PRUDENT
THE FUTURE OF INSURANCE

LIABILITY CLAIMS TAKEAWAYS

Welcome to the 26th edition of 'Liability Claims Takeaways' - our monthly insights from industry stalwarts.

February 2023

Content

What was the claim?

The Insured is in the business of providing payment services to its customers through a network of corporate business correspondents. The Insured's customers make over-the-counter cash deposits and online transactions through the Insured's systems. The Insured's role is to approve/disapprove these operations basis the verification details received. While reviewing one such set of transactions, the Insured's employee erroneously approved 261 of 500 transactions instead of rejecting them. On noticing the error, after 24 hours, another employee of the Insured, revoked the transactions. By this time, the Insured's business correspondents, relying on the erstwhile approved instructions processed the transactions and paid the end customer the aggregate monies. However, since these transactions were later rejected, the banking channel did not refund the Insured's business correspon-dents, resulting in the business correspondents suffering a loss. Therefore, the business correspondents claimed the loss from the Insured. The Insured notified this under their Professional Indemnity Insurance (PI Policy).

Professional Indemnity Insurance

Key aspects to remember:

1. **Importance of capturing the Insured's business details under the Policy in a comprehensive manner**

   The Insured had a series of different business operations and constantly developed new verticals across the organisation. While the Insured procured its insurance coverage, the exact nature of the Insured's business operations is required to be captured in the proposal form. Upon assessing the risk exposure based on the Insured's business, the underwriters write the Insured's policy. Therefore, if the risks are not adequately captured, the policy will not adequately protect the Insured's business and in the event of a claim, an inadequate business description can even result in the Insurer rejecting the claim.

   During renewal, in the initial rounds, the Insured declared its business, revenue and other details by way of a single-line description and there was no information regarding the online payment business. Our team of experts, upon learning about the Insured's new line of business, ensured that this information was shared with the Insurance company immediately and an endorsement was procured to the Insured's existing policy to expand the coverage to cover the new line of the Insured's business. On account of this addition, the Insured's claim under the Policy was admissible.

2. **Cover for contractors and sub-contractors**

   A large part of the Insured's work was deployed to a third-party agency that leased workers to the Insured based on the Insured's business requirements. In the instant matter, the error was not committed by an employee of the Insured, but, by the employee of one such agency.

   Typically, a PI Policy covers the Insured's employees, any natural person, who is or has been a principal, partner, or director of the Insured company. Contractors of the Insured are not automatically covered under the Policy. Once again, having a team of experts who understand the Insured's business model proved critical to the claim. Since the requisite endorsements covering loss caused to the Insured on account of the errors and omissions of its contractors and sub-contractors, in providing the Insured professional services was added to the policy, the instant claim fell within the ambit of the policy.

3. Insurer’s right of subrogation

In the instant matter, the Insured’s contract with the third-party agency had a clause wherein the agency had the obligation to make good the loss suffered by the Insured on account of any action, error, or omission of the employees of the agency.

Owing to the right of subrogation included in the Insured’s policy, once the Insurer paid the Insured’s claim under the policy, the Insurer could enforce the Insured's rights against the third-party and also, claim the amount paid by the Insurer to the Insured.

Since the Insured had a recourse to recover its losses, upon receiving the reimbursement under the Policy, the Insured surrendered its right of subrogation to the Insurer, which allowed the Insurer to make a claim against the third-party agency.

What was the claim?

The Insured made certain remote purchases from a department store and wished to make an online bank transfer to pay the value of the goods. At this stage, a person, acting as an employee of the store with the intent to defraud the Insured, generated an OTP using the Insured's debit card details. When the OTP was generated, he called the Insured to ask for the OTP. Assuming the transaction was for the purchase made by the Insured, he shared the OTP with the employee of the department store. On entering the OTP, a value of INR 2,50,000 instead of the nominal value of INR 900 was deducted from the Insured's bank account. The Insured immediately called the store and requested that the transaction be reversed. At such time, the perpetrator verbally confirmed that the transaction is reversed. To pay for the goods purchased, the employee initiated another transaction, and an OTP was generated. The Insured shared the OTP with the store employee and lost an additional sum of INR 1,90,000. The perpetrator was then unreachable and therefore, the instant loss was suffered by the Insured. The Insured notified this claim under his Individual Cyber Policy.

Individual Cyber Safe Insurance Policy (Individual Cyber Policy)

Key aspects to remember:

1. **What does an Individual Cyber Safe Insurance Policy cover?**

   An Individual Cyber Policy covers loss arising out of *inter alia*, identity theft, cyberstalking, IT theft cover, malware cover, phishing cover, e-mail spoofing cover, cyber extortion cover and data, and privacy breach by a third-party.

2. **Elaborating the definition of computer systems**

   Typically, most cyber policies limit the definition of computer systems to desktops, laptops, tablets, and similar gadgets. However, owing to the increasing accessibility and developing technology, mobile phones are the new medium for storing all personal sensitive data and e-wallets, etc. Therefore, a mobile phone should be specifically added to the definition of computer systems to ensure the adequacy of cover under the Policy.

3. **Importance of adhering to policy terms, conditions, and regulatory requirements**

   Each insurance policy is a contract and ought to be treated as such. An insurance policy can only respond when:

   - a cover under the policy is triggered
   - the Insured adheres to the policy's terms and conditions laid thereunder

   Under the Policy, the Insured was required to intimate the loss to the bank and Insurer within 72 hours of discovering the claim. This is not only an insurance requirement but also there are RBI guidelines, which require an accountholder to notify the bank of any unauthorised transactions within 72 hours.

   In the instant matter, the loss took place sometime around January 2022 and the Insured informed the Insurer of the same in April 2022, nearly after three months. At this stage, the Insured still had not intimated this loss to its banker.

   The Insurer was able to raise a contention for delayed reporting and breach of the policy's terms and conditions. This resulted in any recovery becoming almost impossible.

   It is therefore critical that the policy wordings be studied with a fine tooth comb and policy obligations be understood completely to prevent the Insured from being unable to avail of the benefits of the insurance.

February, 2023

What was the claim?

The Insured is a leading bank having branches across various cities in India. They provide various services such as holding deposits, lending Group loans, Business loans for individuals, Agriculture Individual loans, Gold loans, Home Improvement loans, Agriculture Group loans, etc. The Insured Bank was providing small group loans to a group of members who were Co-Guarantor - such groups are usually called 'House'.

In one of the regional offices, the Insured's employee issued fresh loans in fictitious names and/or dormant accounts of such Houses from the Insured's branch and later embezzled and/or took away the sanctioned money. The fraud was identified by the Business team and the matter was handed over to the Fraud Risk Management team (FRM team) for detailed investigation. Further to which, 111 accounts came under suspicion and finally 107 fraudulent/fake/fictitious/ghosts accounts pertaining to 13 different Houses amounting to several crores were identified where fake KYC documents were used for issuing loans. Based on the investigation report, an FIR was filed under sections 120, 406, and 420 of the IPC against the accused bank employees. Due to the fraudulent/wrongful acts of the accused employees, the Insured Bank suffered financial loss and notified the claim under their Bankers' Indemnity Policy.

Bankers' Indemnity Insurance

Key aspects to remember:

1. Coverage under the Bankers' Indemnity Insurance

Bankers Indemnity Insurance aims to provide multi-faceted protection against the loss of money and securities, both on-premises and in transit due to various threats. It provides coverage to the losses caused by employees such as fraudulent acts, criminal acts, unauthorised transactions, and losses caused by any other third-party including but not limited to robbery, forgery, terrorist attacks, etc.

In the subject claim, based on the investigation carried out by the FRM team, it was established that the accused employees committed the offence of cheating, forgery, and misappropriation of money by taking inappropriate advantage of their positions, roles, and responsibilities in the Insured's organisation and created fraudulent/fake/fictitious/ghost accounts to attain financial gain.

As the Insured suffered financial loss due to employee fidelity/dishonesty, the claim was covered under section D of the Bankers' Indemnity Policy which provides coverage to the Insured Banks for loss of money or securities suffered by them due to dishonest or criminal acts of its employees.

2. Applicable Excess

As per section D of the Bankers' Indemnity policy of the Insured, the Insured shall bear the first 25% of each loss or 2% of the basic sum Insured, whichever is higher but not exceeding the maximum of INR 25,000. It further provided that each loss in respect of each dishonest or criminal act shall be treated as a separate loss.

The Insured claimed 107 fraudulent/fake/fictitious/ghosts accounts pertaining to 13 different Houses. Basis the claim and upon perusal of the Insurance policy, the surveyor believed that since there were 107 accounts involved, each account should be treated as a separate loss meaning there would be 107 claims and thus, the excess should be applied separately to each claim.

However, it was explained to the surveyor that these 107 accounts belonged to 13 different Houses and the entire claim could only be divided into 13 Houses. Therefore, the excess should be applicable as per 13 Houses and not 107 accounts. Accordingly, the claim was segregated into 13 different claims and house-wise excess was applied.

3. Assessment of loss under the Bankers' Indemnity Policy

The Insured's claim was considered for a loan amount sanctioned to 107 fraudulent/fake/ fictitious/ghost accounts based on documents submitted by the Insured's employees and sverifications carried out by the surveyor. The accused employees were committing the wrongful activity over a period of time and thus, the loan amounts that were disbursed before the inception of the policy were deducted as they were not covered under the policy.

Further, a deduction was made in the assessment of loss on the ground of recovery made in the respective 107 accounts. The full and final settlement of the accused employees was not paid by the Insured and considered as recovery. These deductions were proportionately divided into 13 claims and deducted from the assessment of loss.

Finally, the policy excess was deducted from each of the 13 claims and payment was made to the Insured Bank.

We are sure you found the anecdotes interesting and got some key points to take away.

Stay tuned for the next edition!

About Prudent Insurance Brokers

We, at Prudent Insurance Brokers, provide industry-leading expertise in designing and managing insurance programs to address unique requirements of your organisation. We have a client-centric service infrastructure that delivers proactively & passionately in a highly systematic manner. Our Liability Team comprises exunderwriters and the largest number of qualified lawyers and legal professionals who can help you across different areas:

- Identifying and addressing gaps in your current insurance programs
- Arranging the most cost-effective cover from Indian and international markets
- Ensuring contract compliance for your insurable indemnities
- Offering 360° claims management by one of the largest claims teams across any broker in India
- Providing global solutions through the strongest international alliances

Our Claim-Handling Expertise

Our team members come from varied areas of expertise, thereby enabling us to ensure that our clients are assisted thoroughly, through every step of the claims handling process. We take pride in our professional competency and diligence, and our team is always willing to walk the extra mile in client service.

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CIN No.: U70100MH1982PTC027681 I License No. 291 (Validity: 18th February 2020 to 17th February 2023)

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