Before

Shahzad Afzal Khan, Director/Head of Department (Adjudication Department-I)

In the matter of

Jubilee Life Insurance Company Limited

Show Cause Notice No. & Issue Date:	ID/Enf/JubileeLife /2020/3406 August 01, 2023
Date of Hearing:	November 22, 2023 January 18, 2024
Attended By:	Mr. Zahid Barki Mr. Junaid Ahmed Mr. Muhammad Asif Khan *(Authorised Representatives)*

ORDER

Under Rule 15(1)(e) of the Takaful Rules, 2012 and Sections 76, 77 & 87 of the Insurance Ordinance, 2000 read with Section 118 and 156 thereof

This Order shall dispose of the proceedings initiated against **Jubilee Life Insurance Company Limited (the Company and/or the Respondent)** vide Show Cause Notice No. ID/Enf/JubileeLife /2020/3406 dated August 01, 2023 **(the SCN)** issued under Rule 15(1)(e) of the Takaful Rules, 2012 **(the Takaful Rules)** and Sections 76, 77 and 87 read with Section 118 and 156 of the Insurance Ordinance, 2000 **(the Ordinance)**.

2. The Company is registered under the provisions of the Ordinance to undertake the business of life Insurance in Pakistan. An onsite inspection of the Company was conducted in order to assess its compliance with the applicable Insurance Laws and AML/CFT framework in pursuance of the Commission's Inspection Order dated November 15, 2022 passed under Section 59A of the Ordinance and Section 6A(2)(f) of the Anti-Money Laundering Act, 2010. The review period of the inspection was from January 1, 2022 to June 30, 2022. Letter of Findings dated April 12, 2023 was sent to the Company to seek its response on the findings communicated therein and the Inspection Report was shared with the Company on September 11, 2023.

3. During the course of the aforesaid inspection proceedings, the inspection team noted that Takaful Policy Membership Document **(PMD)** of the Company defines "Takaful Contribution" as under:

> *"Takaful Contribution means the amount deducted by the Window Takaful Operator at the beginning of each Membership Month from the Participant Investment Account and paid into the IFTPS as consideration for providing the Benefits Covered under this Membership and under those supplementary Takaful Benefit(s) attached to this Membership which are provided through Unit Deduction. It also refers to amounts identified as the difference between Regular Total Contribution and Regular Basic*

Contribution that are paid into the IFTPF in consideration of Supplementary Takaful Benefit(s) that are not provided through Unit Deduction"

4. Clause 2.1 (Misrepresentation and concealment of material facts) of the 'General Conditions' of the PMD of the Company states that:

"Any deliberate false statement or declaration made by the Life Covered or Participant(s) in connection with the Membership or any concealment of information which ought to be made known to the Window Takaful Operator (affects the judgement of the Window Takaful Operator in deciding whether to accept the Membership or not and if it decides to accept, the terms on which it would do so) shall render the Membership null and void. In such an event the Window Takaful Operator will pay the Participant the Cash Value of units available in the Participant Investment Account and terminate the Membership"

5. The inspection team of the Commission noted that in case of rejection of takaful membership due to non-disclosure of pre-existing condition by the policyholder, the Company did not pay cash values of units available in participant investment account denying the basic right of the participants on cash value. It was also in violation of the right stipulated in above referred clause of the participant membership documents.

6. It was further noted that even the top up amounts of cash value received by the Company in addition to regular contributions were denied. The inspection team discussed the matter with the Shariah Advisor of the Company, who also enodorsed that cash value cannot be denied to the policyholder in any case.

7. In order to make an initial estimate, the inspection team called for the details of last five years rejection cases of takaful products and respective policies event date cash value, which were not paid. The inspection team noted that cash values of such policies on event dates aggregated to Rs. 93.55 million and effect of delay in payment against such policies may further increase the foregoing amount. It is also pertinent to mention here that due to above referred discrepancies, Takaful Fund of the Company has been overstated over the years with excess distribution towards other participants/policyholders while making discriminatory treatment towards the policyholders whose claims were rejected.

8. In reply to the aforesaid observation, the Company has furnished a list showing the amounts of other claims settled by it during the period; however, the response of the Company has not been found satisfactory as it failed to clarify its position with regard to the aforesaid observations. Therefore, the Company did not ensure compliance with aforesaid clause of the PMD which, prima facie, is in contravention of Rule 15(1)(e) of the Takaful Rules read with Section 118 of the Ordinance.

9. As per the findings of the inspection report, conventional policy document of the Company defines "Premium" as under:

"Premium is the amount in consideration of which the Policy has been issued. The amount of Premium for the first policy Year is specified in the Policy Schedule. Subsequent Years' Premium(s) may increase due to Indexation in accordance with Condition 11."

10. Review of conventional policy document of the Company disclosed that Clause 2.1 (Misrepresentation and concealment of material facts) thereof states that:

"Any deliberate false statement or declaration made by the Life Assured or Policy Owner(s) in connection with the policy or any concealment of information which ought to be made known to the Company shall render the Policy null and void and all Premiums paid under the Policy shall be forfeited by the Company, except as provided in Condition 12."

11. The examination of the record provided by the Company shows that deposited top-up amounts were also forfeited in case of rejection of policies giving the reason of non-disclosure of material facts at the time of issuance of the policy. However, it is pertinent to mention here that top-up amount is received separately from premium amount in the form of investment by the respective policyholder as it does not have any effect on sum insured mentioned in the respective policy. The above referred Clause of the policy allows forfeiture of amount of premium only but cash value of the top-up amount cannot be forfeited in any case. Further, it has been observed that the Company has a practice in place of combining cash value of the policy with cash value of top-up amount due to which the amounts of conventional claims rejected during the prior years were not ascertained.

12. In its reply the Company has merely shared a list of the amounts of other claims settled by it during the period; however, the response of the Company has not been found satisfactory as it failed to address the observations. Therefore, the Company, *prima facie*, has:

i. violated the requirements of Section 76 of the Ordinance by including unusual terms in policy documents (stating that all Premiums paid under the Policy shall be forfeited by the Company) and tending to limit its liability;
ii. violated the requirements of Section 77 of the Ordinance by incorporating in policy documents ambiguous wording and by not differentiating premium related to risk coverage and that related to investment and constructing the same in favor of the Company; and
iii. violated the requirements of Section 87 of the Ordinance by discriminating conventional policyholders w.r.t. the aforesaid policy terms in comparison to corresponding Clause of the PMD for takaful participants.
iv. contravened the requirements of Rule 15(1)(e) of the Takaful Rules read with Section 118 of the Ordinance by not adhering to clause 2.1 of the participant membership documents and denying the basic right of the participants on cash value and top up amounts.

13. In view of the above, the Company, prima facie, has acted in violation of Sections 76, 77 and 87 of the Ordinance and Rule 15(1)(e) of the Takaful Rules read with Section 118 of Ordinance.

14. Accordingly, SCN was served on the Respondent/Company calling upon it to show cause in writing within 14 days of the date of the SCN as to why penalty may not be imposed on it for contravening the aforesaid provisions of the law.

15. The relevant provisions of the law are reproduced as under:

Rule 15(1)(e) of Takaful Rules, 2012:

15. Participant Membership Document: -

(1) The benefits and obligations of each Participant under a Takaful Contract shall be documented in a Participant Membership Document detailing therein the terms and conditions relating to the relationship amongst the Participants and between the Participants and the Takaful Operator including the following:

a) rights and obligation of Participants;

b) *procedure for division of Contribution between Participant Takaful Funds, Participant Investment Funds and Operator fund/sub-fund;*
c) *method for determination of fees and/or share of investment income payable to the Operator;*
d) *procedure for and timing of transfer of funds between Participant Takaful Funds, Participant Investment Funds and Operator fund/sub-fund;*
e) *procedure for claims and payment of Takaful Benefits and the method of determining such benefits, including, if applicable, any limitations and exclusions;*
f) *in case of Family Takaful contracts, the procedure for pooling of moneys for investment purposes under the Participant Investment Fund; and*
g) *terms and conditions on which the Operator will manage the Participant Takaful Fund and Participant Investment Fund.*

Section 76 of the Insurance Ordinance, 2000:

76. Insurer not to engage in misleading or deceptive conduct: -

(1) An insurer shall not, in the course of its business as an insurer, engage in conduct that is misleading or deceptive or is likely to mislead or deceive.
(2) The inclusion in an insurance policy of unusual terms tending to limit the liability of the insurer, without the express acknowledgement of the policy holder, shall constitute misleading or deceptive conduct.
(3) Nothing contained in sub-section (2) shall be taken as limiting by implication the generality of sub-section (1).
(4) Where a policy holder has relied upon any representations by an insurer or by an agent of an insurer which are incorrect in any material particular, inasmuch as it has the effect of misleading or deceiving the policy holder in entering into a policy, the policy holder shall be entitled to obtain compensation from the insurer for any loss suffered.
(5) Notwithstanding the provisions of the foregoing sub-section, the Commission shall also have the power to levy a fine on the insurer which shall be equal to the lesser of twice the loss determined to be suffered by the policy holder under the foregoing subsection and ten million rupees.

Section 77 of the Insurance Ordinance, 2000:

77. Construction of ambiguities in favor of policy holder: -

1. Any ambiguity in a contract of insurance shall not be capable of being construed in a manner which is contrary to the interests of the policy holder.
2. An insurer or an insurance intermediary shall:
   a. when drafting policy documentation, make reasonable efforts to use plain language; and
   b. when drafting proposal forms and claim forms, make reasonable efforts to ensure that it identifies in those documents the usual information the insurer ordinarily requires to be disclosed; and that those documents are in plain language and provide instructions where necessary on how the questions should be answered; and comply with the law.

Section 87 of the Insurance Ordinance, 2000:

87. Provisions when not to constitute discrimination: -

Notwithstanding anything contained in any other law for the time being in force, provisions in respect of the terms and conditions of insurance policies, shall not constitute discrimination provided that differentiation contained therein is based on reasonable classification and:

(a) is based on actuarial and statistical data from a source on which it is reasonable to rely; and

(b) is reasonable having regard to the data and any other relevant factors.

The onus of proving that the insurer has complied with this section shall lie upon the insurer.

Section 118 of Insurance Ordinance, 2000:

118. Payment of liquidated damages on late settlement of claims: -

1. It shall be an implied term of every contract of insurance that where payment on a policy issued by an insurer becomes due and the person entitled thereto has complied with all the requirements, including the filing of complete papers, for claiming the payment, the insurer shall, if he fails to make the payment within a period of ninety days from the date on which the payment becomes due or the date on which the claimant complies with the requirements, whichever is later, pay as liquidated damages a sum calculated in the manner as specified in sub-section (2) on the amount so payable unless he proves that such failure was due to circumstances beyond his control.
Explanation: for the purposes of this sub-section, failure or delay by any person in making payment (including without limitation payment under a contract of reinsurance) to an insurer shall not constitute circumstances beyond the control of the insurer.

2. The liquidated damages payable under sub-section (1) shall be payable for the period during which the failure continues and shall be calculated at monthly rests at the rate five per cent higher than the prevailing base rate.

16. The Company submitted its reply vide letter dated August 23, 2023 in response to the SCN, which is reproduced as under:

(Quote)

"Takaful:
We would like to present far your kind review the actual facts and figures of the declined claims from 2018 to 2022 (5 years) during which a total of 368 claims were declined. Out of 368 cases, the Company had paid ex-gratia amount in 173 cases. The aggregate cash value as at event dates for these 173 cases was PKR 14,812,884/- whereas the ex-gratia amount paid out under these cases by the Company comes out to PKR 35,578,806/- in aggregate that is quite higher than the aggregate cash value amount. Kindly refer to the attached Annex A for all 368 Takaful claims declined during the stated five (5) years. Please note that of the remaining 195 cases declined where no payment was made the total cash value was only PKR 9,528,278/- as at event date.

Conventional:
Please note that from 2018 to 2022 (5 years), a total of 44 claims were declined where top-up amount was received. Out of 44 cases, the Company had paid ex-gratia amount in 34 cases. The aggregate cash value as at event dates for these 34 cases was PKR 10,863,599/- whereas the ex-gratia amount paid out under these cases by the Company comes out to PKR 14,011,487/- in aggregate that is quite higher than the aggregate cash value amount. Kindly refer to the attached Annex B for all 44 Conventional claims declined during the stated five (5) years. Please note that of the remaining 10 cases declined where no payment was made the total cash value was only PKR 3,327,182/- as at event date.

Apprising the Commission of true facts and figures, Jubilee Life is ready to reevaluate its claim processing procedures according to the Commission's wishes to pay all the claims irrespective of causes and reasons of the claims if the Commission so instructs.

Unquote.

17. In order to provide the Respondent Company an opportunity of making personal representation, hearing in the matter was fixed on November 22, 2023. The hearing was attended by Mr. Zahid Barki, Mr. Junaid Ahmed and Mr. Muhammad Asif Khan as the Authorized Representatives of the Respondent **(the Authorised Representatives)**. During the hearing proceedings, the Authorized Representatives were advised to explain the reasons for the alleged non-compliances, as narrated in SCN. The Authorized Representatives reiterated the written submissions and arguments made by the Respondent vide reply dated August 23, 2023. During the course of hearing, the Authorised Representatives were advised to submit further information/documents on the issues, as discussed during the hearing.

18. The Company vide letter dated December 22, 2023 submitted further information on the issues discussed during the hearing in respect of rejected claims against takaful as well as conventional policies as under:

(Quote)

"Point 4. The Takaful Declined Claims data for the period 2018 to 2022, has been reconciled and the Reconciliation Sheet is attached as Annexure A. Relevant facts are as under:

Cash Value Difference:

i. *In February 2023, in the data provided to the Commission's inspectors, in 82 takaful declined claims, the Cash Value Column showed Sum Assured amounts instead of cash value amounts and consequently the Cash Value was overstated by Rs. 77,497,987. The August 2023 data (sent to the Commission under cover of our letter dated 23 August 2023) tabulated the correct amounts.*

ii. *Furthermore, in the February 2023 data, 27 takaful declined claims of Cash Value amounting to Rs. 3,523,292 were not reported, which were subsequently reported in the August 2023 data sent to the Commission.*

iii. *There was 01 instance mentioned as declined in the February 2023 data, which was then pending and was subsequently paid by August 2023 and removed from declined status. The Cash Value in this instance was Rs. 77,447.*

Ex-Gratia Payment Difference:

iv. *Between February 2023 and August 2023 (when our response dated 23 August 2023 was submitted to the Commission), further ex-gratia amounts aggregating Rs. 15,052,696 were paid to claimants under 50 takaful declined claims. Consequently, these figures stand reflected in the August 2023 data.*

iv. *Furthermore, in the February 2023 data, 27 takaful declined claims ex-gratia payments amounting to Rs. 11,845,037 were not reported, which were subsequently reported in the August 2023 data sent to the Commission.*

Correct Figures:

v.	*173 Ex-gratia Cases:*	*Cash Value Rs.14,812,884*	*Ex-Gratia Rs.35,578,806*
vi.	*195 Non-Payment:*	*Cash Value Rs. 9,528,278*	*Ex-Gratia Rs. 0 (zero)*
vii.	***368 Cases: (TOTAL)***	***Cash Value Rs. 24,341,162***	***Ex-Gratia Rs. 35,578,806***

Point 5. *The Conventional Declined Claims data for the period 2018 to 2022 has been reconciled and the Reconciliation Sheet is attached as Annexure B. Relevant facts are as under:*

i. *With regard to Conventional Declined Claims please note the following:*
The SCN under para 10 stipulates as follows:
Quote
"AND WHEREAS, Clause 2.1 (Misrepresentation and concealment of material facts) of conventional policy document of the Company states that: "Any deliberate false statement or declaration made by the Life Assured or Policy Owner(s) in connection with the policy or any concealment of information which ought to be made known to the Company shall render the Policy null and void and all Premiums paid under the Policy shall be forfeited by the Company, except as provided in Condition 12." Unquote

The SCN under para 11 specifies as follows:
Quote
"AND WHEREAS, the inspection team noted that top up amounts were also denied in case of policy rejection because of non-disclosure of material facts at the time of issuance of the policy. It is pertinent to mention here that top-up amount is received separately from premium amounts as an investment by the respective policyholder as it does not have any effect on sum insured. Above referred clause of the policy only allows forfeiture of premium amount only. Cash Value of the Top-up amount cannot be forfeited in any case, as it is the amount provided by the policyholder for investment purpose only. Further, the Company has a practice of combining policy cash value with top up cash value. Therefore, amounts of conventional claims rejected during the prior years were not ascertained." Unquote

ii. *As per the above paragraphs, the matter under contention was specifically Declined Conventional Policies with Top-Up (Adhoc) amounts, therefore, only the relevant data was submitted as annex to our reply dated 23 August 2023. Total declined policies with top-up premium are 44 cases for the period 2018 to 2022 and this is as per the reported figure in August 23.*
iii. *In 08 Conventional Declined Claims with Top-up amounts minor adjustments were made in Cash Value and Ex-gratia payments between February 2023 and August 2023: 07 Cases Cash Value increased by: Rs.1,209,012; 07 Cases Ex-gratia Payments increased by: Rs.1,181,918; 01 Case Cash Value decreased by: Rs.149,314.*
iv. *The reconciled figures are as follows:*

44 Top-up Cases:	*Cash Value Rs.14,190,781*	*Ex-Gratia*	*Rs.14,011,487*
998 Non Top-up Cases:	*Cash Value Rs.33,469,061*	*Ex-Gratia*	*Rs.34,815,695*
1042 Cases: (TOTAL)	***Cash Value Rs.47,659,842***	***Ex-Gratia***	***Rs.48,827,182***

Point 6(i): *The data now stands submitted as per format prescribed with additional columns to facilitate understanding. Should the Commission require further information we will be pleased to provide. Our CFO has requested for 4 additional weeks to engage statutory auditors and get them to verify and stamp the data. Meanwhile the unaudited data stands provided to the Commission.*

Point 6(ii): Our response to the alleged violations under Section 76, 77, 87 of the Insurance Ordinance 2000 as narrated in the show-cause notice is appended. However, to begin with we wish to narrate the process through which ex-gratia settlements are made on declined claims:

Step 1: All claims falling within the contestable period and those that appear to be fraudulent are investigated and only when it is conclusively established that the claim is legally and/or contractually not payable is it declined.
Step 2: If the claim is established as fraudulent and/or for unlawful purpose, it is declined without settlement of any sort.
Step 3: If during investigation it emerges that, although the claim may not be contractually payable, humanitarian considerations exist and/or the claimant is genuinely unaware of any fraud having been perpetrated against the Company, a settlement is proactively sought with the claimant, provided the claimant agrees that the claim is legally not payable. On reaching an agreement, the amount paid to the claimant in most instances is more than the Policy's Cash Value.
Step 4: Despite best efforts, if the claimant is not agreeable to any amicable settlement and expresses the desire to seek legal remedy, the matter is laid to rest anticipating legal recourse thereof.

(a) Sections 76 & 77 of the Insurance Ordinance, 2000
1. The Insurance Proposal Form is replete with instructions and declarations both in plain simple English and Urdu, urging insurance prospects to understand the contents, terms and conditions of the contract telling them to reveal all material information sincerely and completely. They are warned of the adverse consequences of concealment and distortion of facts pertaining to their health, avocation, habits and pre-existing conditions. Few examples are delineated:

"I confirm that I have properly understood all product features, its benefits, terms and conditions, limitations, rights and privileges and I undertake to fulfill all obligations as required of me under the Policy. I have read and understood the contents, questions and instructions of the Form and I undertake to submit answers and provide information as completely, accurately, and carefully as I possibly can."

Details of Health, Medical Condition and Medical History of Life Proposed

(Explain every 'Yes' answer in the 'Comments Section' after indicating the question number. Do not leave any question unanswered. Use separate sheet(s) if required. If any question is not understood or requires clarification, please consult a qualified underwriter in head office or regional office of the Company)

Comments Section: For any and every 'Yes' answer in the above Sections of this proposal (application) form submit Documents, Reports, Evidence where required and provide details in this 'Comments Section' indicating the question and sub-question number. To provide further information use separate sheet(s) under full signature of Life Proposed.

Important Note: (1) Read and understand every point of the DECLARATION completely and thoroughly (2) Only if you agree with its contents and are in complete acquiescence therewith should you affix your signature at the end of the Declaration here below. (3) Once you affix your signature it will be considered that you understand, agree and acknowledge all the terms

& conditions it embodies. (4) If signature is not as per CNIC/NICOP/PASSPORT, please provide official documentary evidence as proof of signature change with three specimens of old and new signatures duly attested. (5) Unlettered or semi-literate male Life Proposed must affix Left Thumb Impression (LTI) Unlettered or Semi-Literate female Life Proposed must affix Right Thumb impression (RTI) also submitting three specimen thumb impressions duly attested. (6) If Life Proposed is unlettered/semi-literate, then the person who has helped complete this Application / Proposal Form must certify that he/ she, being well aware of the contents of this Application / Proposal Form and of applicable laws and regulations, has explained its contents and all relevant terms and conditions carefully & in detail to the Life Proposed and has accurately recorded the answers provided by the Life Proposed. (7) This certificate is to be attached and submitted as part of this Insurance Proposal documents.

I understand, agree, and acknowledge that it is my responsibility to inform Jubilee Life Insurance Company Limited, immediately if my health, occupation, financial status, avocation, habit or any fact / information provided by me in this Application / Proposal for Insurance charges or is no longer valid while my Proposal is being processed and before life insurance cover commences.
I declare and affirm that the answers provided by me in this Application/Proposal for Insurance and other documents are correct, true and complete and that I have not withheld, distorted or mispresented any material information or fact and I understand, agree, and acknowledge that any misstatement, distortion or concealment of fact/information can adversely affect the insurance benefits and privileges available to me under the Policy. I am aware of Insurance related Laws, Regulations & Guidelines.

2. Call Back Confirmations (CBC), Leaflets and pamphlets are pre-insurance tools and measures in use to educate and guide policy/membership holders regarding their rights and privileges as well as make them aware of their obligations and responsibilities under the contract. The CBC script specifically enquires about the health status of the prospect and the flyers, pamphlets and leaflets clearly mention policy/membership exclusions and limitations regarding insurance coverage and claims.

3. The Policy / Membership Documents too contain numerous clauses, advices and instructions rendered to Policyholders / Members in plain simple language making them aware of terms & conditions that render the Policy operational under law. Few examples related to coverage, disclosure, rights and privileges and policy enforcement are narrated below:
The Policy shall be refundable within the Free Look Period of fourteen (14) days from the receipt of the policy documents by the Policy Owner, in accordance with the provisions mentioned in Condition 3 of this Policy Document. The Policy would lapse if during the first 24 Policy Months any renewal Premium due under the Policy is not paid by the due date or within the period of grace allowed for payment of the Premium. For the purpose of this Policy, Benefit Assured is higher of Sum Assured or Cash Value that shall be payable on death of the Life Assured, provided the Policy does not stand terminated or lapsed under any terms and conditions of this Policy. The Benefit Assured is payable once only on the acceptance by the Company of the happening of the death of the Life Assured in respect of which a claim is duly made and admitted by the Company, whereupon all units allocated to the Policy will be cancelled and the Policy shall terminate.
INCONTESTABILITY: After the Policy has been in force for two (2) complete Policy Years from the later of the date of issuance, reinstatement, enhancement of benefits provided under the Policy and / or alteration in the premium payment mode of the Policy, no representation made in the proposal for insurance, or in any other document leading to the issuance,

reinstatement, enhancement of benefits provided under the Policy and / or change in premium payment mode shall be called in question or shall constitute a cause for rescinding the Policy, except that a wilful misstatement of material fact(s) which was knowingly made to the Company, and was relied upon by the Company, shall make the Policy voidable at the option of the Company.

4.Even the clause quoted in para 10 of the SCN is unambiguous and is crystal clear in intent and meaning. In plain simple language it is stated:
Quote "Any deliberate false statement or declaration made by the Life Assured or Policy Owner(s) in connection with the policy or any concealment of information which ought to be made known to the Company shall render the Policy null and void and all Premiums paid under the Policy shall be forfeited by the Company, except as provided in Condition 12" Unquote

5. Standard Membership Condition General Clause 2.1 quoted by the Commission's Inspector justifying compulsory return of Cash Value stipulates:

Quote:** "Any deliberate false statement or declaration made by the Life Covered or Participant(s) in connection with the Membership or any concealment of information which ought to be made known to the Window Takaful Operator (affects the judgement of the Window Takaful Operator in deciding whether to accept the Membership or not and if it decides to accept, the terms on which it would do so) shall render the Membership null and void. In such an event window takaful operator will pay the participant the cash Value of units available in the Participant Investment Account and terminate the Membership" **Unquote

This clause without any ambiguity refers to cancellation of the Membership during the lifetime of the Participant due to false statement and concealment of material facts.

6. Correspondence and communication with Policy/Membership holders commences immediately and continues constantly throughout the Policy cycle. From Welcome letter at issuance to renewal reminders, premium acknowledgement letters, lapse and non-forfeiture notices, policy conservation letters, grievance redressal letters are sent at every opportunity and touch point. Invariably the emphasis is risk coverage and policy continuation in the best interests of policyholders and their family members. This momentum is maintained through emails and electronic texting. Therefore, hardly can the Company be faulted if the claim is rejected due to contractual stipulations.

7. Therefore, the Company cannot be accused of misleading conduct; usage of unusual terms; nor has the intent been to limit its liability; the express acknowledgement of the Policy/Membership owner has been obtained in the Proposal form and attached application documents and simplified plain narrations of contractual terms and conditions are readily available in Standard Policy/Membership Conditions. Prototype of all Policy and Membership documents stand submitted and filed with the Commission and comply with the requirements of Section 76 and 77 of the Insurance Ordinance.

8. At the proposal stage Policy/Membership holders are encouraged in the Proposal Form to seek information and guidance from the underwriters and officials of the Company located in the Head Office and/or Regional Offices of the Company so as to dispel any misunderstanding or doubts they may harbour or should some point require further clarification.

9. One must understand that whenever a claim is declined fraud if at all, has been perpetrated against the Company and the Company most certainly is not the beneficiary of this malafide act, so how can it be penalized. If the Company were not able to detect the fraud, it would have been the victim of fraud and suffered financially. Would justice be served if the Company were forced to make payment for whenever and for whatever reasons claims were declined. Would this act too be compatible with the laws of the land specifically when fraud has been perpetrated with criminal intent.

10. The procedure adopted by the Company is preferable. It investigates the claim and even if required to decline on merit it refunds up-to premium amount, as a gesture of goodwill (and not as contractual obligation), if and when the situation so demands.

(b) ***Section 87 of the Insurance Ordinance, 2000 stipulates that:***
Quote "Provisions when not to constitute discrimination:-Notwithstanding anything contained in any other law for the time being in force, provisions in respect to the terms and conditions of insurance policies, shall not constitute discrimination provided that differentiation contained therein is based on reasonable classification and: (a) is based on actuarial and statistical data from a source on which it is reasonable to rely; and (b) is reasonable having regard to the data and other relevant factors. The onus of proving that the insurer has complied with this section shall lie upon the insurer." Unquote

1. The data of declined claims, their cash values and ex-gratia payments made thereof, clearly demonstrates the Company's consistent policy and indiscriminate approach in settlement of claims in the best interests of Claimants without compromising on life insurance principles and the requirements of law, as every decision to decline a claim is either based on contractual limitations or is backed by investigation and credible concrete evidence. The ex-gratia decision too emanates from enquiry and verification of the claim's veracity and claimant's eligibility.

2. In total Rs.84,405,988 ex-gratia payments were made against cash value amounting to Rs.72,001,004 which clearly establishes that the Company is not pursuing a policy of discriminatory enrichment at the cost of Policy/Membership holders, as the ex-gratia amounts in excess of cash values were paid from the Shareholder Statutory Fund.

3. Claims paid and declined are reviewed in Board and Management Committees and controls, checks and balances are exercised in rendering ex-gratia payments.

4. As per life insurance practice prevalent the world over, when on merit, claims are declined contractually or due to concealment/distortion of material facts, by default all premiums received are forfeited and no amount whatsoever is refunded. Whatever the Company does pay eventually, it does so voluntarily due to empathic and sympathetic considerations and as gestures of goodwill.

5. From the above facts it is amply clear that no violation of Section 87 of the Insurance Ordinance has occurred.

Point 6 (iii) Our response to the alleged violations under Section 15(1)(e) of the Takaful Rules 2012 is as under:

1. A copy of the Standard Membership Conditions is attached for plain reading.
Going through its contents one finds that:

a. The document is well structured. It is divided into 3 Parts:
i. The General Terms and Conditions
ii. The Operation of the Participant Investment Account
iii. The Operation of the Individual Family Takaful Participant Fund
b. Care has been taken to use plain and simple language.
c. Every term and terminology is carefully and precisely defined.
d. Rights and Obligations of Participants are properly and thoroughly covered.
e. Part 2 & Part 3 of the document (Condition 24 to Condition 33) comprehensively and in quite detail covers the procedure for division of Contribution between Participant Takaful Funds, Participant Investment Funds and Operator fund/sub-fund.

f. Condition 28 of the document read in conjunction with Conditions 24 and 27 delineate the method for determination of fees and/or share of investment income payable to the Operator.

g. Conditions 24,25,26,27 and 28 thoroughly and with lucidity covers the entire spectrum and mechanism, processes and procedures governing the timing of transfer of funds between Participant Takaful Funds, Participant Investment Funds and Operator Fund/sub-funds.
h. As regards Claims:
i. Condition 19.1 covers Notification of Claims
ii. Condition 19.2 covers Proof of Claim
iii. Condition 19.3 covers Late Settlement of Claims
iv. Condition 4 covers the method of determining the Benefit Assured.
v. Condition 4.1 describes 'Suicide' as the only exclusion/ limitation in the Membership.
i. Condition 24 with systematic elaboration unfolds the terms and conditions and working of the Participant Investment Fund including the contributions for investment at the membership level.

j. Conditions 30, 31, 32 and 33 (Part 3 of the document) comprehensively covers the terms & conditions and operations of Participant Takaful Fund.

2. From the above facts it is amply clear that no violation of under Section 15(1)(e) of the Takaful Rules 2012 has occurred.

Point 6 (iv) On the advice of the Commission, the Company proposes the following changes to the policy / membership documents:

(a) Takaful Standard Membership Conditions:
"Misrepresentation and concealment of material facts:

Any fraudulent or criminal act, or any deliberate concealment of information, or any false statement/declaration or distortion of facts, committed by the Life Covered, Participant(s), Nominee(s) that adversely affects the Window Takaful Operator's judgement and decision in acceptance of the Membership and/or admission of Claim under the Membership, shall render the Membership null and void. In such an event, the Window Takaful Operator undertakes to pay, if not otherwise constrained under law, the Cash Value of the Membership to government recognized charity(ies) as shall be decided by the Window Takaful Operator. No other amount shall be payable."

(b) Conventional Standard Policy Conditions

"Misrepresentation and concealments of material facts:

Any fraudulent or criminal act, or any deliberate concealment of information, or any false statement/declaration or distortion of facts, committed by the Life Assured, Policy Owner, Nominee(s) that adversely affects the Company's judgement and decision in acceptance of the Policy and/or admission of Claim under the Policy, shall render the Policy null and void. In such an event, the Company undertakes to pay, if not otherwise constrained under law, the Cash Value of the Policy to government recognized charity(ies) as shall be decided by the Company. No other amount shall be payable."

Clause 2.1 under General conditions of existing Policy/Membership documents would be replaced with respective wordings without any other change in text.

Point 6 (v) Finally specifically with regard to the matter under contention, that is; should the cash value be paid in default to claimants under declined/rejected family takaful contracts, our point of view is as follows:

a. Nowhere in law is this required.

b. In no instance are we contractually obliged to do so.

c. We are of the considered view that the law ostentatiously disallows the abatement of criminal and fraudulent activity through pecuniary means.

d. A claim is only declined when there is a breach of contract and/or concealment, misrepresentation, falsification of facts has occurred on the part of the Policy/Membership holder. Therefore, it is not possible that the law expects payment of sorts in all declined cases without us first establishing the true facts of the matter. If not, it would be quivalent to a wagering contracts where the Policy/Membership holder gambles that his bluff at concealment, misrepresentation, falsification of facts remains undetected and the beneficiary(ies) are rewarded with a windfall payment, failing with the beneficiary(ies)would be guaranteed return back of the Cash Value or its equivalence.

e. Top-up Premiums too are paid as additions to cash values to reduce the Sum at Risk. It is on this reduced sum at risk that mortality charges are applied. In other words, the Company would earn less and pay back more in instances of bluff and cheating by Policy/Membership holders, if by default cash values were to be disbursed blindly in all declined cases involving Top-up amounts.

f. The Insurance Ordinance, Rules and Regulations clearly forbids and bars falsification of facts and distortion of material information by all and everyone including Policyholders. On such occurring specific remedy in law is available to Insurers. A few examples are denoted:

Insurance Ordinance 2000:
75. Duty of utmost good faith.- *(1) A contract of insurance is a contract based on the utmost good faith and there shall be implied in such a contract a provision requiring each party to it to act towards the other party, in respect of any matter arising under or in relation to it, with the utmost good faith.* ***(2)*** *If reliance by a party to a contract of insurance on a provision of the contract would be to fail to act with the utmost good faith, the party may not rely on the provision. (3) In deciding whether reliance by an insurer on a provision of the contract of*

insurance would be to fail to act with the utmost good faith, the Tribunal shall have regard to any notification of the provision that was given to the policy holder, whether or not the insurer was required by this Ordinance to give such notification. (4) The effect of this section is not limited or restricted in any way by any other law, including the subsequent provisions of this Part, but this section does not have the effect of imposing on an policy holder, in relation to the disclosure of a matter to the insurer, a duty other than the duty of disclosure

79. Remedies for non-disclosure or misrepresentation.- *(1) This section shall apply where the person who became the policy holder under a contract of insurance upon the contract being entered into:*

(a) failed to comply with the duty of disclosure; or
{b) made a misrepresentation to the insurer before the contract was entered into.

(2) The insurer may not avoid a contract of insurance by reason only of the failure to comply with the duty of disclosure or the misrepresentation if:

(a) the insurer would have entered into the contract, for the same premium and on the same terms and conditions, even if the insured had not failed to comply with the duty of disclosure or had not made the misrepresentation before the contract was entered into; or
(b) the failure to comply with the duty of disclosure or the misrepresentation was not fraudulent: Provided that in circumstances to which clause (b) refers, the insurer shall be entitled to be placed, in such manner, not otherwise inconsistent with this sub-section, as may be prescribed, in a position in which the insurer would have been if the failure had not occurred or the misrepresentation had not been made.

(3) Subject to sub-section (2), if the failure was fraudulent or the misrepresentation was made fraudulently, the insurer may avoid the contract.

(4) Nothing in this section shall affect any right of an insurer to recover damages from any person in respect of loss suffered by the insurer as a result of a fraudulent act by that person, or any criminal liability to which any person may be subject by reason of a fraudulent act by that person.

80. Policy not to be called in question on ground of mis-statement after two years.-
Notwithstanding anything in section 79, no policy of life insurance effected before the commencement date of this Ordinance shall after the expiry of two years from the commencement date of this Ordinance and no policy of life insurance effected after the commencement date shall, after the expiry of two years from the date on which it was affected, be called in question by an insurer on the ground that a statement made in the proposal for insurance or in any report of a medical officer, or referee, or friend of the policy holder, or in any other document leading to the issue of the policy, was inaccurate or false, unless the insurer shows that such statement was on a material matter or suppressed facts which it was material to disclose and that it was fraudulently made by the policy holder and that the policy holder knew at the time of making it that the statement was false or that it suppressed facts which it was material to disclose: Provided that nothing in this section shall prevent the insurer from calling for proof of age at any time if he is entitled to do so, and no policy shall be deemed to be called in question merely because the benefits payable under the policy are adjusted on subsequent proof that the age of the life insured was incorrectly stated in the proposal.

81. Tribunal may disregard avoidance in certain circumstances.- *(1) In any proceedings by the policy holder in respect of a contract of insurance that has been avoided on the ground of fraudulent failure to comply with the duty of disclosure or fraudulent misrepresentation, the Tribunal may, if it would be harsh and unfair not to do so, but subject to this section, disregard the avoidance and, if it does so, shall allow the policy holder to recover the whole, or such part as the Tribunal thinks just and equitable in the circumstances, of the amount that would have been payable if the contract had not been avoided. (2) The power conferred by sub-section (1) may be exercised only where the Tribunal is of the opinion that, in respect of the loss that is the subject of the proceedings before the Tribunal, the insurer has not been prejudiced by the failure or misrepresentation or, if the insurer has been so prejudiced, the prejudice is minimal or insignificant. (3) In exercising the power conferred by sub-section (1), the Tribunal (a) shall have regard to the need to deter fraudulent conduct in relation to insurance; and (b) shall weigh the extent of the culpability of the policy holder in the fraudulent conduct against the magnitude of the loss that would be suffered by the policy holder if the avoidance were not disregarded, but may also have regard to any other relevant matter. (4) The power conferred by sub-section (1) applies only in relation to the loss that is the subject of the proceedings before the Tribunal, and any disregard by the Tribunal of the avoidance does not otherwise operate to reinstate the contract.*

82. Cancellation of a life insurance policy for fraudulent claim.- (1) Notwithstanding anything to the contrary in this Ordinance, a policy of life insurance may be cancelled in accordance with this section by reason that a person having or purporting to have rights under the policy has made a claim under the policy which is fraudulent.....

SECP AML/CFT Regulations 2020
TFS Obligations:
25. (1) The regulated person shall undertake TFS obligations under the United Nations (Security Council) Act 1948 and/or Anti-Terrorism Act 1997 and any regulations made there under, including:

(b) If during the process of screening or monitoring of customers or potential customers the regulated person finds a positive or potential match, it shall immediately:

i. *freeze the relevant funds and assets without delay the customer's fund/ policy or block the transaction, without prior notice if it is an existing customer in accordance with the respective SRO.*
ii. prohibit from making any funds or other assets, economic resources, or financial or other related services and funds in accordance with the respective SRO.
2) The regulated person is prohibited, on an ongoing basis, from providing a financial service to proscribed/ designated entities and persons or to those who are known for their association with such entities and persons, whether under the proscribed/ designated name or with a different name. The regulated person should monitor their business relationships with the entities and individuals on continuous basis and ensure that no such relationship exists directly or indirectly, through ultimate control of an account and where any such relationship is found, the regulated person shall take immediate action as per law, including reporting to the FMU.

Explanation: - For the purposes of this section the expression associates means persons and entities acting on behalf of, or at the direction, or for the benefit, of proscribed/ designated entities and individuals that may be determined on the basis of appropriate screening of

sanctions lists, disclosed nominee/beneficiary information, publicly known information, Government or regulatory sources or reliable media information, etc.
g. Section 158. Of the Insurance Ordinance 2000- In our humble opinion no case exists for invocation of penalties under this section of the Ordinance."

(Unquote)

19. On the request of the Respondent, second hearing in the matter was held on January 18, 2024. The said hearing was attended by Mr. Zahid Barki, Mr. Junaid Ahmed and Mr. Muhammad Asif Khan as the Authorized Representatives of the Respondent. During the hearing proceedings, the Authorized Representatives were advised to apprise on the latest status of the declined claims along with remaining issues. The Authorized Representatives reiterated the written submissions and arguments made by the Respondent vide reply dated December 22, 2023. During the course of hearing, the Authorised Representatives were advised to intimate the latest status of settlement of declined claims pertaining to takaful membership as well as conventional policies.

20. Subsequent to the second hearing in the matter, the Respondent vide email dated January 31, 2024 apprised the status of rejected cases as under:

"As required, please find below the status of 195 declined claims:
a. About 30 cases are in different litigation/regulatory forums pending adjudication.
b. About 50 cases are in lapsed status without any cash value.
c. Under remaining 115 cases, we are re-investigating the facts and trying to establish the contacts with the claimants in order to resolve the disputed payments. This will require efforts and time and we can update you the updated status by end of February 2024."

21. Finally, the Respondent vide email dated February 21, 2024 provided the latest status of the declined claims as under:

"This is to provide you the progress made towards settlement of takaful declined claims. Please note that out of 115 cases, where possible, we have settled 49 cases, while payment under 8 cases is in process. Our renewed contact with claimants for payment of ex-gratia amounts, has rekindled false hope of claim payment where no such amount is as such payable. We envisage increase in litigation cases in the near future. Furthermore, please note that besides these amounts now settled, no further amicable settlement can be reached."

22. Moreover, the Respondent was advised vide letter dated November 28, 2023 to provide the correct amount of cash value of declined cases by reconciling the data given in February 2023 to the inspection team and in August 2023 to this department. The Respondent explained vide email dated December 22, 2023 that in February 2023, while providing the data to the inspection team, in 82 takaful declined claims, 'Cash Value' Column erroneously reported 'Sum Assured' amount, which resulted in overstatement in amount of Cash Value by Rs. 77,497,987. Thus, the Respondent has stated that the data sent to this department under cover of letter dated 23 August, 2023 reported the correct numbers as under:

Takaful membership:

173 Ex-gratia Cases:	*Cash Value Rs.14,812,884*	*Ex-Gratia Rs.35,578,806*
195 Non-Payment:	*Cash Value Rs. 9,528,278*	*Ex-Gratia Rs. 0 (zero)*
368 Cases: (TOTAL)	***Cash Value Rs. 24,341,162***	***Ex-Gratia Rs. 35,578,806***

Conventional policies:

44 Top-up Cases:	*Cash Value Rs.14,190,781*	*Ex-Gratia*	*Rs.14,011,487*
998 Non Top-up Cases:	*Cash Value Rs.33,469,061*	*Ex-Gratia*	*Rs.34,815,695*
1042 Cases: (TOTAL)	***Cash Value Rs.47,659,842***	***Ex-Gratia***	***Rs.48,827,182***

23. Further, the Respondent vide email dated August 23, 2023 informed to have settled all 1042 previously declined cases of conventional policies by making ex-gratia payment of Rs.48,827,182/- against Cash Value of Rs.47,659,842/-. However, out of 368 cases of Takaful memberships, which were initially declined during the five years period from 2018 to 2022, ex-gratia payment of Rs.35,578,806/- has subsequently been made in 173 cases against Cash Value Rs.14,812,884/-. Thus, only 195 cases of Takaful memberships against the total cash value of PKR 9,528,278/- remained unsettled. As far as 195 declined claims of takaful membership are concerned, the Respondent subsequently provided an update as at end of February 2024 as under:

Cases under litigation	50
Cases of lapses status with no cash value	30
Subsequently settled	49
Payment of claim under process	8
Remaining Declined Cases	58
	195

24. With regards to the Respondent's stance of cancellation of policies/memberships to fraudulent act or deliberate concealment of facts by the policyholders/participants, it is emphasized that likelihood of misleading or deceptive conduct by its sales agents and other marketing staff in inducing prospective policyholder/member to buy an insurance/takaful product cannot be ruled out unless the Respondent puts in place an effective rectification measures to minimize such cases. Emphasis is placed on provisions of Section 95 of the Ordinance that narrates the insurer to be liable for acts and omissions of its agents. Therefore, it would be incorrect approach to deal with such cases invariably as fraudulent act or deliberate concealment of facts ignoring the conduct of sales agents/marketing staff altogether.

25. I have examined the facts of the case in light of the applicable provisions of the law and the written as well as verbal submissions and arguments of the Respondent and its Representatives and have observed as under:

(i) **Misleading and Deceptive Conduct in contravention of Section 76(2) of the Ordinance:**
Review of Clause 2.1 (misrepresentation and concealment of material facts) of conventional policy documents indicates that all Premiums paid under the Policy shall be forfeited by the Company in case the Company cancels the Policy on grounds that any deliberate false statement or any concealment of information has been made by the Life Assured or Policy Owner. However, it is abundantly clear that the Company failed to distinguish between Premium and Top-up amount while including Clause 2.1 in conventional policy documents. In contrast to Premium which is the amount payable in consideration of the Policy issued, Top-up amount is paid by a Policyholder for investment purpose only regardless of Premium payable. Keeping in view the interest of justice and fairness, cash value of Top-up amount cannot be forfeited in case of decision of cancellation of non-disclosure of pre-existing conditions; however, the Company has a practice in place of combining cash value of premium with cash value of Top up amount and when the Company decides that Policy is liable to cancellation on non-disclosure of pre-existing conditions, all the Premium including cash value of top up amount is forfeited. Thus,

inclusion of Clause 2.1 in conventional policy documents effectively tends to limit liability of the Company without the express acknowledgement of the policyholder and constitutes misleading or deceptive conduct on its part. Therefore, the Company has violated the requirements of Section 76(2) of the Ordinance.

(ii) Ambiguous Construction of Clause 2.1 of Conventional Policy Documents Disregarding Interest of Policyholders in Violation of Section 77 of the Ordinance:
In addition to the above, Clause 2.1 of conventional policy documents is constructed in an ambiguous manner which failed to differentiate the amount of 'Premium' that is determined by the insurer and amount of 'Top-up' that is paid by Policyholder as an investment with expectations of having reasonable return on it. The Company usually receive Top up amount from such policyholders regardless of the amount of Premium but the Company has deliberately avoided to segregate the treatment of cash value of Premium and cash value of Top amount in Clause 2.1 disregarding interests of its policyholders. Thus, the ambiguities in aforesaid clause of conventional policy documents are capable of being construed in a manner which is contrary to interests of policyholders. Therefore, the Company has contravened the requirements of Section 77 of the Ordinance.

(iii) Discriminatory Treatment with Conventional Policyholders in Contravention of Section 87 of the Ordinance
The comparative review of the relevant clauses, in respect of cancellation of policy/membership on account of non-disclosure of pre-existing conditions, in conventional policy documents and participant membership documents has been carried out. It has been noted that in comparison to the condition included in participant membership documents providing that "*In such an event the Window Takaful Operator will pay the Participant the Cash Value of units available in the Participant Investment Account and terminate the Membership*", there is no such counterpart condition requiring the Company to make payment of cash value to policyholders in conventional policy documents. Thus, contrary to its obligations under participant membership documents, the Company has deliberately avoided its contractual obligations to make payment of cash value to such conventional policy holders. Resultantly, the terms and conditions contained in conventional policy documents are inclined to discriminatory treatment with conventional policyholders by depriving them from their right to have cash value of premium and top up amount. Considering the sensitivity and impact of such discrimination on confidence of policyholders, Section 87 of the Ordinance emphasizes that "*The onus of proving that the insurer has complied with this section shall lie upon the insurer.*" However, the Company has failed to give any evidence of compliance, in this regard. Therefore, the Company has violated the provisions of Section 87 of the Ordinance.

(iv) Non-Payment of Cash Value to Participants in Contravention of Rule 15(1)(e) of the Takaful Rules:
It has been observed that in case of rejection of unit linked policies on account of non-disclosure of pre-existing condition by the participants, the Company did not pay cash values of units available in participant investment account, disregarding the basic right of the participants, as agreed in Clause 2.1 of participant membership documents. Moreover, the participants were also denied cash value of top up amounts which were received from them for investment purposes only regardless of the amount of regular contributions. Rule 15(1)(e) of the Takaful Rules necessitates that benefits and obligations of the participants shall be documented in participant membership documents by way of the terms and conditions. However, the participant membership documents did not include the terms and

conditions in respect of payment of cash value of top up amounts, which is in contravention of Rule 15(1)(e) of the Takaful Rules. Moreover, the Company has failed to adhere to the terms and conditions laid down under Clause 2.1 of the participant membership documents by denying the payment of cash value of unit available in participants investment account, which constitutes violation of Rule 15(1)(e) of the Takaful Rules.

26. In view of the above, it is clear that the Respondent contravened the mandatory requirements of Rule 15(1)(e) of the Takaful Rules and Sections 76(2), 77 and 87 of the Ordinance. However, the Respondent has reported to have already settled all 1042 previously declined cases of conventional policies and 173 out of 368 previously declined cases of Takaful memberships by making ex-gratia payment of Rs.48,827,182/-against Cash Value of Rs.47,659,842/- and ex-gratia payment of Rs.35,578,806/- against Cash Value of Rs.14,812,884/-, respectively. Further, the breakup of remaining 195 cases of Takaful memberships reveals that only 58 such running declined cases are left. Moreover, the Respondent, vide letter dated December 22, 2023, has consented and proposed to incorporate changes in terms and conditions of the participant membership documents as well as the conventional policy documents considering the aforementioned observations highlighted during the instant adjudication proceedings with regard to rights of participants/policyholders.

27. Considering the above, I, in exercise of the powers conferred upon me under Section 156 of the Ordinance, hereby, impose an aggregate penalty of **Rs. 100,000/-(Rupees One Hundred Thousand Only)** on the Respondent on account of established defaults.

28. The Company is hereby directed to deposit the aforesaid fine in the designated bank account maintained in the name of Securities and Exchange Commission of Pakistan with MCB Bank Limited or United Bank Limited within thirty (30) days from the date of this Order and furnish receipted voucher issued in the name of the Commission forthwith for information and record.

29. Further, the Company is directed to submit the proposed draft amendments in the participant membership documents as well as the conventional policy documents to the Insurance Division of the SECP for seeking approval. Moreover, the Respondent is directed to make settlement of all the remaining declined claims considering cash value of contribution/premium as well as top up amount pertaining to takaful memberships and conventional policies, based on the audited data of declined cases for the years 2018 to 2022 except the cases which are currently pending adjudication before any forum. The Respondent shall also submit a certificate from its statutory auditors to the Onsite Department of the Commission as an evidence of settlement of all the aforesaid cases pertaining to the years 2018 to 2022 within two months of the date of this Order.

30. This Order is being issued without prejudice to any other action that the Commission may initiate against the Company and / or its management (including CEO of the Company) in accordance with the law on matters subsequently investigated or otherwise brought to the knowledge of the Commission.

(Shahzad Afzal Khan)
Director/Head of Department
(Adjudication Department-I)

Announced on:
March 4, 2024
Islamabad