The Insurance Claims Complaints Bureau

保險索償投訴局

Annual Report

2016/2017 年報

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Statement of the Chairman

主席報告

29.04.2016 - 28.04.2017

Mr Michael E Huddart
Chairman
The Insurance Claims Complaints Bureau
保險索償投訴局主席
何達德先生

Holistic Consumer Protection – A New Framework

Since its establishment in 1990, the Insurance Claims Complaints Bureau (ICCB) has acted as an efficient and credible channel in resolving claims disputes between insurers and policyholders of personal insurance contracts or their beneficiaries. Over the past 27 years, the ICCB has built up much valuable and practical experience in handling insurance complaints. Cost-effective and administratively efficient, it has handled more than 8,300 cases and helped resolved over 1,400 complaints with settlement amount totalling nearly HK$62 million.

While we have a proven track record, we are committed to continuous improvement. An in-depth review highlighted that the current ICCB system is restricted exclusively to complaints related to claims decisions, but that there are other legitimate complaint cases which call for some form of monetary restitution. With this in mind, and in order to serve the consumers better, we put forward the idea of introducing a Holistic Consumer Protection Framework as a one-stop service in resolving all insurance-related disputes. Specifically, the proposed Framework seeks to fill the existing gaps by way of:

(1) Expanding the power of the ICCB to handle non-claim related insurance disputes.
(2) Adding a new element of mediation service for handling complaints not related to claims (claims related complaints will continue to be managed through the existing adjudication process).
(3) Restructuring the General Committee by bringing in majority members from outside the industry with a view to enhancing its independence.
(4) Appointing an independent Chairman.

On 21 November 2016, we conducted a townhall meeting of Members to introduce the proposed Holistic Consumer Protection Framework and there were over 80 attendees. This was followed with an Industry Consultation Paper issued to all ICCB Members on 2 December 2016 with 48 member insurers (22 Life Members and 26 General Members) responding:

全面保障消費者權益－新框架

自1990年成立以來，保險索償投訴局（投訴局）一直為個人保單持有人或其受益人提供高效率及可信的途徑，以解決他們與保險公司之間的索償糾紛。在過去的27年，投訴局已建立了不少寶貴及實際處理保險投訴的經驗，運作不但具成本效益，且有效率，至今共處理了超過8,300宗投訴個案，其中逾1,400宗個案獲圓滿解決，總賠償額接近6,200萬港元。

雖然運作一直暢順，但是投訴局仍致力不斷改進，全面檢視現行機制後，投訴局現時僅限處理與索償結果有關的投訴，然而，還有其他的個案，保單持有人理應獲得協助，合理地取回應有的賠償。考慮到這一點，並為消費者提供更妥善的服務，投訴局提出「全面保障消費者權益框架」的理念，旨在為消費者提供一站式服務平台，以解決所有與保險相關的爭議。建議的新框架主要通過下列方式填補現有機制的不足：

(1) 擴大投訴局的權限至處理與索償無關的保險糾紛；
(2) 加入新的調解機制處理與索償無關的投訴（與索償相關的投訴將繼續以現行的裁決方式處理）；

(3) 重組理事會，加入大部分非業界委員，以增強獨立性；

(4) 委任獨立主席。

投訴局於2016年11月21日召開大會，向會員講解「全面保障消費者權益框架」的細節內容，參與人數超過80位，緊接其後是於2016年12月2日向會員發出行業諮詢文件，48名會員（包括22名人壽會員及26名一般保險會員）作出回應如下：

- 100% of the respondents indicated their support to the proposed new Framework.
- Most of the respondents supported the idea of providing mediation services free of charge to consumers while Members would be required to pay for their own mediation costs on per case basis. Eight respondents (16.7%) worried that free mediation services might give rise to potential abuses.
- For the envisaged increase in operating costs and future subscription fee, all respondents except two considered a 20-25% upward adjustment acceptable.

In light of clear support from Members, we started the process of amending the relevant Articles of Association of the ICCB. On 17 March 2017, we issued another Industry Consultation Paper to gather opinions from Members on the "Questions and Answers" relating to the new Framework and the draft amended Articles of Association.

Our objectives are simple and straightforward: to provide consumers with a one-stop, convenient, effective and freely accessible platform in resolving all insurance-related disputes of monetary nature, be they claims or otherwise.

The ICCB in its existing name does not fully and accurately reflect all of the functions and expanded scope of services of the new Framework. As such, we have decided to change its name to the Insurance Complaints Bureau (ICB) so as to embody all insurance-related disputes.

The draft amended Articles of Association is now being reviewed by the Companies Registry. We expect that the change of Articles of Association will be completed in Q3 2017. A nominating board will then be set up to look for right candidates for the new General Committee which is expected to be formed in Q4 2017 together with the change of name to ICB. The General Committee of the future ICB shall comprise of representatives from both industry and non-industry while the Chairman shall be a non-industry professional. Non-industry members shall form the majority to ensure independence and impartiality.

We envisage that the majority of the cases will continue to be resolved by adjudication as at present. We expect that the mediation services will commence operation in Q4 2017 or Q1 2018. The future ICB will provide and maintain a list of

- 100%回答者表示支持建議的新框架；
- 大部分回答者支持向消費者提供免費調解服務的構思，而會員則需支付涉及其公司的每宗個案的調解費，惟八位回答者（佔16.7%）擔心免費調解服務可能會導致潛在濫用的情況；
- 有關預計增加的營運成本及未來會費，所有回答者（除兩位外）均表示接納20-25%的升幅。

因應會員的明確支持，投訴局遂展開修改公司章程的程序，於2017年3月17日，我們發出第二份行業諮詢文件，收集會員對新框架的問題解答及修訂《組織章程細則》草擬本的意見。

投訴局的目標既簡單又直接－為消費者提供方便、快捷及容易使用的一站式服務平台，以解決所有涉及金錢性質的保險爭議，不論是否與索償有關。

投訴局現時的名稱並不能完全及實際反映新框架下的所有功能及擴大的服務範圍，因此我們決定把它的名稱改為「保險投訴局」，以體現新框架下的服務範圍將擴展至所有保險糾紛。

修訂《組織章程細則》草擬本正待公司註冊處審批，我們預計《組織章程細則》的修訂將於2017年第三季內完成，提名委員會將緊接成立，目標是於2017年第四季內，物色新理事會的適當人選，並完成更改名稱為「保險投訴局」的程序。未來的「保險投訴局」的理事會將包括業界和非業界的代表，而主席則為非業內的專業人士。理事會大部分委員將為非業界專業人士，以確保理事會的獨立性及不偏不倚。

我們預期大部分的個案仍然會以現時裁決的方式解決，調解服務將於2017年第四季或2018年第一季正式運作，未來的「保險投訴局」將提供及

suitably trained mediators with relevant experience/qualification from which the parties can select for the provision of mediation services. Our initial idea is to provide mediation services free to consumers, but we will review the system periodically and introduce suitable measures if deemed necessary to prevent abuse. More details on the operations of mediation and the related processing of cases will be provided for industry discussion in due course.

備存具相關經驗／資格及受適當訓練的調解員名單，予參與各方選擇。現時的初步構想是向消費者提供免費的調解服務，但我們會不時檢討，如發現有濫用情況，將會採取適當措施。有關調解的進一步運作方式及處理個案的程序，將於稍後作業界諮詢。

We have been in close dialogue with the Office of the Commissioner of Insurance, Insurance Authority and LegCo Member, the Hon K P Chan, BBS, JP to secure their support to the proposed new ICB framework. We all share the same ultimate goal in providing a credible dispute resolution mechanism for the good of consumers.

我們過去一直與保險業監理處、保險業監管局及陳健波立法會議員BBS太平紳士緊密對話，以確保他們對新框架的支持，我們大家有著共同的最終目標：為消費者提供可靠及具信譽的排解糾紛機制。

Membership

As at 28 April 2017, the ICCB had 111 Members, of whom 98 were Full Members while the remaining 13 were Affiliate Members.

Full Members contribute towards the costs and expenses of running the ICCB by paying an annual subscription. With their financial contributions, the ICCB can continue to provide a free service to assist policyholders in resolving insurance claims disputes to the mutual benefit of policyholders and the insurers concerned.

會員

截至2017年4月28日，投訴局共有111家會員公司，其中98家為基本會員，餘下的13家則為附屬會員。

基本會員需要繳交年費，以分擔投訴局日常營運開支。投訴局衷心感謝會員公司，全賴他們在財務上的支持，投訴局才能得以繼續為保單持有人提供免費服務，協助他們解決保險索償糾紛，以維護保單持有人和保險公司的共同利益。

The Insurance Claims Complaints Panel (Complaints Panel)

The Complaints Panel is an independent body established under the ICCB. 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 Ms Charity C S Au, representing the Life Insurance Council of the Hong Kong Federation of Insurers (HKFI) and Mr Jonathan C H Yau, representing the General Insurance Council of the HKFI. The two non-industry members are Ms Constance H M Choy and Mr Lars Nielsen, nominated respectively by the Consumer Council and the Hong Kong Institute of Certified Public Accountants. The fact that the majority of members come from outside the insurance industry clearly reflects the impartiality and independence of this alternate dispute resolution mechanism.

保險索償投訴委員會（投訴委員會）

投訴委員會是投訴局轄下的獨立運作組織。投訴委員會共有五位成員，現任主席為大律師徐福燊先生，而四位委員當中，兩位來自業界，其餘兩位則是非業界的專業人士。業界委員包括：香港保險業聯會（保聯）屬下壽險總會代表歐之珊女士和一般保險總會代表丘振雄先生。非業界委員則分別為消費者委員會代表蔡學雯女士和香港會計師公會代表倪納思先生。投訴委員會大部分成員為非業界人士，充分顯示這個另類調解糾紛的機制不偏不倚、獨立自主。

The objective of the Complaints Panel is to provide independent and impartial adjudication of claims disputes between insurers and policyholders or their beneficiaries. The decisions of the Complaints Panel are binding on Members of the ICCB, 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/she so desires. His/her legal rights are not affected by the decision of the Complaints Panel.

投訴委員會成立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，提供獨立和公正的判決。投訴委員會的裁決對投訴局會員具約束力，會員並沒有上訴權；然而，如果投訴委員會最後裁定投訴不成立，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，投訴委員會的裁決是不會影響其法律權益的。

Honorary Secretaries

名譽顧問

To date, the ICCB has altogether 39 Honorary Secretaries, comprising 21 from the general business and 18 from the life business.

投訴局現時有39位名譽顧問，包括21位從事一般保險業務及18位專責人壽保險業務。

The duty of Honorary Secretaries is to review complaint cases and provide their expert and professional opinions to the Complaints Panel for reference.

名譽顧問的職責是審理投訴個案，向投訴委員會提供專業意見，以作參考。

For each case which goes to the Complaints Panel, the professional opinions of three Honorary Secretaries have to be sought beforehand. The Complaints Panel values very much the opinions of the Honorary Secretaries and takes fully into account their views when adjudicating these cases. To help ensure the smooth operation of the ICCB and alleviate the workload of the Honorary Secretaries, I would like to take this opportunity to appeal to all Authorized Representatives of Full Members to render support by registering themselves as Honorary Secretaries (if they have not done so) or arranging for senior officers to be their alternates.

個案交予投訴委員會審理之前，一般會先尋求三位名譽顧問的意見。投訴委員會非常重視名譽顧問的意見，並會於審理投訴個案時，充分考慮他們的意見。為有效維持投訴局的運作順利及減輕名譽顧問的工作量，謹藉此機會，呼籲所有基本會員的授權代表加入名譽顧問的行列，或委派高級職員為替任代表，以支持投訴局的工作。

Acknowledgement

鳴謝

On behalf of the General Committee, I would like to convey our sincere appreciation to the following Members of the Complaints Panel for their tireless efforts and remarkable contributions during the year: Mr Michael F S Tsui, Ms Chairty C S Au, Ms Constance H M Choy, Mr Lars Nielsen and Mr Jonathan C H Yau.

謹代表理事會仝仁向投訴委員會委員徐福燊先生、歐之珊女士、蔡學雯女士、倪納思先生及丘振雄先生，致以衷心謝忱，感謝他們過去一年不辭勞苦、勇於承擔。

To my fellow General Committee Members, Mr Praveen M Daswani, Mr Stuart Harrison, Mr Mike S C Lee, Mr Ronnie W F Ng and Mr Jimmy W F Poon, I am most grateful for their unfailing support and wise counsel. A special vote of thanks

我衷心感謝理事會理事戴宏年先生、夏偉信先生、李少川先生、伍榮發先生和潘榮輝先生的戮力支持和指點提撥。同時，感謝已分別於2016年6月

is due to Mr Allan K N Yu, Mr Steven T C Kwok, Mr Charles Stuart Fraser and Mr K H Wong, who resigned from the General Committee on 1 June 2016, 28 October 2016, 31 January 2017 and 1 February 2017 respectively for their valuable contributions in the past years.

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 member companies for their support and co-operation and the ICCB Secretariat and the staff of the HKFI for their dedication and hard work during the year. I look forward to seeing all the new changes to the ICCB in the near future.

Michael E Huddart
Chairman
28 April 2017

1日、2016年10月28日、2017年1月31日及2017年2月1日辭任理事會的余健南先生、郭德才先生、司徒富瑞先生及王覺豪先生，在過去多年來為投訴局作出的貢獻。

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

最後，我感謝投訴局所有會員鼎力支持及衷誠合作。與此同時，多謝投訴局秘書處及保聯所有員工過去一年克盡厥職。我非常期待看到投訴局在不久將來的新轉變。

主席

何達德
2017年4月28日

List of Office-bearers

理事、委員、名譽顧問名錄

29.04.2016 - 28.04.2017

General Committee
理事會

Chairman
主席

Mr Michael E Huddart
何達德先生

Members 委員

Mr Praveen M Daswani
戴宏年先生

Mr Charles Stuart Fraser
司徒富瑞先生
(Resigned on 31.01.2017 退任)

Mr Stuart Harrison
夏偉信先生

Mr Steven T C Kwok
郭德才先生
(Resigned on 28.10.2016 退任)

Mr Mike S C Lee
李少川先生

Mr Ronnie W F Ng
伍榮發先生

Mr Jimmy W F Poon
潘榮輝先生

Mr K H Wong
王覺豪先生
(Resigned on 01.02.2017 退任)

Mr Allan K N Yu
余健南先生
(Resigned on 01.06.2016 退任)

The Insurance Claims Complaints Panel
保險索償投訴委員會

Chairman
主席

Mr Michael F S Tsui
Barrister-at-law
徐福燊先生
大律師

Members 委員

Ms Charity C S Au
Life Insurance
Council of the HKFI
歐之珊女士
保聯壽險總會

Ms Constance
H M Choy
Consumer Council
蔡學雯女士
消費者委員會

Mr Lars Nielsen
Hong Kong Institute of
Certified Public Accountants
倪納思先生
香港會計師公會

Mr Jonathan C H Yau
General Insurance
Council of the HKFI
丘振雄先生
保聯一般保險總會

HONORARY SECRETARIES

Mr Thomas Byington	(Resigned on 08/09/2016)
Mr James C Y Chan	(Resigned on 08/02/2017)
Mr Simon K Chan	
Mr P L Chan	
Ms Betty Chang	
Mr Chen Zhaonan	
Mr Simon Y K Cheng	
Mr Kevin Cheung	
Ms Vivian L C Choi	
Ms Ann Coughlan	(Resigned on 12/06/2016)
Mr Praveen M Daswani	
Ms Hazel Etherington	
Mr Anthony Forster	
Mr Eric L P Fung	
Ms Peggy K H Fung	
Mr William W M Ho	
Mr Eric K K Hui	
Mr Chris K K Ip	
Mr K C Kong	
Mr Steven T C Kwok	(Resigned on 28/10/2016)
Mr Y M Lai	
Mr Allan Lam	(Resigned on 30/09/2016)
Mr Mike S C Lee	
Mr Robson K L Li	
Mr S K Li	
Ms X L Li	
Mr Ross E Matthews	
Mr Guy R Mills	
Mr Ronnie W F Ng	

名譽顧問

Thomas Byington先生	(08/09/2016退任)
陳自然先生	(08/02/2017退任)
陳坤先生	
陳沛良先生	
張敏慧女士	
陳照男先生	
鄭銳強先生	
張子健先生	
蔡靈芝女士	
郭蔚霖女士	(12/06/2016退任)
戴宏年先生	
Hazel Etherington女士	
Anthony Forster先生	
馮立邦先生	
馮潔荇女士	
何偉文先生	
許金桂先生	
葉家駒先生	
江劍清先生	
郭德才先生	(28/10/2016退任)
賴遠文先生	
藍沛樂先生	(30/09/2016退任)
李少川先生	
李嘉倫先生	
李相健先生	
李曉麗女士	
麥劭斯先生	
萬士家先生	
伍榮發先生	

Mr Jimmy W F Poon		潘榮輝先生	
Mr Tony C F Poon		潘志輝先生	
Ms Angela J C Shen	(Resigned on 23/05/2016)	沈瑞芝女士	(23/05/2016退任)
Mr Ivan K W Tam		譚國榮先生	
Ms Candice Y M Tang		鄧苑明女士	
Mr Clement H C Tang		鄧漢宗先生	
Ms Margaret K C Tsang		曾潔聰女士	
Ms K Y Tsang		曾菊英女士	
Mr Robert L Valitchka		Robert L Valitchka先生	
Mr Mark Walker	(Resigned on 08/08/2016)	Mark Walker先生	(08/08/2016退任)
Mr Patrick C T Wan		尹志德先生	
Mr Simon K M Wan		溫敬文先生	
Ms Connie Y P Wong		王劉玉屏女士	
Mr Harry K T Wong		黃國添先生	
Mr K H Wong	(Resigned on 01/02/2017)	王覺豪先生	(01/02/2017退任)
Ms Kelly Y H Wong		黃苑桁女士	
Mr Stephen H K Wong		黃雄光先生	
Ms Winnie C S Wong		黃子遜女士	
Mr George K P Yan	(Resigned on 26/05/2016)	甄健沛先生	(26/05/2016退任)
Mr Allan K N Yu	(Resigned on 01/06/2016)	余健南先生	(01/06/2016退任)

Members List

會員名錄

28.04.2017

FULL MEMBERS

基本會員

ABCI Insurance Co Ltd	農銀國際保險有限公司
AIA International Ltd	友邦保險(國際)有限公司
AIG Insurance Hong Kong Ltd	美亞保險香港有限公司
Allianz Global Corporate & Specialty SE	Allianz Global Corporate & Specialty SE
Allied World Assurance Co Ltd	世聯保險有限公司
Asia Insurance Co Ltd	亞洲保險有限公司
Asia Pacific Property and Casualty Insurance Co Ltd, Hong Kong Branch	亞太財產保險有限公司香港分公司
Assicurazioni Generali SpA	忠利保險有限公司
Aviva Life Insurance Co Ltd	英傑華人壽保險有限公司
AXA China Region Insurance Co (Bermuda) Ltd	安盛保險(百慕達)有限公司
AXA Corporate Solutions Assurance	AXA Corporate Solutions Assurance
AXA General Insurance Hong Kong Ltd	安盛保險有限公司
Bank of China Group Insurance Co Ltd	中銀集團保險有限公司
BEA Life Ltd	東亞人壽保險有限公司
Berkley Insurance Co	Berkley Insurance Co
Berkshire Hathaway Specialty Insurance Co	Bershire Hathaway Specialty Insurance Co
Blue Cross (Asia-Pacific) Insurance Ltd	藍十字(亞太)保險有限公司
BOC Group Life Assurance Co Ltd	中銀集團人壽保險有限公司
Bupa (Asia) Ltd	保柏(亞洲)有限公司
California Insurance Co Ltd	加洲保險有限公司
The Canada Life Assurance Co	The Canada Life Assurance Co
Canadian Insurance Co Ltd	加拿大保險有限公司
Chevalier Insurance Co Ltd	其士保險有限公司
China BOCOM Insurance Co Ltd	中國交銀保險有限公司
China Life Insurance (Overseas) Co Ltd	中國人壽保險(海外)股份有限公司
China Merchants Insurance Co Ltd	招商局保險有限公司
China Overseas Insurance Ltd	中國海外保險有限公司
China Pacific Insurance Co (Hong Kong) Ltd	中國太平洋保險(香港)有限公司
China Ping An Insurance (Hong Kong) Co Ltd	中國平安保險(香港)有限公司
China Taiping Insurance (Hong Kong) Co Ltd	中國太平保險(香港)有限公司

China Taiping Life Insurance (Hong Kong) Co Ltd	中國太平人壽保險(香港)有限公司
Chong Hing Insurance Co Ltd	創興保險有限公司
Chubb Insurance Hong Kong Ltd	安達保險香港有限公司
Chubb Life Insurance Co Ltd	安達人壽保險有限公司
CIGNA Worldwide General Insurance Co Ltd	信諾環球保險有限公司
CIGNA Worldwide Life Insurance Co Ltd	信諾環球人壽保險有限公司
Concord Insurance Co Ltd	合群保險有限公司
Dah Sing Insurance Co (1976) Ltd	大新保險(1976)有限公司
Dah Sing Life Assurance Co Ltd	大新人壽保險有限公司
Desjardins Financial Security Life Assurance Co	Desjardins Financial Security Life Assurance Co
Direct Asia Insurance (Hong Kong) Ltd	豐亞保險(香港)有限公司
Falcon Insurance Co (Hong Kong) Ltd	富勤保險(香港)有限公司
First American Title Insurance Co	第一美國業權保險公司
Friends Provident International Ltd	英國友誠國際有限公司
FTLife Insurance Co Ltd	富通保險有限公司
Fubon Life Insurance (Hong Kong) Co Ltd	富邦人壽保險(香港)有限公司
FWD General Insurance Co Ltd	富衛保險有限公司
FWD Life Insurance Co (Bermuda) Ltd	富衛人壽保險(百慕達)有限公司
GAN Assurances	GAN Assurances
Generali Life (Hong Kong) Ltd	忠意人壽(香港)有限公司
Generali Worldwide Insurance Co Ltd	Generali Worldwide Insurance Co Ltd
Hang Seng Insurance Co Ltd	恒生保險有限公司
HDI – Global SE	HDI – Global SE
Hong Kong Life Insurance Ltd	香港人壽保險有限公司
Hong Leong Insurance (Asia) Ltd	豐隆保險(亞洲)有限公司
HSBC Life (International) Ltd	匯豐人壽保險(國際)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
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
MetLife Ltd	大都會人壽保險有限公司
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

MSIG Insurance (Hong Kong) Ltd	三井住友海上火災保險(香港)有限公司
The New India Assurance Co Ltd	新印度保險有限公司
Old Mutual International Isle of Man Ltd	Old Mutual International Isle of Man Ltd
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
Phoenix Life Ltd	Phoenix Life Ltd
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
Prudential General Insurance Hong Kong Ltd	保誠財險有限公司
Prudential Hong Kong Ltd	保誠保險有限公司
QBE General Insurance (HK) Ltd	昆士蘭保險(香港)有限公司
QBE Hongkong & Shanghai Insurance Ltd	昆士蘭聯保保險有限公司
RL 360 Insurance Co Ltd	RL 360 Insurance Co Ltd
RL 360 Life Insurance Co Ltd	RL 360 Life Insurance Co Ltd
Scottish Widows Ltd	Scottish Widows Ltd
The Sincere Insurance and Investment Co Ltd	先施保險置業有限公司
Sompo Insurance (Hong Kong) Co Ltd	日本財產保險(香港)有限公司
St. James's Place International (Hong Kong) Ltd	St. James's Place International (Hong Kong) Ltd
Standard Life (Asia) Ltd	標準人壽保險(亞洲)有限公司
Starr International Insurance (Asia) Ltd	Starr International Insurance (Asia) Ltd
Sun Hung Kai Properties Insurance Ltd	新鴻基地產保險有限公司
Sun Life Hong Kong Ltd	香港永明金融有限公司
Swiss Re International SE, Hong Kong Branch	Swiss Re International SE, Hong Kong Branch
Target Insurance Co Ltd	泰加保險有限公司
The Tokio Marine & Fire Insurance Co (Hong Kong) Ltd	東京海上火災保險(香港)有限公司
Transamerica Life (Bermuda) Ltd	全美人壽百慕達
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
Wing Lung Insurance Co Ltd	永隆保險有限公司
XL Insurance Co SE	XL Insurance Co SE
Zurich Insurance Co Ltd	蘇黎世保險有限公司
Zurich International Life Ltd	Zurich International Life Ltd

AFFILIATE MEMBERS

AIA Co Ltd

AXA China Region Insurance Co Ltd

AXA (Hong Kong) Life Insurance Co Ltd

AXA Life Insurance Co Ltd

AXA Wealth Management (Hong Kong) Ltd

Canada Life Ltd

The Manufacturers Life Insurance Co

The Pacific Life Assurance Co Ltd

Phoenix & London Assurance Ltd

Sompo Japan Nipponkoa Insurance Inc

The Sincere Life Assurance Co Ltd

Zurich Assurance

Zurich Life Insurance Co Ltd

附屬會員

友邦保險有限公司

安盛金融有限公司

安盛(香港)人壽保險有限公司

安盛人壽保險有限公司

安盛財富管理(香港)有限公司

Canada Life Ltd

The Manufacturers Life Insurance Co

太平洋人壽保險有限公司

Phoenix & London Assurance Ltd

Sompo Japan Nipponkoa Insurance Inc

先施人壽保險有限公司

蘇黎世人壽

蘇黎世人壽保險有限公司

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$1,000,000*.
   索償金額不超過100萬港元*。

3. The insurer concerned is an ICCB Member.
   涉案保險公司屬投訴局會員。

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 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。

7. The complaint is filed with the ICCB 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。

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

9. 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$1,000,000 should the causes of the claim rejection 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$1,000,000.*

如果被保人持有多份保單，而被拒絕賠償的原因相同或類同，則索償總額以不超過100萬港元為限；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100萬港元。

Complaints Handling Procedures

處理投訴步驟

1. Any complaint received by the ICCB shall be screened by the ICCB 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 ICCB.

2. The ICCB 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 ICCB, the ICCB 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 ICCB.

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

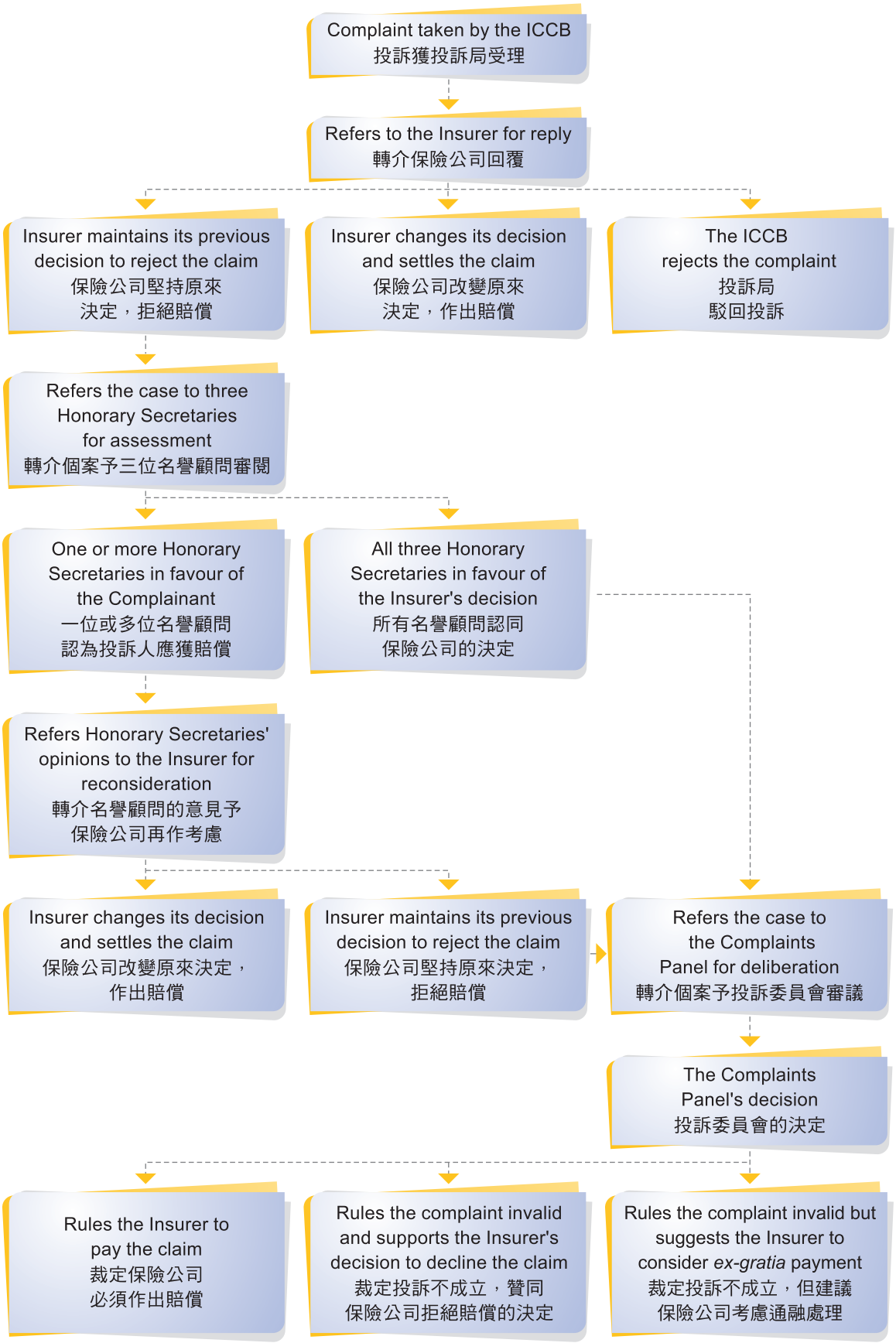
4. Following any meeting or hearing of a complaint, the Complaints Panel may upon resolution by the Members of the Complaints Panel facilitate the satisfactory settlement or withdrawal of the complaint by making an Award against the Member against whom the complaint is made, or making a recommendation, 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，他必須同意投訴有實質內容，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《組織章程細則》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，投訴委員會委員可通過表決，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。


Complaint taken by the ICCB
投訴獲投訴局受理
Refers to the Insurer for reply
轉介保險公司回覆
Insurer maintains its previous decision to reject the claim
保險公司堅持原來決定，拒絕賠償
Insurer changes its decision and settles the claim
保險公司改變原來決定，作出賠償
The ICCB rejects the complaint
投訴局駁回投訴
Refers the case to three Honorary Secretaries for assessment
轉介個案予三位名譽顧問審閱
One or more Honorary Secretaries in favour of the Complainant
一位或多位名譽顧問認為投訴人應獲賠償
All three Honorary Secretaries in favour of the Insurer's decision
所有名譽顧問認同保險公司的決定
Refers Honorary Secretaries' opinions to the Insurer for reconsideration
轉介名譽顧問的意見予保險公司再作考慮
Insurer changes its decision and settles the claim
保險公司改變原來決定，作出賠償
Insurer maintains its previous decision to reject the claim
保險公司堅持原來決定，拒絕賠償
Refers the case to the Complaints Panel for deliberation
轉介個案予投訴委員會審議
The Complaints Panel's decision
投訴委員會的決定
Rules the Insurer to pay the claim
裁定保險公司必須作出賠償
Rules the complaint invalid and supports the Insurer's decision to decline the claim
裁定投訴不成立，贊同保險公司拒絕賠償的決定
Rules the complaint invalid but suggests the Insurer to consider ex-gratia payment
裁定投訴不成立，但建議保險公司考慮通融處理

Statistics

統計數字

01.01.2016 - 31.12.2016

In 2016, the Insurance Claims Complaints Bureau (ICCB) handled altogether 770 cases, of which 659 were new cases (a 2% increase compared with 647 in 2015) and 111 cases were brought forward from 2015. Out of these 770 cases, 276 were dismissed because they did not fall within the terms of reference of the ICCB. Of the remaining 494 cases, 374 were closed while the balance of 120 cases were carried forward to 2017 (see Table 1).

保險索償投訴局（投訴局）於2016年共處理了770宗投訴個案，其中659宗屬新接獲的個案，比2015年的647宗增加2%，而111宗則是2015年度尚未審結的個案。在770宗已處理的投訴個案中，有276宗超出投訴局的職權範圍，至於其餘的494宗受理個案中，有374宗已經審結，餘下的120宗尚未結案，須留待2017年處理（見表一）。

Summary of Complaints Handled
處理的投訴個案概覽

Table 1 表一

	2012	2013	2014	2015	2016
Cases brought forward 承接上年度尚未審結的個案	58	94	97	81	111
Cases received 新接獲的個案	479	535	603	647	659
Cases handled 已處理的個案	537	629	700	728	770
Outside Terms of Reference 超逾職權範圍的個案	165	189	275	284	276
Cases closed 審結的個案	278	343	344	333	374
Cases carried forward 留待來年處理的個案	94	97	81	111	120

For the 374 cases closed, the main categories of complaints included application of policy terms, non-disclosure, excluded items, amount of indemnity and breach of warranties or policy conditions (see Figures 1 and 2). And hospitalization/medical and travel insurance policies constituted the two largest groups of claim disputes (see Figures 3 and 4).

374宗已審結個案的糾紛主要涉及保單條款的詮釋、沒有披露事實、不保事項、賠償金額和違反保證條款或保單條件（見圖一及二），而引起最多索償糾紛的兩類保險產品分別是住院／醫療保險及旅遊保險（見圖三及四）。

Amongst the 374 cases closed, 60 were mutually settled between the insurers and the complainants with the aid of the ICCB secretariat. These cases did not need to go to the Complaints Panel. No *prima facie* evidence was found in 220 cases and 49 cases were withdrawn by the claimants. The remaining 45 cases (12%) were referred to the Complaints Panel for deliberation (see Figure 5). The Complaints Panel ruled in favour of the complainants in seven cases and upheld the insurer's decision in 38 cases. Amongst these 38 cases, the Complaints Panel recommended *ex-gratia* payment in two cases and the recommendation was readily accepted by the insurers concerned (see Figure 6).

在374宗已審結的個案中，有60宗個案在投訴局秘書處的調停下，保險公司與索償人雙方達成和解，毋須轉交投訴委員會處理。另有220宗個案的表面證據不成立，49宗的索償人撤銷投訴，而餘下的45宗個案（12%）則交由投訴委員會審理（見圖五）。投訴委員會裁定七宗個案的投訴人得直而可獲賠償，而贊同保險公司的賠償決定的個案則有38宗，投訴委員會亦就其中兩宗個案，建議保險公司通融處理，而相關保險公司均欣然接納委員會的建議（見圖六）。

In dollar terms, 69 complainants received from insurers a total claims amount of HK$2.60 million comprising HK$2.41 million from mutual settlement and HK$190,000 from awards made by the Complaints Panel. The highest single case award was around HK$75,000.

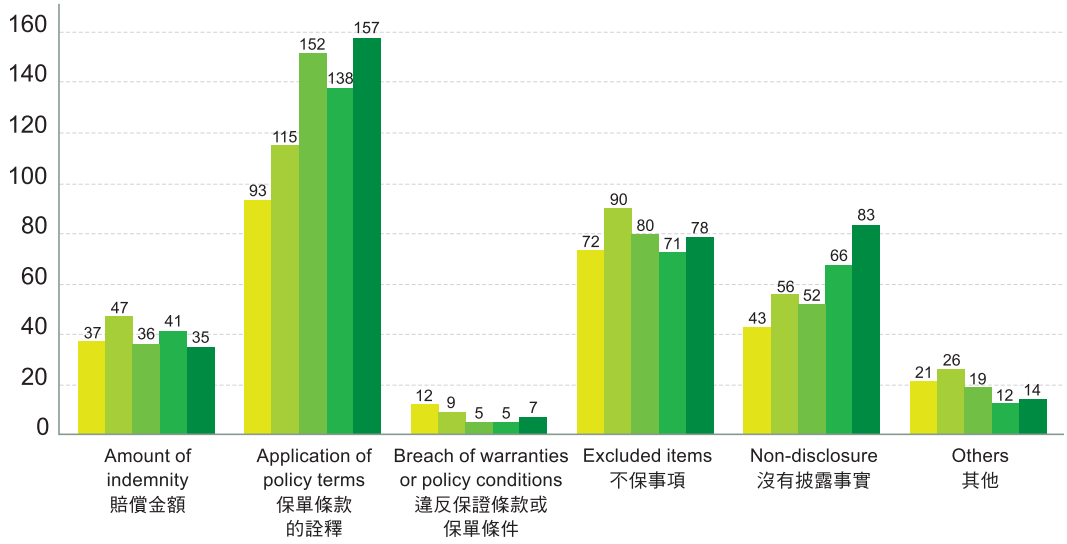
若以金額計算，共有69位投訴人獲得保險公司賠償，涉及的賠償額達260萬港元，當中包括雙方和解金額241萬港元及投訴委員會裁定得直個案的賠償額19萬港元，而單一宗得直個案的最高賠償額則約為7.5萬港元。

Further analyses of the 374 cases closed in 2016 are detailed in Tables 2 and 3.

至於2016年已審結的374宗個案的進一步分析，請參看表二及表三。

Nature of Complaints Closed 結案投訴類別

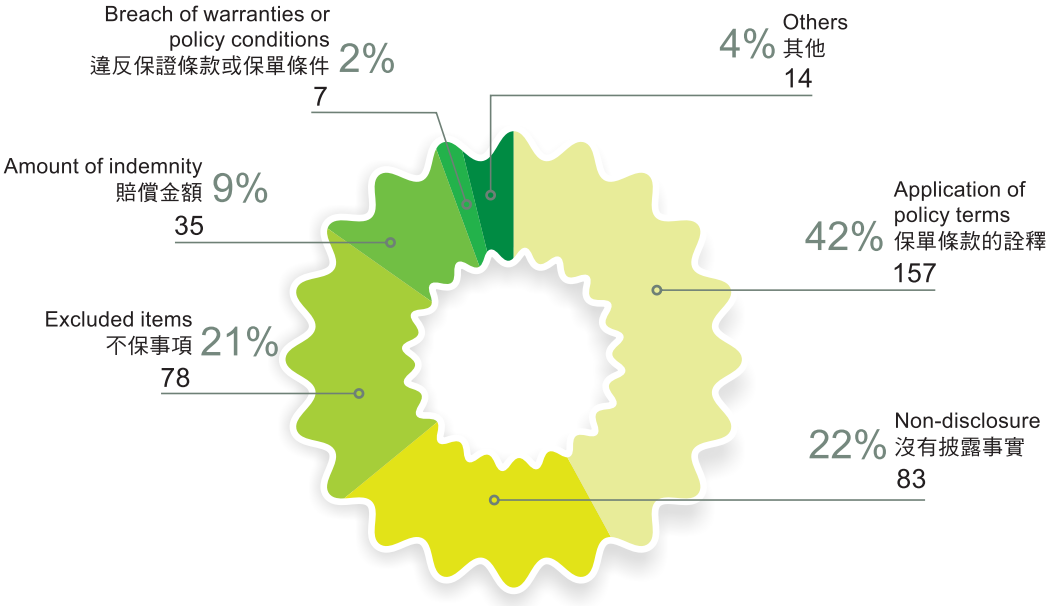
Figure 1 圖一



	2012	2013	2014	2015	2016
Total 總數	278	343	344	333	374

Nature of Complaints Closed in 2016 2016年結案投訴類別

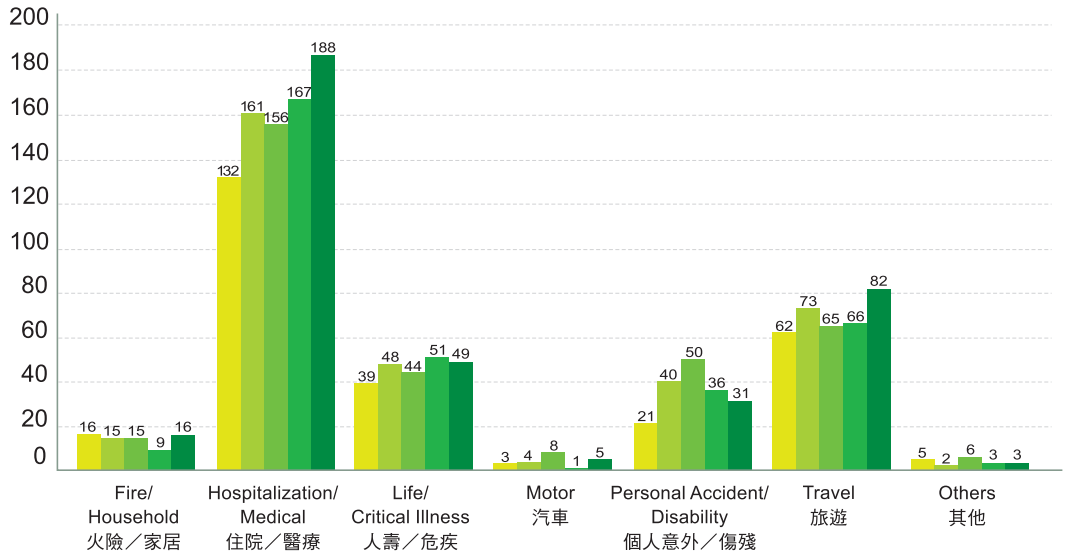
Figure 2 圖二



Total 總數	374

Types of Policies Closed 結案保單類別

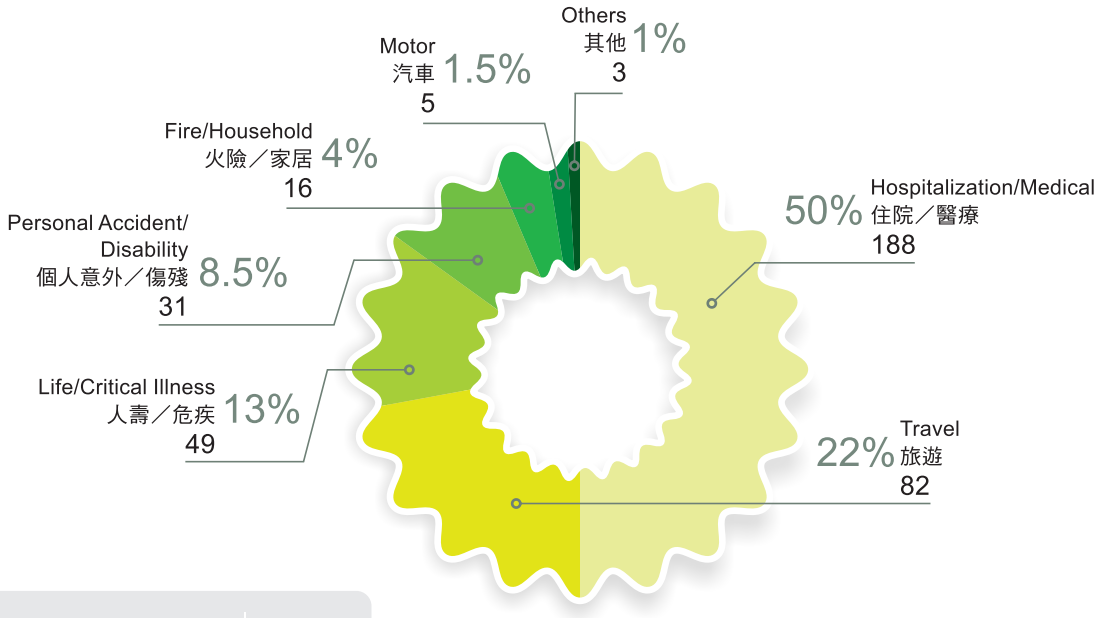
Figure 3 圖三



	2012	2013	2014	2015	2016
Total 總數	278	343	344	333	374

Types of Policies Closed in 2016 2016年結案保單類別

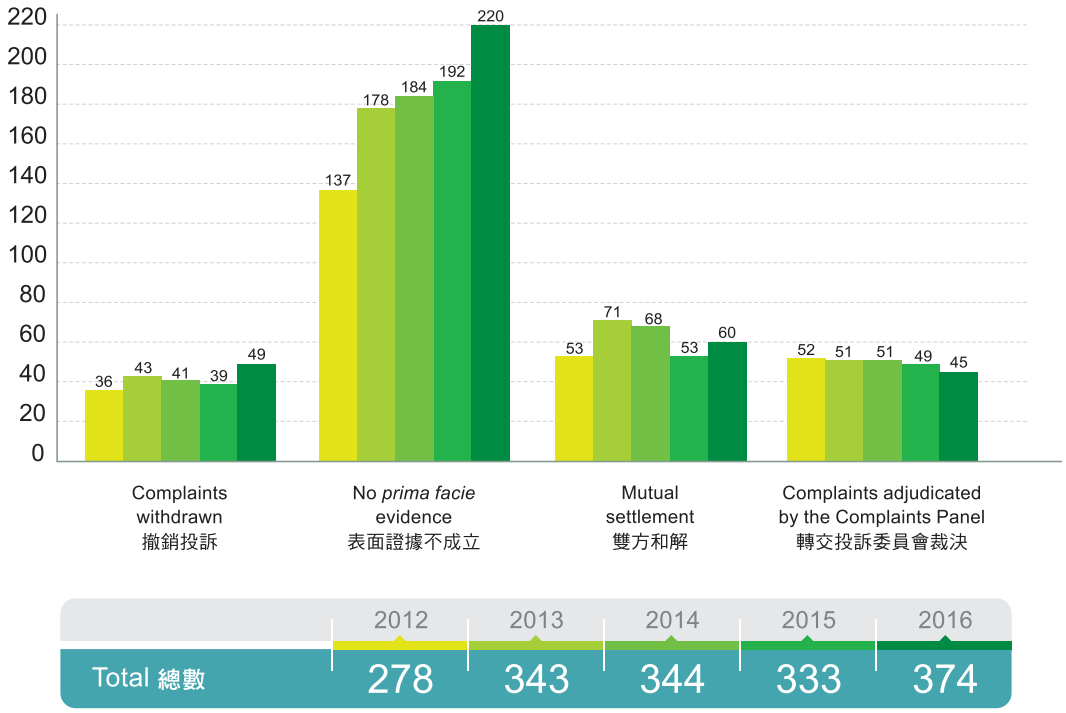
Figure 4 圖四



Total 總數	374

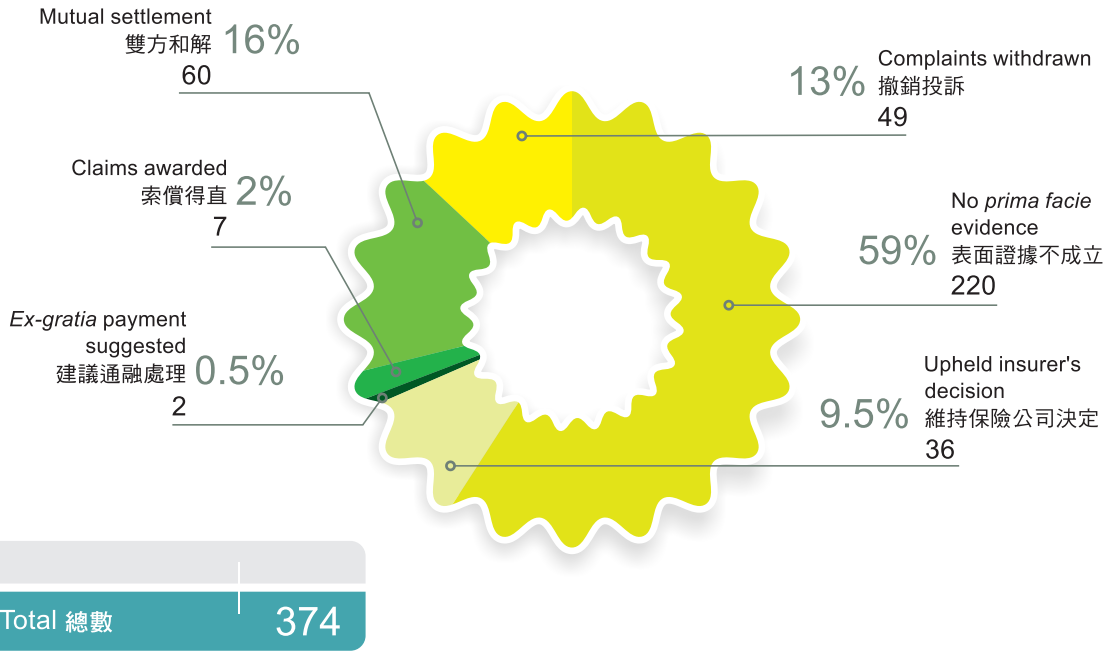
Outcome of Cases Closed 結案分類

Figure 5 圖五



Outcome of Cases Closed in 2016 2016年結案分類

Figure 6 圖六



Nature
of Complaints by Types of Policies
各類型保單的投訴類別

Table 2 表二

Nature of complaints 投訴類別 / Types of policies 保單類別	Fire/ Household 火險／家居	Hospitalization/ Medical 住院／醫療	Life/ Critical Illness 人壽／危疾	Motor 汽車	Personal Accident/ Disability 個人意外／傷殘	Travel 旅遊	Others 其他	Total 總數
Amount of indemnity 賠償金額	0	17	1	2	4	11	0	35
Application of policy terms 保單條款的詮釋	8	65	17	0	23	44	0	157
Breach of warranties or policy conditions 違反保證條款或保單條件	3	1	1	1	0	1	0	7
Excluded items 不保事項	5	43	1	0	2	25	2	78
Non-disclosure 沒有披露事實	0	56	24	2	1	0	0	83
Others 其他	0	6	5	0	1	1	1	14
Total 總數	16	188	49	5	31	82	3	374

Outcome
of Cases Closed by Types of Policies
各類型保單的結案分類

Table 3 表三

Outcome of cases closed 結案分類 / Types of policies 保單類別	Fire/ Household 火險／家居	Hospitalization/ Medical 住院／醫療	Life/ Critical Illness 人壽／危疾	Motor 汽車	Personal Accident/ Disability 個人意外／傷殘	Travel 旅遊	Others 其他	Total 總數
Claims awarded 索償得直	0	4	0	1	0	2	0	7
Ex-gratia payment suggested 建議通融處理	0	2	0	0	0	0	0	2
Mutual settlement 雙方和解	3	35	4	0	7	11	0	60
Upheld insurer's decision 維持保險公司決定	0	26	3	0	2	5	0	36
Complaints withdrawn 撤銷投訴	0	21	8	1	3	15	1	49
No *prima facie* evidence 表面證據不成立	13	100	34	3	19	49	2	220
Total 總數	16	188	49	5	31	82	3	374

Powers of the Complaints Panel

投訴委員會的權力

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

Members of the Complaints Panel attend a media gathering on 30 March 2017.
投訴委員會委員出席2017年3月30日舉行的新聞界聚會。

Powers of the Complaints Panel

According to Articles 82(a) & (b) of *Articles of Association* of the ICCB, 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 ICCB. 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.

投訴委員會的權力

投訴局《組織章程細則》第82條（a）及（b）款規定，投訴委員會裁決時「必須尊重及遵守保險合約條款、優良保險慣例的原則、任何適用法例或司法機構法規、保聯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險合約條款的後果對投訴人既不公道，又不合理，否則必須以保險合約條款為準」。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，會參照保聯編製的《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。為求判決公道和合理，投訴委員會會小心考慮每宗個案的曲直是非，方行裁決。《組織章程細則》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。

Case Review

個案分析

01.01.2016 - 31.12.2016

Case 1 個案

Essence of Complaint: Medically Necessary (investigation for minimizing operative risks)
Type of Insurance: Hospitalization

投訴爭議點：醫療需要（為減低手術風險的檢查）
保險類別：住院保險

The Complaint

The insured consulted a general practitioner for submandibular right neck lump which grew in size, recent chest pain, high blood pressure and arrhythmia. He was admitted to a private hospital for exploration of right submandibular neck and excision of neck lump. The final diagnosis was large lipoma. The insurer settled most of the hospital expenses but excluded the cost for computed tomography (CT) coronary angiogram because it considered that such test was unrelated to the admission diagnosis. Furthermore, as the insured was not required to consult a cardiologist or take medication for his chest discomfort during confinement, the insurer concluded that the taking of CT coronary angiogram was not medically necessary in accordance with the policy terms.

投訴內容

受保人因右頸頷下腫塊增大、近期胸痛不適、高血壓及心律失常而向普通科醫生求診，其後入住私家醫院接受右頸頷下檢查及頸部腫塊切除手術，最後被診斷患上大脂肪瘤。保險公司賠償了大部分的住院費用，惟由於冠狀動脈電腦斷層造影與受保人的入院診斷無關，故拒絕賠償有關檢查費用。此外，由於受保人於住院時並沒有需要看心臟科醫生或服食治療胸部不適的藥物，因此根據保單條款，保險公司認為受保人接受冠狀動脈電腦斷層造影沒有醫療需要。

Findings of the Complaints Panel

The Complaints Panel noted that the insured had performed the CT scan of neck in the outpatient department of the hospital two weeks prior to his admission. It initially doubted why the CT coronary angiogram could not be done together with the CT scan of neck but to be arranged during his confinement. Having clarified with the attending physician, the Complaints Panel learnt that the insured only mentioned about chest discomfort after he was admitted to the hospital. CT coronary angiogram was then arranged to minimize the operative risks before the scheduled neck surgical procedure. The test confirmed a partially occluded anterior descending coronary artery.

Having duly taken into consideration the clarifications from the attending doctor, the Complaints Panel was convinced that the CT coronary angiogram was medically necessary to be taken during the insured's hospital confinement.

投訴委員會的調查結果

投訴委員會得悉受保人於住院前兩星期，在醫院門診部接受頸部電腦斷層掃描，委員會起初質疑受保人為何不在接受頸部電腦斷層掃描的當天，一併進行冠狀動脈電腦斷層造影，卻要安排於住院期間進行。然而，委員會聽取主診醫生的澄清後，明白受保人在入院後才向主診醫生提及他有胸痛不適，為減低進行頸部外科手術的風險，主診醫生遂安排受保人進行冠狀動脈電腦斷層造影，而有關結果亦確定受保人的冠狀動脈前降支管腔部分閉塞。

經仔細考慮主診醫生提供的進一步資料後，委員會相信受保人有醫療需要於住院期間進行冠狀動脈電腦斷層造影。

Ruling of the Complaints Panel

The Complaints Panel ruled in favour of the insured and resolved that the insurer should pay an extra HK$6,070 to the insured for the expenses relating to the CT coronary angiogram.

投訴委員會的裁決

投訴委員會裁定受保人得直，保險公司需向他額外發放6,070港元，作為有關冠狀動脈電腦斷層造影費用的賠償。

Message from the Complaints Panel

The Complaints Panel often receives cases where insurers declined hospitalization claims on the basis that the investigative tests are not medically necessary to be conducted inpatient since those tests could be safely and effectively performed in an outpatient establishment. However, if there is evidence showing that the investigative tests are medically justified to be done in hospital, the Complaints Panel will rule in favour of the claimants.

投訴委員會的意見

投訴委員會不時收到涉及保險公司以受保人沒有醫療需要於住院期間進行某些檢查，而拒絕住院賠償的投訴，保險公司所持的理由是有關檢查大可於門診診所安全及有效地進行。然而，假如有證據證明相關檢查有醫療需要於住院期間進行，則投訴委員會會裁定索償人得直。

Case 2 個案

Essence of Complaint: Medically Necessary (investigation for diagnostic purpose)
Type of Insurance: Hospitalization

投訴爭議點：醫療需要（用作診斷的檢查）
保險類別：住院保險

The Complaint

The insured had suffered from back pain for one year. He was admitted to a private hospital for x-ray, laboratory tests and medication treatment. The final diagnosis was mechanical back pain. Since all the tests done could have been effectively and safely performed on an outpatient basis, the insurer considered that the insured's admission to hospital was solely for diagnostic purposes. It therefore declined to settle his hospitalization claim on the grounds that the confinement was not medically necessary.

投訴內容

受保人患有背痛一年，在私家醫院接受X光、化驗及藥物治療，最終被診斷患上機械性背痛。由於他進行的所有測試均可於門診診所有效及安全地進行，保險公司認為受保人的住院純粹為了診斷病因，故以其住院沒有醫療需要為理由，拒絕他的住院索償申請。

Findings of the Complaints Panel

The Complaints Panel learnt from the available information that the insured had consulted another physician for neck and back pain around two weeks before his admission. He indicated his anxiety about weight gain with related health concerns and opted for admission for workup.

The insured received a series of investigative tests during the confinement. However, apart from oral medication, there was no essential treatment given to him. Some of the tests such as prostate-specific antigen, carcinoembryonic antigen and electrocardiography were done for the sake of cancer marker and medical baseline checking which were not related to the insured's diagnosis. Furthermore, the confinement was marked "elective" in nature instead of "emergency" in the nursing assessment.

Given that the investigative tests could have been done on an outpatient basis and that the purpose of the admission was solely to find out the cause of the insured's pain condition, the Complaints Panel agreed that the insured's confinement was not medically necessary.

投訴委員會的調查結果

投訴委員會從現有資料中得悉受保人於入院前兩星期，曾因頸背痛向另一位醫生求診，並表示擔憂體重上升及相關健康問題而選擇住院跟進。

受保人於住院時曾接受一系列的檢查，惟除了口服藥物外，他並沒有接受任何必要的治療，而部分測試根本與受保人的診斷無關，例如：前列腺癌抗原檢查、癌胚抗原檢查及心電圖，乃屬癌症風險評估及醫療基線檢查。此外，於護士評估報告內，受保人的住院安排被標示為「選擇性」，而非「緊急性」。

鑑於有關測試檢查大可於門診診所進行，而住院的目的只為診斷受保人的痛症原因，委員會因此同意受保人的住院沒有醫療需要。

Ruling of the Complaints Panel

The Complaints Panel supported the insurer's decision to decline the hospitalization claim for about HK$8,000.

投訴委員會的裁決

投訴委員會支持保險公司拒絕住院醫療賠償的決定，涉及金額約8,000港元。

Message from the Complaints Panel

If there is concrete evidence to show that the hospital confinement is arranged solely for conducting diagnostic or laboratory tests with no element of medical emergency, the Complaints Panel will generally agree that such confinement is not medically necessary.

投訴委員會的意見

倘若有充分證據證明住院純粹是為了接受診斷或測試，而當中並不涉及醫療緊急的情況，投訴委員會一般會同意這類住院沒有醫療需要。

Case 3 個案

Essence of Complaint: Accidental Bodily Injury (spondylolisthesis)
Type of Insurance: Personal Accident

投訴爭議點：意外受傷（脊椎前移）
保險類別：個人意外保險

The Complaint

The insured consulted the outpatient department of a private hospital for lower back pain sustained 16 days ago while performing leg lift exercise during the physical education (PE) class at school. No external signs of injury were noted. He was referred to have magnetic resonance imaging on the same day. The final diagnosis was spondylolisthesis C5 and S1.

Most of the medical expenses were settled by the insured's hospitalization policy with another insurer. The complainant (mother of the insured) submitted an accident claim to the insurer for the remaining medical expenses incurred. However, due to lack of evidence proving that the claimed loss was caused by accidental bodily injury, the insurer rejected the claim.

投訴內容

受保人因下背痛向私家醫院門診部求診，原因是16天前在學校上體育課時做提腿動作所導致，應診時受保人的身體表面並沒有損傷，受保人同日被轉介接受磁力共振，最終被確診患上頸椎第五節及骶椎第一節前移。

受保人的大部分醫療費用已從另一家保險公司承保的醫療住院計劃獲得賠償，投訴人（受保人的母親）只就餘下的醫療費用向保險公司提出意外索償申請。然而，由於沒有證據確實有關索償乃由意外受傷所導致，保險公司因此拒絕賠償。

Findings of the Complaints Panel

According to the policy provisions of the personal accident insurance, "accidental bodily injury" means "an injury effected directly and independently of all other causes by accident as evidenced by a visible bruise or wound on the body".

It is also stated in the policy that ".....written proof of loss, such as the necessary information, documents, medical evidence and reports signed by a doctor, which the insurer requires the insured to provide at his/her expense must be received by the insurer within 90 days after it receives written notice of the claim".

The Complaints Panel noted that the insured sought medical consultation for back pain only 16 days after the alleged accident. The attending physician stated in the claim form that the insured sustained sudden lower back pain while lifting his leg during the PE lesson and opined that his injury might be related to congenital anomalies. The insurer had advised the complainant to provide all investigation reports for its review. However, she refused to provide such reports but requested the insurer to contact the hospital directly for further clarification.

Having duly considered all the relevant facts, the Complaints Panel did not think that "sudden onset of pain while lifting leg" and "spondylolisthesis C5 and S1" would be regarded as an accident. Furthermore, there was a lack of objective evidence to prove beyond doubt that the insured's condition was caused solely and directly by an accident independent of all other causes.

投訴委員會的調查結果

有關個人意外保單的條款訂明：「意外受傷」是指「直接及純粹因意外而非其他原因，導致身體受傷，並有明顯的瘀傷或傷口」。

此外，保單又訂明：「在保險公司接獲書面索償通知後的90天內，受保人必須呈交有關的索償證明文件，例如相關的資料、文件、醫療證明及由醫生簽署的報告，並由保單持有人負責有關支出……」。

投訴委員會得悉，受保人於聲稱的意外發生後16天才就背痛求診，而主診醫生於索償表格中指出，受保人於上體育課做提腿動作時突然感到下背痛，認為有關受傷或與先天性異常有關。保險公司曾建議投訴人提供所有檢查報告以作查核，惟她拒絕，並要求保險公司直接聯絡醫院查問。

委員會仔細考慮所有相關事實後，並不認為「提腿時突然感到痛楚」及「頸椎第五節及骶椎第一節前移」屬意外事故。此外，現時亦沒有客觀證據可毫無疑點地證明受保人的情況是純粹及直接因意外事故造成，並不涉及其他因素。

Ruling of the Complaints Panel

Since the burden of proof was on the complainant to provide the insurer with the necessary information to prove the case, in the absence of such information, the Complaints Panel supported the insurer's decision in rejecting the accident claim for around HK$2,000.

投訴委員會的裁決

基於投訴人有責任向保險公司提交所需資料，以證明受保人的情況符合保單的要求，在欠缺相關資料的情況下，投訴委員會支持保險公司拒絕賠償意外醫療費用的決定，涉及金額約2,000港元。

Message from the Complaints Panel

In order to ascertain whether or not an injury was caused directly and independently by an accident, the Complaints Panel will consider the nature of the injury and the diagnoses made by the attending doctor. If the evidence available is not sufficient and concrete enough to support that an injury is caused solely and independently by an accident, the Complaints Panel will tend to support the decision to decline the related claim.

投訴委員會的意見

為斷定某傷患是否直接和純粹由某宗意外事故獨立造成，投訴委員會會考慮傷患的性質和主診醫生的診斷結果。如果提供的證據未能充分及具體地證明有關傷患乃直接及純粹由意外事故導致，則投訴委員會傾向支持不予發放意外賠償的決定。

Case 4 個案

Essence of Complaint: Permanent Total Disability (contributed by Parkinson's disease)
Type of Insurance: Personal Accident

投訴爭議點：永久完全傷殘（由柏金遜症導致）
保險類別：個人意外保險

The Complaint

The complainant sustained a fall injury while on duty 10 years ago when he worked as a gardener. He slipped and rolled down from a slope and resulted in severe back/neck pain and left leg swelling. He was granted sick leaves for more than two years. The insurer granted permanent total disability (PTD) benefit to him one year after the accident for 60 consecutive months.

When the complainant submitted further claim for his continued disability, the insurer noted that he suffered Parkinson's disease two years after the accident with impairment in activities of daily living. Since the complainant's disability was due to Parkinson's disease and there was no supportive evidence to prove that his continued disability was caused directly and independently by an accident, the insurer declined his further claim for PTD benefit.

投訴內容

投訴人是一名園丁，10年前工作時從山坡失足滾下受傷，導致背／頸部嚴重痛楚及左腳腫脹，他因而獲發病假愈兩年，保險公司於意外發生一年後向他發放連續60個月的「永久完全傷殘保障」賠償。

當投訴人就其持續傷殘再度提出索償時，保險公司發現投訴人在意外發生後兩年患上柏金遜症，日常活動能力受損。由於投訴人的傷殘乃因柏金遜症導致，加上現時沒有具體證據證明他的持續傷殘是純粹及直接因意外事故導致，保險公司因此拒絕他再度就「永久完全傷殘保障」提出的索償申請。

Findings of the Complaints Panel

It is stipulated in the policy provisions of the personal accident contract that "When as a result of injury and commencing within 180 days from the date of an accident, the insured is totally and permanently disabled and prevented from engaging in any gainful work, occupation or business for which he/she is reasonably qualified or fitted by knowledge, training or experience, the insurer shall pay, provided such disability has continued for a period of 12 consecutive months, the principal sum in monthly installments payable at the end of each month during such total, continuous and permanent disability, at the rate of 1% per month for not more than 100 months. If during the 100 month period the disability ceases or the insured becomes able to return to work, the payments under this benefit shall immediately cease".

From the various medical reports, the Complaints Panel noted that the complainant suffered Parkinson's disease two years after the accident and received medical treatment since then. The doctors opined that his Parkinsonism was unrelated to the injury 10 years ago but his medical condition was complicated by depression and Parkinsonism. He was not expected to have a fundamental or marked change of his present condition in future as Parkinson's disease was a progressive neuro-degenerative disorder.

The Complaints Panel was inclined to believe that the complainant's current disability was more likely contributed by his Parkinsonism rather than the residual injury of the accident occurred 10 years ago.

投訴委員會的調查結果

有關個人意外保單的條款訂明：「倘在意外發生後180日內，受保人因意外受傷而引致永久完全傷殘，並無法從事符合其知識、訓練或經驗，並可賺取報酬的任何工作、職業或商業活動，而該傷殘持續12個月後，受保人仍然完全、持續及永久傷殘，則保險公司會支付永久完全傷殘賠償。該項賠償將於永久完全傷殘期內的每月月底攤付總賠償額的1%，而支付期不得超過100個月。若在100個月的支付期內傷殘狀況消失或受保人回復工作能力，則此永久完全傷殘賠償會即時終止」。

投訴委員會從多份醫療報告得悉，投訴人於意外發生後兩年患上柏金遜症，並自此接受相關治療，醫生認為他的柏金遜症與10年前的受傷無關，而他的病況亦因抑鬱症及柏金遜症而變得複雜。由於柏金遜症是一種越趨嚴重的腦部神經退化疾病，醫生預計投訴人現時的狀況在將來不會有基本或明顯的改善。

投訴委員會傾向相信投訴人現時的傷殘較大可能是因他的柏金遜症導致，而非10年前的意外事故殘留的損傷。

Ruling of the Complaints Panel

As there was no substantial evidence to prove that the complainant's current disability was caused solely and directly by an accidental injury independent of all other causes, the Complaints Panel concurred with the insurer's decision in declining the complainant's claim for further PTD benefit amounting to approximately HK$128,700.

投訴委員會的裁決

由於沒有充分證據證明投訴人現時的傷殘是純粹及直接因意外事故導致，而不涉及其他因素，投訴委員會贊同保險公司拒絕投訴人再度申索「永久完全傷殘保障」的決定合理，涉及金額大約128,700港元。

Message from the Complaints Panel

In determining whether or not an insured is entitled to further accident claim in case of a continued disability, the Complaints Panel pays particular attention to whether the further claim is in any way related to the previous injury. In this respect, the nature of diagnosis, the probability of continued disability and the existence of any new factor leading to the present injury will be taken into consideration.

投訴委員會的意見

為確定受保人是否有資格就持續傷殘再次索取意外賠償，投訴委員會會特別留意受保人再次提出的索償與之前的受傷是否有任何關係；為此，投訴委員會會斟酌考慮診斷結果的性質、傷患持續的可能性，以及是否有新的因素出現而導致現時的傷患。

Case 5 個案

Essence of Complaint: Same Disability (bilateral osteoarthritis knees)
Type of Insurance: Hospitalization

投訴爭議點：同一傷病（雙膝關節炎）
保險類別：住院保險

The Complaint

The complainant had both knee pain for 10 years. He was admitted to a private hospital twice for left and right total knee replacement respectively, of which the two confinements were separated by a period of seven months. The diagnosis of the two confinements was bilateral osteoarthritis (OA) knees.

The insurer settled most of the medical expenses incurred in the complainant's first confinement, but considered that his second confinement was for the subsequent follow up treatment of his bilateral OA knees during the first hospitalization. The insurer then treated the two hospitalizations as arisen from the same disability. Since the amount settled under the miscellaneous (misc.) expenses benefit for the complainant's first hospitalization was very close to the maximum limit payable for such benefit, the insurer only paid the residual amount under the misc. expenses benefit for his second hospitalization. Such amount was approximately 20% of the total misc. expenses incurred during the complainant's second confinement.

投訴內容

投訴人患有雙膝疼痛十年，於七個月內先後兩次入住私家醫院，分別接受左膝及右膝關節置換術，兩次住院的診斷均為雙膝骨關節炎。

保險公司支付投訴人首次住院的大部分醫療費用，由於他的第二次住院主要是接受首次住院期間雙膝骨關節炎的後續治療，保險公司因此認為他的兩次住院皆因同一傷病導致。由於保險公司已在投訴人首次住院理賠時，向他發放接近雜費項目保障上限的賠償，因此在處理他第二次住院理賠時，只賠付雜費項目餘下的保障額，有關金額大約佔投訴人第二次住院總雜費的20%。

Findings of the Complaints Panel

According to the provisions of the hospitalization benefit, "disability" means "injury, sickness, disease or illness and shall include all disabilities arising from the same cause including any and all complications arising thereof, except that if the insured completely recovers for a period of 90 days continuously following the latest discharge from hospital, or the date of last treatment by the registered medical practitioner, whichever is later, any subsequent treatment shall be considered a new disability".

The Complaints Panel noted that the complainant had already suffered from bilateral knee pain for 10 years when he first sought consultation. Given that the diagnosis for his two confinements was bilateral OA knees and that his right knee had not recovered until he underwent the right knee operation during the second confinement, the Complaints Panel accepted the insurer's view that the two confinements should be considered as arisen from the same disability.

投訴委員會的調查結果

有關住院保單的條款訂明：「傷病」是指「受傷、不適、疾病或病痛，並包括由同一原因造成的所有傷病及其一切併發症。不過，若受保人完全康復持續90天（由最後經註冊醫生治療或出院日起計算，以較後者為準），任何繼發的治療皆作新的傷病計算」。

投訴委員會得悉，投訴人首次求診時已患有雙膝疼痛十年，鑑於他兩次住院的診斷結果均為雙膝骨關節炎，而他右膝的病況一直持續至第二次入院接受右膝關節置換術，從未康復，委員會因此接納保險公司的看法，把投訴人的兩次住院視作因同一傷病導致。

Ruling of the Complaints Panel

The Complaints Panel ruled in favour of the insurer and supported its decision in declining the remaining misc. expenses incurred during the complainant's second confinement, amounting to approximately HK$46,000.

投訴委員會的裁決

投訴委員會裁定保險公司得直，支持拒絕就投訴人第二次住院餘下約46,000港元的雜費作出賠償。

Message from the Complaints Panel

Nearly all medical insurance policies have "same disability" provision to limit its coverage to recurrent confinements due to disabilities arising from the same cause. In most cases, subsequent treatment arising from the same cause will be considered as the same disability unless they are separated by at least a specified period with no treatment or consultation in between and the insured has fully recovered with no further sign or symptom. The Complaints Panel urges the policyholders to pay special attention to such policy term and the maximum benefit limits of the policy if they need to be re-admitted for the same medical condition.

投訴委員會的意見

幾乎所有住院醫療保單均載有「同一傷病」條款，為由同一原因導致的傷病而需重覆住院的賠償設限。在大多數的情況下，因相同原因引致的後續治療會被視為同一傷病，除非兩次的治療相距至少某個日數，而期間受保人亦不需要接受任何相關治療或求診，並且完全康復，沒有任何徵狀或病徵。委員會敦促保單持有人如因相同醫療狀況而需再度住院，應特別留意有關條款及醫療保單內各保障項目的最高保障額。

Case 6 個案

Essence of Complaint: Medical Expenses (cost of knees brace)
Type of Insurance: Travel

投訴爭議點：醫療費用（護膝套費用）
保險類別：旅遊保險

The Complaint

The complainant took out a travel policy for her six-month trip to Europe. She sustained left knee injury while snowboarding in Germany during the second month of her trip. She was diagnosed by a local doctor as suffering from left knee cruciate ligament tear. Since her mobility was affected by the knee injury, she was admitted to a local hospital for arthroscopic operation. After the surgery, she was recommended to put on a knee brace and to receive follow-up consultations and physiotherapy.

The insurer offered to settle the medical expenses incurred by the complainant in Germany in full, but excluded the cost of knee brace since the item did not belong to a medical expense.

投訴內容

投訴人為她歷時六個月的歐洲旅程購買旅遊保單，她於旅程第二個月，在德國進行單板滑雪時不慎弄傷左膝，被當地醫生確診患上左膝十字韌帶撕裂。由於左膝傷勢影響了她的活動能力，她遂入住當地醫院接受關節鏡手術。手術後，醫生建議她穿上護膝套及接受覆診和物理治療。

保險公司向投訴人提出賠償她在德國的所有醫療費用，惟不包括護膝套的費用，理由是護膝套並不屬於醫療費用。

Findings of the Complaints Panel

It is stipulated in the provisions of the travel policy that "the insurer will indemnify the insured person against medical expenses, hospitalization charges, treatment expenses..... necessarily incurred for continuous medical treatment outside Hong Kong.....as a direct result of accidental bodily injury sustained by or sickness of the insured person occurring during the period of insurance".

The Complaints Panel noted that the travel insurance policy did not explicitly exclude the cost of knee brace. Since the complainant was recommended by her doctor to put on a knee brace after the surgery for stabilization, it thus formed part of her medical treatment.

投訴委員會的調查結果

有關旅遊保單的條款訂明：「如受保人於保險期內，因事故導致身體損傷或因疾病而需接受治療，保險公司將……對所有在香港以外地區必要而連續的醫療治療開支，包括所需的醫療費用、住院費用、治療費用……作出賠償」。

投訴委員會留意到旅遊保單並沒有明確地指出護膝套費用屬不受保障項目，由於投訴人獲醫生建議於手術後穿上護膝套以穩定傷勢，因此有關護膝套應被視為她治療的一部分。

Ruling of the Complaints Panel

The Complaints Panel ruled in favour of the complainant and resolved that the insurer should settle the cost of knee brace at around HK$9,400 as medical/treatment expenses.

投訴委員會的裁決

投訴委員會裁定投訴人得直，保險公司需就有關護膝套作出醫療／治療費用的賠償，涉及金額約9,400港元。

Message from the Complaints Panel

Medical expenses generally cover a wide range of costs paid for medical services, treatments, drugs, devices, equipment, etc. Unless the term is clearly defined in the policy or there are clear provisions to exclude certain items, the Complaints Panel agrees that all costs incurred to assist in the stabilization or to prevent further deterioration of a medical condition should be included as part of the medical expenses.

投訴委員會的意見

醫療費用一般包括醫療服務、治療、藥物、器材、儀器等廣泛費用，除非相關詞彙的定義於保單內已清楚界定或保單的不受保事項條款已明確豁免承保某些項目，否則，委員會同意所有協助穩定傷勢或防止情況惡化的費用，應被視為醫療費用的一部分。

Case 7 個案

Essence of Complaint: Terrorist Attack
Type of Insurance: Travel

投訴爭議點：恐怖活動
保險類別：旅遊保險

The Complaint

The complainant took out a travel insurance policy for her family trip to Bangkok from 22 to 26 Aug 2015. Due to the bomb explosion which occurred in Bangkok on 17 Aug 2015 and the fact that the Security Bureau of the HKSAR issued a red Outbound Travel Alert for Bangkok the next day, the family finally decided to cancel their trip. As terrorism is one of the insured perils as stated under the "cancellation of trip" benefit of the travel policy, the complainant filed a claim to the insurer for the irrecoverable air tickets fares and the hotel cancellation fee.

The insurer considered that the bomb attack was not defined as "terrorist attack" under the policy. As the cause of the family's trip cancellation did not fall within other insured perils as specified under the policy, the insurer declined the claim.

投訴內容

投訴人一家原定於2015年8月22日至26日前往曼谷旅行，並向保險公司購買旅遊保險。然而，曼谷於2015年8月17日發生炸彈爆炸，而香港特區政府保安局亦於翌日向曼谷發出紅色外遊警示級別，投訴人一家最後決定取消有關旅程。由於恐怖活動屬保單內旅程取消保障的其中一個受保風險，投訴人就未獲退回的機票費及取消酒店的手續費向保險公司提出索償。

保險公司認為有關炸彈爆炸不符合保單內「恐怖襲擊」的定義，由於投訴人一家取消旅程的原因並非因保單內的其他指定風險所導致，保險公司因此拒絕賠償。

Findings of the Complaints Panel

It is stipulated in the policy provisions that "Terrorism" shall mean "an act of terrorism includes any act, preparation or threat of action including the intention to influence any government de jure or de facto of any nation or any political division thereof and/or to intimidate the public or any section of the public of any nation, of any person or group(s) of persons whether acting alone or on behalf of or in connection with any organization(s) or government(s) de jure or de facto committed for political, religious, ideological, or similar purposes, and which (i) involves violence against one or more persons; or (ii) involves damage to property; or (iii) endangers life other than that of the person committing the action; or (iv) creates a risk to the health or safety of the public or a section of the public; or (v) is designed to interfere with or disrupt an electronic system".

The Complaints Panel noted that the government of Thailand did not announce the bomb attack incident as a "terrorist attack" and there was no individual or group claiming responsibility for this particular incident. Given that the cause of the incident was still unknown, the Complaints Panel agreed that the bomb incident in Bangkok on 17 Aug 2015 should not be regarded as a "terrorism".

投訴委員會的調查結果

有關保單訂明:「恐怖活動包括任何人或團體為達到政治、宗教、思想或同類目的作出的行動、策劃或威脅活動，包括意圖影響任何國家法律上或實際上的政府或其政府部門，及／或威脅任何國家的公眾或部分公眾，不論是獨自行動或代表或聯同任何組織或法律上或實際上的政府亦然。『恐怖活動』包括：(i)涉及以暴力對待一人或多人；或(ii)涉及財物損毀；或(iii)危害生命但不包括執行行動的人；或(iv)對公眾或部分公眾的健康或安全製造風險；或(v)設計用作干擾或破壞某電子系統」。

投訴委員會留意到，泰國政府沒有宣布炸彈爆炸事件為「恐怖襲擊」，且未有任何人或組織對有關事件承認責任。鑑於導致爆炸事件的原因仍未明確，委員會同意於2015年8月17日在曼谷發生的炸彈爆炸事件不應被視為「恐怖襲擊」。

Ruling of the Complaints Panel

Since the trip cancellation was not caused by any one of the specific insured perils as listed in the policy, the Complaints Panel endorsed the insurer's decision in declining the complainant's claim for around HK$11,400, being the irrecoverable air tickets fares and the hotel cancellation fee.

投訴委員會的裁決

鑑於有關旅程取消並非由保單內列明的任何一項受保風險所導致，投訴委員會遂贊同保險公司拒絕賠償投訴人未獲退回的機票費及取消酒店的手續費的決定合理，涉及金額約11,400港元。

Message from the Complaints Panel

All insurance contracts contain an insuring clause which specifies the types, nature and circumstances of loss covered by the policy. The definitions of those terms with specific meanings are usually listed out therein. If an incident is not caused by a specified insured peril or if the circumstances leading to a loss do not fulfil the definition of a specific term, the Complaints Panel will tend to support the insurer's decision in declining the claim.

投訴委員會的意見

所有保險合約均清楚列明承保條款，詳細交待合約將承保的損失類別、性質及情況，而具特別含義的詞彙一般會在保單的定義部分清楚列出，並闡明含義。假如某宗意外事故並非因指定的受保風險導致，又或引致損失的情況並不符合保單內指明的定義要求，投訴委員會傾向支持保險公司拒絕賠償的決定。

Case 8 個案

Essence of Complaint: Congenital Condition (cavernous haemangioma)
Type of Insurance: Hospitalization

投訴爭議點：先天性疾病（海綿狀血管瘤）
保險類別：住院保險

The Complaint

A 19-year-old boy experienced tonic clonic seizure for a few minutes and was diagnosed as suffering from cavernous haemangioma by magnetic resonance imaging of brain. He was admitted to a private hospital for craniotomy to remove the brain tumour. The insurer considered that the insured's diagnosis was a congenital condition since such view was generally supported by most medical literatures. As the policy does not cover congenital condition, the insurer declined the hospitalization claim.

投訴內容

一名19歲青年因強直陣攣發作持續數分鐘，接受腦部磁力共振掃描，被確診患上海綿狀血管瘤，他其後在私家醫院接受開腦切除腦腫瘤手術。由於大部分醫療文獻普遍支持海綿狀血管瘤屬先天性情況，保險公司因此認為受保人的診斷屬先天性；鑑於保單並不承保先天性疾病，保險公司遂拒絕有關住院索償申請。

Findings of the Complaints Panel

It is stipulated in the policy provisions of the hospitalization policy that "congenital conditions" shall mean "any medical, physical or mental abnormalities existed at the time of birth, whether or not being manifested, diagnosed or known about at birth or any neo-natal abnormalities developed within six months of birth".

The Complaints Panel noted that the attending physician confirmed that the insured's condition was not due to or associated with congenital condition since most cavernous haemangioma are not found at birth and the lesions are usually developed in the first few years after birth.

On the other hand, the Complaints Panel also learnt from some available medical literatures that "most cases of cavernous are congenital, however, they can develop over the course of a lifetime……" and "not all cavernomas are present at birth and in some cases they develop where the pressure where the brain has been subjected to high pressure within the veins over prolonged periods of time".

Based on the above, the Complaints Panel was not convinced that there was concrete and sufficient medical evidence to prove that the insured's cavernous haemangioma or its symptoms had existed at birth or developed within six months after birth. The Complaints Panel believed that the burden was on the insurer to adduce evidence to the contrary. The Complaints Panel then relayed the message to the insurer and requested it to seek further clarification with the insured's attending physician. The insurer duly reconsidered the case and subsequently agreed to settle the claim.

投訴委員會的調查結果

有關住院醫療保障的條款訂明：「先天性疾患」指「任何於出生時已存在的醫學、身體或精神異常，不論該異常是否於出生時已出現、確診或獲知悉，或任何於出生後六個月內出現的新生嬰兒異常」。

投訴委員會留意到主診醫生的意見，指受保人的情況並非由先天性疾病導致或與先天性疾病相關，理由是大多數的海綿狀血管瘤不會在出生時出現，它們通常於出生後數年才形成。

另一方面，委員會亦從一些現有的醫療文獻中得悉：「大多數的海綿狀血管瘤屬先天性，然而，它們亦可以在人一生的成長過程中形成……」及「不是所有海綿狀血管瘤在出生時已存在，有些個案顯示它們是因腦部靜脈長時期承受高壓力而引致」。

據上述，投訴委員會並不相信現時有具體及足夠的醫療證據，證明受保人的海綿狀血管瘤及其病徵在他出生時已存在或在他出生後六個月內形成，並認為保險公司有責任提出相反的證據。投訴委員會向保險公司傳達有關訊息，並要求保險公司向主診醫生進一步釐清受保人的病況。保險公司重新考慮後，最終同意作出賠償。

Ruling of the Complaints Panel

The Complaints Panel welcomed the insurer's revised decision to settle the hospitalization claim, amounting to around HK$75,000.

投訴委員會的裁決

投訴委員會歡迎保險公司就個案作出住院賠償的決定，涉及金額約75,000港元。

Message from the Complaints Panel

Most hospitalization policies contain exclusion clauses to exclude losses directly or indirectly due to congenital conditions. In deciding whether or not a condition is congenital in nature, the Complaints Panel, other than referring to common medical literatures or references, would rely very often on the opinions given by the attending doctors.

投訴委員會的意見

大部分住院保單均載有豁免條款，豁免保障因先天性疾病直接或間接引致的損失。在判斷某項病狀是否屬於先天性時，投訴委員會除了參考一般醫療文獻或參考資料外，很多時亦會倚重主診醫生的意見。

Case 9 個案

Essence of Complaint: Pre-existing Condition
(medical condition known to exist at the time of policy application)
Type of Insurance: Travel

投訴爭議點：已存在的情況（投保前已知悉的病況）
保險類別：旅遊保險

The Complaint

The insured joined a four-day tour of Taiwan with her relatives. Three days prior to the trip commencement, the insured's grandfather (Mr Chan) was admitted to a public hospital at 9:20pm due to pneumothorax. He received surgery for right pneumothorax and stayed in hospital for over one month. The insured cancelled her trip to Taiwan to look after him.

The insured's aunt enrolled the travel insurance policy online for all family members at 9:01pm on the day Mr Chan was admitted to hospital. In view of the short time gap between Mr Chan's admission and the policy enrollment, the insurer considered that her aunt should have known of the medical condition of Mr Chan at the time of policy application. It therefore declined the insured's claim for trip cancellation benefit on the grounds of pre-existing condition.

投訴內容

受保人與親戚參加四天台灣旅行團，在旅程出發前三天的晚上9時20分，受保人的祖父（陳先生）因爆肺入住公立醫院接受右氣胸手術，並留院一個多月，受保人遂取消前往台灣的旅程，以留港照顧他。

受保人的姑媽於陳先生入院當晚9時01分於網上替所有家庭成員購買旅遊保險。鑑於陳先生的入院時間與保單的投保時間接近，保險公司認為受保人的姑媽於投保時應該已知悉陳先生的病況，因此以投保前已存在的疾病為理由，拒絕受保人就旅程取消而提出的索償申請。

Findings of the Complaints Panel

It is stipulated in the "Cancellation" provisions of the travel insurance policy that "the insurer shall pay……for each insured person as a result of loss or irrecoverable deposits or charges paid in advance or contracted to be paid……in the event of necessary and unavoidable cancellation of each planned journey by the insured person arising from death, sickness or serious accident or like event occurring to the insured person or his spouse, parent, parent-in-law, grandparent…… after the policy has been effected". There is also an exclusion stating the "the insurer shall not be liable for any claims arising directly or indirectly from, in respect of or due to medical condition or circumstances known to exist on or before the date of application for the insurance".

The insured alleged that both her aunt and she were not aware of Mr Chan's medical condition at the time of policy enrollment since they were not living with him. Furthermore, as pneumothorax is an acute medical condition, it should not be regarded as a pre-existing condition.

Having duly reviewed all the available information, the Complaints Panel was not convinced that there was concrete and strong evidence to fully support the insurer's inference that the insured or her aunt should have known of Mr Chan's medical condition at the time the policy were applied online.

投訴委員會的調查結果

有關旅遊保單內「取消旅程」保障的條款訂明：「保險公司將……賠償每名受保人在保單生效後，因受保人或其配偶、父母、姻親、祖父母……因身故、疾病或嚴重身體受傷或類似事故而必須及無可避免地取消計劃旅程，以致損失已預繳或承諾支付而不可退回的訂金或相關旅程費用……」。此外，一般除外責任條款亦訂明：「保險公司不會賠償予直接或間接因任何在申請本保單前已存在的疾病或身體缺陷而引致的任何索償」。

受保人聲稱她和她的姑媽於投保時均不知道陳先生的病況，原因是他們並非與陳先生同住；加上爆肺是緊急的醫療情況，故不應被視為保單前已存在的疾病。

投訴委員會仔細審視所有的資料後，並不認為現時有具體及實質的證據，充分支持保險公司認為受保人或她的姑媽於網上投保時已知悉陳先生病況的推斷。

Ruling of the Complaints Panel

The Complaints Panel ruled in favour of the insured and resolved that the insurer should pay her the unrecoverable tour fee, amounting to nearly HK$5,000.

投訴委員會的裁決

投訴委員會裁定受保人得直，保險公司需支付她不獲退回大約5,000港元的團費。

Message from the Complaints Panel

In handling disputes involving the "pre-existing conditions" exclusion, the Complaints Panel usually takes into account whether or not there is concrete and sufficient evidence to prove that the medical condition is known to exist by the applicant at the time of policy application.

投訴委員會的意見

在處理涉及「保單前已存在的疾病」條款的個案，投訴委員會會考慮是否有具體及充足的證據，證明申請人在投保時已知悉有關醫療情況已存在。

Case 10 個案

Essence of Complaint: Pre-existing Condition
(symptoms and diagnosis existed prior to policy application)

Type of Insurance: Hospitalization

投訴爭議點：已存在的情況（投保前的症狀和診斷）

保險類別：住院保險

The Complaint

A man consulted a specialist in Otorhinolaryngology for symptoms of nasal discharge and obstruction. Two weeks after the consultation, he was admitted to a private hospital for functional endoscopic sinus surgery with turbinoplasty. The final diagnoses were sinusitis and turbinate hypertrophy.

The insurer noted from the various medical documents issued by the hospital that the insured had sinusitis for seven to eight years. From the medical report of the insured's family doctor, it was known that the insured had consulted for nasal congestion and rhinitis eight months before the policy was issued. He was referred to see an ear, nose and throat (ENT) specialist for further assessment. He was diagnosed as suffering from turbinate hypertrophy and septal deviation at that ENT consultation.

Given that the symptoms of the insured's sinusitis and turbinate hypertrophy had existed prior to the policy effective date, the insurer rejected the hospitalization claim in accordance with the pre-existing exclusion clause of the policy.

The ENT specialist later clarified that although the insured had nasal discharge and obstruction in the consultation, he only suffered from rhinitis (an acute illness) which was different from his current suffering of sinusitis which required surgical intervention. Given that the insured had presented symptoms of nasal congestion which warranted the referral to an ENT specialist for assessment prior to the policy effective date and that the diagnosis of turbinate hypertrophy at that time was related to his current operation, the insurer maintained its previous decision to decline the claim.

投訴內容

一名男士因鼻分泌及鼻塞向耳鼻咽喉專科醫生求診，兩星期後入住私家醫院接受功能性內窺鏡鼻竇手術及鼻甲成形術，最終診斷為鼻竇炎及鼻甲肥大。

保險公司從醫院發出的多份醫療文件中得悉，受保人患有鼻竇炎七至八年；而保險公司亦從受保人的家庭醫生發出的醫療報告得知，受保人於保單繕發前八個月曾因鼻塞和鼻炎求診，被轉介至耳鼻咽喉專科作進一步評估，而受保人亦於該專科應診中被確診患上鼻甲肥大和鼻中隔偏曲。

由於受保人的鼻竇炎和鼻甲肥大的病徵於保單生效日前已存在，保險公司遂根據投保前已存在疾病的不保事項條款，拒絕有關住院索償申請。

該耳鼻咽喉專科醫生其後澄清，雖然受保人於應診時有鼻分泌及鼻塞的病況，惟他只是患上鼻炎（屬急性疾病），與現時需要以手術介入治療的鼻竇炎不相同。然而，由於受保人於保單生效前已呈現鼻塞的病徵，並獲轉介至耳鼻咽喉專科接受評估，加上當時被確診的鼻甲肥大與他現時的手術有一定的關係，保險公司維持不予賠償的決定。

Findings of the Complaints Panel

It is stipulated in the exclusions of the medical policy that "the insurer will not pay if……the life assured's injury or illness (or signs and symptoms of which) existed before the effective date of the plan……"

Having duly considered all available information, the Complaints Panel found that there was solid medical evidence to conclude that the insured's sinusitis and turbinate hypertrophy had existed prior to the policy effective date.

投訴委員會的調查結果

有關住院醫療保障的不受保障條款訂明：「保險公司將不會就於本計劃生效日期前……受保人已存在的受傷或疾病（或其徵狀及病徵）作出賠償」。

經仔細考慮所有現有資料，投訴委員會發現現時有具體的醫療證據，證明受保人的鼻竇炎及鼻甲肥大於保單生效日前已存在。

Ruling of the Complaints Panel

The Complaints Panel endorsed the insurer's decision in declining the insured's hospitalization claim for around HK$99,300 based on the "pre-existing condition" exclusion.

投訴委員會的裁決

投訴委員會支持保險公司以投保前已存在疾病的不保事項條款，拒絕賠付受保人住院索償的決定，涉及金額約99,300港元。

Message from the Complaints Panel

"Pre-existing conditions" are commonly found in hospitalization policies to exclude injuries or sicknesses which occur, exist, originate or present signs or symptoms prior to 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 or existed earlier than the policy effective date, or whether there exists any sign or symptom of the illness before the policy is effected.

投訴委員會的意見

大部分的住院保單均載有「投保前已存在疾病」條款，豁免保障於保單生效前已發生、存在、引起、顯現的病徵或症狀。在審理這些個案時，投訴委員會非常重視是否有充分的證據，證明有關傷患或病症在保單生效前已經出現或存在，或病症的病徵或症狀是否在保單生效前已經顯現。

Case 11 個案

Essence of Complaint: Evidence to prove a non-disclosure
Type of Insurance: Hospitalization

投訴爭議點：沒有披露事實的證據
保險類別：住院保險

The Complaint

The insured was admitted to a private hospital for magnetic resonance imaging of brain and neck vessels, laboratory tests, ultrasound, x-ray, etc. He also sought consultation from a neurologist specialist during confinement. The final diagnoses were dizziness, suspected benign paroxysmal positional vertigo, brain vessel atherosclerosis, diabetic mellitus and hyperlipidaemia.

During claims investigation, the insurer found that the insured had attended the Accidental and Emergency (A&E) department of a public hospital 11 months prior to the policy application. He attended for left lower leg contusion injury at a construction site by metal bar. His blood pressure reading recorded during triage was a bit higher than normal and the attendance record stated that he had a past health history of asthma. However, the insured left the A&E department without receiving any treatment. Since the insured had failed to disclose the aforesaid medical information at the time of policy application, the insurer declined his hospitalization claim on the grounds of material non-disclosure.

投訴內容

受保人入住私家醫院接受腦部及頸部血管磁力共振掃描、化驗檢查、超聲波、X光等，並於住院期間向神經科專科醫生求診，最終被診斷患上暈眩、懷疑良性陣發位置性眩暈、腦部血管動脈粥樣硬化、糖尿病和高脂血症。

保險公司於調查索償期間，發現受保人於投保前11個月曾因在地盤工作時被鐵條撞傷左下腿，向公立醫院急症室求診，於急症室分流時，他的血壓讀數較正常指標稍高，而應診紀錄顯示他有哮喘的病史，然而，受保人沒有接受任何治療便離開急症室。鑑於受保人於投保時沒有披露上述病歷資料，保險公司遂以受保人沒有披露重要事實為理由，拒絕其住院索償。

Findings of the Complaints Panel

The insured denied having any past history of hypertension or asthma. The Complaints Panel noted that the ground for the insurer to decline the claim was mainly based on an attendance record of the A&E department of the public hospital the insured had attended. However, there was no concrete evidence to prove that he had suffered from hypertension or asthma and/or received related consultation or treatment before the policy application. Under such circumstances, the Complaints Panel was not convinced that the insurer's decision to decline the claim for material non-disclosure was strong and valid.

投訴委員會的調查結果

受保人否認有任何高血壓或哮喘的病史，投訴委員會留意到保險公司拒絕賠償的理由，主要是基於受保人在公立醫院急症室的應診紀錄。由於現時未有具體證據證明受保人於投保前確實患有高血壓或哮喘及／或接受相關的會診或治療，投訴委員會因此並不認為保險公司以沒有披露重要事實而拒賠的理由合理有力。

Ruling of the Complaints Panel

The Complaints Panel ruled in favour of the insured and awarded him the hospitalization claim of about HK$13,000.

投訴委員會的裁決

投訴委員會裁定受保人得直，保險公司需向他發放約13,000港元的住院賠償。

Message from the Complaints Panel

In dealing with non-disclosure disputes, the Complaints Panel focuses mainly 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 fixing the premium or terms and conditions of the contract;
2. a fact within the knowledge of the applicant; and
3. a fact which the applicant could reasonably be expected to disclose.

If there is no concrete and objective evidence to prove that the insured has actually suffered from a particular medical condition before policy application, the Complaints Panel believes that it would be unseemly for the insurer to base on that medical condition to decline a claim on the grounds of material non-disclosure.

投訴委員會的意見

於審議涉及沒有披露事實的糾紛時，投訴委員會會集中考慮下列各點：

1. 沒有披露的資料是否重要事實，足以影響審慎的承保商決定應該接受或拒絕承保，或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。

如果沒有具體和客觀的證據，證明受保人於投保前的而且確患有某種疾病，投訴委員會則認為保險公司基於該項病況，以沒有披露重要事實為理由拒絕賠償並不合理。

Case 12 個案

Essence of Complaint: Disclosure obligation (benefit upgrade vs new plan)
Type of Insurance: Hospitalization

投訴爭議點：披露病歷的責任（保障升級／新計劃）
保險類別：住院保險

The Complaint

The complainant declared clean health history including a checkup done two years ago with normal results in the application form. His hospitalization policy was then issued with standard terms. Seven months after the policy was effected, the complainant was admitted to a private hospital for transurethral ultrasound guided biopsy of prostate. The final diagnosis was elevated prostate specific antigen (PSA). He was later confirmed by an urologist as suffering from prostate cancer. He subsequently submitted a hospitalization claim to the insurer for the remaining hospital expenses not yet settled by his group medical policy.

During claims review, the insurer discovered from a medical report that the complainant had elevated PSA levels in the two check-ups done approximately three years prior to the policy application. Special referral was given to him for further diagnostic workup. Since the aforesaid information was not disclosed in the policy application form, the insurer declined the hospitalization claim on the grounds of material non-disclosure.

投訴內容

投訴人於投保申請書上申報健康病歷，包括兩年前身體檢查結果正常，保險公司遂以標準條款繕發有關住院保單。投訴人於保單生效七個月後，入住私家醫院接受經尿道超聲波引導活檢前列腺檢查，最終診斷為前列腺特異抗原水平偏高，其後被泌尿科專科醫生確診患上前列腺癌。投訴人隨後就其團體醫療保險未能作出賠償的住院費用，向保險公司提出索償申請。

保險公司於審核索償期間，從醫療報告發現投訴人約於投保三年前接受了兩次身體檢查，有關結果均顯示他的前列腺特異抗原水平偏高，並獲轉介接受進一步診斷。由於投訴人沒有把上述資料於投保申請書上申報，保險公司遂以沒有披露重要事實為理由，拒絕他的住院索償。

Findings of the Complaints Panel

Having duly considered the available information, the Complaints Panel agreed that the complainant's elevated PSA history was material which would have affected the insurer's underwriting decision. It therefore concurred with the insurer's decision in declining the hospitalization claim for material non-disclosure.

However, the Complaints Panel noted that the complainant's old hospitalization benefit, which had been effected for over 20 years with the same insurer, was deleted after the existing hospitalization policy was issued notwithstanding the fact the complainant believed that the purchase of the new hospitalization policy was merely a benefit upgrade.

投訴委員會的調查結果

投訴委員會仔細考慮現有資料後，同意投訴人的前列腺特異抗原水平偏高乃屬重要事實，對保險公司的核保決定有重要影響，因此贊同保險公司以沒有披露重要事實為理由拒絕賠償的決定。

然而，投訴委員會留意到投訴人於同一家保險公司的舊住院保障已生效超過20年，當新的住院保單繕發後，投訴人便取消了舊住院保障，原因是他以為新購的住院保單，乃是舊住院保障的升級版。

Ruling of the Complaints Panel

Given that the current hospitalization claim would probably be eligible under the complainant's old hospitalization benefit if it had not been replaced and that there was no time gap in the coverage, the Complaints Panel believed that there were extenuating circumstances in this case that would merit the insurer to consider, on the basis of goodwill, the granting of an *ex-gratia* payment to the complainant. The insurer accepted the views of the Complaints Panel and agreed to settle the claim at HK$42,400 on a one-time *ex-gratia* basis.

投訴委員會的裁決

如果投訴人的舊住院保障沒有被新的保單取代，是次住院索償應該亦會符合資格在舊住院保障中獲得賠償。由於投訴人的住院保障從未間斷，投訴委員會因此認為此個案案情特殊，保險公司值得考慮基於商譽理由而向投訴人作出通融賠償；保險公司接納投訴委員會的建議，同意酌情作出一次性賠償，涉及金額42,400港元。

Message from the Complaints Panel

Insurers often introduce from time to time new or advanced hospitalization plans with better and comprehensive benefits. Depending on circumstances, the purchase of the new plan may either be considered as a benefit upgrade or a new policy application. In any case, the Complaints Panel urges the policyholders to pay special attention to the disclosure obligation and make full and proper disclosure of past medical history as required whenever they are switching or upgrading their existing hospital plans to new ones.

投訴委員會的意見

保險公司不時推出更優越及全面的新住院計劃，因應不同情況，購買新住院計劃可以是舊保障的升級或是全新保單的申請。投訴委員會敦促保單持有人，每當轉換或提升現有住院保障至新住院計劃時，必須特別留意披露病歷的責任，並根據指示向保險公司完全及準確地披露過去的病歷資料。

Case 13 個案

Essence of Complaint: Information affecting underwriting decision
Type of Insurance: Critical Illness

投訴爭議點：影響承保決定的病歷資料
保險類別：危疾保險

The Complaint

A woman applied for a life policy with critical illness benefit. She declared clean health history in the application form. The insurer then issued the policy with standard terms. Three months later, the insured was admitted to a private hospital for chest x-ray, ultrasound, mammography, trucut biopsy of left breast mass. The final diagnosis was carcinoma of left breast. The insured then attended a hospital in China for further investigation and chemotherapy treatments. She later submitted a critical illness claim to the insurer for cancer.

Upon claims assessment, the insurer learnt that the insured had a health check up at the same hospital in China four days prior to the date of policy application with abnormal findings. Given that the insured did not disclose her abnormal checkup findings in the policy application form and that such information was material to its underwriting decision, the insurer declined the insured's critical illness claim on the grounds of material non-disclosure.

投訴內容

一名女士投購人壽保險附加危疾保障，在投保申請書上申報健康病歷，保險公司遂以標準條款繕發保單。三個月後，受保人入住私家醫院接受胸部X光、超聲波、乳房X光造影和左乳腫塊組織穿刺檢查，最終被確診患上左乳乳癌。她隨後往國內醫院接受進一步檢查及化療，及後向保險公司提交癌症危疾保障索償。

保險公司於評核索償期間，得悉受保人在投保四天前曾於國內同一醫院接受身體檢查，結果呈現異常。鑑於受保人並沒有在投保申請書上披露該異常的身體檢查結果，而有關資料對核保決定非常重要，保險公司因此拒絕受保人的危疾索償，原因是她沒有披露重要事實。

Findings of the Complaints Panel

From the health checkup report, the Complaints Panel noted that the insured had abnormal findings, including haematuria and evaluated cholesterol levels. However, she did not disclose such medical information in the application form and answered "no" when being asked if she had undergone or been advised to undergo diagnostic test such as X-ray, CT scan, MRI, ultrasound, mammogram, ECG, biopsy or blood test (including but not limited to cholesterol, hepatitis, hepatitis carrier status, anaemia, AIDS) or any other investigation of the body in the past five years.

The Complaints Panel agreed that the insured's abnormal findings revealed during the health checkup in China four days prior to the date of policy application were material which would have prejudiced the insurer from making a fair and accurate underwriting assessment at the time of policy application.

投訴委員會的調查結果

投訴委員會從受保人的身體檢查報告得悉，受保人的檢查結果異常，包括：血尿及多項膽固醇指數偏高，惟她卻沒有於投保申請書上披露相關病歷資料，當被問及曾否在過去五年內接受或被建議接受如X光、電腦掃描、磁力共振、超聲波、乳房X光造影、心電圖、活體檢驗或血液檢驗（包括但不限於膽固醇、肝炎、肝炎帶菌、貧血、愛滋病）等診斷性測試或任何身體檢查時，她回答「否」。

投訴委員會同意受保人於投保四天前在內地接受身體檢查及結果異常乃屬重要事實，會影響保險公司在處理保單申請時，作出公平及準確的承保決定。

Ruling of the Complaints Panel

The Complaints Panel supported the insurer's decision in rejecting the critical illness claim of HK$350,000 for material non-disclosure.

投訴委員會的裁決

投訴委員會贊同保險公司以受保人沒有披露重要事實為理由，拒絕其危疾賠償申請，涉及金額350,000港元。

Message from the Complaints Panel

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. Insurers, on the other hand, are not aware of these facts unless the insured tells them. The insured, therefore, is always obliged to tell the whole truth.

If the information provided in the application form is inaccurate, the insurer will have the right to decline claim payment even if the non-disclosed information is not related to the current illness. This is because the non-disclosure has prejudiced the insurer from making a fair and accurate underwriting assessment. In order to avoid unnecessary claims disputes, the Complaints Panel urges all applicants to disclose information fully and accurately when filling in the application form. If in doubt as to whether a fact is material, it is better to disclose it.

投訴委員會的意見

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，此之謂「最高誠信原則」。投保事項的性質，以及與之相關的各種狀況，均是受保人認知範圍內的事實，除非受保人主動相告，否則，保險公司不會知道。因此，保單持有人有責任交代所有事實。

即使沒有披露的資料與索償的病症沒有關係，假如投保申請書上提供的資料不盡準確，保險公司也有權拒絕作出賠償，因為沒有披露的事實令保險公司無法作出公平及準確的核保決定。為免引起不必要的索償糾紛，投訴委員會敦促所有申請人在填寫投保申請書時，必須如實披露所有資料，即使不確定某些事實是否重要，最好還是加以披露。

Case 14 個案

Essence of Complaint: Pre-accident Value of Insured Vehicle
Type of Insurance: Motor

投訴爭議點：受保車輛發生意外前的價值
保險類別：汽車保險

The Complaint

A man took out a motor comprehensive policy for his car with an estimated value at HK$170,000. He used to park his car in a public area in front of his home in a village in Fanling. One morning, when he went to get his car, he found the car disappeared from its usual parking area. He then reported the loss to the police and subsequently submitted a claim to the insurer for vehicle loss.

The insurer appointed two motor surveyors to estimate the pre-accident market value of the insured vehicle. One motor surveyor advised that the value of the insured vehicle was in the range of HK$110,000 to HK$120,000 while the other indicated that the value was approximately HK$120,000. The insurer then offered HK$115,000 (before deducting theft loss excess) to the insured for total loss compensation of the insured vehicle.

The insured disagreed with the offer. He submitted a vehicle valuation from his own motor surveyor which indicated that the pre-accident market value of the insured vehicle was HK$165,000. He also provided information searched from the Internet to show that the selling price of vehicles of the same model as the insured vehicle ranged from HK$148,000 to HK$188,000. The insurer later revised its offer to HK$120,000, but was not accepted by the insured.

投訴內容

一位男士為他的私家車投購汽車全險保單，投保額為170,000港元。他通常把私家車停泊在粉嶺住所的村屋前的公眾地方，一天早上，他前往取車，卻找不到他的私家車，於是向警方報案，並向保險公司提出汽車全險索償。

保險公司委託兩家汽車公證行評估受保汽車於意外發生前的價值，一家汽車公證行表示受保汽車的價值應介乎110,000港元至120,000港元之間，而另一家則指出受保汽車的價值約為120,000港元。保險公司於是向受保人建議賠償115,000港元（於扣除偷竊墊底費前），作為受保汽車全損的賠償。

受保人不同意保險公司的賠償建議，並提交由他自行委託的汽車公證行的評估報告，內容指受保汽車於意外發生前的價值為165,000港元。此外，他又提供從互聯網搜集的資料，顯示與受保汽車相同型號的車輛售價介乎148,000港元至188,000港元之間。保險公司其後增加賠償至120,000港元，惟仍不獲受保人接受。

Findings of the Complaints Panel

The Complaints Panel noted that the estimated pre-accident market value of the insured vehicle varied significantly among the motor surveyors appointed by the insurer and the insured. Having duly considered the fact that the insured purchased the insured vehicle at HK$180,000 eight months before the loss and the selling price of vehicles of the same model as the insured vehicle at the material time, the Complaints Panel concluded that the insurer's final offer of HK$120,000 was at the low end which might not be sufficient for the insured to purchase a replacement of the same model from the second hand market at the time of loss. The Complaints Panel therefore recommended the insurer to reasonably increase its final offer. The insurer accepted the Complaint Panel's recommendation and increased its final offer to HK$142,500.

投訴委員會的調查結果

投訴委員會留意到，保險公司和受保人委託的汽車公證行就受保汽車於意外發生前的估價有很大差距。投訴委員會得悉受保人於事發八個月前以180,000港元購入受保汽車，加上考慮到事發時與受保汽車同款的車輛的售價後，認為保險公司最終的120,000港元賠償建議略低，或許未能足夠讓受保人於事發時在二手市場購入與受保汽車同款的車輛，遂建議保險公司合理地提高最終賠償額。保險公司接受投訴委員會的建議，提高最終賠償額至142,500港元。

Ruling of the Complaints Panel

The Complaints Panel considered the insurer's final offer reasonable and acceptable since it had already exceeded the average of the highest and the lowest estimated values as quoted by the motor surveyors.

投訴委員會的裁決

由於保險公司的最終賠償建議，已超出了不同汽車公證行為受保汽車作評估的最高和最低估價的平均值，投訴委員會因此認為有關賠償建議合理及可接受。

Message from the Complaints Panel

In handling disputes relating to the settlement amount offered for total loss compensation of insured vehicles, the Complaints Panel would consider the reasonableness of the insurer's offer. The valuation reports of motor surveyors would also carry great weight.

投訴委員會的意見

於審議涉及汽車全損補償金額的糾紛時，投訴委員會會考慮保險公司的賠償建議是否合理，亦會十分倚重汽車公證行的估價報告。

Case 15 個案

Essence of Complaint: Reasonable and Customary Charges
Type of Insurance: Hospitalization

投訴爭議點：合理及慣常收費
保險類別：住院保險

The Complaint

The insured was diagnosed as suffering from bilateral thyroid nodules by fine needle aspiration examination. She was recommended for surgery of "bilateral thyroidectomy, neck gland biopsy and resection". The estimated surgeon fee was HK$180,000. The insurer considered that the surgeon fee charged by the insured's doctor was much higher than its reasonable and customary (R&C) range for the said surgery. It therefore approved only HKD125,125 as a guarantee of payment (GOP) for the surgeon fee. It was also stated in the GOP that the insured would have to pay the balance if the final bill had exceeded the approved limit.

The final surgeon fee charged by the insured's attending doctor was HK$180,000. The insurer then settled the surgeon fee at HK$125,125 according to the terms as stated in the GOP and requested the insured to settle a shortfall of HK$54,875, being the difference for the surgeon fee.

投訴內容

受保人於接受細針抽取細胞檢查後，被確診患上雙側甲狀腺結節，並被建議接受「雙側甲狀腺切除手術、頸腺活檢及切除」，預計醫生手術費為180,000港元。保險公司認為該醫生收取的手術費遠高於此手術的合理及慣常收費，因此在付款保證信上只批准了125,125港元的手術費；而付款保證信亦訂明，如受保人的最終醫療費用超出獲批准金額，受保人便需負責支付有關差額。

受保人的主診醫生最後收取了180,000港元的手術費，保險公司遂按照付款保證信訂明的條款支付手術費，並要求受保人繳付54,875港元的手術費差額。

Findings of the Complaints Panel

According to the policy provisions of the medical policy, "the insurer will pay the insurance benefits……as follows: all costs incurred must be medically necessary and subject to reasonable and customary charges…." while "reasonable and customary charges" shall mean "the average amount charged in respect of valid services or treatment costs, as determined by the insurer's experience in any particular country, area or region and substantiated by an independent third party, being a practicing surgeon/ physician/specialist or government health department".

The Complaints Panel noted that the insurer's estimation on the R&C charges was based on its own internal claims experience and references from other private hospitals, including the one the insured stayed for her surgery, for similar surgeries. Since the insurer's R&C range for the surgery of "thyroidectomy, total or subtotal for malignancy with limited neck dissection" was HK$100,100, its approved surgeon fee of HK$125,125 had already included a 25% buffer.

Based on the above, the Complaints Panel was convinced that the insurer's final offer was reasonable and in full accordance with the terms in the GOP. Furthermore, the insurer had already informed the insured before the surgery of the fact that the surgeon fee charged by her doctor was higher than its R&C range and had provided her with the approved amount of surgeon fee.

投訴委員會的調查結果

有關醫療保單的條款訂明：「保險公司將會支付以下的保障項目……：所有具醫療需要並符合合理及慣常收費的費用……」而「合理及慣常收費」乃指「關於合資格服務或治療費用的平均合理收費，乃根據保險公司於某國家、地區或區域的經驗而釐定，以及由獨立的第三方包括外科醫生／醫生／專科醫生或政府醫療部門證實」。

投訴委員會得悉，保險公司對合理及慣常收費的評估乃根據其內部索償的經驗及參考其他私家醫院（包括受保人入院接受手術的那所醫院）對同類型手術的收費。保險公司對「甲狀腺切除術，全部或部分針對惡性腫瘤的局部頸淋巴結根除」的合理及慣常收費為100,100港元，故獲批准的125,125港元手術費，已預留了25%的緩衝額。

基於上述理由，投訴委員會認為保險公司的最終賠償方案合理，並完全符合付款保證信內的條款。此外，保險公司於手術前已通知受保人，其主診醫生收取的手術費高於保險公司的合理及慣常收費，並知會了她獲批准的手術費金額。

Ruling of the Complaints Panel

The Complaints Panel supported the insurer's decision to settle the hospital bill according to the terms as stated in the GOP.

投訴委員會的裁決

投訴委員會贊同保險公司根據付款保證信所顯示的條款支付有關醫院賬單。

Message from the Complaints Panel

It is common to have "reasonable and customary charges" clause in hospitalization insurance contracts. Such clause aims to prevent potential abuse of overcharging of medical fees and to control costs for the ultimate benefit of the insuring public.

投訴委員會的意見

醫療保單普遍載有「合理及慣常收費」條款，旨在剔除濫收醫療費用的潛在風險，以及控制成本，從而維護投保大眾的整體利益。

The ICCB always believes that claims disputes can be best resolved by way of conciliation. The existing claims handling procedures provide an opportunity for insurers to settle disputes without having to be referred to the Complaints Panel for adjudication. The referral of cases to the Honorary Secretaries for assessment is an important and critical part of the process. In quite a number of cases, insurers alter their positions after taking due consideration of the opinions of the Honorary Secretaries who are seasoned and experienced insurance professionals.

投訴局一直堅信和解是解決索償糾紛的最佳方法，在目前的投訴機制下，保險公司有機會與投訴人達成和解，毋須投訴委員會介入審理。轉介個案予名譽顧問審理是非常重要及關鍵的步驟，有不少的個案是保險公司考慮了經驗豐富及具專業知識的名譽顧問的意見後而改變初衷，作出賠償。

Case 16 個案

Essence of Complaint: Late submission of claim
Type of Insurance: Hospitalization

投訴爭議點：遲交索償申請
保險類別：住院保險

The Complaint

The complainant was admitted to a private hospital for a series of investigative tests. The final diagnoses were accelerated hypertension, chest and back pain. She settled the hospital bill using her group medical card. The group medical insurer informed her two months later that there was a shortfall of around HK$39,000. The complainant then informed the insurer in writing that she would submit a claim for the shortfall amount when she received the certified true copies of the claim documents from her group insurer. After she got the certified true copies two more months later, she immediately filed her claim to the insurer.

The insurer considered that the complainant did not submit her claim within 60 days after her group medical insurer had settled her claim. It thus rejected the claim on the grounds of late submission.

投訴內容

投訴人入住私家醫院接受一系列的檢查，最終被確診患有急進性高血壓、胸及背部疼痛。投訴人以她的團體醫療保險卡支付醫院賬單，而團體醫療保險公司於兩個月後通知她約有39,000港元的醫療費用未獲賠償，她遂書面通知保險公司，並表示將會於收到團體醫療保險公司的索償文件的核實副本後，就未獲賠償的金額提出索償。當她於兩個多月後收到索償文件的核實副本後，便立即向保險公司遞交索償申請。

然而，保險公司認為投訴人沒有在她的團體醫療保險公司作出賠償後的60天內遞交索償申請，因此拒絕她的索償，理由是她過遲提交索償。

Brief Facts

According to the policy provisions of the hospitalization policy, "all claims must be submitted to the insurer within 60 days after the date of discharge from hospital or the date treatment is received for the disability for which the claim is being made".

The insurer indicated that it did not receive the complainant's written notification of claim. According to the market practice, an insured is required to submit the claims within 60 days from the settlement date of the first insurer.

基本資料

有關住院保單的條款訂明：「所有索償必須於出院或就索償的傷病而接受治療後60天內向保險公司遞交申請」。

保險公司表示沒有收到投訴人的書面索償通知，而根據市場慣例，受保人需於首家保險公司作出賠償後的60天內遞交索償申請。

Comments of the Honorary Secretaries

The case was referred to three Honorary Secretaries and all of them disagreed with the insurer's decision to decline the claim. Two Honorary Secretaries considered that the complainant's case was a genuine case and there was no evidence supporting that the late submission of claim would prejudice the insurer's position in investigating the claim while the remaining one opined that the complainant had given proper notice to the insurer soon after she was informed by her group medical insurer of the shortfall.

名譽顧問的意見

個案轉交三位名譽顧問審理，而三位名譽顧問皆不同意保險公司的拒賠決定。其中兩位名譽顧問認為投訴人的個案真確，且未有證據顯示她遲了遞交索償申請會影響保險公司的調查，而另一位名譽顧問則認為投訴人於收到她的團體醫療保險公司的賠償結果後，已適當地知會了保險公司。

Feedback of the Insurer

Having duly considered the opinions of the Honorary Secretaries, the insurer agreed to pay the shortfall amount to the complainant on a without prejudice basis.

保險公司的回應

經考慮名譽顧問的意見後，保險公司同意於無損權益的情況下，支付投訴人未獲團體醫療保障賠償的餘下費用。

Case 17 個案

Essence of Complaint: Experimental treatment for bilateral knees arthritis
Type of Insurance: Hospitalization

投訴爭議點：雙膝關節炎的試驗性治療
保險類別：住院保險

The Complaint

A 30-year-old man was diagnosed as suffering from bilateral knee arthritis. He was admitted to a private hospital for drainage and injection of Synvisc One to both knees. As part of the medical expenses were settled by his group medical policy, he lodged a claim to the insurer for the remaining medical expenses incurred during hospitalization.

Since Synvisc One injection was considered as an experimental treatment for arthritis, the insurer declined the claim based on a related exclusion clause of the policy.

投訴內容

一名30歲男士被確診患上雙膝關節炎，入住私家醫院接受雙膝引流及善行天然關節液（Synvisc One）注射。由於部分的醫療費用已獲受保人的團體醫療保單賠償，故他就餘下的住院醫療費用向保險公司提出索償。

由於善行天然關節液注射被視為關節炎的試驗性治療，保險公司因此根據保單內相關的不受保障項目條款，不予作出賠償。

Brief Facts

According to the "General Exclusion" provisions of the hospitalization policy, "unless the contract expressly provides to the contrary, the insurer shall not be liable to pay expenses incurred directly or indirectly in connection with and/or for, or in relation to……experimental and/or new medical technology or procedure not yet approved by the insurer".

During the claims assessment, the attending doctor confirmed that the insured had suffered from post-traumatic arthritis. The doctor also indicated that Synvisc One is an injection of hyaluronic acid for knee arthritis as part of the treatment in combination with oral medication and physiotherapy to reduce knee inflammation.

基本資料

住院保單的不受保障項目的條款訂明：「除非合約另有特別註明，否則保險公司將不會負責賠償未經保險公司批准之實驗性及／或最新治療的費用」。

保險公司在評估索償期間，主診醫生確定受保人患上創傷後關節炎，並指出善行天然關節液是透過注射透明質酸作為膝關節炎的一部分治療，並需配合口服藥物及物理治療以減少膝部炎症。

Comments of the Honorary Secretaries

The case was referred to three Honorary Secretaries. Whilst one Honorary Secretary supported the insurer's decision to decline the claim, the other two disagreed and considered that hyaluronic acid has been widely used for viscosupplementation of diseased articular joints and was approved by Food and Drug Administration in the United States. As the insured suffered osteoarthritis, being a form of arthritis resulting from trauma to the joint, they did not think Synvisc One injection was an experimental procedure and hence recommended the insurer to pay the claim.

名譽顧問的意見

此個案轉交三位名譽顧問審理，其中一位名譽顧問支持保險公司不予賠償的決定，而另外兩位卻不同意，認為透明質酸已被廣泛應用，為受損的關節提供黏性補給，並已獲美國食品藥品監督管理局批准作為治療處方。由於受保人患上骨關節炎，屬關節創傷引起的關節炎，因此他們不認為善行天然關節液注射是實驗性治療，並建議保險公司支付賠償。

Feedback of the Insurer

Having duly considered the opinions of the Honorary Secretaries, the insurer was willing to reconsider the case, but the attending doctor requires a fee of HK$4,500 for a report of additional information. As it was the responsibility of the insured to furnish the insurer with all necessary information at his own expense for claim assessment, the insurer reached an agreement with the insured whereby the insurer would pay for the fee in obtaining the medical report on the condition that the fee so incurred would be deducted from the eligible amount payable to the insured if the insurer finally honoured his claim after reviewing the additional information. Otherwise, such fee would be absorbed by the insurer.

Having further considered the additional information from the attending doctor, the insurer finally reversed its previous decision and agreed to settle the claim at HK$15,900 (after deducting the medical report fee of HK$4,500).

保險公司的回應

經考慮名譽顧問的意見後，保險公司願意重新檢視有關個案，惟向主診醫生索取進一步資料需收費4,500港元。由於受保人有責任自費向保險公司提交所有必須資料以作索償審核用途，保險公司因此與受保人達成協議，保險公司將支付索取醫療報告的費用，條件是如保險公司於審核進一步資料後最終作出賠償，則索取相關醫療報告的費用將於賠償金額中扣除，否則，保險公司將承擔有關醫療報告的費用。

經再三考慮主診醫生的進一步資料後，保險公司最後改變初衷，同意向受保人賠償15,900港元（此金額已扣除4,500港元的醫療報告費用）。

Financial Statements

財務報表

Independent auditor's report to the members of The Insurance Claims Complaints Bureau

(Incorporated in Hong Kong and limited by guarantee)

Opinion

We have audited the financial statements of The Insurance Claims Complaints Bureau ("the ICCB") set out on pages 70 to 80, which comprise the statement of financial position as at 31 December 2016, the statement of profit or loss and other comprehensive income, the statement of changes in accumulated surplus and the cash flow statement for the year then ended and notes to the financial statements, including a summary of significant accounting policies.

In our opinion, the financial statements give a true and fair view of the financial position of the ICCB as at 31 December 2016 and of its financial performance and its cash flows for the year then ended in accordance with Hong Kong Financial Reporting Standards ("HKFRSs") issued by the Hong Kong Institute of Certified Public Accountants ("HKICPA") and have been properly prepared in compliance with the Hong Kong Companies Ordinance.

Basis for opinion

We conducted our audit in accordance with Hong Kong Standards on Auditing ("HKSAs") issued by the HKICPA. Our responsibilities under those standards are further described in the *Auditor's responsibilities for the audit of the financial statements* section of our report. We are independent of the ICCB in accordance with the HKICPA's *Code of Ethics for Professional Accountants* ("the Code") and we have fulfilled our other ethical responsibilities in accordance with the Code. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Information other than the financial statements and auditor's report thereon

The members of the General Committee of the ICCB are responsible for the other information. The other information obtained at the date of this auditor's report is the Report of the General Committee, other than the financial statements and our auditor's report thereon.

Our opinion on the financial statements does not cover the other information and we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated.

If, based on the work we have performed on the other information obtained prior to the date of this auditor's report, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Responsibilities of the members of the General Committee for the financial statements

The members of the General Committee are responsible for the preparation of the financial statements that give a true and fair view in accordance with HKFRSs issued by the HKICPA and the Hong Kong Companies Ordinance and for such internal control as the members of the General Committee determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the members of the General Committee are responsible for assessing the ICCB's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the directors either intend to liquidate the ICCB or to cease operations, or have no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. This report is made solely to you, as a body, in accordance with section 405 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.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with HKSAs will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with HKSAs, we exercise professional judgement and maintain professional scepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations or the override of internal control.

- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances but not for the purpose of expressing an opinion on the effectiveness of the ICCB's internal control.

- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the members of the General Committee.

– Conclude on the appropriateness of the members of the General Committee's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the ICCB's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the ICCB to cease to continue as a going concern.

– Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

KPMG
Certified Public Accountants
Honorary Auditors
Hong Kong, 30 March 2017

Statement of financial position as at 31 December 2016

(Expressed in Hong Kong dollars)

	Note	2016	2015
		$	$
Employment of funds			
Assets			
Non-current assets			
Deferred tax assets	5	541	-
Current assets			
Tax recoverable	5	5,673	2,461
Prepayments and other receivable		20,212	20,268
Cash and cash equivalents	4	2,037,572	1,810,836
		2,063,457	1,833,565
Total assets		2,063,998	1,833,565
Funds employed			
Accumulated surplus		590,998	589,465
Liabilities			
Current liabilities			
Accounts payable		192,000	100
Subscriptions received in advance		1,281,000	1,244,000
Total liabilities		1,473,000	1,244,100
Total funds employed and liabilities		2,063,998	1,833,565

The notes on pages 74 to 80 form part of these financial statements.

On behalf of the General Committee

Michael Huddart	Mike Lee
Chairman	Member

Statement of profit or loss and other comprehensive income for the year ended 31 December 2016

(Expressed in Hong Kong dollars)

	Note	2016	2015
		$	$
Income			
Subscriptions	7	2,004,000	1,912,000
Interest income		15	14
		2,004,015	1,912,014
Expenses			
Administration fees charged by the HKFI	7	1,650,000	1,650,000
Printing and stationery		102,520	103,020
Legal and professional fee		192,000	-
Liability insurance		34,500	34,500
Entertainment		5,300	76,991
Web-site fees		5,600	5,600
Sundry expenses		17,359	7,504
		2,007,279	1,877,615
(Deficit)/surplus for the year before taxation		(3,264)	34,399
Income tax recovery	5	4,797	428
Total surplus and comprehensive income		1,533	34,827

The notes on pages 74 to 80 form part of these financial statements.

Statement of changes in accumulated surplus for the year ended 31 December 2016

(Expressed in Hong Kong dollars)

	Note	2016	2015
		$	$
Accumulated surplus as at 1 January		589,465	554,638
Surplus for the year		1,533	34,827
Accumulated surplus as at 31 December		590,998	589,465

The notes on pages 74 to 80 form part of these financial statements.

Cash flow statement for the year ended 31 December 2016

(Expressed in Hong Kong dollars)

	Note	2016 $	2015 $
Cash flows from operating activities			
(Deficit)/surplus for the year before taxation		(3,264)	34,399
Interest income		(15)	(14)
Increase/(decrease) in accounts payable		191,900	(19,480)
Decrease in prepayments and other receivable		56	-
Increase/(decrease) in subscriptions received in advance		37,000	(84,000)
		225,677	(69,095)
Hong Kong profits tax recovered/(paid)		1,044	(9,742)
Net cash inflow generated from/(used in) operating activities		226,721	(78,837)
Cash flows from investing activities			
Interest received		15	14
Net cash inflow generated from investing activities		15	14
Net increase/(decrease) in cash and cash equivalents		226,736	(78,823)
Cash and cash equivalents at beginning of the year		1,810,836	1,889,659
Cash and cash equivalents at end of the year	4	2,037,572	1,810,836

The notes on pages 74 to 80 form part of these financial statements.

Notes to the financial statements

(Expressed in Hong Kong dollars)

1 Legal status

The ICCB is a company incorporated under the Hong Kong Companies Ordinance and is limited by a guarantee of $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. The address of its registered office is 29th floor Sunshine Plaza, 353 Lockhart Road, Wanchai, Hong Kong.

The ICCB's principal activities are to receive complaints relating to claims made in connection with or arising out of Personal Insurance Contracts with any members and to facilitate the satisfaction, settlement or withdrawal of such complaints, disputes or claims.

The financial statements are presented in Hong Kong dollars (HK$), unless otherwise stated. These financial statements have been approved for issue by the General Committee on 30 March 2017.

2 Summary of significant accounting policies

The principal accounting policies adopted in the preparation of these financial statements are set out below. These policies have been consistently applied to all the years presented, unless otherwise stated.

(a) Statement of compliance and basis of preparation

These financial statements of the ICCB have been prepared in accordance with Hong Kong Financial Reporting Standards ("HKFRSs"), which collective term includes all applicable individual Hong Kong Financial Reporting Standards, Hong Kong Accounting Standards ("HKASs") and Interpretations issued by the Hong Kong Institute of Certified Public Accountants ("HKICPA"), accounting principles generally accepted in Hong Kong and the requirements of the Hong Kong Companies Ordinance. A summary of the significant accounting policies adopted by the ICCB is set out below. The financial statements have been prepared under the historical cost convention.

The preparation of financial statements in conformity with HKFRSs requires the use of certain critical accounting estimates. It also requires management to exercise its judgment in the process of applying the ICCB's accounting policies. There is no area involving a higher degree of judgment or complexity, or areas where assumptions and estimates are significant to the financial statements.

The HKICPA has issued certain amendments to HKFRSs that are first effective for the current accounting period of the ICCB. None of these developments have resulted in changes to the ICCB's accounting policies.

The ICCB has not applied any new standards or interpretation that is not effective for the current accounting period (see note 8).

(b) Foreign currency translation

Items included in the financial statements are measured using the currency of the primary economic environment in which the entity operates ("the functional currency"). The financial statements are presented in Hong Kong dollars, which is the ICCB's functional and presentation currency.

(c) Revenue recognition

Revenue is measured at the fair value of the consideration received or receivable. Provided that it is probable that the economic benefits will flow to the ICCB and the revenue and costs, if applicable, can be measured reliably, revenue is recognised in the statement of profit or loss and other comprehensive income as follows:

(i) Subscriptions received and receivable by the ICCB are recognised 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 statement of financial position as subscriptions received in advance.

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

(d) Cash and cash equivalents

Cash and cash equivalents include cash in hand, deposits held at call with banks and other short-term highly liquid investments with original maturities of three months or less.

(e) Income tax

Income tax for the year comprises current tax and movements in deferred tax assets and liabilities. Current tax and movements in deferred tax assets and liabilities are recognised in the statement of profit or loss and other comprehensive income except to the extent that they relate to items recognised in other comprehensive income or directly in equity, in which case the relevant amounts of tax are recognised in other comprehensive income or directly in equity, respectively.

Current tax is the expected tax payable on the taxable income for the year, using tax rates enacted or substantively enacted at the end of the reporting period, and any adjustment to tax payable in respect of previous years.

(f) Related parties

(1) A person, or a close member of that person's family, is related to the ICCB if that person:
   (i) has control or joint control over the ICCB;
   (ii) has significant influence over the ICCB; or
   (iii) is a member of the key management personnel of the ICCB.

(2) An entity is related to the ICCB if any of the following conditions applies:

(i) The entity and the ICCB are members of the same group (which means that each parent, subsidiary and fellow subsidiary is related to the others).

(ii) One entity is an associate or joint venture of the other entity (or an associate or joint venture of a member of a group of which the other entity is a member).

(iii) Both entities are joint ventures of the same third party.

(iv) One entity is a joint venture of a third entity and the other entity is an associate of the third entity.

(v) The entity is a post-employment benefit plan for the benefit of employees of either the ICCB or an entity related to the ICCB.

(vi) The entity is controlled or jointly controlled by a person identified in (1); or

(vii) A person identified in (1)(i) has significant influence over the entity or is a member of the key management personnel of the entity (or of a parent of the entity).

Close members of the family of a person are those family members who may be expected to influence, or be influenced by, that person in their dealings with the entity.

3 Financial risk management

Exposure to credit, liquidity and interest rate risks arises in the normal course of the ICCB's operations.

The ICCB's exposure to these risks and the financial risk management policies and practices used by the ICCB to manage these risks are described below:

(a) Credit risk

The ICCB's credit risk is primarily attributable to cash and cash equivalents. Cash and cash equivalents are deposited with a reputable and creditworthy bank. The ICCB considers there is a minimal risk associated with the deposit balances held by the bank.

The maximum exposure to credit risk is represented by the carrying amount of each financial asset in the statement of financial position.

(b) Liquidity risk

The ICCB's policy is to regularly monitor its liquidity requirements, to ensure that it maintains sufficient reserves of cash to meet its liquidity requirements in the short and longer term.

The following table shows the remaining contractual maturities at the end of the reporting period of the ICCB's financial liabilities, which are based on contractual undiscounted cash flows (including interest payments computed using contractual rates or, if floating based on rates current at the end of the reporting period) and the earliest date the ICCB can be required to pay.

2016

	Contractual undiscounted cash outflow					
	No stated maturity or on demand	1-6 months	6-12months	More than 12 months	Total	Carrying amount at 31 December
Accounts payable	$192,000	$ -	$ -	$ -	$192,000	$192,000

2015

	Contractual undiscounted cash outflow					
	No stated maturity or on demand	1-6 months	6-12months	More than 12 months	Total	Carrying amount at 31 December
Accounts payable	$100	$ -	$ -	$ -	$100	$100

(c) Interest rate risk

The ICCB's only interest bearing financial instruments are balances with bank, which bear interest at market rates. Hence the ICCB's income and operating cash flows are not subject to significant interest rate risk.

4 Cash and cash equivalents

	2016 $	2015 $
Cash at bank and in hand	2,037,572	1,810,836

5 Taxation

Hong Kong Profits Tax has been provided at the rate of 16.5% (2015: 16.5%) on the estimated assessable profit for the year.

(a) Taxation in the statement of profit or loss and other comprehensive income represents:

	2016 $	2015 $
Current tax - Hong Kong Profits Tax		
Provision for the year	-	-
Over-provision in respect of prior years	(4,256)	(428)
	(4,256)	(428)
Deferred tax		
Origination and reversal of temporary differences	(541)	-
	(4,797)	(428)

(b) Reconciliation between tax recovery and the (deficit)/surplus at applicable tax rate:

	2016 $	2015 $
(Deficit)/surplus before tax	(3,264)	34,399
Notional tax on (deficit)/surplus before taxation, calculated at the tax rate of 16.5% (2015: 16.5%)	(539)	5,676
Tax effect of non-taxable income	(2)	(2)
One-off tax reduction	(4,256)	(6,102)
Others	541	-
Actual tax recovery	(4,256)	(428)

(c) Tax recoverable in the statement of financial position represents:

(i) Current taxation in the statement of financial position represents:

	2016 $	2015 $
Provision for Hong Kong Profits Tax for the year	-	5,674
One-off tax reduction	(4,256)	(6,102)
	(4,256)	(428)
Provisional Profits Tax paid	(1,417)	(2,033)
Tax recoverable	(5,673)	(2,461)

(ii) Deferred tax assets recognised:

The components of deferred tax assets recognised in the statement of financial position and the movements during the year are as follows:

	Tax loss carried forward $	Total $
Deferred tax arising from		
At 1 January 2016	-	-
Credited to profit or loss	(541)	(541)
At 31 December 2016	(541)	(541)

	2016 $	2015 $
Net deferred tax assets recognised in the statement of financial position	(541)	-

6 General Committee members' emoluments

During the years ended 31 December 2016 and 2015, no amounts have been paid in respect of General Committee members' emoluments, pensions or for any compensation in respect of services provided by the General Committee members.

7 Related party transactions

The following transactions were carried out with related parties during the year:

	2016 $	2015 $
Management and administration support fees paid to the HKFI (note)	1,650,000	1,650,000

Note: The 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.

The ICCB received subscriptions amounting to $2,004,000 (2015: $1,912,000) from its members during the year ended 31 December 2016.

8 Possible impact of amendments, new standards and interpretations issued but not yet effective for the year ended 31 December 2016

Up to the date of issue of these financial statements, the HKICPA has issued a number of amendments and new standards which are not yet effective for the year ended 31 December 2016 and which have not been adopted in these financial statements. These include the following which may be relevant to the ICCB.

	Effective for accounting periods beginning on or after
Amendments to HKAS 7, *Statement of cash flows: Disclosure initiative*	1 January 2017
Amendments to HKAS 12, Income taxes: *Recognition of deferred tax assets for unrealised losses*	1 January 2017
HKFRS 15, *Revenue from contracts with customers*	1 January 2018

The ICCB is in the process of making an assessment of what the impact of these amendments and new standards is expected to be in the period of initial application. So far the ICCB has identified some aspects of the new standards which may have a significant impact on the financial statements. As the ICCB has not completed its assessment, further impacts may be identified in due course and will be taken into consideration when determining whether to adopt any of these requirements before their effective date and which transitional approach to take, where there are alternative approaches allowed under the new standards.

Annual Report
2016/2017年報

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