

THE INSURANCE CONTRACT : A CASE FOR REFORM AND PROTECTION

BY

KIMANI P.N.

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To my parents, Mr. & Mrs. J.K. Watenga
- for always being there for me, and
never losing faith in us.

And to all others who have urged
me on and wished me well.

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2. Life Assurance Control Ordinance
Cap 104 (Laws of Kenya)

3. The Credit Trade with Natives Ordinance
Cap 130 (Laws of Kenya)

4. The Insurance Act
Cap 487 (Laws of Kenya)

5. The Insurance Companies Act
Act No.46 of 1960

ABBREVIATIONS

1. AC Appeal Cases
2. All E.R. All England Law Reports
3. Burr Burrow
4. Com Cas Commercial Cases
5. D.L.R. Dominion Law Reports
6. K.B. Kings' Bench
7. Lloyds Rep Lloyds Law Reports
8. Q.B.D. Queen Bench Division

INTRODUCTION

Insurance is one of the most rapidly growing industries in Kenya today. Almost certainly, not a single Kenyan has not come into contact with insurance in one form or another. If he rides in a "matatu" or other vehicles, such are required by law to be covered by an insurance policy against third party liability. If he belongs to a co-operative, such an organisation will, almost certainly have some insurance cover of some sort or another. The National Health Insurance Fund is almost a household name especially in the urban areas where most people are engaged in wage employment. It is therefore self-evident that every Kenyan is, however indirectly, affected by the institution of Insurance. The tragedy of the situation is that few Kenyans can competently pursue their rights against insurance. There is widespread ignorance about insurance which may contribute to the escalation of exploitation to be found in insurance transactions. This thesis addresses the rules of law and practice concerning insurance, always attempting to show the rationale for the application of such rules. A persistent question asked throughout the thesis is whether the rules are justified by the rationales advanced. The attempts to create fairness and protect the parties to the insurance contract are evaluated. Reforms are also recommended and it is hoped that the persons or institutions concerned will take regard of them, and actually implement them where possible. If this is done, the writing of this thesis will have been vindicated.

CHAPTER 1

1.1 DEFINITION OF INSURANCE

"Insurance may be described as a social device whereby a large group of individuals through a system of equitable distribution may reduce or eliminate certain measurable risks of economic cost resulting from the accidental occurrence of disastrous events. Its effect is to spread the cost, which normally would fall upon a single individual in an equitable manner over the members of a large group exposed to the same hazard". (1)

It should be noted that the foregoing is not the only or universal definition of insurance. Other definitions exist. Thus, Channel J in Prudential Insurance Company v Inland Revenue Commissioners (2)

defines insurance as:

"...the agreement between two parties whereby one party, the insurer undertakes for an agreed periodical (usually annual) payment, called the premium to pay to the other party, the insured, a certain sum of money on the occurrence of a specified (but uncertain) event....."

This event is specified but when or whether or not this event will occur is uncertain and the risk insured against is included in the uncertainty. Channel J adds:

"...an insurance does not mean that the insured will not die or that his property will not be destroyed but merely that if and when this happens, a sum of money will be paid to him or the beneficiary under the policy. (3)

Insurance has also been defined as:

"a contract of indemnity against a contingency. The insurer assumes the risk of the contingency in consideration of the payment of a premium, so that the insured who suffers damage will be paid to him or the beneficiary under the policy". (4)

The above definitions have been quoted in extenso to demonstrate the ~~differing views of different people in regard to insurance - and to~~ demonstrate the nature of insurance. Yet, the differences are not at all an indication as to the "rightness or wrongness" of the definitions. This is because the definitions are functional and will

therefore necessarily vary with the purpose(s) for which they are invoked. Thus, for a sociologist, insurance would be defined as a device whereby the participants provide financial compensation to those among them encountering the many misfortunes or contingencies that befall humanity. On the other hand, the economist would define insurance as a device for the transfer of some risks of economic loss from the insured who otherwise would have borne the risk to an insurer in return for premiums. For our present purposes, all the above definitions are useful in so far as they serve to illuminate the nature or essence of insurance from different perspectives.

1.2 THE HISTORICAL DEVELOPMENT OF INSURANCE LAW AND PRACTICE : ITALY & ENGLAND

Insurance as a practice has ancient origins in the Mediterranean region - so ancient in fact that it can be traced to times long before Christ. This is seen in the classical traders use of the maritime sea loan. The general principle of all these maritime contracts was that, if the goods or the ship did not arrive safely at the port of destination, the risk of loss was to be sustained by the lender i.e. safe arrival would mean that the lender would be repaid. Although the transaction is not one of pure insurance, it can be seen that an element of insurance was involved. The combined function of finance and risk-bearing fell upon the lenders, and the specified interest had to be sufficient to meet both the service of loan and the risk of loss by sea (5). Such a transaction gave the opportunity to capitalists to ~~participate in the profits from overseas trade and encouraged them to trade in amounts exceeding those justified by their own capital.~~

Insurance as we know it today, developed only gradually (piece-meal;

in response to new developments and needs) over a number of centuries.

"Among Roman traders, the need of insurance of ships was met by a system of partnerships In Mercantile ventures, this is well illustrated by a recommendation of Cato (243 to 149 B.C.) to the capitalist not to fit out a single ship with his money, but to enter into partnership with forty-nine other capitalists so as to send out a fifty ships and take an interest in each to the extent of a fiftieth share". (6)

Cato's advice though cloaked in the guise of prudent commercial conduct corresponds so closely to the definitions of insurance given above that there can be no doubt that it is in fact evidence of insurance as practiced in these early times. This submission is supported by the objectives of the practice i.e.

"By such a system, each merchant would average his losses so that the net sum would correspond to what at a later age would be the premium charged by an underwriter". (7)

The above examples have alluded to the fact that:

"The business of insurance law had its origin in the underwriting of ships and their cargoes against the perils of the sea". (8)

Shivji has explained the prevalence of Marine Insurance at these early times thus:

"Foreign trade of necessity meant that commodities had to be transported across the seas and land. Given the communication systems of those days, mishap during the voyage could result in the complete ruin of individual merchants. It was this objective necessity to provide some protection against hazards and perils which gave rise to insurance". (9)

Thus, Marine Insurance was the earliest form of insurance practiced in the Mediterranean region. This type of insurance spread to other areas where the merchant ships called to trade. But

"Although insurance had its origins in the ancient world, the development of insurance as we know them (Sic) today did not begin until about the Fourteenth century". (10)

As already noted, before the end of the thirteenth century (In Palermo and probably elsewhere), a form of loan was practiced under which the lender was the ship-owner and the borrower the shipper of the goods.

The loan was repayable on safe arrival. In such practices, the ship-owner was indeed undertaking the insurance of a fraction of the value of the goods. (11)

"In Genoa, transactions which were in fact purely ones of insurance were drawn by rotaries in the form of a loan without interest, made "in mutuo gratis et amore" (12) i.e. a friendly loan.

With time, even these practices changed and later in the fourteenth century, Genoese rotaries used a form of insurance modelled on a purchase and sale instead of the loan "In mutuo gratis et amore". The contract of sale was adapted to the purposes of insurance by regarding the property insured (covered) as sold to the insurer subject to a "restitutive condition" in the event of its safe arrival. The goods were at the insurer's risk who undertook to purchase them in the event of their loss at sea. If they arrived safely, no liability would attach to the "purchaser/insurer" and the insured would again have to bear all the risks of loss with regard to the goods. These practices of purchase and sale are significant in as much as they led to the emergence of the two principles of insurance law which are still of great importance up to the present day. These were, firstly, that the insured had to be owners or at least take some interest in the property insured; for a man cannot transfer to another what he himself does not own (later expressed at common-law as the "nemo dat quod non habet" maxim). This requirement meant that the contract was a contract of indemnity and not a mere wager on the safe arrival of ship or merchandise. The principle of indemnity remains central to the contract of insurance (with the exception of life insurance which is more in the nature of a saving or investment). Secondly, if the goods or ship did not arrive safely and the restitutive condition failed to operate, the insurers were entitled to so much of the property insured

as could be recovered. Harold E Raynes says that:

"The advantage of a contract so drawn as a purchase was that any goods salvaged (sic-saved or salvaged) would belong to the purchaser". (13)

This is clear evidence of the origins of the principle of subrogation as currently practiced. Basically, the principle enables the insurer, as it were, to "step into the shoes" of the insured, so that after payment to the insured, the insurer can recoup his costs from any third-party tortfeasor. The insured gives up all his rights and remedies and the insurer subrogates himself into those rights. This principle is complementary to the indemnity principle and ensures that the insured gets no more than a full idemnity.

It is worth noting here that such developments were not isolated or only confined to Genoa. During this period, the Mercantile age, other Mediterranean (Italian) city states were also involved in trade which employed more or less, similar practices. Thus, although the trade of Florence involved the transportation of cloth from Champagne in France over land, river and sea, the agents responsible for the transport undertook the risk of loss together with the transport charges. (14)

Insurance practices never became uniform, however, as they varied widely in the level of their development. Thus, some cities had experienced very rapid development in regard to insurance. Thus,

"the first genuine policy of insurance drawn in contract form as such, of which we have record was executed in Palermo dated 13th March 1350". (15)

~~"But while such genuine insurances expressed by a separate policy were in use in Palermo, the form of the fictitious loan~~
"In mutuo gratis et amore" was being used in Genoa, but as the century progressed actual policies of insurance drawn as such came into common use among Genoese merchants". (16)

"During the latter part of the Fourteenth century the practice of underwriting risks became part of the functions of merchants

and formed a sideline of the business of large firms". (17)

The growing importance of insurance both as to the scope and the amounts involved may be gleaned from the intervention of the (city) state(s) in the industry:

"To Barcelona goes the honour of being the first in the medieval world to establish a maritime code, which has been the basis of subsequent ones. It was compiled in the "Libro del consulado del Mar" in the thirteenth century". (18)

Barcelona also "recorded a first" in being the first city state to regulate insurance by legislation. This 1435 ordinance was enacted:

"...with the object of preventing fraudulent abuses and to give a preference in treatment to their own ship-owners". (19)

Although the origin of true insurance was with the Italian merchants of the fourteenth century, it was obviously common among the mixed mercantile class resident in Bruges (a city in North Western Belgium) in the following century. (20)

The practice of Marine Insurance however did not come to London via Bruges but directly from Italian merchants, or as they were called, the Lombards. Bensa notes that:

"while there is not documentary evidence of the practice of Marine Insurance in England before the sixteenth century, Italian merchants residing in London may have insured their cargoes just as they did when exporting, from their Italian branches, Mediterranean products". (21)

"The conception of insurance in England as elsewhere, arose out of the mercantile adventure of transporting goods across the seas, the adventure consisting in early times of the enormous fortune to be made if the project turned out to be successful as contrasted with the disastrous loss, even ruin, which resulted if the project foundered amid the perils of the sea. It is not surprising therefore, that the common-law of insurance developed in the first instance through decisions on questions of Marine Insurance". (22)

In fact, the earliest policy sued upon in an English court was an Italian one in 1548 in the Court of Admiralty. Policies were not sealed and could not be enforced at common-law and although in 1601

the government gave approval to the chancellor's practice of appointment of commissions to deal with insurance disputes (23), insurance remained in a poor way throughout the sixteenth century. (24)

Sir William Holdsworth (25) has it that the earliest policy to be found is in the case of BROOKE C MAYNARD (26) in which an action was brought by the insured on a policy written in Italian and subscribed by two underwriters. The action was defended on the ground that the insurer had already paid part of the sum and that they had received no part of the goods which had been salvaged. It was further alleged that there had been a deviation i.e. that the insured had breached some of the terms of the contract.

This case shows that by this date (1547), the practice of insurance was well known in England. Indeed, Queen Elizabeth I of England established in 1570 an institution where, for the first time, businessmen could meet and transact deals and exchange information. This institution was to be called the Royal Exchange (of London) i.e.

"after she (Queen Elizabeth I) had viewed every part thereof above the ground.... she caused the name of the Bourse by an (sic) herald and trumpet to be proclaimed the Royal Exchange, and so to be called thenceforth and not otherwise". (27)

With the transfer of the merchants' meetings to the Royal Exchange went their business or Marine Insurance where it was to remain for the next three and a half centuries. (28) Soon thereafter, attempts were made at organizing the practices and market of Marine Insurance by requiring that all insurances be registered and by the erection of an office, the Chamber of Assurance, in the Royal Exchange. (29) The compulsory registration of insurances was aimed at combating the evils of double or over-insurance so that underwriters might see the terms of and the total amounts of, assurance placed on any venture.

"There were two important results from the creation of the Chamber of Assurance. First, in consequence of the policies being drawn by one person, or in one office, the clauses became standardized anda form was adopted which has essentially persisted to the present day. The second was a lull of litigation in the Admiralty court owing to the facilities for arbitration through the expert commissioners". (30)

It should be noted that during this period, the insurance business was practiced by individual underwriters. However, despite the system of individual underwriting of Marine Insurance being common among all the Mercantile cities and ports of Europe, the promotion of a large joint-stock company had been proposed as early as 1629 in Holland. (31)

Incorporation of insurance companies was, however, not to come to England until a century later in 1720. Incorporation at this time could only occur by Royal charter or by a private Act of Parliament and was by no means easy, especially at this period when the governments' policy showed a reluctance on its' part to encourage incorporations. Shivji (32) writes that it was only the temporarily poor finances of the English Government which introduced corporate underwriting in Britain i.e.

"Those who fought for incorporation lost battle after battle until they decided to rely on the power of money rather than on objective arguments. So they proposed to hand over to the crown's treasury £ 600,000 in exchange for two corporation charters and a monopoly of corporate underwriting in the field of Marine Insurance".

Raynes (33) puts it more bluntly:

"No further progress might have been made had not the two interested parties resorted to genuine bribery: this time of His Majesty himself, who was deeply in need of money".

It was thus that the first two insurance companies namely The Royal Exchange Assurance Corporation and the London Assurance Corporation came into being. "Bribery or no bribery", incorporation of insurance companies conferred great advantages to the individual underwriters

who could now become members and enjoy the requisite limited liability.

In 1721, the two corporations sought and obtained similar supplementary charters to enable them to undertake fire and life insurance. "Both companies are flourishing institutions, transacting all classes of insurance business after two hundred and forty years". It is interesting to note that they were among the first pioneering companies to set up agencies in Kenya at the beginning of this century.

The above situation (Incorporation of insurance companies) did not, however, spell the death knell of individual underwriting. The fear that the creation of joint-stock companies would be detrimental to the position of individual underwriters in the market proved to be baseless. To the contrary, Raynes (34), writes that "Indirectly the granting of the ^{Charters} ~~charters~~ to the Royal Exchange and the London Assurance Corporations brought about the organization of underwriters in that institution known throughout the world as Lloyds, an institution which in its mature strength now enters every branch of commercial insurance".

Indeed, Alan Harding (35) in his book, "A Social History of English Law" has submitted that:

"The eighteenth century was the century of Lloyd's. Amongst the insurance brokers who resorted to the coffee-house in Lombard Street from C.1720, and the merchants who did the actual underwriting, as just one of their varied activities, flourished the careful judgement of risks and premiums.... which has always been the insurer's particular skill".

The eighteenth century was also the one in which the common-law moved into the commercial field. Since a large risk would be underwritten by several insurers, the courts had to permit the "consolidation of actions". Mansfield was the first judge to understand "to the full that insurance was a contract and he particularly emphasized the need for good faith in Marine Insurance which was open to monstrous frauds on the part of the ship-owners". (36)

In CARTER V BOEHM (37) he laid down the obligation of a policy-seeker to disclose "all his circumstances".

From this point on the practice of insurance and the rules to govern it grew at a very rapid rate. This was accompanied by a widening of the scope of activities and classes covered by insurance. Insuring life did not, however, become commercially feasible until the end of the eighteenth century when the growth of acturial science made it possible to estimate life expectancy. This was also the time when a large middle-class clientele of clergymen, lawyers, millowners and others, living in a reasonably settled political climate emerged. This development was assisted by the Life Assurance Act 1774 (38) which prohibited insurances without interest. This meant that wagering policies in which the policy holders had no legitimate interest were forbidden. The Act further provided that no greater amount would be recoverable from the insurers than the amount or value of the Assured's interest. (39)

The insurance industry in England continued to develop throughout the 19th century. Since 1862, the Companies Act applied to all companies including insurance companies. Ease of incorporation meant that there

were well over four hundred insurance companies by the turn of the century (40). It therefore comes as no surprise that it was corporate underwriters who pioneered in the insurance business in Kenya in 1904 as noted earlier. (41)

1.3 THE HISTORY OF INSURANCE LAW & PRACTICE IN KENYA; ITS DEVELOPMENT AND PRESENT STATUS

"Kenyan" insurance law was adopted from England based mainly on the English statutes of General Application, the common-law and the doctrines of Equity in force in England on 12th August 1897, the importation being statutorily provided for in the 1902 Judicature Ordinance. As W. Alotch writes:

"Insurance as practiced in Africa (and hence in Kenya) is mainly an introduction of the colonial powers, as it was insurance companies from the then "mother countries" which extended their activities to the territories newly acquired by their respective governments". (42)

Thus, insurance was introduced in Kenya by the overseas insurance companies merely opening new agencies in the colony. This was in 1904 when the London and Lancashire insurance companies appointed agents for insurance business in Nairobi. Some time later, some of the companies established full fledged branch offices. One such pioneer company was the Royal Exchange Assurance of London which opened a full branch office in Kenya in 1922. The Commercial Union followed suit in 1929. (43)

It has however been contended that "The concept of insurance is not totally new to Africa and (that) the preceding comments only apply to the industry as it is currently known to us. Our communities have always had traditional forms of managing some of the risks facing them. An example of this is the extended family system, whereby members of a family, a clan or even a larger group, shared certain responsibilities Such security as is provided by some insurance policies is therefore part of our traditional way of living....". (44)

Others have rejected this idea of "traditional insurance" on the grounds that it differs so much in function from its "modern" counterpart (insurance as commercially practiced today) that it is not insurance at all. Shivji (45) writes:

"Bourgeois ideologiesfail to see the qualitative difference between the institution of insurance of (sic) a capitalist society and the communal social (security) devices of traditional societies..... At the same time....they fail to relate insurance to the capitalist mode of production.... hence too, they fail to give a rational expose' of the functions of insurance - for them it is there to provide protection, to share out losses etc. - In short a benevolent institution for social service".

Shivji further argues that the institution of insurance is an "important institution for accumulating capital in concentrated forms" and is therefore impelled by a profit maximisation motive:

"Thus like slavery, insurance, banking and such other institutions were directly and fundamentally instrumental in financing the industrial development of Britain and Europe generally. To wrap insurance in the clothing of a "social device for equalising and distributing losses" is therefore to miss the basic function of insurance as financing institution i.e. insurance is primarily a capital accumulation and investment device". (46)

Regardless of the differences in function between "the institution of insurance (in) capitalist society and the communal social devices in traditional (african) societies", it is my submission that some elements of insurance as per our functional definitions (47) are plainly apparent in the "traditional" institutions. For our purposes in this thesis, it will be sufficient merely to note the similarities and differences between the two institutions as has been done above. This is especially so in view of the fact that:

"These traditonal forms of insurance aredying out fast in most developing countries (Kenya included) as a result of economic and social developments which have brought about anew and foreign economic and social order. ("Modern") insurance is thereforeslowly replacing the traditional methods of providing security to members of our (african) communities. The industry is as a result, gradually assuming an important role in our countries" (48) (emphasis mine).

This thesis will therefore be mainly confined in scope to modern insurance practices and law. Dealing with the traditional methods of

providing security would, in my opinion, be merely of academic importance with little or no practical application.

The fact that "modern" insurance is only "slowly replacing the traditional methods of providing social security to members of our (African) communities" needs emphasis. (49) A historical basis for this slow pace in africans' adoption of modern insurance practices may be found in the statutory discrimination against them which effectively impeded their entry into the insurance business.

As early as 1903, the colonial government had enacted an ordinance - The Credit Trade with Natives Ordinance (50) which in its effect excluded African participation in business, including insurance business.

This ordinance was to apply to such provinces or districts as the Governor "shall proclaim or declare". (51) By the exercise of the powers conferred to him by the provisions of section 2 of the said ordinance, the Governor declared the ordinance to apply to the whole country. (52)

Section 3 of this ordinance contained the important provision that:

"No contract for the sale on credit of goods to the value or at the price of more than 10 pounds by any trader or other person not being a native of such provinces or districts shall be valid unless it is in writing and attested by the District Commissi~~on~~er of the district to which the native belongs". (53)

The ordinance further provided that no evidence whether documentary or oral was admissible in any court in proof of the contract unless the above conditions had been complied with. (54)

The Credit Trade with Natives ordinance was replaced by the Credit to Africans (control) Ordinance of 1948 (55), - an even more detailed and restrictive ordinance than the 1903 one. The headnote of the 1948 ordinance left no doubt as to the objectives of the statute:

"An ordinance to provide for controlling the granting of credit by non-Africans to Africans".

Ostensibly, such laws were enacted to "protect" the inexperienced African from the vices of the non-African. In practice, they merely denied him a chance to participate in business, including the insurance business. Infact, legislation geared towards curtailing (or indeed preventing) African participation in the insurance had been enacted by 1945, namely, the Control of the Business of Life Assurance with Africans Ordinance. (56) By this ordinance, elaborate procedures were instituted which effectively "safeguarded" the African from the security offered by life insurance! Under the ordinance, no person other than a person approved by the Governor in Council could effect any life assurance business with an African, and the approval could be withdrawn on three weeks notice. (57)

This ordinance was repealed and replaced by the African Life Assurance (control) Ordinance of 1948. (58) The 1948 ordinance prohibited, per section 4(1), the canvassing or soliciting for any life assurance proposal from any African without first obtaining a written permit from the Provincial Commissioner of the province in which such canvassing or soliciting was to be carried on. Such a permit would be issued at the Provincial Commissioners' discretion and an appeal against such a decision lay with the Governor whose decision was final. Section 5 of the ordinance provided that any African could (in theory) get certificate of exemption from the operations of the legislation by applying either to the Chief Native Commissioner or to

the Provincial Commissioner. The ordinance however gave no indication of the factors considered - but the chief one seems to have been literacy on the part of the African so that he could at least read what he was agreeing to, even if he could not grasp its implications.

Compliance with the requirements of the ordinance was buttressed by such draconian penalties that, as Professor O.K. Mutungi (59) states:

"only a foolhardy underwriter determined to wind up his business would have dealt with Africans under such circumstances".

Such penalties included a fine of 10,000/- for transacting life assurance business with an African without the prior approval of the Governor (S.6).

Professor O.K. Mutungi further states that the effect of all this was to effectively discourage underwriters from dealing with Africans. He proceeds to criticise the legislation as discriminatory, unreasonable and misconceived: i.e.

"There seems to have been no way of ensuring that the African understood the proposal form, the policy and the terms contained therein, unless he read them and interpreted his understanding of the same to the administrative agency". (60)

He argues further that the administrative agency would have to be in possession of specimen proposal forms from all the insurance companies operating within the colony. This would have been administratively emerous. But even if this were practicable, the African would not be in possession of the policy itself which was only issued after formalities including medical certificates and reports. In my opinion, this brings up the paradox of "the egg and the hen" for it would be impossible for the African to demonstrate his understanding of the policy since he could not obtain one unless he accepted one; and equally impossible to accept the terms because he could not do so

unless he got one. This dilemma denied the African virtually all hope of ever obtaining a life assurance policy.

Secondly, the literacy test to determine which Africans ^owould be granted exemption to the above requirements (of the Life Assurance (control) ordinance - Cap 104 of 1948) would be insufficient. This is because insurance documents are highly complex and literacy perse might not suffice to ensure the correct interpretation of the technical words often to be found in Insurance Law and hence in policies too. These are best understood by insurance lawyers and the courts. Thus, even the literate Chief Native Officer or the Provincial Commissioner might well be incompetent to interpret the policy correctly leave alone testing others' understanding of it. This would mean that the ideal position in this regard would have been to "protect" everybody in the colony, African and Non-African alike. Besides, illiterates should not be denied their rights to freely enter into contracts. All that would be necessary would be prior explanation to the party of the terms and conditions of the contract before the agreement is effected.

This unsatisfactory state of affairs meant that by "1964, only 0.5% of the population of East Africa (and hence a similarly small propotion of the Kenyan population) held life assurance policies and very few of these were held by Africans". (61)

This problem was further intensified by the fact that pioneering companies offered their services mainly in the urban areas whereas

about about

"about 80% of the Africans lived in the rural areas. Even those who lived in the urban areas were unable to actively participate in the industry as policyholders or shareholders for a long time during the colonial period, due to their low economic status.

Worse still, those who took out assurance policies in particular

had special rates applied to them which were higher than those payable by Europeans and other members of foreign communities..." (62)

There is evidence that insurance companies still concentrate their activities in urban areas almost to the total exclusion of the rural areas. Thus, as recently as July 1990, there were still appeals to insurance companies to "extend their services to rural areas where small and large-scale farmers may benefit easily". (63)

It should be noted here that the African Life Assurance (control) ordinance of 1948 was repealed by S 48 (4) of the Insurance Companies Act, 1960. (64) This "new" Act however left many loopholes through which a lot of mischief was committed by insurance companies. Consequently, after a lot of criticism and concerted public outcry, the Insurance Companies Act of 1960 was repealed and replaced by the insurance Act of 1984. (65) This act came into force in January 1987 and is still the applicable statute on insurance in Kenya today. The need for such new legislation was imperative i.e.

"According to the Commissioner of insurance (an office itself established under the 1984 Insurance Act), Mr. Marcellin Muruthi, the replacement of the insurance companies Act of 1960 with the new Act (Insurance Act 1984) was necessary to remove the numerous defects and loopholes which existed in the insurance environment. Apart from seeking to protect the interests of the insured public, the new law is intended to protect the interest of the insurers as well as developing a strong, healthy and solvent infrastructure of insurance operators". the overhaul of the legislation governing the insurance industry, he said, reflected the universal trend taken by both developed and developing countries of introducing strict supervision of their respective insurance markets". (66)

Kenya has followed this trend because, inter alia, of the important ~~role played by the insurance industry in the national economy.~~

"This role of the insurance industry is often not well conceived as the public often think (sic) that insurance companies merely collect premiums, are stingy in settling claims and do very little in the task of nation building". (67)

The contributions made by the insurance industry are numerous.

Briefly, they include "acting as a main channel of collecting and harnessing national savings and making sure that they are readily available for productive investments". (68) Insurance companies do not hoard the funds collected. Like banks, they do business with the money given to them. Insurance should, therefore, not be seen as a benevolent institution for the collection of premiums and administration of the same in the event of a claim arising.

....."In Kenya, the financial resources mobilised by insurance companies have grown substantially since independence" (69) i.e.

Gross Premium Income stood at KShs 153 million in 1965 compared to gross outgoings of KShs 71 million. By 1983, a gross premium level of over KShs 1.1 billion and outgoings of close to KShs 500 million were recorded. In 1986, gross premiums on Life Assurance alone stood at (K£ 50,120,000) i.e. KShs 1.0024 billion and total outgoings stood at (K£46,172,000) i.e. KShs 923 million. In the non-Life Insurance category, similar results were recorded i.e. gross premiums of (K£ 63,532,000) KShs 1.4 billion and total outgoings of (K£ 47,068,000) KShs 942 million were recorded. (70) Taking into account that "over the last six years or so (From 1982), Kenya's insurance industry has experienced tremendous growth" (71), it may safely be concluded then that the insurance industry now controls even more awesome amounts of money. With this fact in mind, it is even easier to appreciate the industry's contributions in creating direct and indirect employment (which is crucial especially in the face of the "unemployment crisis" currently facing the country), creating a protective climate necessary for industrial growth (the risks involved in certain industries i.e. aviation, food-processing, jewelleries etc. are so large that without insurance few businessmen would ever think of venturing into them) etc.

One contribution of the insurance industry which is often overlooked

but which deserves closer scrutiny and emphasis is the role it plays in minimizing losses and accidents against which they insure.

"Insurance involves a pooling of risks and an insurer - or a fortiori, a combination of insurers may find it worthwhile to reduce or eliminate risks which no individual risk-bearer would find profitable". (72)

It is interesting to, for instance, note that,

"...fire brigades in England were originally established and maintained by insurers (and that it was) not until 1865 (that the) responsibility for fire-fighting (was) transferred to the Local Authority". (73)

Moreover, the fact that premiums payable are based on the degree or probability of loss acts as an incentive for others generally, to reduce the risks they are exposed to or else be declared bad risks and forfeit insurance cover.

It should be noted here, that contrary to popular belief

"the scope of direct loss prevention by insurers is limited by a number of factors i.e. "the incentive of the insurer to minimize loss is small because the insurers would in turn come under pressure to reduce their premiums". (74)

It may therefore be correctly said that this is one area of activity in which the insurer acts, largely, in the spirit of public service. This may be seen as a genuine act of self sacrifice on the part of the insurer, who it must be remembered,

"...tries to have a balanced portfolio in order to achieve a certain profit ratio over a period of years to so that (he) can look after the interests of the shareholders and at the same time build up adequate premium reserves for coping with unforeseen contingencies". (75)

In short, the Insurer is also compelled by a profit maximisation motive. On this ground, it has been suggested that in fact, insurance exists merely as "one more institution for absorbing the (economic) surplus in capitalist society i.e. that it is not really necessary to have an insurance industry for.

".... much of what appears to be essential, productive, rational to bourgeois economic and social thought turns out to be non-essential, unproductive and wasteful". (76)

Shivji therefore concurs with Baran and Sweezy (Monopoly capital - Penguin Books at P 143) that:

"If all sorts of insurance were automatically provided for everyone as part of a comprehensive social security system, all the footless trapping of agents and salesmen and collectors and accountants and actuaries and huge buildings to house them could be dispensed with". (77) (emphasis mine)

This to me appears merely cosmetic, for nationalised or not, insurance would still remain insurance. The nationalised industry would still require "accountants, actuaries and huge buildings!" Moreover, the nationalised industries, inefficiency, complacency and bureaucracy would set in.

This, it is my submission, would in practice be "a cure worse than the disease". No one has (so far!) advocated for the complete abolition of the insurance industry as such. That would be unthinkable in today's world where more "accidents will happen" - and actually do happen!

The insurance industry is today experiencing a surge of vitality due to the booming business. However, in the highly competitive local insurance markets, the 38 insurance companies and 48 Insurance Brokers' firms (78) have little room for complacency. This is especially true in view of the fact that they are constantly faced with new challenges to grapple with for instance

"(The Vice President, Professor George Saitoti) said that the scourge of AIDS presented a challenge to insurers not only to evolve life policies which excluded the disease but also to make a contribution towards containing its spread". (79)

Whatever little complacency has been creeping into parts of the

industry is no more - Mr Sastry, an acturial scientist says:

"a sudden gloom has descended over the life insurance industry and all the complacency of improving mortality has been swept away". (80)

However, the general outlook or mood in the insurance industry is far from gloomy. This is evidently clear from the booming business recorded by insurance companies. (81)

Similar results can be contemplated for the future because, "not more than5% of the insurable population in Kenya is insured". (82)

Further evidence of this optimism in the industry may be seen in the fact that the idea of a second, but private reinsurance firm has been mooted:

"The Association of Kenya insurers has supported a proposal for the establishment of a private local reinsurance company The private company, to be capitalised at Shs 50 million, is expected to complement the services of Kenya Reinsurance Corporation". (83) *Rendered nugatory by Insurance Act*

minimum capital required is US. 100

This idea if implemented would be of great benefit in minimising "foreign exchange outflow from Kenya in respect of external reinsurance purchased by insurance companies". (84) Besides trapping extra foreign exchange from being siphoned off abroad, such a second reinsurance company would provide competition leading to greater efficiency in the reinsurance field.

In conclusion, it may be said that the present atmosphere in the Kenyan insurance industry is very healthy. Gerald Malynes (d 1641) remark in the 17th century that "man cannot invent or imagine anything but the value of it may be assured" (85) appears an apt description of Kenyan insurers' aspirations.

Yet, the insurance industry has its own problems - both as to the practice and the law applicable. The insurer's booming business must correspondingly mean better terms for the insured who makes all this possible. The extent to which (if any) insurance practice and law balances these varying interests in the insurance contract will be assessed in this thesis. The insurance contract; its basis nature and operation will be examined to establish whether and if it is merely a device to assure the insurer of unlimited profits or for the benefit of both parties thereto.

CHAPTER 1

FOOT NOTES

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50. *Act No.5 of 1903*
51. Section 2 of Cap 130 (Laws of Kenya)
52. It applied to every district in the provinces of Ukambani, Kikuyu, Nyanza, Coast and the districts of Mombasa, Naivasha, Laikipia, Baringo, Ravine, Elgeyo, Marakwet, TransNzoia, Turkana, West Suk and Uasin Gishu. The only place omitted appears to have been the Maasai District).
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CHAPTER TWO

2.1 DEFINITION OF THE INSURANCE CONTRACT

Examining and evaluating the nature, strengths and frailties of the Insurance contract is a formidable task. It would be impossible even to embark on such a task unless we defined our subject matter, the insurance contract, at the outset. Failure to do this would be tantamount, metaphorically of course, to "putting the cart before the horse" and would inevitably prove fatal to the success of such an important endeavour. An attempt will therefore be made, at this juncture, to illustrate the basic nature of the insurance contract and therefore lay the ground for further scrutiny.

By far the simplest and most useful definition of the insurance contract was given by Channel J in Prudential Insurance Co V. Inland Revenue Commissioners (1) as

"..... a contract whereby one party (the insurer) promises in return for a money consideration (the premium) to pay to the other party (the assured/insured) a sum of money to provide him with some corresponding benefit upon the occurrence of one or more specified events"

At page 663, he (Channel J) went on to state:

"..... the next thing that is necessary is that the event should be one which involves some amount of uncertainty. There must either be some uncertainty whether the event will ever happen or not; or if the event is one which must happen at some time or another, there must be uncertainty as to the time when it will happen"

He further added at P664 that

"the specified event must further be of a character more or less adverse to the interest of the assured".

This illustrates to some extent, the nature of the insurance contract.

The requirement of an event "more or less adverse to the interest of the assured" is however not universally true of all insurance

contracts. Thus, in life policies with endowment provisions, it usually does not feature. This requirement of what is technically known as Insurable Interest in insurance law is a basic feature in any insurance contract. However, the need for it to entail some "adverse character" is strictly speaking, only required in indemnity insurance contracts. The concept of indemnity will be dealt with at a later stage of this chapter.

In a nutshell, the nature of an insurance contract may be stated as aleatory (depending on an uncertain event or contingency as to both profit and loss), standard form (made habitually in a standard document(s)), unilateral (because only one party, the insurer has to perform), of utmost good faith (under which the status of uberrimae fidei and the duties as to full disclosure arise) and a contract of adhesion (because one party, the insurer, usually dictates the terms). These features have important implications, some of which will be considered in this chapter.

2.2 THE STANDARD FORM

By nature, the usual contract of insurance used in the insurance industry falls squarely within that class of contracts known as "standard form contracts". A standard form contract has been defined as:

".....every contract whether simple or under seal and whether contained in one or more documents, one of the parties (to which) habitually makes contracts of the same type in a particular form and will allow little, if any, alteration from that form". (2)

Contracted under a standard form or not, it is important to remember that the insurance contract is first and foremost, a "contract" and only subsequently to be differentiated on the basis of its, sometimes, peculiar features. Thus, the insurance contract is not exempt from

the rules of the general law of contract which require consideration, intention to create binding legal relations and an offer and acceptance - if a valid contract is to arise.

But the offer and acceptance under insurance contract law is somehow looked at differently. In legal theory, insurance companies (and other insurers) do not go to the public (insureds-to-be) and ask them to be insured. Instead, the public is thought to go to the insurance company and ask it to insure them. The company may accept or refuse to insure. So the offer comes from members of the public and the acceptance from the company (insurer).

In practice, however, the insurance company issues its proposal form to the intending insured. After filling it in, the applicant leaves it to the company to study it before it accepts or rejects "his offer". If the offer is accepted, the company issues the policy - a document(s) embodying the insurance contract.

Since the proposal form largely contains the terms of the contract to be effected, the insured is being presented with a document containing the terms of the contract, to which terms' formulation he has not contributed at all. As already noted, this is in keeping with the characteristic of standard form contracts as contracts of adhesion - where one party (insurer) expects the other (Proposer/insured) to adhere to the terms of the contract which he presents to him.

~~having no choice but to take whatever is offered. In insurance, he has~~
Under the theory of Freedom of Contract as promulgated under the common law, each party to a contract can vary, modify, amend or even refuse to enter into the transaction if he deems its terms to be harsh.

A contract should therefore mean a bargain in every sense of the word, that is, a freely negotiated and a freely entered into agreement. This is based on the assumption that both parties acting at arms-length and each looking after his own best interests, have equal bargaining power.

In practice however, the theory of Freedom of Contract has acted as a smokescreen behind which a very ruthless type of exploitation is carried on. For one party to the contract (the insured), the theory of Freedom of Contract has resulted in the emergence of practices which are the very antithesis of the freedom of choice it professes. The insured is usually presented with the fixed terms of contract on a "take it or leave it" basis. There is not even a semblance of a bargain involved!

The contract is, as it were, rammed down the insured's throat because he has very little choice in the matter. The insured, even if he rejects a particular contract is unlikely to get a better deal elsewhere because the other insurers offer largely the same terms in the standardized contract. This situation is clearly articulated by J H Baker when he states that

"..... even if a party has the freedom to refuse to make a particular contract, he rarely has the freedom to co-determine the terms of the contract and very often because of the universality of the standard forms or the existence of monopolies, neither kind of freedom is present". (3)

For the insured who needs and is sometimes statutorily required to have insurance cover (as in Motor Vehicle Third Party Liability Insurance), he has no choice but to take whatever is offered.

The insured's woes are further exacerbated by the fact that the standard form contract almost invariably contains exclusion clauses

inserted by the insurer. The insurer uses these clauses to limit or even escape liabilities, obligations or duties he would normally have to meet under the contract. For the insurer, who is the economically more powerful party with correspondingly more bargaining power:

"The standard form contract carries with it a temptation to which it is only too easy to succumb. It is often drawn up by one party to the contract (the insurer) often by lawyers on his behalf and the opportunity is there to insert provisions favourable to the drafting party. Where it is known that the other party is unfamiliar with the subject matter of the contract, that he is unlikely to take advice before entering into the contract and in particular that he is unlikely even to read the provisions, it is perhaps only natural that one-sided terms should find their way into the contract". (4)

In such circumstances, the insured is completely walled-in and compelled to accept the terms unilaterally inserted by the insurer in the standard form contract. This explains to some extent why, for instance, an insured would be willing to contract and pay premiums under a Personal Accident policy which provides that "compensation shall be payable ONLY when the claim shall have been proved to the satisfaction of the (insurer) company". (5) In "normal" circumstances we would expect the insured to object to a clause which empowers the insurer to judge when a claim he has to pay is satisfactorily proved. The likelihood of bias in such a case is so probable that an insured must accept such a clause under great pressure.

handwritten notes:
bias against insured
no justice
no justice
no justice
no justice
no justice

The failure of the Freedom of Contract Theory to take into account that differences exist as to the amount of bargaining power possessed by the parties enables such a situation to exist. The fact that such a situation can exist and does in fact exist, sufficiently proves the theory of freedom of contract to be just that - a theory or abstract notion not corresponding with reality at all! With that, the insurers justification (as the "stronger party") for inserting whatever terms

he wishes is exposed as no more than an excuse to perpetrate open exploitation.

In recognition of the fact that some parties may be prejudiced because of the inequality of bargaining power, the courts have attempted to reduce their disadvantages by applying special rules in regard to standard form contracts. Thus, by following the contra preferentum rule, the courts have been able to construe exclusion clauses against the person who inserted them and is relying on them, where some ambiguity exists.

The contra preferentum rule has one great limitation:- it is applicable only where ambiguities exist. But the insurance companies (insurers) usually have at their disposal well paid and experienced lawyers. These lawyers enable the insurers to draw up and validly incorporate exclusion clauses covering almost every contingency imaginable. Such clauses are couched ⁱⁿ such clear language that the contra preferentum rule is inapplicable, and the insured is left almost literary at the mercy of the insurer.

By formulating and applying the theory of fundamental breach. Courts have further attempted to protect the weaker party; the insured. Under the theory, an insurer would not be allowed to exclude the central or core obligations of the insurance contract which constitutes its actual essence. The idea here is that a party should not exclude his liability for breaches of fundamental obligations or those that go to the root of the contract. In the absence of such a rule, absurd results might come up, such as of a party to a contract excluding any liability that might conceivably arise under all ~~Moreover, the party who alleges fundamental breach is himself centered~~

circumstances whatsoever. Commenting on just such an occurrence, Lord Devlin in Firestone Tyre and Rubber Co. V. Vokins & Co. Ltd. said:

"This is not in law a contract at all! It is illusory to say: we promise to do a thing but we are not liable if we do not do it". (6)

Contracts of insurance approaching the above situation, are in my opinion, in existence today. How else can one construe a Personal Accident Policy (7) in which the insurer undertakes to "pay the appropriate benefit to the insured" if "the insured person shall suffer accidental bodily injury which shall independently of any other cause result within two years in the death, disablement or incurring of medical expenses", and then lists down twenty three excluded activities. Included in such activities are boxing, football including rugby, motor-cycling, use of wood-working machinery, wrestling etc. These are activities which the insurer undoubtedly feels increase the risks of personal accident too much, but they are so common place that for instance, a football/rugby enthusiast would be quite surprised to learn that the insurer would give no compensation if he met an accident while playing the game. In this manner, the insurer seems to be undertaking to cover people for personal accident only if he is reasonably sure that no such personal accident can occur! It may be that the insurers are therefore avoiding falling foul of the theory of fundamental breach only marginally so that the insured is still largely unprotected by the theory.

~~The scope of the protection offered by the theory of fundamental breach is substantially limited because it can only be applied through the courts when a dispute has arisen, and not at the time the contract is entered into. Moreover, the party alleging fundamental breach~~

bears the burden of proving it and this is sometimes too much for the insured who has only a limited amount of resources or experience to devote to litigation. Since it can only be invoked after fundamental breach has occurred, the theory offeres "too little too late" to the weaker party. It appears to be an attempt to cure after allowing the disease free reign to develop. It is therefore felt lthat this area of insurance contract law should be reviewed with a view to coming up with viable solutions aimed at prevention rather than correction.

Lest we be accused of blotting out "the other side of the story" it should be mentioned here that the standard form contract is not "all bad". Thus it continues to exist in commercial activities because of the convenience it endows. Where as in insurance contracts, a large number of largely similar type of contract is transacted, the standard form is an "indispensable" aid in expediting the transactions. In fact, the lack of bargaining which is such a great disadvantage to the insured has been cited as an advantage as it leads to expeditious transactions. The standard forms, being used routinely, are easier to fill, to check and even to correct. It has also been argued that the standard form is also advantageous in helping parties to attain certainty in their dealings. The standard form contract anables parties to transcend the need for them to re-negotiate and bargain for every transaction. Moreover, as it is conceded that the insured posseses insufficient knowledge and experience to properly comprehend the insurance contract, little benefit, it is argued, would accrue to him merely by his having a chance to negotiate for his "own" terms.

It is submitted however, that despite all the foregoing justifications for retaining the standard form contract in its rigid form in

insurance law, so many abuses and injustices are disclosed in practice that there can be no doubt that a less rigid system is by far to be preferred. Although the terms under a standard form contract of insurance can sometimes be altered by endorsement, this is so limited as to be deemed a mere ornamental provision. Mr Kephers Atieno Usenge, an Assistant Manager at Blue Shield Insurance Company Ltd stated that endorsements are in practice only used at the option of the insurer. They are also not subject to negotiations and may be used to further oppress an insured since they may exclude liability in certain specific circumstances or make indemnification of the insured subject to certain conditions. Thus, it would undoubtedly be against the interests of the insured to insert an endorsement reading:

"EXCLUSION OF THIRD PARTY WORKING RISK

It is hereby understood and agreed that except so far as is necessary to meet the requirements of the Legislation, the company shall be under no liability under section II of this policy in respect of liability incurred by the insured arising out of the operationhereto". (8)

But although endorsements can be used to oppress, it would be erroneous to consider them as totally against an insured's interests. Thus, endorsements do exist which actually increase the insurer's liability as where one declares:

"It is hereby understood and agreed that the limit of the amount of the company's liability for Medical Expenses under section III in respect of any one accident is increased to Shs ...".(9)

It is therefore submitted that the endorsement is a neutral tool which can either be used to benefit the insured or oppress him. Since the insurer is in control of this tool, he should be discouraged from ~~using the endorsement as a weapon against the insured either by~~ Legislation penalising him for this or by other measures.

~~In conclusion, it may be stated without a doubt that the standard form~~

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contract in insurance is here to stay. What should however be constantly reviewed is in what form it is used and whether it is being used as a means of unjustified exploitation of one party by the other. In the next chapter, what the legislature has done under the Insurance Act (1984) to ensure that such exploitation does not occur will be evaluated.

2.2 THE CONCEPT OF DISCLOSURE

The very nature of the insurance contract as a prime example of the class of contracts Uberimae Fidei, that is, of the utmost good faith, forms the basis of the duty of disclosure imposed on the parties thereto. This means that parties to the insurance contract are bound to volunteer to each other before the contract is concluded, information which is material to the risk undertaken. This duty is in vivid contrast to the caveat emptor (buyer beware) rule employed in the wider commercial contract context, where utmost good faith is not required, and each party is expected to bargain for his terms as best as he can. In this wider context, none of the parties is under any such duty and they can withhold any information privately held - even where it is central to the subject matter of the contract - from the other party. Thus, the contract is by its very nature as a contract uberrimae fidei distinguished from other contracts. This concept is not of recent development as is evidenced by Lord Mansfield's statement in the now famous case of CARTER V BOEHM made in the mid-eighteenth century that:

~~"Goodfaith forbids either party by concealing what he privately~~
knows to draw the other into a bargain from his ignorance of the
fact and his believing the contrary". (10) (Emphasis mine).

As can easily be discerned from the above, the utmost goodfaith, at
least in theory, is required of the insurer as well as the proposer

for insurance (the would-be-insured). Note the more recent statement of Ivamy that:

"It is a fundamental principle of Insurance Law that the utmost good faith must be observed by each party", (11) (Emphasis, again, mine).

This ideal position does not, in fact, obtain in practice as the duty is imposed solely on the proposer/insured while the insurer is free to virtually disregard his duty. The justification advanced in support of this practice is that the insured is at an advantage in that he knows more than the insurer about the subject matter. Scrutton L J in Pickergill V. London & Principal Marine and General Insurance Co. Ltd stated:

"The underwriter knows nothing of the particular circumstances of the voyage to be insured. The insured knows a great deal and it is the duty of the assured to inform the underwriter of everything that he is not taken as knowing so that the contract can be entered into on an equal footing". (12)

This justification must have been convincing as at the time of its formulation in the 18th century, but it no longer is. During the eighteenth century, it was the usual practice to insure sea-going vessels before they sailed. The vessels were sometimes so far from the underwriter(s) that it became impossible for him inspect the ship. The underwriter(s) therefore has to rely almost exclusively on the information given to him by the insured who clearly had an advantage as to the knowledge relating to the ship. Today, the same conditions do not subsist even in marine insurance. Present day underwriters, usually in the form of insurance companies, have at their disposal specialists in the field of risk assessment - actuarial scientists - whose special knowledge and experience puts the underwriter at par with the insured's knowledge, if not higher. Contemporary communication systems mean that an actuarial scientist or agent can be dispatched to inspect the subject matter and can report back to the

underwriter immediately if necessary. In such a setup, the underwriter has a distinct advantage over the proposer and the latter's personal knowledge of the subject matter may only even out the differences in the extent of knowledge between them. Both the parties should therefore, it is submitted, be under a similar duty of disclosure "so that the contract can be entered into on an equal footing".

× The duty of disclosure imposed on the parties has enormous implications:

"An applicant for insurance is under a duty to disclose to the insurer (and vice versa), prior to the conclusion of the contract but only up to this date, all material facts within his knowledge which the latter does not or is not deemed to know. A failure to disclose, however innocent entitles the insurer to avoid the contract ab initio, and upon avoidance it is deemed never to have existed". (13) (Emphasis mine)

Because the insurer need not, under the common law, plead non-disclosure at the commencement of the contract, he can wait until the insured has paid up large amounts of premiums, suffered a loss and put in an apparently valid claim before he (insurer) conveniently pleads non-disclosure and avoids the contract. The fact that the avoided contract is "deemed never to have existed" means that the insurer can profitably retain any premiums already paid since the insured can claim nothing under the erstwhile, "non-existent contract".

Criticism may also be levelled at the application of this doctrine as causing too much uncertainty. It is not clearly discernible if and when non-disclosure has occurred. The duty of disclosure demands that the proposer makes only statements of fact and not opinion. The demarcation between these two concepts is very thin and it is not always an easy task to distinguish between them in practice. Such a

distinction is however of the greatest importance in practical terms. This is well illustrated in Joel V. Law Union & Crown Insurance Co. (14). In this case, a statement as to the health of the proposer made by her was regarded as a statement of opinion and that therefore, it disclosed no breach on her part to make a full disclosure. The insurer had alleged that the proposer was in breach of her duty to make a full disclosure because she had failed to state that she suffered from mental illness. The reasons for the holding is that a proposer who is not a medical expert or told specifically by such an expert of facts as to his health cannot be expected to give more than an opinion.

But further to the requirement to make a full disclosure of facts and not opinions, the insured must disclose all material facts. He will still be in breach of his duty even if he discloses all the facts in his knowledge but fails to disclose some material facts deemed to be within his knowledge. His duty is not to disclose facts - period! - but those facts which are material. What is material is defined by the Marine Insurance Act (15), S 18(2) thus:

"A circumstance is material if it would influence the judgement of a prudent underwriter in fixing the premium or determining whether he will take the risk" (my emphasis).

The definition of what is "material" is hence hinged upon "the judgement of a prudent underwriter" or insurer. The test is meant to be objective - what a reasonable insured would regard as material and therefore likely to

"influence the judgement of a reasonable or prudent insurer in deciding whether or not to accept the risk, or what premium to charge, or whether to impose particular terms such as an excess or an exclusion in its contract with the proposer" (16).

The test boils down to a determination based on the "reasonable insurer" who acts in accordance with longstanding practices.

Because the test of materiality depends on the opinion of a prudent insurer, the courts have long been prepared to accept as evidence of whether or not particular facts are material, the opinion of other insurers. This, to my mind represents a very dangerous yardstick to depend on. The court should act with extreme caution bearing in mind that what represents prudence to the insurer may culminate in the undoing of the insured. Add to this the fact that all insurers are impelled by the profit maximisation motive and the result is, in my opinion, a very volatile and distressing situation. This is especially so because the insurers called to give expert evidence may be setting up precedents which may come in handy in their own subsequent litigations. An insurer must also feel a certain amount of affinity for their insurers and the operation of the trite but true adage "birds of a feather flock together" cannot be completely ruled out. The evidence of an insurer on what is "prudence" for other insurers should therefore not be taken to be the gospel truth. As shown in the case of Roselodge Ltd V Castle (17), this is not merely the alarmist warning. In this case, an insurer's evidence that it would be material to an application for insurance many years later that the proposer was caught stealing apples at the age of 12 was ridiculed by McNair J. The judgement of Forbes J in Reynolds V Phoenix Assurance Co (18) is similarly instructive. He rejected the argument that if an insurer is telling the truth and is held to be a reasonable insurer, the courts must accept his evidence as conclusive. This evidence like all other expert evidence, he held, assists the court in reaching its decision but never binds it. This must be so especially because a situation can arise where the court receives conflicting evidence from different insurers.

The proposer's position regarding his duty to disclose all material facts is unenviable. Despite what is, at least in theory, an objective test, how is he to know what is going to influence the reasonable underwriter? In an interview with Mr M M Kogi, an insurance officer I at the office of the Commissioner of Insurance, he stated that this predicament is very easily solved by the insured/proposer disclosing all the facts in which he may harbour some doubt as to materiality. This may be a neat solution in theory but it fails to take into account the fact that an insured knows so little about a "prudent insurer" that everything may be in doubt concerning the transaction. Mr Kogi's test, in such circumstances would require the insured to write out his autobiography if he is to discharge all his duties. Professor O K Mutungi, talking about Life Assurance has clearly articulated the insured's dilemma when he says:

"Human beings are susceptible to all sorts of ailments, some serious, others minor. For instance, the number of times one experiences headaches or stomach complaints are countless and no human memory should beexpected to recall all of them. To the layman, there may be nothing in any of those headaches to give the danger signal of a hidden problem" (19).

To expect the insured to disclose all that he knows on the subject on the mere off-chance that the insurer might consider them material is unfair. In addition, I found that the proposal form currently in use in the Kenyan insurance industry is such that the insured/proposer may reasonably conclude that brevity is required of his answers to the proposal questions. Thus, a proposal question asking "Is your sight or hearing now impaired or have you ever had any affliction of the eyes or ears?" (20) may appear to require the proposer to detail a list of any such "afflictions" suffered since birth. But this is in direct contradiction with the answer a proposer may give because the

space actually provided for his answer in the proposer form measures a mere 8cm squared. In the absence of any further instruction as to whether the answer can be written separately and annexed to the proposal form, it comes as no surprise that proposers/insureds usually give what are deemed to be inadequate answers to proposal form questions.

The situation is blantly unfair because such answers are construed as not discharging the duty of full disclosure, making the whole contract voidable at the instance of the insurer. This is irrespective of and inspite of the fact that the insured had disclosed all that he thought was material. This has been addressed judicially in Zurich General Accident and Liability Insurance Co v. Morrison and Others where the court stated:

"It seems to us to follow from the accepted definition of materiality that a fact may be material to insurers, in the light of the great volume of experience of claims available to them, which would not necessarily appear to a proposer for insurance, however honest and careful, to be one which he ought to disclose" (21).

But considerations of the shortcomings that encumber the application of the concept of disclosure should not blind us to its positive aspects. Firstly, it is vital to note here that the duty to disclose does not, as it were, require the proposer to "spillforth" all he knows to the smallest details. Some facts, though material need not be disclosed to the insurer. Included under this exception are facts which diminish the risk, facts which the insurer knows or is deemed to know as matters of common knowledge and facts about which the insurer waives disclosure. The harshness of the non-disclosure rule is to some extent abated by these exceptions. In Joel V Law Union and Crown Insurance Co. (22). Fletcher Moulton, L J stated:

"The duty is a duty to disclose and you cannot disclose what you

do not know. The obligation to disclose, therefore, necessarily depends on the knowledge you possess".

In Carter V Boehm (23), Lord Mansfield conveniently and fully set out the limits of the duty:

"There are many matters as to which the insured may be innocently silent - he need not mention what the underwriter knows - scientia untrunque par pares contrahentes facit. An underwriter cannot insist that a policy is void because the insured did not tell him what he actually knew; whatsoever he came to the knowledge. The insured need not mention what the underwriter ought to know, what he takes upon himself the knowledge of; or what he waives being informed of".

An insurer will be deemed to have the knowledge that his agent has if that knowledge was acquired by the agent acting in the scope of his authority, actual or ostensible but:

"It should be noted.....that the fact that the agent could have known of the material factsis not enough. Similarly, the fact that the means of knowledge, for example the name of the doctor of the proposer for life insurance does not relieve the insured of his duty of disclosure" (24).

But the position is quite different where the proposer warrants the accuracy of all statements made in the proposal form. If such warranty exists, no knowledge will be imputed on the agent or insurer even when they know the true position regarding an erroneous statement made by the proposer. Irukwu has stated in his book Insurance Law in Africa that:

"Insurers have taken full advantage of this contractual freedom (under Freedom of Contract theory) by extending the duty of disclosure imposed on the insured. In some of these modern insurance contracts, the insured party virtually warrants the accuracy of all the information (material or not material) supplied in the proposal form". (25)

As an illustration, a warranty of the type referred to above found at the foot of the typical proposal form usually reads:

"I hereby warrant that the statements made in this proposal are true and complete and that, to the best of my knowledge, nothing material affecting the risk has been concealed by me.... I further agree that this proposal shall be incorporated in and taken as the basis of the proposed contract between me and the American Life Insurance Company (Kenya) Ltd whose usual policy

form for this class of insurance I agree to accept". (26)

Irukwu comments:

"The legal effect of this declaration in the proposal form is that if it turns out that the insured's answer to a question in the form is inaccurate, or if he fails to disclose a material fact which he never knew about, the insurance company would be entitled to avoid all liability under the contract despite the fact that the insured acted honestly and in good faith in completing the proposal form". (27)

John Birds states that by means of such a declaration warranting the accuracy of statements in the proposal form:

"Insurers have succeeded in equipping themselves with a potential defence to an action on the policy, much wider than that arising by virtue of the duty of disclosure". (28)

Through these types of clauses, the insurer can wield formidable power enabling him to repudiate policies for non-disclosure even where the facts are not material. Thus, in McKay V London General Insurance Co (29); the proposer for motor insurance stated that he had never been convicted in a proposal form which contained a basis clause. In fact, he had been fined ten (10) shillings many months previously for driving without efficient brakes because a nut had come loose on his motorcycle. Even though this was held not be a material fact for the purposes of the duty of disclosure, the insurers were entitled to repudiate the policy for breach of warranty!

By way of conclusion, it should be put on record that this rather harsh position is somewhat mellowed down by the fact that insurers themselves do not (in the United Kingdom, this as per the Statements of Insurance Practice) always insist on their strict legal requirements and may waive their right to repudiate the contract for non-disclosure especially where the facts not disclosed do not affect the risk or the premium charged. This is still unsatisfactory because it merely provides a paper-thin guarantee based solely upon the

insurers' charitable nature. But as his prime objective is to maximise his profits, it is submitted that his charitable nature (if any) may not always come to the fore. Mr M M Kogi from the office of the Commissioner of Insurance did mention that insurers almost always complied with the Commissioner's "advice" in waiving their strict legal rights for non-disclosure where repudiation would result in clearcut injustice. He however conceded that there were some "difficult" insurance companies. The Commissioner's "advice" is therefore still not a guarantee that the insured can bank on at all times.

The law as it stands now (or fails to stand) may also be partly to blame for what may appear to be the insurer's ruthlessness in avoiding contracts. The insurer is forced to make a very hard choice in "all or nothing" terms. The insurer's only option where the warranty has been breached is either to repudiate the whole contract, or else be deemed to have waived his rights and therefore be compelled to honour all other claims under the policy. The insurer is not free to disclaim a particular liability only and rather than face the torrent of claims that might be pending on the policy if he fails to avoid it, he logically opts to repudiate it. But this may not be such a hard choice to make since he would not have inserted the clause warranting the accuracy of the proposer's statements if he was not prepared to use it!

~~The insurer will also be deemed to have waived his right to disclosure~~ The
if he frames his proposal form question as to suggest that he did not
want to solicit certain kinds of information. Thus, a question
framed: "In the last five (5) years, have you suffered loss by any

event against which you wish to insure?" (30) necessarily implies that any loss occurring more than 5 years ago need not be disclosed. The limit comes down to 3 years where the proposal form requires one to:

"state what accidents have occurred during the past three years immediately preceding the date of this proposal in connection with motor vehicle owned or driven by you". (31) It would no longer be open to the particular insurer to plead non-disclosure in regard of an accident which occurred three and a half years from the date of the proposal. The insured has set his limits and he must adhere to them!

From the foregoing analysis, it may be safely concluded that although the concept of disclosure is to some extent necessary in insurance contracts, its application exposes one party, the insured, to so much exploitation and oppression that its benefits are literally overshadowed and almost cancelled out. Although the concept had built-in protections by which the courts have attempted to check and reduce such oppression, these protections are far from adequate especially in the face of the overwhelming range of powers/rights wielded by the insurer.

In the next chapter, an attempt will be made to evaluate the extent to which and the effectiveness of the measures, if any, taken under the Insurance Act 1984 (Cap 487) to balance the scales between insured and insurer with regard to the concept of disclosure.

2.3 THE INDEMNITY CONCEPT

In Insurance Law, indemnity is understood to mean that where an insured suffers loss or damage, then on the strength of the insurance policy, the insurers will re-imburse him, subject to his compliance with the terms of the policy, for the loss or damage incurred by him (32).

Non-life insurance policies entail, in general, contracts to indemnify the insured only in respect of the loss suffered if it is actually suffered. Such indemnity will be limited to the amount of the loss actually suffered. Property insurances are usually contracts of indemnity and the insured can recover only the value of the interest at the date of the loss.

An insurance contract is not the only contract of idemnity known to the english common law:

"In the widest sense of the term (a contract of indemnity) will include most contracts of insurance and also a contract of guarantee. The word indemnity has however frequently been used to denote a contract by which the promisor undertakes an original and indepedent obligation to idemnify as distinct form a collateral contract in the nature of a guarantee by which the promisor undertakes to answer for the default of another person who is primarily liable to the promisee". (33)

This concept is at the very core of the insurance contract. An important qualification of the above statement must however be made here. This is that the indemnity concept does not apply to all insurance contracts generally but is limited to what is called, the indemnity contract, for lack of a better term. Thus in life assurance, the concept does not operate and the insured does not have to show that he has sustained loss. Indemnity contracts are primarily for the reinstatement of the promisee and would therefore, logically, not apply to Life Assurance becuase it is far beyond even the insurer to claim to be able to reinstate a life. Life assurance contracts are therefore generally regarded as a form of investment for the insurer, and in general, different rules are applied in respect of them. But

"all insurances on property are contracts of indemnity, that is, their object is to place the insured as nearly as possible in

the financial position after a loss as that he occupied immediately before the loss" (34).

Taken at face value, the statement above indicates that the indemnity concept is geared towards protection of insured's interest under such contracts. This, as will be seen, is a misconstruction in the light of how the concept is really applied in practice. The concept stipulates that:

".... the assured in case of a loss against which the policy has been made, shall be fully indemnified, but shall never be more than fully indemnified that is the fundamental principal of insurance and if ever a proposition is brought forward which is at variance with it, that is to say, which either will prevent the assured from obtaining a full indemnity or which will give the assured more than a full indemnity, that proposition must certainly be wrong"(35)

The reasons for the "full indemnity but not more than a full indemnity" rule are, to my mind, based on sound logic;

"If this were not so, there would then be present the temptation to destroy the thing insured for his own (insured's) ends, and that would be contrary to public policy. In the words of Lush J "a policy of insurance is a contract of indemnity against loss and not to produce gains". The law does not sanction any insurance which would directly and immediately make the assured party to gain by the destruction of the thing insured because, if otherwise, there would be a temptation to destroy the thing insured and thereby get the money". (36)

All this is logical and with very noble and proper objectives. Problems, however, begin to crop up because it is not settled what constitutes a full indemnity. Courts have construed indemnity to be of two kinds.

The first construction is based on the general presumption that an indemnity is made in the form of cash. The damage or loss is assessed and a monetary value put on it which is paid to the insured.

In the second instance, parties may contract to the effect that the indemnity be in kind rather than in cash. This means that in the

event of partial loss, the insurers may repair the insured article or otherwise restore it to its original state before damage, without any expense to the insured where there is total loss, the insurers may elect to replace the article with a new one because repairs would be prohibitively expensive.

As noted above, the whole purpose of indemnity is generally acknowledged as being to reinstate the insured to the position he was in before the loss or damage took place. Infact, virtually all policies considered during the research for this thesis contained an express undertaking by the insurer to indemnify (or pay certain benefits in Life Assurance) the insured e.g.

"The company will indemnify the insured against loss of or damage to the motor vehicle and its accessories and spare parts whilst thereon. At its own option the company may pay in cash the amount of the loss or damage or may repair, reinstate or replace the motor vehicle or any part thereof or its accessories or spare parts". (37)

But "indemnification" in terms of cash does not always mean reinstatement in real value of the lost or damaged subject matter. Due to inflationary trends in the economy, the money value of the subject matter as assessed at the time the contract was entered into will not always correspond with its real value at the time when it is damaged, lost or destroyed. (It is conceded that the reverse may occur as when the currency has been devalued - but this occurs only rarely as in Yorkshire Insurance Co V Nisbet Shipping Co. (38)

Hence where the insurer has the option of "indemnifying" in cash or kind, as he usually has, he usually elects to do so in cash because this represents a lower amount in real terms, than the real value of the subject matter as at the time of loss. If and when he elects to do this, the insured gets a "raw deal" because even though the insurer

has apparently paid a "full indemnity" and is therefore free from legal reproach, the same "full idemnity" cannot replace or even repair the subject matter at current market prices. The insured has not been reinstated in real terms and he often has to meet the deficit from his own pocket if he wants to occupy the same financial position as he did before the loss occurred. All this is based on the justification that the insured should never get more than a full idemnity. Apparently, the first part of the rule prescribing that the insured must get a full indemnity is disregarded!

In view of the above, it is submitted that instead of basing the indemnification on the value of the subject matter as assessed at the time when the policy was taken out, it would be more equitable and just to base it on the real value of the subject matter as at the time when the loss or damage occurs. Since the actual loss suffered is what the insurers undertake to make good, simply paying the money fixed in the contract at its inception often falls far short of indemnifying an insured who suffers loss at a much later date. Brett L J in his dissenting judgement in Pitman V Universal Marine Insurance Co (39) stated inter alia, that:

"It is true that the contract of insurance is a contract of indemnity, and that the assured must not be paid more than is sufficient to indemnify him against the loss which the underwriter by the contract of insurance has agreed to indemnify. But the question is, what is the loss against which he indemnifies?...the business inconvenience to the shipowner i.e. the loss in his business can only be met by repairing the ship (the subject matter of the insurance contract) so as to make her as good a carrying machine as she was before. That is the object he desires to attain by the insurance. The loss which he desires to recover and which the underwriter knows he desires to cover, is therefore the cost of repairs, not the dimunition in value of the ship to sell. The cost of repairs is therefore the matter to be indemnified".

It is therefore submitted that real reinstatement will be impossible

if the duty to make good actual loss is limited to the value recorded in the policy as constituting the value of the insured subject matter. This, I am firmly convinced would be best corrected by basing indemnification in the form of cash on the replacement value or the cost of repairs of the property damaged occurs. This would prevent the insurer from hiding behind the "not more than full idemnity" rule while merely paying lip-service to it and paying less than a "full indemnity".

The remarks above should however not be construed as stating that the insurer completely disregards market values when paying his "indemnity". Thus insurance companies must necessarily base their indemnity for repairs and replacement on current market values as at the time of loss. For instance, a Private Car Policy states:

"The liability of the company shall not exceed the value of the parts lost or damaged and the reasonable cost of filling such parts it being understood that the company's liability shall be limited to the reasonable market value of the Motor Vehicle at the time of loss or damage...." (40)

What should be noted however, is that the market values are used when they fall below the value of the subject matter fixed in the policy. The insurers argue that if they paid the higher amount fixed in the policy, the insured would be getting more than a full indemnity since even in case of total loss, such an amount would exceed the replacement value at market prices at the time of loss. In relation to the above clause, the insurers are therefore careful to insert a phrase limiting the maximum amount payable to the amount fixed in the policy i.e. that indemnity may be paid at "reasonable market value" but not exceeding the insured's estimate of value as stated in the schedule". by this phrase alone, the insurer's interests are well covered to meet any eventuality. Thus, if the replacement value at

indemnification on current market prices may also pay... based on indemnifi

current market prices is less than the amount fixed in the policy, the insurer can pay at market prices. (This is the ideal situation for the insured but unfortunately, it rarely arises because of inflation etc). On the other hand, if the value of replacement at market prices exceeds the amount fixed in the policy, he will only pay up to "the insured's estimate of value" in the policy. The insured in this situation does not get a full indemnity since the amount fixed in the policy does not cover what he has lost in real terms. The insurer can conveniently seek assylum in the rule prohibiting the payment of more than a full indemnity even though in reality, he has not even paid a full indemnity.

But this principle that an insured should not get more than a full indemnity does not always work to the insurers advantage. He may in fact, be disadvantaged in certain circumstances. For instance, a machine breaks down whose make is so unique or of such antiquity that spares to fit are virtually impossible to procure locally or within a reasonable time. In such a situation, is the machine to be treated as partial or as a total loss?. The insurer in such a situation may be forced to replace this antique with a new model or to pay a ridiculously large sum of money for the loss which has occurred. But it should not be forgotten that the insurer would have been receiving higher premiums so that he could undertake this higher risk. Moreover, he may still have recourse to the doctrines of salvage and subrogation which may go somewhat towards reducing his actual costs incurred in indemnifying the insured. But this, too, may have more value in theory than in practice because the insurer may be unable to sell the antique at a reasonable price or even to sell it at all!

Basing indemnification on current market prices may also pose problems

of its own. It might be that while such a practice would undoubtedly afford the insured some advantages in the short-term, the uncertainty created by such a measure would cancel out any such benefits in the industry as a whole. Certainty is at the very heart of the insurer's survival and this is why he employs highly qualified actuarial scientists, loss assessors and adjusters etc for the assesment of risks so as to ensure that the premium charged will enable him (insurer) to meet all the claims as they fall due and also guarantee him a reasonable amount of profits for his labours (The 'balanced portfolio' mentioned in Chapter 1). Basing the amount of indemnification on market values as at the time of loss would mean that the insurer could never accurately predict what obligations he might be called upon to meet in the future. The insurer might be unable or unprepared to meet such obligations which would be dependent upon the fickle economic trends. It is therefore suggested here that if such a practice were to be uniformly adopted, it should be open to the insurer to charge higher premiums to cover the inflation of risks resulting from basing indemnity on uncertain market values as at the time of loss. Mr Wanjohi, the Technical Manager at Access Insurance Company Ltd stated that insurers were quite ready to pay an indemnity based on market values at the time of loss. Such a policy was however subject to an escalation clause by which the insured can protect himself from any adverse resulting from the vagaries of economic trends. Such an escalation clause would mean that the insured would have to pay more or else that the insured would exclude liability from the increased risk beyond a certain amount. Although all other insurance companies contacted Blueshield, SunAlliance, Union & Corporate Insurance Companies - Offered a similar clause. Mr Wanjohi, Makwaya and Otieno from different Companies said that escalation

clauses were rarely used, probably because of lack of public awareness of their existence. Another reason for this almost total failure to utilise escalation clauses is the additional cost to the insured. This is a cost the insured should be prepared to pay as a guarantee of full indemnification or reinstatement when loss occurs.

The rationale behind the "not more than a full indemnity" rule is that it prevents the creation of a moral hazard, that is, the temptation for an insured to destroy the subject matter insured deliberately in hopes of making a profit through the fraudulent insurance claim. It is submitted that if the compensation was based on the market values of the articles similar to the insured article or subject matter, this would substantially increase the temptation for fraud. For this reason, it is submitted that insurers are justified in paying no more than the depreciated value of the subject matter at the time of loss. This is, after all, the same principle used under the tort system for satisfactory compensation, that is;

"Compensation for property damage in the tort system...(is subject to the same principle).. - the owner recovers the value at the time of loss or destruction and the value is taken to mean the second-hand value" (41)

But this does not blot out the problems the principle, as applied to insurance law, gives rise to. There is therefore a very immediate need to find a compromise which caters for both the insured's and insurer's needs. Such a compromise may be implied in the statement of Raoul Colinvaux, an undoubted authority on insurance law, that:

"There is nothing to prevent the parties (to the insurance contract from) agreeing in the policy the value of the thing incurred. If they do so, the assured will be entitled in the absence of fraud to recover the agreed value in the event of a

total loss, or if the loss be partial, a proportion of the agreed value; and that the insured can only recover the extent of his loss if it be less. There is nothing illegal about such a contract, provided the over-valuation is not so gross as to amount to a wager. Despite the dicta in Castellain v Preston... it is clear then that a contract of insurance that gives the assured more than an indemnity may be enforceable provided it is not invalid on other grounds" (42)

It therefore appears that by using this avenue of valued policies², the insured can escape the disadvantages of the "no more than a full indemnity rule". The Kenyan position in this regard is however, quite different. Mr Kephers Usenge Atieno, Assistant Manager at Blue Shield stated that although the potential for the use of the valued policy existed they were not actually used because the premiums would be prohibitively high. He stated that he had personally never encountered a valued policy except for academic purposes. Thus, the open avenue apparently open to the insured to use to escape the "no more than a full indemnity rule" turn out to be no more than a cul de sac - a blind alley. It is therefore submitted that the insured is still very much under the bonds imposed on him by the indemnity principle. A resigned attitude is not what is needed in this situation but a spirit of innovation to open up such avenues of escape as the valued policy, reinstatement in real terms etc to the insured. If this is done, the insured can easily circumvent the great disadvantages of the indemnity principle while the advantages to be derived from it are not in any way prejudiced.

2.4 SUBROGATION

The doctrine of subrogation essentially owes its existence to the principle of indemnity. Subrogation is an essential adjunct to and ~~is only another proposition which has been adopted~~ facilitates the application of the principle of indemnity which aims at restoring the insured to the position he occupied just before the loss. As has already been stated above under the section on indemnity, the duty of the insurer to indemnify the insured only goes so far as

to make sure that the latter "shall be fully indemnified but shall never be more than fully indemnified" The doctrine of subrogation facilitates the attainment of this avowed central objective of the (indemnity) insurance contract.

The doctrine of subrogation is one of the mediums used to realise the objectives of the indemnity principle. the word subrogation itself denotes that the insurer 'steps into the shoes' of the insured. This means that if an insured on the occurrence of the events insured against (loss resulting) possesses alternative remedies against third parties who cause such events to occur, then the insurers are allowed, after they have indemnified the insured pursuant to the policy, to take over those rights and to institute proceedings. The insurer's rights to subrogate are not merely confined to pursuing a right of action in the insured's name. He can also take any steps open to the insured so as to effect or facilitate recovery in mitigation or extinguishment of the indemnity they have paid.

From the foregoing, it is manifest that the doctrine of subrogation ~~is~~ is employed in the insurance contract as a means to an end, that end being to realise and adhere to the indemnity principle which will not countenance the insured "profiting from his loss" (a misnomer). This idea was put succinctly by Brett & J in the now famous case of CAPTELLAN V PRESTON. (43)

"The doctrine does not arise upon any terms of the contract of insurance, it is only another proposition which has been adopted for the carrying out of the fundamental rule of indemnity and it is a doctrine in favour of the underwriters or insurers in order to prevent the assured from recovering more than a full indemnity. It has been adopted solely for that reason" (The emphasis is mine).

In DARREL V TIBBITS, (43) Brett L J said that ~~under~~ under the doctrine of

subrogation, the insurers

"are put into the place of the assured with regard to every right given to him by the law respecting the subject matter insured".

Lord Cairns in SIMPSON & Co et al v THOMPSON BURREL et al, (45) said that the insurer was, through the doctrine of subrogation "entitled to

"succeed to all the ways and means by which the person indemnified might have protected himself against or reimbursed himself for the loss"

A vital point to note is that in strict-legal terms

"The right of subrogation does not arise unless and until the insurers have admitted the assured's claim and have paid the sum payable under the policy" (46)

It was found via fieldwork that the Kenyan insurer assures his rights of subrogation by inserting what is technically known as a 'subrogation condition' in the policy. An example of such a subrogation condition read:

Njoki

"Every right of the insured occurred or to occur will by way of subrogation pass to and absolutely vest in the insurer to the extent that the loss or damage insured by this policy may be ultimately made good or diminished thereby" (47)

But in addition to the above condition, 'special conditions relating to claims' are imposed amongst which one reads that

"No one without the written consent of the insurer shall make any admission, offer or promise of payment" (48)

Mr Kepher Otieno of Blue Shield Insurance Company was of the view that such a clause which deprives the insured of the right to make any admission, compromise or promise until allowed to do so by the insurer in effect constitutes subrogation even before the insured has received an indemnity of any sort. I am prepared to agree with him to some extent since such a clause is a mere safeguard to ensure that the insurers rights of subrogation are not tampered with while it deprives the insured of all his rights regarding his property. The insurer has already taken over the insured's prerogative as owner to

decide what course of action to take with regard to the loss or damage he has suffered, while the insurer has not even indicated whether he will admit a claim leave alone pay the insured his indemnity. I am also of the view that such a clause may be criticized as being against public policy in that it may "open the flood gates of litigation" by denying the insured his right to admit liabilities which he can not legally controvert. If the insured fails to admit liability, the most likely result is that a law suit will ensue where the court's time and other resources will be expended unnecessarily.

Ideally, however, the doctrine of subrogation should only attach after the insured has received a full indemnity. McCardie J has articulated this condition as follows.

"The principle of subrogation is ever a latent and inherent ingredient of the Contract of indemnity, but it does not become operative or enforceable until actual payment be made by the insurer.. A not till payment is made does equity, hitherto held in suspense grasp and operate upon the assured's choses in action". (49)

In a nutshell, the doctrine of subrogation enables the insurers so long as they have indemnified the insured under the policy, to acquire the right to pursue anything that the assured may recover from third parties over and above the indemnity money paid by them to the assured. The acquisition of these rights by the insurers is justified by the reason that allowing the insured to keep anything recovered from third parties after he has already received a full indemnity' would be to allow him to get "more than a full indemnity" This would be clearly a contravention of the indemnity principle.

This may be a proper justification for the application of the doctrine of subrogation. In practice however, such a justification fades into obscurity in the face of the lucrative opportunities offered under

subrogation for the insurer to be unjustly enriched.

Having indemnified the insured, the insurer recoups the amount from a third party through the doctrine of subrogation. Prima facie such recoupment may appear to be only fair since the insurer has paid the insured all that is due to him as indemnity. But the insured has already given consideration for the indemnity through premiums which the insurer is entitled to retain in addition to any amounts he may obtain from third parties by way of subrogation. It is submitted that for the doctrine to operate equitably as between the insured and the insurer, the latter should not be solely entitled to retain the premiums even when he has covered his costs (of indemnifying the insured) through subrogation. If the whole concept of subrogation operates to prevent the insured from being 'unjustly enriched' under the insurance contract, shouldn't the insurer also be put under a similar requirement?. The insurer has already received his just reward by way of premiums, which are calculated and charged so as to precisely cover the risks involved and guarantee a reasonable amount of profits. Through subrogation, what is called 'recoupment' in fact operates as an indemnity of the insurer for what he has, in turn, paid to the insured as an indemnity. This being so, it is submitted that the insured should also be entitled to a 'recoupment' of the premiums he has paid to an insurer who has been "indemnified fully" through the doctrine of subrogation.

As already noted in the preceding section, 'indemnification' as used in the insurance contract does not always mean reinstatement. This uncertainty compounds an already serious problem. Thus, it is uncertain whether an insurer's right will arise merely on the insured

receiving that is called an 'indemnity' or whether the test must go further and require a "full reinstatement" The distinction between the two should not be obscured since the parties' fates turn on this. Thus, where for instance, property is insured at KSh 1,000 (Replacement value at the time when the contract is made) while its replacement value at the time of loss that is, what would be needed to get a new item at current market values) is Ksh 2,000, its destruction will entitle the insured to an 'indemnity' of Ksh 1,000. If the insured subsequently receives the other Ksh 1,000 from the party responsible for the loss, must he account for this latter Ksh 1,000 to the insurers on the ground that they have fully indemnified him under the terms of the insurance?. It is suggested that the insured's duty to account should arise only when he has been 'fully compensated' and reinstated to his position just before the loss. In this regard therefore, one must be warned to note that even a reinstatement in the circumstances of the above hypothetical situation would not ignore depreciation, and that the insured is only entitled to the depreciated value of his property ie its actual value just before the loss. It is encouraging to note that the distinction between 'indemnification' and "full compensation" has not been glossed over by Canadian courts. The Supreme Court of Canada stated in LEDINGHAM V ONTARIO HOSPITAL SERVICES (50) that

"The purpose of subrogation is to prevent unjust enrichment and an insured can hardly be said to be unjustly enriched until he receives more than a full compensation for a loss"

Such a view is encouraging in so far as it may lead other courts 'into the light' of this situation and also because other commonwealth courts, Kenya included, are likely to be of the same mind.

The House of Lords in STEARNS V VILLAGE MAIN REEF GOLD MINING CO (51) expressed the limits of the doctrine of subrogation. Thus although gifts given to an insured by a third party after the insurer has fully indemnified him (the insured) are generally subject to the doctrine of subrogation, such rights of subrogation can be defeated but only if

"this money was paid purely as a gift and intended to benefit the insured over and above the insurance money"

recovered by him from the insurer. Sadly, this case establishes only an exception because the insured will only be entitled to retain the gift if it was intended as extra compensation for him. In general, where no such intention has been made expressly clear the doctrine of subrogation will operate to entitle the insurer to the gifts.

In the rare situation where a surplus remains after the insurers have recouped their expenses, the insured is entitled to such a surplus. The credit for this goes to the recoupment rule which entitles the insurers only to the amount paid out to the insured under the principle of indemnity. Such a situation arose in YORKSHIRE INSURANCE CO V NISBET SHIPPING COMPANY (52). The facts of the case were as follows: ✓

An insured ship was lost in 1945 as a result of a collision and the insurers paid the insured its agreed value of £72,000. With the insurers consent, the insured started proceedings against the Canadian Government and the owners of the other ship. The Canadian Government was eventually, in 1955, found liable. The damages awarded were some £75,000 which were properly converted into Canadian dollars at the rate of interest prevalent at the time of loss. That sum was paid to the insured in 1958, but when it was transmitted to the United Kingdom

it produced some £126,000 because the English pound had been devalued in 1949. The insured could not of course deny the insurers entitlement to £72,000 but disputed that they were entitled to the surplus of £55,000.

Diplock, J held that the subrogation rights of the insurers extended only to the terms in which they had paid out.

John Birds (53) has criticised this decision as unfair although logically unimpeachable ie

"After all, the insured had the benefit of prompt payment of the money in 1945. It was the insurers who were out of pocket for some 13 years or more. Had the insurers actually exercised their rights to sue the Canadian Government in the insured's name, they would probably have been better off because they would have been entitled to claim interest on the money for their own benefit"

It appears to me that the insurers failure to take up the option and bring the suit for themselves in the insured's name has contributed to most of their disadvantage. It is therefore just for the insured to have been rewarded for his efforts in organising and directing the litigation.

In conclusion, it may be remarked that being able to retain premiums while they have recouped their expenses under the doctrine of subrogation, Insurers are making pure profits in the form of the premiums already received from the insured but this may not amount to much in real terms because it will depend on how long the policy has been in existence. Moreover, the insurer may not always succeed in his attempts to recover from third parties and his right of subrogation may be of little practical value. Attached to such rights are the disadvantages of expensive litigation which the insurer often has to undertake in the insured's name. When the cause of action fails, the

insurer will get nothing and may in fact, have to bear his own and the third party's costs although this will depend on the courts orders.

Be that as it may, the whole doctrine of subrogation as it is applied today appears unjust. It also appears to be an engagement in double standards in that the insurer is allowed to recoup all his expenses under the policy whereas the insured cannot also get refunded for any premiums he has already paid - on the pretext that this would contravene the principle of indemnity by paying more than a full indemnity and would also constitute unjust enrichment. The insurers merely pay lip service to the indemnity principle and preventing unjust enrichment while they remain the principal beneficiaries of unjust enrichment under the doctrine of subrogation. It is submitted that such practices, if they continue unabated may well plunge the whole insurance into chaos in that the insurance contract will become so unfair that none but the most desperate insured will agree to enter into it. An immediate and pressing need to reform the law relating to indemnity and subrogation therefore exists.

2:5 AFTER-LOSS CLAUSES

Byamugisha both cautions and at the same time defines the after-loss clause when he states that:

"....there is an essential difference between warranties and after-loss clauses. Warranties relate to the insured event in the sense of materially increasing the risk of loss when broken and their breach may actually occasion the loss. After-loss clauses are intended to help to insurer and probably the insured, better compute the loss actually sustained: warranties are intended to minimize the risk of loss; after-loss clauses are intended to help the insurer and the insured determine the proper indemnity and if possible minimize it".(54)

Examples of after-loss clauses include those concerned with notice of loss, proof of loss and title; and co-operation and assistance clauses. Each of these will be examined briefly.

2:5 NOTICE OF LOSS CLAUSES

There exists a difference of opinion as to whether in the absence of an express provision in the policy, the insured is bound to notify a loss to the insurer within a reasonable time. Ivamy (55) is of the view that reporting a loss is within the insured's continuing duty of utmost-goodfaith. Macgillivray (56) asserts, in contrast that the duty of utmost good faith does not apply beyond the inception of the insurance.

"THE LITSON PRIDE (57) case settles the issue conclusively. By determining that there can be a post contractual duty of utmost goodfaith, this case removes the basis of Macgillivray's view. This issue is, however of little practical significance because "it is of course the case that all policies do contain notification clauses" (58)

Examples of notice of loss clauses to be found in most Domestic Package policies in the use today include some dubbed "Special conditions relating to claims" (59). These conditions are

"Applicable after any event which gives rise or may give rise to a claim under this policy"

~~For all claims: any amount payable to the insured shall be subject to the other rights of~~

"The insured as soon as possible shall give the insurer full particulars in writing and at his own expense shall provide all certificated information and evidence in the form and as requested by the insurer"

Under property claims, different rules apply in that " the insured

shall notify the police immediately of any loss or damage due to theft, malice, riot and strikes"

These clauses should not be treated as trifles since the consequences of failure to comply with them may be tremendous. Such consequences will, however, depend on the wording of a particular term. If the term is denoted a 'condition precedent' this means that the term must be complied with as a prerequisite to the insurer's liability. The result of failing to comply with a condition precedent which requires notification of loss within a reasonable time means that the insurer may avoid a particular claim. By contrast, where the insured fails to comply with a mere condition the insurer cannot deny the insured's claim; the insured is in breach of contract and must pay damages to the insurer but the insurer may still have to meet a valid claim under the policy.

But the courts mitigate the consequences of an insured being in breach of a "condition precedent":-

"In practice (the courts will only construe a term as a "condition precedent") where the words "condition precedent" are used or where compliance (with the term) is expressed to be of the essence" (60)

In fact, courts may sometimes refuse to treat a term described as a "condition precedent" as having that status.

In the light of the above, it may appear as if the insured is adequately protected with regard to this type of clause. The real situation is so bad that these clauses may be more accurately described as the insurers' licence to hound the insured to the very

end. They enable the insured to escape liability even where the actual loss has occurred and the claim is valid in all other respects except in regard to the notification clause. Byamugisha writes:"

"...after-loss clauses.. are properly forfeiture clauses. The insured is penalised in the whole amount of his indemnity moreover, one that is already due - merely because he has not given due notice of the loss and so on. No regard is given to the fact that such failure or refusal may not have occasioned any damage to the insurer" (61)

Great care should be taken so as not to obscure the distinction and a very important one at that- between the insurers right to preclude recovery in respect of a single claim regarding which an after-loss clause has been breached; and his right to avoid the whole policy. For the breach of an after-loss clause, the insurer is merely entitled to preclude liability for a particular claim but may not avoid the whole policy or terminate cover.

The courts interpret the after-loss clauses to require strict compliance by the insured with it, or else the insurer will not be held liable to pay the claim thus, where the nature of the notification required under the clause is "immediate" or "forthwith" . (see above), it is .pa

"clear that any delay in notification whether or not the delay was within the control of the assured will be fatal to the assured's claim in the absence of a waiver, at least where the clause is expressed to be a condition precedent"(62) (Emphasis mine)

It is submitted that such a notification clause is so unreasonable that it introduces a highly oppressive and exploitative situation.

This was well illustrated in the case of Re WILLIAMS AND THOMAS AND LANCASHIRE AND YORKSHIRE INSURANCE CO. (63)

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that it introduces a highly oppressive and exploitative situation. This was well illustrated in the case of Re Williams and Thomas and Lancashire and Yorkshire and Yorkshire Insurance. (63)

In this case, the policy involved required the employer to give "immediate notice to the company of any accident causing injury to a workman". Notice was not however given for some seven weeks after the accident as it had not become clear until that time that an injury had been caused; Bingham J nevertheless ruled that the provision had been infringed. The insurer escaped liability.

It is submitted that such a ruling asks too much of the insured. He is not at only required to give notice of loss, but also of events likely to lead to losses seven months into the future. This is sometimes so difficult or even impossible that it almost certainly seals the fate of the insured. Any claim made belatedly as per the provision, however nominally, is almost certain to fail and the insurer has again had it his own way!

Why then do such clauses still exist? Why are they tolerated at all? It has been argued that an insured's failure to adhere to an express notice of loss clause or even under an utmost goodfaith duty exposes the insurer to so much prejudice that the draconian consequences for the insured are justified i.e.

"Commercial practicality dictates that the insurer will suffer prejudice if the assured fails to notify his loss in time to enable the insurer to investigate its causes. It might be pointed out that delay by the assured in notification might prejudice the subrogation rights of the insurer, a loss for which the assured will be liable and which may well cancel out any right to recover". (64)

Such an argument has been vehemently opposed as indefensible and an

over-reaction by among others - Byamugisha who states that the argument is "fallacious because it erroneously suggests that insured's usually act in a fraudulent manner and ignore the goodfaith principle which requires the insureds to behave during the insurance, with the diligence of one who is self-insured. Furthermore, it wrongly assumes that insurers have the facilities to prevent further loss which are not available to insureds. Moreover insurers are not always ready and willing to come to the aid of the insured as soon as they are aware of the loss. Finally, many losses are total so that nothing could be coveivably saved after they have occured". (65)

With all due respect for the above opinions, it is felt that they too contain fallacies. Thus, we would be hiding from reality if we were to hold that the insured and the insurer are at par in regard to the facilities available to them for loss mitigation. It is self-evident that since the insurer occupies a much more powerful economic position than the insured in general, this makes available to him more and better facilities to mitigate the loss. Byamugisha may however have a valid point as I received confirmation from Mr Otieno Usenge of Blueshield Insurance Company that insurers had no means of directly mitigating loss. Mr Otieno however said that prompt notification is still necessary because it enables the insurer to look at the evidence when it is still fresh. This may be critical in determining whether the insurer will be able to trace culpable third parties and enforce his rights of subrogation. Failure to make a prompt notification of loss may therefore cost the insurer his "recoupment".

Again, the insurer's failure to act promptly on becoming aware of the loss should be the more reason for requiring the insured to give

notice of loss promptly. This will give the insurer more time to arrange measures that may ultimately mitigate the loss since the delay, as per Mr Wanjohi of Access Insurance Company, often arises from certain procedural constraints. Hence, the sooner the insurer learns of the loss, the sooner he will be in a position to respond.

It is admitted that in cases of total loss, little or nothing can be done to mitigate the loss. However where subrogation rights may exist, it stands to reason that the insurer can still mitigate his "loss" by effecting any necessary measures to secure his recoupment. It is also felt that prompt notification even in the case of total loss is to the insured's eventual advantage because his claim will be processed sooner, and if valid, paid that much sooner. This will save the insured the inconvenience of a delayed payment which might mean that it does not even reinstate him.

2.5.2 PROOF OF LOSS OR TITLE

This will be dealt with briefly as it poses problems which are largely similar to those posed by notice of loss clauses.

The insured, after notifying the insurer of the loss, must file a claim. The claim is made out by filling claim forms provided by the insurers which may require details as to the insured's name, his particulars, particulars of the insured property, circumstances of the loss, particulars of damage or loss and any other related information available to him. The filling of such forms accurately is crucial because compliance with the requirements is a condition precedent to the liability of the insurer to indemnify the insured. In life

policies, the insured or his beneficiary will usually be required to file with the claim, proof of title to the policy. (66)

2.5.3 CO-OPERATION AND ASSISTANCE CLAUSES

The co-operation with and assistance of the insured to the insurer in the prosecution of legal proceedings is usually made a condition precedent to the insurer's liability. Such a condition precedent need not be addressed specifically towards compliance with the co-operation clause but is usually couched in such language as to act as a blanket provision effecting all the insured's obligations under the policy. An example of such a condition is one which reads: .lm12

"The due observance and fulfilment of the Terms of the Policy in so far as they relate to anything to be done or complied with by the insured or his representatives shall be conditions precedent to any liability of the company to make any payment under this policy."

When Such a policy further provides that

"The insured shall give any other assistance that the insurer may require ", (67)

the assistance and co-operation of the insured is made a condition precedent to the payment of any claim. The provision gives the insurer such wide latitude that he may require the insured to give any kind of assistance which might impose impossible demands upon the insured. The insured will also be deemed to be in violation of the co-operation clause if he makes any admissions, compromises or settlements in respect of a suit connected with an insurance claim. Because such acts can mean the complete loss of the amount an insurer could have recouped under the doctrine of subrogation, the insurer is entitled to avoid the particular claim, but cannot avoid the policy as a whole.

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Use of after-loss clauses to disclaim liability may be unjustifiable if the insurer uses it as an excuse not to meet his liabilities at the eleventh hour by relying on trivialities (splitting hairs). But the situation must be considered in its proper context. Such apparently harsh consequences are, in my own opinion, justified where the insured blatantly disregards his duties after loss has occurred and especially if this leads to the insurer losing any chance of successful recoupment under the doctrine of subrogation. What the insurer stands to lose is his recoupment and the insured can rightly be deemed to have forfeited his right to a similar amount of indemnity by neglecting his duties under the policy.

The insured also enjoys some relief against forfeiture. East African courts have refused to accept as valid clauses inserted in the contract by an insurer unless they pass the reasonableness test. If they fail this test, they will not be enforceable and will be severed from the rest of the contract. Reasonableness in content will be lacking if a clause is irrelevant or only remotely relevant to the substance of the contract. Moreover the court will not as a rule recognise and adhere to the label placed on a term (i.e. whether a "condition precedent" or a mere condition) but will construe it in the context of the whole policy. This establishes reasonableness in terminology. The court will also find a term unreasonable if its fulfilment or performance is "impossible or improbable" or "impractical". This test of reasonableness not only applies to the after-loss clause but also to all other terms and conditions of the insurance contract. The test places limits on the classical "theory of Freedom of Contract" which would have allowed the stronger party (the insurer) to insert any terms into the contract, however unjust,

he wished.

2.6 CONCLUSION

Various issues of substantive law have been examined in this chapter, always paying keen interest on how such issues measures up to the basic tenets of justice and fairness under which all law operates or ought to operate.

The shortcomings of the standard form contract such as lack of bargaining or negotiation between the parties, its rigidity and inflexibility and the one-sidedness of the resulting terms and conditions have been explored. The freedom of contract theory as justification for this kind of contract has been weighed and found wanting.

The attempts made by the courts through the theory of fundamental breach and the Contra Preferentum rule to mitigate the rigours of the standard form contract have been found inadequate. The benefits to be gained from the use of standard form contracts have been evaluated against its disadvantage and it is safe to conclude that the standard form contract is at present indispensable in the insurance industry. Since we are "stuck with it" the only issue then is how the benefits to be derived from the standard form contract can be highlighted and its unfairness reduced. What the Legislature has attempted to do in this regard will be evaluated in Chapter Three.

The concept of disclosure has also been examined. Its basis on the uberrimae fidei status of the insurance contract has been considered. Nevertheless, it has been found that the concept has been made

applicable only to the insured whereas in strict legal theory, the insurer is under a similar duty. The mischiefs occasioned by the use of the concept unscrupulously by insurers have been examined. From all this, the overall conclusion is that as it exists and is applied, the concept of disclosure is far from perfect.

Next to be examined has been the indemnity concept, which is at the very core of all indemnity insurance contracts (non-life insurance contracts). Its rationale and the benefits which it affords the parties have been evaluated. Although it may be concluded that the indemnity principle is essentially of benefit to both parties, the abuses resulting from its corrupted application negatives to some extent those benefits. Sometimes, the indemnity principle is twisted to deny the insured an indemnity leave alone having to prevent him from getting more than a full indemnity.

The doctrine of subrogation has been revealed to be one of the means by which the indemnity principle takes effect. It ensures that the insured does not receive more than a full indemnity and as stated in Castellain V Preston, "It has been adopted solely for that reason". But why should the doctrine be used to prevent the insured from getting more than a full indemnity while subrogation in fact allows the insurer to recoup all his expenses and retain all premiums already paid as pure profits? Again, the insurers pretend to strictly follow the doctrine of subrogation as a means of adhering to the principle of indemnity while they are not averse to contravening the doctrine of subrogation. This is done through the insertion of "subrogation conditions" in the policy which enable the insurer to take over the insured's rights to subrogate - even before they have admitted

liability leave alone paid a full indemnity. This clearly reveals that the insurers are only prepared to "adhere" to the doctrine of subrogation as long as they derive some benefit from such adherence. This is no more than paying lip-service to the doctrine.

Notification of loss clauses which require "immediate" notification without any regard to the circumstances of the insured have been found, to that extent, to be unfair and oppressive on the insured. So too have co-operation and assistance clauses which give the insurer infinite powers to require any sort of "assistance" from the insured. The danger of abusing such unlimited powers is grave. It may however be concluded that the after-loss clause is a useful device in the insurance contract but care should be taken to ensure that it is not used to oppress the insured. Reasonable demands only should be made on him always remembering that he is already labouring under the duty to act in utmost good faith.

In the next chapter, the extent to which the Legislature, by means of the Insurance Act (1984) (68) has succeeded in protecting the insured as the "weaker party" from the exploitative tendencies of the insurers, will be examined.

CHAPTER TWO

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CHAPTER 3

As noted in Chapter One of this thesis, relating to insurance is not a recent phenomenon. Thus, in the medieval world, Barcelona was the first city state to regulate insurance by legislation. This was by means of a 1435 ordinance which was enacted "with the objects of preventing fraudulent abuses and to give preference to their own shipowners"(1). Over half of a millenium later, it is remarkable to note that the current Kenyan legislation on insurance, the insurance Act (2), shares markedly similar objectives. This indicates that over five hundred years of experience in insurance has not perfected it to rule out "fraudulent abuses". As shown in chapter one, "fraudulent abuse" was the norm during the colonial period because the legislation of the day was blatantly discriminatory against the african/black policy holder. This explains in part why one of the major objectives of the present Act. Cap 487 (hereafter referred to as "the Act" was the "Kenyanisation" of the insurance industry. This chapter will seek to evaluate the effectiveness of the Insurance Act in protecting the parties in the insurance contract, especially the insured.

In assessing just how effective the Act is in protecting the parties, and specifically the insured, every effort will be made to relate the various relevant provisions of the Act to the issues of substantive law discussed in chapter two. The real position of the parties to the insurance contract cannot be brought out by merely looking at the substantive law as inherited from the common law of England. Local legislation which qualifies or amends issues of substantive law must be considered. In this respect, Cap 487 is of paramount importance as can be seen by the bold statement in its own preamble that it is:-

"An Act of parliament to amend and consolidate the law relating to insurance and to regulate the business of insurance for connected purposes".

Because it represents Kenyan insurance law in its consolidated form, great importance must necessarily attach to its various provisions. However, evaluation of the reforms to substantive law thereby introduced must be preceded by a note of caution since even a cursory examination of the Act readily reveals that any such reforms are not express. Thus, there is no specific reference to such principles as indemnity, subrogation, non-disclosure etc in the Act. Any reforms relating to these principles and concepts are therefore indirect and must be dealt with in the context. This means that reasonable inferences as regards the various issues of the substantive law of insurance must be drawn from the Act's provisions which indirectly impinge on them. One basic fact which should be borne in mind is that much of the protection afforded to the insuring public with regard to the substantive issues is largely incidental. This contrasts vividly with the avowed intentions of the legislature as articulated by Mr Marcellin Muruthi, the Commissioner of Insurance i.e.

"Apart from seeking to protect the interests of the insured public. the new law (Cap 487) is intended to protect the interests of the insurers as well by developing a strong, healthy and solvent infrastructure of insurance operators".(4) (Emphasis Mine)

Perhaps the most significant changes in the insurance industry introduced by the Act was the creation of the office of the Commissioner of Insurance i.e.

"There shall be a Commissioner of Insurance who shall be appointed by the Minister" (5)

Section 3 (2) of the Act further provides that

"The Commissioner shall, subject to any directions of the Minister, be responsible for the general administration of this Act and the performance of all the duties and functions assigned

to him under this Act" (Emphasis mine).

In overseeing "the general administration of ..(the).. Act", the Commissioner of Insurance (herein-after referred to as the Commissioner') acts as some kind of watchdog charged with the duty of policing the insurance industry. It is therefore quite easy to discern that the performance of the commissioner is so closely interlinked with the effectiveness of the Act that it would be a sheer waste of time to attempt to evaluate either in isolation of the other. The effectiveness of the Commissioner as the protector of the insured public validates the provisions of the Act.

The Act confers powers and imposes duties on the Commissioner which are both far-reaching and extensive. Section 5 of the Act spells out particular duties of the commissioner, which duties, if carried out, would constitute the most direct protections of the insured under the Act. Each of these duties will be evaluated in so far as they relate to specific issues of the substantive law of insurance.

The most direct reference to the standard form contract in the Act is under S5(1)(b) which provides that the duties of the Commissioner shall include :

"directing insurers and reinsurers on the standardization of contracts of compulsory insurance"

Undoubtedly, the standardization of contracts of compulsory insurance is advantageous to the general insuring public because it is convenient and time saving and also creates certainty. The Commissioner's involvement in such as exercise is very welcome because he is presumed to speak for the insured. If standardization must exist, it is much better where the policy holder's interests are articulated by the Commissioner so that the insurer is prevented from

inserting oppressive or unfair terms. This provision has one major drawback, however, in that the commissioner's intervention is restricted only to "contracts of compulsory insurance" Fieldwork revealed that there are only two types of compulsory contracts of insurance in existence in Kenya, namely; third party motor vehicle liability policies and workmen's compensation policies. This means that all the other kinds of policies fall outside the jurisdiction of the commissioner under this section despite the fact that they are largely standard form and only minutely differentiated from insurer to insurer. All these non-compulsory policies are bereft of the protection of this provision and are therefore vulnerable to the abuses perpetrated by the stronger party in a standard form contract as examined in chapter two. The insurer is therefore free to dictate terms favourable to himself however grossly unfair they may be to the insured in the majority of insurance contracts constituted under the non-compulsory class.

The commissioner's contribution as regards the standardization of the contracts of compulsory insurance must, however, not be dismissed out inconsequential. Mr Kephers Atieno, an assistant manager at Blue Shield Insurance Company stated that because of their compulsory nature, these kinds of policies were numerous and that the commissioner's intervention benefited a great number of policy holders. Mr Makwaya, from Sun Alliance Insurance Company also lauded the commissioner's role under this provision, specifically as instrumental to the stabilisation of compulsory (third party liability) motor vehicle policies after the unfortunate collapse of the Motor pool.

Although S5(1)(b) represents a welcome change as regards the law on

standard form contracts in insurance, this reform did not reach far enough in not adequately covering all forms of standard form, compulsory and non-compulsory.

S5(1)(b) should not be read in total isolation if the true and correct position regarding standard form contracts under the Act is to emerge. In this regard, the note of warning with which this chapter commenced must be borne in mind. Thus, we must look beyond the beaten track to other provisions of the Act which, though indirectly, represent reforms to the substantive law in the area of standard form contracts. Thus, the provision under S5(1)(c) that the commissioner's duties include directing insurers and reinsurers... to amend or delete the unfair or oppressive terms from a particular contract of insurance, is significant. This means that the Commissioner now has leeway to intervene in any standard form contract, compulsory or non-compulsory, on behalf of the policy holder. But this provision has its limitation too in that the Commissioner's powers under it are exercisable only "in respect of future contracts". If we take into account that policies, especially life assurance policies subsist for several years or even decades, and the fact that the Act has been in force for a mere 4 years, since 1st January 1987; this fact of prospectivity becomes a major issue. It means that a large proportion of policies (all policies commencing before 1st January 1987) are not covered ^{not retrospective} by this provision and that the Commissioner can do nothing to rescue the affected policyholders from any oppression or unfair terms in their policies. ~~Looked at in this light, S5(1)(c) may appear merely ornamental and enacted merely to pacify the insuring public by giving the appearance that everything is being done to protect them from~~ ^{guidelines of stan}

unfairness and oppression. The real benefits will only be felt several years in the future when the Commissioner's intervention in respect of future contracts' will have gradually weeded out an appreciable proportion of unfair and oppressive terms.

Again, the protection afforded the insured cannot really be brought out by looking at the above two paragraphs S5(1)(b) and S5(1)(c) in isolation. Thus, the Commissioner's duty under S5(1)(a) to take part in .

"the formulation and enforcement of standards in the conduct of the business of insurance with which a member of the insurance industry must comply" may be used by him to stigmatize and therefore limit the abuses perpetrated under the standard form contract. By formulating standards of conduct (with which the insurer must comply) which prohibit the use of exclusion clauses with unfair or oppressive effects on the insured and also requiring that insurers should take into account the insured's needs; (enhancing negotiation and bargaining) as proper standards of conduct, the Commissioner can effectively ensure that the standard form is not just a medium for oppression.

However, S5(1)(a) has as its direct target 'the formulation and enforcement of standards in the conduct of insurance'. Under this provision, the Commissioner is expected to promulgate guidelines spelling out the proper conduct to be followed by insurers, and insurance agents alike . Such guidelines should be chalked out with the ultimate objective of ensuring that the insurer (plus the brokers and the agents) adheres to certain principles of justice and fairness in his dealings with the insured. But how far have these ideal and noble aspirations been realized in the Kenyan insurance market today? Speaking to Mr M M Kogi, an Insurance Officer I at the Commissioner's office, I was left in no doubt that the promulgation of such ~~guidelines or standards of conduct~~ was still a distant pipe-dream for the Kenyan insured. One telling remark was that the Commissioner's office had not as yet put a lot of reliance on S5, preferring instead to use S7. Mr Kogi added that although no formal standards had been

set down in black and white nevertheless, the Commissioner's office did in fact adhere to the spirit of S5(1)(a). Thus, he stated, the Commissioner periodically issued circulars to insurers and others in the insurance industry which required them to discontinue or adopt certain practices. Mr Kogi also stated that in addition, the Commissioner looked at individual cases and 'advised' an insurer accordingly which advice was often followed to the letter. To his mind therefore, S5(1)(a) had been implemented in practice if not in form.

Whereas this form of indirect implementation is obviously better than none at all, certain reservations must be expressed as to its adequacy. Thus, although the Commissioner will intervene to protect a particular insured who is suffering under his insurer's misconduct, he cannot do so in every case because he has to await a complaint from the particular insured so affected. What happens when the particular insured is quite unaware that the insurer's conduct is irregular or if he knows it to be irregular, he is unaware that there exists a Commissioner to whom he can resort for help? This question of ignorance is not far fetched in the present circumstances of Kenya. For instance, a research project carried out by insurance students at the University of Nairobi on the Kenyan insurance market as recently as May 1990 revealed that 97% of members of the public interviewed did not understand insurance at all !. (6) To expect such people to pilot their own causes by seeking out the intervention of a Commissioner they most probably don't know exists is to expect too much! I am firmly convinced, therefore, that this strategy of implementation based on individual cases is far too inadequate in so far as it provides redress for a minority of cases only. The Commissioner's office should therefore appreciate the wisdom and foresight of the

legislature in requiring the actual formulation and enforcement of standards in the conduct of the business of insurance. If and when such standards are put down in black and white, proper conduct will then become a matter of common knowledge and deviation will be more easily noticeable and censured by the Commissioner or even the Kenya Association of Insurers. Definite penalties can be set out which are likely to dissuade an insurer from misconduct. Such definite standards would be useful in mitigating the rigours of certain one-sided principles of substantive law. As in the United Kingdom (where definite Statements of Insurance Practice are followed) an insurer would be prevented from disclaiming liability on a mere technicality where gross injustice would result. Thus, disclaiming liability for non-disclosure would be effectively restricted to cases where such non-disclosure ^{materiality} has substantially prejudiced the insurer's interests.

This would also apply in cases of forfeiture for failing to minutely comply with the requirements of an after-loss clause. The practice of the law relating to subrogation would be similarly affected. All this would, to some extent, balance the scales in the insured's favour. It must, however, not be forgotten that the present situation in Kenya falls far short of this ideal, not because the law does not provide for it, but merely because the Commissioner of Insurance has not implemented the relevant provisions. The Commissioner's undertaking to merely adhere to the spirit of the provision, though commendable, is a mere token measure aimed at pacifying the insured, The insured should be given the whole of the protection due to him under section 5(1)(a), not merely by implementing it, but also by enforcing it. We must now examine the provisions of the Act in so far they relate to the duty of disclosure. We have already stated above that S5(1)(a), by the formulation of standards of conduct, may be used to mitigate the

abuses perpetrated under the concept of disclosure such as preventing the insurer from insisting on his strict legal rights regarding non-disclosure that is, repudiation of the whole policy) on a mere technicality. Section 5(1)(c) also relates to the concept of non-disclosure in so far as it provides that the duties of the Commissioner include directing an insurer or re-insurer to clarify, simplify, amend or delete the wording, terms and conditions of a contract of insurance of which he (Commissioner) is satisfied is obscure or ambiguous. But the Commissioner's powers are restricted only to 'future contracts. Further disadvantages spring from the fact that whereas the terms in a proposal form may be ambiguous, the terms in a policy document are usually explicit and great care is taken to ensure that they are clear and capable only of one meaning. Ambiguity of questions or terms in the proposal form is actually to the insurer's advantage. Any failure to clearly or accurately disclose a material fact by the proposer for insurance because the terms are ambiguous entitles the insurer to disclaim liability or repudiate the whole policy for non disclosure. This ambiguity has important ramifications because, as we saw in Chapter Two, the terms in a proposal form are usually incorporated into the contract by a basis of the contract clause.

Mr M M Kogi from the Commissioner's office stated that the yardstick of ambiguity should not be whether an average insured understands them. Rather, it should be whether an insurance expert such as the Commissioner, insurance lawyer and insurer can understand the terms. He reasoned that it would be a practical impossibility to make the terms so simple that every proposed insured could understand them and further that it was open to a proposer for insurance to consult an

expert if he was in any doubt as to the meaning of the terms.

While I am in complete agreement with Mr Kogi's assertion that the insurance contract is of such technical complexity that few people, besides the "experts", can fully hope to comprehend it, I find I cannot subscribe to the formula of "merely consulting an expert" to make the terms clear. To my mind, this is an unbelievable oversimplification and rather naive in the circumstances of present day Kenya! As we saw earlier, the Kenyan proposer may be quite unaware of the existence or availability of an expert who may be consulted, leave alone afford to pay one. Whereas the proposer in more developed insurance markets may be expected to consult an expert for any necessary clarification, it would be hypocritical to expect the same from his Kenyan counterpart. It is therefore my firm conviction that every conceivable measure should be taken to simplify the terms in both the proposal forms and policy documents for the better understanding of our Kenyan proposer/insured. The fact that complete understanding by everyone may never be achieved should not justify abdication of the Commissioner's duty to see that the best that can be done is actually done.

But S5(1)(c) is, fortunately, not the only provision in the Act which deals with or relates to the concept of disclosure. Sections 80 and 81 of the Act build upon the provision of S5(1)(c) by directly coming to grips with the problems of non-disclosure as related to proposal forms.

S80(1) prohibits the use of a form of proposal or a policy or an endorsement or any form of written matter used by an insurer describing the terms or conditions of, or the benefits to be or likely

to be derived from a policy of insurance, from being "inaccurate or incomplete or likely to mislead a proponent or a policy holder". This is an important provision in relation to disclosure. Thus, if the "ambiguity" in a proposal form leads an insured, erroneously, to believe that he has answered the question adequately and is therefore validly covered under the policy; whereas in fact the insurer can plead non-disclosure on this basis and avoid the policy:- such a proposal form falls neatly within the ambit of this provision (S80(1)). Under subsection 2, The Commissioner may notify the insurer (after giving him, a reasonable opportunity of being heard) in writing that he objects to the form. This is not the end of the matter for, under subsection 3, the insurer may no longer use the proposal form or policy document or endorsement in the same form "to the extent that the objection has not been varied or set aside as a result of an appeal under section 173". Compliance with this provision is secured by attaching a penalty in the form of "a fine not exceeding five thousand shillings" under subsection 4. Section 81 deals directly with the problems encountered when a proposer for insurance makes incorrect statements in his proposal. This has direct bearing on the concept of disclosure as discussed in chapter two.

S81(1)(a) states, in effect, that an insurer can disclaim liability or avoid the policy on the basis of an incorrect statement made in a proposal form effectively only if the statement was material to the risk of the insurer AND

~~also protects the proposer/insured~~
"was made in the knowledge that it was untrue or with no reasonable belief that it was true".

This means that the insurer can no longer conveniently escape all liability under a policy by taking assylum in the concept of non-

disclosure based on the declaration warranting the accuracy and correctness of the statements made in the proposal form and making such statements the basis of the contract. Now, the insurer can only disclaim liability if he shows, in addition, that they statements were not made bonafide i.e. in good-faith. This situation is a far cry from the situation described by J O Irukwu (7) where the insured warrants the accuracy of all the information supplied by him, thus enabling the insurer to avoid the whole policy on the basis of even the most insignificant, trival and immaterial detail contained in the proposal form. Now, even the making of the information the basis of the contract will not avail the insurer of this opporutunity since S81(1) applies "notwithstanding anything contained in or incorporated in a contract of life assurance".

It is that apparent S81(1)(a) applies only to contracts of life assurance. This constitutes its major limitation since it leaves all other 'non-life' policies subject to repudiation or avoidance on the basis of a non-disclosure in turn based on flimsy grounds. Thus, an insurer in an indemnity contract can still validly avoid a whole policy for inaccuracies in a porposal form even where they are neither material nor made in bad faith. This shortcoming of the law needs immediate review and overhaul to bring policy holders in 'non-life' insurance under similar protection as that provided to the assured in a life policy under S81(1)(a).

~~Section 81(1)(b) also protects the proposer/insured for non-life and Assurance.~~ This paragraph also provides, in effect, that an insurer cannot disclaim liability for non-disclosure in a proposal form unless the statement was material AND

"was made within the period of three years immediately preceding the date on which the policy is sought to be avoided or the date of the death of the life insured whichever is the earlier".

This section represents a recognition by the legislature of the existence of the fraudulent practice of some insurers whereby they used to collect premiums well knowing that they could avoid the policy at any time for non-disclosure. The insurer could collect such premiums for periods extending over several years, sometimes over a decade, and then neatly and validly avoid the whole policy for non-disclosure on the flimsy grounds that some material fact had not been disclosed (or was inaccurately disclosed) at the inception of the policy several years back. On avoiding the policy, the insurer was not obliged to refund any of the premiums already paid to him by the insured.

By means of this provision, the insured is now estopped from avoiding the policy for non-disclosure if he has accepted premiums for more than three years. The legal basis for this "estoppel" is probably that the insurer is deemed, by this conduct (the receipt and acceptance of the premiums) to have waived his right to avoid the policy for some non-disclosure he already knows or can easily discover to exist from the very day of the commencement of the contract. But why should it take at least three years before such knowledge can be imputed upon an insurer who is an expert, and who accepts to issue a policy only after a thorough and exhaustive scrutiny of the proposal form? And why should the insured have to lose three years worth of premiums if the policy is completely avoided during this period, for a non-disclosure the insurer knew about since the contract came into being? Logically

looked at, the Legislature appears to be giving tacit approval for this sort of exploitation by allowing such a long period within which the insurer can still validly avoid the Contract. The insurer must not be allowed to continue this kind of exploitation. A government which claims to adhere to certain principles of justice should not countenance the continuation of this kind of situation. It is therefore considered that a much shorter period under this provision would serve the needs of the insurance industry just as well while at the same time ensuring that neither of the parties to the contract of insurance takes advantage of the other.

We should not lose sight of the fact S80(1)(a) and S80(1)(b) can only protect the insured when the prerequisite of materiality is satisfied. But as we saw in chapter two, the yardstick for materiality is hinged on the opinion of the insurer, even though on the opinion of the "prudent insurer". The dangers of the courts reliance on the expert opinion evidence of other insurers to determine materiality were also outlined. It may be, therefore, that the insured will be denied the protection of these provisions because the insurer can more easily prove that certain facts were material whereas the insurer honestly believed them to be immaterial to the risk or premiums charged.

The Act also limits, to some extent, the duty placed on the insured to make a full disclosure in cases where he uses an insurance agent. Under S81(2), the common-law myth that an insurance agent who receives commission from the insurer is also the agent of the proposer for purposes of filling in the proposal form, is exploded. At common law, an agents error in reconciling the proposer's correct statements onto the proposal form was deemed to be the proposer's error. On the basis

of such an error, an insurer could validly avoid the whole policy for non-disclosure. This is the situation which subsisted in Kenya until the enactment of Cap 487, of which S81(2) provides, inter alia, that

".... notwithstanding any law and any agreement to the contrary between the proposer and the insurer, a policy issued in pursuance to the proposal (filled in by the insurer's agent or other servant) shall not be avoided by reason only of an incorrect or untrue statement contained in the particulars so written or filled in, unless the incorrect or untrue statement was in fact made by the proposer to the agent or servant for the purposes of the proposal; and the burden of proving that the statement was so made shall be upon the insurer" (Emphasis mine)

This provision was, no doubt aimed at protecting the insured from the reckless agent who used to fill a proposal form carelessly but at no risk to himself, whereas the insured/proposer stood to be penalised by the loss of the whole amount of premiums already paid plus the indemnity he might otherwise have been entitled to. The possibility of the agent intentionally filling in erroneous details so as to provide his paymaster with an easy way to avoid any liability under the policy cannot be completely ruled out. This was therefore a problem of mammoth proportions especially when viewed in the context of the Kenyan insurance market where illiteracy is rife and the practice of an agent filling in the proposal form on the proposer's behalf is prevalent. Section 81(2) is therefore a welcome qualification and departure from the common law position. It now means that a proposer will only have his policy avoided for non-disclosure if he erroneously fills in the proposal form himself or if he gives the agent wrong details, but not where he makes correct statements ~~which are later filled in erroneously by the agent.~~

The Act also protects the insured from the insurer's tendency to overcharge on premiums by providing in S5(1)(d) that the duties of the

Commissioner shall include:

"the approval tariffs and rates of insurance in respect of any class or classes of insurance"

By addressing itself on the insured's pet worry,- exorbitant premium rates - this provisions, no doubt came as a welcome relief to the insured. Mr M M Kogi, of the Commissioner' Office stated that the section was somehow superfluous. He stated that this could be seen from the fact that to the best of his knowledge, the office of the Commissioner of Insurance had, since its establishment, received no complaints about exorbitant premium rates. The reason for this he added, was that it would be against the insurer's own interests to unreasonably raise premium charges in the highly competitive Kenyan market as this would result in his being pushed out of business for lack of clientele.

Although the above reasons do in fact constitute a very important check on raising premium rates, I still find that the enactment of S5(1)(d) is not superfluous. Leaving the insurers to regulate themselves as they will, with regard to premiums may not be far sighted enough. It is my firm conviction that the legislature, in enacting this safeguard, contemplated a situation where self-regulation of insurers based on the fear of losing custom might not work. Thus, if all the insurer's raise their premium rates at the same time, each would maintain his relative market share and still earn more from the raised premiums. The insuring public would be left with no option but to take up the policies at the higher rates of premium offered. In such a situation, the formal enactment of S5(1)(d) requiring that the Commissioner must approve all premium rates is not superfluous but in fact a very solid safeguard protecting insureds from the mischief of exorbitant premium rates. This is of importance in that the insurer is

for instance, prevented from inserting such unreasonable and oppressive rates in the standard form contract which he controls. The insurer's ability to dictate oppressive terms under the standard form is to that extent further eroded - and the insurer is now in a position to get fairer terms.

In the statute (Cap 487), section 5 as a whole represents the most direct protection of the insured party. This is not true in reality. Mr Kogi stated that although S5 details the Commissioner's particular duties, it had not been implemented. He stated that the office of the Commissioner of insurance preferred to lay reliance upon S7 of the Act.

Perusal of S7 revealed that any protection it affords the insured is indirect and therefore largely incidental. Section 7 confers power on the Commissioner of insurance to call for information and production of books or papers from a member of the insurance industry relating to his insurance business. If an insurer fails to comply with such a 'request' for information, he will be deemed to have failed to comply with the provisions of the Act, - which would entitle the Commissioner, ultimately, to petition for that insurer's de-registration (at least in theory).

Read together with S5(2) which requires the Commissioner to furnish to the Minister an annual report on the working of the Act, section 7 would be, in my opinion, an effective safeguard against misconduct by, inter alia, insurers. The annual report is to be laid by the Minister before the National Assembly, therefore becoming a public document available and subject, to the scrutiny of all and sundry. Because insurance as a business is so sensitive to publicity, this laying bare

of the inner workings of an insurer's business would be a great incentive for insurers to avoid misconduct.

The most disheartening thing about section 5(2) is that it has never been put to the test. In the 5 year period that the Act has been in force and the office of Commissioner of Insurance has been in existence, no annual report has been produced. Mr Kogi revealed during the interview that the first annual report, for the year ending December 1989, was just then being prepared. He attributed the 'delay' to lack of adequate staff despite the Act's provision that:

"there shall be appointed such other staff as may be necessary for the efficient administration of this Act". (8)

It remains now to wait and see whether even this belated annual report will finally see the light of day and whether it will have the deserved effect of inhibiting insurers' misconduct .

Now, we must consider other provisions of the Act which provide protection for the insured, though in less direct ways than the provisions already considered. Principal among these are the provisions relating to an insurer's financial status. The Act makes very detailed and specific demands on insurers regarding their financial status. Thus, under Part V in the Act, an insurer must have and maintain certain solvency margins if he is to be registered, or if already registered, if he is not to be deregistered. Part V also prescribes other rules which impose restrictions on the manner in which an insurer's assets may be invested. Thus, the Commissioner may direct an insurer to realize an investment which he (Commissioner) considers undesirable or unsuitable - and the insurer must comply with such direction (9). Part IV of the Act demands that an insurer

keep and maintain a specified amount of deposits at the Central Bank of Kenya, in Kenya Government securities, at all times. Under this Part, detailed rules relating to the maintenance of the deposits are enumerated. In line with its 'Kenyanisation' objective, the Act prescribes the minimum capital or equivalent holding by Kenya citizens (10). All the above elaborate requirements are made on the assumption that the more financially stable an insurer is, the more likely he is to fulfill his obligations to the insured under the contract of insurance. This assumption is taken a step further by the assumption that insurance companies controlled by Kenyan shareholders are less likely to exploit their fellow Kenyan insured.

In general, no one could find fault with these assumptions. These sections are therefore a welcome step on the road to greater fairness and justice in the insurance contract in use today. Failure to meet the financial requirements under the Act has fatal consequences on the continued existence of a member of the insurance industry - in the form of deregistration. The requirements are stringently applied as is indicated by the actual deregistration of Uchumi Insurance Brokers Ltd in June 1988. (11) Access Insurance Company almost suffered the same fate of deregistration in February 1991, on the basis of "insolvency detected as per its 1989 accounts". (12) It managed to save itself at the eleventh hour by an appeal to the Commissioner citing a "substantial improvement" in its finances as at December 1990. Mr Kogi, at the Commissioner's office confirmed that strict observance of insurer's (and other's) financial status was a continuous process taking a great proportion of the staff in the office. This is significant in the light of staffing problems already facing the office and illustrates the Commissioner's firm conviction

that as long as the insurers are financially stable, the insured is bound to get his due under the Contract of Insurance. Mr Kogi revealed that greater emphasis was being laid on this task of ensuring that insurers were financially stable as plans were now at an advanced stage to form a "crack-field team" to be sent to the field to ascertain doubtful information on finances.

But while the general idea behind all this may be true, it must be remembered that it is based on an assumption and that there is no foolproof guarantee that because an insurer is capable of meeting his obligations to the insured, he will do so. Are we to believe that an insurer refuses to waive its strict legal rights in favour of fairness, under the concepts of non-disclosure, exclusion clauses, subrogation or indemnity because he cannot afford to pay? It should also be remembered that even where the insurer is financially stable, he is still impelled by a profit maximisation motive. Mr Kogi refuted this profit maximisation danger by stating that the insurer (or his servant) is a reasonable man too who on being advised to pay a certain claim (a claim he could validly disclaim) for the sake of justice by the Commissioner usually assented to do so. This idea has one main shortcoming: it is based on the assumption that all aggrieved parties will seek the Commissioner's intervention - who will then deal with each case individually. Again, we must remember the ignorance of the Kenyan insured which might mean that the Commissioner is only dealing with the tip of the ice-berg while a great majority of the grievances go unreported and unnoticed. Thus, while monitoring of financial stability is generally beneficial to the whole industry the Commissioner should not regard it as the panacea to solve all the insured's problems. In fact, it may be that more financial stability

might mean less protection for the insured since the insurer is more prepared and ready to defend any legal action that might arise from his avoiding a policy or disclaiming liability. Depending on the insurer's gracious nature provides no guarantee to the insured that he will be justly or fairly treated in all circumstances.

In concluding this chapter, it may be safely stated that although the Insurance Act (Cap 487) was enacted with good intentions, it has not resulted in any radical changes which might provide adequate protection for the insured. Moreover, the provisions already present to do this have largely been left unimplemented. The Commissioner's attempts to provide redress in individual cases are inadequate because he can only do so if and when actual complaints are made. Taking the prevalent lack of public awareness of and about insurance in Kenya today, very few complaints reach the Commissioner's attention. Moreover, the Commissioner almost entirely relies on ensuring that insurers are financially stable as a means to ensuring that the insured's interests are protected. This is not such a guarantee as can be banked on by the insured because it revolves around the insurer's benevolent nature - which benevolence may be in evidence where profits are at stake.

In a nutshell, it may be stated as a fact that the Insurance Act does provide some protection for the insured, but such protection falls short of the insured's needs. In the last chapter of this thesis, it will therefore be necessary to attempt to draw general conclusions and make recommendations for the reform of the Law and practice in the light of these conclusions.

FOOTNOTES

1. Supra, P
2. Cap 487, Laws of Kenya
3. Cap 487, P9
4. Cf, Supra, Chapter 1, Footnote No.66
5. S3 (1), Cap 487
6. Phase I Research Project by Insurance Students, University of Nairobi (NUISA) on the Kenyan Insurance Market, Table 1 - Awareness - P10.
7. Supra P see Chapter 2, Footnote No. 25
8. Cap 487, S4(1)
9. Cap 487, S49
10. Cap 487, S23
11. Finance Magazine October 31, 1988, P21
12. The Weekly Review, March 1 1991, P23

CONCLUSIONS AND RECOMMENDATIONS

In conclusion of this thesis, a brief synopsis of what has been examined in the previous chapters is necessary before we embark on the difficult task of proposing reforms. Such a synopsis must necessarily only deal with the major issues examined in the foregoing chapters.

Thus, Chapter One was basically aimed at tracing back the origins of insurance as a practice. We therefore traced insurance back to the Mediterranean region and specifically to medieval Italy. Insurance initially took the form of a loan without interest - in mutuo gratis et amore. It later on took on the form of a purchase and sale agreement with an in-built restitutive condition. Thus, the restitutive condition applied where the goods being transported by sea arrived safely, so as to restore the ownership to the seller/insured and therefore the corresponding risk of loss. If the goods were lost or destroyed at sea, the purchaser/insurer undertook the whole risk of loss in that the restitutive condition failed to operate. The purchaser/insurer could however retain any goods salvaged after having paid the seller/insured the equivalent of the value of the goods being transported. This, we noted, marked the origins of the important principle of indemnity and of the doctrines of subrogation and salvage.

By 1350, insurance had grown so rapidly that policies of insurance drawn as such were in common use in Palermo and Genoa. This period also saw the advent of the state's intervention in the insurance field

by the city state of Barcelona.

Insurance came to England in the (14th) fourteenth century through Italian merchants known as the Lombards. By 1570, insurance had become so important that it merited the establishment of an independent Chamber of Assurance under the Royal Exchange of London established by Queen Elizabeth I. This development led to the standardization of clauses in marine insurance contracts since they (the contracts) were being drawn up by one person, or more accurately, in one office, This therefore marks the origin of the standard form insurance contract.

In 1720, two insurance companies were incorporated through a royal charter, albeit obtained by resort to actual bribery of the Mornach. With the advantage of limited liability that members could enjoy, insurance companies grew in financial strength and could undertake bigger risks and a wider scope of cover. Individual underwriting, however, did not die out with the incorporation of insurance companies. In fact, individual underwriting of risks flourished under the institution called Lloyd's prompting some people to call the eighteenth century - "the century of Lloyds".

In the same century, Lord Mansfield gave clear articulation to the utmost good faith nature of the insurance contract. He emphasized the need for good faith in marine insurance and laid down the obligation of the policy seeker (proposer) to disclose "all his circumstances" in the landmark case of Carter V Boehm. (1) Thus, the case marks the first clear articulation of the concept of disclosure too.

In 1774, the enactment of the Life Assurance Act distinguished wagering contracts from insurance contracts for all time by requiring an insured to have insurable interest. The Act also provided that no greater amount would be recoverable from the insurers than the amount or value of the assured's/insured's interest.

The importation of insurance and practice into Kenya from England was provided for statutorily in the 1902 Judicature Ordinance. Although there existed in pre-colonial traditional African societies mechanisms for distributing risks, these were purely benevolent while the "imported version" is "primarily a capital accumulation and investment device". (2) These traditional mechanisms are dying out fast and being replaced by the imported "modern insurance".

In the colonial period, there existed several discriminatory statutes which militated against the participation of Africans in the insurance business either as insurers or insureds. These statutes were repealed around the time of independence. In the insurance field, this was through the enactment of Insurance Companies Act in 1960. This Act however left many loopholes through which the insured was exploited and a great many frauds committed by members of the insurance industry. There was a public clamour for changes which eventually led to the enactment of the Insurance Act in 1984 (Cap 487). This Act came into force on first January 1987 and still represents the consolidation of insurance law in Kenya today.

In looking back and taking stock of the issues addressed in chapter two and chapter three, we will combine these evaluations so as to come up with reasonable conclusions based not merely on the common law position on the various issues, but also on the relevant provisions of the Insurance Act, 1984 (Cap 487).

Chapter two commenced with the definition of the insurance contract and a brief exploration of its nature. The insurance contract is unique in that one party (the insurer) receives his payment (premiums) while the performance on his part of the obligations under the contract depends on the occurrence of some event which may not happen for many years. Indeed, a basic feature of the insurance contract is its alcatory nature. This raises the important question of how the insured, who begins paying premiums at the beginning of the contract, can be sure that the insurer will infact honour his obligations when the time comes. This assurance is of great importance in maintaing public confidence in the institution of insurance. It is therefore crucial that ways be found to ensure that both parties get what they contracted to get.

The standard form contract, of which insurance contracts are a prime example, are (as per our evaluation in chapter two) one of the obstacles strewn in the path of ensuring that both parties fulfil their obligations to each other. The insurance contract made under the standard form is rigid and not amenable to alteration. It is a contract of adhesion not subject to bargaining or negotiation between the parties thereto on its terms and conditions. It is therefore a contract of adhesion in that the insurer has drafted the terms and

expects the insured to adhere to those terms. The insurer's greater bargaining (economic) power enables him to dictate those terms and to present it to the insured on a "take it or leave it basis". The insurer can therefore insert terms favourable only to his interests, and therefore unfavourable to the insured's interests. In this regard, the insurer inserts numerous exclusion clauses which limit or extinguish some of his liabilities and obligations under the contract. Examples of such clauses are reproduced in chapter two of this thesis.

Why is this blatantly unfair situation allowed to subsist? It is ironical to note that the standard form contract, being the result of an "agreement" almost totally lacking even the semblance of negotiations and bargaining is justified and sheltered by the theory of Freedom of Contract. This theory myopically expects the parties to the contract to have varied, modified, or amended the terms of the contract through bargaining. The fact that the insured has entered into the contract is seen as signifying his sincere acceptance of its terms since he should (the theory postulates) have refused to contract at all if he deemed its terms to be too harsh. This freedom to refuse to contract is non-existent as where the use of the standard form is universal, where there exists monopolies and in cases where insurance cover is compulsory as in Workmen's Compensation and Third Party Motor Vehicle Liability insurances.

In the face of such a situation, it can only be concluded as a matter of course that the insured not only needs protection, but needs to be rescued from this unfairness and oppression.

The Courts have attempted to protect the insured through the contra proferentum rule under which any ambiguous terms in the contract are construed strictly against the interests of the insurer. However, as we noted in chapter two, this protection is inadequate firstly, because it can only be invoked where the dispute gets to court. Secondly, there must be ambiguity in the terms and it will not operate against clear unequivocal terms however unfair and oppressive they are against the insured.

The courts have also attempted to protect the insured (as the "weaker party") by formulating the theory of Fundamental breach. The theory prevents either party (but actually the stronger party - insurer) from excluding the central or core obligations of the contract. Its major shortcoming is that, like the contra proferentum rule, it can only come to the aid of the insured when a dispute has arisen and has reached the court. Moreover, the insured bears the burden of proving the alleged fundamental breach. Further, the insurer can employ such experienced draftsmen (lawyers) that though the terms of the contract are only marginally removed from constituting fundamental breach, they never actually fall foul of the theory. Similarly, experienced lawyers are employed by the more economically powerful insurer to "get him off the hook" when he is in actual breach.

To supplement these protections are the provisions of the Insurance Act (Cap 487) 1984 which are relevant to the standard form contract. These were noted in Chapter 3 but a brief recapitulation is necessary at this juncture. Thus S5(1)(b), empowering the Commissioner of

Insurance to direct insurers and reinsurers on the standardization of contracts of compulsory insurance was welcomed as an important step towards the better protection of the insured. The Commissioner's contribution in this regard in the area of Third Party (Motor Vehicle) Liability insurance after the unfortunate collapse of the Motorpool in 1986 was lauded by various insurers. S5(1)(b) has one major limitation: it is applicable only to policies of compulsory insurance. This leaves a majority of insureds - holding non-compulsory insurance policies - vulnerable to the abuses perpetrated by the drafting of standardform contracts by one party (the insurer) who is uninhibited and free to insert any terms that take his fancy.

In respect of S5(1)(b), it is therefore recommended that the scope of application be extended to cover non-compulsory insurances. As this remains the preserve of the legislature, it may be recommended in the wider context of other reforms proposed later in this thesis that this widening of the scope be made only after reviewing the whole Act.

S5(1)(C) empowers the Commissioner to direct insurers and reinsurers to amend or delete unfair or oppressive terms from a particular contract of insurance. This in effect means that even where oppressive or unfair terms find their way into the contract, the Commissioner can effectively intervene on behalf of the insured to have them removed. This protection is however applicable only in respect of future contracts. As noted in chapter three, this leaves all contracts entered into before 1st January 1987 outside the scope of this provision. This limitation is, to my mind, justified since

making the provision of retrospective effect would really amount to altering the legal rights and obligations of the parties - which would be unfair to them and also contrary to public policy. But because of the limitation on the Commissioner's jurisdiction, he should in turn diligently apply the powers conferred on him under S5(1)(C) to ensure that all new contracts have neither oppressive nor unfair terms. If this is done, unfairness and oppression under the insurance contract should become a thing of the past in the Kenyan insurance market with the expiration of policies contracted before the 1st of January 1987.

S5(1)(d) requires that tariffs and rates (premiums) charged by insurance companies must be approved by the Commissioner of Insurance before they come into effect. It was noted in chapter three, sadly, that this provision was disregarded and not used, the Commissioner preferring to rely on free market forces to push an over-charging insurer out of business. It was however also noted that this later method was ineffectual where the insurers "ganged up" to raise premiums uniformly in the whole industry. An insurer may also continue to overcharge indefinitely while his business thrives due to the lack of perfect knowledge in the market. This means that insureds may not be aware that there are better deals elsewhere. But even where the insurer eventually becomes insolvent through the operation of market forces, this means that unwary insureds who contract with him towards the end may suffer loss and inconvenience in looking for alternative insurers despite the protection offered by solvency margins. Why should these insured be treated like sacrificial lambs if an alternative, and a viable one at that under S5(1)(d) is within easy reach? It is recommended therefore that S5 (1)(d) be implemented

as soon as possible as market forces provide only unsatisfactory protection which is further more, not foolproof or guaranteed. As the situation stands today, the Commissioner is definitely remiss in his duty and also guilty by default of facilitating the continued exploitation of the insured through exorbitant premium charges.

It may be safely concluded from the foregoing that the law and practice of insurance contract law in the specific area of the standard form contract leaves a lot to be desired. However to give credit where it is due - the statutory provisions already in existence appear to provide comprehensive and substantial protection, and the major problem, in my view, is that these provisions have never been implemented. Thus, as noted earlier, it was learnt that the office of the Commissioner of Insurance had never put section 5 to the test but preferred to rely on section 7 of the Act instead. Section 7 requires inter alia, the insurers to provide information to the Commissioner from which the latter is expected to prepare annual reports for the Minister who is in turn expected to table such reports before the National Assembly. Sadly, even Section 7 has never been fully implemented and it may therefore be said with certainty that since section 5 has also been left to lie idle in the statute, then the insured has enjoyed no extra protection from the enactment of (Cap 487) the Insurance Act 1984.

The Standard form is today indispensable in insurance contracts. Its use confers great benefits in terms of expediting transactions certainty and enabling the parties to transcend the need to re-

negotiate for terms at every transaction. In a word, the standard form is indispensable because it is convenient - and because there is no other viable alternative. It facilitates commerce. It is however important to remember Lord Justice Ackner's observation that "convenience and justice are often not on speaking terms". (3) The convenience or dictates of commerce must therefore not be allowed to conveniently trample justice underfoot. The area of the standard form contracts must, therefore, be kept under constant review so as to keep a balance between convenience and the ends of justice.

We also addressed ourselves to the concept of disclosure (or non-disclosure as it is more commonly called). In its original form, the duty to make a full disclosure was imposed on both parties to the contract of insurance because utmost goodfaith - or uberrimae fidei - was equally required of both the parties. Later, it was applied in a one sided manner - on the insured alone who was deemed to have superior knowledge about the subject matter of the insurance while "the insurer knew nothing". This was justified in the field of marine insurance in the circumstances of that period in history. In chapter two, the continued one-sided application of the doctrine in present day circumstances was found to be completely unjustified and the cause of great unfairness and injustice to the insured party. In today's world, the insurers knowledge may, in some instances, even exceed the insured's, and where it is less, the insurer has the resources and ability to easily acquire the necessary knowledge. Problems with the duty to disclose were also discussed in relation to the sometimes obscure distinction between facts and opinions. This problem arises due to the existence of ambiguous questions in proposal forms which

often elicit opinions from a proposer while the insurer can avoid the whole policy for non-disclosure on the basis of incorrect or inaccurate statements in the proposal form. We also noted the extension of the duty of disclosure by the use of the basis of the contract clause or declaration at the foot of typical proposal form in use in Kenya today. These clauses convert all statements made in the proposal form into warranties since the proposer must warrant their correctness and accuracy. This gives the insurer even more room to "conveniently" avoid the whole policy if and only when a claim arises. The policy is avoided abinitio and it is deemed never to have existed thus preventing the insured from recovering any of the premiums already paid under the policy. The fact that the insurer acted honestly and in good faith and also reasonably in the circumstances while filling in the proposal form does not prevent the insurer from avoiding the policy abinitio. It is also irrelevant (where the basis of the contract clause exists) that such "non-disclosure" did not prejudice the interests of the insurer. Thus even where there is no causal connection between the non-disclosure and the loss which has occurred, or where the non-disclosure would not have affected the insurer's decisions to undertake the risk or on the premium to charge, the insurer can still validly avoid the contract abinitio.

Thus, where a basis of the contract clause and declaration occurs, avoidance is completely independent of the materiality or non-materiality of the "undisclosed facts" (and sometimes opinions!). But even if materiality is taken into account, very little difference is seen since the definition of what is material is itself hinged upon

the reasoning of a prudent insurer. The probability of bias in determining materiality was noted and illustrated by case law in chapter two. All in all, we are putting it mildly when we conclude that the concept of disclosure is one-sided and unfair against the insured person.

Although the Insurance Act has not made any direct reference to the concept of disclosure, we noted in chapter three that there have been, nevertheless, substantial reforms of the concept instituted indirectly in the Act. First among these is section 5 (1)(a) which empowers the Commissioner to formulate and enforce standards of conduct for members of the insurance industry. This calls for the promulgation of guidelines and a definite code of conduct which will ensure ethical/moral conduct by insurers, among others. With such wide latitude, the Commissioner could make it unethical for an insurer to avoid a contract for non-disclosure where such breach was not fraudulent and has neither increased the risk he undertook nor the premium he would have charged had he known of the undisclosed fact.

But section 5 as a whole has not been implemented at all. The Insurance Commission claims to have adhered to the spirit of section 5(1)(a) in substance if not in form through the issue of circulars to insurers and "advising" them to adopt or desist from certain practices. It was conceded that there were some "difficult" insurance companies who refused to heed his "advice". In fact, this may be more widespread than the Commission was prepared to admit and raises the spectre of the insurers coming to regard the Commissioner as an enemy to be resisted at all costs. This is clearly illustrated by the

attitude of one insurer who wrote:

"..... the Commissioner in exercise of his purported authority trend to force an insurance company to pay a claim the company refused his arbitrary demand ...".(4)

It is submitted that unless this dangerous escalation of hostilities is checked, the protection of these informal circulars and advice will be negligible.

The following recommendations are made in respect of section 5 (1)(a).

Firstly, standards of conduct akin to the statements of Insurance Practice in force in the United Kingdom should be formulated and enforced! In relation to the duty of the parties to make a full disclosure, such standards should provide that

1. The declaration at the foot of the proposal form should be restricted to completion according to the proposer's knowledge and belief. In this respect, some Kenyan insurance companies must be wholeheartedly commended for having adopted this formula already.
2. Blanket conversion of statements as to past or present facts in proposal or policy documents should be prohibited. Insurers should however be free to require specific warranties about matters that are material to the risk.
3. Prominently displayed on the proposal form should be a statement:
 - i) drawing the attention of the proposer to the consequences of the failure to disclose all material facts.

The determination of materiality should be based on a more objective test taking into account both the insurer's and insured's (reasonable persons in each case) circumstances

ii) Warning the insured/proposer to disclose any facts about which he is in doubt about materiality. In addition, adequate space should be provided on the proposal form to permit full-disclosure.

4. The insurers should use clear questions in the proposal form to elicit statements considered material.
5. Questions requiring expert knowledge or which would require a value judgement (opinion) on the part of the proposer should not be included in the proposal form.

The above recommendations should be made to apply uniformly to all contracts of insurance.

It is also important to put on the record the reforms to the law of non-disclosure effected by sections 80 and 81 of the Act.

Section 80(1) prohibits the use of any documents by the insurer which are "inaccurate, or incomplete or likely to mislead a proponent or a policyholder". The Commissioner can object to such documents and they must be set aside forthwith.

Section 81 limits the insurers entitlement to repudiate or avoid the contract for non-disclosure to only those situations where the

statement in the proposal form was material to the risk and was made in the knowledge that it was untrue or with no reasonable belief that it was true.

Again section 81(1)(b) requires that avoidance of the contract for non-disclosure will be valid only if the statement was material and was made within the period of three years immediately preceding the date on which the policy is sought to be avoided. This prevents the insurer from fraudulently refusing to avoid a contract he knows is invalid for non-disclosure until a claim is made, so that he can unjustly retain the premiums collected up to the time the claim was made. However, it is recommended that this period of three years is too long and that a shorter period of say, six months be imposed to ensure that the insurer does not gain so much at the expense of the insured.

It is also recommended that the ambit of these sections be extended to include non-life (indemnity) insurance contracts especially because they are in the majority.

These recommendations would no doubt require the commitment of more resources if they are to have the desired effects. It has, for instance been contended that including the warnings and provisions recommended above would make proposal forms and policies unmanageably lengthy. I submit respectfully that slightly or even more voluminous documentation in the insurance contract is by far to be preferred to the rampant injustice that pervades this area of insurance law at present.

To ensure more enthusiastic adherence to the Standards of Conduct, it is recommended that the insurers should be invited to contribute towards their formulation. With the feeling of affinity that would result from participation, adherence would be more probable and would with time, eventually develop into self-discipline. The insurers should also be involved in reviewing these standards and even in any additions, amendments or repeals to make the standards promptly responsive to changing needs. This flexibility would definitely be an advantage over statutory enactments.

In the preceding chapters, we also addressed ourselves to the principle of indemnity which requires the insured to get "a full indemnity but never more than a full indemnity" Non-Life insurance is all about indemnity in that the insured pays premiums in the hope that if he suffers loss within the terms of the policy, the insurers will reimburse him (or indemnify him) to the extent of that loss. The insured can recover only up to the value of his interest at the date of the loss because it is feared that he would cause deliberate loss to the subject matter if he could recover more. This is clearly a valid justification. However, insurers have been so intent to ensure that the insured does not recover more than an indemnity that they have completely neglected the other part of the rule requiring them to pay at least a full indemnity. Although the insured should not "profit from his loss", he should be put back in the position he occupied immediately prior to the occurrence of the loss, that is, he should be reinstated to his pre-loss financial position.

In practice, the insured gets less than a full indemnity because when payment is made in terms of cash, inflationary trends are not taken into account. The insurer pays only up to the amount fixed in the policy and this is usually inadequate to replace or repair the damaged or lost item. It is therefore recommended that indemnification, if in cash, be based on the depreciated value of the subject matter as assessed at the time of loss. I am firmly convinced that by this means, real reinstatement would be possible and it would be more equitable and just to both parties.

The principle of indemnity also serves the interests of the insurers in that he has the option to pay either in cash or in kind and he often chooses the method which is less costly. This means that the insurer will pay only the amount specified in the policy if restoration or replacement of the subject matter would be more expensive. If the reverse is true, the insurer will always choose to actually replace or repair the subject matter. By this means, the insurer can again take advantage of his superior position as the draftsman of the contract by providing for this option. It is recommended that the insurer should be made to be consistent so that he does not deny the relevance of actual loss in calculating indemnity where such loss is greater than the amount specified in the policy while he pays only up to the actual loss where it is less than the amount stated in the policy. A viable means of ensuring this, while still keeping within the indemnity principle, is by consistently calculating indemnity on the basis of the actual loss sustained. After all, this is what indemnity is all about - reimbursement for the

actual loss suffered. Allowing the insurer the freedom to insert the option so that he can always pay the lesser amount is tantamount to abetting or indeed facilitating a no risk situation for the insurer - a "heads I win tails you lose" scenario - at the expense of and to the insured's detriment.

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It was noted in chapter three, with concern, that the Insurance Act 1984 (Cap 487) did not address itself directly to the area of indemnity. However, it was pointed out that the Act contains stringent financial requirements which must be fulfilled by an insurance company before it can be allowed to engage or continue in the insurance business. The insured is thereby said to be protected from financially weak companies which are seen as unreliable and therefore more likely to fail to ^{honour} their obligations towards the insured. It is assumed that strong insurers will be of benefit to the insured because their financial strength assures the insured that the insurer will meet his obligations, including his major obligation of indemnifying the insured. But as we have noted above, the insurer may only go through a farce of paying a paltry sum "in full indemnification" which does not really constitute reimbursement. To crown it all, the insurers may in fact use their greater economic strength to deny the insured any indemnity by contesting all claims since he can now retain experienced lawyers to argue his case. It is therefore little more than wishful thinking for the Commissioner of Insurance to stress economic strength of insurers so much in hopes that this strength will directly, be translated into the greater protection of the insured.

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This supports the need for the recommendations made earlier in the principle of indemnity. It may be that if such reforms are not made, soon, the only tie connecting the insurer and insured will not be the hope of an indemnity but actual enmity!

The fourth issue of the substantive law of insurance dealt with in this dissertation is the doctrine of subrogation. Per Brett L J in Castellain V Preston

"subrogation is a doctrine in favour of the underwriters or insurers in order to prevent the assured from recovering more than a full indemnity. It has been adopted solely for that reason". (5)

The doctrine of subrogation is therefore a means to facilitate adherence to the principle of indemnity. After indemnifying the insured fully for his loss, the insurer is entitled, under subrogation, to step into the former's shoes with regard to his rights against third parties who may be liable for the loss. However, current insurance practice is such that the insurer can gain subrogation rights by employing a "subrogation condition", even before he has paid any indemnity to the insured. It is manifest that this is done in contravention of the doctrine of subrogation itself. The insurer should therefore be prevented from benefiting from his wrong. In this regard, it is recommended that the "subrogation condition" should always contain an express undertaking by the insurer to pay a full indemnity before it can take effect. This recommendation may be effected by the Commissioner employing his powers under section 5(1)(c) - directing the insurer to amend or delete oppressive terms or under section 5(1)(a) - the formulation and enforcement of standards of conduct in the insurance industry.

When the insurer takes over the insured's rights under the doctrine of subrogation, he is entitled to recoup his expenses in regard to the indemnity paid out to the insured from anything which can be recovered from tortious third parties. Recoupment may also be recovered from any other sources which go towards diminishing or extinguishing the insured's loss. The insurer is almost certain to get back any money paid out in indemnity since he only pays indemnity to the extent to which the insured was blameless for the loss or damage sustained. In effect, the insurer will only pay out an indemnity where there are tortious third parties. The insured could have recovered compensation for his loss from such tortious third parties and the insurer (having paid an indemnity) now proceeds against them in the insured's name under the doctrine of subrogation. Where the insurer has completely recouped his expenses through subrogation, he is still entitled to retain the premiums paid under the policy. Thus, the doctrine of subrogation appears hypocritical and one sided in its objective of preventing the insured from getting unjustly enriched while the insurer gets a net profit in the form of premiums from the transaction. Both parties are at par as having already received what was due to them under the contract. The insured has received an indemnity for his loss. In turn, the insurer has received recoupment of his expenses. Why then should the insurer retain the premiums paid ^{saved} by the insured as a form of profit when he has incurred no net expenditure? *double profits? why not insured?*

Two propositions for reforms borrowed from French (civil systems) law in this area are recommended.

Firstly, if the insurers can prove that the recoupment sums they received were less than they paid out so that they can be deemed to have lost by the contract, then they should only get the sum equivalent to the full indemnity money less the premiums they had received from the insured. Anything that remains should go to the insured.

Where the insurer has been fully recouped, neither party can be deemed to have lost anything under the contract. It is respectfully submitted that the above position is somehow inequitable in that it recommends that only the insured should profit. It is therefore recommended that any surplus should be shared equally pari passu - as between the insured and the insurer.

One important fact needs to be remarked upon at this juncture. This is the disheartening fact that the Insurance Act 1987 (Cap 487), made not a single reform to the doctrine of subrogation. The Act does not even mention the doctrine by name and the legislature appears to have been oblivious of its existence, leave alone that it had any problems requiring urgent reform. Be that as it may, we are "only interested in securing the future not in avenging the past". As such, it is hoped that this important though somehow troublesome doctrine will receive the attention it deserves so that it can become more fair and thereby acquire some form of moral, if not legal, legitimacy. This will only occur if reforms such as the ones recommended above are implemented. It is however recommended that further research, much more detailed than constituted in this thesis, should be carried out

to determine with precision what needs and can be done to reform the law surrounding the doctrine of subrogation. This is the only way of ensuring that reforms to ensure fairness for the insured are not themselves unfair to the insurers.

Lastly, we looked at the issue of after loss clauses in the second chapter. We noted that after-loss clauses are intended to help the insurer better compute a loss that has already occurred and therefore to determine the proper indemnity and if possible minimize it. We considered Byamugisha's (6) assertion that after-loss clauses "are properly forfeiture clauses". They are forfeiture clauses because the insured (who fails to comply with the after-loss clause) is penalised in the whole amount of his indemnity - moreover, one that is already due - because he has not given due notice of loss, fulfilled his assistance and co-operation obligations and so on. We illustrated the harshness of this by various examples taken from policy documents from a number of insurance companies. These after-loss clauses required strict compliance and this compliance was found to be a condition precedent to the insurers' liability. These clauses are usually couched in peremptory language as where the notification is required to be "immediate" or "forthwith". Any delay in notification whether or not the delay was within the control of the insured will be fatal to the insured's claim especially where the clause is expressed as a condition precedent. Further, no regard is given to the fact that such failure or refusal may not have occasioned any damage or loss to the insurer.

As portrayed above, the use of the after-loss clause to disclaim liability appears to be no more than a convenient way of escaping liability for a claim that is otherwise valid and already due, by relying on a trivial technicality. However, it should be remembered that these clauses may appear inordinately draconian only because they represent the insurer's last assurance against the loss of any recoupment that may be had the doctrine of subrogation. This should however not excuse the fact that such clauses, on the other hand, deny the insured any hopes of getting an indemnity for which he may have been paying premiums for a long time.

The Insurance Act 1984 (Cap 48) has not addressed itself to the law relating to after-loss clauses as such. However, it must not be forgotten that in addressing itself, albeit indirectly, to the problems posed by the unfairness of the standardform contract, the Act has thereby provided a means to reform all terms in the contract. Thus, the formulation of standards of conduct by the Commissioner of insurance should include provisions prohibiting the use of unreasonably onerous after-loss clauses. The Commissioner should also use his powers under Section 5(1)(c) to direct insurers to amend the wording or completely delete unfair or oppressive after-loss clauses from the contract. It can not be over-emphasized that the Commissioner needs to urgently rouse himself (the whole commission of insurance) by breathing life into the provisions of the Act by implementing them as soon as possible.

The following specific reforms are recommended to the law relating to after-loss clauses.

Firstly, on conditions regarding notification of a claim, the policyholder shall not be asked to do more than report a claim and subsequent developments as soon as reasonably possible. Thus such words as "immediate" and "forthwith" should never appear in after-loss clauses.

Secondly, if the failure or delay in notification did not prejudice the insurer's rights under subrogation to a recoupment of his expenses, such failure or delay should not be used to disclaim liability by the insurer. The insurer should only be entitled to damages which should be deductible from the amount payable under the claim.

Thirdly, where it is possible to calculate with some degree of certainty the amount of recoupment "lost" by the insured due to a failure to comply strictly with an after-loss clause, the insurer should still be held liable to pay an indemnity less that amount of "loss". The insurer is still, of course, entitled to sue the insured for breach of contract at his option.

The courts should further be encouraged to construe the labeling of after-loss clauses as "condition precedent" strictly against the insurer's interests especially where such a label makes performance impossible or impractical.

In conclusion, it may be remarked that although the existence of some form of after-loss clauses is justified and in some cases even desirable, care must be taken to ensure that they are not used to trap the insured into forfeiting valid claims by making totally unreasonable demands upon him. This can only be done if the above, and similar recommendations for reform are actually implemented.

In concluding this thesis, it is felt that certain general remarks need to be made. First of all, it must be conceded that the study giving rise to this thesis was neither comprehensive nor exhaustive in so far as it dealt only with a few selected issues of the law of the insurance contract. Thus, such important areas of that law as insurable interest, assignment, fault, contribution, double insurance and so on received little or no mention. Therefore, the conclusions reached and the recommendations made in this thesis are likewise, neither comprehensive nor exhaustive. The herculian tasks of undertaking a really exhaustive study on the law of the insurance contract must, of necessity, be left to a person(s) with adequate means and the resources to do a good job.

Nevertheless, it is felt that certain general conclusions can be safely drawn from this study and within its limitations. The first such major conclusion is that insurance contract law, as it stands today, is manifestly unfair and unjust to one party - the insured. This is hardly surprising in the circumstances and would appear to lend credence to the statement of one Henry Ward Beecher in the 19th century that: "organised business is a thing of law; and law is always

hard and unrelenting towards the weak" (7). The Insurance Act (Cap 487) has however attempted to alleviate some of this unfairness and this is commendable. Not so commendable is the failure of the Commissioner of Insurance to implement most of those provisions of the Act which would undoubtedly convert the intentions of the Legislature into reality. It is therefore submitted that the present difficulties that the insured is facing are not so much the result of lacunas in the law as in the laxity of enforcement of the existing law. But it should be remembered that unless attended by the resources necessary for their implementation, reforms not only fail to improve a situation, but (when attended by publicity) potentially make it worse, as the public can be lulled into a false sense of security. It may be therefore true (as evidenced by the lack of adequate staffing) that the Commission of Insurance is not so much lethargic in the implementation of the provisions of the Act as it is restricted by the inadequacy of limited resources.

Finally, let us conclude this thesis by making some general recommendations without which the specific reforms recommended earlier may have little or no impact on the insured's welfare.

Firstly, it is recommended that programs be instituted with the assistance of the insurance companies to educate the insuring public on the basics, and even the intricacies, of the insurance industry where possible. In this regard, the Nairobi University Insurance Students' Association's "take insurance to the people project" referred to in chapter three is commendable. This project did infact reveal

that insurance is an undecipherable enigma to a majority of the Kenyan people. This problem of ignorance was highlighted in chapter two as one of the major problems facilitating the exploitation of the insured under the standard form contract. In addition, every effort must be made to make the terms and conditions of the insurance contract as simple and unambiguous as practically possible.

All the recommendations made in this thesis can never, of course, amount to a magic elixir to cure all the ills of the insurance contract law and practice. No single recommendation can ever hope to do so. However, as a final recommendation, I would advocate the continued review of the law and practices being used in the insurance business today. This may require the establishment of a body in the form of a commission of inquiry, comprised of insureds, insurers and even the Commissioner of Insurance and other members of the industry such as the insurance brokers. Only in this way can we ever hope to ensure that justice is done to both parties of the insurance contract. Only then can we join Disraeli, that eloquent British politician and statesman, in saying that "Justice is truth in action"(8) and American Justice Potter Stuart that "Fairness is what justice really is".

CONCLUSIONS AND RECOMMENDATIONS

FOOTNOTES

1. (17) 3 Burr 1905; 97 ER 1162
2. Footnote No.46, Chapter 1
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Vol 3, April 1970, No.2, P152
3. Lord Justice Ackner, Observer, "Sayings of the Week" 25th October 1981.
4. The Weekly Review, April 26 1991, P27; "The Problems of the Insurance Commissioner.
5. Op Cit P395
6. Op Cit P19
7. Henry Ward Beecher (1813-87) Proverbs from Plymouth Pulpit, 1887.
8. Benjamin Disraeli (1804-81), House of Commons, 11th February 1851

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