Volume VI, No. 9

Journal

September 2008

Claim Repudiation in Insurance

बीमा विनियामक और विकास प्राधिकरण

Printed by Alapati Bapanna and
published by J. Hari Narayan on behalf of
Insurance Regulatory and Development Authority.

Editor: U. Jawaharlal

Printed at Kala Jyothi Process Ltd.
(with design inputs from Wide Reach)
1-1-60/5, RTC Cross Roads
Musheerabad, Hyderabad - 500 020
and published from
Parisrama Bhavanam, III Floor
5-9-58/B, Basheer Bagh
Hyderabad - 500 004
Phone: +91-40-66820964, 66789768
Fax: +91-40-66823334
e-mail: irdajournal@irda.gov.in

From the Publisher

For an insurance customer, the most important event during his relationship with the insurer or the moment of truth is the settlement of claim. The policyholder looks forward to the occasion when the promise to pay the sum assured is kept by the insurer. In long term contracts particularly, the occasion may arise after several years during which period the policyholder has diligently fulfilled his role in keeping the contract alive. No wonder then that when a claim is rejected, he is thoroughly disillusioned and regrets being associated with the insurance company. It has to be ensured that such incidences are reduced to the barest minimum when no other avenue is open.

While the reasons for a claim rejection could be several, and on many occasions justifiable from the insurer's point of view; in the case of a policyholder, it is always a case of a denial – particularly in nascent markets where the awareness levels are low. In order to overcome such situations, insurers should adopt a proactive stance and explain the limitations of the contract to the insured – especially the retail customers. Underwriting standards should be of a high order and wherever decisions hinge on the borderline, efforts should be made to explain the conditions of acceptance to the policyholder so that heartburn at a later stage is avoided.

Despite all the care undertaken, there could still be need for repudiating a claim. In such cases, insurers should empathize with the policyholders and explain the reasons for repudiation. It would at least demonstrate that they care; and would appease the policyholder to some extent. One very important aspect that has to be considered with great importance is that the distribution personnel being the ones to be in direct contact with the policyholders, have to be thoroughly trained and should be in a position to ensure that occasions for repudiating a claim are greatly reduced. Further, top management should take stock of the various reasons that lead to repudiation, analyze them rationally and work out strategies to bring down the incidence of claim repudiation drastically.

'Repudiation of Claims in Insurance' is the focus of this issue of the **Journal**. For an insurance contract to be smoothly concluded, to be sustained for its entire term, and at every point that needs an interface between the insurer and the insured; the intermediary plays a very crucial role. The focus of the next issue of the **Journal** will be on 'Role of the Intermediary in Insurance Contracts'.

J. Hari Narayan

INSIDE

ISSUE FOCUS

THINKING CAP

Overcoming Claim Settlement Blues ...

Insurance contracts are heavily dependent on reciprocal obligations and in an ideal situation, where both the parties have fully understood their rights and responsibilities, and acted accordingly; the need for repudiating a claim would never arise. It has often been said that there is a great deal of asymmetry of information in insurance contracts; and most of this asymmetry arises because the policyholder does not understand the nuances of the contract – either on account of the lack of awareness or owing to the fact that the insurer has not bothered to explain the terms of the contract in their exhaustive detail. In any case, the controversy arises only when there is a repudiation of a claim, and by then it is too late.

In order to avoid such a scenario, there is need for making the proposal form more exhaustive, simple and meaningful; and to ensure that the proposer is explained the terms of interpretation of the queries and the replies thereto. It needs no emphasis to mention that in most repudiated cases, one common argument is that the proposer has simply signed on the dotted line. The importance of the queries and the declaration has to be clearly explained to the proposer before obtaining his signature to ensure that the asymmetry is reduced to a great extent. The insurers should also highlight the utility of the free-look period in order that the policyholder takes an informed decision.

Looking at it from the other side, there have often been attempts to defraud the insurance companies either by making a claim that does not exist or by exaggerating a claim. In view of the lack of deterrent punishment, such incidences do not attract sufficient publicity and tend to get tacit approval. Taking a cue from the more advanced markets where the punitive measures for such offences are really strong, there is need to at least highlight such incidences, if not strictly apply them at this stage when the awareness levels are still relatively low. It will certainly reduce the number of attempts at defrauding insurers. Further, the importance of the concept of utmost good faith in insurance has to be clearly explained to the common public. Interpretation of the clauses very strictly and in their word – and not in their spirit – should be avoided; and should there be any occasion for dual interpretation, the benefit of doubt should always be cast in favour of the policyholder.

'Repudiation of Claims in Insurance' is the focus of this issue of the **Journal.** We open the debate with an article by Mr. Trevor Bull who talks about the importance of the companies registering as low ratios as possible in claim repudiation, in order that their reputation is held high. In the next article by Mr. Arman Oza, you get to see the process of claims and remedies against repudiation. Health insurance has been clearly one area where several controversies with claim rejection have been reported. Dr. Subodh P. Sirur looks at the problem and suggests a few ways to tackle this sensitive domain. In the next article by Mr. Arun Agarwal, there is emphasis on the fact that claim repudiation is an act that is not desired by any of the stakeholders or the consumer forums, unless the situation really demands such a repudiation.

A cursory look at some of the claim denials by insurers brings to light some very common reasons that could have led to repudiation. Mr. Sanjay Seth throws light on some of these areas and suggests ways to overcome them. In the last article on the issue focus, Mr. D.V.S. Ramesh exhaustively deals with the subject, aided by case laws that bring out the legal perspective. In the 'Thinking Cap' section, we have for you an article by Mr. Sanjeeb Chaudhary that talks about the vagaries of the nature and their impact on Indian agriculture and the insurance market.

There was a time when insurance intermediation was synonymous with the tied-up agents. With the onset of fresh channels like brokers, corporate agents, bancassurance etc, insurance intermediation has assumed new challenges. 'Role of the Intermediary in Insurance' will be the focus of the next issue of the **Journal.**

U. Jawaharlal

Report Card:LIFE

First Year Premium of Life Insurers for the Period Ended July, 2008

Sl No.	Insurer	Premium u/w (Rs. in Crores)			No. of Policies / Schemes			No. of lives covered under Group Schemes		
		July, 08	Up to July, 08	Up to July, 07	July, 08	Up to July, 08	Up to July, 07	July, 08	Up to July, 08	Up to July, 07
1	**Bajaj Allianz**									
	Individual Single Premium	35.35	106.89	136.44	8003	24842	23785			
	Individual Non-Single Premium	324.42	1060.40	929.98	224243	703817	725622			
	Group Single Premium	0.33	0.84	3.21	0	0	0	94	950	2694
	Group Non-Single Premium	8.62	29.82	6.30	49	169	84	548860	1307594	163543
2	**ING Vysya**									
	Individual Single Premium	2.13	12.54	5.16	272	1499	402			
	Individual Non-Single Premium	55.36	201.77	144.28	27378	109385	84605			
	Group Single Premium	1.05	5.24	0.85	0	0	0	215	1085	168
	Group Non-Single Premium	0.26	1.19	0.97	5	35	6	5311	12034	30942
3	**Reliance Life**									
	Individual Single Premium	38.17	163.64	37.50	9688	40560	7564			
	Individual Non-Single Premium	232.68	633.95	254.66	144166	392060	153561			
	Group Single Premium	5.25	32.06	32.95	0	4	17	0	14536	37198
	Group Non-Single Premium	4.79	8.57	7.26	25	111	94	91830	234854	138082
4	**SBI Life**									
	Individual Single Premium	55.03	201.37	173.68	8879	29582	24935			
	Individual Non-Single Premium	206.74	664.38	324.94	56529	189519	112638			
	Group Single Premium	21.52	70.53	57.46	0	0	0	10170	35892	30710
	Group Non-Single Premium	25.68	521.36	44.79	3	20	13	446593	888521	121321
5	**Tata AIG**									
	Individual Single Premium	4.05	17.37	7.46	820	3676	940			
	Individual Non-Single Premium	63.26	275.51	175.07	52397	198985	134140			
	Group Single Premium	2.46	15.23	22.31	4	5	0	8069	52088	138668
	Group Non-Single Premium	3.47	25.77	12.02	12	33	16	13266	65494	66343
6	**HDFC Standard**									
	Individual Single Premium	11.58	44.90	32.72	3698	20067	62567			
	Individual Non-Single Premium	180.89	609.72	455.55	72177	216338	158078			
	Group Single Premium	0.99	21.06	9.36	11	47	39	11950	88512	45307
	Group Non-Single Premium	1.30	9.48	29.37	0	2	11	149	12790	13700
7	**ICICI Prudential**									
	Individual Single Premium	22.27	93.57	103.55	4070	16776	16577			
	Individual Non-Single Premium	487.71	1654.22	1191.60	212921	814545	638766			
	Group Single Premium	21.66	98.56	65.27	21	122	68	60431	249902	107439
	Group Non-Single Premium	70.43	345.99	148.08	24	273	172	23669	397229	196516
8	**Birla Sunlife**									
	Individual Single Premium	2.93	12.35	8.65	11109	41212	17794			
	Individual Non-Single Premium	196.43	676.07	238.71	75493	214028	89100			
	Group Single Premium	1.59	2.93	1.23	1	1	3	4324	6539	1567
	Group Non-Single Premium	3.59	14.73	25.96	11	47	44	13621	52243	40882
9	**Aviva**									
	Individual Single Premium	1.14	5.70	6.64	181	840	975			
	Individual Non-Single Premium	55.39	211.28	205.66	30290	106177	89904			
	Group Single Premium	0.00	0.04	1.06	0	0	0	0	63	425
	Group Non-Single Premium	3.00	7.85	9.71	7	25	32	130670	305848	196889
10	**Kotak Mahindra Old Mutual**									
	Individual Single Premium	2.79	9.00	5.96	242	961	722			
	Individual Non-Single Premium	101.35	312.64	134.62	53687	160762	51004			
	Group Single Premium	3.77	10.87	6.17	0	2	0	12421	46374	53095
	Group Non-Single Premium	3.17	12.64	13.20	19	121	65	44995	193627	139512

11	**Max New York**									
	Individual Single Premium	18.59	85.68	62.28	1335	6459	3826			
	Individual Non-Single Premium	120.01	538.61	316.18	87866	381629	210483			
	Group Single Premium	1.13	5.76	0.00	3	10	0	322	187394	0
	Group Non-Single Premium	0.94	11.78	9.05	33	214	138	28815	217935	194851
12	**Met Life**									
	Individual Single Premium	0.52	1.61	8.03	145	367	1201			
	Individual Non-Single Premium	71.18	246.31	115.17	19877	64225	42756			
	Group Single Premium	1.68	6.34	3.40	12	34	33	18571	68794	77905
	Group Non-Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
13	**Sahara Life**									
	Individual Single Premium	4.69	13.68	6.43	1196	3522	1699			
	Individual Non-Single Premium	6.39	20.17	12.37	6761	22940	20024			
	Group Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Group Non-Single Premium	0.00	0.00	0.00	1	2	0	51	78	0
14	**Shriram Life**									
	Individual Single Premium	17.32	65.41	29.58	3056	10806	5847			
	Individual Non-Single Premium	11.10	40.54	29.04	6261	20807	16877			
	Group Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Group Non-Single Premium	0.00	0.00	0.00	0	0	1	0	0	571
15	**Bharti Axa Life**									
	Individual Single Premium	0.55	2.20	0.19	102	524	17			
	Individual Non-Single Premium	21.09	62.30	8.20	11563	41935	7487			
	Group Single Premium	0.84	2.77	0.00	0	1	0	5073	12043	0
	Group Non-Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
16	**Future Generali Life**									
	Individual Single Premium	0.13	0.15		24	28				
	Individual Non-Single Premium	1.62	2.70		2903	6226				
	Group Single Premium	0.00	0.00		0	0		0	0	
	Group Non-Single Premium	1.16	2.72		4	16		27007	46215	
17	**IDBI Fortis Life**									
	Individual Single Premium	12.35	26.74		1530	3642				
	Individual Non-Single Premium	19.41	30.64		6280	11053				
	Group Single Premium	0.00	0.00		0	0		0	0	
	Group Non-Single Premium	0.00	0.00		0	0		0	0	
18	**Canara HSBC OBC Life**									
	Individual Single Premium	0.00	0.00		0	0				
	Individual Non-Single Premium	12.49	12.69		1120	1139				
	Group Single Premium	0.00	0.00		0	0		0	0	
	Group Non-Single Premium	0.00	0.00		0	0		0	0	
19	**Aegon Religare**									
	Individual Single Premium	0.01	0.01		1	1				
	Individual Non-Single Premium	0.07	0.07		91	91				
	Group Single Premium	0.00	0.00		0	0		0	0	
	Group Non-Single Premium	0.00	0.00		0	0		0	0	
	Private Total									
	Individual Single Premium	**229.60**	**862.81**	**624.28**	**54351**	**205364**	**168851**			
	Individual Non-Single Premium	**2167.60**	**7253.98**	**4536.03**	**1092003**	**3655661**	**2535045**			
	Group Single Premium	**62.26**	**272.23**	**203.28**	**52**	**226**	**160**	**131640**	**764172**	**495176**
	Group Non-Single Premium	**126.42**	**991.90**	**306.72**	**193**	**1068**	**676**	**1374837**	**3734462**	**1303152**
20	**LIC**									
	Individual Single Premium	1293.17	3433.13	4754.34	413266	933103	1267567			
	Individual Non-Single Premium	1347.02	4482.77	6717.11	2369880	6666847	8091571			
	Group Single Premium	632.35	2881.20	2714.59	2089	4831	6266	1624344	4245142	5199031
	Group Non-Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Grand Total									
	Individual Single Premium	**1522.76**	**4295.94**	**5378.63**	**467617**	**1138467**	**1436418**			
	Individual Non-Single Premium	**3514.62**	**11736.75**	**11253.14**	**3461883**	**10322508**	**10626616**			
	Group Single Premium	**694.61**	**3153.43**	**2917.86**	**2141**	**5057**	**6426**	**1755984**	**5009314**	**5694207**
	Group Non-Single Premium	**126.42**	**991.90**	**306.72**	**193**	**1068**	**676**	**1374837**	**3734462**	**1303152**

Note: 1. Cumulative premium upto the month is net of cancellations which may occur during the free look period.
2. Compiled on the basis of data submitted by the Insurance companies

FIRST YEAR PREMIUM OF LIFE INSURERS FOR THE QUARTER ENDED JUNE 2008

INDIVIDUAL SINGLE PREMIUM (INCLUDING RURAL & SOCIAL)

(Rs.in Crore)

Sl. No.	PARTICULARS	PREMIUM		POLICIES		SUM ASSURED	
		June 2007	June 2008	June 2007	June 2008	June 2007	June 2008
	*Non linked**						
1	*Life*						
	with profit	37.33	52.35	2781	2171	39.82	84.95
	without profit	46.23	38.65	38055	52850	505.88	771.31
2	General Annuity						
	with profit	0.00	0.00	0	0	0.00	0.00
	without profit	3.26	3.38	438	261	0.09	0.35
3	Pension						
	with profit	23.98	9.98	1023	894	0.62	0.77
	without profit	0.08	21.54	13	822	0.00	0.00
4	Health						
	with profit	0.00	0.00	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0.00	0.00
A.	Sub total	110.88	125.91	42310	56998	546.40	857.38
	*Linked**						
1	*Life*						
	with profit	0.00	0.00	0	0	0.00	0.00
	without profit	674.51	1816.05	170408	405204	1339.66	2976.34
2	General Annuity						
	with profit	0.00	0.00	0	0	0.00	0.00
	without profit	0.38	0.00	0	49	0.00	0.46
3	Pension						
	with profit	0.00	0.00	0	0	0.00	0.00
	without profit	2351.55	829.40	622265	210342	9.09	34.72
4	Health						
	with profit	0.00	0.00	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0.00	0.00
B.	Sub total	3026.44	2645.44	792673	615595	1348.75	3011.51
C.	Total (A+B)	3137.32	2771.35	834983	672593	1895.16	3868.89
	Riders:						
	Non linked						
1	Health#	0.00	0.00	5	0	0.00	0.00
2	Accident##	0.00	0.00	33	0	0.14	0.03
3	Term	0.00	0.00	1	0	0.00	0.07
4	Others	0.00	1.69	0	0	0.00	0.00
D.	Sub total	0.00	1.70	39	0	0.15	0.09
	Linked						
1	Health#	0.00	0.01	6	0	0.05	0.27
2	Accident##	0.03	0.15	2418	60	16.94	115.15
3	Term	0.00	0.00	0	0	0.00	0.02
4	Others	0.00	0.00	0	0	0.00	0.00
E.	Sub total	0.03	0.16	2424	60	16.99	115.44
F.	Total (D+E)	0.03	1.86	2463	60	17.14	115.53
G.	**Grand Total (C+F)	3137.35	2773.21	834983	672593	1912.30	3984.42

* Excluding rider figures.
** for policies Grand Total is C.
# All riders related to critical illness benefit, hospitalisation benefit and medical treatment.
Disability related riders.
The premium is actual amount received and not annualised premium.

FIRST YEAR PREMIUM OF LIFE INSURERS FOR THE QUARTER ENDED JUNE 2008

INDIVIDUAL NON-SINGLE PREMIUM (INCLUDING RURAL & SOCIAL)

(Rs.in Crore)

Sl. No.	PARTICULARS	PREMIUM		POLICIES		SUM ASSURED	
		June 2007	June 2008	June 2007	June 2008	June 2007	June 2008
	*Non linked**						
1	*Life*						
	with profit	1836.66	2006.85	2779146	3559180	27138.22	34714.23
	without profit	46.39	38.14	211509	340535	3753.18	5649.64
2	General Annuity						
	with profit	0.03	0.00	37	0	0.72	0.00
	without profit	0.00	0.00	0	0	0.00	0.00
3	Pension						
	with profit	4.90	9.06	3755	10980	39.82	130.10
	without profit	5.04	3.63	1767	2400	0.00	0.33
4	Health						
	with profit	0.00	0.00	0	0	0.00	0.00
	without profit	18.44	29.60	86644	114917	6562.95	8784.02
A.	Sub total	1911.47	2087.28	3082858	4028012	37494.88	49278.32
	*Linked**						
1	*Life*						
	with profit	0.01	0.01	6	0	0.09	0.00
	without profit	4949.05	4783.32	3934155	2440729	51142.14	44546.18
2	General Annuity						
	with profit	0.00	0.00	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0.00	0.00
3	Pension						
	with profit	0.01	0.00	1	0	0.00	0.00
	without profit	760.43	1312.74	324824	371912	542.76	1283.64
4	Health						
	with profit	0.00	0.00	0	0	0.00	0.00
	without profit	0.00	27.64	0	27977	0.00	0.00
B.	Sub total	5709.50	6123.72	4258986	2840618	51684.99	45829.82
C.	Total (A+B)	7620.97	8211.00	7341844	6868630	89179.87	95108.13
	Riders: *Non linked*						
1	Health#	0.46	0.47	3244	28	41.61	323.26
2	Accident##	0.98	1.22	63886	344	1074.11	1144.24
3	Term	0.06	0.26	1138	10	10.53	64.79
4	Others	3.45	0.31	325	1	373.09	6.77
D.	Sub total	4.95	2.27	68593	384	1499.34	1539.05
	Linked						
1	Health#	0.88	1.26	2205	86	78.06	332.88
2	Accident##	4.40	7.29	35278	453	1986.82	2255.68
3	Term	0.10	0.05	1771	13	29.64	18.05
4	Others	0.10	0.83	1466	3	622.34	127.05
E.	Sub total	5.47	9.43	40720	555	2716.87	2733.66
F.	Total (D+E)	10.42	11.70	109313	939	4216.21	4272.71
G.	**Grand Total (C+F)	7631.39	8222.70	7341844	6868630	93396.08	99380.85

* Excluding rider figures.
** for policies Grand Total is C.
# All riders related to critical illness benefit, hospitalisation benefit and medical treatment.
Disability related riders.
The premium is actual amount received and not annualised premium.

FIRST YEAR PREMIUM OF LIFE INSURERS FOR THE QUARTER ENDED JUNE 2008

GROUP SINGLE PREMIUM (INCLUDING RURAL & SOCIAL)

(Rs.in Crore)

Sl. No.	PARTICULARS	PREMIUM		NO. OF SCHEMES		LIVES COVERED		SUM ASSURED	
		June 2007	June 2008	June 2007	June 2008	June 2007	June 2008	June 2007	June 2008
	*Non linked**								
1	*Life*								
a)	*Group Gratuity Schemes*								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	218.01	502.28	345	320	200026	178840	699.79	773.68
b)	*Group Savings Linked Schemes*								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	1.83	1.31	90	114	15161	23465	107.84	150.69
c)	*EDLI*								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	1.15	1.20	193	139	216867	182514	1109.47	510.38
d)	*Others*								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	457.46	576.03	3505	2216	3740507	2794940	16167.59	17720.10
2	General Annuity								
	with profit	132.25	72.02	1	1	501	130	0.00	0.00
	without profit	453.43	622.87	30	42	2230	1250	0.00	0.00
3	Pension								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	190.92	617.88	45	62	45607	28298	0.00	0.00
4	Health								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0	0	0.00	0.00
A.	Sub total	1455.05	2393.58	4209	2894	4220899	3209437	18085	19154.86
	*Linked**								
1	*Life*								
a)	*Group Gratuity Schemes*								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	29.94	54.90	25	19	14162	43676	125.88	55.71
b)	*Group Savings Linked Schemes*								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0	0	0.00	0.00
c)	*EDLI*								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0	0	0.00	0.00
d)	*Others*								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0	0	0.00	0.00
2	General Annuity								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0	0	0.00	0.00
3	Pension								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	14.13	10.22	2	3	25378	217	0.00	0.00
4	Health								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0	0	0.00	0.00
B.	Sub total	44.07	65.12	27	22	39540	43893	126	55.71
C.	Total (A+B)	1499.12	2458.70	4236	2916	4260439	3253330	18210.58	19210.57
	Riders:								
	Non linked								
1	Health#	-0.05	-0.04	4	5	1233	1947	79.57	51.77
2	Accident##	0.06	0.15	8	8	3745	2021	240.54	327.57
3	Term	0.00	0.00	0	0	0	0	0.00	0.00
4	Others	0.00	0.00	0	0	0	0	0.00	0.00
D.	Sub total	0.01	0.12	12	13	4978	3968	320.11	379.34
	Linked								
1	Health#	0.00	0.00	0	0	0	0	0.00	0.00
2	Accident##	0.00	0.00	0	0	0	0	0.00	0.00
3	Term	0.00	0.00	0	0	0	0	0.00	0.00
4	Others	0.00	0.00	0	0	0	0	0.00	0.00
E.	Sub total	0.00	0.00	0	0	0	0	0.00	0.00
F.	Total (D+E)	0.01	0.12	12	13	4978	3968	320.11	379.34
G.	**Grand Total (C+F)	1499.13	2458.82	4236	2916	4260439	3253330	18530.68	19589.91

* Excluding rider figures.
** for no.of schemes & lives covered Grand Total is C.
# All riders related to critical illness benefit, hospitalisation benefit and medical treatment.
Disability related riders.
The premium is actual amount received and not annualised premium.

FIRST YEAR PREMIUM OF LIFE INSURERS FOR THE QUARTER ENDED JUNE 2008

GROUP NEW BUSINESS — NON-SINGLE PREMIUM (INCLUDING RURAL & SOCIAL)

(Rs.in Crore)

Sl. No.	PARTICULARS	PREMIUM		NO. OF SCHEMES		LIVES COVERED		SUM ASSURED	
		June 2007	June 2008	June 2007	June 2008	June 2007	June 2008	June 2007	June 2008
	*Non linked**								
1	*Life*								
a)	*Group Gratuity Schemes*								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	20.30	130.63	9	26	13185	208064	123.46	773.68
b)	*Group Savings Linked Schemes*								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	5.22	6.58	0	0	50821	45575	779.70	150.69
c)	*EDLI*								
	with profit	0.09	0.08	50	63	26072	52765	298.95	0.00
	without profit	0.60	1.14	42	60	54736	129672	392.48	510.38
d)	*Others*								
	with profit	0.66	1.28	58	95	57576	125777	1011.38	0.00
	without profit	31.97	391.06	186	310	471207	1360155	8211.15	17720.10
2	**General Annuity**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0	0	0.00	0.00
3	**Pension**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.07	0.65	0	0	0	0	0.00	0.00
4	**Health**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0	0	0.00	0.00
A.	**Sub total**	58.90	531.41	345	554	673597	1922008	10817	19154.86
	*Linked**								
1	*Life*								
a)	*Group Gratuity Schemes*								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	83.94	87.47	100	194	230697	391625	1622.84	55.71
b)	*Group Savings Linked Schemes*								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.42	9.48	7	23	1799	10447	27.11	0.00
c)	*EDLI*								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0	0	0.00	0.00
d)	*Others*								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	1.61	13.88	2	7	407	578	2.10	0.00
2	**General Annuity**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	1.11	0.73	4	0	846	15	1.11	0.00
3	**Pension**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	97.27	221.57	78	97	5101	34952	0.00	0.00
4	**Health**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0	0	0.00	0.00
B.	**Sub total**	184.35	333.13	191	321	238850	437617	1653	55.71
C.	**Total (A+B)**	243.25	864.54	536	875	912447	2359625	12470.29	19210.57
	Riders:								
	Non linked								
1	Health#	0.45	0.66	5	8	3379	8248	349.97	51.77
2	Accident##	0.07	0.27	6	18	4694	12859	236.93	327.57
3	Term	0.00	0.00	0	0	22	8	0.43	0.00
4	Others	0.00	0.01	2	3	206	1114	40.70	0.00
D.	**Sub total**	0.53	0.94	13	29	8301	22229	628.02	379.34
	Linked								
1	Health#	0.00	0.00	0	0	0	0	0.00	0.00
2	Accident##	0.16	0.00	10	0	9857	0	375.82	0.00
3	Term	0.00	0.00	0	0	0	0	0.00	0.00
4	Others	0.00	0.00	0	0	0	0	0.00	0.00
E.	**Sub total**	0.16	0.00	10	0	9857	0	375.82	0.00
F.	**Total (D+E)**	0.68	0.94	23	29	18158	22229	1003.85	379.34
G.	****Grand Total (C+F)**	243.93	865.48	536	875	912447	2359625	13474.14	19589.91

* Excluding rider figures.
** for no.of schemes & lives covered Grand Total is C.
# All riders related to critical illness benefit, hospitalisation benefit and medical treatment.
Disability related riders.
The premium is actual amount received and not annualised premium.
$ Reflects revised data submitted by ICICI Prudential Life Insurance Company Ltd.

CIRCULAR

August 25, 2008 Ref: 011/ IRDA/ Brok-Comm/ Aug-08

Re: Limits on payment of commission or brokerage on general insurance business with effect from 1 st October 2008

By virtue of the power vested in the Authority under Section 14 of the Insurance Regulatory and Development Authority Act, 1999 and in terms of the provisions of Sections 40(1), 40A(3) and Section 42E of the Insurance Act, 1938, the Authority hereby directs that the percentage of premium that can be paid by way of commission or brokerage on a general insurance policy shall not exceed the percentages of premiums set out below. No brokerage can be paid in respect of an insurance where agency commission is payable and likewise, no agency commission can be paid in respect of an insurance where brokerage is payable.

S. No.	Class of Business	Maximum percentage of premium payable as agency commission or' brokerage (% of final premium excluding service tax)	
		Agency Comm.	Brokerage
1.	Fire, IAR and Engineering insurances		
	i. General	10%	12.5%
	ii. Risks treated as large risks under para 19(v) of File & Use Guidelines	5%	6.25%
2	Motor insurance business (OD portion), WC/EL & statutory Public Liability Insurance	10%	10%
3	Motor Third Party insurance	Nil	Nil
4	Marine Hull insurance	10%	12.5%
5	Marine Cargo business	15%	17.5%
6	All other business	15%	17.5%

No payment of any kind, including "administration or servicing charges" is permitted to be made to the agent or the broker in respect of the business in respect of which he is paid agency commission or brokerage.

This direction supersedes all existing directions on the subject and shall take effect in respect of insurances or renewals commencing on or after 1 st October 2008.

(J. Hari Narayan)
Chairman

CIRCULAR

August 22, 2008 REF: INV/CIR/008/2008-09

The CEOs of all Insurers

Dear Sir / Madam

Sub: IRDA (Investment) (Fourth Amendment) Regulations, 2008- Reg.

1. As you are aware, a Working Group was set up by the Authority, to review comprehensively the current regulatory and other provisions on Investments of Insurance companies and suggest changes considered necessary in the light of experience gained / the constraints faced by Insurance Companies, as well as the developments in Financial Markets. The Working Group reviewed the statutory provisions on the pattern of Investment, Operational and Policy issues of Investment Regulations and suggested amendments that would provide flexibility to the Authority in the manner of Regulation on Investment of Life and General Insurance Companies. The Group also looked into the concurrent modifications in the formats of the prescribed Returns to reflect the changes.

2. The recommendations of the Working Group have been

examined by the Authority in the light of legal provisions and keeping in view the interests of the stakeholders. The implementation of some of the proposals requires appropriate changes in Regulations and evolution of suitable regulatory framework. It was also observed by the Authority while monitoring compliance with the regulations over a period that some of the extant instructions/guidelines also needed clarity and consistency.

3. Accordingly, the Authority has initiated action to amend the provisions of IRDA Investment Regulations 2000 in order to implement the recommendations of the Working Group and also to effect such changes that are considered necessary to clarify the existing regulatory requirements. A copy of the Gazette notification on the amended regulations is available at our website www.irdaindia.org. Insurers are advised to peruse the notification to take the modifications on record for further compliance. For the sake of convenience a brief summary of the changes proposed to be effected in the Regulations is furnished in Annexure – I.

4. Besides the amendment in regulations, it has also been decided to effect some modifications in the extant Guidelines / Circulars on investment portfolio [Annexure-II] and also introduce certain requirement on the Systems / Process of investment in the context of Risk Management requirements. The proposals in this regard are outlined in Annexure – III.

5. Insurers are advised to place the Circular before the Board at the next meeting in order to apprise the Directors of the important changes brought about in the management of investment portfolio. The Board should also be advised of the specific time bound action taken to comply with the requirements on investment systems and process wherever considered necessary.

6. The changes would be effective from the dates indicated therein.

/sd-
(C R Muralidharan)
Member

CIRCULAR

August 13, 2008

Circular No. 009/IRDA/F&A/Aug.-08

To
The CEOs of
Insurers & Reinsurer

Dear Sir/Madam,

IRDA (Assets, Liabilities and Solvency Margin of Insurers) Regulations, 2000

The Authority vide Circular Nos. 045/IRDA/F&A/Mar-06 dated March 31, 2006 and IRDA/F&A/060/Mar-08 dated March 11, 2008 had issued directions on the IRDA (Assets, Liabilities and Solvency Margin of Insurers) Regulations, 2000.

The Authority had vide circular no. IRDA/F&A/060/Mar-08 dated March 11, 2008 deferred implementation of the directions requiring insurers to value the debt securities at lower of the amortized cost and the market value for the purpose of computation of solvency margin. As per the circular, these instructions were to be implemented effective financial year 2008-09.

Keeping in view the requests of the insurers and pending finalisation of the guidelines on segregation of the investment portfolio into Held to Maturity and Held for Trading, the Authority hereby defer implementation of the instructions.

Yours faithfully,

(C. R. Muralidharan)
Member (F&I)

Achieving Higher Standards

Role of the Intermediary

'IN THE CHANGING PARADIGM OF NEW CHALLENGES AND ACHIEVING GLOBAL STANDARDS, THE INSURANCE INTERMEDIARY HAS A HUGE ROLE TO PLAY. WELL-PLACED INSURANCE INTERMEDIATION CAN ALSO BE AN EFFECTIVE TOOL IN PROVIDING THE KEY FOR SEVERAL PROBLEM AREAS' OBSERVES U. JAWAHARLAL.

The importance of the role of the intermediary in insurance needs no emphasis. Although this could be a universal phenomenon, it is of particular significance in emerging markets. In view of the intangibility of the insurance product, there is need for explaining the intricacies of insurance to the prospect. The Indian insurance domain, which has been undergoing several major changes over the last few years, needs a special mention in this regard. In pursuit of spreading the awareness of insurance and widening the client base, the need for enlarging the distribution was felt. There has been a steady transformation from the tied agency model alone to the introduction of several other intermediaries in the form of brokers, corporate agents, bancassurance etc. Especially in the detariffed regime, there is a very important role for the intermediary to play to ensure that the market registers a sustained growth and attains global standards in the near future. Further, there is need for the intermediaries to be thoroughly equipped with the required inputs in order that they emerge successful in the face of stiff competition, unlike in the past.

It has often been debated on what would amount to sufficient training for the intermediary. The focus in this regard should be not on the mandatory requirement of the training but on how skilled the intermediary is. Apart from the basic requirement, there should be frequent updation of skills in the form of orientation and reorientation programs to be in tune with the changing demands of the market. A well-informed intermediary can play a crucial role in bringing down the number of problems associated with mis-selling and other ills akin to it.

The new channels of distribution introduced more recently into the market viz. the brokers, the corporate agents and bancassurance have been consolidating their strengths steadily, although they are yet to achieve dizzy heights. The role of the broker is ever so crucial, especially in a detariffed regime. The institution of brokers can play a very vital role in identifying the risks of a corporate customer and be the perfect bridge between the insurer and the client. Similarly, for making use of the excellent goodwill that they have generated by virtue of their operations in other financial services; corporate agents can be another form of effective distribution for insurance. Banks have spread their roots to every nook and corner of the country, and have a very strong customer base. These strengths of reach and penetration come in very handy for Bancassurance to be the perfect model for the Indian insurance market.

It has been almost two years since we have focused on the role of the intermediary in insurance business. However, these two years have seen a lot of transformation in the way insurance is distributed. So we thought it pertinent to focus on this key aspect once again. 'Role of the Insurance Intermediary' will be the focus of the next issue of the **Journal.**

Intermediary
- The Vital Link

in the next issue...

Promise in the Face of Repudiation

Insurance Claims

TREVOR BULL ASSERTS THAT CONSUMER FORUMS OR COURTS, EVEN WHILE RECOGNIZING THE NEED FOR REPUDIATION IN LEGITIMATE CASES, AT TIMES PROVIDE STIFF VERDICTS AGAINST THE DECISION TO REPUDIATE.

Insurance is the business of settling claims and a vast majority of claims received by an insurance company are settled with minimum of effort, either for the policyholder/claimant or for the company. Claimant has the right to a fair, quick and correct claim decision, and this is every insurer's duty to ensure. Claim processes in insurance companies are designed to serve this purpose and provide support to all valid claims.

At the same time, we need to recognize that not all claims are valid, and these claims need repudiation. Claim Repudiation surely has a major impact on the customer, both financial as well as emotional. The financial and reputation impact on an insurance company is even larger, as the "promise of insurance" faces the toughest test during such occasions. This may be the case when,

- The policy does not cover (or specifically excludes) the claimed event;
- The insurance policy is invalid (when the policy has lapsed or as can be the case when due to misrepresentation / suppression of facts at the time of application the policy may be rescinded), or
- The claimed event did not happen.

Under any of the above circumstances the insurer cannot be expected to settle the claim, and the claim is thereby "repudiated"; this especially so as payment of any such claims would have a negative impact on the returns to the "genuine" policyholders as well as the financial health of the insurance company.

Besides these reasons, we need to look at influencing factors like internal processes and practices; and the regulatory and legal environment. By taking the right choices, insurers can ensure that claim repudiation is kept to a minimum.

Ability to keep repudiation to the absolute minimum is likely to be a key to business growth in the changing environment where the consumers expect settlement and business reputation is built on settlement rates. Consumer forums or courts, even while recognizing the need for repudiation in legitimate cases, at times provide stiff verdicts against the decision to repudiate.

Ability to keep repudiation to the absolute minimum is likely to be a key to business growth in the changing environment where the consumers expect settlement and business reputation is built on settlement rates.

Contract of Insurance

A life insurance contract provides financial assistance in case of an unfortunate death of the policyholder and it may be associated with periodic or maturity payments and bonuses to the policyholder, depending on the product in question. Since the industry was opened to private players, many new products have been designed and marketed. These products may provide "special" coverage for various events ranging from accidental death to hospital stay and from heart attack to a specific surgical operation. Adding to these, market linked / unit linked products of various configurations have become the flavour of the market.

As a step towards developing the market, the Regulator has encouraged new products.

With a variety of products, each with their own covers and returns, the customer while having a wide choice, might be left with less than complete understanding of what she has bought. Product complexity also might create more possibility of misselling or less than

Industry initiative to educate the customer on the importance to understand the product they have bought will create the right environment over the long run.

adequate sales explanation. This would bring in circumstances where the customer feels safe of having covered herself against the risks perceived, may yet be left exposed to them and would reflect at the time of claim submitted for an event that is not covered by the product or when returns from an equity linked product falls short of providing the assumed returns.

While details of any product cover are detailed exhaustively in the contract of insurance, often the customer is not aware of these. Though the legal standpoint in such cases is that the policyholder is accountable post signing the contract, the business or service differentiator would be where insurance company's advisor has been able to adequately explain the product details during the sale or post sale servicing.

A combination of customer and sales initiatives is effective for clear explanation to the customer; and the bedrock of this is effective product training to sales and distribution; simple and illustrative sales literature; and post sale customer calling more for specialised products. Industry initiative to educate the customer on the importance to understand the product they have bought will create the right environment over the long run. The industry has already instituted good practices like sales illustrations; need-based selling; welcome calling to customers etc. but there is still a long way to go.

Validity of the Contract of Insurance

An insurance policy is valid only as long as premiums are paid and only when it is kept in an "active" state. There are several instances where delay in premium payment may result in the policy being "lapsed" during which period the customer is not covered under the benefits of the policy. This is quite often a major reason due to which customers / claimants are unable to receive benefits which may have otherwise been available to them.

Insurance companies need to continue to strengthen the mechanism of collection of premiums from the customer and simplify the process to ensure highest degree of persistency of their portfolio. Innovative modes of collection now need to be commonly used, including direct bank debits, mobile collection units, etc.

On a very different consideration, we must also talk about the principle of "*Uberrima fides*", or the principle of utmost good faith, on which all insurance contracts are based. This dictates that while applying for an insurance policy the customer must disclose all facts known to her. The insurer would then decide the appropriate rates for the policy (or that whether a policy can be given at all) based on these declarations with or without further clarifications / documentation from the customer.

Under breach of this principle (where the customer misrepresents / suppresses facts), the insurer may be placed under an unfavourable position where appropriate rates may not be applied or a policy may be given where none was financially viable. In the financial interest of the insurer (and the interest of other policyholders) such claims may be repudiated and the policy may be considered "void".

Section 45 of the Insurance Act and its interpretation through the Supreme Court in its few decisions, defines specific circumstances where such mis-representation or suppression of facts may lead to the policy being considered void and the claim being repudiated. The Section 45 also seeks to differentiate the treatment of such suppression within the first two years of the policy and the period thereafter.

While this is most important to consider and merits investigation in certain cases to find evidence of possible misrepresentation / suppression of facts, it may be pointed out that the legal environment may be changing rapidly and providing further grounds to customers to challenge any repudiation made on these grounds. In recent times the consumer forums and lower courts have been more inclined to rule in favour of the consumer even where the misrepresentation / suppression of facts may have been particularly severe and may have had a very significant impact on the rates of the policy.

Reference may be made to an article by Mr. K. P. Narasimhan named "Amendments to Insurance Legislation" in IRDA Journal of October 2007, where he mentions "There would seem again to be a misplaced perception with regard to the detailed investigation to be made after a claim has arisen that, it is considered, could have well been made at the time of the proposal for grant of insurance. What has not apparently received adequate consideration, while accepting the application of the principle of *Uberrima fides* to contracts of insurance, is that (1) at the proposal stage the volume could be unmanageable to think in terms of detailed enquiry, (2) even the most arduous effort could fail to uncover information to check fully on the

statements made by the proposer, and (3) time is of essence in handling new proposal and a balance has to be struck by the insurers between advisability of a few more measures of check and the need to be speedy in the disposal of proposals received. In striking this balance the insurers do keep in mind the application of the principle of *Uberrima fides* and have only very bare checks at the underwriting stage"

We need to be continuously aware of these changing environments, as also being sensitive that minor / insignificant misrepresentations and suppressions are not being taken as a ruse to repudiate the claim. Also, there may be a need to identify better and more efficient risk management tools at the New Business stage. This is not without its possible disadvantages with regard to the cost of new business operations and / or the time taken to provide the policy to the customer and a very fine balance needs to be struck between cost, time and ease of new business customer interaction and risk management to maintain Underwriting product and business profitability.

This would involve stronger interface between the Actuarial, Claims and New Business Units of the company and a better defined involvement of these teams in the product development and maintenance. This need is most pronounced in the 'new' products involving health, disability and accident benefits where the product design, pricing assumptions, underwriting practices and claim experience may show very dynamic correlation with each other.

Interested readers may want to read an article by Avinash Dixit and Pierre Picard named "On the Role of Good Faith in Insurance Contracting" where statistical modeling has been used to identify the relation between the insurance risk types, application of good faith, investigation at claims and legislative environment.

There may be a need to identify better and more efficient risk management tools at the New Business stage.

Claim Fraud

Premiums payable for buying an insurance cover is but only a small amount as compared to the amount receivable on settlement of a claim. This is likely to result in scenarios where insurance cover is taken not for the valid need of financial security but for in anticipation of gain if a claim is settled.

The industry has already witnessed several concerted efforts by individuals, and groups of people, who have devised intriguing methods to claim for these amounts when none was payable. These range from the common, taking cover on people during terminal illness or providing altered documents to prove loss, to the more severe where people are 'invented' and their deaths purported to claim for the proceeds. Often, these incidents come to fore at the time of claim processing and investigation. Multiple insurance companies operating within the same market clearly adds to the ease in which such operations may be carried out and not be discovered. Claim declinature alone is not going to be enough in such instances, unless we are able to take legal action against the individuals and groups involved.

The challenge for the industry is to recognise the presence of such cartels and ability of individual insurers to successfully work in tandem to uncover and to take action against them.

Appropriate due diligence, verification of documentation required for claim processing and the usual investigation efforts on the claim need to be supplemented by early warning mechanism, depending on the market and portfolio carried by each insurer as also their individual perceived risks, which would identify any trends in the claims experience. Agents, agency groups, locations, loss event types, beneficiaries involved are only some of the indicators which may need close monitoring.

Insurance companies in their growth also need to be aware of loss of data / information or frauds emanating from within the organisation. Internal controls may be more difficult to manage since these require coordination among multiple departments.

Fairness of Claim Procedures

Summing up, the business of insurers is to settle claims, fairly and quickly; and the key to business reputation and growth lies in claims management process and philosophy. Empathy with the claimant or policyholder must not be lost even on claims which are not valid, and benefit of doubt may be given to the policyholder/ claimant. The efforts directed towards repudiation of claims may need to be redirected towards developing abilities to reduce the declinature rates through effective customer education measures as well as adequate risk selection practices. A close watch on claim frauds, and industry co-operation for this, though, would be an important area for us to work towards as the industry grows at impressive rates and reaches unexplored markets.

The author is the MD of Tata AIG Life Insurance Co. Ltd.

Business of Claims

Inconvenience Regretted

ARMAN OZA COMMENTS THAT PROPER CARE ON THE CLIENT'S PART AT THE POINT OF SALE REDUCES THE RISK OF REPUDIATION OF A CLAIM TO A GREAT EXTENT.

Background

Consumers the world over have been generally skeptical about insurance as a reliable risk management instrument. A layman policyholder is never sure whether he will receive the promised benefit, until it is actually paid. Insurance is device where the sacrifice is real and immediate, while the benefits are distant and contingent. A claim is the only event that gives the proof of this concept to the customer. All insurance policies are designed to provide coverage against low frequency events. Hence the chances of availing benefits under insurance are generally rare at the very outset. Amidst this, repudiation of a claim by the insurer hits at the very root of the faith and confidence of the insured. A major cause of customer dissonance towards insurers and insurance is the fact that claims do get rejected, for one reason or the other.

Most often, only a total repudiation of a claim by the insurer is debated and discussed while considering rejection of claims. However, settlement of claims for amounts lesser than the actual entitlement, is also equally serious and needs to be treated at par with total repudiation. An insurance contract casts an obligation upon the insurer to honour his liability as per the terms and conditions of the policy in full. Wrongful deductions towards depreciation, betterment charges, non-standard settlements are just a few examples of partial repudiation of claims. Just because the claimant gets 'something' towards his claim, such instances mostly go unchallenged and unreported. Whether the repudiation is partial or total and regardless of the fact whether the insured opts to challenge it or not, the credibility of the insurer and the overall reliability of insurance as a mechanism that protects the policyholder in times of peril, definitely gets dented.

From a consumer's standpoint, it is extremely essential to be clear on several aspects of the product and post-sale service at the point of sale itself.

In this article, we try to take a look at the whole issue of repudiation of claims from the policyholders' perspective. The attempt is to analyse the fundamental causes of repudiation of claims and to provide with some insights for policyholders to avoid this unpleasant eventuality. We also look at various remedial options for the policyholder in case of repudiation as well as the overall scenario of consumer protection in India.

Point of Sale Limbos

The perception of the product created in the mind of the policyholder at the point of sale, plays a crucial role in building his expectations at the time of claim. Hence from a consumer's standpoint, it is extremely essential to be clear on several aspects of the product and post-sale service at the point of sale itself. Insurance selling has become an aggressive business after private players entered the marketplace. While this was required to a great extent in the interest of increasing insurance penetration in the country, it has, on the flip slide, also resulted in instances of gross mis-selling by unscrupulous salespersons. In the lure of 'closing a deal', critical elements of insurance selling like explaining the coverage, exclusions, duties of insured in the event of claims and the like are often not communicated to the insured. These are

A proposal form contains vital details about person / property to be insured and questions about the risk. These details may be referred to at the time of loss to ascertain the intention of the insured.

the lapses that hurt the insured more than the salesperson in the eventuality of a loss.

A claim arises on account of happening of a loss producing event (peril) inflicting financial damage (loss) to the insured. For the claim to be admissible, both the peril as well as the nature of loss should be insured or not excluded from the coverage. Exclusion of a peril (like terrorism unless specifically included) or nature of loss (like consequential loss) are grounds on which a large number of claims are rejected. This is bound to happen unless policyholder thoroughly understands the coverage and particularly the exclusions before singing the premium cheque, so as to avoid frustration later on. The client should insist upon a full disclosure of all terms, conditions and exclusions *in writing* before closing the deal. Despite the urgency provoked by the salesperson, clients would do well to take time on understanding the coverage.

The quotations, brochures and other material furnished at the point of sale should be preserved for future reference. Unfortunately, insurance in India is still purchased on the basis of 'word of the mouth' of the salesperson. Such a practice should be avoided.

The proposal form constitutes an 'offer' under the law of contract and hence is the basis of relationship between insured and the insurer. The act of filing up of proposal form is often delegated to the intermediary. A proposal form contains vital details about person / property to be insured and questions about the risk. These details may be referred to at the time of loss to ascertain the intention of the insured. Silly mistakes like declaring a wrong location of the property insured could lead to rejection of claim. While filling up the proposal form it is in the interest of insured to be fair in disclosing material facts. Any non-disclosure or misrepresentation of material fact is likely to jeopardize the claim. Signing on the dotted line in the proposal form binds the proposer as regards facts disclosed therein. It will not be possible for the insured to banish the declarations made in the proposal form later on.

Once the deal is closed, the matter does not end there. It is essential to obtain a proper policy document evidencing the contract. Many times the policy schedule containing details of insured person / property, sum insured, period of insurance, etc. is passed on as complete policy. An insurance policy, in fact comprises of policy schedule *and* terms, conditions and exclusions. The insured should insist on full text of policy wordings along with schedule. The policy schedule should match the details mentioned in the proposal form. The terms and conditions should also be verified with the quotations and brochures furnished earlier. This is very important since in the final analysis, the policy wordings will prevail over other material. This is also very important in the context of de-tariffing where every insurer may eventually offer different coverage for the same class of insurance.

The IRDA has on its part has prescribed elaborate regulations[1] covering the above aspects. The consumer is advised to go through the same and ensure that insurers strictly abide by them. Proper care on the client's part at the point of sale reduces the risk of repudiation of a claim to a great extent.

Claims Process

Every insurance policy, by virtue of its conditions, imposes certain duties on the insured, in the event of a claim. Breach of these conditions can lead to partial / total repudiation of claims. It is thus in the policyholder's interest to go through all the policy conditions, and act in accordance with them to avoid repudiation. Most of these conditions like intimating a loss to the insurer within stipulated time frame, submission of documents, preserving the salvage, etc. are matters of common sense. Violation of these conditions by the insured will provide the insurer pretence to reject the claim totally or partially.

Where claims have been repudiated on grounds of breach of policy conditions, principle of reasonableness and gravity has been strictly applied by courts. A breach of policy condition does not *ipso facto* make the claim liable to be repudiated. How serious was the breach in terms of admissibility of liability as well as quantum of loss, has to be established. If the breach has no bearing on any of

1 IRDA (Protection of Policyholders' Interests Regulations) 2002

these two factors, or it is shown that the breach was unavoidable, the claim still has to be settled in full. The situation in case of a warranty[2] however, is different. A breach of warranty renders the contract void and makes the claim redundant even if the breach has no direct relation with loss. Warranties are clauses appearing on face of the policy and start with words 'Warranted that…". Hence utmost attention is required for observance of warranties.

In general, providing authentic documentary evidence as regards the cause of loss and the quantum of loss should sufficient in substantiating the claim. In case a surveyor / investigator is appointed by the insurer, proper communication with him is also warranted. Throughout the process of claims, it is advisable for the claimant to insist on written communication from the insurer, surveyor or investigator. Moreover it is also essential to maintain copies of all documents submitted to the insurer or surveyor. Direct communication with the insurer, rather than through the intermediary, may be preferred. The claimant is entitled to obtain a copy of the survey report under the Policyholders' Regulations. This right should be exercised and any factual or technical inconsistency in the survey report should be immediately represented against.

Whenever a claim is rejected on account of some procedural lapse like non-submission of documents reasonable notice has to be given to the insured for rectifying the deficiency before rejecting a claim. If this is not done, the insured should make a representation citing this fact and demand re-opening of claim.

A claim that falls within the coverage and does not attract any exclusion ought to be paid and paid in full.

Remedies Against Repudiation

If the insured feels aggrieved upon the repudiation of a claim, whether partial or total, there are various tiers of redressal mechanism available to him. All insurers have grievance cells where the insured can represent his case. The IRDA also has a grievance cell which can be approached. Insurance ombudsman has been a major step towards offering the policyholders a cost-effective as well as neutral grievance redressal option. Only individuals can approach the ombudsman who has offices in almost all state capitals. Upon receiving a complaint the ombudsman will hear both parties and deliver his award. The insured has to personally appear before the ombudsman and appearance through lawyer or other representative is not allowed. Going further, the insured can also approach the consumer forums at the district, state and national level established under the Consumer Protection Act 1986.

Insurance contracts are synallagmatic[3] in nature. Both parties to the contract – the insured and the insurer – have mutual obligations with each other. So long as the insured is fair in disclosing material facts and has paid the requisite premium, he is deemed to have performed his part of the obligation. A claim that falls within the coverage and does not attract any exclusion ought to be paid and paid in full. Instances of avoiding or reducing liability by the insurer on frivolous grounds have been viewed very strictly by courts. Even when it comes to interpretation of policy wordings it has been held that rule of *contra proferentem*[4] *will apply. In simple words, benefit of doubt has to go to the insured.*

Despite the above remedies there is a definite feeling that policyholder grievance redressal has a long way to go. In-house grievance cells of insurers most often toe the same line adopted by their operations departments. The IRDA merely facilitates the taking up of the grievance with concerned insurer and does not have any adjudicating authority.[5] *Not all policyholders have access to ombudsman since they are located in major centres only. Moreover this institution has not*

2 A warranty is a stipulation or agreement on the part of the insured, in the nature of a condition precedent. It may be affirmative; as where the insured undertakes for the truth of some positive allegation: as, that the thing insured is neutral property: or, it may be promissory; as, that the ship shall sail on or before a given day. The warranty being in the nature of a condition precedent, it is to be performed by the insured, before he can demand the performance of the contract on the part of the insurer. www.lectlaw.com

3 Bilateral or reciprocal contract in which both parties provide consideration and have mutual rights and obligations. A sale, for example, is a synallagmatic contract while a gift is not www.merriam-webster.com

4 A universally applied rule that ambiguities in an insurance policy will be strictly interpreted against the insurer. Application of this rule is a three-step process: (1) the court examines the policy language to determine if it is ambiguous. (2) If the language is unclear, the court will admit extrinsic evidence to clarify the policy and determine the parties' intent at the time they entered into the contract; if the extrinsic evidence dispels the ambiguity, the contract is applied in accordance with its true meaning as ascertained by the extrinsic evidence. (3) If the extrinsic evidence does not clarify the ambiguities, the contra proferentem rule is applied, and the ambiguous language is construed in favor of the insured and against the insurer.www.irmi.com

An endeavour on addressing the fundamental issue of improving the risk consciousness of the population also needs to be undertaken along with other measures to expand the market.

been adequately publicized. Consumer courts on the other hand have started taking too long to dispose cases and hence are proving to be costly. Cost, time and accessibility factors inhibit most of the redressal options in our country. Consumer protection mechanism has not been able to cope with geographic and demographic expansion of markets, especially in the financial services segment. Due to systemic deficiencies very few consumers get inclined to pursue their grievances before these forums. Those who do, most probably end-up with claims being paid. Unfortunately, these numbers are too small to credibly deter delinquent service providers.

Conclusion

As indicated earlier, the aleatory nature of insurance makes it a dilemma for the layman consumer at the very outset. Instances of repudiation of claims on flimsy or merely technical grounds make things worse. Even if such instances are few in number, they gather wider publicity thus tarnishing the credibility of insurers in general. Outright rejection of a claim should be rarest of the rare case (like cases of fraud, etc.). In India, insurance had remained a subdued activity till recently. On the life side, aggressive marketing of endowment policies has built a public perception of insurance as an investment and tax savings tools only. The non-life side till recently was dominated by compulsory motor insurance. The broader role of insurance as a risk management tool is neither known to the consumer, nor has there been any effort to educate him on these lines from the industry. As a result, while products keep selling, the concept underlying that product always remains obscure. Thus an endeavour on addressing the fundamental issue of improving the risk consciousness of the population also needs to be undertaken along with other measures to expand the market. Without this the prospects for robust market growth will always remain elusive. Leaving the naïve customer to the mercy of market forces and learn bitter lessons on his own, would also not be a considerate way of developing the insurance market. Only a reasonably risk literate population can deliver sustainable demand for financial services. To attain this long term objective, IRDA in collaboration with other financial service regulators should encourage market players to undertake better risk education in schools and colleges so that at least the next generation is much more aware about risk and insurance. In the short run, alongside investment friendly steps like increasing Foreign Direct Investment (FDI) limit to 49%, regulatory tightening that ensures better accountability of insurers towards their customers is also required.

The current trend however, is towards bracing big volumes. Glossy advertisements and celebrity endorsements portray insurance as a quick fix solution to all your financial problems. Insurance is a subject matter of solicitation – the statutory message displayed in small font, if at all, hardly makes any sense to the consumer. Selling insurance products 'over the counter' just like any other commodity only aggravates the chances of deception at the point of sale. Tie-up sales of insurance with loans and credit cards, ensures lower transaction costs for insurers but also deprive the insured of his right to take informed decisions.

Claims handling by general insurers is likely to become stricter as de-tariffing puts margins under squeeze.

All this, however, does not mean that the consumer should refrain from buying insurance. Modern world poses diverse and complex risks, which the average citizen can hardly afford to retain. The solution lies in showing finesse while shopping for insurance and determination in pursuing claims. It is ultimately up to the consumer to navigate across the vying marketplace, see through the wily promotional vibes and spot the right product that serves his needs in times of distress. The seemingly clichéd maxim of *caveat emptor* continues to apply.

The author is an independent insurance professional; and is presently with Quadrant and based at Ahmedabad.

5 Annual Report of IRDA 2006-07

Tricky and Contentious

Repudiation of Health Claims

DR. SUBODH P. SIRUR MENTIONS THAT WHILE IT IS AGREED THAT NOT MANY ARE GIVEN TO KNOW ABOUT THE PRE-EXISTENCE OF A DISEASE, THERE IS NO DENYING THE FACT THAT ATTEMPTS HAVE OFTEN BEEN MADE TO TAKE THE INSURERS FOR A RIDE AND EVEN COURTS HAVE ENDORSED THIS VIEW.

Repudiation of health claims is undesirable to any claimant. Quite often, this is as a result of difference or dispute in the interpretation of the terms and conditions of the applicable policy. Further, the inherent characteristics of a health claim increases the propensity for differences or disputes to occur.

One of the major areas of dispute is one pertaining to the pre-existing ailments. Repudiation of health claims have been agitated before various forums such as Consumer Disputes Redressal Agencies. In ***National Insurance Company Ltd vs Mukesh Bhargava***, the Delhi State Consumer Disputes Redressal Commission was dealing with a matter pertaining to a repudiation of a claim on the ground that the ailment for which claim for reimbursement of hospitalization expenses was made existed prior to the commencement of the policy. The facts of the complaint were as under:

The claimant was hospitalized following complaints of chest pain while traveling in a train. Later he had to undergo an open heart surgery. The claim of the insured was repudiated on the ground that the insured had withheld information that he had been suffering from breathlessness for many years.

The Honorable State Commission while allowing the complaint held that "*We have taken a view that unless the patient or insured is hospitalized or undergoes an operation for some particular disease but otherwise leads a normal and healthy life is not supposed to disclose the factum of normal and day to-day minor problems of life. In such type of cases where the patient suffers heart attack without any past history of having suffered any disease, being hospitalized or operated upon, he is neither supposed nor expected to know as to the medical terminology of the disease like problem of breathlessness".*

Thus, in the instant matter, the Honorable State Commission was of the opinion that the fact that the insured had some complaints which could be indicative of a pre-existing ailment cannot be sole basis for holding the ailment to be pre-existing. Failure to disclose the information of such complaints for which hospitalization or operation has not taken place was not held to be suppression of material facts.

It is not infrequently that the medical records of the insured make a mention of past illnesses and their duration. Based on the information in these medical records, the pre-existence of ailments are inferred and wherever appropriate, the claim is repudiated. The Rajasthan State Consumer Disputes Redressal Commission in ***New India Assurance Company Limited vs Vishwanath Manglunia and another*** has held that merely based on the information in the medical records that the insured had history of hypertension and IHD

The claim of the insured was repudiated on the ground that the insured had withheld information that he had been suffering from breathlessness for many years.

It is the contention of the complainant that he was thoroughly checked up by the doctors who were nominated by the insurance company and at that time he was found hale and hearty.

(ischemic heart disease) for 2-3 years without there being any document or evidence to show that the insured was indeed having a cardiac ailment, it cannot be said that the insured had suppressed material fact pertaining to his past illness. The complaint was allowed and the insurance company was directed to settle the claim of the insured; the effect being that the onus of proving suppression of material fact is heavily on the insurance company.

The question that arose in a complaint before the Punjab State Consumer Disputes Redressal Commission in ***Oriental Insurance Company Limited vs Rajinder Singh*** was whether a claim could be repudiated on the ground that an ailment was pre-existing notwithstanding the fact that the insured had no knowledge of its existence prior to the commencement of the policy. The State Commission relied on the order of the National Consumer Disputes Redressal Commission in deciding this question in the negative. The National Commission has held in ***Praveen Damani vs Oriental Insurance Company Limited*** as under:

"18. The District Forum also relied on clause 4.1 of the policy which states that is not material whether the insured had knowledge of the disease or not, and even existence of the symptoms of the disease prior to the effective date of insurance enables the Insurance Company to disown the liability.

19. If this interpretation is upheld, the insurance company is not liable to pay any claim, whatsoever, because every person suffers from symptoms of any disease without the knowledge of the same. The policy is not a policy at all as it is just a contract entered only for the purpose of accepting the premium without the bona fide intention of giving any benefit to the insured under the garb of pre-existing disease. Most of the people are totally unaware of the symptoms of the disease that they suffer and hence they cannot be made liable to suffer because the insurance company relies on their clause 4.1 of the policy in a mala fide manner to repudiate all the claims. No claim is payable under the mediclaim policy as every human being is born to die and diseases are perhaps pre-existing in the system totally unknown to him which he is genuinely unaware of them. In hindsight everyone relies much later that he should have known from some symptom". Further it held that- "In any case, it is the contention of the complainant that he was thoroughly checked up by the doctors who were nominated by the insurance company and at that time he was found hale and hearty. In such set of circumstances it would be difficult to arrive at the conclusion that the insured had suppressed the pre-existing disease."

It is not a startling fact that the needs for health cover are not palpably felt by a larger segment of the population, maybe, until they start experiencing some health related complaints. The insured may want to suppress such vital information (of previous hospitalization or surgery done or treatment taken) to the insurance company for fear of refusal of coverage or loading of premium. Insurance contracts are built on utmost good faith or *uberrima fides.* The insured is expected to disclose material information to the insurance company which would have a bearing on the decision that the insurer would take regarding coverage or the terms or conditions of the coverage. This, though, may not always happen. In the above referred to judgment, it has been observed that the panel doctor of the insurance company had thoroughly examined the insured and had found the insured to be hale and hearty. It is significant to note that the physical examination or investigations conducted prior to issuance of policy by the panel doctor may or may not reveal any health abnormality even if the prospective insured has an illness. Ailments such as hypertension and diabetes mellitus can be well controlled with medications. Therefore, the blood pressure reading or the level of blood sugar may be normal at the time of examination by the panel doctor of the insurance company. Thus, certain pre-existing ailments may not be detected if well controlled with medications. Secondly, it would not be worthwhile or even not feasible in every case to order every conceivable investigation/test to rule out pre-existing ailment.

There are instances where a claim is repudiated on the basis of the duration of ailment mentioned in the medical records. Subsequently, the claimants produce a letter from the treating doctor

With increasing consumer awareness, the insured as a consumer is cognizant of the rights and remedies available to him/her in case of wrongful repudiation of his/ her claim.

that the duration of the illness has been wrongly recorded in the medical records. The rectified document would help make the claim payable. It is pertinent to point out here that the duration of an illness is mentioned to the treating doctor at the time of hospitalization or consultation by the patient or the relatives of the patient (in case the patient himself is unable to provide the history in view of his illness). The treating doctor (more often) has no personal information regarding the duration of the illness. This certainly raises a penumbra of doubt that the change of duration of illness is brought about at the instance of the insured patient as an afterthought to make a claim payable that is otherwise not payable.

Fraudulent claims need to be carefully worked upon before they are repudiated so that they can stand the legal scrutiny. Not infrequently, private investigators are appointed to determine the genuineness of the claim. There have been instances where reportedly certain quasi-judicial authorities have refused to rely on the report of a private investigator. This question arose before the National Consumer Disputes Redressal Commission (***Ummadi Simhachalam vs Oriental Insurance Company Limited)*** while deciding an appeal "whether under the Insurance Act apart from surveyor and assessor, any investigator could be appointed, and if so, what shall be the value of the report of the investigator." An opinion was sought from IRDA on this issue. The IRDA while giving a detailed opinion quoted an extract of the Supreme Court in National Insurance Company Limited vs Harjeet Rice Mills wherein it has been held that Section 64 UM of the Insurance Act .1938 cannot stand in the way of the insurer in establishing (by engaging a private investigator) that the claim was a fraud on the insurer or that it was a case deliberately causing loss so as to lay the foundation for an insurance claim.

In appropriate cases, health claims may be repudiated on the grounds that the hospitalization is not for any active line of treatment or that the hospitalization is primarily for investigations or evaluation and hence not covered under the terms and conditions of the policy. Quite often, in such cases the treating doctor or the insured or both would be under the false impression that the expenses incurred for investigations (generally expensive investigations such as CT scan, MRI) would be reimbursed only if hospitalization takes place and hence admission is advised though no active line of management is otherwise necessitated during hospitalization. Sometimes, the insured would want to avoid the inconvenience of making multiple visits to health care facilities for undergoing various investigations and an admission becomes more comforting. The shock comes in when the claim is repudiated.

With increasing consumer awareness, the insured as a consumer is cognizant of the rights and remedies available to him/her in case of wrongful repudiation of his/ her claim. This makes it imperative that the repudiation is in consonance with the decisions of the judicial and quasi-judicial authorities. It would also be desirable to have in place a grievance handling mechanism to avoid the possibility of numerous complaints piling up before the various judicial and quasi-judicial authorities.

The author is the Chief Administrative Officer of Paramount Health Services Private Ltd. He also heads the Provider Management Department.

Repudiation – The Last Resort

Non-Life Insurance Claims

ARUN AGARWAL WRITES THAT EXPERIENCE HAS SHOWN THAT REPUDIATION OF CLAIMS BY THE INSURERS ON THE PLEA OF FRAUD BY THE INSURED CANNOT ALWAYS BE MAINTAINED BEFORE THE COURTS AND THE CONSUMER FORUMS, FOR LACK OF ADEQUATE EVIDENCES TO SUPPORT THEIR DECISION.

The Indian insurance industry has been witnessing a phenomenal growth of business year after year ever since it was opened up for participation by private players. This growth is primarily attributed to the spread of retail insurances, namely Motor, Health, Travel, Personal Accident etc. which are intended to extend insurance benefits to the individuals at large. Inevitably, the number of claims is also witnessing the increase, commensurate with the number of policies issued.

While dealing with the claims portfolio, the insurers do face a number of claims, which may not be found admissible within the scope of the policy issued. This includes cases where there is misuse of the policy by the policy holder for undue gains.

A simple dictionary meaning of the word 'Repudiation' is something like 'reject', disown 'refuse to accept' etc. But in the context of insurance policies it may have to be approached in two distinctively different angles in the following two different scenarios:

- Claims for losses caused by un-insured perils or perils specifically excluded from the scope of the policy.
- Claims which are otherwise admissible under the policy but violation or non-compliance by the insured of some of the policy conditions gives the right to the insurer to refuse admittance of the claim.

For a claim to be admissible under the policy the following requirements are paramount:

- The insured should have paid the appropriate premium
- The subject matter affected by the peril should have been covered for insurance
- The loss to the insured should have been caused by one of the perils insured
- The peril should have taken place within the period of insurance
- The loss claimed by the insured should not fall under any of the exclusions of the policy.

If any one or more or all of the requirements are not met with, the loss claimed by the insured becomes inadmissible under the policy. If in such situation a claim of the policyholder is not entertained by the insurer, it cannot be termed as repudiation of the claim by the insurer, but should be considered as a contingency uncovered under the policy coverage.

A repudiation of the claim by the insurer, on the other hand, would arise only when the policy holder fails to comply with any of the following:

- Conditions precedent to the contract
- Conditions subsequent to the contract and
- Conditions precedent to liability

Conditions precedent to the contract relate to non-disclosure or mis-representation of material facts by the proposer which would affect the judgment of the insurer in accepting the proposal and fixing the appropriate rates, terms and conditions for the coverage sought for.

Conditions subsequent to the contract broadly relate to the Dos and Don'ts by the policyholder during the period of insurance.

While dealing with the claims portfolio, the insurers do face a number of claims, which may not be found admissible within the scope of the policy issued.

Conditions precedent to liability relate to requirements to be complied with by the policyholder if and when a loss is sustained by him arising out of an insured peril.

All the three conditions stipulated above will fall under two categories, namely the implied conditions which any prudent man should be aware of, and the express conditions which will be specifically stated in the policy.

Observance of utmost good faith, existence of the subject matter of insurance and existence of insurable interest on the part of the policyholder etc. are the important implied conditions about which we are all aware of.

Express conditions are the ones which comprise of common ones which will appear almost in all polices of insurance whether it be assets related, person or liability related, and specific ones which are applicable in respect of the particular policy of insurance . Here again, the express conditions appear in the policy in two forms: some of the conditions as imposed by the insurer and some in the form of warranties which are basically undertakings by the insured to the extent

- that certain state of affairs exist in relation to the insured risk and/or
- that the policyholder undertakes to do certain things or not to do certain things during the period of insurance.

Suffice it to mention here that the conditions whether implied or express, the warranties incorporated in the policy should be strictly complied with by the insured in order that he would become entitled to recover under the policy, the loss sustained by him by any of the insured perils.

The warranties incorporated in the policy should be strictly complied with by the insured in order that he would become entitled to recover under the policy, the loss sustained by him by any of the insured perils.

While the insurer has the right to repudiate a claim in the event of non compliance of some of the warranties/ conditions stipulated in the policy by the insured, it is never an easy job as it may sound. Apart from the insured who is the directly affected party by the repudiation of the claim, even the forums like Ombudsman and Consumer Forums to which the consumer represents against the denial by the insurer, or even the courts, wherever cases are filed by the policyholder; may not appreciate such repudiations, unless there are well founded reasons and incontrovertible evidences cited by the insurer.

Historically, a few of the cases where insurers have resorted to repudiations of claims are:

Insured's non-compliance of conditions/ warranties relating to:

- Occupation of the insured premises, process, un-occupancy of the premises beyond a specified period, delay in notification of claim, non-submission of documents within a specific period after the loss etc. in relation to assets related policies
- Avoidance of liability in case of accidental injuries while the insured was under the influence of intoxicating liquors, in relation to personal accident policies
- Pre-existing diseases in relation to Health Insurance policies
- Non-disclosure or misrepresentation of material facts by the insured
- Insured committing fraud or resorting to fraudulent means to secure benefits under the policy

Non-Compliance of the conditions/ warranties or other stipulations stated in the policy by the insured may also arise not out of an intentional action on his part but out of sheer ignorance of the existence of such conditions and the consequences of his failure to comply with them.

The regulations put in place by the IRDA to protect the interests of the policyholder require the insurer to ensure the following:

- A prospectus of any insurance product shall clearly state the scope of benefits, the extent of insurance cover; and in an explicit manner explain the warranties, exceptions and conditions of the insurance cover
- A proposal for grant of a cover must be evidenced by a written document. It is the duty of an insurer to furnish to the insured, free of charge, within 30 days of the acceptance of a proposal, a copy of the proposal form.
- Where a proposal form is not used, the insurer shall record the information obtained orally or in writing, and confirm it within a period of 15 days thereof with the proposer and incorporate the information in its cover note or policy. The onus of proof shall rest with the insurer in respect of any information not so recorded, where the insurer claims that the proposer suppressed any material information or provided misleading or false information on any matter material to the grant of a cover.

Further, in regard to the contents that should appear in the policy the IRDA Regulations state that a general insurance policy shall *inter alia* clearly state:

- the name(s) and address(es) of the insured and of any bank(s) or any other person having financial interest in the subject matter of insurance;
- full description of the property or interest insured;
- period of Insurance;
- sums insured;
- perils covered and not covered;
- policy terms, conditions and warranties;
- action to be taken by the insured upon occurrence of a contingency likely to give rise to a claim under the policy;
- the obligations of the insured in relation to the subject matter of insurance upon occurrence of an event giving rise to a claim and the rights of the insurer in the circumstances;
- any special conditions attaching to the policy;
- provision for cancellation of the policy on grounds of mis-representation, fraud, non-disclosure of material facts or non-cooperation of the insured;

An onerous responsibility, therefore, rests with the insurer in ensuring that the prospect is made fully aware of the complete details of the insurance coverage, with all the inclusions and exclusions, his duties and responsibilities, and other procedural aspects to be complied with for entitlement of a recovery under the policy in case of a loss. And barring exceptional circumstances the insurer should in all cases insist on obtaining from the insured a duly completed proposal form. Once these are taken care of and the policy with all terms and conditions is issued and delivered to the insured, instances of un-intentional violations by the insured get substantially reduced and consequent repudiation of claim for policy violations should be minimal.

Fraud in any form can never be encouraged and fraudulent claims deserve a summary rejection. But experience has shown that the repudiation of claims by the insurers on the plea of fraud by the insured in some cases in the past could not be maintained before the courts and the consumer forums for lack of adequate evidences to support their decision. Insurers therefore need to have clear evidences to deal with cases of fraud.

An onerous responsibility, therefore, rests with the insurer in ensuring that the prospect is made fully aware of the complete details of the insurance coverage, with all the inclusions and exclusions, his duties and responsibilities, and other procedural aspects to be complied with

The Insurance Surveyors and Loss Assessors Regulations passed by the IRDA specify that as a part of their duties the surveyors should, in case of claims recommended by them to be repudiated, give their reasons for repudiation with due reference to the policy terms and conditions. It should be ensured by the insurer that the surveyor's report fully satisfies this requirement whenever they recommend a claim for repudiation. If the evidences collected by the surveyors are not adequate enough, the insurers in consultation with the surveyors should arrange for further detailed investigation of the case before deciding to repudiate. Sometimes legal opinion is also resorted to on the admissibility of the claim before the final decision is taken. Wherever the surveying jobs are carried out by the company personnel or any other expert appointed by the company, they need to have sufficient documentary / other evidences to treat the claim as one to be repudiated, should the situation warrant.

On the subject of fraud by insured for getting undue gains under the policy, it may be mentioned that fraud is not always restricted to the cause of loss. In many cases it arises out of an over stated claim, a claim for assets which did not exist, false documentation or altered invoices etc. It has been held by the courts that exaggerated or overstated claim is not necessarily a fraudulent claim and that whether the overstatement amounts to fraud depends on the intention of the insured and the whole attitude of the insured. In view of this, the insurer looks into such cases of exaggerated or overstated claims very carefully before coming to the conclusion of fraud by the insured.

When a decision is taken by the insurer for repudiation of the claim, the communication to the insured/claimant in this connection needs to clearly specify the reasons for such repudiation.

Conclusion

As a matter of course, no insurer would like to repudiate liability as long as the coverage has been granted after receipt of premium and loss has been genuinely incurred by the insured by a covered contingency. It is therefore, in the interest of all concerned that the insurer takes all possible steps to make the policyholder aware of all aspects of the coverage and communicates them to the insured transparently.

The author is Chief Underwriting Officer, ICICI Lombard General Insurance Co. Ltd.

Repudiation of Claims

What Triggers Them?

SANJAY SETH OPINES THAT THE VERY USE OF THE PHRASES 'REPUDIATION OF A CLAIM' AND 'REPUDIATION OF LIABILITY' IS MISPLACED AND THE BETTER TERMS ARE 'REJECTION OF A CLAIM' AND 'DENIAL OF LIABILITY'.

Insurance is a contract between two parties wherein the insurer on receipt of a consideration (premium) contracts to indemnify the insured (proposer) for the losses sustained by the insured following the operation of the perils against which the designated subject matter was insured. Thus it is evident that insurance is a contract between the insurer and the insured and is subject to the general principles of the law of contract.

It is a general principle of any contract that a valid contract may be avoided (or rescinded) by one of the parties to it on the ground of a misrepresentation, either by a positive act or by an omission, made during pre-contractual negotiations.

What the misrepresentation or non-disclosure does, where it is established to be material and induced the contract to the prejudice of the other party, is that the party who has been induced to enter the contract may rescind the contract from its inception. This is the ordinary remedy available to the person who has concluded a contract on the basis of a misrepresentation. The contract is not void, but is voidable from inception.

Repudiation of a contract means a refusal to perform the duty or obligation owed to the other party to refuse to accept something or someone as true, good or reasonable.

In the context of insurance contracts, in the backdrop of what is stated above, the decision to avoid the contract is then made by the insurer. The insurer needs to notify the insured of that decision and the intention to rescind the contract.

In the context of rejection of a claim it is confusing to use the term "repudiation" to describe the insurer's conduct. The use of the phrases *"repudiation of a claim"* and *"repudiation of liability"* are common in the insurance industry. The better terms are *"rejection of a claim"* and *"denial of liability".*

Insurers may refuse to pay claims for a variety of reasons. As all insurance is an agreement (contract) between the insured and the insurer, the insurer will always rely on the insurance agreement, which is contained in:

i) The Schedule of insurance, read together with

ii) The Policy

The Schedule details the specific items and amounts insured; and exclusions and preconditions, it may also include the statements insured has made (proposal) as a basis on which the insurer has entered into the agreement. The Policy details the general conditions items insured under most contracts, procedures and all of the other relevant terms of the agreement. Collectively they form the evidence of the contract of insurance.

Some reasons that insurer may offer when rejecting (refusing payment) a claim are:

- False statements made when applying for insurance;
- Failure to disclose relevant facts when applying for insurance;
- Claim does not fall within the items insured under the policy;

It is a general principle of any contract that a valid contract may be avoided (or rescinded) by one of the parties to it on the ground of a misrepresentation, either by a positive act or by an omission, made during pre-contractual negotiations.

It is not that the insurers reject insurance claims at their whims and fancies. All insurers are very cautious in denying liability under a Policy.

- Failure of the insured to comply with the terms of the agreement;
- Fraud;
- Inordinate and unreasonable delay for the reporting of the incident which may lead to a claim;
- Failure to pay the premium on time/ at all;
- No consequential losses covered under policies;

This list is not all-inclusive, but designed to cover the most commonly occurring reasons.

- **False statements made when applying for insurance**

  When one applies for insurance, a number of questions will be asked. If one answers any of the questions wrongly, in other words if one is not entirely honest, and the "misstatement" is discovered, the insurer may be entitled to deny.

  If the insured's circumstances have changed since answering the questions, it is extremely important that he notifies the insurer of the changed circumstances.

- **Failure to disclose relevant facts when applying for insurance**

  It is imperative when one applies for insurance that he includes the minutest of detail which he thinks may have an influence on either the decision whether to insure, or the amount of premium chargeable. One must disclose not only what he knows but also what he ought to know in respect of the subject matter and the risks pertinent thereto.

- **Claim does not fall within the items insured under the policy**

  The schedule does not list the item on which the insured prefers a claim. This means that the subject of the claim is out of the ambit of the contract of insurance and hence there can and will be no consideration from the insurers for indemnity in respect thereof.

- **Failure of the insured to comply with the terms of the agreement**

  Any breach of the conditions and warranties which are a part of the contract of insurance will entitle the insurers to reject the claim of the insured.

- **Fraud**

  If the insured makes an untrue statement in an effort to get the insurer to pay for something it isn't obliged to, he does not deserve to be compensated. This may also entail a possibility of initiation of criminal proceedings by the insurer against the insured.

- **Inordinate and unreasonable delay in reporting of the incident which may lead to a claim**

  Insured are required by most insurers to notify them within a reasonable period of time of any incident which **may give** rise to a claim. Should the insured fail to do so without suitably and satisfactorily explaining the reasons for the delay to the conviction of the insurer, the claim may be jeopardized.

  What constitutes a "reasonable period of time" will differ from case to case. However, usually a timeline of two weeks is considered reasonable for such purpose.

- **Failure to pay the premium on time/ at all**

  The agreement with the insurer comes into effect on the payment of insurance premium or guaranteeing the same through a Bank, before the inception of the proposed cover. Should the insured fail to honour its commitment towards the payment initially or subsequently at any stage (in case premium is staggered over instalments) the policy is liable to be cancelled and claim is liable to be denied.

- **Policy does not include consequential loss**

  Most ordinary short term personal policies exclude consequential loss of the insured. The effect is that the damage is covered, but not the loss that results as a consequence of the damage. However, it is possible to insure business against consequential loss by opting for a specific cover for the purpose.

It is not that the insurers reject insurance claims at their whims and fancies. All insurers are very cautious in denying liability under a Policy. Further, reasons for rejection of claims have to be cogent and have to be suitably communicated to the insured, failing which the aggrieved (insured) has a right of action against the insurer. For the purpose, the insured are offered easy access to the authorities like the Insurance Regulatory and Development Authority, Insurance Ombudsman, Consumer Disputes Redressal Forum and last but not the least Courts of Law.

The author is Head - Claims, IFFCO Tokio General Insurance Co. Ltd.

Reputation vs. Repudiation

The Intertwining Contradiction

D V S RAMESH ARGUES THAT WHILE IT IS DESIRABLE FOR AN INSURER TO HAVE A ZERO REPUDIATION RECORD, IT MAY BE ESSENTIAL TO TURN DOWN A FEW CLAIMS THAT ARE OTHERWISE WRONGFUL; AS IT IMPEDES WITH THE PRINCIPLE OF EQUITABILITY.

The passage of time transforms the course of subjects, the specialisation and the terminology; and so on and so forth. The awesome advancement in medical science is testimony to the treatment now being available, as contrasted with that of yesteryears. The subject of insurance can be likened to this phenomenon, with each branch of insurance having remarkably increased in scope. Till a few years back, the subject of insurance was rarely heard as a specialised course in the corridors of academia. With the developments that shook the financial services as a whole, in particular the insurance sector, there are a number of insurance focused courses offered by various institutions. This ultimately helps in further evolution of the interlinked subjects associated with the concept of insurance. The current issue focus of repudiation which is a sub-branch of claims speaks of the growing importance of the inherent conceptual issues of the insurance subject.

Settlement of claims being the core of the insurance business, the action or inaction of an insurance company would have an impact on the service standards adopted by the company. Of all those decisions, repudiation of a claim is the most sensitive action taken by a prudent insurer. On the one hand, contractual obligation to settle the claim entreats insurers for initiating pro-active measures for accomplishment of the task. On the other, it acts as the custodian of all policyholders. Imprudent approach while settling death claims in life insurance would be a burden on other classes of policyholders by way of both reductions of bonuses or by way of hike in insurance costs. At the same time, an imprudent repudiation of claims would involve reputation issues to the insurance companies leading to possible legal backlash.

The repudiation of claims deserves to be examined mainly from two angles - one is the legal aspect and the other is the operational aspect. As regards the repudiation of death claims, Section 45 of Insurance Act, 1938 has a major role in deciding whether or not a claim deserves to be repudiated.

When Insurance Act, 1938 itself is a time-tested legislation, Section 45 of the Act that enables life insurers to repudiate life insurance claims stood the test of time, withstanding the rancour of legal pronouncements. The section protects the claimants of a claim by shifting the onus of proving the reasons for repudiation on to the life insurer in the event of a policy resulting into a death claim, two years after the commencement of the policy while safeguarding the interests of insurer and its other policy holders to call in question the bona fides of the claim that resulted within two years of commencement of the policy. This section also attracted the attention of various committees that examined the provisions of insurance law.

Law Commission of India in its 112th report while examining the question of repudiation of a life insurance policy

Settlement of claims being the core of the insurance business, the action or inaction of an insurance company would have an impact on the service standards adopted by the company.

recommended the revisiting of Section 45 with the objective of striking a balance between protecting the interests/rights of policyholders and the rights of life insurers to repudiate on valid grounds. As per this recommendation, in brief, Section 45 would need to be recast in such a way that a policy of life insurance cannot be called in question after the expiry of 3 years from the date of commencement of the policy or its revival. And a life insurer may call in question a policy of life insurance within such 3 years on grounds of non-disclosure of material information pertaining to life expectancy of the life to be assured. The consultation paper floated by Law Commission of India on Insurance Act endorsed the view. Going by these recommendations, the role of life insurers would be very much marginalised in dealing with fraudulent claims and may also pave way for the fraudsters taking a chance up to three years especially with the developments in the medical front.

However, the 190th report of law commission on revision of Insurance Act 1938 and IRDA Act 1999 proposed an elaborate amendment to Section 45 after considering the views of various stakeholders. In brief, the amended section proposes that life insurers can repudiate a claim and forfeit the premiums within 5 years from the commencement of policy or risk or revival whichever is later - only on grounds of fraud. In the event of repudiation within 5 years on grounds of suppression of misstatements, insurers have to refund the premiums collected. A distinct essence of the proposed amendment is refraining life insurers from repudiating the life policy on grounds of suppression of material fact if it is with the knowledge of the agent of the life insurer and introduction of the word 'fraud' into the section. Going by these recommendations; number one - it may be difficult for the insurance companies to establish the *mens ria* (mental intention) of the proposer. Number two – it would be difficult to establish a possible connivance of an agent with fraudsters and/or claimants, claiming that the agents acted with the knowledge of the materiality of contents declared. As a recourse, when insurers are at liberty to take an action against such erring agents, the damage would already have been done to the life insurers. It may also pave way for a legal wrangle with agents.

In advanced economies like US, insurance frauds are also considered as acts of crime; and punishments for such frauds are deterrent per se.

Also, given the lower levels of insurance education even amongst the higher strata of society, who envisage insurance as a source of benefit than a source of social security at large; the possibility of an adverse selection may impact the objective of building up the insurance funds. In advanced economies like US, insurance frauds are also considered as acts of crime; and punishments for such frauds are deterrent *per se*. There are certain enabling provisions in the statutes of these advanced countries to deal with insurance frauds. For example: As per provisions of Insurance Law of New York, insurance fraud is defined in the penal laws. Section 403 of Insurance Law of New York empowers the state insurance regulatory authorities to levy a civil penalty up to US$ 5000 on any person committing an insurance fraud. This law further designates its deputed employees as peace officers and mandates them to work in co-ordination with other law enforcement agencies. In the absence of such enabling provisions, establishment of fraud by insurance executives is a difficult task.

As regards not allowing repudiations after 5 years after the commencement of policy; with medical advancements successfully prolonging the life span, it compels insurers to come out of the cocoons of these legal statutes. Be that as it may, now the question that arises from the perspective of the core life insurance subject is, whether such lives, which are not standard otherwise,

1. Compilation of Legal Decisions of Hon'ble Supreme Court & High Courts in Life Insurance by Mr Sudhir Kumar Jain

deserve to be extended the protection of life insurance coverage at ordinary rates at par with the healthy lives, especially given the limitations for carrying out an exhaustive pre insurance investigation in all cases across the board.

The KPN committee on provisions of Insurance Act dealing with the provisions of Section 45 of Insurance Act recommended status quo of the section.

Of late, there is a growing concern on the way in which the repudiations are taking place. While recommending the status quo of the section, even the KPN committee laments "The Committee, while accepting in humility the considerations that had led the Law Commission to recommend amendments to Section 45 of the Act, is of the view…" It indicates the gravity of the situation that this matter deserves its attention at this hour. Also in Life Insurance Corporation of India vs Asha Goel[1], Supreme Court observed;

"In course of time the Corporation has grown in size and at present it is one of the largest public sector financial undertakings. The public in general, and crores of policyholders in particular; look forward to prompt and efficient service from the corporation. Therefore, the authorities in charge of the management of the affairs of the corporation should bear in mind that its credibility and reputation depend on its prompt and efficient service. Therefore, the approach of the corporation in the matter of repudiation of a policy admittedly issued by it should be one of extreme care and caution. It should not be dealt with in a mechanical and routine manner."

Further the following recent pronouncements in some decided cases reiterate the gravity of problem of claim repudiations.

- "It appears that the insurance companies have a tendency of insuring each and every person under its medical policy without verifying or getting them examined by their doctor only to enhance their premium and business. It's a sorry state of affairs in which, we have numerous cases wherein, the claims of the insured persons are deliberately and intentionally repudiated under the garb of non-disclosure of pre-existing disease" Chandigarh District Consumer Redressal Forum (The Indian Express dt. 28/07/2008).
- "The insurance companies often act in an unreasonable manner and after having accepted the value of a particular insured goods, disown that very figure on one pretext or the other when they are called upon to pay compensation. This 'take it or leave it' attitude is clearly unwarranted not only as being bad in law but ethically indefensible" - Observations of Supreme Court bench. (Financial Chronicle dt. 04/08/2008)

Though, these pronouncements are with reference to various insurance companies involved, it is open for all insurance companies to draw lessons and redraw their course of action with regard to their respective claims philosophies. The increase in percentage of repudiated cases would be a cause of concern for all the stakeholders of the industry; as insurance being an intangible service, policyholders would be apprehensive of the promises of their insurance contracts being fulfilled.

Operational imbroglio

Death Claim Investigations – Professional Vs Procedural: In order to ascertain the bona fides of a death-claim, investigation into such cases is the only available avenue to the life insurers. However, quite often the job of investigation is considered as ancillary to the job of marketing in life insurance and hence it is more commonly assigned to marketing executives in some life insurance companies. However, these executives need to be kept informed that the core activity of investigations shall be to ascertain the facts of the case than to depart from the objective of settling the claims. Though, there may or may not be much dilution in the standards of the investigation that is carried out by such in house officials vis-à-vis the investigations carried out by other professionals, it surely lacks the completeness that it acquires if it is carried out by such a professional. There are certain common areas where there may not be much difference in their respective approaches like area of importance to confirm the antecedents of the life assured's death, cause of death (say possibility of a suicide, life style etc.); sources of information like neighbourhood, family members, family doctors etc. The specific areas that may distinctly differ are reliance on/accessing the investigation records of other agencies/financial institutions/insurers. There are various problems that come in the way in cracking these things like accessibility of records,

It's a sorry state of affairs in which, we have numerous cases wherein, the claims of the insured persons are deliberately and intentionally repudiated under the garb of non-disclosure of pre-existing disease.

It is necessary that more care is taken at various levels while a claim is repudiated. In order to achieve this, it is also desired to put in place various layers of operational hierarchy before repudiating a death claim.

absence of common data base (of claims under investigation) amongst insurers, confidentiality matters etc, which may be better handled by professionals. Also there is a possibility that the investigation reports carried out by these professionals may be viewed as unbiased by the aggrieved claimants.

Issues of interpretations: The wordings of the policy documents vis-à-vis the interpretation at the operational level do have a bearing in repudiating the claims. Therefore it is necessary that more care is taken at various levels while a claim is repudiated. In order to achieve this, it is also desired to put in place various layers of operational hierarchy before repudiating a death claim. The pronouncement of Calcutta High Court in the following case law speaks of the need for attentive interpretation of the terms and conditions of the policy contract.

In Prabir Kumar Nath Vs LIC of India[1] the respondent company has repudiated the accident benefit claim of the respondent on the ground that injuries sustained are not 100% as per the policy terms and conditions; whereas the policy terms and conditions did not refer to any specific percentage to define what constitutes a total disability. Disposing the writ petition in favour of the petitioner, Calcutta High Court observed that there is no pre condition of 100% disability for qualifying for compensation under the policy. It appears that reliance on the percentage before deciding the claim and its mention in the communication addressed to the aggrieved policyholder is the focus of attention in deciding the case.

Communications with the policyholders: Communications to the policyholders at various stages of insurance policies weighs the obligations of the insurers. There needs to be a better clarity in defining roles of various parties involved in the contract. The following decided case law stands as an example in emphasising the need for a fair communications directly with the policyholders.

In Delhi Electric Supply Undertakings (DESU) Vs Basanti Devi invoking article 142 of the constitution, the Supreme Court held LIC of India responsible for payment of claim liability though, the employer did not remit the premiums recovered from the salary of the life insured to LIC of India. One of the points raised in this case law is that employees of DESU were not with the knowledge of the fact that DESU is acting as an agent of employees not that of LIC. Thus, here is a lesson for life insurers to intimate the status, be it legal or operational, of various parties involved in the insurance contract to policyholders directly, especially in schemes like Salary Savings Schemes.

Dealing with pending proposals: Despite advancements in the information technology, there is possibility of insurers to delay underwriting the proposals though, there would be no requirements required to be submitted by the proposers. As far as insurers are concerned, pending decision on a proposal, contract could not be said to have been concluded. However, from the perspective of proposers they may deem contract concluded in the event of non receipt of any negative information from the insurers after a specific period. While it would be prudent on the part of insurers not to delay deciding on pending proposals, there is no ground available to the aggrieved claimants. Now if any insurer decides to settle the claims as gratis, the issue that comes to the fore is who should foot these costs; is it from shareholders' fund? Or policyholders' fund? Whether the quantum of claims settled under this head in a particular year is significant or not, the practice adopted would pave the way in strengthening the faith of the policyholders as also the operational efficiencies of insurers.

Underwriting Lacunae: Higher number of repudiations indicates lacunae in the prevailing underwriting standards adopted by insurers. It would be worthwhile in referring the claims due for repudiation for a re-underwriting based on new revelations which enables insurers to take a final call on repudiation. This practice also strengthens the underwriting policy as relevant operational personnel would be updated with the knowledge of latest developments in the claims arena. It helps when insurers periodically revisit their prevailing underwriting policies.

Do not outsource repudiations: The

There is a need to increase awareness amongst all classes of policyholders about the availability of other alternate dispute redressal mechanisms like Ombudsman.

evolution of Third Party Administrators enabled insurers to outsource the settlement of claims under health insurance policies. While it may reduce the operational costs of insurers at a macro level, they remain liable to the decisions taken by these TPAs thereby partly increasing their exposure to operational risk. Repudiation of a death claim in haste may lead to an uproar in the financial markets thereby affecting the reputation of insurer as well. And the decisions taken by these TPAs would have an impact on the insurers. It is in this direction, it would be prudent for all insurers to direct their respective TPAs to refer those cases that are considered for repudiation for taking a final call from their offices. Given the expertise levels that are available with insurance companies vis-à-vis those of the outsourced entities, it would be prudent for insurers to review these cases at their level itself.

Need for promoting alternate dispute redressal mechanism: At a time when there is a growing concern as to both quantity of repudiated cases and quality of their respective decisions, there is need for proactive initiatives by insurers as part of their larger business ethics philosophy to let the claimants know about the availability of alternate dispute redressal mechanisms like Ombudsman in all their correspondence. Though some classes of non-life insurance contracts do have arbitration clauses in policy terms and conditions to refer the matter to arbitration in the event of a dispute on the quantum of the compensation on insured loss, it is not available to cases of repudiations. Hence there is a need to increase awareness amongst all classes of policyholders about the availability of other alternate dispute redressal mechanisms like Ombudsman. Though regulations mandate furnishing of information relating to ombudsman in all policy contracts, it would be prudent to proactively mention this information again in the communication sent informing about repudiation.

In an increasingly competitive environment, insurers' reputation depends on their ability in meeting their contractual obligation in the years ahead. It is a well known fact that handling of repudiations is a precarious task to the insurers managing interests of both claimants and its policyholders. Based on MIS reports/performance parameters and based on experience gained - be it with ombudsman cases or other decided case laws, it is imperative upon insurers to revisit their operational procedures and claims philosophies leaving no procedural gaps. It deserves to be mooted if it is worthwhile to put in place broad based policy approaches while dealing with claim settlements on gratuitous basis so as to uniformly apply them to all cases fitting in similar parameters in a given period of time.

The author is Senior Assistant Director (Inspection), IRDA. The views expressed in the article are personal.

It is proposed to discontinue the publication of the monthly business figures (topline) of the insurers shortly. Can we look forward to your thoughts on this please?

– Editor

The Indian Monsoon

Between a Curse and a Blessing

'THE SIGNIFICANT INCREASE IN EXTREME MONSOON RAINFALLS, A BURGEONING OF INSURED VALUES, AND FIERCER PRICE COMPETITION ARE MAJOR CHALLENGES FOR THE INSURANCE INDUSTRY IN INDIA. THE MARKET IS CURRENTLY GOING THROUGH A COMPLEX PROCESS OF LIBERALISATION AND ADJUSTMENT' WRITES SANJEEB CHAUDHARY.

The monsoon is as much a part of India as the country's extensive dry seasons. Producing about 80-90% of the country's annual precipitation, the summer monsoon (June–September) is a source of life to India, regulating, as it does, the gigantic country's water balance. It is particularly crucial for the agricultural sector, which accounts for about a fifth of India's gross domestic product and provides work for around two-thirds of the population. But the monsoon itself has changed. The frequency and intensity of extreme rainfall have both increased considerably, whilst exceptional rainfall levels have given rise to serious floods and ensuing damage in recent years. In 2005, the highest level of precipitation ever measured on a single day in India was recorded in Mumbai. In 2007, the effects of the summer monsoon were extremely intense for the third year in succession.

The annual overall loss due to flood in the years 2005–2007 averaged roughly US$ 4bn, three to four times higher than the average for the period 1980–2004. Escalating concentrations of values in exposed regions like Mumbai combined with growing insurance awareness caused insured losses to soar during this period. Is this latest development merely an outlier or the herald of a long-term change in monsoon activity?

Climate change as the cause

Scientific studies show that monsoon activity in central India has changed significantly (Goswami *et al* 2006). The daily variability of monsoon rainfall, i.e. the range between severe and less severe daily rainfall events, has increased markedly in the last 50 years. In central India, the number of intense precipitation events per day (at least 100 mm/day) has increased by about a third since 1950. The figure is even more dramatic in the case of extreme precipitation events, involving levels of at least 150 mm/day. It has roughly doubled since 1950 – a highly significant increase in scientific terms. At the same time, there were considerably fewer instances of moderate precipitation events in the observation period. Although these opposing trends mean that average rainfall has not changed, this is not good news. On the contrary, whilst the moderate monsoon is important for India's water balance, especially for the agricultural sector and the supply of drinking water; intense and extreme rainfalls have a major bearing on losses. What is more, the majority of models quoted by the Intergovernmental Panel on Climate Change in its report assume that the total rainfall depths of the summer monsoon will increase in future. Even if there are large deviations between the individual scenario calculations, there is no doubt about the outcome - Indian summer monsoons are very likely to become more extreme.

The frequency and intensity of extreme rainfall have both increased considerably, whilst exceptional rainfall levels have given rise to serious floods and ensuing damage in recent years.

And this is due to global warming. Sea surface temperatures in the tropical Indian Ocean, for instance, have risen by

about 0.5°C over the last 50 years. This results in more moisture reaching India with the monsoon.

It is a risk of change that is difficult to quantify and the Indian insurance industry must give greater attention to devising appropriate solutions – particularly as the values to be insured are rapidly increasing.

Losses increase – Premiums come under pressure

In India, the natural perils of windstorm and flood (STIF) are automatically included in any property insurance policy. Weather risks, particularly monsoon rainfall, have always constituted a major threat. The process of global warming has made it more and more difficult to forecast the beginning and magnitude of annual monsoon rainfall. Between 1980 and 2007, weather disasters (floods, storms, droughts) caused overall losses amounting to US$ 53bn (2007 values). The main peril is flood, which accounted for about 77% of the overall losses and 66% of the insured losses over the said period.

The summer floods in 2005 (Mumbai Floods) exhausted nearly all the market players' cat XL programmes for the first time ever. Due to the agreed net retentions, some of them had large losses that were not covered. There is already a broad consensus in the market that the rates, especially for flood risks, have to be adjusted substantially. Some insurers are considering the possibility of quoting separate premium rates, but this is not to be expected in the short term due to the shortage of claims statistics and especially to the fact that as of 1 January 2008 pricing controls have been removed in all lines of property insurance except motor third-party liability.

Market and market players in a learning process

For the insurance industry, the question is how the Indian insurance market will develop in the medium to long term. If there are no major loss events with large insured losses, pricing pressure will certainly be maintained for some time. Moreover, companies have in the past compensated underwriting losses with high returns on India's booming stock exchange. Reinsurance capacity is generally available in good measure.

At present, however, India is going through a process of learning and adjustment. The market has yet to encounter a phase with the scarcity of reinsurance capacity that necessitates risk-based pricing. Generally speaking, the private insurance industry should in the long term offer coverage concepts, such as a pool solution with compulsory insurance for natural hazards. These require both technical know-how and financial resources, however. International reinsurers could provide both, but the scope for efficient risk transfer in India is limited at present. Reinsurance is mainly provided by the General Insurance Corporation of India (GIC Re), to which non-life insurers must currently cede 15% of their cessions.

There is already a broad consensus in the market that the rates, especially for flood risks, have to be adjusted substantially.

Low market penetration – High growth potential

The socio-economic transformation of India presents its insurance industry with great challenges. Forecasts suggest that the country's insurance market will increase to some €100bn, five times its current volume, over the next ten years. This growth will be driven above all by rising demand from India's middle class, currently numbering some 300 million people, and the improvement and expansion of the infrastructure.

Freedom of establishment for foreign insurers is limited at present to joint ventures with a maximum foreign capital share of 26%. The government is currently examining the possibility of increasing this share to 49%. At the time of writing this article, 17 property insurance companies and 17 life insurers are licensed to do business.

These figures vividly illustrate how much the insurance industry has already profited in recent years from the opening of India's market as well as from the country's high rate of economic growth. Between 2001 and 2006, the annual increase in premiums averaged roughly 24% in life and 11% in non-life. In an international comparison based on total population, market penetration is still comparatively low in what is the second most heavily populated country in the world. With an average premium volume as a percentage of GDP, market penetration is about 0.6% (non-life) and 4% (life). In the non-life sector, it is estimated that 90% of the Indian population have no insurance protection whatsoever. In terms of absolute premium volume, however, the country already ranks fifth in Asia after Japan, South Korea, China, and Taiwan; and fifteenth in the world (2006). And experts agree that the speed of expansion will continue to be high in the years to come.

With a view to offering attractive insurance solutions in rapidly growing emerging markets, new products have to be developed in tune with the requirements.

Positioning as a Reinsurer

For a reinsurer, it is essential that they are backed by years of experience on the Indian insurance market; and know the market players and local customs and practice. They should enjoy the confidence of the Indian insurance market and, on the strength of long-standing business relations, should be recognised as a reliable reinsurance partner.

In the current market phase, there is need to look beyond traditional reinsurance business, positioning oneself as a global reinsurer particularly in niche markets and in sectors where quite specific, individual solutions are required. For example: Stepping up involvement in renewable energy projects. With a view to offering attractive insurance solutions in rapidly growing emerging markets, new products have to be developed in tune with the requirements.

The reinsurers have to make available their risk knowledge and financial strength in connection with large and very large risks – a segment that is continuously gaining in importance in the dynamically growing economy of India. Further, they have to not only provide capacity but also make an important contribution to the development of risk awareness.

Finally, to ensure the stability of India's strongly expanding insurance market, deregulation must be extended from its primary insurance market to include international reinsurance business as well.

Climate change and summer monsoons in India

Summer monsoon activity (June-September) in central India has changed significantly in the past 50 years. The extremes have increased.

Central India (74.5°E-86.5°E; 16.5°N-26.5°N)

1. Variability of daily rainfall anomalies in the summer monsoon

   Broken line: Linear trend.

2. Number of heavy rainfall events per day (at least 100 mm/day)

   Broken line: Linear trend.

3. Number of extreme rainfall events per day (at least 150 mm/day)

   Broken line: Linear trend.

4. Number of moderate rainfall events per day (between 5 and 100 mm/day)

   Broken line: Linear trend.

Source: Goswami, B. N. et al. (2006), Science 314

Weather-related natural catastrophes in India from 1980 to 2007

Losses from weather-related catastrophes have risen strikingly since the early 1990s. The largest insured loss was generated by the Mumbai Floods in 2005 (US$ 770m). The highest overall losses were caused by the floods in Gujarat and Punjab in northern India in 1993.

Largest events

A: 1993: Flood, Gujarat, Punjab

B: 1996: Cyclone, Andra Pradesh

C: 1998: Cyclone, Gujarat, Kandia

D: 1999: Cyclone, Orissa

E: 2005: Flood, Mumbai

F: 2006: Flood, Surat

Overall losses

Insured losses

Source: NatCatSERVICE, Geo Risks Research, Munich Re

Losses caused by floods

	2005	2006	2007	Average 1980-2004
Overall losses	5,400	6,200	750	1,150
Insured losses	850	410	n/a	5
Fatalities	1,650	1,100	2,000	1,100

Losses in US$ m, 2007 values.

Water as a risk factor - Soil sealing and glacial lake outburst flood

Floods and inundation are influenced not only by the intensity of the precipitation but also by the characteristics of the area on which the rain falls. Is the terrain flat or sloping? Are there narrow or wide valleys in the region? What about the discharge capacity of river courses? How big are the retention and storage capacities? The degree of sealing determines how much water can seep into the ground. This involves not only artificial sealing, resulting from road-building and urban development, but also natural sealing, which depends on the type of soil and the amount of precipitation involved. In the case of prolonged and intensive rainfall, the ground becomes so satur-ated that sooner or later it cannot absorb any more water. Further precipitation then quickly leads to floods.

Artificial sealing, on the other hand, is usually a result of urbanisation. In many of India's urban areas, upgrading of the sewage and drainage systems cannot keep up with the rapid pace of urban development. The systems are overloaded, there is back-water, and the ground is flooded.

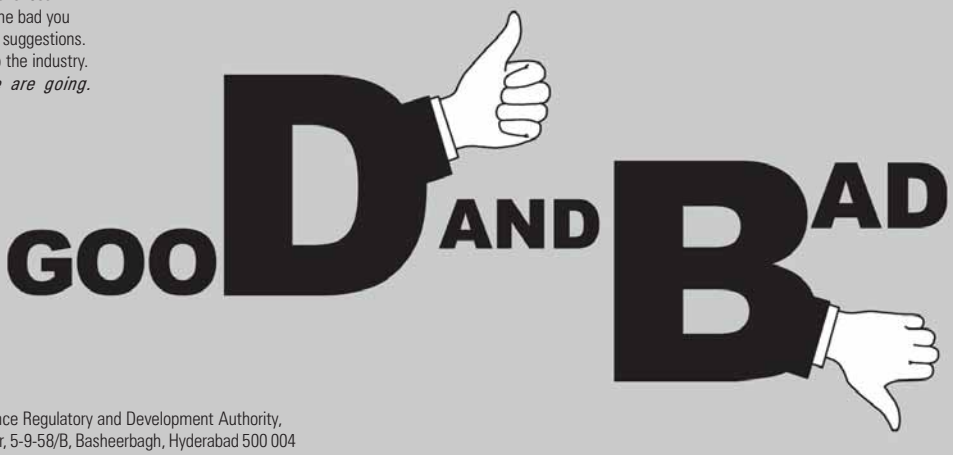
Further perils emerge when glacial lakes burst and permafrost melts. The main factors for the advance or retreat of glaciers in the Himalayas are the volume and type of summer precipitation. In the wake of global warming, the zero-degree border rises, glaciers receive less snow and more liquid precipitation, and what were once giant masses of ice shrink. At the same time, the frozen (permafrost) slopes melt at an increasing rate at higher levels. Lakes that have been formed by glaciers and moraines burst, destabilising the sides of hills and mountains and dragging down loose material and debris flows. With the volumes of rain increasing, there is also a mounting danger of soil erosion. Moreover, debris, gravel, and sand add to the sediment carried in rivers, creating problems at reservoirs and hydropower stations.

Heavy monsoon rain in India from June to September 2007 caused major losses affecting agriculture, livestock, infrastructure, and commerce. Thousands of towns and villages were swamped.

The main factors for the advance or retreat of glaciers in the Himalayas are the volume and type of summer precipitation.

The author is Chief Representative for India, Munich Re Kolkata Representative Office.

We welcome consumer experiences.
Tell us about the good and the bad you have gone through and your suggestions.
Your insights are valuable to the industry.
Help us see where we are going.



Send your articles to:
Editor, IRDA Journal, Insurance Regulatory and Development Authority,
Parisrama Bhavanam, III Floor, 5-9-58/B, Basheerbagh, Hyderabad 500 004
or e-mail us at irdajournal@irda.gov.in

• प्रकाशक का संदेश

एक बीमा ग्राहक के लिए बीमाकर्ता के साथ सम्बन्ध के लिए सबसे महत्वपूर्ण घटना दावे का निपटान करते समय समय की सच्चाई होती है। पालसीधारक उस समय की ओर देखता है जब बीमाकर्ता द्वारा बीमित राशि को देने का वचन निभाया जायेगा। विशेषत लम्बे समय के समझौते के लिए ऐसे अवसर कई वर्षों के बाद आ सकता है जब पालसी धारक ने बड़े परिश्रम के साथ अपनी भूमिका को बीमा समझौता को जीवित रखने के लिए किया है। किसी कारण से दावा निरस्त होता है तो वह भ्रमित हो जाता है तथा इसका खेद प्रकट करता है कि वह इतने समय से बीमा कंपनी से सम्बन्ध रहा। यह सुनिश्चित किया जाना चाहिये ऐसी घटनाओं को कम किया जाए बिल्कुल निम्न स्तर तक जब कोई दूसरा विकल्प उपलब्ध न हो।

दावे को निरस्त करने के अनेक कारण हो सकते हैं और कई अवसरों पर बीमाकर्ता के दृष्टिकोण से न्याय संगत हो सकते हैं। पालसी धारक के मामले में हमेशा यह मामला निषेध का होता है विशेष रूप से शैशव बाजारों में जहाँ बीमा जागरुकता का स्तर काफी कम है। इस स्थिति से उभरने के लिए बीमाकर्ता को एक व्यवहार्थ दृष्टिकोण अपना चाहिये जोकि बीमा समझौते की सीमितता के सम्बन्ध में हो - विशेष रूप से खुदरा ग्राहकों के लिए। बीमालेखन के सिद्धान्त उच्च स्तर के होने चाहिये और जाए कही निर्णय सीमा पर लिया गया हो ऐसे प्रयास किया जाने चाहिये जिसमें पालसी धारक को शर्ते समझायी जाए जिससे बाद में दिल जलने से रोका जा सके।

सभी प्रकार की रखवाली के बवजूद, फिर भी जरूरत हो सकती है दावों को निरस्त करने की। ऐसे मामले में बीमा कर्ता को पालसीधारक को बल पूर्वक निरस्त करने के कारण बताने जाहिये। यह प्रदर्शित किया जाना जाहिये की वह देखभाल करते है तथा वह पालसीधारक को कुछ सीमा तक समझ सकते हैं। एक महत्वपूर्ण कारक जिसको समझना चाहिये महत्व के साथ कि वितरण व्यक्ति वह व्यक्ति है जो पालसी धारण से सीधे सम्पर्क में आता है उसको विस्तृत रूप से प्रशिक्षित किया जाना चाहिये तथा इस स्थिति में होना चाहिये की ये सुनिश्चित कर सके की दावे निरस्त करने के अवसरों के काफी कम किया जा रके, उच्च प्रबन्धकों को विभिन्न करणों को समझना चाहिये जो दावे निरस्त करने का सबब बनते हैं। उनका विश्लेषण प्रमाणित ढ़ग से किया जाना चाहिये और ऐसी निति बनायी जाती चाहिये जिसस दावे निरस्त करने को तीव्र से कम किया जा सके।

जर्नल के इस अंक का विषय दावों को निरस्त के सम्बन्ध में है। एक बीमा संविदा में यह निष्कर्ष निकाल सकते हैं कि यह पूर्ण काल तक जारी रहे तथा सभी बिन्दुओं पर जब बीमाकर्ता तथा बीमाकृत के मध्य एक मध्यस्थ की आवश्यकता हो, मध्यवर्ति एक नाजूक भूमिका निभा सकते हैं। जर्नल के अगले अंक के केन्द्र में "बीमा संविदा में मध्यवर्तियों की भूमिका'' होगा।

जे. हरि नारायण
अध्यक्ष

दृष्टि कोण

हमे अपने प्रयासों को कुशल तकनिक व्यवसायों को बनाने के लिए दोहराना होगा जिससे सम्बन्धित तकनिकी कुशलता तथा सही अनुमान हो।

श्री लाओ कोक मून
कार्यकारी निदेशक (बीमा सुपरवाईजर) मोनेटरी अथोरिटी आफ सिंगपूर

कम आय के समुह के लोगों के लिए यह आवश्यकता है कि प्रस्ताव में विविध विकल्प उपलब्ध करवाये जाए। उद्योग को कमजोर वर्गों के प्रति सहानु भूति रखने की आवश्यकता है।

श्री जे हरि नारायण
अध्यक्ष,बीमा विनियामक विकास और प्राधिकरण, भारत

आर्थिक अपराध का एक तत्व बाजार का दुरुपयोग करना है और यह देखना आसान है की इसका बाजार पर क्या प्रभाव होगा।

श्री फिलिप रोबिन्सन
वित्तिय अपराध व सर्तकता मंडल निदेशक, एफ एस ए. यूके

लम्बी आयु अवधि ने हैल्थ केयर लागत को बढाया है तथा सेवानिवृति के लिए वर्तमान बाजार में अवसर बीमाकर्ता तथा निधि प्रबंधकों के लिए जरूरी है।

श्री ली हैसंन लूंग
प्रधान मंत्री, सिंगपूर

यह नाजूक है कि अपभोक्ता अपनी हैल्थ की जिम्मेदारी लेता रहता है जिससे हम तंदरुस्त जीवन के सभी लाभ उठा सके तथा हैल्थकेयर अधिक वहन योग्य हो।

सुश्री संडी प्रैग्रेर
एन ए आई सी अध्यक्ष तथा कंसास बीमा कमीशनर

आंतरिक निर्विघ्न अथवा बीमा व्यवसाय को आराक्षित के बारे में सोचना - इसलिए क्योंकी कोई दावा नहीं आया, बीमा गैर जरूरी नहीं हो जाता।

श्री किय चैपमैन
कार्यकारी महा प्रबन्धक, आस्ट्रेलियन प्रूडेंशल विनियामक प्राधिकरण

न्यूजीलैंड का बीमा तथा बचत लोकपाल आई एस ओ

(Insurance & Savings Ombudsman)

न्यूजीलेंड में बीमा तथा बचत लोकपाल जिसे आईएसओ के नाम से जाना जाता है एक सफल योजना है इस योजना के सफल बिन्दु यहाँ दिये जा रहा है। - संजीव कुमार जैन

आईएसओ द्वारा प्रदान की जाने वाली सेवाएँ

- आईएसओ योजना उपभोक्ताओं के बीमा बचत कंपनियों के साथ होने वाले विवादों को सुलझाने का अवसर प्रदान करती है।
- यह विवादों पर स्वतत्र और निष्पक्ष विचार प्रदान करती है।
- उपभोक्ताओं के लिए निशुल्क है।
- आईएसओं के निर्णय उपभोक्ताओं के लिए अनिवार्य नहीं है। यदि कोई उपभोक्ता आईएसओ के निर्णय से खुश नहीं है तो वह उस मुद्धे को कोर्ट या अन्य विवाद सुलझाने वाली सेवा के पास ले जा सकते हैं।
- सेवा प्रदान करने वालें के लिए आईएसओ योजना में शमिल होना अनिवार्य नहीं है।

आईएसओ का क्षेत्र

आईएसओ योजना में भागीदार कंपनियों द्वारा न्यूजीलैंड में प्रदान किये गए व्यक्तिगत बीमा तथा बचत के उत्पादनों के बारे में की गई शिकायतों पर विचार करती है। इसमे निम्न लिखित क्षेत्र शामिल है।

- अग्नि तथा साधारण बीमा
- स्वास्थ्य बीमा
- जीवन बीमा
- बचत सेवाएँ

आईएसओ किसी कंपनी के बारे में शिकायत पर विचार कर सकती है यदि वह (शिकायत) निम्न लिखित से सम्बधित है।

- घर, समान, वाहन या गाडी, यात्रा, स्वास्थ्य, आमदनी सुरक्षा, गिरावी सुरक्षा, गंभीर बीमारी, जीवन बीमा तथा पेशन।
- विकलांगता भत्ते के 1,00,000 डालर प्रति सप्ताह से कम के दावे (अन्यथा कंपनी से इसकी सहमति ली गई हो)।
- नीति की व्याख्या।
- पालसी धारक या उसकी ओर से किये गये दावे।
- दावे के अन्तर्गत भुगतान की जाने वाले भुगतान की राशि।

आईएसओ किसी कंपनी के बारे में शिकायत पर विचार नहीं कर सकती है।

- क्षतिपूर्ति या हानिपूर्ति का निर्णय।
- व्यापार तथा कारोबार सम्बधित निर्णय।
- तृतीय पक्ष या बीमा रहित नुकसान।
- प्रीमियम (किश्तें), व्यय या लागत, एक्सेस, वापसी बीमा संलेख्य निर्णय।
- अर्थिक / वित्तिय सलाहकार तथा दलाल।
- शिकायतें जो अन्य फोरमों क द्वारा कार्यवाही का या तो विषय हैं या बन चुकी हैं जैसे कि कोटों में (इसके बारे में) पहले ही निर्णय लिया जा चुका है।

आईएसओ सेवा का प्रयोग कौन कर सकता है।

भागीदार कंपनी के उपभोक्ता अपनी शिकायतों को आईएसओ के लिए ले जा सकते हैं बशते कि शिकायत आईएसओ के अधिकार क्षेत्र में आती हो।

> आईएसओ योजना में भागीदार कंपनियों द्वारा न्यूजीलैंड में प्रदान किये गए व्यक्तिगत बीमा तथा बचत के उत्पादनों के बारे में की गई शिकायतों पर विचार करती है।

शिकायत करने वाले उपभोक्ता के लिए पालसी धारक होना जरूरी है या फिर शिकायत को आईएसओ के पास पालिसी धारी की ओर से ले लाया गया हो।

आईएसओ बीमा रहित तृतीय पक्ष से शिकायतें स्वीकार नहीं कर सकती।

शिकायत कर्ता के विचार में कंपनी का निर्णय गलत क्यो है। शिकायत के जल्द निपदान के लिए यह अपेक्षा की जाती है कि पत्र अंग्रेजी भाषा में ही लिखा जाए। आईएसओ शिकायत पर शिकायत कर्त्ता द्वारा नियुक्त व्यक्ति के साथ भी चर्चा करने को सहर्ष तैयार रहता है।

शिकायत करना

कोई व्यक्ति आईएसओ के पास शिकायत दर्ज करना चाहते हैं तो यह जरूरी है कि वह इन्हें सम्पर्क करने से पहले निम्नलिखित कदम उठा चुके हो।

- उसकी कंपनी की आईएसओ योजना के अन्तर्गत भागीदार होनी चाहिये।

  आईएसओ केवल उन्हीं कम्पनियों के विरूध्द कंपनियों पर विचार कर सकती है जो आईएसओ योजना के भगीदार है। यह जानने के लिए कि कंपनी की भागीदारी है या नहीं तो वेब साईट के पृष्ठ अथवा टोल मुक्त टेलीफोन नंबर पर सम्पर्क किया जा सकता है।

- कम्पनी द्वारा लिए गये निर्णय पर पुनर्विचार के बाद ही।

  आईएसओ द्वारा किसी भी शिकायत पर विचार करने से पहले यह जरूरी है कि उस मुद्धे पर कंपनी की आतंरिक शिकायत प्रक्रिया द्वारा विचार किया जा चुका हो। आईएसओ का सुझाव होता है कि कंपनी से लिखित रूप में सम्पर्क किया जाए।

- यदि समस्या का समाधान न हो तो

  यदि पालसी धारक / शिकायतकर्ता कम्पनी के निर्णय से खुश नहीं हो तो आईएसओ उसकी मदद कर सकता है। इससे पहले कि आईएसओ शिकायत पर विचार करें आईएसओ को एक गत्यारोध पत्र (Deadlock) पत्र दिया जाना जरूरी है इस पत्र में यह स्पष्ट किय जायेगा कि आप कम्पनी की आंतरिक शिकायत प्रक्रिया का पूरी तरह किस प्रकार प्रयोग कर चुके हैं और आप आईएसओ से शिकायत कर सकते हैं।

- आईएसओ से सम्पर्क करें।

  जब आपको कंपनी से गत्यारोध पत्र (Deadlock) पत्र शिकायत को मिल जाता है तब पत्र में दी गई दिनांक के दो माह के भीतर उसे आईएसओ को भेजा जाना जरूरी है इसके अभाव में आईएसओ कोई जाचॅ पडताल नहीं कर सकता। इस पत्र के साथ यह पत्र भी भेजा जाना चाहिये कि शिकायत कर्ता के विचार में कंपनी का निर्णय गलत क्यो है। शिकायत के जल्द निपदान के लिए यह अपेक्षा की जाती है कि पत्र अंग्रेजी भाषा में ही लिखा जाए। आईएसओ शिकायत पर शिकायत कर्त्ता द्वारा नियुक्त व्यक्ति के साथ भी चर्चा करने को सहर्ष तैयार रहता है।

न्युजीलेंड का बीमा तथा बचत लोकपाल आईएसओ (Insurance & Savings Ombusman) के कार्यालय का पता निम्नलिखित हैः

बीमा तथा बचत लोकपाल
पो. बाक्स 10-845
वैलिगंटन

लेखक उपनिदेशक, आईआरडीए

बीमा विनियामक और विकास प्राधिकरण अधिनियमः 1999

बीमा विनियामक और विकास अधिनियम 1999 के हिन्दी पाठ की माँग को देखते हुए इस अधिनियम को दो भागों में प्रकाशित किया जा रहा है। किसी भी वैधानिक व्याख्या के लिए अंग्रेजी पाठ ही मान्य होगा।

एक ऐसी प्राधिकरण की स्थापना, जो पालसी धारक के हितों की रक्षा करना, बीमा उद्योग का क्रमबद्ध विनियमन, संवर्धन तथा संबधित व अकस्मिक मामलों पर कार्य करे तथा बीमा अधिनियम 1938, जीवन बीमा अथिनियम 1956 तथा साधारण बीमा व्यवसाय (राष्ट्रीयकरण) अधिनियम 1972 में संशोधन।

भारत की संसद द्वारा गणतन्त्र के पचासवें वर्ष में बनाया गया अधिनियम इस प्रकार हैः

अध्याय I

परिभाषा

1 संक्षिप्त नाम, विस्तार तथा प्रारंभ -

(1) इस अधिनियम को बीमा विनियामक और विकास प्राधिकरण अधिनियम 1999 कहा जायेगा।

(2) यह अधिनियम सम्पूर्ण भारत पर लागू होगा।

(3) यह अधिनियम सम्पूर्ण भारत में लागू होगा तथा केन्द्रीय सरकार द्वारा सरकारी गजट में अधिसूचित तिथि से लागू होगा। इस प्रतिज्ञा से कि अधिनियम के विभिन्न प्रावधानों के लिए अलग अलग दिनांक से यह लागु किये जायेगें।

2 परिभाषाएँः

(1) इस अधिनियम में, जबकि संदर्भ की अन्यथा आवश्यकता न होः

(ए) निर्धारित दिन का अर्थ है वह तिथि जिस दिन इस अधिनियम के अन्तर्गत प्राधिकारण की स्थापना धारा 3 की उपधारा (1) के अन्तर्गत की गई।

(बी) ''प्राधिकरण'' बीमा विनियामक विकास प्राधिकरण जिसकी स्थापना धारा 3 की उपधारा (1) के अन्तर्गत की गई।

(सी) ''अध्यक्ष'' से आश्य प्राधिकारण के अध्यक्ष से है

(डी) ''निधि'' धारा 16 की उपधारा (1) के अन्तर्गत बीमा विनियामक विकास प्राधिकरण की निधियाँ।

(ई) ''अन्तरिम बीमा प्राधिकरण'' से अभिप्रायः केन्द्र सरकार द्वारा ज्ञापन संख्या 17 (2)/94 - आईएनएस-V दिनांक 23, जनवरी 1996 द्वारा स्थापित बीमा विनियामक प्राधिकरण।

(एफ) ''मध्यवर्ति अथवा बीमा मध्यवर्ति'' जिसमें शामिल हैं बीमा दलाल, पुनर्बीमा दलाल, बीमा सलाहकार, सर्वेयर, तथा हानि निर्धारक।

(जी) ''सदस्य'' में शामिल है प्राधिकरण के पूर्णकालिक सदस्य तथा अंशकालिक सदस्य तथा अध्यक्ष।

(एच) ''अधिसूचना'' से अभिप्राय है कि एक अधिसूचना जो अधिकारिक गजट में प्रकाशित की गई।

(आई) ''विहित'' से अभिप्रायः इस अधिनियम के अन्तर्गत बनाये गये नियम से है।

(जे) ''विनियमन'' से अभिप्रायः प्राधिकरण द्वारा बनाये गये अधिनियम से है।

(2) शब्द दथा उक्ति जिसका प्रयोग किया गया है तथा उनकी परिभाषा इस अधिनियम में नहीं की गई है लेकिन बीमा अधिनियम (4 का 1938) 1938 में परिभाषित हैं अथवा जीवन बीमा निगम अधिनियम 1956 (1956 की 31) अथवा साधारण बीमा व्यवसाय (अधिसूचना) अधिनियम, 1972 (1972 का 57) में परिभाषित अर्थ को लिया जायेगा।

अध्याय II

बीमा विनियामाक और विकास प्राधिकरण

3 प्राधिकरण की संरचना तथा निगमनः

(1) उस दिनांक से जैसा की केन्द्रीय सरकार, अधिसूचना नियुक्त करेंगी यह स्थापित हो

भारत की संसद द्वारा गणतन्त्र के पचासवें वर्ष में अधिनियम बनाया गया।

जायेगा, इस अधिनियम के प्रयोजन के लिए प्राधिकरण जिसे ''बीमा विनियामक और विकास प्राधिकरण'' कहा जायेगा।

(2) यह प्राधिकरण एक निगमित संस्था होगी जो चिर उत्तराधिकार तथा सार्वमुद्रा की शक्ति रखेगी। जिसको इस अधिनियम के प्रवधानों के अनुसार परिसंपत्ति खरीदने, रखने एवं बेचने तथा कोई अनुबंध करने का अधिकार होगा। वह अपने नाम से किसी अन्य पर अभियोग चला सकेगी या इस पर अभियोग चलाया जा सकेगा।

(3) प्राधिकरण का प्रधान कार्यालय ऐसे स्थान पर होगा जहाँ समय समय पर केन्द्र सरकार निर्धारित करेगी।

(4) प्राधिकरण अपने कार्यालय भारत में अन्य स्थानों में स्थापित कर सकेगी।

4 प्राधिकरण की संरचनाः प्रधिकरण के निम्न सदस्य होगें अर्थातः

क. अध्यक्ष

ख. पांच की संख्या तक पूर्ण कालिक सदस्य

ग. चार की संख्या तक अंश कालिक सदस्य

इनकी नियुक्ति केन्द्र सरकार द्वारा उन लोगों में से चयन कर होगी जो योग्य हैं, ईमानदार है तथा सम्मानित हैं। जिनको जीवन बीमा, साधारण बीमा, वित्त, अर्थशास्त्र, विधि, लेखा कार्य प्रशासन अथवा अन्य कोई विद्या, जो केन्द्रीय सरकार के विचार से प्रधिकरण के लिए उपयोगी सिद्ध होगी, का ज्ञान अथवा अनुभव है।

अध्यक्ष तथा पूर्णकालिक सदस्य की नियुक्ति के समय केन्द्रीय सरकार को यह सुनिश्चित करना अनिवार्य है कम से कम एक व्यक्ति जीवन बीमा, साधारण बीमा तथा बीमांकन विज्ञान का अनुभव रखता हो।

5 अध्यक्ष एवं अन्य सदस्यों के कार्यालय की अवधिः

(1) अध्यक्ष तथा प्रत्येक पूर्ण कालिक सदस्य का कार्यकाल उसके अपने पद ग्रहण करने के पांच वर्ष तक का होगा लेकिन यह पुन प्रतिनियुक्ति के योग्य होगा। कोई भी व्यक्ति 65 वर्ष की आयु प्राप्त करने पर अध्यक्ष पद पर नहीं बना रह सकता तथा कोई भी व्यक्ति 62 वर्ष की आयु प्राप्त करने पर पूर्ण कालिक सदस्य नहीं रह सकता।

(2) अंश कालिन सदस्य पद ग्रहण करने के बाद अधिकत्तम पांच वर्ष से अधिक के लिए पद पर नहीं रह सकता है उस दिनांक से जिस दिन से उसने कार्यालय में सदस्य के रूप में प्रवेश किया हो।

(3) तथापि उपधारा

(1) अथवा उपधारा

(2) के अनुसार एक सदस्यः

(क) कोई भी सदस्य केन्द्र सरकार को कम से कम तीन महीने का लिखित नोटिस देकर अपना पद छोड सकता है।

(ख) निम्न प्रावधानों के अनुसार उसे पद से हटाया जा सकता है।

6 पद से मुक्त करनाः

(1) केन्द्रीय सरकार किसी भी व्यक्ति को उसके पद से मुक्त कर सकती है जो किः

(क) दिवालिया है या घोषित किया गया हो।

(ख) शारिरक अथवा मानसिक रूप से सदस्य बने रहने के अयोग्य हो।

किसी भी सदस्य के वेतन, भत्ते एवं अन्य सेवाशतों में ऐसा फेरबदल नहीं किया जायेगा जिससे नियुक्ति पश्चात उसे कोई हानि रहे।

(ग) किसी अपराध के लिए दोषी करार दिया जा चुका जिसमें केन्द्रीय सरकार की दृष्टि में अनैतिक आचरण हो।

(घ) ऐसे वित्तिय अथवा अन्य हित प्राप्त कर लिए है जिनके कारण वह अपने सदस्य में रूप में कार्यों में पक्षपात करता है।

(ड) जिसने अपने पद का इतना दुरूपयोग कर लिया है कि उसका पद पर बने रहना सार्वजनिक हितों के विरूद्ध होगा।

(2) किसी भी सदस्य को उपवाक्य (घ) अथवा (ड) के अन्तर्गत उसको सफाई देने के उचित अवसर दिये बिना हटाया नहीं जायेगा।

7 अध्यक्ष तथा सदस्यों कर वेतन तथा भत्तेः

(1) अंश कालिक सदस्यों को छोडकर अन्य सदस्यों का वेतन तथा भत्ते एवं अन्य सेवाशतें वही होगी जिनको निर्धारित किया जायेगा। अंश कालिक सदस्यों को निर्धारित भत्ता मिलेगा। किसी भी सदस्य के वेतन, भत्ते एवं अन्य सेवाशतों में ऐसा फेरबदल नहीं किया जायेगा जिससे नियुक्ति पश्चात उसे कोई हानि रहे।

8 सदस्यों की भविष्य की नियुक्ति पर रोकः अध्यक्ष तथा पूर्ण कालिक सदस्य अपने पद से मुक्त होने की तिथि से दो वर्ष तक बिना केन्द्रीय सरकार की पूर्व अनुमति के स्वीकार नहीं करेंगेः

(क) केन्द्रीय सरकार अथवा किसी भी राज्य सरकार के अधीन किसी भी प्रकार का रोजगार अथवा

(ख) बीमा क्षेत्र कह किसी भी कंपनी में कोई नियुक्ति

9 अध्यक्ष के प्रशासनिक अधिकारः अध्यक्ष को प्राधिकरण के प्रशासनिक मामलों के सामान्य अधिक्षण एवं निदेशक के अधिकार होगें।

10 प्राधिकरण की बैठकेंः

(1) प्राधिकरण की बैठकें पूर्व निर्धारित नियमों के अनुसार निर्धारित समय एवं स्थान पर होगी तथा सभा में कार्यवाही (कोरम

सहित) के सम्बध में निर्धारित नियमों एवं प्रक्रिया का पालन करेगी।

(2) अध्यक्ष किसी कारण वश उपस्थित नहीं है तो उपस्थित सदस्य अपनों में से ही किसी एक को चुन लेंगें जो कि मीटिंग की अध्यक्षता करेगा।

(3) प्राधिकरण की किसी भी मीटिंग में जो भी प्रश्न उठेंगें उनका निर्णय उपस्थित सदस्यों के द्वारा मत डालकर बहुमत से किया जायेगा। मतों के बराबर होने पर अध्यक्ष अथवा अध्यक्षता कर रहे व्यक्ति का दूसरा अथवा निर्णायक मत होगा।

(4) प्राधिकरण अपनी बैठकों की कार्यवाही के लिए नियमों को भी तय कर सकती है।

11 रिक्त पद इत्यादि प्राधिकरण की कार्यवाही की वैधता का समाप्त नहीं कर सकतेः- प्राधिकरण का कोई कार्य अथवा कार्यवाही केवलः

(क) प्राधिकरण की कार्यवाही में अनियमितताएँ लेकिन जो मामले की गुणवत्ता को प्रभावित न करती हों

(ख) प्राधिकरण के सदस्य की दोष पूर्ण नियुक्ति अथवा

(ग) प्राधिकरण की कार्यवाही में अनिमितताएँ लेकिन जो मामले की गुणवत्ता को प्रभावित न करती हो, के कारण अवैध नहीं होगी।

12 प्राधिकरण के अधिकारीगण एवं कर्मचारीः

(1) प्राधिकरण ऐसे अधिकारी एवं कर्मचारियों की नियुक्ति कर सरती है जिन्हें वह इस अधिनियम के अन्तर्गत अपने कार्यो को कुशलता से इस अधिनियम के अन्तर्गत चलाने के लिये आवशयक समझती है।

(2) प्राधिकरण के अधिकारियों तथा कर्मचारियों की सेवा शर्ते इस अधिनियम के अन्तर्गत बनाये गये विनियमों के व्दारा शसित होगी।

अध्याय III

आन्तरिक बीमा विनियामक प्राधिकरण की परिसंपत्तियों, देयताओं आदि को प्राधिकरण को हस्तान्तरित करना।

13 आन्तरिक बीमा विनियामक प्राधिकरण की परिसंपत्तियों, देयताओं आदि को प्राधिकरण को हस्तान्तरित करना। निर्धारित दिनः-

(क) आन्तरिक बीमा विनियामक प्राधिकरण की सभी परिसंपत्तियों, देयतायें प्राधिकरण को स्थानांतरित है अथवा प्राधिकरण में व्याप्त है।

स्पष्टीकरणः आन्तरिक बीमा विनियामक प्राधिकरण की सभी परिसंपत्तियों, देयतायें प्राधिकरण को स्थानांतरित है। और चल तथा अचल सम्पति जिसमें शामिल है नकद शेष, जमा तथा अन्य हित तथा अधिकार अथवा सभी लेखा पुस्तकें तथा दस्तावेज जिनका इससे सम्बन्ध है। ऐसी सम्पतियाँ जो आन्तरिक बीमा विनियामक प्राधिकरण के अधिकार क्षेत्र में हैं तथा अन्य सभी लेखा बहियाँ तथा अन्य सम्बधित दस्तावेज, तथा दायित्व में शामिल माना जायेगा सभी ऋण, तथा किसी भी प्रकार के दायित्वः

(ख) धारा (क) के बिना किसी पुर्वाग्रह के सभी ऋण, देयता, तथा दायित्व जो व्यय किया गया सभी समझौते जिनमें शामिल हुए हो तथा सभी मामले जो किये जाने का समझौता आन्तरिक बीमा विनियामक प्राधिकरण हुआ है उस दिनांक से पहले, जो विनियामक प्राधिकरण के उद्देश्य के लिए था, ऐसा माना जायेगा की यह हुआ है अथवा जिसको प्रयुक्त होना है प्राधिकरण के साथ अथवा उसके लिए।

(ग) आन्तरिक बीमा विनियामक प्राधिकरण को देय सभी राशि उस दिनांक से पूर्व प्राधिकरण को देय मानी जायेगी। तथा

(घ) सभी दावे तथा अन्य वैधानिक प्रक्रियाएँ जिनको प्रारंभ किया गया अथवा जो कि प्रारंभ की जा सकती थी, आन्तरिक बीमा विनियामक प्राधिकरण के द्वारा अथवा इसके विरूद्ध उस दिनांक के तुरन्त पहले, वह जारी रहेंगी।

अध्याय IV

प्राधिकरण के दायित्व, अधिकार व कार्य

14. इस अधिनियम एवं वर्तमान में लागू अन्य किसी कानून के प्रावधानों के अनुसार प्राधिकरण का बीमा व्यवसाय एवं पुनर्बीमा व्यवसाय के नियमन, प्रवर्तन एवं नियमित विकास को सुनिश्चित करने का दायित्व है। प्राधिकरण के अधिकार एवं कार्यों में सम्मिलित हैः

अध्यक्ष किसी कारण वश उपस्थित नहीं है तो उपस्थित सदस्य अपनों में से ही किसी एक को चुन लेंगें जो कि मीटिंग की अध्यक्षता करेगा।

(1) इस अधिनियम के प्रावधानों के विषय में तथा किसी अन्य विधान जो अभी लागु हो, प्राधिकरण का यह कर्तव्य है कि वह विनियमन करे, प्रोत्साहन करे तथा बीमा तथा पूनर्बीमा के क्रमबद्ध विकास को सुनिश्चित करे।

(2) साधारणतः उप धारा (1) के प्रावधानों से बिना पूर्वग्रह के, पाधिकरण की शक्तियों तथा कार्यों में शामिल होगा।

(ए) आवेदक को पंजिकरण प्रमाणपत्र जारी करना, उसे नवीकृत करना, सुधारना, आहरित करना, मुअत्तल करना, रद करना।

(बी) पालसीधारक के हितों की रक्षा उन मामलों में जहाँ पालसी का समनुदेश किया जाता है, बीमा हित बीमा दावों की विवरणिका, पालसी की अभ्यर्पण मूल्य, तथा बीमा समझौते की अन्य निबंधन और शर्ते

(सी) बीमा मध्यवर्ति, मध्यवर्ति तथा ऐजेन्टों के लिए आर्हता, आचरण संहिता विनिर्दिष्ट करना।

(डी) सर्वेयर तथा हानिनिर्धारकों के लिए आचरण संहिता विनिर्दिष्ट करना।

(ई) बीमा व्यवसाय में कुशलता को प्रोत्साहन देना।

(एफ) बीमा तथा पुनर्बीमा से सम्बन्धित व्यवसायिक संघटनों का विनियमन तता प्रोत्साहन देना।

(जी) अधिनियम के प्रयोजनों के लिए शूल्क तथा अन्य प्रभार लगाना।

(एच) उपक्रमों के निरिक्षण, पूछताछ तथा जाँच पडताल जिसमे लेखा परिक्षा शामिल है, मध्यवर्तियों, बीमा मध्यवर्तियों तथा अन्य संस्थओं जिनका सम्बन्ध बीमा व्यवसाय से है की सूचना प्राप्त करना।

(आई) दरों निवृत्ति लाभ, निबंधन शर्तों, तथा प्राशुल्क सलाहकार समिति द्वारा बीमा अधिनियम 1938 (1938 के 4) के अन्तर्गत धारा 64 यू के अनुसार शर्तें जो साधारण बीमा व्यवसाय के अन्तर्गत नियंन्त्रित नहीं की जाती पर उन पर नियंत्रण तथा उनका विनियमन,

(जे) वह फार्म तथा प्रकार विशिष्ट करना जिसके अन्तर्गत लेखा पूस्तकों को रखा जाना है तथा लेखा की विवरणी को बीमाकर्ता तथा अन्य बीमा मध्यवर्तियों द्वारा सुपुर्दगी किया जाना है।

(के) बीमा कंपनियों की निवेश निधि को विनियमित करना।

(एल) शोधन-क्षमता को बनाये रखने को विनियमित करना।

(एम) बीमा कंपनियों तथा मध्यवर्तियों अथवा बीमा मध्यवर्तियों के मध्य विवादों पर अधिनिर्णय प्रदान करना।

(एन) प्राशुल्क सलाहकार समिति के कार्यों का पर्यवेक्षण करना।

(ओ) खण्ड ''एफ'' में उल्लेख किये गये व्यवसायिक संस्थाओं को विनियमित तथा प्रोत्साहित करते हुए प्रिमियम आय के प्रतिशत को बीमाकर्ता की वित्तिय योजनाओं के लिए विनिर्दिष्ट करना।

(पी) बीमाकर्ता द्वारा सामाजिक तथा ग्रामीण व्यवसाय के लिए जीवन बीमा व्यवसाय तथा साधारण बीमा व्यवसाय के लिए प्रतिशत विनिर्दिष्ट करना। तथा

(क्यू) ऐसी शक्तियों का प्रयोग जिनको निर्धारित किया गया है।

बीमाकर्ता द्वारा सामाजिक तथा ग्रामीण व्यवसाय के लिए जीवन बीमा व्यवसाय तथा साधारण बीमा व्यवसाय के लिए प्रतिशत विनिर्दिष्ट करना।

अध्याय V

वित्त, लेखे तथा अंकेक्षण

15 केन्द्रीय सरकार का अनुदानः इस सम्बन्ध में संसद द्वारा अधिनियम विनियोजन द्वारा केन्द्रीय सरकार प्रधिकरण को अनुदान धनराशि, जैसे सरकार ठीक समझे इस अधिनियम के प्रयोजन के लिए होगा।

16 निधि का गठनः

(1) एक निधि का गठन ''बीमा विनियामक और निकास प्राधिकरण निधि'' के नाम से किया जायेगा। तथा उसके लिए जमा ऋण होगेंः

(ए) प्राधिकरण द्वारा अनुदान, फीस, तथा शुल्क की प्राप्ति

(बी) उन सभी स्त्रोत से को प्राप्त की गई सभी धनराशि जिसका निर्णय केन्द्रीय सरकार द्वारा किया जायेगा।

(सी) बीमाकर्ता से प्राप्त प्रिमियम आय का प्रतिशत।

(2) निधि का उपयोग उपादानों के लिए होगाः

(ए) प्राधिकरण के अधिकारी / कर्मचारी, सदस्यों का वेतन, भत्ते तथा अन्य पारिश्रामिक

(बी) प्रधिकरण के कार्य को करने के तथा इस अधिनियम को अनुपालित करने के लिए अन्य खर्च

17 प्राधिकरण उचित खाते एवं अन्य आवश्यक अभिलेख तैयार करेगा तथा केन्द्रीय सरकार द्वारा भारतीय महा लेखा नियंन्त्रक एवं अंकेक्षक से परामर्श कर निर्धारित स्वरूप में खातों का वार्षिक वितरण तैयार करेगा। प्राधिकरण के खातों का अंकेक्षण भारत का महालेखाकार के द्वारा निश्चित समय अंतराल पर किया जायेगा तथा इस संम्बन्ध में हुए खर्चों का भुगतान प्राधिकरण करेगा। भारतीय महा लेखा नियंन्त्रक एवं अंकेक्षक के खातों के अंकेक्षण के सम्बन्ध में नियुक्त अन्य व्यक्ति के अंकेक्षण के सम्बन्ध में वही अधिकार एवं विशेषाधिकार होंगे जो महा लेखा नियन्त्रक एवं अंकेक्षक के सामान्यत सरकारी खोतों के अंकेक्षण के सम्बन्ध में होते हैं। विशेष रूप से उसे लेखा पुस्तकों, सम्बन्धों एवं अन्य दस्तावेजो तथा प्रलेखों को माँगने तथा प्राधिकरण के किसी भी अधिकारी की जांच करने का अधिकार है। भारतीय महालेखा नियन्त्रक एवं अंकेक्षक अथवा उसके नियुक्त व्यक्ति के द्वारा प्रधिकरण के खातों को अंकेक्षण रिपोर्ट के साथ प्रति वर्ष केन्द्रीय सरकार को भेजा जायेगा जिसे सरकार संसद के दोनों के पटल पर रखेगा। -

जारी...

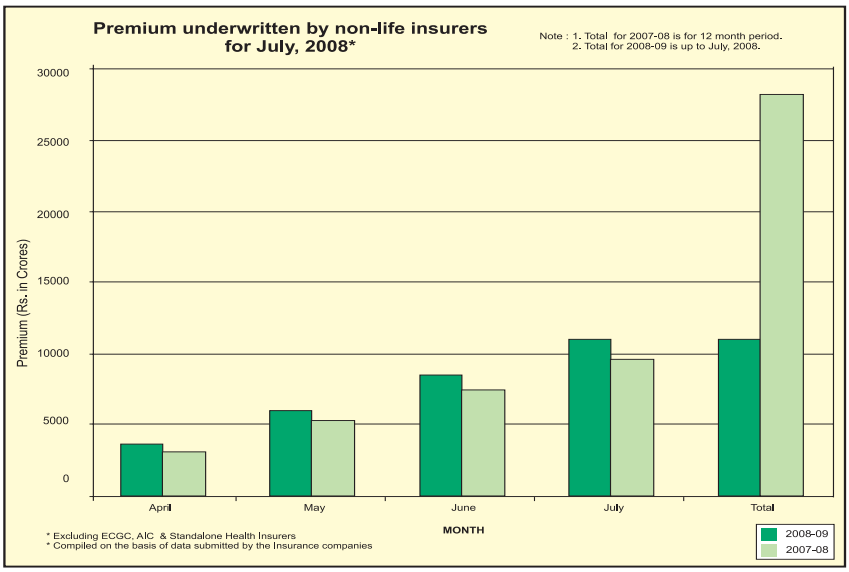
Report Card: General

GROSS PREMIUM UNDERWRITTEN FOR AND UP TO THE MONTH OF JULY, 2008

(Rs.in Crores)

INSURER	JULY		APRIL - JULY		GROWTH OVER THE CORRESPONDING PERIOD OF PREVIOUS YEAR
	2008-09	2007-08	2008-09	2007-08	
Royal Sundaram	67.36	51.90	257.87	220.02	17.20
Tata-AIG	79.78	72.83	368.46	298.15	23.58
Reliance General	143.54	124.17	699.98	653.22	7.16
IFFCO-Tokio	114.03	86.92	528.22	397.00	33.05
ICICI-lombard	284.32	275.36	1361.44	1162.00	17.16
Bajaj Allianz	238.76	186.01	972.29	759.74	27.98
HDFC ERGO General	30.13	18.90	82.38	70.91	16.18
Cholamandalam	55.24	37.76	255.59	185.69	37.64
Future Generali	15.45	0.00	43.26	0.00	0.00
Universal Sompo	0.10	0.00	1.01	0.00	0.00
Shriram General*	0.25	0.00	0.25	0.00	0.00
New India	432.46	409.24	1970.78	1851.49	6.44
National	342.73	322.67	1516.86	1371.33	10.61
United India	323.84	285.75	1437.09	1288.49	11.53
Oriental	386.20	374.01	1452.29	1423.77	2.00
PRIVATE TOTAL	1028.97	853.85	4570.75	3746.74	21.99
PUBLIC TOTAL	1485.23	1391.67	6377.02	5935.08	7.45
GRAND TOTAL	2514.20	2245.52	10947.77	9681.82	13.08
SPECIALISED INSTITUTIONS					
Credit Insurance					
ECGC**	59.54	61.34	224.24	203.63	10.13
Health Insurance					
Star Health & Allied Insurance	99.85	3.47	224.60	40.30	457.36
Apollo DKV	1.41	0.00	8.36	0.00	0.00
Health Total	101.26	3.47	232.96	40.30	457.36
Agriculture Insurance					
AIC	60.61	60.09	114.16	142.56	-19.92

Note: Compiled on the basis of data submitted by the Insurance companies
** Commenced operations in July,2008.*
*** Data Upto June,2007 is revised by ECGC and is Rs.142.29 crores*



GROSS PREMIUM UNDERWRITTEN BY NON-LIFE INSURERS WITHIN INDIA (SEGMENT WISE):

Sl. No.	Insurer	Fire	Marine	Marine Cargo	Marine Hull	Engineering	Motor
1	**Royal Sundaram**	**23.74**	**5.05**	**5.05**	**0.00**	**11.90**	**106.23**
	Previous year	*31.00*	*5.95*	*5.95*	*0.00*	*12.50*	*80.43*
2	**TATA-AIG**	**72.21**	**38.99**	**38.99**	**0.00**	**14.60**	**64.55**
	Previous year	*55.92*	*27.72*	*27.72*	*0.00*	*9.44*	*58.09*
3	**Reliance**	**40.67**	**12.22**	**9.81**	**2.41**	**23.78**	**275.46**
	Previous year	*72.34*	*13.19*	*10.19*	*3.00*	*30.35*	*278.89*
4	**IFFCO Tokio**	**92.77**	**29.19**	**21.24**	**7.96**	**20.30**	**177.14**
	Previous year	*119.07*	*15.69*	*13.97*	*1.72*	*20.19*	*94.78*
5	**ICICI Lombard**	**118.91**	**90.27**	**34.86**	**55.41**	**73.05**	**311.80**
	Previous year	*163.95*	*53.84*	*19.32*	*34.52*	*53.30*	*283.75*
6	**Bajaj Allianz**	**74.45**	**32.52**	**26.81**	**5.71**	**40.38**	**416.92**
	Previous year	*100.84*	*26.92*	*25.46*	*1.46*	*40.76*	*276.01*
7	**HDFC ERGO**	**1.89**	**0.95**	**0.95**	**0.00**	**3.72**	**32.80**
	Previous year	*3.07*	*1.02*	*1.02*	*0.00*	*1.18*	*29.91*
8	**Cholamandalam**	**26.44**	**10.78**	**10.78**	**0.00**	**8.06**	**79.15**
	Previous year	*31.55*	*9.22*	*9.15*	*0.06*	*8.10*	*45.11*
9	**Future Generali $**	**4.16**	**1.10**	**1.10**	**0.00**	**1.45**	**9.00**
	Previous year	*0.00*	*0.00*	*0.00*	*0.00*	*0.00*	*0.00*
10	**Universal Sompo ***	**0.27**	**0.17**	**0.17**	**0.00**	**0.00**	**0.00**
	Previous year	*0.00*	*0.00*	*0.00*	*0.00*	*0.00*	*0.00*
11	**New India**	**267.44**	**108.21**	**54.96**	**53.25**	**59.44**	**496.36**
	Previous year	*292.49*	*97.95*	*47.39*	*50.56*	*55.30*	*490.74*
12	**National**	**138.25**	**63.36**	**38.27**	**25.09**	**36.49**	**902.84**
	Previous year	*147.45*	*54.93*	*33.92*	*21.02*	*38.64*	*514.05*
13	**United India**	**195.20**	**101.70**	**62.31**	**39.39**	**67.89**	**373.95**
	Previous year	*207.86*	*97.68*	*40.22*	*57.46*	*54.32*	*334.36*
14	**Oriental**	**151.75**	**78.47**	**44.00**	**34.47**	**63.53**	**378.04**
	Previous year	*176.08*	*85.31*	*49.28*	*36.03*	*53.85*	*408.46*
	Grand Total	**1,208.15**	**572.99**	**349.30**	**223.69**	**424.60**	**3,624.23**
	Previous year	1,401.61	489.42	283.59	205.83	377.92	2,894.57
	SPECIALISED INSTITUTIONS						
15	**ECGC**						
	Previous year						
16	**Star Health & Allied Insurance**						
	Previous year						
17	**Apollo DKV $**						
	Previous year						

Note: In case of public sector insurance companies, the segment wise data submitted may vary from the flash Nos filed with the Authority. As such, the industry totals may vary from the flash figures published for the month of June-2008.
$ Commenced operations in November, 2007.
* Commenced operations in February, 2008.
Compiled on the basis of data submitted by the Insurance companies

FOR THE PERIOD APRIL - JUNE - 2008 (PROVISIONAL & UNAUDITED)

(Rs. Crores)

Motor OD	Motor TP	Health	Aviation	Liability	Personal Accident	All Others	Grand Total
85.05 *65.79*	**21.17** *14.64*	**31.22** *27.04*	**0.00** *0.00*	**1.91** *1.10*	**6.89** *8.24*	**3.57** *1.87*	**190.51** *168.13*
54.75 *49.58*	**9.80** *8.51*	**25.91** *18.67*	**0.00** *0.00*	**35.14** *27.43*	**35.37** *27.48*	**1.92** *0.56*	**288.68** *225.32*
198.02 *206.90*	**77.44** *71.99*	**128.09** *90.27*	**4.76** *1.48*	**12.45** *4.09*	**37.77** *14.12*	**21.25** *24.32*	**556.44** *529.05*
124.51 *65.17*	**52.63** *29.61*	**43.91** *26.48*	**1.19** *0.35*	**15.44** *3.64*	**5.84** *4.09*	**28.41** *25.79*	**414.18** *310.07*
212.39 *206.45*	**99.41** *77.30*	**363.30** *236.59*	**11.10** *7.73*	**32.88** *30.72*	**35.61** *29.19*	**40.21** *27.57*	**1,077.12** *886.65*
301.79 *201.69*	**115.13** *74.31*	**75.84** *64.25*	**2.46** *3.27*	**14.98** *11.99*	**15.74** *10.83*	**60.25** *38.86*	**733.53** *573.73*
28.97 *26.61*	**3.83** *3.30*	**3.04** *7.60*	**0.17** *0.00*	**2.30** *1.23*	**1.59** *1.78*	**5.80** *6.23*	**52.25** *52.01*
63.25 *37.15*	**15.90** *7.96*	**50.54** *35.23*	**0.00** *0.00*	**4.02** *3.44*	**7.40** *3.70*	**13.97** *11.59*	**200.35** *147.93*
7.47 *0.00*	**1.53** *0.00*	**9.81** *0.00*	**0.00** *0.00*	**0.62** *0.00*	**1.28** *0.00*	**0.40** *0.00*	**27.81** *0.00*
0.00 *0.00*	**0.00** *0.00*	**0.00** *0.00*	**0.00** *0.00*	**0.00** *0.00*	**0.47** *0.00*	**0.00** *0.00*	**0.91** *0.00*
272.56 *277.37*	**223.80** *213.37*	**422.56** *261.02*	**18.50** *16.77*	**30.05** *24.24*	**21.50** *22.70*	**112.33** *180.54*	**1,536.38** 1,441.76
597.60 *319.26*	**305.24** *194.79*	**228.96** *159.56*	**26.03** *15.09*	**12.94** *9.69*	**20.27** *15.54*	**87.72** *93.71*	**1,516.86** *1,048.66*
216.59 *210.85*	**157.36** *123.52*	**196.15** *114.37*	**5.50** *9.09*	**22.05** *20.57*	**17.46** *15.76*	**137.17** *148.72*	**1,117.07** *1,002.73*
223.21 *254.95*	**154.83** *153.51*	**193.26** *143.20*	**16.43** *26.11*	**23.15** *18.57*	**21.72** *25.07*	**139.73** *113.10*	**1,066.08** *1,049.76*
2,386.15 1,921.76	**1,238.08** 972.80	**1,772.57** 1,184.29	**86.14** 79.90	**207.92** 156.71	**228.88** 178.51	**652.70** 672.87	**8,778.18** 7,435.79
						164.70 **142.29**	**164.70** *142.29*
		123.42 **36.40**			**0.77** **0.43**	**0.56** **0.00**	**124.75** *36.83*
		6.82 *0.00*			**0.06** *0.00*	**0.07** *0.00*	**6.95** *0.00*

"ക്ലെയിമിനെ സംബന്ധിച്ച എല്ലാ രേഖകളും അയച്ചു കൊടുത്തിട്ട് 3 ആഴ്ചയായി. അവർ പണം വേഗം അയച്ചു തരുമെന്നാണ് എന്റെ പ്രതീക്ഷ."

"തീർച്ചയായും തരും. എല്ലാ കടലാസ്സുകളും നിയമാനുസൃതമാണെങ്കിൽ 30 ദിവസത്തിനകം അവർ ക്ലെയിം തീർപ്പു കല്പിക്കണം. അതാണ് നിയമം !"

ഇന്ത്യയിലെ ഇൻഷുറൻസ് കമ്പനികളുടെ മേലന്വോഷണച്ചുമതലയുള്ള സ്ഥാപനമായ ഇൻഷുറൻസ് റെഗുലേറ്ററി ആൻഡ് ഡെവലപ്മെന്റ് അതോറിറ്റി (ഐ ആർ ഡി എ) പോളിസി ഹോൾഡേഴ്സിന്റെ താല്പര്യങ്ങൾ സംരക്ഷിക്കുന്നു. ഐ ആർ ഡി എ കല്പിച്ചിട്ടുള്ള ചില ചട്ടങ്ങൾ താഴെ പറയുന്നു:

- പ്രസക്തമായ എല്ലാ രേഖകളും കിട്ടിയ 30 ദിവസത്തിനകം ഒരു ഇൻഷുറൻസ് കമ്പനി ക്ലെയിം (അവകാശം) കൊടുത്തു തീർക്കണം അല്ലെങ്കിൽ പ്രസക്തമായ കാരണങ്ങൾ കാണിച്ച് ക്ലെയിം ചോദ്യം ചെയ്യണം.
- ഒരു പ്രൊപ്പോസൽ അംഗീകരിച്ച് 30 ദിവസത്തിനകം ഇൻഷുറൻസ് കമ്പനി ഭാവി പോളിസിഹോൾഡർക്ക് പ്രൊപ്പോസൽ ഫോറത്തിന്റെ ഒരു പകർപ്പ് യാതൊരു ചാർജ്ജും വസൂലാക്കാതെ നല്കണം.
- ഇൻഷുറൻസ് കമ്പനി പ്രൊപ്പോസലുകൾ കിട്ടിയ 15 ദിവസത്തിനകം അവ കൈകാര്യം ചെയ്ത് തീരുമാനം അറിയിക്കണം.
- ആവശ്യമായ എല്ലാ രേഖകളും സമർപ്പിച്ച ശേഷവും ക്ലെയിം കൊടുക്കാൻ കാലതാമസം ഉണ്ടായാൽ ഒരു നിശ്ചിത നിരക്കിൽ പലിശ കൊടുക്കാൻ ഇൻഷുറൻസ് കമ്പനി ബാദ്ധ്യസ്ഥമായിരിക്കും.
- ഒരു ലൈഫ് ഇൻഷുറൻസ് പോളിസിഹോൾഡർക്ക് പോളിസി നിരസിക്കുന്നതിന് 15 ദിവസത്തെ (പോളിസി കിട്ടിയ ദിവസം മുതൽ) ഫ്രീ ലുക്ക് പിരിയഡിന് (സൗജന്യ പരിശോധന സമയം) അർഹത ഉണ്ടായിരിക്കും.
- പോളിസി ഹോൾഡേഴ്സിൽ നിന്നും ലഭിക്കുന്ന കത്തുകൾക്ക്, കിട്ടിയ 10 ദിവസത്തിനകം ഇൻഷുറൻസ് കമ്പനി മറുപടി നലക്കണം.

പൊതു താല്പര്യാർത്ഥം ഇറക്കുന്നത്:

ഇൻഷുറൻസ് റെഗുലേറ്ററി ആൻഡ് ഡെവലപ്മെന്റ് അതോറിറ്റി,

3-ഫ്ളോർ, പരിശ്രമ ഭവനം, ബഷീർബാഗ്, ഹൈദരാബാദ് - 500 004.

വെബ്സൈറ്റ് www.irda.gov.in

SPREAD THE WORD...

The above advertisement is issued by IRDA in the Public interest.
Those wishing to publish it for spreading consumer awareness of Insurance may use this artwork for reproduction.

17 - 18 Sep 2008 Venue: Mumbai	**Insurance Summit 2008** By *Infor-Media India, Mumbai*
19 Sep 2008 Venue: Mumbai	**Indian Microinsurance - What Works?** By *Microfinance Insights & Centre for Insurance and Risk Management*
21 - 23 Sep 2008 Venue: Shanghai, China	**9th China Rendezvous 2008** By *Asia Insurance Review, Singapore*
22 - 23 Sep 2008 Venue: Pune	**CD Deshmukh Seminar on Balance Score Card for Life Insurance Industry** By *National Insurance Academy, Pune*
24 Sep 2008 Venue: New Delhi	**Doubling the Insurance Penetration** By *FICCI, New Delhi*
24 - 25 Sep 2008 Venue: Shanghai, China	**4th Insurance Executives' Summit on Technology** By *Asia Insurance Review, Singapore*
26 - 27 Sep 2008 Venue: New Delhi	**Fast Forwarding the Other Half of Financial Inclusion** By *Birla Institute of Management Technology, Greater Noida*
7 - 8 Oct 2008 Venue: Singapore	**5th Asian Conference on Claims Management in Insurance** By *Asia Insurance Review, Singapore*
9 - 10 Oct 2008 Venue: Singapore	**Conference on Terrorism and Political Risk in Asia** By *Asia Insurance Review, Singapore*
13 - 15 Oct 2008 Venue: Pune	**Workshop on Microinsurance** By *National Insurance Academy, Pune*
20 - 25 Oct 2008 Venue: Pune	**Programme on Management of Marine Insurance (Hull & Cargo)** By *National Insurance Academy, Pune*

RNI No: APBIL/2002/9589

view point

We have to redouble our efforts to build a sufficiently large pool of expertise (of technically skilled professionals), with the relevant technical skills and the right intuitions.

Mr Low Kwok Mun
Executive Director (Insurance Supervision), Monetary Authority of Singapore

There's a need for greater customisation and offering greater choice to people in the low-income segment. The industry needs to show greater sympathy towards the underprivileged.

Mr J Hari Narayan
Chairman, Insurance Regulatory & Development Authority, India

Market abuse is one element of economic crime, and it's easy to see the impact that it has on market stability.

Mr Philip Robinson
Financial Crime & Intelligence Division Director, FSA, UK

Longer life spans, rising healthcare costs and the need to provide for retirement present market opportunities for insurers and fund managers.

Mr Lee Hsien Loong
Prime Minister, Singapore

It's critical that consumers continue to take responsibility for their health, so that we can all benefit from healthier lives and more affordable healthcare.

Ms Sandy Praeger
NAIC President and Kansas Insurance Commissioner

Think of reserving as an internal smoothing or insurance arrangement – merely because there has been no claim, insurance does not become unwarranted!

Mr Keith Chapman
Executive General Manager, Australian Prudential Regulation Authority