CIRCULAR LETTER

TO: INSURANCE COMPANIES, MUTUAL BENEFIT ASSOCIATIONS, TRUST FOR CHARITABLE USES, INTERMEDIARIES AND THE GENERAL PUBLIC

SUBJECT: GUIDELINES DEFINING UNSAFE BUSINESS PRACTICES OR ACTS AND PROVIDING ADMINISTRATIVE FINES FOR VIOLATION THEREOF

WHEREAS, Section 438 of the Insurance Code, as amended by R.A. 10607, authorizes the Insurance Commissioner to impose, among other things, fines not less than Five thousand pesos (Php 5,000.00) and not more than Two hundred thousand pesos (Php 200,000.00) upon insurance companies, their directors and/or officers and/or agents for conducting business in an unsafe or unsound manner as may be determined by the Insurance Commissioner;

WHEREAS, unsafe business acts or practices are not defined in the Insurance Code or any of the Commission’s existing circulars, memoranda, rules and regulations;

WHEREAS, there is a need to define unsafe business practices or acts in order to protect the interest and welfare of the insuring public and to provide the imposable administrative fines for the commission thereof;

NOW THEREFORE, by virtue of the powers vested in the Insurance Commissioner under Section 437 (c) of the Insurance Code, as amended by R.A. 10607, the following Guidelines Defining Unsafe Business Acts or Practices and Providing Administrative Fines for Violation Thereof are hereby promulgated:

Section 1. Applicability. This Circular shall govern unsafe business acts or practices of insurance companies, reinsurance companies, mutual benefit associations, intermediaries and adjustment companies arising from their contractual relationships with the insuring public.
This Circular does not cover business practices likely to cause insolvency or substantial dissipation of assets or earnings of a covered entity or likely to seriously weaken its financial condition.

Section 2. Definition of Terms. —For purposes of this Circular, the following definitions shall apply:

(a) "Adjustment" – Process of ascertaining the liability of the insurer (or proportionate share in the liability of each insurer if there are more than one) arising under an insurance contract or policy and the amount or indemnity which the insured is entitled to receive under said contract or policy.

(b) "Advertisement"—Any communication, notice, or presentation designed to motivate and/or inform the public with respect to any insurance product or related services.

(c) "Agent" – agents, brokers and adjusters as defined under the Insurance Code, as amended.

(d) "Beneficiary/ies"—The person/s designated or entitled to receive benefits under the insurance policy.

(e) "Commission" – Insurance Commission.

(f) "Commissioner" – Insurance Commissioner.

(g) "Claim" – A request or a demand for payment of proceeds or benefits under an insurance policy.

(h) "Claimant" – The insured, beneficiary, or any of their authorized representative/s.

(i) "Days" - Calendar days.

(j) "Documentation" – All pertinent communications, receipts, bills, records, reports, and all other papers relative to the insurance claim.

(k) "Insurance Code" – The Insurance Code of the Philippines, as amended by R.A. 10607, including any amendments thereto.

(l) "Insured" – Any person who entered into a contract of insurance with the insurer or any person designated as such under the policy.

(m) "Insurer" – Any person, partnership, association or company duly authorized to transact insurance business as set forth in Section 6 of the Insurance Code.

(n) "Investigation" – All activities of an insurer related to the determination of liabilities under coverage of an insurance contract.
(o) "Liability" – Obligation of an insurer under an insurance policy.

(p) "Mutual Benefit Association" – is any society, association or corporation, without capital stock, formed or organized not for profit but mainly for the purpose of paying sick benefits to members, or of furnishing financial support to members while out of employment, or of paying to relatives of deceased members of fixed or any sum of money, irrespective of whether such aim or purpose is carried out by means of fixed dues or assessments collected regularly from the members, or of providing, by the issuance of certificates of insurance, payment of its members of accident or life insurance benefits out of such fixed and regular dues or assessments.

(q) "Person" – May refer to juridical or natural person.

(r) "Policy" – A written instrument in which a contract of insurance or suretyship is set forth including but not limited to riders, endorsements, certificates of cover and certificates of membership.

(s) "Proof of Loss" – Are the documents given the company by the insured or claimant under a policy upon occurrence of the loss, the particulars thereof and the data necessary to enable the company to determine its liability and the amount thereof.

(t) "Reasonable Time" – Such time as is necessary under the circumstances for a reasonably prudent and diligent man to do.

(u) "Suit" – Any action instituted before competent judicial or quasi-judicial bodies or tribunals for the purpose of recovery of claims or benefits under an insurance policy.

(v) "Surface Bargaining" – An act or series of acts in the guise of negotiating the insurance claim but made without any intent to reach an agreement or a settlement.

Section 3. Unsafe Business Acts or Practices. The following are considered as unsafe business acts or practices in the insurance business:

A. Misrepresentation to the public —

1. On policy provisions

Misrepresenting to prospective insured or claimants pertinent facts or provisions relating to the terms and conditions of the policy such as but not limited to:

(a) Making, issuing, circulating, or permitting to be made, issued or circulated any literature, illustration, circular or statement of any sort which misrepresents the terms of any policy with regard to benefits or advantages promised;
(b) Misrepresenting the terms of the policy with regard to the estimate of the dividends or share of surplus to be received thereon;

(c) Making any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy;

(d) Making any false or misleading statement regarding the financial position of any person with respect to insurance business or with respect to any person in the conduct of the insurance business;

(e) Using any name or title of any policy or class of policies misrepresenting the true nature thereof;

(f) Misleading or making false representation or incomplete comparison of policies to any person insured in such company for the purpose of inducing or tending to induce such person to lapse, forfeit, or surrender his said insurance;

(g) Misrepresenting any insurance policy as being shares of stock or purely investment product; or,

(h) Failing to disclose all applicable charges.

2. On payment of claim—

2.a. Indicating on a payment draft, check, or in an accompanying letter for payment of proceeds of the policy made to claimant that said payment is a final release of any claim under the policy, except:

i. the insured already claimed the maximum limit of the policy; or

ii. the claimant and the insurer had amicably settled regarding the amount payable and coverage under the insurance policy.

2.b. Making partial settlement of a claim which contains a statement which directly or indirectly releases the insurer from total liability under the insurance policy.

3. On advertisement —

Advertising an insurance product which has not been approved by this Commission in a misleading manner.

B. Unfair discrimination. —The following are considered unfair discrimination:

1. Making any discrimination against any Filipino, or any other race, in the sense that he is given less advantageous rates, dividends or
other policy conditions or privileges than are accorded to other nationals solely because of his race; or

2. Making or permitting to make any unfair discrimination in any person similarly situated with respect to fees or rates charged, dividends, conditions or privileges of a policy, or in any other manner or means constituting the same.

C. Unfair claims management. — The following acts are considered as Unfair claims management:

1. Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies;

2. Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under its policies;

3. Denying to pay claims without conducting reasonable investigation based on all available documentation, proof, or any other information relative to a claim;

4. Failing to affirm or deny claims within a reasonable time after all relevant and required documentation and proof of loss had been submitted to the insurer;

5. Failing to provide within a reasonable time a reasonable explanation, based on facts and/or applicable laws, for the offer of compromise settlement or for the denial of a claim;

6. Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;

7. Failing to promptly effectuate settlement of claim/s, where liability has become reasonably clear under one portion of the policy coverage in order to affect the settlement under other portions of the policy coverage;

8. Compelling policyholders to institute suits to recover amounts due under its policies by offering without justifiable reason substantially less than the amounts ultimately recovered in suits brought by them;

9. Attempting to settle a claim for less than the amount to which a reasonable person would have believed to be due to him by reference to written or printed advertising material accompanying or made part of a policy or doing an inequitable settlement which includes offering a proposal without any legal or factual basis;
10. Attempting to settle claims based on a policy which was unilaterally altered or modified without notice, knowledge or consent of the insured or his authorized representatives;

11. Failing to accompany the claim payments with a formal and written statement, served upon claimant, setting forth the coverage under which the payments are being made;

12. Delaying the investigation or payment of claims by requiring a claimant to submit a preliminary claim report and then requiring the subsequent submission of formal report wherein both submissions contain substantially the same document and/or same information; or by requiring any document, information or any other paper which are superfluous or irrelevant to the insurance claim or could have been required or requested in the initial request;

13. Directly advising a claimant not to obtain the services of an attorney with respect to his insurance claim;

14. Misleading a claimant with respect to the applicable statute of limitations pertaining to his claim; or

15. Surface Bargaining.

D. Misrepresentation in insurance applications or claims. —

1. Making false or fraudulent statements or representations on or relative to an application or claim under a policy for the purpose of obtaining a fee, commission, money or other benefit from any insurers or its agents; or

2. Making a false or fraudulent statement or representation in or with reference to any insurance application or claim by an agent, broker, solicitor, applicant or other person.

E. Failure to effectively control and supervise its agent/s. — Failing to maintain reasonable standards of supervision and control over its agents, and, by such reason, the latter committed or was permitted to commit an act or omission which is prejudicial to its consumers or the insuring public in general.

F. Failure to respond to regulatory inquiries. — Unjustifiably failing to provide substantial and reasonable response to an inquiry made by the Commission regarding the denial of claim, cancellation, nonrenewal, or any alleged violation of this Circular, within fifteen (15) days from such inquiry or, if a period for submission of a response is specifically fixed by the Commission, within such period. A response in compliance with this paragraph shall not preclude the provision of additional information responsive to the inquiry which must be answered within the same period as above prescribed.
The activities enumerated herein shall not be deemed to be an exclusive list of unsafe acts or practices in the business of insurance. The Commissioner, in the exercise of his discretion, may NOW AND THEN consider any other conduct as unsafe business acts or practices.

SECTION 4. **Penalties.** If, after an administrative hearing before the Regulation, Enforcement and Prosecution Division (REPD), the Commission determines that the person charged has engaged in an unfair business act or practice as defined under this Circular, the Commissioner shall issue a written Order, Resolution or Decision containing said findings and shall include therein an order requiring such person to cease and desist from engaging in such act or practice and shall, in his discretion, impose the following fines:

(1) **FIRST OFFENSE**

(a) Php 10,000.00 for each and every conduct or violation but not to exceed an aggregate fine of Php 50,000.00 in any cumulative conduct or violation committed for the same purpose, in the same incident, and against the same person.

(b) If the punishable conduct or violation was made deliberately or wilfully; or was made with his or its knowledge or should have been reasonably known by him or it, a fine of Php 50,000.00 for each and every conduct or violation but not to exceed an aggregate fine of Php 100,000.00 in any cumulative conduct or violation committed for the same purpose, in the same incident, and against the same person.

(2) **SECOND OFFENSE**

(a) Php 50,000.00 for each and every conduct or violation but not to exceed an aggregate fine of Php 100,000.00 in any cumulative conduct or violation committed for the same purpose, in the same incident, and against the same person.

(b) If the punishable conduct or violation was made deliberately or wilfully; or was made with his or its knowledge or should have been reasonably known by him or it, a fine of Php 100,000.00 for each and every conduct or violation but not to exceed an aggregate fine of Php 150,000.00 in any cumulative conduct or violation committed for the same purpose, in the same incident, and against the same person.

(3) **THIRD AND SUBSEQUENT OFFENSE**

(a) Php 100,000.00 for each and every conduct or violation but not to exceed an aggregate fine of Php 150,000.00 in any cumulative conduct or violation committed for the same purpose, in the same incident, and against the same person.

(b) If the punishable conduct or violation was made deliberately or wilfully; or was made with his or its knowledge or should have been
reasonably known by him or it, a fine of Php 150,000.00 for each and every conduct or violation but not to exceed an aggregate fine of Php 200,000.00 in any cumulative conduct or violation committed for the same purpose, in the same incident, and against the same person.

Notwithstanding the fines herein prescribed, the Commissioner may, at his discretion, modify the application of the foregoing prescribed penalties depending upon the severity of the offense, the frequency of its commission, the gravity of the damage caused, the history of the offender, or other circumstances which warrant imposition of a lower or a more severe amount of fines and penalties than that prescribed in this Circular.

In addition to the foregoing, suspension or removal from office may also be imposed upon directors and/or officers and/or employees of insurance companies found to have violated this circular as the circumstances would warrant.

Section 5. SEPARABILITY CLAUSE

Should any provision of this Circular or any part thereof be declared invalid, the other provisions, insofar as they are separable from the invalid ones, shall remain in full force and effect.

Section 6. REPEALING AND AMENDING CLAUSE

All Orders, Rules and Regulations, Memoranda and other issuances inconsistent with or contrary to the provisions of this Circular are hereby repealed/amended accordingly.

Section 7. EFFECTIVITY

This Circular shall take effect immediately.

DENNIS B. FUNA
Insurance Commissioner