2004/2005
年報
Annual Report

The Insurance Claims Complaints Bureau

Incorporated with limited liability

29/F Sunshine Plaza
353 Lockhart Road
Wanchai, Hong Kong
Tel: 2520 1868 Fax: 2520 1967
Website: http://www.iccb.org.hk
E-mail: iccb@iccb.org.hk

保險索償投訴局

註冊有限公司

香港灣仔駱克道353號
三湘大廈29樓
電話：2520 1868 傳真：2520 1967
網址：http://www.iccb.org.hk
電郵：iccb@iccb.org.hk

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主席報告

2004年5月14日至2005年4月29日

We the Insurance Claims Complaints Bureau (Bureau) had another year of success in 2004/2005. As an alternative dispute resolution mechanism, we offer a free service of handling claims complaints from Hong Kong resident policyholders with personal insurance contracts. Since its establishment in February 1990, the Bureau has played an important role in strengthening the self-regulatory regime of the insurance industry.

保險索償投訴局（投訴局）在2004／2005年度再接再厲，工作異常成功。作為另類調解糾紛機制，投訴局為持有個人保險合約的香港居民，提供免費索償投訴服務。投訴局自1990年2月成立以來，一直擔當加強香港保險業界自律監管的重要角色。

With more people taking out personal insurance, the Bureau is expecting greater challenges in the years to come.

隨著投購個人保險的人數越來越多，相信投訴局來年將會面對更大的挑戰。

Increase the Jurisdiction Limit to HK$700,000

可裁定賠償上限提高至70萬港元

The jurisdiction limit of the Bureau has remained at HK$600,000 for eight years since 1996. The General Committee believed that it might be about time to have an adjustment in 2005. Having regard to all relevant factors and to ensure the smooth operation of the Bureau within the available resources, the General Committee recommended an increase of the jurisdiction limit to HK$700,000.

自1996年起，投訴局可裁定賠償限額在這八年來一直維持於60萬港元，理事會認為2005年是適當時候作出調整，理事會考慮所有相關因素，並為了確保投訴局能夠在現有資源下繼續順利運作後，建議提高投訴局可裁定的賠償上限至70萬港元。

At the Extraordinary General Meeting held on 10 December 2004, Members approved the proposed increase of the jurisdiction limit from HK$600,000 to HK$700,000 effective 1 January 2005.

投訴局會員於2004年12月10日舉行的特別會員大會上，通過修訂建議，由2005年1月1日開始，投訴局可裁定的賠償上限由60萬港元調升至70萬港元。

Since the Bureau last adjusted its jurisdiction limit in 1996, around 400 claims disputes were successfully resolved, the aggregate settlement amount of which was over HK$20 million. We believed that an increase in the jurisdiction limit would help extend our free consultative services to more people.

投訴局自1996年修訂可裁定的賠償上限以來，先後圓滿解決約400宗索償個案，涉及金額超過2,000萬港元。理事會相信提高投訴局可處理的賠償限額，會有更多市民受惠於我們的免費諮詢服務。

Membership

As at 29 April 2005, the Bureau had 122 Members, of whom 100 were Full Members while the remaining 22 were Affiliate Members. Full Members contribute towards the costs and expenses of running the Bureau by paying an annual subscription. With their financial contributions, for which we are most grateful, the Bureau can continue to provide a free service to assist in resolving insurance claims complaints to the mutual benefit of insurers and their clients.

The Insurance Claims Complaints Panel

The Complaints Panel is an independent body established under the Bureau. The five-member Complaints Panel is currently chaired by Mr Michael F S Tsui, barrister-at-law. Two of the other four members are from within the insurance industry and the remaining two are non-insurance professionals. The two industry members are Mr Edward W K Lau, representing the Life Insurance Council of the Hong Kong Federation of Insurers (HKFI) and Mr Leo C H Ma, representing the General Insurance Council of the HKFI. The two non-industry members are Mr Larry L K Kwok and Mr Paul F Winkelmann, nominated respectively by the Consumer Council and the Hong Kong Institute of Certified Public Accountants.

The objective of the Complaints Panel is to provide independent and impartial adjudication of claims complaints between insurers and policyholders or their beneficiaries. The decisions of the Complaints Panel are binding on Members of the Bureau, without any right of appeal. However, if the Complaints Panel rules the complaint unsubstantiated and supports the insurer's decision to decline the claim, the complainant can seek legal action if he so desires. His legal rights are not affected by the decision of the Complaints Panel.

會員

以2005年4月29日計，投訴局共有122家會員公司，其中100家為基本會員，其餘22家為附屬會員。基本會員需要繳交年費，分擔投訴局日常營運開支，投訴局衷心感謝會員公司，全賴他們財務上的支持，投訴局才能夠以保險公司及其客戶的共同利益為目標，繼續提供免費調解保險索償投訴的服務。

保險索償投訴委員會

投訴委員會設於投訴局之下，是個獨立運作的組織。投訴委員會有五位成員：現任主席為大律師徐福燊先生，另有兩位來自業界的成員，其餘兩位則是非業界的專業人士。業界委員為香港保險業聯會（保聯）屬下壽險總會代表劉允剛先生和保聯屬下一般保險總會代表馬陳鏗先生。非業界委員分別為消費者委員會代表郭琳廣先生和香港會計師公會代表Paul F Winkelmann先生。

投訴委員會的宗旨是為保險公司與保單持有人或其受益人之間的索償投訴，提供獨立和不偏不倚的判決。投訴委員會的裁決對投訴局會員有約束力，會員並無上訴權；但是如果投訴委員會裁定投訴不成立，贊同保險公司拒絕賠償的決定，投訴人仍然有權訴諸法律途徑，投訴委員會的裁決不會影響其法律權益。

Complaints from non-Hong Kong residents

At present, the Bureau only handle complaints about claims from Hong Kong resident policyholders according to the provision stipulated in the *Code of Conduct for Insurers* issued by the HKFI in March 1999. In response to the increasing number of individual travellers from the Mainland, the General Committee, upon the request from a Member Company, discussed the feasibility of expanding the ambit of the Bureau to handle complaints from non-Hong Kong residents.

From a service point of view, the General Committee agreed that it was reasonable for the Bureau to handle claims complaints from policyholders as long as their policies are issued by Member Companies under the law of Hong Kong and their complaints fall within the scope of the Bureau's jurisdiction.

However, from a cost point of view, the inclusion of claims complaints from non-Hong Kong residents would add unpredictable complication and complexity to the current operation of the Bureau. Complaints from non-Hong Kong residents usually involve the submission of documents such as hospital receipts, medical reports, police reports, death certificates etc. issued by their local authorities. As the issuing standard of these documents varies, a considerable longer time may be needed for investigation and the Complaints Panel may also encounter difficulties in verifying the authenticity of these documents and their possible translation.

It should also be noted that some Member Companies have also offered offshore insurance to residents in other countries. The extension of the Bureau's service to non-Hong Kong residents might trigger potential complaints from those offshore policyholders, the number of which is hard to predict. As the Bureau is an industry body, the General Committee agreed to seek the majority views

非香港居民的投訴

按保聯於1999年3月編訂的《承保商專業守則》的條文規定，投訴局現時只可處理由香港居民提出的索償投訴。隨著內地遊客數目日增，理事會應某家會員公司的要求，研究能否將投訴局的職權範圍擴大，以便處理由非香港居民提出的投訴。

從服務角度來說，理事會同意只要保單是由會員公司簽發、受香港法律管制、而投訴又在投訴局的職權範圍之內，投訴局便應當處理有關保單持有人的索償投訴。

不過，從成本的角度來看，接納非本港居民的索償投訴，會對投訴局現時的運作增添無法預計的難度和複雜性。非本港居民的投訴通常會牽涉由當地機構發出的文件，例如：醫院發票、醫療報告、警方報告、死亡證等，由於簽發這些文件的標準有異，調查也相對需時，而投訴委員會在核實有關文件的真偽，以至翻譯的準確性時，也會面對不少困難。

此外，理事會得悉部分會員公司有為其他國家的居民提供離岸保險。假如擴大投訴局的服務範圍至非香港居民，可能會引發這些離岸保單的持有人提出投訴，潛在的投訴數目實難以預計。由於投訴局乃一行業組織，理事會遂決定徵詢會員公司對未來發展方向的意見，同時諮詢他們是否

from Member Companies on the proper way forward and whether they are prepared to share the potential extra operating cost that may be incurred as a result of the proposed expansion of its scope of service. As a consequence, the Bureau will be writing to Member Companies to seek their views on this issue.

Shortage of Honorary Secretaries

To date, the Bureau has altogether 58 Honorary Secretaries, comprising 35 from the general business and 23 from the life business.

Since the implementation of a new practice in March 2000 requiring three instead of one Honorary Secretary to review each complaint case, the Bureau has been facing a shortage of Honorary Secretaries, particularly from the life assurance sector. In order to share the workload, I would like to take this opportunity to appeal to all Authorized Representatives of Full Members, in particular those engaged in long-term business, to render support by registering themselves as Honorary Secretaries or appointing their senior officers as alternates.

Acknowledgement

On behalf of the General Committee, I would like to convey our sincere gratitude to all members of the Complaints Panel for their tireless efforts and remarkable commitment during the year. A special vote of thanks is due to Mr Michael F S Tsui, Mr Larry L K Kwok, Mr Edward W K Lau, Mr Leo C H Ma and Mr Paul F Winkelmann.

To my fellow General Committee Members, Mr K P Chan, Mr Raymond P K Chan, Mr Kenneth T W Kwok, Mr Keith B Land and Mr James C K Wong, I am most grateful for their unfailing support and wise counsel. A special vote of thanks is due to Mr Nicholas J G Donne, who resigned from the General Committee on 27 April 2005.

願意分擔擴大服務範圍後可能增加的營運開支，投訴局稍後會去信搜集會員公司的意見。

名譽顧問短缺

投訴局現有58位名譽顧問，包括35位從事一般保險業務及23位專責人壽保險業務。

自2000年3月實施新措施以來，由三位而非一位名譽顧問審閱每宗投訴個案後，投訴局便面對名譽顧問短缺的情況，尤其是人壽保險業的專才。本人謹此促請所有基本會員，尤其是從事人壽保險業務的授權代表，加入名譽顧問的行列，或者委派高級職員為替任代表，分擔名譽顧問的工作量。

鳴謝

謹代表理事會仝仁向投訴委員會委員徐福燊先生、郭琳廣先生、劉允剛先生、馬陳鏗先生及Paul F Winkelmann先生致以衷心謝忱，感謝他們過去一年不辭勞苦、勇於承擔。

本人衷心感謝理事會理事陳健波先生、陳炳根先生、郭振華先生、林啟富先生和王建國先生戮力支持和指點提撥。另唐寧浩先生已於2005年4月27日請辭，謹此致意。

I would also like to express my heartfelt appreciation to all the Honorary Secretaries who have volunteered their precious time and expertise so generously in support of our work.

Lastly, I want to thank all of our Members for their support and co-operation and the Bureau Secretary and the staff of the HKFI for their dedication and hard work during the year.

Roddy S Anderson
Chairman
29 April 2005

謹此向所有名譽顧問致謝，多謝他們慷慨地貢獻寶貴的時間及資源出任名譽顧問，以支持投訴局的工作。

最後，本人感謝投訴局所有會員鼎力支持及衷誠合作。與此同時，多謝投訴局秘書及保聯所有員工過去一年克盡厥職。

主席
安德生
2005年4月29日

List of Office-bearers 14 May 2004 - 29 April 2005

理事、委員、名譽顧問名錄

2004年5月14日至2005年4月29日

GENERAL COMMITTEE

Chairman

Mr Roddy S Anderson

Members

Mr K P Chan
Mr Raymond P K Chan
Mr Nicholas J G Donne (resigned on 27/04/2005)
Mr Kenneth T W Kwok
Mr Keith B Land
Mr James C K Wong

理事會

主席

安德生先生

理事

陳健波先生
陳炳根先生
唐寧浩先生 (27/04/2005 退任)
郭振華先生
林啟富先生
王建國先生

THE INSURANCE CLAIMS COMPLAINTS PANEL

Chairman

Mr Michael F S Tsui

Members

Mr Larry L K Kwok
Consumer Council

Mr Edward W K Lau
Life Insurance Council of the HKFI

Mr Leo C H Ma
General Insurance Council of the HKFI

Mr Paul F Winkelmann
Hong Kong Institute of Certified Public Accountants

保險索償投訴委員會

主席

徐福燊先生

委員

郭琳廣先生
消費者委員會

劉允剛先生
保聯壽險總會

馬陳鏗先生
保聯一般保險總會

Paul F Winkelmann先生
香港會計師公會

HONORARY SECRETARIES

Mr Roddy S Anderson
Mr Gary R Bennett
Mr Laurence Besemer (resigned on 04/03/2005)
Mr Bob Bettridge
Mr Denny Y L Chan
Mr F K Chan
Mr James C Y Chan
Mr K P Chan
Mr Paul H S Chan
Mr Simon K Chan
Mr K P Cheng
Mr M K Cheng
Mr Simon Y K Cheng
Ms Manlo Cheung
Mr Richie H W Cheung
Mr L Robin Chi (resigned on 29/03/2005)
Ms Sophia S F Chiu
Ms Agnes H K Choi
Ms Vivian L C Choi
Mr K Y Chow
Mr Nicholas J G Donne (resigned on 29/11/2004)
Mr Peter R Fancke
Mr Stuart Fraser
Mr Nicholas L Griffin
Mr S K Ho
Mr Ralph S T Hui
Mr Chris K K Ip
Mr John V Jones (resigned on 03/01/2005)
Mr Robert J Knight
Mr Vineet Kumar
Mr Andy W H Kwok
Mr Keith B Land
Mr Edward W K Lau
Ms Helena Y M Lee (resigned on 23/03/2005)
Mr Mike S C Lee

名譽顧問

安德生先生
彭勵志先生
Laurence Besemer 先生 (04/03/2005 退任)
白理祁先生
陳用樑先生
陳富根先生
陳自然先生
陳健波先生
陳漢生先生
陳坤先生
鄭國屏先生
鄭文光先生
鄭銳強先生
張文璐女士
張鴻威先生
齊萊平先生 (29/03/2005 退任)
趙淑芬女士
蔡香君女士
蔡靈芝女士
周家彥先生
唐寧浩先生 (29/11/2004 退任)
Peter R Fancke 先生
司徒富瑞先生
范力奇先生
何少強先生
許樹棠先生
葉家駒先生
莊忠斯先生 (03/01/2005 退任)
羅斌拉特先生
Vineet Kumar 先生
郭渭洪先生
林啟富先生
劉允剛先生
李奕梅女士 (23/03/2005 退任)
李少川先生

Mr Raymond C K Leung	(resigned on 15/06/2004)	梁志強先生	(15/06/2004 退任)
Mr Stephen N W Lo		盧乃惠先生	
Mr Terry K W Lo		老建榮先生	
Mr W M Loi		來煒明先生	
Mr Jecky S W Lui		呂新榮先生	
Dr Damien V Marmion		馬明安醫生	
Mr N R Modi		N R Modi 先生	
Mr Andreas Mueller		慕安傑先生	
Ms Patricia C M Ng		吳昭敏女士	
Mr Ronnie W F Ng		伍榮發先生	
Mr Mark D Rawson	(resigned on 27/09/2004)	馬克遜先生	(27/09/2004 退任)
Mr Peter E Schelling		施瀚霖先生	
Mr Peter W H So	(resigned on 08/07/2004)	蘇永雄先生	(08/07/2004 退任)
Mr Ivan K W Tam		譚國榮先生	
Mr Raymond K N Tam		譚廣能先生	
Mr K Y To		杜國英先生	
Ms Eugenia Y C Tsui		徐緣珍女士	
Mr Robert L Valitchka		Robert L Valitchka 先生	
Mr Mark Wearmouth		Mark Wearmouth 先生	
Ms Connie Y P Wong		王劉玉屏女士	
Mr Dannis C M Wong		黃志明先生	
Mr Harry K T Wong		黃國添先生	
Mr James C K Wong		王建國先生	
Mr John Y W Wong		王耀宏先生	
Mr K H Wong		王覺豪先生	
Mr Stephen M F Wong		王文輝先生	
Mr George K P Yan		甄健沛先生	
Mr Barry C K Yeung		楊超群先生	
Mr Thomson W W Yeung		楊永華先生	
Mr Allan K N Yu		余健南先生	
Mr P Zhou		周平先生	

Terms of Reference
職權範圍

1. The complaint is claim-related.
   投訴與索償有關。

2. The claim amount does not exceed HK$700,000*.
   索償金額不得超過70萬港元*。

3. The insurer concerned is a Bureau Member.
   涉案保單屬投訴局會員。

4. The policy concerned is a personal insurance policy.
   涉案保單屬個人保單類別。

5. The complaint is filed by a policyholder/beneficiary/rightful claimant.
   投訴人為保單持有人/受益人/合法索償人。

6. The policyholder must be a resident in Hong Kong.
   涉案保單持有人必須為香港居民。

7. The insurer concerned has made its final decision on the claim.
   涉案保險公司已對索償申請作出最終賠償決定。

8. The complaint is filed with the Bureau within six months from the day of notification by the insurer of its final decision.
   投訴人必須於接獲保險公司最終賠償決定的六個月內向投訴局作出書面投訴。

9. The dispute in question does not arise from industrial, commercial or third party insurance.
   索償糾紛並不涉及工業、商業、第三者保險。

10. The claim is not subject to legal proceedings or arbitration.
    索償案件並非正在進行法律程序或仲裁。

* *If an insured holds multiple policies, the aggregate amount of the individual claims involved should not exceed HK$700,000 should the causes of claims be identical or similar. As regards long-tail and periodic claims, the total claim amount, calculated up to a period of five years, should not exceed HK$700,000.*

如果被保人持有多份保單，而要求賠償的原因相同或類同，則索償總額以不超過70萬港元為限；如果索償涉及長期和定期賠償，則五年合計的索償總額不得超過70萬港元。

Complaints Handling Procedures
處理投訴步驟

1. Any Complaint received by the Bureau shall be screened by the Bureau Secretary who must first be satisfied that there is some substance in the Complaint, and that the Complaint falls within the Terms of Reference of the Bureau.

2. The Bureau shall refer the Complaint to the Member for a reply. Unless the Member settles the Complaint, or the Complaint is determined to be groundless at this stage by the Bureau, the Bureau shall pass the Complaint to three Honorary Secretaries for their opinions in accordance with the rules, practice and procedures regarding the handling of Complaints determined by the Complaints Panel and Article 82 of the *Articles of Association* of the Bureau.

3. Following receipt of the advisory reports from the Honorary Secretaries in relation to any Complaint, the Bureau shall refer any recommendation for settlement to the Member for reconsideration. Unless the Member settles the Complaint at this stage, the Bureau shall pass the Complaint together with the advisory reports of the Honorary Secretaries to the Complaints Panel for final determination.

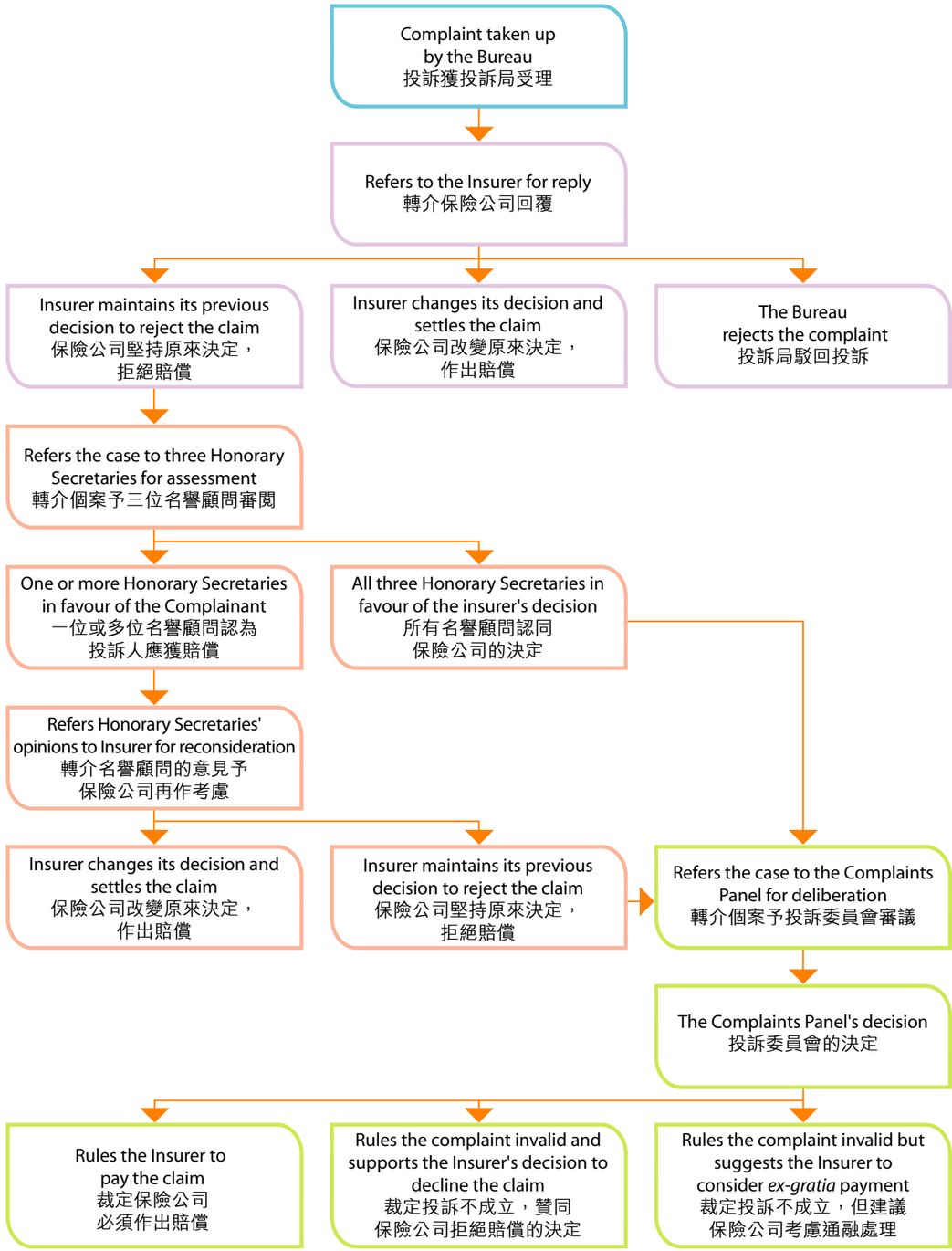
4. Following any meeting or hearing of a Complaint, the Complaints Panel may upon resolution by the members of the Complaints Panel facilitate the satisfactory settlement or withdrawal of the Complaint by making an Award against the Member against whom the Complaint is made, or making a recommendation, or dismissing the Complaint.

1. 投訴局接獲的每宗投訴必須經由投訴局秘書篩選，他必須滿意投訴有實質內容，而且在投訴局的職權範圍之內。

2. 投訴局必須轉介投訴予會員公司回覆，除非會員公司在這個階段作出賠償，或投訴局確定投訴並無理據，否則投訴局會將投訴轉介三位名譽顧問，要求他們根據投訴委員會審理投訴的規則、慣例、步驟，以及投訴局《公司章程》第82條的規定提交意見。

3. 投訴局接獲名譽顧問的意見後，會將建議賠償的意見轉介涉案會員公司再作考慮。除非會員公司於這個階段作出賠償，否則投訴局必須將投訴連同名譽顧問的意見，一併轉介投訴委員會作最終裁決。

4. 經開會審議或聆訊投訴後，投訴委員會可通過表決，裁定被投訴的會員公司必須作出賠償、提出建議或駁回投訴，以便圓滿解決或撤銷投訴。



Members of the Insurance Claims Complaints Panel: (from left of the front row) Mr Larry L K Kwok, Chairman Mr Michael F S Tsui, Mr Paul F Winkelmann, (from left of the back row) Mr Leo C H Ma and Mr Edward W K Lau, pictured with the Bureau Secretary Miss Alice Y C Kong.

保險索償投訴委員會委員：（前排左起）郭琳廣先生、主席徐福燊先生、Paul F Winkelmann先生、（後排左起）馬陳鏗先生、劉允剛先生與投訴局秘書江潤珠小姐合照。

Statistics 1 January - 31 December 2004
統計數字
2004年1月1日至12月31日

STATISTICS

In 2004, the Bureau received a total of 292 complaint cases. This represents a 14% increase over the previous year. The main categories of complaints include amount of indemnity, application of policy terms, breach of warranties or policy conditions, excluded items and non-disclosure (see figures 1 and 4). Amongst various types of personal insurance products, personal accident/disability and hospitalization/medical insurance policies constituted the two most common categories of claim disputes (see figure 2).

A total of 351 cases were handled, 59 of which were brought forward from 2003. Of the 291 cases closed, 65 were dismissed because they did not fall within the Terms of Reference of the Bureau. Of the 226 cases accepted, 48 were mutually settled between the insurers and the complainants through the auspices of the secretariat without having to be heard by the Complaints Panel. There was no *prima facie* evidence in 81 cases and 34 cases were withdrawn by the claimants (see figure 3).

The remaining 63 cases (28%) were presented to the Complaints Panel for deliberation. The Complaints Panel ruled in favour of the complainant in six cases and upheld the insurer's decision in 57 cases. In two out of these 57 cases, the Complaints Panel recommended the insurers concerned to consider making *ex-gratia* payments and such recommendations were duly followed (see figure 5).

In total, 56 complainants received altogether HK$2.66 million claims compensation from insurance companies, of which HK$198,000 was awarded by the Complaints Panel. The highest award in a single case was HK$116,000. The aggregate claim amount involved in the 63 cases deliberated by the Complaints Panel totalled HK$5.89 million.

統計數字

投訴局於2004年共接獲292宗投訴，比去年增加14%，糾紛主要涉及賠償金額、保單條款的詮釋、違反保證條款或保單條件、不保事項及沒有披露事實（見圖一及圖四）。在眾多個人保險產品中，最常見的兩大類索償糾紛涉及個人意外／傷殘保險及住院／醫療保單（見圖二）。

年內處理的投訴個案總數達351宗，包括59宗2003年尚未結案的個案；已經審結的291宗投訴中有65宗超出投訴局的職權範圍，至於其餘226宗受理的個案，有48宗在秘書處調停下，保險公司與索償人雙方達成和解，毋須上呈投訴委員會介入處理。此外，共有81宗表面證據不成立、34宗索償人撤銷投訴（見圖三）。

餘下的63宗個案（28%）交由投訴委員會審理。投訴委員會裁定六宗個案的投訴人得直，獲得賠償；贊同保險公司賠償決定的個案則有57宗，而投訴委員會建議其中兩宗個案的有關保險公司通融處理，兩家保險公司均從善如流，接納有關建議（見圖五）。

共有56位投訴人獲得保險公司賠償，涉及266萬港元，而投訴委員會判予得直投訴人的總金額佔19.8萬港元，單一宗個案的最高賠償金額為11.6萬港元。投訴委員會審理的63宗個案涉及的索償總額為589萬港元。

Figure 1 Nature of Complaints Accepted
圖一口 受理投訴個案類別

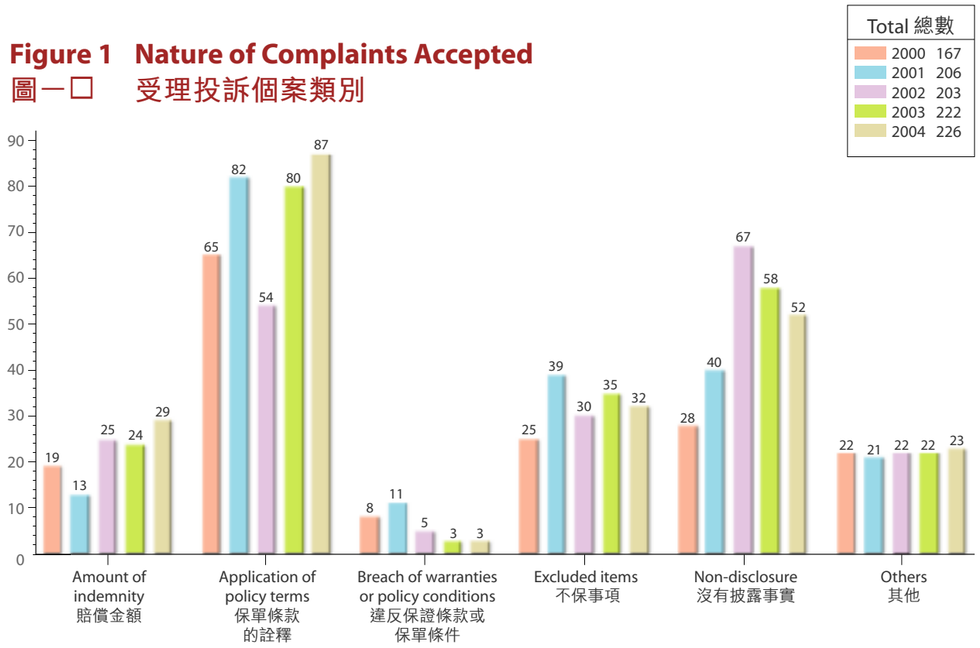


Figure 2 Types of Policies
圖二口 保單類別

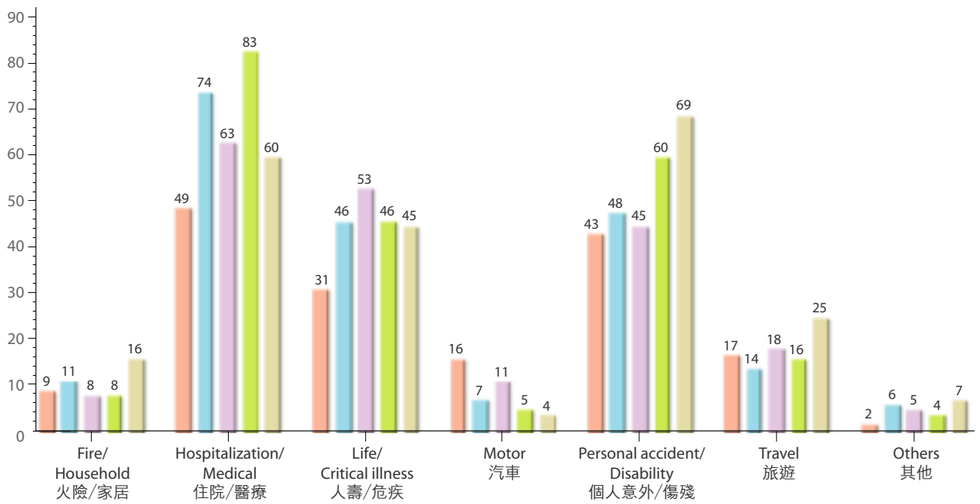


Figure 3 Outcome of Cases Closed
圖三口 結案分類

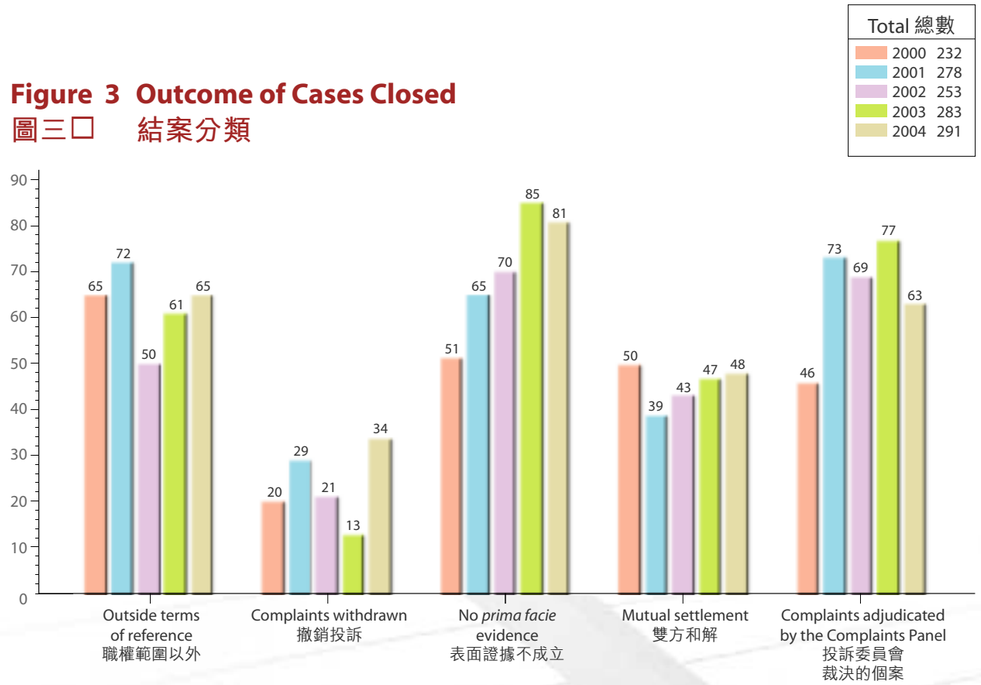


Figure 4 Nature of Complaints Accepted in 2004
圖四 2004 年受理投訴個案類別

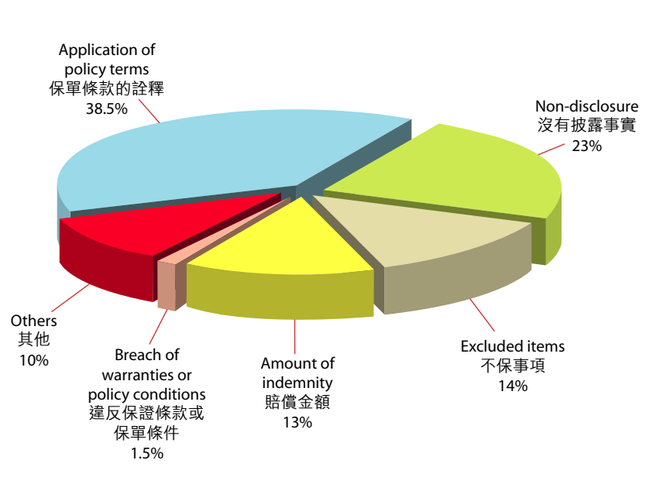
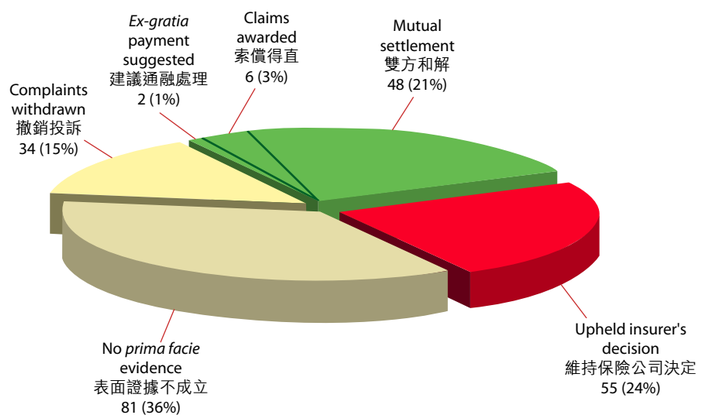


Figure 5 Conclusion: Outcome of Cases Closed in 2004
圖五 總結：2004 年的結案分類



Powers of the Complaints Panel
投訴委員會的權力

According to Articles 82(a) & (b) of *Articles of Association* of the Bureau, the Complaints Panel, in making its ruling, "*shall have regard to and act in conformity with the terms of the relevant policy, general principles of good insurance practice, any applicable rule of law or judicial authority; and any codes and guidelines issued from time to time by the HKFI or the Bureau. In respect of the terms of the policy contract, these shall prevail unless they would, in the view of the Complaints Panel, produce a result that is unfair and unreasonable to the complainant*". In other words, the Complaints Panel, in making a ruling, is given the power by its Members to look beyond the strict interpretation of policy terms.

As far as good insurance practice is concerned, the Complaints Panel relies heavily on the expected standards set out in *The Code of Conduct for Insurers* published by the HKFI, with particular reference to "Part III: Claims". The first requirement of the section states, "*Insurers should seek to handle all claims efficiently, speedily and fairly*". As such, as to whether or not an insurer has acted fairly in the settlement of claims is subject to the scrutiny of the Complaints Panel.

In the deliberation of complaints, the Complaints Panel often faces the arduous task of balancing evidence submitted by one party against the other, without the benefit of exhaustive examination and cross-examination as in a proper court of law. In order to achieve what would be a fair and reasonable solution to the complainant, the Complaints Panel would carefully consider the merits of each case before making a ruling. This unfettered power of the Complaints Panel is reflected in Article 82(c) of the *Articles of Association*, which stipulates that the Complaints Panel shall not be bound by its previous decisions.

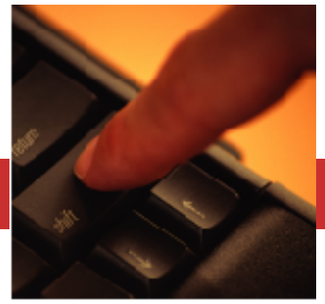
保險索償投訴局《公司章程》第82條（a）及（b）款規定，投訴委員會裁決時「必須尊重及遵守保單條款、優良保險慣例的原則、任何適用法例或司法機構法規、香港保險業聯會或投訴局不時頒布的守則及指引。除非投訴委員會認為履行有關保單條款的後果對投訴人既不公道，又不合理，否則必須以保單條款為準」。換言之，投訴委員會獲會員賦予權力，裁決時可考慮個案涉及的其他事宜，毋須死硬詮釋保單條款。

投訴委員會界定何謂優良保險慣例時，會參照香港保險業聯會制訂的《承保商專業守則》列舉的預期水平，尤以「第三章：索償」為主，其首要條文是：「承保商應迅速、快捷及公道地處理索償」。有鑑於此，投訴委員會會仔細查究承保商處理賠償時是否公道。

由於投訴委員會並非如正規法庭般運作，只能從控辯雙方提交的證據取得平衡，不能巨細畢究及盤問控辯雙方，故此審理個案時經常面對嚴峻考驗。為求判決公道、合理，投訴委員會會小心考慮每宗個案的曲直是非，方行裁決。《公司章程》第82條（c）款賦予投訴委員會彈性斷案的權力，說明投訴委員會的裁決並不囿於以往案例。

Mr Michael F S Tsui
Chairman
The Insurance Claims Complaints Panel

保險索償投訴委員會主席
徐福燊先生



Case Review 1 January - 31 December 2004
個案分析
2004年1月1日至12月31日

APPLICATION OF POLICY TERMS

Disputes arising from the application of policy terms formed the largest category of complaints in 2004.

Many terms in insurance contracts have very specific definitions. Very often, the meaning attributed to a term in an insurance contract has to be very strict for underwriting purposes and thus may not be identical to its common and everyday usage. Unless specific conditions or limitations are attached, this is prone to attract frivolous claims.

Accidental Bodily Injury

A personal accident insurance policy or rider provides cover for the insured when he sustains an accidental bodily injury. This type of policy usually contains the proviso of a visible bruise or wound on the exterior of the body as evidence of an accidental bodily injury. The "Visible Injury Clause" is widely adopted because it is clear and unambiguous.

Over the years, when assessing this type of dispute, the main focus of the Complaints Panel has been to determine whether or not there has been genuine injury caused solely and directly by an accident independent of all other causes. It is the understanding of the Complaints Panel that the requirement of apparent contusion exists only to protect insurers from being prejudiced by invalid or fraudulent claims. Moreover, it would not be used as a ready and handy excuse by insurers to avoid liability.

If there is concrete and supportive evidence to prove beyond reasonable doubt that an insured did suffer from a genuine injury that was directly and independently caused by an accident, the Complaints Panel would rule in favour of the insured despite the fact that there is no visible bruise or wound because this is only fair and reasonable to the insured. The explicit powers of the

保單條款的詮釋

2004年間受理的個案中，為數最多的是因保單條款詮釋而起的糾紛。

保險合約內很多用語都有嚴謹的定義，即使是同一個詞彙，保險合約賦予它的定義，必須非常明確，以便進行核保，因此用語的定義往往並不等同於一般慣常用法，如果保單不予以附加特定條件或規限，可能會導致被保人隨便地提出索償。

因意外事故造成身體受傷

個人意外保單或附加保險為因意外事故造成身體受傷的被保人提供保障，這類保單通常都有條款訂明被保人身體表面必須有明顯傷痕或瘀痕，以資證實被保人因意外事故造成身體受傷。由於「明顯傷痕條款」十分清晰，絕不含糊，因此得到廣泛應用。

多年來投訴委員會審理這類糾紛時，會把焦點放在判斷被保人是否確實純粹和直接因某宗獨立意外事故造成傷患，並不涉及任何其他因素。投訴委員會明白，要求有明顯傷痕的原意在於避免保險公司因虛假或詐騙索償受損，但是保險公司不會動輒以此作為拒絕賠償的藉口。

如果實證旁證俱在，毋庸置疑地證實被保人確實因某宗獨立意外事故造成傷患，絕不涉及其他因素，即使被保人並無明顯瘀痕或傷痕，投訴委員會仍會裁定他得直，因為此舉才算對被保人公道和合理。投訴局會員於2000年3月13日起，明確地賦予

Complaints Panel to go beyond the strict application of contract terms were given to it by the Members of the Bureau effective 13 March 2000.

投訴委員會權力，可以凌駕合約條款。

Case 1

The insured, who works as a store assistant in a fruit juice store, sprained his lumbar region while carrying a heavy load of sugar cane shoots. He was granted 14 days sick leave due to the sprain back injury.

The insurer rejected the insured's claim for the accident benefit on the ground that there was no visible contusion or wound noted on his body. Moreover, the x-ray taken showed no abnormal finding.

The Complaints Panel learnt from the attending physician's report that there was redness, stiffness and swelling noted on the insured's para lumbar region and the injury would have prevented him from working as the pain had limited his lumbar movement. The Complaints Panel believed that such physical signs and findings could reasonably be interpreted as a visible sign of an injury. Having further taken into consideration relevant circumstances, the nature and the extent of the injury, the Complaints Panel was convinced that a genuine accident had taken place resulting in the insured's back injury. It therefore ruled in favour of the insured and awarded him 14 days temporary disability benefit, amounting to nearly HK$2,000.

個案1

在果汁店任職助理的被保人搬運大量甘蔗時，不慎扭傷腰椎部位，並因為背部受傷而獲發14天病假。

保險公司以被保人沒有明顯傷痕或瘀痕，加上X-光檢查也沒有異樣為理由，拒絕發放意外賠償。

投訴委員會從主診醫生的報告中得悉，被保人的腰椎位置赤紅、僵硬和隆腫，由於傷患引起的痛楚局限了被保人的腰椎活動能力，令被保人無法工作，投訴委員會相信這些身體症狀和發現也可被視為表面傷痕，經過再三考慮有關情況、傷患性質和嚴重程度後，投訴委員會認為被保人的背傷是因真正的意外引致的，故裁定被保人得直，獲發14天暫時性傷殘賠償，涉及金額近2,000港元。

In assessing an accidental bodily injury claim, the insurer would require the claimant to prove that his injury was effected directly and independently by an accident. The accident date and the onset date of a symptom are crucial evidence from which one may draw a conclusion as to whether or not the injury was caused solely and directly by an accident independent of all other causes. The following illustrates a case where the Complaints Panel endorsed the insurer's claim decision as the information regarding the accident date and the onset date of the insured's back pain was inconsistent.

保險公司審理因意外事故造成身體受傷的索償個案時，會要求索償人證明傷患是直接因意外造成，與其他因素無關；意外發生的日期和出現症狀的日期都是重要的證據，可用以推斷傷患是否純粹及直接因意外造成，而不涉及其他因素。就以下個案來說，投訴委員會同意保險公司的賠償決定，因為有關意外日期和被保人出現背痛症狀的日期並不一致。

Case 2

The insured submitted a claim to the insurer reporting that he was granted 10 days sick leave as a result of a lower back injury which occurred on 25 January 2004.

From a medical report, the insurer learnt that the insured consulted a private medical practitioner on 29 January 2004, complaining of severe pain on his lower back as a result of an injury sustained on 22 January 2004. Physical examination showed there was swelling and tenderness on his lower back, but there was no bruise or wound. As there was a discrepancy on the onset date of the insured's back problem, the insurer declined his accident claim.

The private practitioner later amended the date of accident to 25 January 2004. However, the insurer maintained its decision not to honour the claim on the basis that there was no visible bruise or wound noted on the insured's body.

Other than the report of the private practitioner, the Complaints Panel also noted that the insured had consulted the out-patient department of a government hospital on 26 January 2004, complaining of low back pain for one week before the consultation.

Given the inconsistent information regarding the onset date of the back pain, the Complaints Panel doubted if the insured's back pain was directly and independently caused by the alleged accident. In the circumstances, the Complaints Panel concurred with the insurer's decision to decline the accident claim for nearly HK$4,000.

個案2

被保人向保險公司索償，報稱於2004年1月25日因腰傷而獲發10天病假。

保險公司從醫療報告中得悉被保人於2004年1月29日向私家醫生求診，指於同年1月22日受傷以致腰部劇痛，身體檢查結果顯示被保人腰背有腫脹及疼痛，但並沒有任何瘀痕或傷痕。由於受傷日期與被保人腰部傷患出現的日期有異，故保險公司拒絕發放意外賠償。

該名醫生其後修正意外的日期為2004年1月25日，但是保險公司維持原判，不予發放賠償，理由是被保人身上沒有表面瘀痕或傷痕。

除了私家醫生的醫療報告之外，投訴委員會發現被保人曾於2004年1月26日向政府醫院門診部求診，指於求診前一星期持續感到腰背痛楚。

鑑於被保人出現背痛的日期不一，投訴委員會懷疑他的背痛是否直接因他所指的意外造成，而不涉及其他因素，因此，同意保險公司拒絕發放意外賠償的決定，涉及金額約4,000港元。

Many insureds may think that once they have sustained an accidental injury, confirmed by the medical doctors that they were unable to work, they would be eligible to claim for the temporary disability benefit continuously for the whole sick leave period until fully recovered. However, the criteria for claims assessment are not that straightforward and as a result, disputes are likely to arise.

In reviewing this type of dispute, the Complaints Panel focuses on whether the insured's entire disability period was caused directly and independently by the aforesaid injury. If there is evidence showing that other factors co-exist or subsequently develop which has exaggerated the insured's condition, the Complaints Panel would be inclined to support the insurer's decision of not paying the accident benefit for the entire period. The following case is an example.

許多被保人以為只要曾經因意外受傷，並得到醫生證明他們無法工作，便合乎資格於整段病假期間一直申領暫時性傷殘賠償，直至完全康復為止。其實評估賠償的準則並非如此容易理解，糾紛往往便因此而起。
蟎

投訴委員會審理這類糾紛時，會將焦點放在被保人的整段傷患期，是否直接因所述的傷患引起，而不涉及其他因素。假如有證據顯示同時存在其他因素，或因此而導致被保人的情況惡化，投訴委員會便傾向支持保險公司的決定，不應發放整段病假期間的意外賠償，以下是其中一個例子。

Case 3

A cook sustained an injury to his right middle finger and left index finger at work. He was initially given 10 days sick leave. As the condition worsened, he attended a government hospital and was diagnosed of systemic scleroderma with acute cellulites of finger. Physical and radiological examinations showed signs of infection. He was discharged four days later and was referred to a rheumatologist for further treatment. Additional 31 days sick leave were given.

The insurer offered him 10 days temporary disability benefit but declined to pay further benefit on the ground that his further sick leaves were not caused solely from an accidental bodily injury.

The Complaints Panel was aware that scleroderma is a systemic disease causing ulcers or non-healing wound over extremities. Moreover, it was revealed in the report of the hospital that the insured had complained of right middle finger swelling for one month when he first attended the hospital 10 days after the aforesaid work accident. In this regard, the Complaints Panel was not convinced that the insured's latest condition was solely and directly caused by the aforesaid work accident. As the insurer had already settled 10 days temporary disability benefit, the Complaints Panel was of the view that it should have fully compensated the loss the insured had sustained from the aforesaid work accident. The Complaints Panel, therefore, endorsed the insurers' decision to decline further claim for about HK$10,000.

個案3

一名廚子於工作期間弄傷右手中指和左手食指，因此獲發10天病假，及後病情轉壞，遂向政府醫院求診，被診斷為系統性硬皮病、手指急性窩蜂織炎，而身體檢查和放射性檢查結果均顯示有受感染的症狀。被保人於四天後出院，被轉介至風濕科專家接受進一步治療，額外獲發31天病假。

保險公司發放10天暫時性傷殘賠償，但拒絕作進一步賠償，原因是被保人其後的病假並非純粹因為意外事故造成身體受傷。

投訴委員會發現硬皮病是系統性疾病，會引致末端位置的傷口潰爛或無法治癒。此外，投訴委員會從醫院的醫療報告中得悉，當被保人在有關工業意外發生後十天首次到醫院就診時，曾表示右手中指腫脹已達一個月之久。因此，投訴委員會相信被保人最新的病況並非純粹及直接因所述的工業意外造成，由於保險公司已經發放十天暫時性傷殘賠償，故投訴委員會認為保險公司已經悉數補償被保人在所述的工業意外中所受的損傷。投訴委員會因此同意保險公司拒絕進一步賠償約10,000港元的決定。

The following is a case where the insured suffered from an infectious disease after being bitten by infected mites. As the contracting of a disease or an illness could not be regarded as an accidental bodily injury, the Complaints Panel upheld the insurer's decision in rejecting the accident claim.

以下案例的被保人被受感染的蟎蟲咬傷，因而患上傳染病，由於染病或患病並不能視作因意外事故造成身體受傷，故此投訴委員會支持保險公司拒絕發放意外賠償的決定。

Case 4

The insured suffered from scrub typhus which was transmitted by the bites of infected mites. He was admitted to hospital for six days and was granted 11 days sick leave.

The insurer settled his hospitalization claim but rejected his claim for the accident benefit. This was because scrub typhus was an infectious disease and was not caused solely and independently by an accidental bodily injury.

The insured alleged that he was bitten by mites during hiking in Sai Kung and the bite was evidenced by a visible wound on his abdomen. As the bite was unforeseen and unexpected, he insisted that the cause of his

個案4

被保人被蟎蟲咬傷而染上恙蟲病，因此住院六天，獲發11天病假。

保險公司發放住院賠償，但卻拒絕發放意外保障的賠償，因為恙蟲病屬於傳染病，並非純粹因意外事故造成，不涉及其他因素。

被保人指他在西貢遠足期間被蟎蟲咬傷，腹部的傷口可資佐證，由於被蟎蟲咬傷是不可預見和預知的，故此被保人堅持他入院的

hospitalization and the subsequent sick leaves was due to an accident.

Having considered the whole circumstances, the Complaints Panel opined that the cause of the insured's hospitalization was not the bite, but scrub typhus, which is an acute infectious disease caused by a parasitic micro-organism. As such, it concurred with the insurer to decline the accident benefit for around HK$4,600 on the ground that the claim was not an accidental event.

原因和隨後的病假是因意外事故造成的。

投訴委員會審閱整體情況後，認為被保人入院的原因並非因為被咬傷，而是因為一種由寄生微生物引起、名為恙蟲病的急性傳染病所致。因此，同意保險公司拒絕發放意外賠償，涉及金額約4,600港元，理由是索償並非因意外事故所致。

Total and Permanent Disability

"Total and Permanent Disability" is defined in some disability policies as "*the complete inability of the insured to engage in any gainful occupation or to perform any work for compensation or profit as a result of injury or sickness*".

This means that an insured, who is merely unable to continue his previous or old occupation, will not be regarded as suffering from "Total and Permanent Disability". In order for him to be qualified for the total and permanent disability benefit, he must prove that he is unable to engage in any gainful occupation at all.

完全及永久傷殘

某些傷殘保險界定「完全及永久傷殘」一詞的定義為：「被保人因受傷或疾病導致完全不能從事任何有報酬的職業，或做任何工作以賺取薪金或收入」。

換言之，如果被保人只是無法繼續從事先前或原本的職業，將不會被視為「完全及永久傷殘」，要符合申請完全及永久傷殘賠償的資格，被保人必須證明他完全無法從事任何可獲報酬的職業。

Case 5

The insured was a bus driver at the time of the accident. He was struck by a bus driven by his colleague while he was having a rest at a bus station. His left foot and the left side of his trunk were severely hurt. He developed a great fear of buses and complained of anxiety, poor sleep and nightmares after the accident. He was later diagnosed with post-traumatic stress disorder complicated with psychiatric impairment and depression. He was assessed by the Employees' Compensation Board to have 8.5% permanent loss of earning capacity due to the injury.

個案5

被保人發生意外時任職巴士司機，當他在車站休息時被同事駕駛的巴士撞倒，左腳及左邊身體嚴重受傷。事發後被保人對巴士感到非常恐懼，並經常焦慮、失眠及造惡夢，及後被診斷為創傷後因壓力而出現失常，同時患上心理創傷及抑鬱症，僱員補償委員會評估被保人因傷患而永久喪失8.5%的賺取收入能力。

The insurer offered him total and permanent disability benefit for 24 months. However, as there was no evidence showing that he was totally and permanently disabled in any gainful occupation after 24 months, the insurer refused to pay further total and permanent disability benefit.

The insurer had arranged an independent examiner specialist in psychiatry to conduct an assessment on the insured's condition. Although it was clearly indicated in the examiner's report that the insured was incapable to resume his previous job as a bus driver at the moment or probably in the future, there was no evidence that he was unable to perform any gainful work. Furthermore, the report had confirmed that the insured should be capable of performing odd jobs or jobs with lesser stress such as watchman, cleaner, carpark attendant or canteen worker.

As the insured's latest condition failed to fulfill the definition of total and permanent disability in the policy provision, the Complaints Panel upheld the insurer's decision in declining further claim, involving a maximum amount of about HK$500,000.

被保人獲發24個月的完全及永久傷殘賠償，但是由於沒有證據證明被保人在24個月後，仍然完全及永久喪失從事任何有報酬職業的能力，故此保險公司拒絕進一步發放完全及永久傷殘賠償。

保險公司安排獨立心理專家評估被保人的情況，雖然心理專家的報告清楚顯示被保人現階段，甚至以後都沒有能力重操故業，任職巴士司機，但是沒有證據顯示被保人無法從事任何有報酬的工作。此外，報告確定被保人應該有能力從事工作量較輕或壓力較少的工作，例如管理員、清潔工人、停車場管理員或食堂工人。

鑑於被保人最新的情況並不符合保單條款所訂的完全及永久傷殘定義，因此投訴委員會支持保險公司拒絕進一步發放賠償的決定，涉及的最高金額近500,000港元。

Temporary Total Disability vs Temporary Partial Disability

Most personal accident policies or riders have two kinds of temporary disability benefits namely, "Temporary Total Disability" and "Temporary Partial Disability". "Temporary Total Disability" means "*total and continuous disability which prevents the insured from the date of accident from performing each and every duty of the insured's regular occupation*", while "Temporary Partial Disability" means "*partial disability which prevents the insured from the date of accident or immediately following Temporary Total Disability from performing one or more duties of the insured's regular occupation*". The compensation amounts for these two types of disability differ significantly. The amount payable under temporary partial disability

「暫時性完全傷殘」與「暫時性局部傷殘」

大部分個人意外保單或附加保險都提供兩種暫時性傷殘保障，即：「暫時性完全傷殘」和「暫時性局部傷殘」。「暫時性完全傷殘」指：「由意外發生當日起，被保人因完全及持續傷殘無法執行日常工作範圍內的任何職務」；「暫時性局部傷殘」則指：「由意外發生當日起或者完全傷殘狀況過後，被保人因局部傷殘無法執行日常工作範圍內的一項或多項職務」。上述兩種傷殘保障的賠償金額相差很大，暫時性局部傷殘的賠償金額往往只是暫時性完全傷殘的四分之一，也許正好解釋為何糾紛總是圍繞著保險公司自哪一天

benefit is usually a quarter of that payable under temporary total disability benefit. This may explain why disputes often arise when an insurer replaces temporary total disability benefit with a temporary partial disability benefit. The following case is an example.

起以暫時性局部傷殘賠償取代暫時性完全傷殘賠償，以下是一案例。

Case 6

The insured slipped and hit herself on a washing basin at home and sustained contusion over her sacrum area. She was granted a total of 13 days sick leave. The insurer paid her eight days temporary total disability benefit and five days temporary partial disability benefit. However, the insured was not satisfied with the settlement and considered that the insurer should settle her entire claim as 13 days temporary total disability benefit. The difference in the claim amount was nearly HK$540.

The Complaints Panel noted that the insured had no fracture or nerve injury and there was also no healing complication. As the insured was a self-employed director and her job mainly involved office duties, the Complaints Panel, in the light of the nature of the injury and the degree of severity and complication, was of the view that she should be able to perform some of her duties eight days after the injury.

As the insured's condition during her last five days of sick leave only fulfilled the definition of temporary partial disability but not temporary total disability in the policy, the Complaints Panel concluded that the insurer's claim offer was appropriate.

個案6

被保人在家中滑倒撞向洗滌盆，挫傷薦骨部位，獲發13天病假，保險公司發放八天暫時性完全傷殘賠償及五天暫時性局部傷殘賠償，但是被保人對此並不滿意，認為保險公司應該悉數發放13天暫時性完全傷殘賠償，涉及的賠償差額近540港元。

投訴委員會得悉被保人身體沒有骨折，神經沒有受損，也沒有出現癒合併發症，由於被保人是自僱人士，任職公司董事，主要負責文職工作，投訴委員會考慮到被保人的傷患性質、病況的嚴重和複雜程度，認為她可以於受傷後八天履行部分職務。

由於被保人最後五天病假期間的情況，只符合保單內暫時性局部傷殘的定義，而不符合暫時性完全傷殘的定義，故此投訴委員會裁定保險公司的賠償決定恰當。

Benign Brain Tumour

Critical illness benefit offers a lump sum to the insured if he is diagnosed as suffering from any of the critical illnesses, the diagnostic criteria of which are stipulated in the policy contract. Very often, there are provisions in the diagnostic criteria specifying the designated methods or tests by which the critical illness should be confirmed. Below illustrates a case where the Complaints Panel endorsed the insurer's decision following confirmation by the designated test of the absence of the critical illness.

良性腦腫瘤

危疾保單的被保人一旦被診斷患上任何一種危疾，保險公司便會發放一筆過賠償予被保人，保單往往清楚訂明診斷危疾的標準，並通常有條款註明應該用甚麼特定方法或測試來診斷危疾。就以下個案而言，被保人經過特定測試，證實沒有患上危疾，故此投訴委員會贊同保險公司的決定。

Case 7

The insured was diagnosed with epidermis tumour at the frontal lobe of his brain. He then submitted a critical claim for "Benign Brain Tumour", which is one of the 28 major illnesses covered under his policy.

According to the policy provisions, "Benign Brain Tumour" means "*a non-cancerous tumour in the brain which must be confirmed by imaging studies such as computerized tomography scan, or magnetic resonance imaging (MRI). Cyst, granulomas, malformations in, or of, the arteries or veins of the brain, haematomas, and tumours in the pituitary grand or spine are excluded*".

The insurer considered that the epidermoid tumour suffered by the insured was not a tumour situated in the brain, but a tumour of the skull. As such, it failed to fulfill the diagnostic requirement for benign brain tumour as stated in the policy provisions.

Whilst it appeared doubtful that such a tumour, which originated from the skull enlarging towards the brain, should fall under the category of brain tumour, the insured submitted a report from his attending physician, who declared that this particular kind of tumour is classified by the World Health Organization as a "Benign Brain Tumour".

個案7

被保人經診斷發現患上腦額葉表皮腫瘤，由於良性腦腫瘤屬保單保障的28種主要疾病之一，故此被保人申請索取危疾賠償。

保單條款訂明「良性腦腫瘤」指：「在腦部出現的非惡性腫瘤，並必須以影像檢查來確定病情，例如：電腦斷層掃描或磁力共振；惟良性腦腫瘤並不包括囊腫、肉芽腫、腦動脈或靜脈畸形、血腫、腦垂體或脊骨腫瘤。」

保險公司考慮到被保人患上的上皮腫瘤並非位處腦部，而是頭顱上的腫瘤，因此認為該腫瘤並不符合保單條款內訂明的良性腦腫瘤的診斷要求。

雖然這類由頭顱擴散至腦部的腫瘤究竟應否歸類為腦腫瘤，實屬疑問，但投保人的主診醫生在報告卻聲明，世界衛生組織界定此類腫瘤為「良性腦腫瘤」。

It was stated in the MRI report that "*the ventricles and the cerebrospinal fluid spaces are normal*" and "*normal signal intensity is seen in the cerebrum, cerebellum, basal ganglion and brain stem*". As the MRI report, which was the only imaging studies available, failed to confirm that there was benign brain tumour, the Complaints Panel supported the insurer's decision to reject the critical illness claim for HK$390,000.

磁力共振報告卻指：「腦室及腦脊液腔正常」，而「大腦、小腦、基部神經中樞及腦幹訊號強度亦見正常」。由於磁力共振報告是唯一可供考據的影像檢查，而報告卻沒有證實腦部有良性腫瘤，因此投訴委員會支持保險公司拒絕被保人索取危疾賠償的決定，涉及390,000港元。

Medically Necessary

The Complaints Panel came across many cases where an insurer declined a hospitalization claim on the basis that hospitalization was deemed unnecessary, either because no treatment had been applied during hospitalization or the diagnostic tests conducted during the hospital confinement could be performed in an outpatient establishment.

As the circumstances may differ greatly from case to case, the Complaints Panel, when reviewing this type of dispute, pays particular attention to the following:

1. whether the attending physician had declared that it was, in his opinion, necessary to admit the patient;
2. whether any treatment was given during the hospitalization, other than the diagnostic test done; and
3. whether the diagnostic tests formed part of the treatment which had to be done in a hospital setting.

If it can be shown that the hospital confinement was only for the sake of diagnostic or laboratory tests without medical emergency, the Complaints Panel will usually rule in favour of the insurer.

醫學上必要的治療

投訴委員會曾處理數宗投訴個案，關於保險公司拒絕賠償被保人的住院索償，原因是被保人沒有必要住院，其理據是被保人在住院期間並沒有接受任何治療，或所接受的診斷性化驗大可於門診進行。

由於每宗個案的情況可能有很大的差異，投訴委員會審理此類糾紛時會留意下列要點：

1. 主診醫生有沒有明確指出他認為病者必須入院；
2. 被保人住院期間除了進行診斷性檢查之外，有否接受任何治療；及
3. 診斷性檢查是否治療的其中一部分，而必須在醫院進行。

一旦證實住院只是為了進行非緊急醫療需要的診斷性或化驗性檢查，投訴委員會通常會裁定保險公司不予賠償的決定合理。

Case 8

The insured was admitted to hospital complaining of the symptoms of vertigo for almost four months. Magnetic resonance imaging (MRI) of brain was performed during the hospitalization. She was diagnosed as suffering from Meniere's Disease and was discharged the next day.

The insurer rejected her hospitalization claim for unnecessary in-patient stay based on the following grounds:

1. The primary purpose for the insured's hospitalization was to have diagnostic scanning with MRI to rule out any intracranial pathology.
2. MRI is not an invasive test. It could be effectively done during day time and did not require the patient to stay overnight in a hospital.
3. There was no dispute that MRI was necessary for the insured's diagnostic purpose. However, the policy does not cover the expenses incurred as a result of overnight hospital confinement merely for performing the MRI scan.

The Complaints Panel noted from the available information that the insured's hospital confinement was only for the MRI scan of brain and there was no medication prescribed or treatment performed during the confinement. More importantly, the insured's attending doctor also failed to indicate any specific medical reason as to why the MRI scan should be done inpatient.

Given that the hospital confinement was not for emergency needs and that the MRI scan could have been performed on an out-patient basis without the need for overnight confinement, the Complaints Panel concluded that the insured's confinement was not medically necessary and ruled that the insurer's decision to reject the claim for nearly HK$5,500 was appropriate.

個案8

被保人因連續四個月感覺眩暈而被送院，住院期間進行腦部磁力共振檢查，被診斷為耳水不平衡，並於翌日出院。

保險公司認為她沒有必要住院而拒絕她的索償，原因如下：

1. 被保人住院的主因是進行診斷性磁力共振檢查，判斷是否患有頭臚內疾病。
2. 磁力共振檢查並非創傷性檢查，大可在日間進行，毋須要求病者入院留宿。
3. 要診斷被保人的病況，就必須使用磁力共振檢查，這點毋庸置疑，但是有關保單並不保障被保人純粹為了進行磁力共振檢查而要住院的開支。

投訴委員會審閱已有資料，得悉被保人住院只為進行腦部磁力共振檢查，住院期間並沒有服用藥物或接受治療。更重要的是，被保人的主診醫生無法提出任何特定醫療理由，解釋為何必須留院進行磁力共振檢查。

由於被保人並非因緊急需要住院，而磁力共振檢查可以在門診進行而毋須留院，因此投訴委員會認為被保人住院並非醫學上必要的治療，裁定保險公司拒絕賠償的決定恰當，涉及金額5,500港元。

NON-DISCLOSURE

The Complaints Panel devoted considerable time last year to deal with disputes concerning non-disclosure of material information.

Insurance contracts are based on trust. The insurer trusts the policyholder to give precise and true details of the subject matter to be insured. This is called the principle of Utmost Good Faith. The nature of the subject matter of insurance and the circumstances pertaining to it are facts within the knowledge of the insured. Insurer, on the other hand, is not aware of these facts unless the insured tell them. Care should, therefore, always be taken by the policyholder to tell the whole truth. Non-disclosure arises when an applicant for an insurance policy fails to disclose on the application form material facts within his actual or presumed knowledge. It should be noted that the information given by an applicant on the application form has great impact on the insurer's underwriting assessment. From the information given on the application form, the insurer can identify high-risk features and decide whether or not to take the risk and at what premium and terms. Over the years, the majority of non-disclosure disputes were related to the medical history of applicants.

In dealing with non-disclosure disputes, the Complaints Panel focuses on whether or not the non-disclosed fact is:

1. a material fact, which would influence a prudent underwriter in accepting or declining a risk or in determining the premium or terms and conditions of the contract;

2. a fact within the knowledge of the applicant;

3. a fact which the applicant could reasonably be expected to disclose.

沒有披露事實

投訴委員會去年花了不少時間處理有關沒有披露重要事實的個案。

保險合約建基於信任，保險公司信任保單持有人會對投保事項提供準確和真實的資料，此乃「最高誠信」原則。投保事項的性質、與之相關的各種狀況，均是被保人認知範圍內的事實，除非被保人主動相告，否則保險公司不會知道有關事實，因此保單持有人應常常留意交代所有事實。如果投保人在投保當時沒有披露已知或應該知道的重要事實，會被指沒有披露事實。大家必須明白，投保人在投保申請書上提供的資料，對保險公司的核保評估影響重大；保險公司會根據投保申請書上的資料，判斷是否有高風險的特徵，從而決定應否承保有關風險、釐定保費水平和保單條款。多年來大部分沒有披露事實的糾紛都與被保人的病歷有關。

投訴委員會審理涉及沒有披露事實的糾紛時，會考慮下列各點：

1. 沒有披露的資料是否重要事實，足以影響作風審慎的承保商決定應該接受、還是拒絕承保該項風險，或者如何釐定保費和保單條款及條件；

2. 投保人是否知道有關事實；

3. 在正常情況下，預期投保人披露有關事實是否合理。

The decision as to whether a piece of medical information is important in underwriting lies with the insurer, not the applicant. An insurance agent is not trained as a professional underwriter. An applicant should not rely solely on his insurance agent on whether a piece of information is material. One should always bear in mind that non-disclosure could result in policy repudiation and claim rejection. In order to avoid unnecessary claims disputes, an applicant should disclose all information fully and accurately when filling in the application form. There is one golden rule to follow, i.e. if in doubt as to whether a fact is material, it is better to disclose it.

In the following case, the Complaints Panel ruled in favour of the claimant as there was no concrete proof that the non-disclosure concerned a fact within the knowledge of the claimant.

病歷資料對核保是否重要，應該由保險公司而非投保人決定；保險代理沒有接受過專業的核保訓練，因此投保人不應單靠保險代理的建議，決定某些資料是否重要。投保人必須緊記：沒有披露事實會導致保單遭撤銷或索償被拒，為免引起不必要的索償糾紛，投保人在填寫投保申請書時，必須如實披露所有資料，即使不敢肯定某些事實是否重要，最好還是加以披露。

就以下個案，投訴委員會裁定索償人得直，因為沒有實質證據證明沒有披露的事實是在索償人的認知範圍內。

Case 9

The insured applied for a life insurance with critical illness supplementary rider when he was 23 years old. As clean health history was declared on the application, the policy was issued at standard terms and conditions.

The insured submitted a critical illness claim to the insurer after he was diagnosed to have brain tumour. During the claim investigation, the insurer discovered that the insured was a contracted hepatitis B carrier acquired from his infected mother. As such information had not been disclosed on the application, the insurer declined his critical illness claim.

The insured declared that he only learnt from his mother that he was a hepatitis B carrier when he was admitted to hospital for the brain tumour. Although he had made a consultation for hepatitis B when he was only 11 years

個案9

被保人在23歲時投保附加危疾保障的人壽保險，並在投保申請書上申報健康情況良好，於是保險公司發出標準保單。

被保人其後被診斷患上腦腫瘤，因而索取危疾賠償。在調查索償期間，保險公司發現被保人是乙型肝炎帶菌者，病源來自其受感染的母親。由於被保人並沒有於申請書上披露此等資料，故保險公司拒絕其危疾索償。

被保人聲稱直至因腦腫瘤入院時，才從母親口中得悉自己是乙型肝炎帶菌者。雖然他曾於11歲時因乙型肝炎求診，但是事隔

old, he could not remember details of such consultation when he applied for the policy more than 10 years later.

十多年，他在投保時已記不起求診時的細節。

From the information available, the Complaints Panel noted that the insured was only around 11 years old when he was told of being a hepatitis B carrier by a doctor during a medical examination. There was also no evidence that he had attended any follow-up consultation or treatment which would have alerted him to his hepatitis B carrier status. In this regard, the Complaints Panel was of the view that it was not safe and reliable to expect an 11-year-old boy to have fully understood the implication of being a hepatitis B carrier. The Complaints Panel believed that it was very likely that the insured was in fact not aware of his hepatitis status when he applied for the policy some 12 years later.

投訴委員會從有關資料得悉，被保人檢查身體時發現是乙型肝炎帶菌者，當時他只有11歲，沒有證據顯示他其後曾接受任何跟進治療，令他意識到自己是肝炎帶菌者。因此，投訴委員會認為期望一個11歲男童充分理解乙型肝炎帶菌者的意義，既不穩妥，又不可靠。投訴委員會相信事發已經12年，被保人在投保時極可能並不意識到自己是肝炎帶菌者。

Based on the above, the Complaints Panel concluded that there was no evidence to support that the non-disclosed fact was a fact within the knowledge of the insured at the time of policy application, and disagreed with the insurer to reject the claim for non-disclosure. All in all, it ruled in favour of the insured and awarded him the critical illness benefit for HK$ 117,000.

基於以上種種，投訴委員會認為並無證據證明被保人沒有披露的事實，是被保人在投保時所知的，投訴委員會並不同意保險公司以被保人沒有披露事實為理由拒絕賠償，故裁定被保人得直，可獲發危疾賠償，涉及117,000港元。

To a layman, a non-disclosed fact may be totally unrelated to the disease the insured suffers and he may therefore question the rationale of declining a claim based on non-disclosure. However, it should be noted that if the non-disclosed information is material enough to have affected the underwriting decision of an insurer, it is legitimate for an insurer to decline a claim even though the non-disclosed information is not related to the current illness. This is because the non-disclosure had prejudiced the insurer from making a fair and accurate underwriting assessment and thus it is entitled to repudiate the contract from inception.

對於門外漢來說，沒有披露的事實可能與被保人的疾病毫無關係，因此或會質疑保險公司用沒有披露事實作為拒絕賠償的理據；但是，投保人必須注意：如果沒有披露的資料足以影響保險公司的核保決定，即使這些資料和被保人當時所患的病症無關，保險公司也有權拒絕賠償，因為沒有披露的資料一開始便不利於保險公司作出公道和準確的承保評估；在這個大前提下，保險公司有權撤銷合約。

In this regard, the Complaints Panel urges all prospective policyholders to fully and accurately disclose all material facts when completing application forms.

基於上述理由，投訴委員會敦促所有準保單持有人在填寫投保申請書時，必須全面準確地披露所有重要事實。

Case 10

The insured was diagnosed with carcinoma of colon nine months after he had taken out a policy. His claims for the critical illness benefit and the waiver of premium benefit were rejected by the insurer on the ground that he had not disclosed on the application the medical history of his obstructive sleep apnoea.

It was noted from the medical report that the insured had consulted for heavy snoring and was first diagnosed to have obstructive sleep apnoea by a sleep study 12 years before his policy application. He had five follow-up consultations in the following year. Continuous positive airway pressure therapy was recommended but the insured declined. He defaulted follow up since then. The insured was referred to have sleep study assessment again one year before his policy application. He still had the symptoms of snoring and excessive daytime sleepiness. Further sleep study was arranged but he did not return for follow up.

The insured admitted that he had suffered from obstructive sleep apnoea for a long time, however, such symptoms were in no way related to the colon cancer he had suffered. He also emphasized that the symptoms had not affected his work as a bus driver for 20 years and he had passed the annual body check provided by the bus company.

The Complaints Panel learnt from the insurer's underwriting manual that the severity of an applicant's obstructive sleep apnoea and the co-existence of other associated diseases would affect the underwriting decisions for the benefit of critical illness and waiver of premium.

As there was no detailed sleep study to assess the severity of the insured's obstructive sleep apnoea, the insurer had no information to determine the risk. The Complaints Panel believed that had the insurer been

個案10

被保人於投保後九個月證實患上結腸癌，故索取危疾保險及豁免保費賠償，但是被保險公司拒絕，理由是被保人在投保時沒有申報患有梗阻性睡眠窒息症的病歷紀錄。

醫療報告顯示被保人早於投保前12年，曾經因為嚴重打鼾求診，經過睡眠檢查，首次被診斷患上梗阻性睡眠窒息症，翌年更先後五次接受跟進治療，醫生建議被保人進行連續性正壓呼吸道治療，但遭被保人拒絕，此後他再沒有接受任何跟進治療。被保人於投保前一年再次被轉介接受睡眠檢查，結果顯示他仍有打鼾和日間非常昏昏欲睡的症狀，故醫生安排他接受進一步睡眠檢查，但被保人卻沒有覆診。

被保人承認患上梗阻性睡眠窒息症已有一段長時間，但是這症狀與他所患的結腸癌完全無關，他並強調自己任職巴士司機20年，這病症沒有影響他的工作，他更通過巴士公司每年例行的身體檢查。

投訴委員會從保險公司的核保手冊中得悉，申請人患有梗阻性睡眠窒息症的嚴重程度，以及有否同時患有其他相關病症，均會影響保險公司對危疾保障和豁免保費保障的核保決定。

由於被保人沒有接受詳細睡眠檢查，以評定所患梗阻性睡眠窒息症的嚴重性，令保險公司無從評估風險。投訴委員會相信如果保險公司在被保人投保時得悉有關情況，

informed of the condition at the time of policy application, it would have asked for more related information or arranged the insured to have further medical examination before accepting the risk. Since the non-disclosed medical condition was material which would have affected the underwriting decision of the insurer, the Complaints Panel upheld the insurer's decision in rejecting the claim for around HK$250,000.

定會要求取得更多相關資料，或者於承保風險之前，安排被保人進行身體檢查。由於被保人沒有披露的病徵誠為重要，足以影響保險公司的核保決定，故此投訴委員會贊同保險公司拒絕賠償的決定，涉及金額250,000港元。

The Complaints Panel would like to remind all applicants for insurance that it is their responsibility to ensure all information on the application form is true and complete before signing on the application. This is because the signing on the application will imply that the applicant has agreed with what is stated on it. The applicant may have to bear any undesirable consequences for the declaration he makes on the application.

投訴委員會謹此提醒所有投保人，他們簽署投保申請書之前，有責任確保申請書上所有資料真確及完整，因為一旦在申請書上簽署，即表示同意所填報的資料，投保人或許需要承受因為簽署聲明而帶來的不良後果。

Case 11

The insured sustained a left eye injury while carrying out his duties as a cook. He was later assessed by the Employees' Compensation Board as suffering from total loss of vision of left eye. He then submitted a claim for permanent total loss of sight of one eye under the personal accident policy purchased in a bank some 20 months ago.

The insurer later revealed that the insured had sustained a work injury six years prior to policy application and the injury had led to his right eye blindness. However, the insured declared on the application form that he was in good health and free from physical impairment or deformity. As the insured had made a false statement on the application, the insurer repudiated its liability for claims under the policy.

個案11

任職廚子的被保人在工作期間弄傷左眼，及後獲僱員補償委員會判定為完全喪失左眼視力。由於他在20個月前於銀行投購了個人意外保單，故此他為其完全及永久喪失一眼的視力提出索償。

保險公司及後發現被保人於投保前六年曾因工傷導致右眼失明，但是被保人在投保申請書上申報他的身體狀況良好，沒有殘障或缺陷。由於被保人在投保申請書上作出虛假陳述，故此保險公司根據保單拒絕發放賠償。

The insured contended that he had informed the customer officer, who assisted him to fill in the application, that his right eye was blind after an accident six years ago. As the customer officer was busy and it was near the closing time of the bank, he signed the application without checking the information on it. Moreover, he believed that the customer officer, who was face to face with him during the policy application, should have been aware of his right eye problem as the shape of his right eye had changed due to shrinkage and there was no reflection from his right eyeball.

被保人反駁稱他已告知協助他填寫申請書的客戶主任，他因意外導致右眼失明，由於客戶主任工作繁忙，加上臨近銀行關門時間，於是他並未檢查清楚申請書上的資料，便匆匆簽名作實，而且他以為填寫申請書時，該名客戶主任與他面對面，必定察覺他的右眼收縮變型、眼球並無反光。

Regardless whether the insured had informed the customer officer of his right eye blindness at the time of policy application, the Complaints Panel considered that it was his responsibility to ensure all information on the application was complete and true. His signature on the application implied his agreement with what was stated on it. Furthermore, it was not reasonable to assume that the customer officer should be aware of his right eye problem during policy application.

不論被保人投保時有否通知客戶主任他右眼失明，投訴委員會認為被保人有責任確保申請書上所有資料完整及真確，他在投保申請書上簽署即表示同意所申報的資料，而且認為客戶主任在他投保期間理應留意到他右眼的毛病，此等假設並不合理。

As the non-disclosed information would have materially affected the underwriting decision of the insurer at the time of policy application, the Complaints Panel agreed with the insurer to decline the claim for HK$500,000 on the ground of material non-disclosure.

由於被保人在投保時沒有披露的資料，對保險公司的核保決定誠為重要，因此投訴委員會同意保險公司以沒有披露重要事實為理由，拒絕被保人索償500,000港元的決定。

Although the majority of non-disclosure disputes arise from the insureds' failure to disclose their previous medical history, material information is not only restricted to medical records. Other information, such as the average length of stay outside Hong Kong, history of past claims, or occupation details, may also affect an insurer's decision in fixing the premium or determining whether or not to underwrite the risk.

雖然涉及沒有披露事實的糾紛大部分源於被保人沒有披露過往的病歷，但是重要資料不只限於醫療紀錄，其他資料諸如：平均離港時間、過往索償紀錄、或者職業詳情，都有可能影響保險公司釐定保費的決定，或者決定是否承保有關風險。

Case 12

The insured stated on the application form that he was an owner of an investment company in Hong Kong when he applied for a hospitalization policy. He further declared that he had not stayed or intended to stay outside Hong Kong for more than an average of six months per year. The insurer approved his application and issued the policy on standard terms.

Eight months later, the insured was admitted to a hospital in Harbin for treatment of cerebral embolism, upper respiratory tract infection and hyperlipaemia. During the investigation of his claim, the insurer learnt that he had only stayed in Hong Kong for less than two months during the previous three years. As the insured had misrepresented his actual duration of time of stay in Hong Kong on the application, the insurer declined his hospitalization claim for material non-disclosure.

Due to the differences in the medical systems, admission criteria, etc between Hong Kong and the Mainland, the risks involved would be different. As such, the Complaints Panel was convinced that the insured's non-disclosure of his average length of stay outside Hong Kong would have materially affected the underwriting decision of the insurer. The Complaints Panel further believed that the insurer would not have issued the policy with the same underwriting decision if the insured's average length of stay in the Mainland had been fully disclosed at the time of policy application. In this regard, the Complaints Panel endorsed the insurer's decision in declining the hospitalization claim of around HK$39,000.

個案12

被保人在住院保險投保申請書上報稱自己是香港一家投資公司的東主，並申報沒有或不打算在香港以外地區每年居留平均超過六個月，保險公司接受其申請並發出標準保單。

八個月之後，被保人在哈爾濱入院治療腦栓塞、呼吸道感染和高脂血症。在調查索償期間，保險公司得悉被保人過去三年來逗留在香港的時間少於兩個月，由於被保人在投保申請書上，就實際留港的時間有所誤導，保險公司因被保人沒有披露重要事實，拒絕發放住院賠償。

由於香港與內地的醫療制度、住院準則等方面存在差異，因此投訴委員會認為被保人沒有披露逗留在香港的平均時間，對保險公司的核保決定十分重要，並相信如果被保人投保時如實披露平均留港的時間，保險公司不會以相同的核保決定發出保單。據此，投訴委員會贊同保險公司拒絕住院賠償的決定，涉及金額約39,000港元。

EXCLUDED ITEMS

All insurance contracts contain an "exclusion" section which lists all the losses, perils, situations, conditions or circumstances that are excluded from the policy coverage. As additional cover may warrant an additional charge in the premium, the purpose of exclusions is to limit the coverage to only those risks the policies are intended to cover at the agreed premium. Claims disputes often arise when the insured neglects or fails to make reference to these exclusions.

Pre-existing Medical Conditions

"Pre-existing Conditions" are commonly found in most medical and hospitalization policies to exclude injuries or sicknesses which occur, exist or present signs or symptoms before the commencement of policy coverage.

In dealing with these cases, the Complaints Panel relies heavily on whether or not there is sufficient evidence to show that the injury or sickness occurred earlier than the policy effective date, or whether there exist signs or symptoms of the illness before the policy is effected.

不保事項

所有保險合約均載有「不保項目」，羅列所有不受保單保障的損失、危險、情況、事態或環境，目的是以設定的保費，限制保單只會保障應予承保的風險，索償糾紛往往因為被保人忽略或沒有詳閱這些不保項目而起。

投保前已存在的疾病

大多數醫療及住院保單均載有「投保前已存在的疾病」豁免條款，豁免保障在保單保障生效之前已經出現、存在或呈現病狀或病徵的傷患或疾病。

處理這類個案時，投訴委員會非常重視是否有足夠證據顯示在保單生效日之前，投保人的傷患或疾病已經出現，或者已經呈現病狀或病徵。

Case 13

The insured was admitted to hospital for abdominal pain and blood in stool 10 days after she has effected a hospitalization policy. Histopathology report confirmed a colon tumour measuring about 5 cm.

The insurer revealed that the insured had consulted for rectal bleeding with hard stool 15 months prior to her policy application. Furthermore, based on the size of the tumour, the insurer was of the view that the tumour could not have developed within 10 days. As such, the insurer rejected her hospitalization claim on the basis of pre-existing condition.

The insured alleged that her previous consultation for rectal bleeding some 15 months ago was only due to haemorrhoid and she had fully recovered. She believed

個案13

被保人於住院保單生效後第十天因腹痛、糞便有血入院，組織病理報告證實她的結腸長了一個約5厘米的腫瘤。

保險公司發現被保人於投保前15個月曾因為肛門出血和硬糞便求診。此外，保險公司根據腫瘤的大小，認為該腫瘤不可能於短短十天之內形成，因此以投保前存在的疾病為理由，拒絕發放住院賠償。

被保人辯稱於15個月前因肛門出血就醫是因為痔瘡所致，現已完全康復。由於她於保單生效後十天才被診斷患上結腸癌，

that the insurer was unreasonable to decline her current hospitalization claim as the diagnosis of carcinoma of colon was only made 10 days after the policy effective date.

因此認為保險公司拒絕是次住院索償，並不合理。

Although the available information failed to indicate the exact onset date for the insured's colon cancer, the Complaints Panel, having taken into account the size of the colon tumour, was of the view that the tumour might take some time to grow until it was revealed by colonoscopy.

雖然有關資料沒有顯示被保人所患的結腸癌的確實發病日期，但是投訴委員會考慮到結腸腫瘤的大小，認為該腫瘤或許需要醞釀一段時間方可長成至內窺鏡可偵察的大小。

Given the diagnosis of carcinoma of colon was made only 10 days after the policy was effected, the Complaints Panel was of the view that tumour of that size could not have developed within less than 10 days after the commencement date of the policy. As the policy excludes any illness or injury commenced or presented signs and symptoms prior to the policy commencement date, the Complaints Panel endorsed the insurer's decision in rejecting the hospitalization claim for HK$62,000.

鑑於被保人於保單生效後十天被證實患上結腸癌，投訴委員會認為以腫瘤的大小看來，該腫瘤不能於保單生效後的十天之內形成。由於保單豁免保障在保單生效之前已經出現、存在或呈現病狀或病徵的傷患或疾病，故此投訴委員會同意保險公司拒絕發放住院賠償，涉及金額62,000港元。

Pre-existing Conditions are also commonly found in travel insurance policies to exclude those illnesses or injuries which have existed before taking out of the policies. However, due to the different nature of a travel policy and a medical policy, the Complaints Panel adopts different criteria in assessing the claims concerned. In the opinion of the Complaints Panel, the spirit of a travel insurance is to provide coverage to an insured for unexpected and sudden medical conditions during a journey. If there is no evidence to prove that the insured has suffered from a certain illness or the signs or symptoms of which have manifested before a travel policy is effected, the Complaints Panel will rule in favour of the insured. The following case is an example.

旅遊保單均載有「投保前已存在的疾病」豁免條款，豁免保障被保人於投保前已存在之病症或傷患。但是由於旅遊保單和醫療保單的性質不盡相同，因此投訴委員會採納不同的標準審理有關索償個案。投訴委員會認為旅遊保險的精神，是保障被保人在旅程期間發生未能預期或突發的病症，如果沒有證據證明被保人某些疾病、病徵或症狀是旅遊保單生效前已經存在的，則投訴委員會會裁定被保人得直。以下是案例之一。

Case 14

A 67-year-old man experienced sharp pain at his lower spine during his flight to Kunming with his wife. He sought consultation in local hospital immediately on arrival. As pain persisted, he gave up the rest of the tour and returned to Hong Kong. He then lodged a claim to the insurer for the medical expenses incurred and the curtailment of trip benefit.

The insurer learnt that the underlying cause of the insured's back pain was due to degeneration of his spine. As degeneration was a condition which existed prior to the commencement of his trip, the insurer declined his claim for pre-existing medical condition exclusion.

The Complaints Panel learnt that the insured had episodes of on and off back pain some 20 years ago and there was no relapse since then. Whilst the Complaints Panel understood that the cause of his back pain during the trip might be due to degeneration of spine, it was of the view that the insurer should have been aware of the risk of degeneration when it accepted the insured's travel application at his age of 67.

Furthermore, the Complaints Panel believed that a reasonable person would expect such an unexpected and sudden attack during his or her journey to be covered by a travel insurance policy, the spirit of which is to provide coverage for unexpected and sudden medical conditions during a journey.

Under the circumstances, the Complaints Panel resolved to rule in favour of the insured and award him and his wife the trip curtailment benefit, as well as the medical expenses incurred. The total amount awarded was nearly HK$11,000.

個案14

一名67歲老翁與妻子在前往昆明的航機途中感到頸椎劇痛，到埗後隨即往當地醫院求診，由於痛楚持續，被保人於是取消餘下行程，折返香港，隨後向保險公司索取醫療開支及縮短行程的賠償。

保險公司得悉被保人背痛的潛在原因是頸椎退化，由於退化的狀況在被保人出發前已存在，因此保險公司根據「投保前已存在的疾病」豁免條款，拒絕發放有關賠償。

投訴委員會發現被保人於20多年前曾間歇地出現背痛，但自此沒有再復發，投訴委員會雖然明白被保人於旅程中出現背痛，可能是因為退化所致，但是卻認為保險公司既然接受年屆67歲的被保人申請旅遊保險，理應得知存在退化的風險。

此外，投訴委員會相信一般人會期望旅遊保單保障此類在旅途中未能預計及突如其來的事故，因為旅遊保險的精神正是為了保障旅程中出現這類未能預期及突如其來的病患。

在這情況下，投訴委員會裁定被保人夫婦得直，可獲發放縮短行程及醫療開支的賠償，涉及金額接近11,000港元。

Proximate Cause

Very often, the occurrence of one event will cause another event, or even a series of events, to happen. It is thus important for insurers to determine the "proximate cause" leading to a loss before arriving at any claim decision. Proximate cause of a loss is its effective or dominant cause.

If it can be proved that the proximate cause of a claim is due to an excluded item stated in the policy, the insurer will not be liable for the resultant loss or damage.

近因

通常某事件會引發另一件事件，甚至一連串事件發生，因此保險公司在作出任何賠償決定之前，必須決定甚麼是引致損失的「近因」。「近因」指損失的有效或主導成因。

假如得以證實索償的近因是由保單訂明的不保事項所致，則保險公司毋須為不保事項引致的損失或損壞負責。

Case 15

The insured was admitted to a hospital in Shenzhen for low back pain five months after she had effected a medical policy. She was diagnosed with prolapsed intervertebral disc and a surgical operation (first operation) was performed.

During the first operation, the abdominal aorta wall was punctured. The insured's condition worsened and she went into shock with internal bleeding. As a matter of urgency, she was transferred to another hospital to undergo a repair operation for pseudoaneurysm (second operation).

While assessing her claim, the insurer learnt that the insured had been experiencing the symptom of incessant waist and leg pain for seven years. As the insured's back problem had existed before the policy effective date, and the abdominal aorta injury was a consequence of the first operation, the insurer refused to honour her claims for both operations.

The insured admitted that her first operation for treatment of prolapsed intervertebral disc was a pre-existing condition which should be excluded from the policy. However, her emergency confinement for the second operation which aimed at remedying the "puncture" during the first operation was entirely unforeseen and unexpected. In this regard, she considered that the insurer should reimburse her the medical expenses incurred during the second operation.

It was clear that the insured's first operation was related to the treatment of prolapsed intervertebral disc which was a pre-existing condition. The Complaints Panel opined that the insured's second operation was caused by a potential operational risk arising from the first operation. If the first operation had not taken place, the second operation would not be necessary. As the proximate cause for the second operation was related to the first operation and the first operation was excluded under the policy, the Complaints Panel supported the insurer to decline the hospitalization claim for around HK$90,000, being the expenses incurred as a result of the second operation.

個案15

被保人於醫療保單生效後五個月，因腰椎痛在深圳入院，被診斷為椎盤間脱出，因而進行首次手術。

在首次手術進行期間，她的腹主動脈壁被刺穿，令被保人的病情惡化，造成內出血引致休克。由於事態緊急，她被轉送另一家醫院進行假性動脈瘤修復手術（即第二次手術）。

保險公司審理索償時，發現被保人七年來一直有腰痛和腿痛的症狀，由於被保人背部的毛病於保單生效前已經存在，而腹主動脈受傷是因第一次手術而起，因此拒絕為兩次手術發放賠償。

被保人承認第一次手術是為治療椎盤間脱出，屬投保前已存在的病患，故不受保單保障，但是為了修補在首次手術期間「刺穿」的傷口而緊急住院動第二次手術，卻是不能預知及未能預期的。因此，她認為保險公司應該賠償第二次手術引致的醫療開支。

被保人動首次手術明顯是為了治療投保前已存在的椎盤間脱出毛病，投訴委員會認為被保人進行第二次手術，是源於首次手術的潛在風險，假如沒有動首次手術，根本毋須進行第二次手術。由於第二次手術的近因與首次手術有關連，而首次手術屬於保單的不保事項，因此投訴委員會支持保險公司拒絕發放第二次手術引致的住院賠償，涉及金額約90,000港元。

BREACH OF POLICY CONDITIONS

All insurance contracts are subject to conditions. Insurers usually impose certain conditions in insurance policies to ensure that no high risk features would be introduced without their knowledge. Although breaching a condition may render a claim invalid, the Complaints Panel, when dealing with disputes arising from a breach of policy condition on the part of the insured, will take a less strict approach if it can be ascertained that the breach is innocent or inadvertent.

Conditions for Claims Notification

An insured is required to give notice to the insurer with full particulars of losses within a specified period of time after the happening of any event which was likely to give rise to a claim under the policy.

違反保單條款

所有保險合約均載有條款，保險公司通常會於保單中附加某些條款，以確保不會在不知情下引入任何高風險元素。雖然違反保單條款或會導致索償無效，但是當糾紛涉及被保人違反保單條款時，如果能夠證明被保人是無辜或並非故意違反有關條款，則投訴委員會會考慮較寬鬆處理。

索償通知條款

一旦發生任何可能引致被保人根據保單索償的事件，被保人必須在事件發生後的特定時間內，通知保險公司有關事件，以及提供損失的詳情。

Case 16

The insured dropped a luxury watch on the floor accidentally at home. He immediately brought the damaged watch to the designated service centre for repair. He collected the repaired watch two weeks later and lodged a claim to the insurer for the repair cost of the watch under his household insurance policy.

The insurer appointed a loss adjuster to carry out the investigation. As the watch had already been repaired when the claim was filed, the loss adjuster was unable to investigate the cause of the incident and the extent of the damages. The insurer, having no chance to evaluate or assess the reasonable or genuineness of the claim, declined the insured's claim on the ground that he had breached the policy condition which requires the insured to advise the insurer in writing as soon as reasonably possible in any event of any happening which may give rise to a claim.

The insured contended that the insurer's allegation of late notification of claim was not appropriate as the claim was lodged within 20 days after the watch was damaged. Moreover, the debris of the hands and dial of the damaged watch was shown to the loss adjuster during their visit.

Whilst the Complaints Panel agreed that the insured's reporting of the claim after the watch was repaired had prejudiced the insurer from investigating the claim, the Complaints Panel was convinced that this was a genuine case as the circumstances leading to the damages were simple and consistent with the statement given by the insured. Moreover, the insurer was able to verify the extent of damage from the repair slip issued by the service centre stating that the dial, hands, glass, case, bezel and band of the watch had been scratched, cracked and dented, and from an inspection of the damaged parts of the watch.

個案16

被保人在家中不慎把名貴手錶掉到地上，遂立刻將手錶送到指定的維修中心修理，兩星期後取回手錶便隨即根據其家居保單，向保險公司索取維修費用賠償。

保險公司委派理賠師調查，由於被保人提出索償時已經將手錶修理妥當，以致理賠師無法調查事發的原因及手錶的損壞程度。保險公司由於沒有機會評估或估計有關索償是否合理及是否真有其事，因此拒絕被保人的索償，理由是他違反保單條款，有關條款要求被保人在發生任何可能引致索償的事故後，盡可能及早以書面通知保險公司。

被保人辯稱保險公司指他沒有及早通知的指控並不恰當，因為他是在手錶損毀後20天之內提出索償的。此外，他已經在理賠師調查時，向他展示受損手錶的時針和錶盤等碎片。

雖然投訴委員會同意被保人維修手錶後才申報索償，有礙保險公司進行調查，但是投訴委員會相信真有其事，因為引致手錶損毀的理由簡單，並與被保人提交的報告一致。此外，維修中心發出的收據列明手錶的錶盤、時針、玻璃、錶殼、嵌槽、錶帶均被刮花、砸碎及撞凹，以及從手錶損毀零件的檢查，均足以讓保險公司核實手錶的損毀程度。

While the Complaints Panel noted that reporting a loss only after repair was not desirable, it believed that a layman, in this particular instance, would expect a claim which was lodged within 20 days after a loss to be considered as "as soon as reasonably possible". In the absence of any proof that the insured had a poor claims record, the Complaints Panel resolved to give him the benefit of doubt and award him the repair cost of the watch for nearly HK$3,200.

投訴委員會也知道先維修、後申報損失的程序並不理想，但是相信門外漢在這種情況下都會預期，於損失後20天內申請提出索償也可視作「盡可能及早」行動。由於缺乏任何證據證明被保人有不良的索償紀錄，故此投訴委員會裁定疑點利益歸於被保人，可獲發手錶的維修費用，涉及金額近3,200港元。

Condition for Loss Mitigation

All property insurance policies contain a condition which requires the insured to mitigate loss. After a loss has happened, the insured has the duty to take reasonable steps to protect his property from further loss or damage and do whatever else is reasonable to maintain it in efficient condition.

If steps are not taken by the insured to mitigate his loss, he may fail to recover damages for losses which he could reasonably have avoided by his own efforts.

減輕損失條款

所有財產保單均載有條款，要求被保人減輕損失。被保人有責任於出現損失之後，採取合理步驟，防止財物進一步受損或遭破壞，以及盡能力保持財物的良好性能。

如果被保人沒有採取措施減少損失，則被保人可能會因為沒有盡力避免損失，以致無法取得有關損失的賠償。

Case 17

It was raining heavily with amber rainstorm warning effected late one night. The street was flooded and a large volume of water rushed into the insured vehicle. The vehicle stalled shortly afterwards.

After the floodwater subsided next morning, the insured tried to restart the engine and found that some white smoke was emitting from the back of the vehicle and a loud noise was heard. Despite the above conditions, the engine could be restarted. The insured then drove the vehicle to a nearby garage for emergency repairs.

個案17

於某個黃色暴雨警告生效的午夜，路面被水淹浸，大水湧入被保車輛的車廂，沒多久車輛便故障失靈。

翌日早上洪水減退，被保人嘗試開動引擎，但發現汽車尾部冒出白煙及發出巨響，雖然如此，引擎仍然可以啟動，被保人便將車輛駕駛至就近的修車場進行緊急維修。

The insured still felt that the vehicle was not in a good condition even after repair. He drove the vehicle to his acquainted garage for detailed inspection a few days later. It was found that major damages had occurred to the engine and that the cylinder block had been completely damaged. As the repair cost was significant, the insured filed a claim to the insurer under his comprehensive motor insurance policy.

被保人覺得儘管車輛已經維修，但是性能仍然欠佳，因此數天後把車輛送到相熟的修車場進行詳細檢查，結果發現引擎損毀嚴重，汽缸體完全損壞。由於維修費用甚巨，因此被保人根據綜合汽車保單提出索償。

As the heavy rainfall was unlikely to cause such a serious damage to the insured vehicle, the insurer arranged a motor surveyor to conduct a detailed inspection. It was revealed that the severe damage to the engine and the cylinder block of the insured vehicle was not caused directly by the heavy rainfall. Instead, the damage was attributed to the insured's driving of the problem vehicle to the garage when its engine was in a poor condition.

由於暴雨不致於令被保車輛損毀如斯嚴重，因此保險公司安排汽車調查員進行詳細檢驗，發現引擎及汽缸體嚴重損毀，並非因暴雨直接造成，而應歸咎於被保人在汽車引擎有問題的情況下，仍然將車輛開到修車場。

It was stipulated in the policy condition that "*the insured shall take all reasonable steps to safeguard the motor vehicle from loss or damage and to maintain it in efficient condition..... if the motor vehicle be driven before the necessary repairs are effected any extension of the damage or any further damage to the motor vehicle shall be excluded from the scope of indemnity granted by the policy*". In this regard, the insurer considered that it should not be held liable for the claim on the damaged cylinder block and its accessories.

保單條款訂明：「受保人必須採取一切合理步驟，以防汽車損失或損毀，以及保持汽車的性能良好。.....假如被保汽車在必須修理的情況下遭人駕駛，則被保汽車任何增加的損毀或被保汽車任何進一步的損毀，均不得包括在保單的賠償範圍內」。因此，保險公司認為毋須賠償損毀的汽缸體及有關配件。

From the statement made by the insured to the surveyor, the Complaints Panel learnt that the insured had sought assistance from his acquainted garage after the incident and was advised by the repairer that the vehicle ought to be towed to garage for repairs. However, the insured disregarded such advice and drove the problem vehicle for some distance before repairing. As the damage to the cylinder block was due to the insured's own inappropriate action, the Complaints Panel ruled in favour of the insurer and concluded that the insurer was correct in deducting the repair cost for the cylinder block and its accessories upon settlement. The difference in the settlement amount was HK$18,700.

投訴委員會審閱被保人提交予調查員的報告時，發現被保人於事件發生後曾向其相熟的修車場求助，並從維修員處得悉必須將被保車輛拖往修車場修理，但是被保人並不理會，並駕駛有問題車輛行駛了一段路才予以修理。由於汽缸體損毀是因為被保人的不當行為所致，因此投訴委員會裁定保險公司得直，贊同保險公司在賠償總額中扣除汽缸體維修費及有關配件的費用，賠償額相差18,700港元。

NOTEWORTHY POINTS

The Complaints Panel would like to remind consumers of the following points when taking out an insurance policy:

1. Disclose fully and accurately all information in the application form. Ask the agent to explain fully the implications of the questions. If in doubt as to whether a fact is material, it is better to disclose it;

2. Don't rely too much on the insurance intermediaries. Check personally if all the facts are included in the application form.

3. Understand the scope of coverage;

4. Read the policy, in particular any exclusion clauses.

要點備忘

投訴委員會提醒消費者，購買保險時應注意下列事項：

1. 填報投保申請書時，必須巨細無遺，準確無誤地披露所有資料，並應要求代理詳盡解釋問題的含義；如果投保人懷疑有關資料是否屬於重要事實，也應該予以披露；

2. 不要過分依賴保險中介人，應親自檢查投保申請書上是否已填報所有資料；

3. 清楚了解保障範圍；

4. 詳閱保單，尤其是所有豁免條款。

Financial Statements
財務報表

AUDITOR'S REPORT

TO THE MEMBERS OF THE INSURANCE CLAIMS COMPLAINTS BUREAU
(incorporated in Hong Kong and limited by guarantee)

We have audited the accounts set out on pages 50 to 56 which have been prepared in accordance with accounting principles generally accepted in Hong Kong.

Respective responsibilities of members of the General Committee and Auditors

The *Hong Kong Companies Ordinance* requires the members of the General Committee to prepare accounts which give a true and fair view. In preparing accounts which give a true and fair view it is fundamental that appropriate accounting policies are selected and applied consistently.

It is our responsibility to form an independent opinion, based on our audit, on those accounts and to report our opinion solely to you, as a body, in accordance with section 141 of the *Hong Kong Companies Ordinance*, and for no other purpose. We do not assume responsibility towards or accept liability to any other person for the contents of this report.

Basis of opinion

We conducted our audit in accordance with Statements of Auditing Standards issued by the Hong Kong Institute of Certified Public Accountants. An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the accounts. It also includes an assessment of the significant estimates and judgements made by the members of the General Committee in the preparation of the accounts, and of whether the accounting policies are appropriate to the ICCB's circumstances, consistently applied and adequately disclosed.

核數師報告

致保險索償投訴局會員

(於香港註冊的有限公司，負債以擔保為限)

本核數師（以下簡稱「我們」）已完成審核刊於第50至56頁之賬目，該等賬目乃按照香港普遍採納之會計原則編製。

理事會理事及核數師各自之責任

《香港公司條例》規定理事會理事須編製真實兼公平之賬目。在編製該等真實兼公平之賬目時，理事會理事必須採用適當之會計政策，並且貫徹應用該等會計政策。

我們之責任是根據審核工作之結果，對該等賬目作出具獨立意見，並按照《香港公司條例》141條，僅向投訴局會員報告，除此之外，本報告別無其他目的。我們不會就本報告的內容向任何其他人士負上或承擔任何責任。

意見之基礎

我們已按照香港會計師公會所頒布之核數準則進行審核工作。審核範圍包括以抽查方式查核與賬目所載數額及披露事項有關之憑證，亦包括評審理事會理事於編製該等賬目時所作出之重大估計和判斷，所採用之會計政策是否適合投訴局之具體情況，及有否貫徹應用並足夠披露該等會計政策。

We planned and performed our audit so as to obtain all the information and explanations which we considered necessary in order to provide us with sufficient evidence to give reasonable assurance as to whether the accounts are free from material misstatement. In forming our opinion we also evaluated the overall adequacy of the presentation of information in the accounts. We believe that our audit provides a reasonable basis for our opinion.

Opinion

In our opinion the accounts give a true and fair view of the state of affairs of the ICCB as at 31 December 2004 and of its surplus for the year then ended and have been properly prepared in accordance with the *Hong Kong Companies Ordinance*.

PricewaterhouseCoopers
Certified Public Accountants,
Honorary Auditors

Hong Kong, 30 March 2005

我們在策劃和進行審核工作時，均以取得所有我們認為必須之資料及解釋為目標，以便能獲得充分憑證，就該等賬目是否存有重要錯誤陳述，作合理之確定。在作出意見時，我們亦已評估該等賬目所載的資料在整體上是否足夠。我們相信我們之審核工作已為下列意見建立合理之基礎。

意見

我們認為上述之賬目足以真實兼公平地顯示投訴局於 2004 年12月31日結算時之財政狀況及截至該日止年度之盈利，並已按照《香港公司條例》妥為編製。

羅兵咸永道會計師事務所
香港執業會計師
義務核數師

香港，2005年3月30日

INCOME AND EXPENDITURE ACCOUNT
For the year ended 31 December 2004

收支賬目
截至2004年12月31日止年度

	Note 附註	**2004 HK$ 港幣**	2003 HK$ 港幣
Income 收入			
Subscriptions 會費		**1,274,500**	1,183,000
Interest income 利息收入		**21**	119
Other income 其他收入		**7,930**	7,924
		1,282,451	1,191,043
Expenditure 支出			
Administration fees charged by the HKFI 支付香港保險業聯會的行政支援費用	5	**1,083,000**	1,089,000
Printing and stationery 印刷及文具支出		**89,785**	89,360
Liability insurance 責任保險		**52,631**	45,998
Professional fees 專業意見費用		**1,920**	2,040
Entertainment 款待費用		**3,000**	3,894
Sundry expenses 雜項支出		**5,956**	4,440
		1,236,292	1,234,732
Surplus / (deficit) for the year before taxation 本年度除税前盈餘／（虧損）		**46,159**	(43,689)
Taxation charge / (credit) 税項支銷／（入賬）	3	**8,074**	(11,945)
Surplus/(deficit) for the year after taxation 本年度除税後盈餘／（虧損）		**38,085**	(31,744)

BALANCE SHEET
As at 31 December 2004

資產負債表
於2004年12月31日

	Note 附註	**2004 HK$ 港幣**	2003 HK$ 港幣
Employment of funds 資金運用			
Assets 資產			
Deferred tax asset 遞延税項資產	3	**49,151**	57,225
Prepayments 預支項目		**23,523**	20,610
Bank balances and cash 銀行結餘及現金		**1,033,246**	870,010
		1,105,920	947,845
Liabilities 負債			
Subscriptions received in advance 預收會費		**948,990**	829,000
		948,990	829,000
Net assets 淨資產		**156,930**	118,845
Funds employed 資金來源			
Accumulated surplus 累積盈餘		**156,930**	118,845

On behalf of the General Committee
承理事會命

Roddy S Anderson 安德生
Chairman 主席

Kenneth T W Kwok 郭振華
Member 理事

STATEMENT OF CHANGES IN ACCUMULATED SURPLUS

For the year ended 31 December 2004

累積盈餘變動報表

截至2004年12月31日止年度

	Note 附註	**2004** **HK$ 港幣**	2003 HK$ 港幣
Accumulated surplus as at 1 January, as previously reported 截至1月1日累積盈餘，如前呈報		**118,845**	105,309
Change in accounting policy- recognition of net deferred tax asset 會計政策更改—確認遞延稅項資產淨額☐ ☐	☐ ☐	**-** ☐	45,280
Accumulated surplus as at 1 January, as restated 截至1月1日累積盈餘，經重列		**118,845**	150,589
Surplus/(deficit) for the year 本年度盈餘／（虧損）		**38,085**	(31,744)
Accumulated surplus as at 31 December 截至12月31日累積盈餘		**156,930**	118,845

NOTES TO THE ACCOUNTS

1. Legal status

The ICCB is a company incorporated under the *Hong Kong Companies Ordinance* and is limited by a guarantee of HK$100 per Member. Income and assets of the ICCB shall be applied solely towards the promotion of the objectives of the ICCB as set forth in its *Memorandum of Association* and no portion thereof shall be payable to the Members of the ICCB.

2. Principal accounting policies

The principal accounting policies adopted in the preparation of these accounts are:

(a) Basis of preparation

The accounts have been prepared in accordance with accounting principles generally accepted in Hong Kong and comply with accounting standards issued by the Hong Kong Institute of Certified Public Accountants (HKICPA). The accounts are prepared under the historical cost convention.

(b) Recently issued accounting standards

The HKICPA has issued a number of new and revised Hong Kong Financial Reporting Standards and Hong Kong Accounting Standards (new HKFRSs) which are effective for accounting periods beginning on or after 1 January 2005. The ICCB has not early adopted these new HKFRSs in the financial statements for the year ended 31 December 2004. The ICCB is in the process of making an assessment of the impact of these new HKFRSs and has so far concluded that the adoption of these new HKFRSs would not have a significant impact on its results of operations and financial position.

賬目附註

1. 法律地位☐

☐ 投訴局乃按照《香港公司條例》正式註☐
☐ 冊，其負債以擔保為限。每位會員所承☐
☐ 擔的法律責任則以 100 港元為限。投訴☐
☐ 局的收入及資產只可用於推廣及實踐該☐
☐ 局列於《立案章程》內的宗旨，並且不☐
☐ 可支付任何數額予投訴局的會員。

2. 主要會計政策

☐ 本賬目的編製所採用的會計政策如下：

☐ (a) ☐製準則

☐ ☐ 本賬目乃按照香港普遍採納的會計☐
☐ ☐ 原則及香港會計師公會頒布的準則☐
☐ ☐ 編製。賬目乃按照歷史成本常規法☐
☐ ☐ 編製。

☐ (b) ☐近期頒布的會計準則

香港會計師公會頒布多項新訂和修☐
☐ ☐ 訂的香港財務報告準則及香港會計☐
☐ ☐ 準則（新準則），此等新準則於☐
☐ ☐ 2005年1月1日或以後的會計年度生
☐ ☐ 效。投訴局並沒有於截至2004年
12月31日止計的財務報表中，提前
☐ ☐ 採納此等新準則。投訴局正評估此
☐ ☐ 等新準則的影響，至目前為止，認
☐ ☐ 為採納新準則將不會對營運和財務
☐ ☐ 情況有重大影響。

(c) Income recognition

Subscriptions received and receivable by the ICCB are recognized as income in the accounting period to which the subscription relates. That portion of fees received during the year which relates to future accounting periods is carried forward in the balance sheet as subscriptions received in advance.

Interest income is recognized on a time proportion basis, taking into account the principal amounts outstanding and the interest rates applicable.

(d) Deferred taxation

Deferred taxation is provided in full, using the liability method, on temporary differences arising between the tax bases of assets and liabilities and their carrying amounts in the accounts. Taxation rates enacted or substantively enacted by the balance sheet date are used to determine deferred taxation.

Deferred tax assets are recognized to the extent that it is probable that future taxable profit will be available against which the temporary differences and tax losses can be utilized.

3. Taxation

No provision for Hong Kong profits tax has been made as the ICCB has sufficient taxation losses brought forward to offset the current year's liability.

The amount of taxation charged/(credited) to the income and expenditure account represents:

(c) 收入確認

投訴局已收及應收的會費乃按有關的時期確認為該會計年度的收入，已收取的跨年度會費乃按時間比例在資產負債表上確認為預收會費。

利息收入依據尚未償還本金及適用利率按時間比例確認。

(d) 遞延稅項

遞延稅項採用負債法就資產負債之稅基與它們在賬目之賬面值兩者之短暫時差作全數撥備。遞延稅項採用在結算日前已頒布或實質頒布之稅率釐定。

遞延稅項資產乃就有可能將未來應課稅溢利與可動用之短暫時差抵銷而確認。

3. 稅項

投訴局並無為香港利得稅作稅項撥備，因為有充足的提撥稅項以抵消本年度的負債。

於收支賬目內支銷／（入賬）之稅項如下：

	2004 HK$ 港幣	2003 HK$ 港幣
Deferred taxation relating to origination and reversal of tax losses 與稅損的產生及轉回有關的遞延稅項	**8,074**	(7,693)
Deferred taxation resulting from an increase in tax rate 稅率提高產生之遞延稅項	**-**	(4,252)
	8,074	(11,945)

The taxation on the ICCB's surplus before taxation differs from the theoretical amount that would arise using the Hong Kong standard profits tax rate as follows:

投訴局除稅前溢利之稅項與假若採用香港標準利得稅稅率計算之理論稅額之差額如下：

	2004 HK$ 港幣	2003 HK$ 港幣
Surplus/(deficit) before taxation 除稅前盈餘／（虧損）	**46,159**	(43,689)
Calculated at a taxation rate of 17.5% 以17.5%稅率計算	**8,078**	(7,646)
Income not subject to taxation 毋須課稅之收入	**(4)**	(47)
Increase in opening deferred tax asset resulting from an increase in tax rate 稅率提高產生之期初遞延稅項負債淨額之增加	**-**	(4,252)
Taxation charged/(credited) to income and expenditure account 於收支賬目內支銷／（入賬）之稅項	**8,074**	(11,945)

Deferred taxation is calculated in full on temporary differences under the liability method using a principal taxation rate of 17.5% (2003: 17.5%). Deferred income tax assets are recognized for tax loss carry forwards to the extent that realization of the related tax benefit through the future taxable profits is probable based on the ICCB's management forecasts. The deferred tax asset is expected to be recovered gradually on a yearly basis.

遞延稅項採用負債法就短暫時差按主要稅率17.5% （2003年：17.5%）作全數撥備。遞延所得稅資產乃因應投訴局管理層預測之相關稅務利益可透過未來應課稅溢利變現而就所結轉之稅損作確認。遞延稅項預期可以逐年撥回。

The movement on the deferred tax asset account is as follows:

遞延税項資產賬目之變動如下：

Tax losses 税項虧損		**2004 HK$ 港幣**	2003 HK$ 港幣
As at 1 January 截至1月1日		**57,225**	45,280
Taxation (charged)/credited to income and expenditure account 於收支賬目內（支銷）／入賬之税項衞	衞	**(8,074)**衞	11,945
As at 31 December 截至12月31日衞	衞	**49,151**衞	57,225

4. General Committee members' emoluments

During the years ended 31 December 2004 and 2003 no amounts have been paid in respect of General Committee members' emoluments, pensions or for any compensation in respect of loss of office.

4. 理事會理事酬金□

截至2003年及2004年12月31日止年度，理事會理事並無收取任何為投訴局服務酬金。

5. Related party transaction

Management and administration support fees paid to the HKFI

2004 HK$	2003 HK$
1,083,000	1,089,000

HKFI incurs costs on behalf of the ICCB. The above fees are re-imbursements of actual and shared costs determined by a contract renewable annually.

5. 關連人士交易□

衞 支付香港保險業聯會管理及行政費用

2004 港幣□	2003 港幣
1,083,000	1,089,000

衞 衞 衞

香港保險業聯會代投訴局支付費用。上述費用為根據每年更新的合約而償付實際和分擔的費用。

6. Approval of accounts

The accounts were approved by the General Committee on 30 March 2005.

6. 賬目核准

此賬目乃於2005年3月30日經理事會衞核准。

Full Members

ACE Insurance Ltd
Allianz Insurance (Hong Kong) Ltd
American Home Assurance Co
American International Assurance Co Ltd
Anglo Starlite Insurance Co Ltd
Asia Insurance Co Ltd
Assicurazioni Generali S p A
Aviva General Insurance Ltd
Aviva Life Insurance Co Ltd
AXA China Region Insurance Co (Bermuda) Ltd
AXA General Insurance Hong Kong Ltd
AXA Life Insurance Co Ltd
Bank of China Group Insurance Co Ltd
Blue Cross (Asia-Pacific) Insurance Ltd
BOC Group Life Assurance Co Ltd
BUPA (Asia) Ltd
CAF International Insurance Co Ltd
California Insurance Co Ltd
Canadian Insurance Co Ltd
Chevalier Insurance Co Ltd
China Communications Insurance Co Ltd
China Life Insurance (Overseas) Co Ltd Hong Kong Branch
China Merchants Insurance Co Ltd
China Overseas Insurance Ltd
China Pacific Insurance Co (Hong Kong) Ltd
China Ping An Insurance (Hong Kong) Co Ltd

基本會員

安達保險有限公司
安聯保險（香港）有限公司
美安保險公司
美國友邦保險有限公司
星輝保險有限公司
亞洲保險有限公司
忠利保險有限公司
英傑華一般保險有限公司
英傑華人壽保險有限公司
國衞保險（百慕達）有限公司
安盛保險有限公司
安盛人壽保險有限公司
中銀集團保險有限公司
藍十字（亞太）保險有限公司
中銀集團人壽保險有限公司
保衞（亞洲）有限公司
農銀國際保險有限公司
加洲保險有限公司
加拿大保險有限公司
其士保險有限公司
中國交通保險有限公司
中國人壽保險（海外）股份有限公司 香港分公司
招商局保險有限公司
中國海外保險有限公司
中國太平洋保險（香港）有限公司
中國平安保險（香港）有限公司

Members List | 會員名錄

CIGNA Worldwide Insurance Co	信諾環球保險公司
Citi Fubon Life Insurance Co Hong Kong Ltd	香港富邦花旗人壽保險有限公司
Clerical Medical Investment Group Ltd	Clerical Medical Investment Group Ltd
CMG Asia Ltd	康聯亞洲有限公司
Concord Insurance Co Ltd	合群保險有限公司
Cosmic Insurance Corporation Ltd	全球保險股份有限公司
Crown Life Insurance Co	皇冠人壽
Dah Sing General Insurance Co Ltd	大新保險有限公司
Dah Sing Life Assurance Co Ltd	大新人壽保險有限公司
Dao Heng Insurance Co Ltd	道亨保險有限公司
Desjardins Financial Security Life Assurance Co	Desjardins Financial Security Life Assurance Co
Falcon Insurance Co (Hong Kong) Ltd	富勤保險（香港）有限公司
Federal Insurance Co	聯邦保險公司
First American Title Insurance Co	First American Title Insurance Co
Friends Provident International Ltd	友誠國際有限公司
GAN Assurances IARD	GAN Assurances IARD
Generali International Ltd	Generali International Ltd
Gerling General Insurance Co	德國保險
Hang Seng Insurance Co Ltd	滙生保險有限公司
Hong Kong Life Insurance Ltd	香港人壽保險有限公司
HSBC Insurance (Asia) Ltd	滙豐保險（亞洲）有限公司
HSBC Life (International) Ltd	滙豐人壽保險（國際）有限公司
ING General Insurance International	安泰保險有限公司
ING Life Insurance Co (Bermuda) Ltd	安泰人壽保險（百慕達）有限公司
International Health Insurance	International Health Insurance
Jerneh Insurance (Hong Kong) Ltd	澄心保險（香港）有限公司
Kono Insurance Ltd	工安保險有限公司
Liberty International Insurance Ltd	利寶國際保險有限公司
Liu Chong Hing Insurance Co Ltd	廖創興保險有限公司
Lloyd's	勞合社
Manulife (International) Ltd	宏利人壽保險（國際）有限公司
MassMutual Asia Ltd	美國萬通保險亞洲有限公司
Metropolitan Life Insurance Co of Hong Kong Ltd	美商大都會人壽保險香港有限公司
Min Xin Insurance Co Ltd	閩信保險有限公司
The Ming An Insurance Co (Hong Kong) Ltd	香港民安保險有限公司
Mitsui Sumitomo Insurance Co (Hong Kong) Ltd	三井住友海上火災保險（香港）有限公司
MLC (Hong Kong) Ltd	萬誠保險（香港）有限公司
National Insurance Co Ltd	國民保險有限公司
The New India Assurance Co Ltd	新印度保險有限公司
New York Life Insurance Worldwide Ltd	紐約人壽環球保險有限公司
Nipponkoa Insurance Co (Asia) Ltd	日本興亞保險（亞洲）有限公司
Nissay Dowa General Insurance Co Ltd	日生同和損害保險株式會社
Pacific Century Insurance Co Ltd	盈科保險有限公司
The Pacific Insurance Co Ltd	太平洋保險有限公司
Paofoong Insurance Co (Hong Kong) Ltd	寶豐保險（香港）有限公司
The People's Insurance Co of China (Hong Kong), Ltd	中國人民保險（香港）有限公司
Pioneer Insurance & Surety Corporation	信孚保險有限公司
Principal Insurance Co (Hong Kong) Ltd	美國信安保險有限公司
The Prudential Assurance Co Ltd	英國保誠保險有限公司
QBE Hongkong & Shanghai Insurance Ltd	昆士蘭聯保保險有限公司
Royal & Sun Alliance Insurance (Hong Kong) Ltd	皇家太陽聯合保險（香港）有限公司
Royal Skandia Life Assurance Ltd	萊斯基亞
Scottish Mutual International plc	Scottish Mutual International plc
Scottish Provident International Life Assurance Ltd	Scottish Provident International Life Assurance Ltd

Members List | 會員名錄

The Sincere Insurance and Investment Co Ltd	先施保險置業有限公司
Sompo Japan Insurance Inc	Sompo Japan Insurance Inc
Standard Life (Asia) Ltd	標準人壽保險（亞洲）有限公司
Summit Insurance (Asia) Ltd	健峯保險（亞洲）有限公司
Sun Hung Kai Properties Insurance Ltd	新鴻基地產保險有限公司
Sun Life Financial (Hong Kong) Ltd	永明金融（香港）有限公司
Target Insurance Co Ltd	泰加保險有限公司
Through Transport Mutual Insurance Association (Eurasia) Ltd	聯運保賠協會
The Tokio Marine and Fire Insurance Co (Hong Kong) Ltd	東京海上火災保險（香港）有限公司
Transamerica Occidental Life Insurance Co	全美人壽保險公司
Trinity General Insurance Co Ltd	三聯保險有限公司
Tugu Insurance Co Ltd	德高保險有限公司
United Builders Insurance Co Ltd	建安保險有限公司
United Kingdom Mutual Steam Ship Assurance Association (Bermuda) Ltd	聯合皇國保賠協會
UOB Insurance (Hong Kong) Ltd	大華保險
Wing Hang Zurich Insurance Co Ltd	永亨蘇黎世保險有限公司
Wing Lung Insurance Co Ltd	永隆保險有限公司
Winterthur Life	瑞士豐泰人壽保險
Zurich Assurance Ltd	蘇黎世人壽
Zurich Insurance Co	蘇黎世保險

Affiliate Members

附屬會員

American International Assurance Co (Bermuda) Ltd	美國友邦保險（百慕達）有限公司
AXA China Region Insurance Co Ltd	國峯保險有限公司
Bankers Alliance Insurance Co Ltd	銀業聯合保險有限公司
Canada Life Ltd	Canada Life Ltd
CMI Insurance Co Ltd	誠美國際保險有限公司
Cosmos Fire Insurance Co Ltd	宇宙火險有限公司
Hang Seng Life Ltd	峯生人壽保險有限公司
HSBC Medical Insurance Ltd	峯豐醫療保險有限公司
The Manufacturers Life Insurance Co	宏利人壽保險有限公司
Mitsui Sumitomo Insurance Co Ltd	三井住友海上火災保險株式會社
National Union Fire Insurance Co of Pittsburgh, Pa	National Union Fire Insurance Co of Pittsburgh, Pa
New Hampshire Insurance Co	New Hampshire Insurance Co
The Pacific Life Assurance Co Ltd	太平洋人壽保險有限公司
Phoenix Assurance Ltd	Phoenix Assurance Ltd
The Sincere Life Assurance Co Ltd	先施人壽保險有限公司
Sun Alliance and London Assurance Co Ltd	Sun Alliance and London Assurance Co Ltd
Sun Alliance and London Insurance plc	太陽聯合保險集團
The Symbol Underwriters Ltd	先寶保險有限公司
The Tokio Marine and Nichido Fire Insurance Co Ltd	東京海上日動火災保險株式會社
William S T Lee Insurance Co Ltd	曉莊保險股份有限公司
Zurich International Life Ltd	Zurich International Life Ltd
Zurich Life Insurance Co Ltd	蘇黎世人壽保險有限公司