SECP
INSURANCE DIVISION
Islamabad

Before Tahir Mahmood, Commissioner (Insurance)

In the matter of

Pak Qatar Family Takaful Limited

Show Cause Notice No. and Issue Date:	ID/Enf/PQFTL/2018/13252 Dated January 15, 2018
Date of Hearing:	March 7, 2018
Attended By:	1. Mr. M. Nasir Ali Syed Chief Executive Officer Pak Qatar Family Takaful Limited 2. Mr. Farrukh V. Junaidy Director Pak Qatar Family Takaful Limited 3. Mr. M. Kamran Saleem CFO & Company Secretary Pak Qatar Family Takaful Limited 4. Mr. Waqas Ahmad Chief Operating Officer Pak Qatar Family Takaful Limited
Date of Order:	March 21, 2018

ORDER

Under Section 12(1)(a) & (4) read with Section 156 of the Insurance Ordinance, 2000

.....

This Order shall dispose of the proceedings initiated against M/s. Pak Qatar Family Takaful Limited (the "Company"), its Chief Executive and Directors for alleged contravention of Section 12(1)(a) & (4) of the Insurance Ordinance, 2000 (the "Ordinance"). The Company and its Directors shall be collectively referred to as the "Respondents" hereinafter.

2. The Company is registered under the Ordinance to carry on family takaful business in Pakistan.

3. The Commission had initiated thematic review of bancassurance business of insurers / takaful operators in order to check compliance of conduct of business with applicable regulatory provisions. Accordingly, the Company was advised to submit the statement of claims.

4. The Company submitted detail of all the claims intimated/reported to the Company during the year 2016 and half year ended June 30, 2017, vide letter dated October 10, 2017.

5. While reviewing the statement of claims, it was observed that as on October 30, 2017, many claims were pending for a period up to 600 days from the claim intimation date. Whereas, time lags of up to 400 days were also noted in the claims settled by the Company. Synopsis of the aforesaid analysis was as follows:

Claims Reported in 2016 and half year ended 2017	Time Lag/Period	Claims Pending	Claims Settled
71 claims	Less than 90 days	0	12
	90 to 180 days	9	11
	180 to 300 days	11	7
	300 to 400 days	9	4
	400 days and above	6	2

6. Due to long time lags noted in the claims, the Company, vide email dated October 30, 2017, was advised to provide claim documents along with last letter of the Company issued to the claimants entailing pending requirements. The Company provided the claim documents vide email dated October 31, 2017. While reviewing the aforesaid information, few instances were observed wherein unnecessary and irrelevant documents/information were called from the claimants causing delay in the processing of their claims.

7. As per Company's claim submission form, burial certificate is only required in case the deceased policyholder is buried abroad. However, in one instance (Policy No. 4408010005659/ Claim no. Banca0181), it was noted that the Company advised the claimant to submit burial certificate of the deceased, whereas the claimant had already submitted death certificate of the deceased issued by NADRA. Further, a certificate from Cutchi Memon Graveyard (where the deceased was buried) was also submitted by the claimant, which was received by the Company on August 12, 2016. However, the Company advised the claimant to submit the burial certificate vide letters dated July 25, 2016 and October 4, 2017.

8. Explanation was sought from the Company regarding the unreasonable documentary requirements, to which, the Company responded with the following clarification:

"Claim of Mr. Farooq having claim no. Banca0181, was an early death claim wherein death of the covered person occurred within 6 days of the policy issuance date which made

the claim look suspicious to the Company. During initial investigation, it was also noted that the deceased also applied/took an insurance policy from M/s Jubilee Life Insurance one day prior to buying insurance from the Company which made the claim more suspicious. Detailed fact finding was conducted through internal and external investigator. As a result PQFT requested family to arrange

1) Proof of business i.e Transport. (help to establish the financial worth and capacity of deceased).

2) Copies of medical treatment record.

Based on NADRA death certificate, company is not insisting for CNIC number which is a mandatory information on Burial Certificate as per standard practice. As soon as family will share above mentioned information, this claim will process as per merit within 10 working days maximum."

9. The Company did not provide comments on solicitation of burial certificate from the claimant vide letters dated July 25, 2016 and October 4, 2017. The aforesaid clarification could not be considered to be appropriate, as the death claim of Mr. Farooq was also filed with another insurer, which was duly settled by that insurer on August 11, 2016. The Company sought the information from the claimant, i.e. *Proof of business i.e. Transport. (help to establish the financial worth and capacity of deceased,* which should have been collected from the deceased at the time of underwriting of the policy. The Company failed to process the claim despite completion of all reasonable documentary requirements. Therefore, it was inferred that the Company failed to conduct its business with due regards to the interests of its policyholders.

10. In another case (Policy No. 4408780003423/Claim No. Banca0156), the policyholder died from myocardial infarction (heart attack) as per the claim documents, however, the Company advised the claimant to submit police FIR, which apparently did not relate to the said claim. In this regard, the Company provided its response as follows:

"In respect of Claim of Mr. Zulfiqar Ali, Company's investigation revealed that the deceased was a drug addict died outside of his residence. The death certificate from NADRA shows reason of death to be unnatural, which raises concerns with respect to reason of death to be suicide or murder. Therefore, the Company has been asking the claimant to submit copy of FIR. This will help us to evaluate the circumstances of claimed event."

11. The requirement for mandatory submission of FIR in the case of Mr. Zulfiqar Ali was irrational as the cause of death stated in the medical attendant's statement was "myocardial infarction" leading to "cardio pulmonary shutdown. Moreover, the claimant also submitted an affidavit stating that no FIR was filed at the time of death and it was not possible to file FIR after one year of the death of policyholder. Also, solicitation of FIR was not appropriate for ascertaining the cause of death, as in case of death due to myocardial infarction/ heart attack only (natural death), FIR is not registered.

12. Since the Company failed to decide on the outcome of the aforesaid claims for more than 400 days, and also levied unreasonable and unnecessary documentary requirements on the claimants, the Company therefore, failed to conduct its business with due regards to the interests of its policyholders. The long time lags in claim settlement and levy of unreasonable and unnecessary documentary requirements lead to gross inconvenience for the policyholders / claimants and was not, by any means, reflective of the favorable service or regard to the policyholders' interests. The Company *prima facie* contravened the provisions under Section 12(4) of the Ordinance for which penalty could be imposed on the Company and/or its Board under Section 156 of the Ordinance.

13. The Company also submitted persistency levels of its different products in terms of premium due and premium renewed as under:

Bank	Product code	2nd Yr Premium Due		2nd Yr Premium Renewed		Persistency %	
		HY June 30, 2017	2016	HY June 30, 2017	2016	HY June 30, 2017	2016
Bank Islami	103	56,881,456	113,796,385	29,094,663	56,970,849	51.15%	50.06%
	104	12,012,500	23,580,000	7,320,000	9,617,500	60.94%	40.79%
DIB	103	38,957,221	228,685,202	18,100,129	130,701,921	46.46%	57.15%
	104	3,675,500	16,966,500	1,265,500	10,030,500	34.43%	59.12%
MCB	103	26,504,282	153,661,035	16,221,882	78,760,128	61.20%	51.26%
Al-Baraka	103	79,942,709	148,317,273	33,952,672	81,199,826	42.47%	54.75%
	104	5,396,500	6,595,000	2,825,000	3,544,500	52.35%	53.75%
Burj	103	13,461,709	34,353,216	5,459,567	16,946,924	40.56%	49.33%
	104	2,804,000	9,172,000	1,442,500	4,789,500	51.44%	52.22%
Faysal Bank	103	59,073,258	146,961,930	28,737,153	64,380,539	48.65%	43.81%
	104	7,342,500	25,341,000	3,834,000	14,581,500	52.22%	57.54%
NIB	103	3,242,596	7,667,954	2,737,329	2,942,033	84.42%	38.37%
	104	282,000	1,524,000	153,000	942,000	54.26%	61.81%
Alfalah*	103	-	4,024,211	-	656,000	nil	16.30%
Silk Bank	103		923,156		155,128	nil	16.80%
	104	30,000	612,000	-	120,000	0.00%	19.61%
Askari Bank	103	3,235,185	9,379,829	2,636,000	5,313,583	81.48%	56.65%
	104	509,500	2,010,000	194,000	918,500	38.08%	45.70%

**Bank Alfalah (conventional)*

Bank	Product code	3rd Yr Premium Due		3rd Yr Premium Renewed		Persistency %	
		HY June 30, 2017	2016	HY June 30, 2017	2016	HY June 30, 2017	2016
MCB	103	6,167,022	14,668,000	5,089,776	8,122,000	83%	55%
Al-Baraka	103	44,378,634	54,345,996	24,162,033	37,455,497	54%	69%
	104	2,036,500		1,056,500		52%	nil
NIB	103	1,837,366	8,996,667	1,728,002	4,458,000	94%	50%
	104	612,000	1,590,000	438,000	975,000	72%	61%
Silk Bank	103	100,000	2,573,280	100,000	1,032,256	100%	40%
	104	120,000	252,000	60,000	90,000	50%	36%

14. It was observed that second and third year persistency levels in terms of premium due and premium renewed for multiple products were at an alarmingly low level, particularly, for products with Silk Bank, NIB Bank and Bank Alfalah Conventional.

15. It appeared that majority of the bancassurance policyholders of the Company lost their policies and the Company did not give due consideration to the interests of its policyholders. Resultantly, it was inferred that the Company was not undertaking its bancassurance business with due regard to the interests of its policyholders in case of the aforementioned products.

16. In view of the above, it appeared to the Commission that the Company was not undertaking its bancassurance business in a sound and prudent manner, which is in contravention of Section 12(1)(a) and (4) of the Ordinance.

17. Section 12(1)(a) & (4) of the Ordinance states that:-

> *"**Criteria for sound and prudent management.-** (1) For the purposes of this Ordinance, the following shall, without limitation, be recognized as criteria for sound and prudent management of an insurer or applicant for registration as a person authorized to carry on insurance business:*
>
> *(a) the business of the insurer or applicant is carried on with integrity, due care and the professional skills appropriate to the nature and scale of its activities;*
> .....
>
> *(4) The insurer or applicant shall not be regarded as conducting its business in a sound and prudent manner if it fails to conduct its business with due regard to the interests of policy holders and potential policy holders"*

18. Accordingly, a Show Cause Notice (SCN) No. ID/Enf/PQFTL/2018/13252 dated January 15, 2018 was issued to the Respondents, calling upon them to show cause as to why the fine as provided under Section 156 of the Ordinance should not be imposed on them for the aforementioned alleged contraventions of the law.

19. The Company vide letter dated January 23, 2018 sought an extension to submit reply to the aforesaid Show Cause Notice, however, the Company was allowed extension until February 2, 2018 to submit its response.

20. Thereafter, the Respondents submitted their reply vide letter dated February 2, 2018, which is summarized hereunder:

i. The Ordinance and rules made thereunder do not clarify what are the documents that the insurer/takaful company must request in order to process the claim, leaving each insurer/takaful company to have their own pre-set list of documents. The Company processes the claims as per agreed terms and conditions and as per WAQF rules and/or Participant Membership document (PMD).

ii. Moreover, the law does not explicitly stipulate the maximum timeframe in which a claim must be processed after the date of incident or event after the intimation of incident/ death. As per Section 118 of the Ordinance, an insurance/takaful company should only process the merit based claims within 90 days from the date of receipt of all the requisite documents from the claimants.

iii. That the burden of furnishing the evidence/documents within the due course of time rest with the claimant and not with the insurer. Once all the requisite documents are received, then the burden of deciding the same on merit within 90 days shifts to the insurer.

iv. All claims are processed within the allocated time of 90 days after the receipt of all requisite documents, which are needed to verify a claim.

v. Moreover, all claims are processed keeping in mind exclusions as stated in Clause 34 of the Participant Membership document (PMD) already approved by the Commission.

vi. The Commission has quoted two instances wherein it is alleged that the claim documents required of the claimants are frivolous. In the case of Mr. M Farooq, burial certificate was requested from the claimant due to a suspicious nature of the claim. In the case of Mr. Zulfiqar Ali, brother of the deceased undertook to submit a copy of the statement he gave to the police. We have asked for the same report and sent numerous reminders to the claimant.

vii. The Company will not be able to pay out claims without verifying them as all claims are to be approved by the retakaful partners in Germany as they have to pay around 90% of the claim amount. If our retakaful partners do not find the claim convincing, we are told to reject it. Therefore, we need to analyze all merits of a claim, which can only be established once all relevant documentation has been submitted.

viii. Also under Section 204 (2) of Companies Act, 2017, a company has a fiduciary duty to act in the best interest of its members. By paying out the unverified claims, the Company would be in breach of this duty.

ix. Moreover, with reference to the issue of low persistency rates as highlighted in the SCN, we would like to submit that the table seems not correct. As the table was presented at the time of year closing. The new updated table shows that there has been a significant change in the persistency rates.

x. The Company has always kept the interest of policyholders as a top most priority, resulting in dire measures being spelled out by the management in order to retain the existing business. Despite the measures being taken by the Company, the positive outcome of the same remains a big question mark as the decision to continue the membership solely rests with the policyholders.

xi. In light of the above the Company is being run in a sound and prudent manner while ensuring protection of the rights and interests of all the stakeholders.

21. The Commission, vide its notice no. ID/Enf/PQFTL/2018/13883 dated March 2, 2018, scheduled the hearing for March 7, 2018 at the Company Registration Office Karachi.

22. The hearing was attended by the authorized representatives of the Respondents namely Mr. Nasir Ali Syed, Mr. Farrukh V. Junaidy, Mr. M. Kamran Saleem, and Mr. Waqas Ahmed representing all the Respondents before the Commission in the instant matter.

23. During the hearing the Representatives of the Company apprised of the steps taken to improve the claim processing system. They assured the Commission that proactive approach is being followed by the Company and the Company also shares the pending claims report with the respective banks. With regard to the low persistency level, the Representatives stated that the Company's persistency has improved after December 2017 and the Company is working to improve it further. The Representatives requested the Commission to take lenient view in the matter. The Representatives were advised to share the measures/actions taken by the Company to improve persistency level and its claims handling process.

24. In terms of Section 12(4) of the Ordinance, the Company shall not be regarded as conducting its business in a sound and prudent manner if it fails to conduct its business with due regard to the interests of policyholders and potential policyholders.

25. The Respondents have argued that the Commission has calculated the time lag of claims settlement/rejection from the date of intimation and not from the date of completion of claim requirements. Furthermore, the Respondents have insisted that Section 118 of the Ordinance provides a threshold of payment of claims within a period of ninety (90) days from the date of completion of claim requirements by the claimant.

26. The Company has placed the onus of delay for completion of documents on the claimants. However, it is remain to be seen whether the claimants were put under burden to provide unnecessary documents, which were cumbersome to collect and provide to the Company. It is also pertinent to mention here that the Commission did not initiate the instant proceedings under Section 118, which also suggests that liquidity damages be paid to the claimants in cases where the Company has failed to settle the claims within 90 days despite completion of the documents.

27. Needless to say, the Commission initiated the proceeding under Section 12(4) of the Ordinance as it was observed in general that the excessive delay in processing of claims lead to gross inconvenience to the policyholders, which was by no means, reflective of favorable service or regard to the policyholders' interests.

28. The response of Company is not tenable as the long time lags in claim settlement and levy of unreasonable and unnecessary documentary requirements was leading to gross inconvenience for the policyholders / claimants and was not, by any means, reflective of the favorable service or regard to the policyholders' interests. In case of Mr. Farooq, the death claim was also filed with another insurer, which was duly settled by that Company on August 11, 2016. However, the Company did not process the claim despite lapse of significant time since completion of all reasonable documentary requirements.

29. With regards to the low persistency, the Company has argued that as per the year end data, persistency levels have improved. However, the Commission calculated the persistency based on the data provided by the Company i.e. year 2016 and June 2017. Furthermore, the Company has also put the onus of low persistency on the policyholders. As per the revised persistency data, it is apparent that the Company still has low persistency in the products being offered through certain banks, where the bancassurance policyholders of the Company have lost their policies. The Company has explained reasons for low persistency, however assured that it is expanding measures for scrutiny of the persistency levels. The Respondents have assured that the management of the Company shall regularly monitor its business to improve the persistency.

30. I have carefully examined and given due consideration to the written and verbal submissions of the Respondents, and have also referred to the provisions of the Ordinance, the Rules made thereunder and/or other legal references. I am of the view that the violations of Section 12(1)(a) & (4) of the Ordinance are clearly established, for which the Respondents may be penalized in terms of Section 156 of the Ordinance and/or direction to cease entering into new contracts of insurance may be issued.

31. Section 156 of the Ordinance provides that:

> *"**Penalty for default in complying with, or acting in contravention of this Ordinance.-** Except as otherwise provided in this Ordinance, any insurer who makes default in complying with or acts in contravention of any requirement of this Ordinance, or any direction made by the Commission, the Commission shall have the power to impose fine on the insurer, and, where the insurer is a company, any director, or other officer of the company, who is knowingly a party to the default, shall be punishable with fine which may extend to one million rupees and, in the case of a continuing default, with an additional fine which may extend to ten thousand rupees for every day during which the default continues."*

32. In exercise of the power conferred on me under Section 156 of the Ordinance read with S.R.O. 750(I)/2017 dated August 2, 2017, I, instead of imposing a fine as provided under the said provision, take a lenient view, and hereby issue a stern warning to improve its governance and service to the policyholders and in case of similar non-compliance in future, action against the Respondents will be taken.

33. This Order is issued without prejudice to any other action that the Commission may initiate against the Company and / or its management (including the CEO of the Company) in accordance with the law on matters subsequently investigated or otherwise brought to the knowledge of the Commission.

Tahir Mahmood
Commissioner (Insurance)