Irreconcilability Between the Ethiopian Commercial Code and Contracts of Insurance, with Special Emphasis on Personal Accident and Life Policies

*by BELAYNEH SEYOUM**

INTRODUCTION

Insurance is a product of succeeding modes of production, and it is aimed at transferring the risks of individual entities to an insurer, who agrees for a consideration to assume to a specified extent losses by the insured. An insurance policy is a conditional contract whereby the insurance company agrees to pay the insured for some specified loss damage or liability which may arise from some contingent event.

As Ethiopia started to increase contacts with the outside world, more and more foreign insurance companies appointed agents and started to transact business in Ethiopia, even as early as in the 1920s. These agents were foreign merchants, some of which later opened branch offices of the parent companies. However, laws regulating these insurance companies did not appear until 1960.

The aim of all present-day insurance is to make a provision against the dangers which beset human life and property. Insurance is generally a scheme of distributing and equalising losses. Those who seek it endeavour to avert disaster from themselves by shifting possible losses on to the shoulders of others who are willing, for a consideration, to take the risks, and, in the case of life insurance, they can assure to those dependent on them a certain provision in case of their death, or provide a fund out of which their creditors can be satisfied.[1]

The purpose of a modern insurance scheme is not based on shouldering any unspecified risk which has not been agreed upon by the contracting parties, but on compensating for a risk undertaken by the insurer for a consideration called the premium. There are certain conditions, warranties and exceptions in the insurance policy contract, outlining the duties and responsibilities of the insured as well as of the insurer. There are also the Commercial Code provisions on insurance, regulating the business of insurance so as to protect the interests of the insured against abusive clauses, and the legitimate interests of the insurer.

The insurance part of the Commercial Code of Ethiopia was drafted by a European lawyer, and there has been a great influence of French and Italian laws

*Lecturer, Faculty of Law, Addis Ababa University (on study leave, Mac Gill University)

1. Preston and Clinvaux, *Laws of Insurance*, p.1

of insurance. But the concept and practice basically originated in England, and much influence has been exerted by English jurisprudential thought in this field.[2] It is also true that the Ethiopian insurance market was originally dominated by Lloyds (a British insurance giant); the transactions are those of the English type with small amendments, and these amendments have not contributed to a major reconciliation between the policy and the law of insurance. The inconsistency has became even wider since the nationalization of insurance business.[3] This paper tries to analyse the areas of inconsistency between the Commercial Code provisions on insurance, and the planning policy. The paper dwells on six major areas of inconsistency: payment of premium, limitation period, concealment of material fact, increase of risk, life policy and cumulative insurance.

I. Payment of Premium

On the payment of premium, in order to spare the insured from a sudden unforeseen rupture of the contract, a provision has been included in the Commercial Code requiring a mandatory waiting period followed by a period of one month, during which the insurance is only suspended. This provision is a matter of public policy and cannot be varied by the parties.[4] In accordance with this policy, Article 666(2) of the Commercial Code provides: "Notwithstanding any provision to the contrary, the policy shall not terminate as of right when the premium is not paid in due time. The Insurer shall demand payment". But Article 666 does not specify under what situations it is applicable. Is Article 666 applicable when there is non-payment of an instalment premium before the expiry period of the policy, or when renewal is sought for after the expiry period?

(a) Payment by Instalments

The parties to an insurance policy may agree to the payment of premium by instalments which have a fixed date for payment. In cases in which the instalment premium is not paid in due time, the policy contract does not terminate, because there is a subsisting policy which provides the assured opportunity to pay the premium due within a certain period of time.

It seems that Article 666 is applicable to the question of nonpayment of an instalment premium before the expiry date of the policy. In cases in which a premium is paid by instalments which have a fixed date for payment, the policy does not terminate when it is not paid in due time. The insurer demands payment, and thereafter, after one month from a demand for payment, the policy shall be suspended.

(b) Payment for Renewal

In practice, shortly before the expiration of the policy in force, the insurer sends to the insured a renewal notice intimating that the premium is about to fall

2. Berhanu Kidane, *Insurance Damages in Ethiopia: Compensation or myth*, Addis Ababa 1971, p.11
3. Proclamation No. 26, 11 March 1975.
4. Peter Winship, *Background Documents of the Ethiopian Commercial Code*, 1960, p. 86.

due. The sending of this notice to the insured amounts to an offer by the insurers to renew the policy, on the footing of the original proposal or of any variation of the terms indicated in the renewal notice, such as an increased premium.

The Ethiopian Commercial Code provisions on insurance do not make specific statements as to how an insurance policy can be renewed or the legal effect of such renewal. Can we apply by analogy other provisions of the Commercial Code to renewal?

The insurance provisions of the Commercial Code state only as to how a contract of insurance enters into force (Article 659); how an insurance policy may be suspended for failure to pay the premium; how such a suspended policy re-enters into force with the payment of the premium (Article 666); and on the particular case of redeeming a life insurance policy (Article 710). Any attempt to use these Articles to apply for a renewal of insurance will fail, since the above Articles refer only to the issue of premiums and provide nothing as to expiration of a contract.

A contract lapses or becomes extinct as soon as it is performed in accordance with the contract, or where the contract itself provides that it will lapse after a certain period or a given date (Article 1807, Civil Code). Once a contract is extinguished, then obviously there is no contract that can be enforced. Where the parties have agreed that an insurance policy will be renewed by payment of premium, failure to pay it within the specified period or the period of grace stated in the policy will result in the termination of the policy contract; Article 666 of the Commercial Code, which provides that failure to pay does not give the power to the insurer to terminate the policy, does not apply here, since there is no policy or contract existing, because failure to pay extinguishes it.

However, Article 666 has frequently lent itself to different interpretations. In certain cases, courts have applied clear policy provisions, intimating that an obligation shall be extinguished on the date as agreed by the parties. In other cases, courts have used Article 666 (3) and (4) to revive an already extinct contract. The matter is made explicitly controversial in the cases explained below.

In the case of Dinsa Lapisa Aba Joubir v. Blue Nile Insurance Company,[5] the plaintiff entered a contract of private car insurance in April 1969 with the Blue Nile Insurance Company, and the policy was renewed every year till 1 May 1972. The car of the insured was damaged as a result of an accident on 8 May 1972, i.e. seven days after the previous policy had expired. The insured notified the company of the accident and demanded that the risk that had occurred be made good. The Company disclaimed liability on the grounds that the policy had expired at the time when the accident took place. The plaintiff instituted a suit in the High Court against the insurance Company after a failure to settle the case by arbitration. The High Court held for the defendant company on the ground

5. Civil Case No. 1099/1965 G.C.

that the policy had expired a the time when the accident took place, and added that no insurance claim could be indemnified on a policy that was ineffective. The case went to the Supreme Court on appeal, and the decision of the High Court was reversed. The Supreme Court held that, al hough according to the policy contract the period of cover had expired, there was an obligation imposed by law on the part of insurer to demand payment, and then to provide a one-month grace period from the time of demand for payment (Article 666 (3) and (4)). The Supereme Court added that, since only one week had passed after the previous policy period had lapsed, and there was a one-month grace period from the time of demand for payment, the insured could claim indemnity.

This decision caused a considerable amount of worry and tension on the part of insurers and lawyers, because they feared that it might set a precedent for other cases on the same grounds. They felt that this decision undermined the value of policy contracts and their effect after the expiry date. Article 1806 of the Civil Code says that an obligation shall be extinguished where it is performed in accordance with the contract, and that, according to the policy contract, the contract shall be binding only up to the expiry date and not after.

In the case of Wakene Feldasso v. Blue Nile Insurance,[6] the plaintiff had insured his shop against fire and lightining on 13 June 1970. On 13 June 1971 the shop caught fire for unknown reasons, and most of the goods in the shop were destroyed. A day after the loss by fire, the Company was informed of this loss, but it repudiated liability on the grounds that the policy had expired, stating that the policy could be valid only between 13 June 1970 and 13 June 1971, at 4 p.m., as mentioned in the policy contract, whereas the accident took place on 13 June 1971 at 7.30 p.m. The High Court held that since the insured took the majority of his goods out of his shop a few hours before the event of loss, this was an intentional act performed in order to claim indemnity from the defendant company, and therefore the insured could not recover. The Supreme Court, on appeal, examined the various arguments of both the plaintiff and the defendant company and upheld the High Courts decision, but on a different ground. The major emphasis was on whether indemnity could be recovered for a risk of loss after the period of expiration of the insurance policy. The accident took place on 13 June 1971 at 7.30 p.m., and the period of cover was till 13 June 1971 at 4 o'clock in the afternoon. The insurance policy read as follows: "The (insurance) corporation agrees with the insured, subject to the terms and conditions contained herein or endorsed or otherwise expressed herein, which terms and conditions shall be deemed to form part of this policy, that if, after payment of the premium, the property insured described in the schedule hereto or any part thereof shall be destroyed or damaged by fire or lightning at any time before 4 o'clock of the last day of the period of insurance stated in the schedule, or of any subsequent period in respect of which the insured shall have paid and the corporation shall have accepted the premium required for renewal of this policy, the corpora-

6. Civil Appeal Case No. 1184/1965 G.C.

tion will pay or make good to the insured the value of the property at the time of the happening of its destruction or the amount of such damage, or at its option reinstate or replace such property or any part thereof."[7] In accordance with the above condition in the policy contract, the Supreme Court held that the insured could not recover, because the loss by fire took place after the policy had expired.

II. Doctrine of Limitation

Another relevant area is the doctrine of limitation. The main objective of including this provision in our Commercial Code is to fight against abusive clauses in a policy contract.[8] The Personal Accident Policy Condition No. 4 says: "... If the corporation shall disclaim liability to the insured for any claim hereunder, and such claim shall not within six months from the date of such disclaim have been referred to arbitration under the provision herein contained, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder."[9] This is probably a good example of a direct copy of conditions from policies used in England, with no attempt to amend the standard of the condition to follow Ethiopian legal provisions. According to Article 674 (1)[10] of the Commercial Code, the period of limitation in Ethiopia is two years from the date of the occurrence of the damage giving rise to the claim, or from the date when the parties knew of the occurrence. This does not mean that the period of limitation will be two years when there is interruption of payment. According to Article 1852 (1) of the Civil Code, a new period of limitation shall begin to run upon each interruption. The Code policy does not provide for interruption, but simply reduces the period of limitation to six months. In a Personal Accident Policy, Condition No. 3 provides that in no circumstances will the insurance company be liable for any claim unless notice thereof be received within three months after the occurrence of the accident. Article 670 of the Commercial Code provides that, unless he is prevented by *force majeure*, the beneficiary shall inform the insurer of any occurrence likely to render the insurer liable as soon as he knows of such occurrence, or within not more than five days. Article 670 reduces the period of notification of an occurrence of damage to a period a great deal shorter than that provided in the policy provisions. On the other hand, both the provision of the insurance policy and Article 670 of the Commercial Code conflict with the period of limitation as provided in Article 674 of the Commercial Code.

Article 674 (1) says that the period of limiting the insurer's liability is two years from the date of occurrence of the damage. It is also interesting that Article 674 (3) specifically provides that this period may not be shortened in the policy, and this is indicative of the importance attached by the law-makers to this matter. There seems to be an interesting case that was decided relating to this contro-

7. Fire and Lightning Policy - Paragraph 11.
8. Punctuated for reasons of increased clarity. (See note at top of page.)
9. Peter Winship - *Background Docments of Ethiopian Commerciall Code*,, 1960, p. 86.
10. All Risks policy - Exceptions, No. 9 Consequential Loss Policy, Condition No. 11; 15; Workman's Compensation Policy; Condition No. 10, Burglary and Housebereaking Policy, Condition No. 11.

versial area of notice and limitation. It was that of Woizero Kidist v. Michell Cotts Ltd. Ato Getahun, the husband of Woizero Kidist, had taken out a personal accident policy from Mitchell Cotts Co. Ltd, Insurance-Division, whereby in the event of death or accident the company would pay the insured a sum of 40,000 dollars. While driving to Jimma, Ato Getahun had a serious car accident on 5 January 1967, and died on 23 January 1967. The company was informed in writing by the deceased family on 26 February 1967, together with documentary evidence that the cause of the death was the car accident. The insurance company disclaimed liability on the grounds that, according to condition No. 2 of the policy, the insured was to submit a notice in writing to the corporation within fourteen days of the occurrence of the accident or the commencement of the disease. But since the notice in writing was submitted 21 days after the accident (5 January, 1967 to 7 February 1967), the company disclaimed liability. The High Court emphasised the policy condition which demanded notice within fourteen days, and held for the defendant. The Supreme Court, on appeal, examined the case and submitted that a person who had died of an accident could not provide a notice of the accident, and that the section applied only to people who are injured or sick as a result of an accident. In either of the courts, the decision was not based on a proper interpretation of the legal provisions in the Commercial Code.

Another recent case which again manifests the striking differences between the various policies and the Commercial Code on similar subject matter is that of Mekane-Yesus Church v. Ethiopian Insurance Corporation. A contract was made between Môroni Private Company Ltd. (contractor) and the African Solidarity (AFSOL) Insurance on 16 December 1974. This was a performance bond policy whereby the AFSOL Insurance Co. was "held and bound unto the Ethiopian Evangelical Church (the employer) to the sum of 200,000 birr in the event of default—on the part of the contractor".@

After construction of a certain portion of the building, the contractor suddenly left Ethiopia, and the building was left in an unfinished form for some months. After some indications that the contractor had left Ethiopia for good, the employer notified the insurance company of the damage and claimed that the damage sustained should be made good by the surety (i.e. the insurance corporation). The insurance corporation disclaimed liability, and (among others) some of the arguments submitted to the arbitral tribunal were as follows:

(a) that the employer had not submitted immediate notice of the situation to the insurance company as provided in policy No. 1. It submitted that the contractor left before June 1975, whereas the written notice was made on November 1976 to the insurance company.

(b) the limitation period as provided in policy No. 4 was 12 months from the time of the discovery of the act or omission of the contractor, and the corporation submitted that no legal proceedings could be

[a]Civ. App. No. 1166/1974

instituted against the defendant company, as the plaintiffs instituted legal proceedings about 16 months after having discovered the default on the part of the contractor.

Here there are two striking factors which fall within the ambit of irreconcilability.

(1) Performance Bond Policy Provision No. 1 makes it mandatory for any claimant (insured) to submit a written notice to the corporation immediately after the discovery of any act or omission that shall or might involve a loss. Personal Accident Policy Condition No. 2 (as seen in the case of Woizero Kidist V. Mitchell Cotts) specifies the period after which no claim is valid. It says that the insured has to submit in writing to the corporation within fourteen days of the occurrence of the accident or of the commencement of the disease. While one policy provision requests immediate notice, another policy qualifies the exact period upon which notice of accident is to be made. In the former case, the word "immediate" could lend itself to different interpretations. This plainly illustrates the fact that, even among the various insurance policies which are in force, there are certain striking irreconcilabilities, with some policy provision being vague, while others are quite specific with regard to similar subject-matter, as explained in the above case.

(2) Performance Bond Policy Condition No. 4 says that legal proceedings for recovery hereunder may not be brought unless begun within twelve months from the time of the discovery of the act or omission of the contractor on account of which claim is made.

The above provision is in conflict with Article 674 (1) of the Commercial Code, which says that the period of limitation in Ethiopia is two years from the date of the occurrence of the damage giving rise to the occurrence. This is another example of terms used in insurance policies used in England, with no attempt to amend the standard of such conditions to follow Ethiopian legal provisions.

III. Concealment of Material Fact

The Commercial Code also provides certain articles for cases of material concealment by the insured. The Ethiopian Jurisprudence has always recognised the principle of *uberrima fide*, "utmost good faith".[11] This is required not only before but also after occurrence of loss. In fact, an insured person who suffers a loss and makes a claim under his policy must always realise that he may face a defence on the grounds that, upon the issuance of the policy, the insured did not fully and failry disclose to the insurer every fact which would have shown the nature or extent of the risk, or which might have prevented the undertaking of it, or affected the rate of premium. Generally speaking, there are three main classes

11. See Commercial Code, Article 668.

of breaches of good faith, in accordance with their effect on the validity of the contract under the provisions of the Ethiopian Commercial Code. They are

(a) Concealment this relates to a breach of good faith by intentional suppression of a fact which is material.

(b) Innocent Misrepresentation this relates to a statement which is inaccurate but made innocently, i.e. without any fraudulent intention.

(c) Fraudulent Misrepresentation this relates to a statement made knowingly that it is false. But a false statement which is made through want of care in investigation of the facts is not fraudulent.[12]

According to Artic e 668(1) of the Commercial Code, the insurance policy shall be of no effect where the beneficiary has intentionally concealed facts or has made false statements and where such concealment or false statements cause the insurer wrongly to appreciate the risks to be insured, so that, had he been aware of the truth, the insurer would not have entered into the policy or would have imposed terms less favourable to the beneficiary. But the law also provides for cases where the false statement is not deliberate. It says that the insurance policy shall remain in force where the concealment is in good faith and that, if this is discovered before the risk materialises, the insurer is given an option either of terminating the policy by giving one month's notice or of maintaining the policy and increasing the premium.[13] But if the concealment is discovered after the risk meterialises, the code provides that the sum to be paid by the insurer will be reduced accordingly.[14] But the insurance policy conditions tend to vary from the legal provisions. All Risks Policy Condition No. 8 says: "...and if the insured, either in the proposal aforsaid or in any renewal of this insurance or in connection with any claim hereunder, makes any misrepresentation or intentional overstatement or intentional omission, the policy shall be void, and premiums shall be forfeited.."[15] The insurance policy and the legal provision impose a duty on the insurer to represent fully and fairly every fact which shows the nature and extent of the risk and every fact which may prevent the undertaking of it, or affect the rate of premium. But this cannot camouflage the major differences on the effect of concealment or non-disclosure of material facts between the policy conditions and the Commercial code. In summary, the situation is illustrated below.

12. Disdale & Mcmurdie, *Elements of Insurance* p. 84.
13. *Commerciel Code of Ethioeia*, Article 668(2)
14. *Commercial Code of Ethioeic*, Article 668(3)
15. Consequential Loss Policy, Condition No. 1, Money Policy Conditions, No. 3;6, Public Liability Policy Condition, No. 12, Burglary Policy Condition, No. 2.

EFFECT IN INSURANCE POLICIES AND LAW OF CONCEALMENT BY THE INSURED OF MATERIAL FACT

		Effect in the Commercial Code
1.	Where concealment is intentional:	Termination of contract by insurer; premium retained by insurer.
2.	Where concealment is in good faith	
	(a) Discovery by insurer before risk:	Termination of contract after a month's notice or maintenance of contract and increase of premium.
	(b) Discovery after risk:	Indemnity reduced having regard to the difference between the premiums actually paid and premiums which ought to have been paid, had the facts not been concealed.
		Effect in the Insurance Policy Conditions
	False statement in proposal (either intentional overstatement or intentional omission)	Policy shall be void and all premiums by the insured shall be forfeited.

Thus, the insurance policy says that any misrepresentation either intentional or non-intentional gives rise to the nullification of the policy, whereas the law divides the effect on grounds of deliberate concealment and unintentional misrepresentation. The law provides that where concealment is intentional, the contract may be terminated, whereas, when it is in good faith and discovered before the risk materializes, the insurer is given the option of either terminating the contract after a month's notice or maintaining the contract and increasing the premium. But when it is discovered after the risk materializes, the insurer may reduce the indemnity accordingly. Article 1678 of the Civil Code provides that parties are free to consent to any contract as long as the provisions in the contract do not depart from the obligatory provisions of the law. This is to remind us that, even though the insurer and insured are free to consent to any contract, their contract cannot be made in such a way as to depart from or contravene the mandatory provisions of the law.

MacGillvray[16] says, "In order to establish that a fact is material and ought to have been disclosed, it is not necessary for the insurers to prove that they would have acted differently if the fact had been disclosed, it is sufficient for them to establish that the facts, if known, might have induced reasonable insurers to

16. MacGillvray - *Insurance Law*, Vol. 1 No. 893.

decline the risk or increase the premium" When a claim is made and the insurer disclaims liability on the grounds of non-disclosure of material facts, the burden lies on the insurer to establish:

(a) that the fact was misrepresented or was not disclosed; and
(b) that the said fact was material.

How would the court be satisfied that the said fact was material and was misrepresented? From the analysis of Ethiopian Commercial Jurisprudential background, we see that a material fact is any of the following:[17]

(a) a fact which shows the nature or extent of the risk, or
(b) a fact which may prevent the undertaking of the risk, or
(c) a fact which may affect the rate of premium.

Generally, the question of materiality is a matter of fact which can be proved by expert evidence, and then the court will be able to decide intelligently if, in truth, a reasonable insurer's appreciation of the risk would have been affected by the fact misrepresented or hidden.[18] In the case of Woizero Kidist v. Mitchell Cotts, one of the defences of the defendant Company was that the insured had concealed certain material facts when filling in the proposal form, and that these facts would have made the insurer either terminate the contract or increase the premium. But the most dishertening point is that this issue was not even raised in the decision; hence we could not report the stand on this issue; the plaintiff submitted that the hidden facts were not material and that they could not therefore affect the basis of the contract.[19]

IV. Increase of Risks

Article 669 of the Commercial Code provides for cases where there is increase of risks. It says: "Where the risks increase in such a manner that the insurer, had he known the facts at the time when the policy was made, would not have entered into the policy or would have imposed terms less favourable to the beneficiary, the beneficiary shall inform the insurer within fifteen days from the occurrence increasing the risks, where such occurrence is due to the beneficiary, or within fifteen days from the beneficiary being aware of such occurrence." The insurer may terminate the policy, or maintain it and increase the premium. But the effect of non-notification where there is increase of risk in the policy is quite different from what is provided in the law. The Personal Accident Policy, paragraph III, says: "If the insured engages in any occupation in which greater risk may be incurred without giving notice to the corporation and obtaining permission and paying additional premiums as may be required by the corporation, then this policy becomes absolutely void and no claim shall be made in respect thereof." Hence we see the difference between the law and the insurance policy in terms of

17. See Articles 668 and 669 of the Commercial Code of Ethiopia
18. Asegedech Indaylalu v. Imperial Insurance Co. Civil Case No. 1055-59.
19. W/Kidist v. Mitchell Cotts.. Civil Case Case No. 1001/61

the effect of non-notification in the event of increase of risk. Where there is increase of risk and the insurer is notified within fifteen days of the occurrence increasing the risks or within fifteen days from the beneficiary being aware of such occurrence, the insurer may either terminate the policy or maintain it and ncrease the premium. But if there is no notification, then the effect will be according to the provisions of Article 668, as shown below.

EFFECT OF NON NOTIFICATION WITHIN A SPECIFIED TIME OF INCREASE OF RISK BY THE INSURED IN THE POLICY AND THE LAW

		Effect in the Commercial Code[20]
1.	Where non-notification of increase of risk is intentional:	Termination of policy by insurer: premium retained by insurer.
2.	Where non-notification of increase of risk is in good faith	
	(a) Discovery by insurer before risk:	Termination after a month's notice, or maintence of contract and increase of premium.
	(b) Discovery after risk:	Indemnity reduced, having regard to the difference between the premiums actually paid and the premiums which ought to have been paid, had the facts been notified.
		Effect in the Policy Conditions
3.	Non-notification of increase of risk to the corporation	The policy becomes void and no claim is made in respect thereof.

Thus, the insurance policy generally invalidates the policy in the event of non-notifiction of increase of risk, but the law divides it into intentional and unintentional non-notification of increase of risk, and explains the legal effect accordingly.

V. Life Policy

Insurance companies also make provisions in a policy to help to attract customers. The Life Policy, General Provision No. 9, says: "If the insured commits suicide, while sane or insane, within two years from the date of issue or from any reinstatement of the policy, the insurance under this contract shall be a sum equal to the premiums paid and no more." Here the policy talks of giving back the insured the total premiums paid, whereas the law looks at this aspect in a compartmentalised fashion. Article 699(1) says that, notwithstanding any

20. Commercial Code of Ethiopia, 1960, Article 669 (3)

provision to the contrary, an insurance policy for the event of death shall be of no effect where the insured person knowingly commits suicide. It also adds that where the beneficiary can show that the suicide was not committed knowingly, the policy shall be effective. The general provision in a life insurance policy also has an area irreconcilable with the law as regards payment of premiums. The policy contract No. 2 says: "Thirty days of grace are allowed for payment of renewal premiums and instalments of premium. Unless continued in force under the automatic premium loan or extended term insurance provisions, *this policy shall lapse without the issue of a summons or of any other formality if any renewal premium or any such instalment is not paid on the due date or within the period of grace.*" This provision in the policy has two relevant points for us to analyse:

(a) The insurer shall give thirty days of grace for renewing premiums.

(b) At the time when the payment for renewal premiums is due, the insurer shall not demand payment. The law divides the effect of non-payment of renewal premiums according to the duration of the policy, i.e. a policy on which less than three annual premiums have been paid, and a policy on which at least three annual premiums have been paid. But in either of these cases, the law imposes an obligation on the part of the insurer to demand payment. Article 709 (2) says that, if a premium has not been paid at the due date on a policy on which less than three annual premiums have been paid, the *insurer may demand payment.* If payment is not made within one month *from the date of demand,* the insurer may terminate the policy. Article 709 (3) says: "If a premium has not been paid at the due date on a policy on which at least three annual premiums have been paid and payment is not made within one month from *the date of a demand* for payment, the policy shall not lapse. The insurer may issue a paid-up policy,[21] or otherwise reduce the capital or life interest of the policy according to regulations and under Article 650." Thus we see that, according to the law, there is a duty on the part of the insurer to demand payment, whereas the policy does not say that, at the time when the payment for renewal premiums is due, the insurer shall demand payment. This is an area where either the insurer or the lawyer should look for a quick remedy.

21. Issue of paid-up policy - A reduced sum assured payable on the maturity of the policy or in case of previous death to the beneficiary. The payment of a paid-up value takes place after at least three annual premiums have been paid and when the insured, for certain reasons, does not want to or cannot pay my further premium. In this case, the insured will be paid in the event of the maturity of the policy or, in the event of his previous death, the beneficiaries will be paid.
Paid-up value $= \frac{\text{No. of years paid}}{\text{duration of policy}}$ the sum assured.
A paid-up value is different from the surrender value of a policy; surrender value is a reduced sum assured payable to the insured on the cancellation of the policy. It is generally called a paid-up value, but it is given a discount rate since it does not wait till the maturity period is up. The option of demanding the surrender (cash) value or reduced paid-up insurance is given to the insured if the premium payment is discontinued; and written notice has to be given within 3 months following the due date of the unpaid premium. (See General Provision No. 4 of the Life nsurance policy.)

EFFECT OF DISCONTINUATION OF PREMIUMS ON A LIFE INSURANCE POLICY

Life Policy General Provision	Provision of the Commercial Code
Thirty days of grace allowed for renewal and instalments of premium.	1. If less than three annual premiums are paid:
When the premium that is due is not paid within the period of grace, the insurer shall not demand payment, and the policy shall lapse without notice.	(a) the insurer demands payment; (b) the policy is terminated if payment is not made within one month from date of demand.
	2. If more than three annual premiums are paid:
	(a) the insurer demands payment; (b) if payment not made within one month from date of demand, the insurer may (i) issue a paid-up policy, or (ii) reduce the capital or life interest of the policy in accordance with Article 656(1).

The Life Policy General Provision on misrepresentation[22] says that the insurance company shall be free from all obligations under such a policy if, within two years from the effective date of the policy, it is proved that there has been any willful or fraudulent misrepresentation on the part of the insured, in which event all monies paid to or payable by the corporation shall be forfeited by the insured. However, the policy goes on to say that if death occurs because of the undisclosed material fact after the policy has been in force for two years, then the insurance company shall be limited to a payment of the surrender value or the total premiums paid, whichever is greater, exclusive of any extra premiums paid. *If material facts are disclosed at any time during the lifetime of the insured, then the insurance company may adjust the premium in accordance with its existing underwriting rules.* Thus the law provides that, if there is discovery of material fact before the risk,[23] then the insured can either terminate the policy by giving a one month's notice, or maintain the policy and increase the premium. But the life policy tends to ignore the right of the insured to terminate the policy by giving one month's notice, and gives only one avenue to the insurer, that is, adjusting the premiums in accordance with its existing underwriting rules if material facts are disclosed during the lifetime of the insured.

22. Life Policy., General Provision No. 10.
23. Commercial Code of Ethiopia 1960, Article 668.

VI. Cumulative Insurance

Cumulative insurance is also an area where the insurance policy and the law do not consistently reflect the reality of the situation. The Personal Accident policy, parapgraph III, says: "... if the assured shall, at any time subsequent to the date of accepting or effecing this policy, be insured against death or disablement by accident with any other insurer, without the written consent of the corporation, --- then this policy shall become absolutely void and no claim shall be made in respect thereof."[24] The Commercial Law also deals with cumulative insurance. It says[25] that, where several insurers insure the same object against the same risk so that the object is overinsured, each insurer, where there has been fraud on the part of the beneficiary, may require the termination of the policy and may in addition claim damages; where the beneficiary is in good faith, each insurer shall, where the risk materialises, pay compensation in proportion to the value insured by him.

EFFECT OF CUMULATIVE INSURANCE IN INSURANCE POLICY AND IN LAW

	Effect in the Policy Contract
If after effecting a policy with one insurer, the insured subsequently insures the same object against the same risk without the written consent of the corporation:	The policy shall become absolutely void and no claim shall be made in respect thereof.
	Effect in the law[26]
(a) If the insured insures with several insurers the same object against the same risk fraudulently:	Each insurer may require the termination of the policy and may in addition claim damages.
(b) If the insured takes out cumulative insurance in good faith:	Each insurer shall, when the risk materializes, pay compensation in proportion to the value insured.

As we can see, there is an area of inconsistency between the policy and the law, but in addition to this fact, the area related to cumulative insurance in both insurance policy and law is out of date. Neither matches the spirit and objective of Proclamation No. 26 of March 1975. In consequence of the attempt to socialise the economy, all the basic means of production—land, factories, mines, etc., be-

24. Private Car Policy Comprehensive, Condition No. 6; All Risks Policy, condition No. 7; Consequential Loss Policy, Condition No. 3, 12; Workman's Compensation Policy, Condition No. 11; Commercial Motor Policy, Condition No. 6; Burglary and Housebreaking Policy, Condition No. 8.
25. Commercial Code of Ethiopia 1960, Article 681.
26. Commercial Code of Ethiopia 1960, Article 681

came social property. According to Section 2 (0) of Proclamation No. 26/1975, insurance was amongst one of the institutions exclusively undertaken by the government. This leads to one major conclusion: all the insurance institutions are under government control, and all the various branches are organised under the National Insurance Corporation. Hence, a person who insures a certain object against a risk cannot insure the same object against a similar risk with *another insurance company* because in Ethiopia at present there is only *one insurer* i.e. the National Insurance Corporation, under which there are several branches, e.g. the AFSOL Branch, the Lion Branch, the Blue Nile Branch, for the sake of expedience in terms of avoiding customers from overcrowding one firm.

CONCLUSION

As Ethiopia has declared its intention to follow the socialist path of development, the existence of institutions and laws straightjacketed to suit the interests of the huge Insurance Multinational in the country appears to be out-of-date. The superstructure will have to reflect the economic base, even though interaction is possible between the two. When we suggest that laws and institutions should suit the existing political and economic conditions, we do not mean that we have to throw away all the former laws and institutions. What we hope to emphasise is that we have to retain those components which are relevant in the light of our social conditions, and discard other components which are not only not in accordance with the spirit and objectives of the new socio-economic system but which also contribute to the perpetuation of the former confused and confusing relationships. Of course, distinguishing irrelevant components in order to discard them is not easy; it demands thorough research in the different fields, and wide reading in both the law and insurance policies.

The main theme of this paper is to pinpoint areas of inconsistancy between the Commercial Code provisions on insurance and the policy of insurance. How should we proceed to resolve such a problem? If it is found necessary to change the law to fit the needs of the insurance world and at the same time to protect the legitimate interests of the insured, of course the law will have to change.

It is apparent that one cannot have a policy contract outlining the legal commitment of both contracting parties and a law governing a similar area going parallel with gross contradictions between each other. The solution lies in either (a) streamlining the policy as well as the law to reflect the actual conditions of the business; this entails the reconciliation of the various provisions in both the Commercial Code and the policy contracts. Or (b) we can change the various policy provisions in accordance with the existing legal provisions.

A failure to realise this would only in the long run help to contribute to the existence of two parallel rules which go on different dimension with no possibility of conciliation i.e. the policy and the law.