not only what to do, but how to do it, then a contract of service existed. (As per Lord Bramwell in *Yeom v Noakes*)\(^2\). In *Stevenson, Jordan & Harrison v MacDonald & Evans*, Denning L.J. suggested a more up-to-date "organisational test". He said,
"Under a contract of service, a man is employed as part of the business and his work is done as an integral part of the business of the employer, whereas his work is not integrated into the business but is only accessory to it in case of a contract for services".

Today's commercial and economic arrangements may be too complex to be solved by the application of any or both of the tests above. To distinguish an employee from an independent contractor therefore, the courts nowadays will look at all the surrounding features, thus applying what is known as a multiple test. Factors to be considered will include:

(a) Can the person engaged delegate his duties to another or hire his own helpers? If he can, there will be a presumption, that he is not an employee but an independent contractor. (As per Mackena J. in Ready Mixed Concrete v. Minister of Pensions).4

(b) Who pays income tax and social security contributions? Independent contractors pay these on their own.

(c) Who provides management and bears a certain degree or financial responsibility for investment or risk? If the person engaged provides his own management and bears a financial risk, there will be a presum-
tion of his being an independent contractor. (As per Cocke J. in *Market Investigations Ltd. v Minister of Social Security*)

(d) Who provides the tools and equipment? Where the employer provides tools and equipment, the person engaged will be presumed to be an employee.

In respect to the Corporation's independent contractor, he is not free to delegate his duties, he is under the control and supervision of a manager of the Corporation and works ordinary official hours and is provided with stationary and equipment for his work by the Corporation. All these raise a strong presumption in favour of the view that he is an employee for whom the Corporation will be held vicariously liable. The Corporation might argue that its independent contractor pays his own tax and contributions towards the Zambia National Provident Fund. It is doubtful whether this argument can be sustained because the Corporation is fully aware that the majority of its independent contractors are not paying any tax on their commissions nor are they contributing towards Zambia National Provident Fund. The author therefore feels that the Corporation is abetting in evasion of tax by the independent contractors because it knows clearly well that these persons never declare themselves to the Tax Department for taxation purposes, but it continues to pay them as though it is unaware of their default.
The other point to note in relation to the independent contractor is that his contract is very uncertain because he can be laid off or resign at any time. This state of affairs brings about a sense of insecurity in him as he does not know whether he will have his job the following day. This further creates a sense of irresponsibility and lack of commitment in the way he will carry out his duties. He may, for example, sell wrong insurance products or make misrepresentations just so that he can convince a client and earn his commission. He will not bother whether the type of policy he has sold will be cancelled the following year or not or how much financial loss may be borne by the Corporation as a result of his misrepresentations to the insured.

The author recommends that the Corporation appoints its independent contractors as full-time representatives under pensionable contracts of employment. This will create a sense of responsibility in the independent contractor whose security of tenure of employment will now be assured.

Note was taken of the fact that where the proposer of insurance is illiterate or blind, the sales representative may complete the form on his behalf and read back the answers to him after which the proposer will be required to sign or thumbprint on the proposal form. It is felt that that practice by the representatives must be discouraged because the representative is an agent of the Corporation and not the proposer and cannot therefore purport to act
on behalf of the latter. Where the proposer is illiterate or blind, he must be allowed to invite a person of his choice to fill in the proposal form on his behalf. This is important because if a misrepresentation is subsequently discovered, it will be imputed to the proposer, but where the representative completed the form, the misrepresentation may be imputed to the insurer on whose behalf the representative acted.

Although the author carried out no research on the educational levels of the Corporation's sales representatives, it cannot be an overstatement to stress the importance of this aspect in the representatives' career. The Sales Representative is the link between the Corporation and the public and therefore the image the public will have about the Corporation depends on the image the representative will have created in the eyes of the public. This therefore calls for a high level of education and proficiency amongst the sales staff. The Corporation must ensure that only personnel with proper educational and professional credentials are appointed as sales representatives. It is not just everyone who should be selling insurance as the case appears to be at present. The failure by Corporation to appoint high calibre representa-
tatives is the cause why most of them use cheap selling methods to woo customers. Most representatives cannot sell a life policy without a mention of the policy-loan which the assured will be entitled to when his policy runs for 2 to 3 years. The policy-loan aspect is therefore used as the bait in the business of almost all the representatives. This poor method of marketing insurance can only be eliminated through the appointment of personnel who are well qualified to sell insurance. To achieve this, the Corporation must be willing to revise its rates of commission to the representatives so as to attract professional qualified staff.

Whilst talking about the salesman, it is worth to note the complaints which have been raised by the clients complaining about lack of after-sales service. The assureds state that they do not see their representatives once the policy has been concluded. The author feels that this blame should be shouldered equally between the Corporation and the representative. The majority of the Corporation's representatives have no cars. Though they are entitled to car loans, it is difficult to obtain one. One representative complained that he submitted his application for a car loan almost one year ago and has had no answer up to now. The
Corporation must realize that easy mobility is the only way by which any sales representative can conduct his business successfully. It should not expect its sales representatives to be walking to visit their clients. On the other hand, the sales representative must make an effort to visit his client at least once in a while, with or without a car. Simply sitting back does not enhance his image or that of the Corporation in the eyes of the client.

**Nomination of Beneficiaries**

The author notes with dismay the failure by the Corporation to include a part in the life assurance proposal form to deal with the nomination of beneficiaries. The form must include a part in which the proposer must nominate which persons he would like to benefit under the policy in case of his death and in what proportions. This will eliminate the problems that are usually encountered upon the death of the assured in identifying the beneficiaries. This writer strongly feels that the present arrangement where the administrator of the estate identifies who the beneficiaries are and in what proportions they will receive their shares is quite unacceptable.
Policy Issue

A lot of proposers have complained about the inability by the Underwriting Office to issue policies promptly. There are some who have had to wait for 4 months before their policies were issued. The Underwriting Office contends that such delay is normally caused by the submission of insufficient medical reports by the proposers. No policy of life assurance can be issued where the proposer has not supplied all the medical reports required by the underwriter. This point calls for the attention of the would-be assureds who must understand the importance and need for submission of all required medical reports to the underwriter before the policy is issued. In respect of stop and debit order cases, the underwriter does not issue the policy until the first stop or debit order premium is received. Where such premium remains unpaid, no policy will be issued.

Record of Premiums

Some assureds have complained about the failure of updating their records of premium payment by the Corporation's Life Head Office. This is often so for those clients who pay their premiums by cash over counter at the District Offices. The assured may wish
to obtain a policy-loan and thus submit an application to Head Office who will indicate to him that his premiums are in arrears and the loan cannot therefore be considered. One client complained that when he submitted his application for a policy-loan, he was told that his premiums were in arrears for 8 months. He had to produce the receipts for the premiums paid for the months in question before his application was approved. It can only be assumed that the lagging behind of Head Office in updating clients' accounts in regard to premium payment is as a result of poor communication between itself and the District Offices. The Corporation must therefore devise a system whereby the District Office will immediately advise Head Office of all the premiums received by it so that the latter can update its records accordingly. Sometimes however, the failure to amend premium records by Head Office is caused by change in the method of payment of premium by the assured. For example, where an employee who resigns from G.R.Z. (which pays premiums through the stop order) joins a private company and starts paying premiums by cash over counter (C.O.C.), then until he informs the Corporation of the change in the mode of payment, his record will show his premiums as outstanding. It is therefore the duty of the assured to
inform the Corporation of any change in the method of payment of premiums.

Revival of Policy

We noted in Chapter 3 that a client whose policy lapses on account of failure to pay premiums must fill in the Declaration of Health Form to revive the policy. This is normally applied to those clients who pay their premiums by C.O.C. The author feels that there should be no segregation between C.O.C clients and stop and debit order clients in the enforcement of the above requirement. All clients must be treated the same way as per policy conditions.

Commission

Another important point noted in the preceding chapter was that the Corporation pays commission to the employers and the banks on stop and debit order premiums collected by them on behalf of and for the Corporation. This commission is deducted from the total premiums due to the Corporation from the employer or bank at the rate of 2.5% on employer's stop orders and 5 ngwee per debit plus 0.25% of gross amount of premium on all debit order premiums. There are plans under way to increase the commission rates.
It cannot be doubted that when an employee instructs his employer to deduct a certain amount from his earnings and send it to the Corporation in settlement of his life premiums, he becomes the principal and his employer the agent. Equally, where an account-holder instructs his bank to remit a specified amount to a third party, the bank acts as an agent of the account-holder. In these two cases therefore, the agent is expected to receive his commission from the principal and not from the third party to whom the payment is made by the agent. If this argument be right, why should the Corporation, which is a third party, pay commission and charges to the employers and the banks? The author feels that this arrangement is very inappropriate in view of the law of agency which states that the agent is entitled to receive his commission from the principal. The Corporation is expected to receive its full premium from both stop and debit order clients as it does from C.O.C clients. In view of the contemplated increases in the commission rates by the banks, the Corporation's net premiums will even be reduced further and the advantage of receiving lump sum premium amounts on stop and debit orders will be outweighed by the exhorbitant charges and commission the Corporation will pay to receive them.
The author would recommend that the Corporation changes its policy by making the employee himself pay the commission on the stop order to his employer and the account-holder also pay the charges on debit order to the bank. This will enable the Corporation to receive its full premiums on the stop and debit orders, unlike the case is now. Alternatively, the Corporation must charge higher premiums for those clients paying through stop and debit orders than C.O.C. clients so that part of the increased premium will cater for the commission payable by the Corporation to the employers and the banks.

Policy loans, Death Claims, Maturities and Surrenders

In respect of policy loans, we noted that the maximum amount payable to any applicant is 90% of the surrender value. This amount is usually too small to be of any meaningful purpose to any applicant. Sometimes, especially in whole life assurances, the amount of surrender value is lower than 1/3 of the total premiums paid. The author recommends that the amount of policy-loan be calculated as a multiple of the premiums paid up to the time of the application. An amount of 75% of the total premiums paid to date would definitely be more equitable and meaningful,
especially under the prevailing adverse economic situation.

Policy-loans obtained from the Corporation are repayable with an interest of 13% per annum, while the Corporation offers only 3.5% bonus on the policy per annum. It is grossly unfair for the Corporation to award such low bonus on the policies and on the other hand charge so much interest on the policy loans. There is urgent need for the Corporation to revise its bonus rate to about 10% as the current rate of 3.5% is just too low. The suggested rate should be subject to review periodically to take into account the current rate of inflation.

The author laments at the red-tape in the settlement of policy-loans, surrenders and death claims by the Corporation. A delay of between 2 and 3 weeks before a policy-loan or surrender cheque can be drawn is quite in ordinate. Some clients who travel from as far away as Mongu, Chipata and Livingstone are made to wait for a fortnight or so in Ndola for their cheques. It is wondered whether the payment of policy-loans, at least, cannot be decentralised to the Corporation's branch offices whose managers can approve and pay them since they are usually nominal sums so that only death claims, maturities and surrenders can be settled by the
Head Office in Ndola. This will reduce the congestion at the Head Office. With regard to death claims, maturities and surrenders, a prompt system of payment of these must be devised so that unnecessary delays do not occur, unlike the case is at present. To achieve this, the Corporation must undertake an aggressive educational campaign to educate the public in the Mass Media on what necessary documents must be submitted when lodging a death claim, surrender or maturity claim. At present, most claimants are ignorant of what documents they must submit when lodging their claim. Many of them therefore end up submitting the required documents in stages resulting in long delays in settling their claims. Additionally, the policy document should contain a part stipulating what documents the assured or his beneficiaries must submit to the Corporation when a claim arises.

We noted in the concluding part of the last chapter that the Corporation has a good number of matured policies which have not been paid because the policy-holders cannot be traced and monies under such policies are kept in a reserve fund. This writer is of the opinion that the Corporation must advertise names of the life assureds under such policies in the Mass Media. Some of the policy-holders may be dead.
and their relatives are therefore entitled to claim the sums assured. Others of these assureds may still be living but have become mad and therefore unable to recall that they had taken up life assurance. Another class of assureds may be alive but have lost their policy-documents or forgotten about the insurance they had taken up long ago. Adverts by the Corporation in the Mass Media would remind these assureds or their beneficiaries about their dues. The Corporation has no right to keep such monies until and only if all possible means of locating the assureds or their beneficiaries fail.

Hope For The Future

It cannot be doubted that the future of the Zambia State Insurance Corporation Ltd, as an insurer in this country is great. The Corporation has grown from a nonentity to a giant and financially sound insurance company, counted amongst the biggest on the continent of Africa. This growth has come about through the deliberate action of the C.R.Z. by creating it as the only insurance company in Zambia as well as sound management by the company's officials and the efforts of the individual employees of the
Corporation. Being the country's only insurer, the Corporation has a great task ahead of it to offer only the best to its nation and people. It must not sit back and relax in self-conceit because it has no competitor. Complacency on the part of the Corporation will only spell its doom because if its clients are dissatisfied, the only way open for them will be to cancel their policies since they cannot insure with anyone else. The Corporation must therefore jump to the occasion by doing the best it can for its clients upon whom its survival depends. The symbiotic relationship between the Corporation and its clients must be maintained for the common good of the Corporation, the clients and the nation of Zambia. Officials and staff of the Corporation must be aware that they are not doing the public a favour, but their very survival and that of the Corporation is dependent on the quality of service they will render to the Corporation's customers.
FOOTNOTES


2. (1880) 6 QB 530, 532-533.

3. (1952) 1 TLR 101.


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