IN THE HIGH COURT OF FIJI AT SUVA

CIVIL JURISDICTION

Action No. HBC 113 of 2014

BETWEEN

HOUSING AUTHORITY a statutory body established by the Housing Authority Act (Cap 267) having its registered office at Suva in the Republic of Fiji.

PLAINTIFF

AND

DOMINION INSURANCE LIMITED a limited liability company having its registered office at No. 231, Waimanu Road, Suva.

DEFENDANT

Counsel	:	Mr. V. Maharaj for the Plaintiff Mr. D. Prasad with Ms. S. Emmanuel for the Defendant
Date of Hearing	:	15th September, 2016

Written Submissions : 22nd September, 2016 & 28th September, 2016

Date of Judgment : 27th October, 2016

JUDGMENT

[1] On 31st December, 2006 the plaintiff obtained an insurance policy from the defendant called "**Group Mortgage Protection and Insurance Scheme**" (1st Policy) for three years and thereafter renewed annually. The purpose of this policy was to provide the clients of the plaintiff who obtained mortgage loans to secure the repayment of the loan in the event of death or permanent disability of debtors.

[2] On 01st January 2008 the plaintiff and the defendant entered into another contract of insurance called "**Housing Authority Mortgage Protection (Extension) Debtors Medical Insurance Scheme**" (2nd Policy) which covered the medical and hospital expenses of the plaintiff's clients.

[3] The plaintiff made a claim in respect of eleven clients who were its debtors amounting to $487,047.48 which was repudiated by the defendant. The present action is to recover the said amount with interests and costs.

[4] The details of the claim made by the plaintiff are as follows:

No.	Name	File Ref.	A/C No.(S)	DOL	Nature of Claim	Outstanding Claims ($)	Date Lodged
01	Loise T. Vulaono	DP 5849/13/Waqadra	481467	6/05/2010	Death	11,291.60	18/04/2013
02	Sheik Ibrahim	M 2418/14/Labasa	511129	4/09/2012	TPD	49,654.38	12/12/2012
03	Jokatama Senivula	DP 7139/6/Tavakubu	425818	10/09/2012	TPD	19,418.16	23/11/2012
04	Kaveri N. Tiko	SO 5408/18/Manoca	502340	1/10/2012	TPD	33,835.67	18/10/2012
05	Prem Chand	DP 8512/6/Nausori	488003	3/10/2012	TPD	1,560.24	13/05/2013
06	Joeli Koroi Kata	DP 2414/15/Vatuwaqa	446866	24/10/2012	Death	15,846.76	22/05/2013
07	Ram Padarath	DP 5069/3/Nadera	1001HL0000167792	15/11/2012	Death	52,476.91	24/12/2012
08	Melaia Rokobote	DP 7370/11/Caubati	354767	18/12/2012	Death	9,507.47	12/02/2012
09	Aisake Kora	SO3788/31/Caubati	1001HL0000001568	18/12/2012	Death	82,916.91	12/02/2013
10	Vishwa Nadan	DP 6245/1/Nakasi	525383	21/12/2012	Death	206,894.98	1/02/2013
11	Josaia B.	SO 67/45/ Narere	394130	29/12/2012	Death	3,644.38	12/02/2013

	Dugucagi						
						$487,047.48	

[5] In reply to the plaintiff's claim the defendant averred in its statement of defence that the policy was cancelled on 06th November, 2012 and in the claims made in respect of Ram Padarath, Melaia Rokobote, Aisake Kora, Vishwa Nadan and Josaia Dugucagi amounting to $355,460.65, the date of loss is a date after the cancellation of the policy and therefore, the defendant is not liable to pay the said sum. The defendant averred further that it agrees to pay the claims in which the date of loss is prior to the cancellation of the policy.

[6] By way of counter claim the defendant claimed $60,040.80 as premium due on the 1st policy and stated further that it agrees to pay the claims in respect of Loise Vulaono, Sheik Ibrahim, Jokatama Senivula, Kaveri Tiko, Prem Chand and Joeli Koroi Kata.

[7] According to the minutes of the pre-trial conference following are the issues for determination at the hearing.

1. Is the defendant entitled in terms of the policy or policies to increase the premium during mid-term or as the plaintiff claims annually?
2. Was the 2nd policy an extension of the 1st policy or was it completely a separate policy from the first one?
3. In calculating the loss ratio of 80% do you combine the two policies to work out the actual loss (as claimed by the plaintiff) or do you treat the two policies separately as claimed by the defendant?
4. Did the conduct of the parties following the dispute have any bearing on issue No. (1) above? If so, in what way?
5. Did the plaintiff continued to collect the insurance premiums from the debtors after 6th November, 2012 when the policy was cancelled and failed to pay the increased premium to the defendants to validate the insurance policies?
6. Is the defendant entitled to cancel the policy on the failure on the part of the plaintiff to pay the increased premium?

[8] At the pretrial conference the parties have *inter alia*, admitted the following facts:

1. On 31st December, 2006 and in consideration of the premium paid or agreed to be paid by the plaintiff (Policy Holder) the defendant issued to the plaintiff an insurance policy known as '**Group Mortgage Protection Insurance Scheme**' for an initial period of 3 years and thereafter renewed annually pursuant to which each of the plaintiff's clients, who have taken a mortgage loan from the plaintiff and those of the borrowers who elected to have the said insurance cover shall automatically effect insurance with the defendant under the policy, subject to the following conditions:-
    (a) He/she attained the age of 18 but not over 65 at the last birthday.
    (b) The outstanding duration of his residential mortgage loan with the plaintiff is at least two years and does not exceed 30 years.
    (c) He/she is not a hospital patient and did not suffer from medical condition for which he could otherwise have claimed for Total Permanent Disablement benefits at entry.
    (d) The borrower is a natural person.
2. On 1st January, 2008 and in consideration of additional premium paid by the plaintiff the defendant issued a further insurance policy to the plaintiff known as Housing Authority Mortgage Protection (Extension) Debtors Medical Insurance Scheme to provide for the plaintiff's clients medical and emergency evacuation and/or Repatriation expenses (Hospitalisation).
3. The maximum sum insured under the said policy was $250,000.00 of any one life or insured member.
4. It was a term of the said policy that upon receipt of proof of the death or total and permanent disability of any insured member the defendant shall pay, subject to the provisions of the said policy, in one lump sum the sum insured and/or the amount of mortgage debt then owing to the plaintiff on the life of such insured member at the date of the member's death or total permanent disability.

[9] The court in this case has been called upon to interpret the two insurance policies which are referred to above as 1st policy and 2nd policy. Before interpreting these policies it is pertinent for the court to consider the principles governing the

interpretation of insurance policies. Since a policy of insurance is also a contract between the insurer and the insured, the same rules that are applicable to the interpretation of contracts are applicable to insurance policies. However, certain rules applicable to the interpretation of the insurance policies are laid down in section 29 of the Insurance Law Reform Act 1996 which provides as follows:

> Notwithstanding any law or agreement to the contrary, the following rules of construction shall be observed in the interpretation of any proposal for insurance or any policy of insurance or endorsement on a policy of insurance:
>
> *(a)* the intention of the parties, ascertained from the face of the documents, documents incorporated therewith and surrounding circumstances, shall prevail;
>
> *(b)* the whole of a document shall be looked at and not a particular clause;
>
> *(c)* written words shall ordinarily be given more effect than printed words;
>
> *(d)* wherever possible, the grammatical construction shall be adopted, but the intention of the parties shall be of paramount consideration;
>
> *(e)* words shall be construed in their plain, ordinary, popular, commonsense and natural meaning except that terms of art or technical words shall be understood in their strict, technical and proper sense unless the context controls or alters the meaning;
>
> *(f)* the meaning of a word is to be ascertained with reference to its context and may be restricted or modified thereby, and where, from the context, it appears that the parties intended to use the word in a special and peculiar sense, and not in a meaning which it might otherwise bear, the word shall be construed in accordance with their intention;
>
> *(g)* subject to the precise terms, subject matter and context of a clause, where specifications of particular things belonging to the same genus precede a word of general signification, the latter word of general signification, shall be confined in its meaning to things belonging to the same genus and shall not include things belonging to a different genus;
>
> *(h)* where a word of general signification is followed by words of limitation or definition, which introduce words of narrower signification, the first word shall not be taken in its full sense but shall be construed as limited by and applying only to the particulars specified;

(i) words shall be construed to mean what they say, unless there is some strong ground for placing a different construction on the words from what they naturally import;

(j) words shall be construed liberally so as to give effect to the real intention of the parties and the document shall not be so construed as to defeat the object of the transaction or as to render it illusory;

(k) in any case of ambiguity, where words are capable of more than one construction, the reasonable construction shall be taken to represent the intention of the parties;

(l) the language of a document shall not be strained in favour of or against any party but if there is any ambiguity, the ambiguity shall be resolved in favour of the person insured;

(m) every effort shall be made to reconcile inconsistencies, but where there is an inconsistency between the wording of a policy and that in the proposal or any earlier document, the policy shall be regarded as expressing the true intention of the parties in the absence of sufficient evidence to the contrary;

(n) an express term shall override any implied term inconsistent with it.

[10] Apart from these rules the learned counsel for both sides has cited various authorities on the question of interpretation of contracts.

[11] In the case of **Trustees Executors Limited v QBE Insurance (International) Limited [2010] NZCA 608 (14 December 2010)** the New Zealand Court of Appeal made the following observations;

> The starting point is, as always, the words themselves. The words of a contract should, unless the context clearly requires otherwise, have their ordinary meaning. Assistance can be gained from the context in which the disputed words occur, including the phrase, the paragraph and the whole of the contract itself. The relevant factual matrix can also assist.
>
> The key is to ascertain objectively the common intention of the parties using the above factors. If there is ambiguity or other interpretative difficulties then an assessment of the commercial realities, common sense and a consideration

of whether a particular result might lead to an unreasonable outcome are relevant.

[12] In **Maye v Colonial Mutual Life Assurance Society Limited (1924) HCA 26; 35 CLR 14** the High Court of Australia held thus;

> There are certain canons of construction relevant to this case which I think I ought to state at once, so as to indicate the course of reasoning applied to the contract in hand. (1) A contract is to be construed as a whole, and in interpreting particular words these cannot be read without reference to what comes before and after; (2) Where a policy incorporates by reference other documents, all must be read and construed together in order to arrive at true contract; (3) If the terms ascertained from the whole of the documents are unambiguous in themselves and independently consistent with each other, effect must be given to each according its verbal tenor, as severally construed; (4) If by reason of its own language in relation to the matter, or by reason of the context or of conflicting or differing provisions elsewhere, a term when fairly read is doubtful or ambiguous and reasonably susceptible of two constructions, that construction should be adopted which is more favourable to the assured, because that is of the two the more reasonable in the circumstances; (5) If one of the documents is ambiguous in its terms but another is clear, then force is to be given to the one the terms of which are clear, so as to interpret the one containing ambiguous terms.

[13] In **Polypearl Ltd v E.On Energy Solutions Ltd** [2014] EWHC 3045 (QB) by Behrens J at para 32:

> The general principles of construction are now very well known. The principles are set out in Investors Compensation Scheme Ltd v West Bromwich Building Society [1998] 1 WLR 896 at 912F-913G; Chartbrook Ltd v Persimmon Homes Ltd [2009] UKHL 38; [2009] 1 AC 1101 at [14]-[15] and [21]-[25] and Rainy Sky SA v Kookmin Bank [2011] UKSC 50, [2011] 1 WLR 2900 at [21]-[30] and may be summarised:
>
> 1. the ultimate aim of interpreting a contractual provision is to determine what the parties meant by the language used, which involves ascertaining what a reasonable person would have understood the parties to have meant;

2. the reasonable person is one who has all the background knowledge which would reasonably be available to the parties in the situation they were at the time of the contract;
3. where a term of a contract is open to more than one interpretation, it is generally appropriate to adopt the interpretation which is most consistent with business common sense;
4. poorly drafted contracts do not attract a different approach, but the poorer the quality of the drafting, the less willing the Court should be to be driven to semantic niceties to attribute to the parties an improbable or unbusiness like intention;
5. however where the parties have used unambiguous language, the court must apply it.

[14] It is also important to note that if the contract is wholly in writing, the discovery of what was written normally presents no difficulty, and its interpretation is a matter exclusively within the jurisdiction of the judge. But on this hypothesis the courts have long insisted that the parties are to be confined within the four corners of the document in which they have chosen to enshrine their agreement. Neither of them may adduce evidence to show that his intention has been misstated in the document. [**Law of Contract by Cheshire, Fifoot & Furmston, 16th Edition, 2012**].

[15] The main issues for determination here are whether the **Housing Authority Mortgage Protection (Extension) Debtors Medical Insurance Scheme** (2nd policy) is an extension to the **Group Mortgage Protection Insurance scheme** (1st policy) entered in to between the parties or they are two different policies and if the 2nd policy is an extension to the 1st policy should they be combined in calculating the loss ratio. The other issue is whether the defendant was entitled to increase the premium at any time during the year or they could only do it at the end the year.

[16] The 1st policy was entered into on 31st December, 2006 and the 2nd policy was entered into by the parties on 1st January, 2008.

[17] The document marked 'P2' is the proposal for group medical insurance for Housing Authority debtors. In the said proposal the defendant has stated as follows;

> We feel that Housing Authority debt will be at risk if claims of this nature are declined. It is evidence that the insured will not be up to date with their

installment payment as they will be on sick leave and eventually out of employment.

We also understand that the Government will not provide any grant to Housing Authority next year to financially assist your customers who do not qualify under MPI cover.

Therefore, Dominion Insurance has decided to offer group medical insurance as an extension to the existing MPI cover for all debtors registered with Housing Authority. The group medical insurance is tailor-made to cater for treatment/surgery for all heart related problem and cancer cases.

[18] The intention of the Dominion Insurance in making this proposal is very clear from the above paragraphs. They have identified the 2nd policy as an extension to the 1st policy. The question then arises whether the 2nd policy, for the mere reason of being an extension to the 1st policy becomes part of the 1st policy. On a careful consideration the two policies the court finds that certain clauses in these two agreements are similar. However, these two contracts of insurance have been entered into between the parties for two different purposes. The purpose of the 1st policy of insurance is to secure the repayment of the loans granted by the plaintiff to its mortgagees in cases where they become totally and permanently disabled or upon their death whereas the 2nd policy is to provide medical facilities to them. The two policies contain many clauses which differ from each other. Therefore, these two policies cannot be amalgamated or considered as one policy. It is more so especially because the clauses relating to the calculation of loss ratio are not the same in the two policies.

[19] In the 1st policy under the "General Provisions" – Section A, clause 4 it is stated as follows;

> It is agreed that the rates are guaranteed for a period of three years effective from 31stDecember 2006 subject to claims (paid/incurred) during any one year of insurance not exceeding 80% of gross premium for the same period. In the event that the **claims exceed 80% during the year**, the insurer has the right to revise the premium.

[20] In Section D of the same Policy it is stated:

It is agreed that the rates are guaranteed for a period of three years effective from 31st December 2006 subject to the Loss Ratio during any one year of insurance not exceeding 80%. In an event that the **Loss Ratio exceeds 80% during the year**, the insurer has the right to increase the premium rates but not by a larger percentage than the difference between 80% and the actual loss ratio.

[21] The defendant relied on the proposal (D1) prepared by the insurance agent which contains the following clause;

> In the event if claims exceed 80% of the premium received, Dominion Insurance Limited will have the right to review the policy at any time during the policy period.
>
> We may review premiums on any review date where the claims incurred for that section has exceeded 80% of the net premium earned.

[22] These two clauses have not been included in the policy relied on by the plaintiff which was tendered in evidence marked as "P1" at the trial. Parties are not bound by what is contained in the proposal or offer unless and until such terms and conditions are included in the contract signed by them.

[23] In the 2nd policy under "**Premium Review**" it is stated as follows;

> We may review premiums on any review date where the claim incurred for that section has exceeded 80% of the net premium earned.

[24] It is therefore clear that the Dominion Insurance has the right under the 2nd policy to review premiums on any review date. It does not indicate that the premiums can only be done annually. Clause 15 of the same policy which provides that the commencement date of this policy is the date shown in the schedule and the policy continues until the next **annual review** date, subject to payment of all premiums due.

[25] The learned counsel for the plaintiff tried to convince the court that in view of this clause the premium reviews could only be done annually with which the court cannot agree. The policy gives power to the insurer to review premiums for any particular section in which the claim incurred exceeded 80% of the net premium earned.

[26] However, as I have already decided above these two policies cannot be considered as one policy in this case. The court has to consider whether defendant was entitled to increase the premium during the course of a particular year under and in terms of the 1st policy.

[27] Loss ratio in contracts of insurance is the proportionate relationship of incurred losses to earned premiums expressed as a percentage. If, for example, a firm pays $100,000 of premium for workers compensation insurance in a given year, and its insurer pays and reserves $50,000 in claims, the firm's loss ratio is 50% ($50,000 incurred losses/$100,000 earned premiums).

[28] The phrases "**Loss Ratio exceeds 80% during the year**" and "**claims exceed 80% during the year**" have more or less the same meaning. The loss ratio exceeds 80% during the year means the defendant in calculating the loss ratio must take into consideration the losses for a period of one year and it is not entitled to review the premium on each and every claim in which the claim exceeds 80%. It could not have been the understanding between the parties when they entered into this contract of insurance. However, it is not clear what was meant by "**during the year**" that is whether the loss ratio review can be done any time during the year or it can only be done at the end of a year by taking into consideration all the losses during that particular year.

[29] When there is an ambiguity of this nature in a contract the Contra Proferentem rule becomes applicable. ***Verba fortius accipiuntur contra proferentem*** which means, words are to be interpreted most strongly against him who uses them.

[30] It refers to a standard in contract law which states that if a clause in a contract appears to be ambiguous, it should be interpreted against the interests of the person who insisted that the clause be included. This usually comes up when a contract is challenged in court. If the court reviews a contract and finds that a clause is ambiguous or could have more than one meaning, it determines which party wanted that clause included and interprets in favor of the other party. However, the contra proferentem rule has no application when both parties are involved in the wording and the inclusion of the ambiguous clause in the contract. Contra Proferentem rule is also known as Ambiguity doctrine.

[31] **Burton & Co v English & Co (1883) 12 QBD 218** from judgment of Bowen LJ at p. 222:

> There is ... another rule of construction which one would bring to bear upon this charter party, and that is, that one must see if this stipulation which we have got to construe is introduced by way of exception or in favour of one of the parties to the contract, and if so, we must take care not to give it an extension beyond what is fairly necessary, because those who wish to introduce words in a contract in order to shield themselves ought to do so in clear words.

[32] In this case there is no doubt that the offer was made by the Dominion Insurance and the proposal had been prepared by Marsh & McLennan Companies on behalf of the defendant which fact is borne out by the proposal tendered in evidence marked as 'D1".

[33] I accordingly apply the *contra proferentem* and hold that the defendant has no right to increase the premium mid-year. It has to calculate the loss ratio for a particular year and decide whether to increase the premium or not at the end of that particular year.

[34] It is important to note that although the defendant did not pay the claim of the plaintiff there is no basis for them not to settle what was due to the plaintiff on the contract of insurance which is still valid and in force. The defendant has not so far terminated the contract. In any of the letters written to the plaintiff, the defendant has not indicated that the contract has been terminated.

[35] In the letter "P12" Mr. Gary Callaghan, a Director of the defendant company has stated as follows (page 75 of the agreed bundle of documents);

> We now look forward to your decision as to which option to accept. If neither is agreed to then it is simply not possible for us to continue with the scheme and in the unlikely event that this situation eventuates and to protect our position if it does we must as a formality give notice of cancellation in accordance with the policy conditions.

[36] Even thereafter many letters have been exchanged between the parties but there is no formal termination of the contract by either party and therefore, the defendant is legally bound to pay the amount claimed by the plaintiff.

[37] Since there is no cancellation of the contract of insurance the defendant's position that it is not liable to pay the claim of $355,460.65 which was, according to the defendant, made after the cancellation of the contract is untenable.

[38] Accordingly, I make the following orders.

ORDERS

1. The defendant shall pay the plaintiff $487,047.48.
2. The defendant shall also pay the plaintiff interest on the said sum in terms of section 4(1) of the Law Reform (Miscellaneous Provisions) (Death and Interest) (Amendment) Decree 2011 from the date of the judgment until the entire sum is paid in full.
3. The defendant shall also pay the plaintiff $4000.00 as costs (Summarily Assessed) of this action.

HIGH COURT OF FIJI
SUVA

Lyone Seneviratne

JUDGE

27th October, 2016