Bima Bemisaal

भारतीय बीमा विनियामक और विकास प्राधिकरण

INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY OF INDIA

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Consumer Affairs Booklet

POLICYHOLDER PROTECTION & WELFARE

CONTENTS

FOREWORD

(T.S. VIJAYAN)
Chairman

Indian insurance industry is currently going through a historic transitional phase. With the legislative changes taking effect and a more enlightened policyholder demanding better benefits, better service and better products, the pressure is both on the industry and the Regulator to live up to the expectations of one and all.

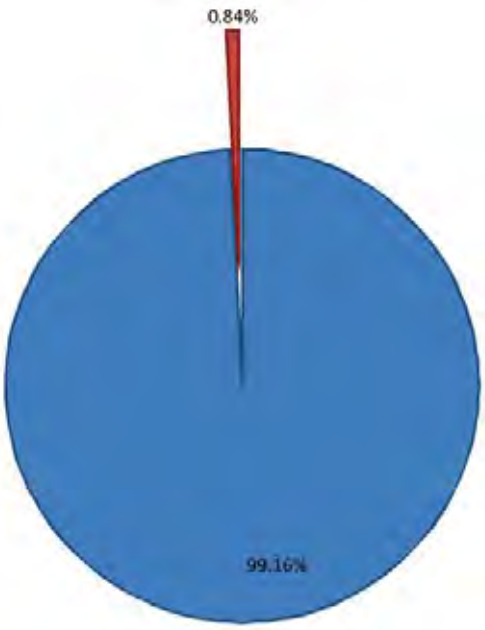
On the regulatory front, the Insurance Regulatory and Development Authority of India has always been leading the path – towards protection of interests of policyholders as also the orderly growth of insurance industry. In this endeavour, IRDAI has been taking several pro-active steps – on regulatory front on one side and creating awareness on insurance related issues on the other.

This booklet is an initiative by IRDAI aimed at dissemination of information not only to policyholders and insurers but also to other financial sector institutions, both within the country and abroad who are interested in knowing about Indian insurance industry. As is well known, in insurance, validated data plays a critical part in knowing the strength of the industry, its robustness, maturity as well as the areas that need attention. This booklet brought out by the Consumer Affairs Department of IRDAI has data relating to number of policyholder complaints and analysis of such policyholder grievances so as to highlight the areas where more efforts are required to be made towards policyholder welfare. The booklet also dwells upon various consumer education initiatives of IRDAI, the Regulations issued by IRDAI in the recent past and the Grievance Redressal System presently in force.

I am sure, the booklet, being launched as part of the consumer education initiative of IRDAI, would help disseminate valuable information and would be useful to all concerned.

Data Relating to Number of Complaints vis-à-vis Number of Policies and Claims Intimated

ANALYSIS OF LIFE COMPLAINTS VIS-A-VIS NO. OF POLICIES



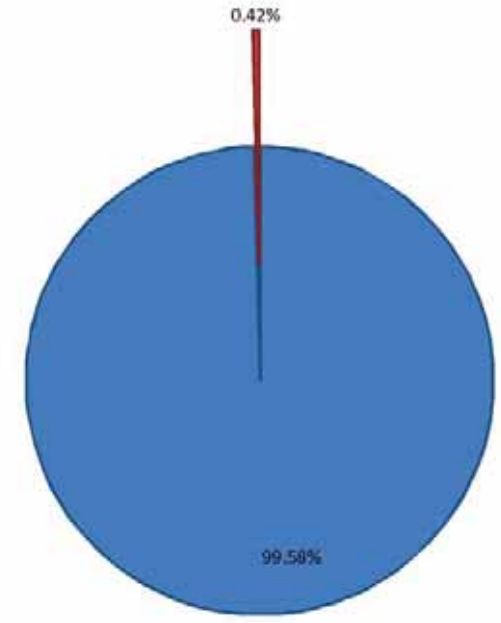
Policies on which complaints were not received

Policies on which complaints were received

No. of Policies for 2012-13 : 44154624

No. of policies Complaints for 2013-14 : 374620

ANALYSIS OF LIFE COMPLAINTS VIS-A-VIS NO. OF DEATH CLAIMS



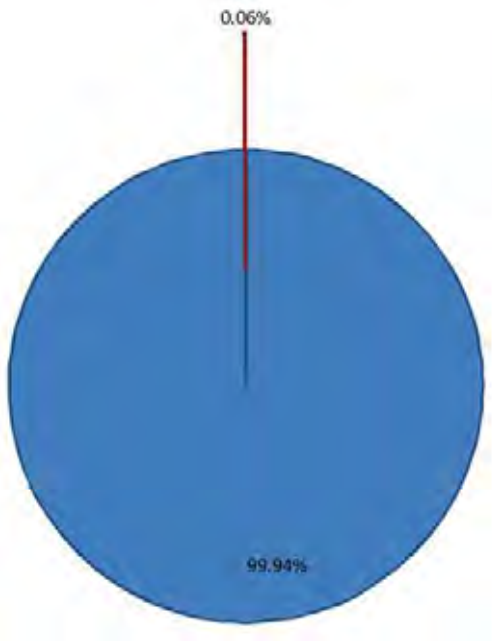
Claims on which complaints were not received

Claims on which complaints were received

No. of Death claims for 2012-13 : 1243919

No. of Death claim Complaints for 2013-14 : 5261

ANALYSIS OF NON-LIFE COMPLAINTS VIS-A-VIS NO. OF POLICIES



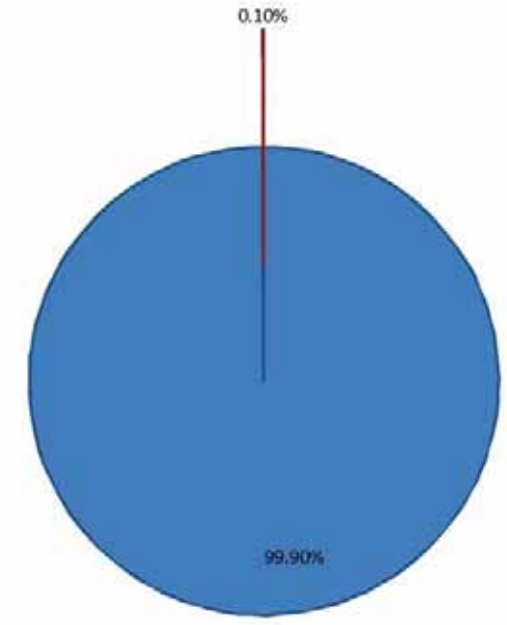
Policies on which complaints were not received

Policies on which complaints were received

No. of Policies for 2012-13 : 109500000

No. of policies Complaints for 2013-14 : 63335

ANALYSIS OF NON LIFE COMPLAINTS VIS-A-VIS NO. OF CLAIMS



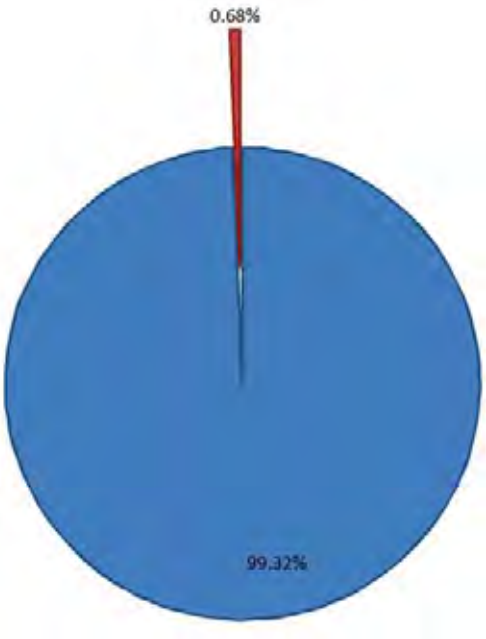
Claims on which complaints were not received

Claims on which complaints were received

No. of claims for 2012-13 : 27400000

No. of claim Complaints for 2013-14 : 27409

ANALYSIS OF LIFE COMPLAINTS VIS-A-VIS NO. OF POLICIES



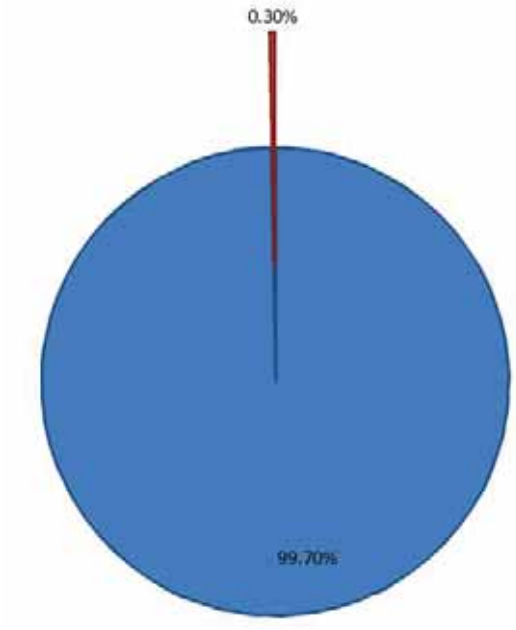
Policies on which complaints were not received

Policies on which complaints were received

No. of Policies for 2013-14 : 40834685

No. of policies Complaints for 2014-15 : 278992

ANALYSIS OF LIFE COMPLAINTS VIS-A-VIS NO. OF DEATH CLAIMS



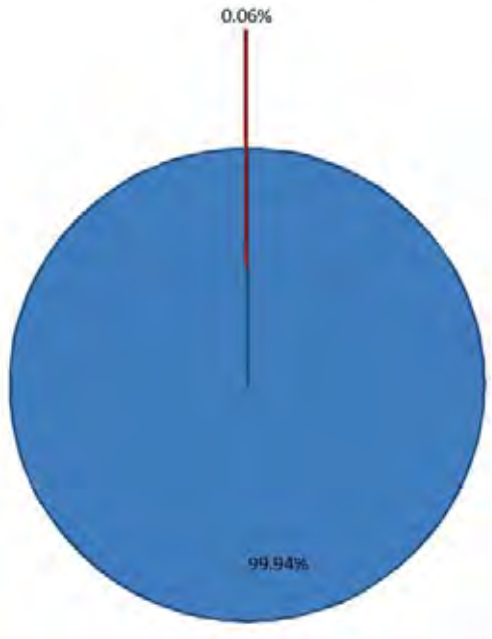
Claims on which complaints were not received

Claims on which complaints were received

No. of Death claims for 2013-14 : 1311339

No. of Death claim Complaints for 2014-15 : 3953

ANALYSIS OF NON-LIFE COMPLAINTS VIS-A-VIS NO. OF POLICIES



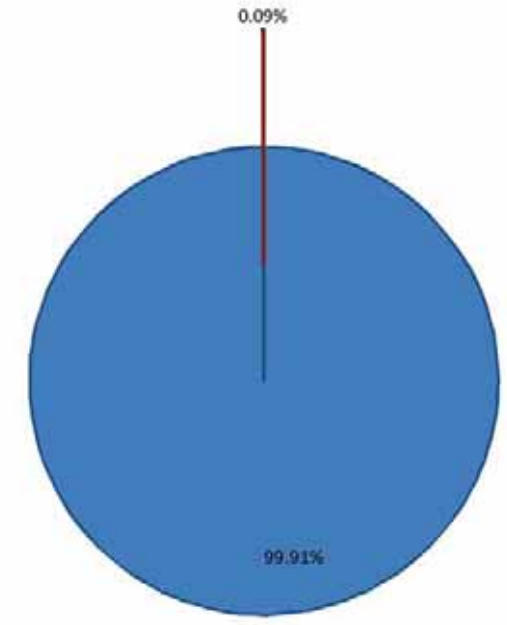
Policies on which complaints were not received

Policies on which complaints were received

No. of Policies for 2013-14 : 107400000

No. of policies Complaints for 2014-15 : 60688

ANALYSIS OF NON LIFE COMPLAINTS VIS-A-VIS NO. OF CLAIMS



Claims on which complaints were not received

Claims on which complaints were received

No. of claims for 2013-14 : 30300000

No. of claim Complaints for 2014-15 : 26467

Policyholder Protection and Welfare – An update

POLICYHOLDER PROTECTION AND WELFARE – AN UPDATE

IRDAI has been set up with the principal objective of protection of policyholders' interests. IRDAI has, over the years, put in place an elaborate regulatory and supervisory framework for the insurers and intermediaries involved in insurance business so that they operate not only on sound financial lines but also to increase the reach of the insurance services to general public so as to have greater insurance inclusion. Greater insurance inclusion can be achieved not only through improved access, greater diversity of insurance products so as to suit the needs of different sections of the society and different classes of people but also through impressing upon the members of public the need for insurance and the benefits that accrue on account of taking insurance. Thus, promoting insurance awareness through a multi-pronged strategy is an integral part for creating an enabling environment for greater insurance inclusion. A grievance redressal system which is easily accessible and effective in redressing customer grievances provides the necessary assurance and strengthens the confidence of general public that problems if any faced by them will be resolved. Thus, consumer awareness and consumer protection help in provides the backbone for greater insurance inclusion.

The Consumer Affairs Department of IRDAI handles work relating to the policyholder protection framework, grievance redressal system and consumer awareness. IRDAI has taken various initiatives during the period 2013-14 and 2014-15, a brief gist of which is indicated below:

I. DRAFT PROTECTION OF POLICY-HOLDERS INTERESTS REGULATIONS

The basic framework for protection of policyholders' interests is contained in the IRDA (Protection of Policyholders' Interests) Regulations 2002 (PPHI Regulations in short). There have been several changes that have come about after 2002 which include introduction of new categories of insurance intermediaries like brokers, web-aggregators and new products like micro insurance products, ULIP products etc. The channels of grievance redressal have also increased with the introduction of IGMS, IRDAI Grievance Call Centre etc. The increasing complaints of alleged mis-selling of life insurance policies, delay in settlement of claims of general insurance introduction of technology in the process of sourcing, sale and servicing of products necessitate a commensurate change in the regulatory framework for better policyholder protection. The grievance redressal guidelines have not been issued as regulations but as guidelines. In order to make the guidelines enforceable, they have to be made a part of the regulations. The consumer protection framework and provisions for securing fair treatment of customers contained in other regulations/ guidelines like group guidelines, distance marketing guidelines, micro-insurance regulations etc. need to be examined, strengthened and incorporated in the PPHI Regulations. The TATs for various services have been provided in the regulations. However, there is a need to review the TATs and direct the insurers to come out with a Citizen's charter. A Model citizen's Charter needs to be introduced for adoption by the insurance industry. The FSLRC recommendations relating to consumer protection also call for an enabling regulation to provide for greater consumer protection at all stages of financial transactions.

In this context, there was a need to have a relook at the PPHI Regulations and amend it suitably to strengthen policyholder protection as well as to keep it in tune with changing times. IRDAI constituted a Standing Advisory Committee under the Chairmanship of Shri DD Singh, Member (Distribution) consisting of officials from Insurance Division of Department of Financial Services, retired senior executives of life and non-life industry, Secretary Generals of Insurance Institute of India and Governing Body of Insurance Council, academicians from National Insurance Academy, Pune and officials of Consumer Affairs Department, IRDAI. The

Committee which is primarily constituted for reviewing the functioning of Ombudsmen was entrusted with a one-time task of reexamining the customer protection framework in insurance industry and suggesting changes to the PPHI Regulations.

Based on the recommendations of this Committee, Draft IRDA (Protection of Policyholders' Interests) Regulations 2014 were drawn up. The Regulations were placed in the public domain for comments. The comments have since been received and are under consideration. Revised IRDA (Protection of Policyholders' Interests) Regulations would be issued in due course which would serve as a new policyholder protection framework.

II. ANNUAL SEMINAR ON POLICYHOLDER PROTECTION AND WELFARE

The Fourth Annual Seminar on Policyholder protection and welfare organized by IRDAI was held at Mumbai on November 27, 2013. The occasion was marked by the release of IRDA's 'Consumer Affairs booklet for 2012-13'; General Insurance Council's 'Indian Non-Life Insurance Industry Yearbook 2012-13' and Insurance Information Bureau's 'Report on spread of Life Insurance Agents in India'. The mobile version of IRDA's consumer education website and a Documentary film on IRDAI initiatives, Animation films of educational comic books and a 'Handbook on surveyors and loss assessors' were also launched.

The Seminar had in depth discussions on issues concerning the Policyholders protection and Welfare and covered four specific topics viz. Insurance Literacy under National Strategy, Can you hear consumer voice?, Use of innovative channels for consumer Education and Delving into Health Insurance where eminent speakers of relevant fields presented their views and responded to the questions raised by the participants.

The seminar was attended by about 300 participants who included Chief executives of insurance companies, Insurance Ombudsmen, academicians, representatives of financial regulators, and consumer organizations; insurance intermediaries and IRDAI officials. The seminar provided valuable inputs to the stakeholders which would help them to steer their efforts towards consumer empowerment.

III. MEETING WITH INSURANCE OMBUSDMEN AND GBIC

A meeting of all the Insurance Ombudsmen in India with Chairman and Members IRDA, Chairman and Secretary, Governing Body of Insurance Council and senior officials of the IRDAI was held on December 20, 2013 at National Insurance Academy (NIA), Pune. Chairman GBIC and Secretary GBIC were also invited for the meeting. The issues faced in the implementation of the Redressal of Public Grievances Rules, 1998 and the suggestions on the Draft Bima Lokpal Rules were discussed with the Ombudsmen. The Insurance Ombudsmen made presentations on the staffing, complaints handled, constraints faced in resolving grievances within 3 months and suggestions relating to RPG Rules and regulations applicable to insurers. The suggestions on the Bima Lokpal Rules were forwarded to the Department of Financial Services, Ministry of Finance, Government of India along with IRDAI's views on the suggestions.

An Annual Conference of Insurance Ombudsmen was organized by Governing Body of Insurance Council on October 14 and 15, 2014 at Hyderabad. During the seminar, the newly appointed Ombudsmen were briefed about the RPG rules and various important IRDAI regulations. Further, considering that there are variations in approach to handling of complaints at the Ombudsman centres, a Brainstorming session among the Ombudsmen was also held to enable bringing about uniformity in handling complaints across all the offices of

Insurance Ombudsmen. Chairman IRDAI and Member (Distribution) addressed the Ombudsmen and apprised them of the expectations from Insurance Ombudsmen. Officials from Consumer Affairs Department and Health Department attended the Conference and clarified doubts of the Insurance Ombudsmen on policyholder protection regulations and health regulations respectively.

IV. WORKSHOP OF GRIEVANCE REDRESSAL OFFICERS (GROs) OF INSURERS

A Workshop of GROs of insurers was conducted on December 19, 2013 at NIA Pune. The workshop was presided by the Member (Distribution) and Senior Officials of IRDAI. The issues in redressal of grievances by insurers and observations on the major areas of grievances of life, non-life and health insurance and measures to reduce their incidence were discussed. The observations regarding maintenance and updating status of resolution on Integrated Grievance Management System were also discussed with the insurers. All the insurers made a presentation on the Organizational Structure of Grievance Redressal in their company, Board Committee and other Committees for Policyholder Protection and Grievance Redressal, Status of pending claims, Status of Legal cases, Policy and Systems in place for speedy settlement of claims by the company, Issues in IGMS, Problems faced in timely resolution of grievances and suggestions for better policyholder protection and speedy grievance redressal. While life insurers were asked to present on the extent of the problem of Mis-selling / Unfair business practices based on complaints and the systems put in place to address mis-selling, non-life insurers were asked to present about the systems in place to supervise performance of surveyors and TPAs handling claims.

V. TRIPURA STATE ACTION PLAN

The Insurance Awareness Campaign in the State of Tripura was launched on 8.1.2015 at Agartala by the Hon'ble Chief Minister of Tripura Shri Manik Sarkar. The Campaign is a collaborative effort of the Insurance Regulatory and Development Authority of India (IRDAI) and the Government of Tripura. The Campaign aims to make the citizens of the State aware about the benefits of insurance so that they can derive maximum advantages for themselves by taking the right decisions. The objective is proposed to be achieved within an outer time limit of two years through a wide range of activities, by adopting a multi-institutional approach with the involvement of Insurers, Life and General insurance councils, Banks, Financial Literacy Centres, Common Service Centres etc. and a multi-pronged strategy which, inter-alia, includes Seminars at District levels, village adoption, educating students, use of media – print and electronic, distribution of education material etc. The Chief Minister launched the booklet outlining the Action Plan of the Consumer Awareness Campaign in Tripura. Shri TS Vijayan, Chairman, Shri M. Ramprasad, Member (Non-Life), Shri Sriram Taranikanti (ED), Shri Lalit Kumar (FA) and representatives of Consumer Affairs Department represented IRDAI in the launch. Shri Bhanulal Saha, Hon'ble Minister of Finance, Government of Tripura, Shri A. Jindal, Secretary, Finance, Government of Tripura, Shri G.K. Rao, Chief Secretary, Government of Tripura were also present in the function and addressed the participants. Nearly 200 participants representing district administration, insurance sector, consumer bodies, insurance councils, members of press etc. attended the launching ceremony. The occasion was also marked by the release of three IRDAI handbooks titled "Introduction to Insurance", "Employment Opportunities in the insurance sector" and "Handbook on Insurance". The Action plan is being implemented by Government of Tripura and IRDAI collaboratively.

VI. INSURANCE AWARENESS POLICY OF INSURERS

IRDAI advised all insurers to have Board approved Insurance Awareness Policy for increasing insurance awareness across the country.

VII. RESEARCH GRANT SCHEME

To promote academic research in the areas of insurance, IRDAI launched a Research Grant Scheme promoting applied research in insurance with focus on policyholders' protection and insurance inclusion. The scheme has been further modified and proposals have been invited for research under the Scheme.

VIII. PARTICIPATION IN NATIONAL STRATEGY FOR FINANCIAL EDUCATION

Realiziing the need to spread financial literacy across all citizens of the country equipping them with knowledge, skills and confidence required to make an informed choice while choosing any financial product, the Government of India, Ministry of Finance, through Financial Stability and Development Council (FSDC), has formulated National Strategy for Financial Education (NSFE) and advised all financial sector regulators for its implementation within a time frame of five years. NSFE aims to promote a smoother and more sustainable co-operation between regulators and stakeholders, avoid duplication of resources and allow development of articulated and tailored roadmaps with measurable and realistic objectives based on dedicated national assessments. IRDAI along with other financial sector stakeholders has been playing an active role in the implementation of National Strategy for Financial Education; and a special institute called National Centre for Financial Education (NCFE) is established under NISM to implement NSFE.

NCFE has conducted National Financial Literacy Assessment Test (NFLAT) for School Children during FY 2013-14 and FY 2014-15 and all stakeholders including IRDAI are involved in this endeavour. While in its launch year, NCFE-NFLAT attracted over one lakh students from around 1400 schools across the country, in the year 2014-15 it attracted over one lakh students from 1800 schools from across the country indicating the overwhelming response for the initiative.

A National Survey on Financial Literacy and Inclusion in India was carried out by NCFE through Mott Mac Donald. The Draft report has been submitted before the Technical Group on Financial Inclusion and Financial Literacy of FSDC.

In order to spread financial literacy to the young, NCFE is also working with CBSE and NCERT for inclusion of basic financial education information in the school curriculum.

IX. PAN INDIA INSURANCE AWARENESS CAMPAIGN

IRDAI sponsored a pan-India insurance awareness campaign through General Insurance Council, disseminating insurance education on common general insurance topics viz. motor, health, rural and property Insurance.

X. INSURANCE AWARENESS DAY CELEBRATION BY IRDAI

In an attempt to enhance insurance awareness across the nation, IRDAI decided to celebrate its formation day as 'Insurance Awareness Day' on 19th April every year. IRDAI celebrated 'Insurance Awareness Day' for the very first time on 19th April, 2014 at Hyderabad. Shri Kalyan Jyoti Sengupta, Hon'ble Chief Justice, High Court of Andhra Pradesh, was the chief guest of the occasion and delivered the key note address. The following Consumer Education material was launched to mark the occasion.

1) IRDAI Brochure

2) Voice-over of virtual Tours of IGMS, IGCC and Consumer Education Website in 12 regional languages including Hindi.

3) Voice-over of 12 Animation Films in 12 regional languages including Hindi.

4) Youtube Page of IRDAI – IRDAI Connects

IRDAI organized 'Pan India Insurance Awareness Quiz' for all intermediaries including agents, corporate agents, TPAs, Surveyors and brokers who play a vital role in the value chain of insurance business. IRDAI also organised in-house Photography Competition with the theme: Mission IRDA. The Chief Guest distributed the prizes to the winners of these competitions and the Southern Zone winners of the NCFE-Financial Literacy Assessment Test. This was followed by cultural programme with performances by members of staff and their family members which included Tableau of children highlighting the importance of insurance and the various categories of insurance. The function was attended by Ex-Chairmen and Ex-Members of IRDAI, Senior executives of the insurance sector and the members and IRDAI with their family

XI. INSURANCE AWARENESS DAY CELEBRATION BY INSURERS

Stepping up its efforts to make insurance awareness a focused activity by the entire insurance fraternity, IRDAI Foundation Day (i.e April 19) was celebrated as Insurance Awareness Day by all the insurers also. The insurers organized a host of activities to promote insurance awareness.

XII. OTHER INSURANCE AWARENESS INITIATIVES

Insurance education helps a consumer to understand their needs and risks, availability of insurance for managing risks, value of possessing an insurance product and know about the dos & don'ts before and after purchase of an insurance policy. IRDA, as insurance sector regulator, has been playing a pro-active role in promoting insurance education since its inception and has adopted multi-pronged approach to enhance consumer awareness on various tenets of insurance. IRDA's strategy of publicity and consumer education has been encompassing both in-house programmes and supporting/ sponsoring external programmes encouraging all stakeholders to promote insurance awareness among the public stepping up its efforts for insurance education.

A. Seminars

During 2013-14, IRDAI sponsored eight seminars conducted by consumer bodies and NGOs in rural, semi-urban areas viz. Nigohan (District Lucknow, UP), Chittoor (Andhra Pradesh), Bhubaneswar (Orissa), Raiganj (Dist. Uttar Dinajpur, W.B), Nagaon (Assam), Mysore (Karnataka), Semaria (District Rewa, M.P) and Itanagar (Arunachal Pradesh).

During 2014-15, as a part of Tripura Action plan, four seminars have been conducted by Government of Tripura in collaboration with IRDAI.

B. Bima Bemisaal Campaign

In addition to the IRDAI launched Hindi version of its consumer education website and introduced a games section 'Young Corner' targeting children to learn insurance in a playful manner.

Comic Book Series and animation films have been translated into 12 vernacular languages and a documentary film on various initiatives of IRDAI towards protecting the interests of the policyholders.

The visual education material has also been placed on Youtube site as IRDAI Connects.

A mobile website of IRDAI has been launched to provide for ease of access of IRDAI website to consumers using mobile.

IRDAI published four handbooks viz. Role of Insurance Surveyors, Life Insurance Riders,

Householders & Shopkeepers Insurance and Grievance Redressal Mechanism in insurance sector for the benefit of policyholders.

IRDAI also published a brochure giving a gist of IRDAI, its history, organizational structure and functions.

The insurance education material developed by IRDAI is not only made available on consumer education website in easily downloadable form but the printed copies are also distributed through various channels such as financial literacy centres, consumer bodies etc.

In order to curb the menace of spurious callers, a massive multipronged campaign in print, electronic and internet media is being carried out by IRDAI for cautioning general public against spurious callers and fictitious offers.

C. IRDAI Calendar

For the first time in 2014, IRDAI published wall calendars and desk calendars with insurance messages and carrying relevant pictures to depict these messages. Considering the response to this effort, IRDAi published similar calendars in 2015 also with insurance related messages.

IRDAI would continue with the initiatives for protecting policyholders' interests and for promoting insurance awareness.

Spurious calls –
Problem, Impact and Efforts taken by IRDAI to caution public

SPURIOUS CALLS – PROBLEM, IMPACT AND EFFORTS OF IRDAI TO CAUTION PUBLIC

I. INTRODUCTION

Spurious calls in the name of regulatory organizations and government or quasi government authorities has been a problem which has been in prevalence for quite sometime now. The calls contain offers of benefits of huge amounts to be released by authorities. As a pre-requisite for such payment, the callers insist upon fulfillment of formalities which include furnishing documents of identity proof and address proof, details of bank account, banking username, password, PIN etc. and finally insisting upon payment of money for fulfilling certain regulatory requirements. The payments are made mostly in cash or sometimes through cheque or net banking. The gullible persons who respond to such calls and who are lured by such offers lose their money and trust in the financial system.

II. INSURANCE RELATED SPURIOUS CALLS

In 2010-11, it was observed that members of general public were receiving calls from individuals who claim to be representatives of IRDAI and offering insurance policies of different insurance companies with various benefits. However, the problem was not very serious in nature. However, to caution members of public IRDAI first issued a public notice on November 1, 2010 (**Annexure I**) informing the general public that Insurance Regulatory and Development Authority is a regulatory body which does not involve directly or through any representative in sale of any kind of insurance or financial products. Any person making any kind of transaction with such individuals/agents will be doing the same at one's own risk. It was also advised that if any member of the public notices such instances he/she may lodge a police complaint in the local police station. This was followed by issuing public caution in newspapers for greater reach. With the introduction of Do Not Call Registry and the coming into force of the "The Telecom Commercial Communication Customer Preference Regulations, 2010" with effect from 27th September, 2011 provided protection to telecom customers from unsolicited commercial calls.

III. RISE IN SPURIOUS CALLS AND MODUS OPERANDI

However, the problem of spurious calls has been on the rise in recent times. More importantly, the calls in the name of IRDAI or its officials rose significantly in 2013-14. In addition to such calls, there have been complaints of spurious calls made in the name of other insurance related agencies like Governing Body of Insurance Council, Life Insurance Council, insurance companies, grievance management department of Central Government etc. The spurious callers are approaching customers either with fictitious offers of bonus on policies, returns, transfer of commission payable to agents etc. or on the threat that their money is transferred to someone else. In either case, the callers insist upon fulfilling certain formalities which include submitting KYC documents, giving their details of bank account, cheques, card etc. and seeking payment of money for reasons like taking a dummy policy, payment of income tax, service tax etc. or for subscribing to some non-financial offers. The consequence of such calls are that members of public fall for such offers or threats and make payment to the spurious callers through various modes like transfer of funds, sharing card and pin, issuing cheque etc. While in certain cases fresh policies are issued to these customers, in certain other cases money is being collected for non-financial purposes without any issue of policy. Sometimes, there is no proof of payment, more so in cases where payments are reportedly made in cash.

IV. OFFERS MADE BY SPURIOUS CALLERS

The general nature of fictitious offers made through such spurious calls, as discerned from the complaints received by IRDAI, are as follows:

- Claiming to be representatives of IRDAI and offering insurance policies of different insurance companies with various benefits.
- Claiming that IRDAI is distributing bonus to insurance policy holders out of the funds invested by insurance companies with IRDAI.
- Claiming that the policyholder would receive bonuses being distributed by IRDAI if they purchase an insurance policy and wait for a few months after which the bonus would be released by IRDAI.
- Advising existing policyholders that money in respect of their policy has been fraudulently transferred to someone else and for receiving that money back from IRDAI, they have to fulfil certain formalities including payment of money
- Claiming that they are from the Grievance Cell or IGMS Department of IRDAI making a call in continuation with a complaint made against an insurer and for resolving the grievance and release of benefit, they have to fulfill certain formalities including payment of money.
- Advising customers to subscribe to a fresh policy after surrender of the existing policy and wait for a few months after which the fresh policy would be entitled for additional enhanced returns / benefits.
- Informing that 'Survival Benefit or Maturity Proceeds or Bonus' is due under their existing policy and investing in a new insurance policy is mandatory to receive the amounts which are due.
- Advising public to invest in insurance policies to avail gifts, promotional offers, interest free loans, or setting up of Telecom towers or other such offers.

V. IMPACT OF SPURIOUS CALLS

Spurious calls of the nature indicated above cause loss of reputation to IRDAI and other agencies and also financial loss to the gullible public who pay money based on such calls in lure of the offers made. Considering the fact that the mission of Government as well as IRDAI is in promoting financial inclusion by improving access to insurance related services in both life and non-life segments, such spurious calls would adversely affect the general sentiment of general public in relation to insurance. Given the fact that insurance is a complex financial product and is a subject matter of solicitation, the trust deficit caused due to such spurious calls can dissuade those who are apprehensive but interested in buying insurance because of the benefits of insurance. Since insurance is a product of risk protection, this can impact the general risk coverage of members of public rendering them more vulnerable to risks to their life and property. The premiums received from insured public forms the corpus for insurance companies to make long term investments in instruments such as Government securities and other securities. The money so invested serves as the investment for nation building. As a result, spurious calls are also indirectly hindering not only growth in the insurance sector but also development of the country through the premium funds available for development.

VI. IRDA'S CAUTION TO PUBLIC

Considering the extent of the problem and the impact of such calls on IRDAI's efforts at protection of interests of policy holders and ensuring the orderly growth of the insurance sector, IRDAI has taken up a campaign to caution members of public. The emphasis is more on dissuading people from believing such spurious calls and acting upon them so that the problem does not manifest into a financial loss to members of public who make payment believing in the veracity of the calls and offers.

Through the caution, IRDAI has been informing the members of public that:

- IRDAI does not involve directly or through any representative in sale of any kind of insurance or financial products.
- IRDAI does not invest the premium received by insurance companies.
- IRDAI does not announce any bonus for policyholders or insurers.
- IRDAI has put in place Grievance Redressal Cell in Consumer Affairs Department, Integrated Grievance Management System and IRDAI Grievance Call Centre to provide an alternate platform for registering grievances against insurers thereby facilitating resolution of customer grievances by insurers.
- IRDAI or its officials dealing with Grievance Management do not make calls in relation to complaints lodged with IRDAI as IRDAI plays a facilitative role and does not adjudicate upon or investigate into such complaints
- Any person making any kind of transaction with such individuals/agents will be doing the same at their own risk.

VII. EFFORTS TAKEN BY IRDAI TO CAUTION PUBLIC

IRDAI has taken concerted efforts at building awareness among the members through a multi-pronged strategy. The modes of campaign used by IRDAI directly for cautioning public about such offers are public notices, press releases, advertisements in news papers, radio spots, television advertisements, caution on the Internet websites of IRDAI and its consumer education website etc. IRDAI has also issued directions to insurers to incorporate caution against such spurious calls in their publicity material – print, internet and electronic – as well as through SMS to their policy holders. Insurers themselves have also been independently taking up steps for cautioning public through print, electronic and internet media.

The following are the various efforts taken in the direction of cautioning public from spurious calls and fictitious offers:

PRINT MEDIA

i. IRDAI issued public notice on January 29, 2014 informing public about the various kinds of spurious calls and cautioning them from falling prey to such spurious calls and fictitious offers. (**Annexure II**).

ii. IRDAI issued several rounds of advertisements carrying the same message as public notice in newspapers both in English and Hindi in major newspapers across the country. **(Annexure III)**

iii. On August 15, 2014, IRDAI issued a detailed advertisement on Right Buying which also included caution against spurious calls amongst other aspects of insurance from buying to servicing and making claims **(Annexure IV)**.

iv. The advertisement in 13 languages, including English, Hindi and major regional languages, is being issued periodically in major newspapers across the country. **(Annexure V)**

v. IRDAI issued a public caution again on August 26, 2014 including a write up on Modus operandi adopted by spurious callers along with audio clips **(Annexure VI)**. A press release was also issued on September 4, 2014 **(Annexure VII)**.

RADIO JINGLE

Considering the growing popularity of FM channels on radio, IRDAI has started using radio jingles also as a mode of conveying the caution in a brief yet effective manner for a larger audience. During the course of the FM radio programme on Question and Answers after the telecast of Satyameva Jayate, a popular programme on television highlighting socially relevant issues, IRDAI broadcast radio clips cautioning against spurious calls. The text of the clip is enclosed as **Annexure VIII.** IRDAI is also planning a full fledged campaign of spreading awareness about the caution through radio jingles.

TV COMMERCIALS

Electronic media are the most effective form of passing message in the most effective manner to

a wide audience. In order to use this medium for cautioning public, IRDAI has recently started telecasting a television commercial on spurious calls in the name of IRDAI. Two advertisements have been prepared conveying the message for telecast at periodic intervals, especially towards the end of the financial year, which is also the time when members of general public purchase insurance for largely for tax purposes. IRDAI is having an integrated campaign using all the above media for creating and promoting public awareness to be cautious against spurious calls and fictitious offers in the name of IRDAI.

INTERNET

The caution against spurious calls has been placed on the home page of the IRDAI website and the consumer education website of IRDAI. The TV commercial prepared by IRDAI has also been placed on the Youtube Site of IRDAI – IRDA Connects.

DELHI METRO CAMPAIGN

IRDAI has been carrying out a consumer education campaign in association with Delhi Metro to build awareness about insurance. In the present campaign, the emphasis is on spreading caution against spurious calls. In addition to posters inside the Metro rails, this campaign also includes posters, banners etc. within the Metro stations as well as on the property of Delhi Metro outside the stations such as walls, foot-over bridges, pillars etc.

INSURANCE AWARENESS CAMPAIGNS

The caution against spurious callers is being incorporated in all the insurance awareness campaigns conducted by IRDAI or in which IRDAI is associated.

DIRECTIONS TO INSURERS

i. On 27 January 2014 IRDAI issued a circular to all life insurers mandating them to caution members of public about spurious calls and fictitious offers in their advertisements / commercials in print and electronic media from February 1, 2014 **(Annexure IX)**. The text of the caution to be included in television commercials was specified and insurers were advised to include voice over of the text with each advertisement.

ii. In a circular dated February 13, 2014, the date from which the caution with voice over was required to be included in TV commercials was extended to March 1, 2014. Further, all Life Insurers also were advised to caution members of public about fictitious /spurious offers by sending an email / SMS to all their existing policyholders and advise them to not respond to such offers **(Annexure X)**.

iii. The modified instructions were issued to all life insurers vide circular dated June 24, 2014 considering the representations of insurers and the Life Council (**Annexure XI**). The requirement of voice over was relaxed and the text of the caution was also simplified. Life insurers were advised to include a slide containing the caution to be included in every TV commercial or cinema advertisement

VIII. RECOURSE FOR MEMBERS WHO PAID MONEY BASED ON SPURIOUS CALLS

In spite of the best efforts in cautioning public there are several persons who complain about making payment to spurious callers. The various categories in cases where payment is made based on spurious calls and the recourse available are briefly indicated below:

i. The amount is paid to an individual

Being a fraud by an individual, the only recourse available is to take up the matter with police for necessary action.

ii. The amount is paid to a non-insurance related service provider or agency

In such cases, depending on whether the services promised by the agency have been provided or not, the individual has to take up the matter with such agency or the police for necessary action. IRDAI would not be in a position to intervene as the institution does not fall within its regulatory purview.

iii. The amount is paid for an insurance related service to an unregulated entity

In such cases, the complaint can be filed with police being a case of fraud. Complaint can

also be filed with IRDAI since the money is paid for insurance related service. IRDAI will take necessary action in the matter as provided for under the Insurance Act, 1938 including issuing of a public notice to caution members of public from dealing with such entities.

iv. The amount is paid to an insurance company and a policy is issued

Being a case of fraud, a complaint can be filed with police for necessary action against the telecallers as well as the insurance company whom they represent. However, as an insurance policy is issued by an insurance company, the person may make a complaint of mis-selling with the insurance company bringing to the notice unfair business practice adopted by the telecaller/agent/intermediary in selling the policy and seek changes in the policy or cancellation of the policy. The other channels of making a complaint offered by IRDAI can also be used for registering a complaint against the insurer such as writing to Consumer Affairs Department of IRDAI, sending an email to complaints@irda.gov.in, making a call to toll free numbers (155255 or 1800 425 4732) of the IRDAI Grievance call centre or online on the Integrated Grievance Management System (IGMS) (www.igms.irda.gov.in).

IX. COMPLAINTS ON SPURIOUS CALLS

The complaints relating to spurious calls are included under the broader complaint category of unfair business practices in the Integrated Grievance Management System of IRDAI which is the industry-wide repository of insurance grievance related information. The number of complaints of this nature as per IGMS are as follows:

Sl. No.	Year	Number of complaints	% increase over previous year
1	2012-13	6351	
2	2013-14	7356	15.82
3	2014-15	9940	35.13

It can be seen that there has been a 35 % increase in the number of complaints relating to spurious calls from 2013-14 to 2014-15 warranting a dedicated and extensive campaign for building awareness amongst public and cautioning them from falling prey to spurious calls.

X. ACTION BY IRDAI ON COMPLAINTS

On receipt of complaints, IRDAI has been sending an advice to the complainant informing them of the caution issued by IRDAI with an advise that the complainant can file a police complaint. The format of advice sent is different depending on the nature of complaint. Where the complainants have been issued an insurance policy as a consequence of the spurious call, the complaint is also registered against the insurer(s) whose policy(ies) have been issued. In cases where the details of policies are reportedly indicated by the spurious caller, the insurer is advised to explain how the information was compromised.

IRDAI takes up the complaint with the insurer for resolution, which is updated by the insurer on the IGMS. In case the complainant is not satisfied with the resolution provided by the insurer, he may take up the matter with insurance ombudsmen (for details visit www.gbic.co.in) for amicable resolution or adjudication under the Redressal of Public Grievance Rules, 1998 (Ombudsmen are entertaining complaints of mis-selling though it is not expressly included as a ground of complaint under the Rules). Alternately, the complainant can file a complaint with Consumer Forum for deficiency of service; or take up before a criminal court for cheating or fraud; or file a suit in a civil court for breach of trust. IRDAI plays a facilitative role in resolution of customer complaints but does not adjudicate upon complaints.

However, through the volume of complaints, IRDAI monitors the market conduct of insurers, agents and intermediaries. Further, during the course of on-site inspection and off-site monitoring of regulated entities like insurance companies, insurance agents, corporate agents and insurance intermediaries (brokers) for examining the

compliance of these entities with the extant regulatory framework, IRDAI focuses on the process of soliciting, offering and selling insurance. Based on the findings, IRDAI initiates regulatory action against the insurers or intermediaries as per the provisions of the Insurance Act and Regulations.

XI. FILING POLICE COMPLAINTS

Considering that the spurious callers operate from various parts of the country, it is impracticable for IRDAI to file police complaints or investigate into case of each such complaint of spurious calls made in the name of IRDAI or its officials given the issues relating to jurisdiction for filing a police complaint. As such, IRDAI has sparingly filed police complaints. However, IRDAI has symbolically filed police complaints in two cases to highlight the problem of spurious calls to the police authorities and to signal to the insurers that they should file complaints against persons who are selling insurance policies or using the insurers' names for soliciting and selling insurance policies by making fictitious offers through spurious calls. Several insurance companies have taken the cue and have filed FIRs against spurious callers and taken up the matter with police authorities given the loss of reputation caused by such spurious calls.

XII. CONCLUSION

As the popular usage in financial circles goes, there can be regulation for need but there cannot be any regulation for greed. The realization of the fact that insurance is for risk protection and not for windfall gains can bring about caution in the members of public. So, there is a need for greater insurance awareness apart from the specific efforts taken by IRDAI in cautioning public against spurious calls. IRDAI on its part has been proactive in devising and implementing a multi-pronged strategy for spreading caution so that people do not fall prey to offers made by spurious callers.

Annexure-I

PUBLIC NOTICE

Ref: IRDA/CAGTS/PNTC/LCE/172/11/2010
1st November, 201 0

Insurance Regulatory and Development Authority (IRDA) is a regulatory body established by an Act of Parliament to protect the interests of the policyholders, to regulate, promote and ensure orderly growth of the insurance industry and for matters connected therewith or incidental thereto.

Some instances have been observed by the Authority that general public are receiving calls from individuals who claim to be representatives of IRDA and offering insurance policies of different insurance companies with various benefits (such as offering of scholarship along with policy etc.).

The general public is hereby informed that Insurance Regulatory and Development Authority is a regulatory body which does not involve directly or through any representative in sale of any kind of insurance or financial products. Any person making any kind of 'transaction with such individuals/agents will be doing the same at their own risk. If any member of the public notices such instances he/ she may lodge a police complaint in the local police station.

KUNNEL PREM
Consultant and Special Officer (Life)

Annexure-II

PUBLIC NOTICE

Ref: IRDA/CAD/PNTC/MISC/046/01/2014
Date : 29-01-2014

IRDA CAUTIONS PUBLIC AGAINST SPURIOUS CALLS AND FICTITIOUS OFFERS

Insurance Regulatory and Development Authority (IRDA) has been receiving complaints , through email/letters and in its Integrated Grievance Management System, from members of public informing the Authority that they are receiving spurious calls from unidentified persons:

- Claiming to be representatives of IRDA and offering insurance policies of different insurance companies with various benefits.
- Claiming that IRDA is distributing bonus to insurance policy holders out of the funds invested by insurance companies with IRDA.
- Claiming that the policyholder would receive bonuses being distributed by IRDA if they purchase an insurance policy and wait for a few months after which the bonus would be released by IRDA.
- Advising customers to subscribe to fresh policy after surrender of the existing policy and wait for a few months after which the fresh policy would be entitled for additional enhanced returns / benefits.
- Informing that 'Survival Benefit or Maturity Proceeds or Bonus' is due under their existing policy and investing in a new insurance policy is mandatory to receive the amounts which are due.
- Advising public to invest in insurance policies to avail gifts , promotional offers, interest free loans , or setting up of Telecom towers or other such offers.

The general public is hereby informed that IRDA is a regulatory body established by an Act of Parliament, i.e. the Insurance Regulatory and Development Authority Act 1999, to protect the interests of the policyholders , to regulate , promote and ensure orderly growth of the insurance industry and for matters connected therewith or incidental thereto. Further, IRDA informs the members of public that:

- IRDA does not involve directly or through any representative in sale of any kind of insurance or financial products.
- IRDA does not invest the premium received by insurance companies.
- IRDA does not announce any bonus for policyholders or insurers.
- Any person making any kind of transaction with such individuals/ agents will be doing the same at their own risk.

IRDA hereby urges the public to remain alert and not to fall prey to frauds or scams perpetrated by miscreants who impersonate to be employees / officers of IRDA or other insurance companies.

If any member of the public notices such instances, he ur she may lodge a police complaint, along with the details of the caller and telephone number from which the call was received, in the local police station.

Consumer Affairs Department
IRDA

Annexure-III

PUBLIC NOTICE

IRDA CAUTIONS PUBLIC AGAINST SPURIOUS CALLS AND FICTITIOUS OFFERS

Insurance Regulatory and Development Authority (IRDA) has been receiving complaints, through email/letters and in its Integrated Grievance Management System, from members of public informing the Authority that they are receiving spurious calls from unidentified persons:

- Claiming to be representatives of I RDA and offering insurance policies of different insurance companies with various benefits.
- Claiming that IRDA is distributing bonus to insurance policyholders out of the funds invested by insurance companies with IRDA.
- Claiming that the policyholder would receive bonuses being distributed by IRDA if they purchase an insurance policy and wait for a few months after which the bonus would be released by I RDA.
- Advising customers to subscribe to fresh policy after surrender of the existing policy and wait for a few months after which the fresh policy would be entitled for additional enhanced returns I benefits.
- Informing that 'Survival Benefit or Maturity Proceeds or Bonus' is due under their existing policy and investing in a new insurance policy is mandatory to receive the amounts which are due.
- Advising public to invest in insurance policies to avail gifts, promotional offers, interest free loans, or setting up of Telecom towers or other such offers.

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- Any person making any kind of transaction with such individuals/agents will be doing the same at his own risk.

IRDA hereby urges the public to remain alert and not to fall prey to frauds or scams perpetrated by miscreants who impersonate to be employees I officers of I RDA or other insurance companies.

If any member of the public notices such instances, he or she may lodge a police complaint, along with the details of the caller and telephone number from which the call was received, in the local police station

बीमा विनियामक और विकास प्राधिकरण
INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY

Promoting Insurance. Protecting Insured.

3rd Floor, Parishram Bhavan, Basheerbagh, Hyderabad - 500 004
www.irda.gov.in www.policyholder.gov.in

Real Value of Insurance Through Right Buying - A Few Tips

1. Make sure you purchase insurance policies only from the following:

- Registered insurance companies
- Licensed insurance Agents
- Licensed Insurance Brokers and Common Service Centres (CSCs)
- Licensed web aggregators

2. Verify genuineness of the person and the entity before making any payment:

- Ask for the identity proof of the person /entity soliciting insurance.
- Ask for the details of address and telephone number of the person and the entity concerned, especially in case of telesales.
- Check the IRDA website to verify the details of insurance companies, brokers and web aggregators.

3. Choose the insurance product suitable to you based on the following:

- Life stage, financial position and financial requirements
- Purpose of the policy to be purchased -
  - to insure against risk to life or property
  - as long-term savings
  - to take care of hospitalization needs in future
  - to save for old age / pension / annuity
  - to meet mandatory requirements
- Benefits offered in terms of adequacy of sum assured/ sum insured
- Tax incentive, if available

4. Ensure the following while purchasing any insurance policy:

- Read the prospectus and proposal form carefully.
- Fill in the details completely before signing the proposal form.
- Retain a copy of the proposal form for ready reference.
- The insurer has a duty to furnish free of charge a copy of the proposal form within 30 days of the acceptance of the proposal. Please collect the same along with the insurance policy.

- If the premium is paid through cheque, please ensure that it is in the name of the registered insurance company; and obtain receipt of payment.
- Do not make payment in the name of any individual, or if the payment is by cash, make sure it is not without ascertaining the credentials.
- Follow up with insurer or agent/broker for prompt receipt of policy document.

5. Life insurance policy mainly provides risk coverage for life. But it can also serve as a tool for long term investment and involves long term commitment.

Take care of the following after receiving the Life insurance policy:

- Read the policy document carefully.
- Check the mode of premium payment, term of the policy, maturity benefits offered, lock-in period, surrender value etc.
- Ensure that the terms and conditions as per policy document are the same as promised at the time of purchase.
- If you disagree with the terms and conditions, return the policy to the insurer within 15 days from the date of receipt of policy giving reasons for objections. You are entitled for refund of the premium paid after deducting proportionate risk premium, the expenses incurred by insurer for medical examination, stamp charges.
- Pay premium regularly and promptly; and do not allow the policy to lapse.
- Continue the policy without a break to derive maximum value out of insurance policy as insurance cover will be available only on timely payment of premium.
- Inform the family members about the purchase of insurance policy and its benefits, especially to the nominee.

6. Never fall prey to fictitious offers made by spurious callers promising high returns or unreasonable gains involving sale or redemption of insurance policies or other financial products.

7. Never fall prey to calls made in the name of IRDA offering bonus or profits on investment. IRDA does not involve in sale of any kind of insurance or financial products or in investment of premium of insurance companies whatsoever.

8. If any unlicensed intermediaries or unregistered insurers solicit insurance, file FIR with the police and intimate IRDA. Any payment made to such unlicensed intermediaries or unregistered insurers is at your own risk.

ইন্ছিওৰেন্স ৰেগুলেটৰী এণ্ড ডেভেলপমেণ্ট অথৰিটি

INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY

আগবঢ়াইছে বীমা। সুৰক্ষিত কৰিছে বীমাকৃত ব্যক্তিক।

পৰিশ্রম ভৱন বশীৰবাগ হাইদৰাবাদ-500004

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সঠিক ক্রয়ৰ জড়িয়তে বীমাৰ প্রকৃত মূল্য কেইটামান আভাস

1. এইটো নিশ্চিত কৰক যে আপুনি কেৱল তলত দিয়া সমূহৰ পৰাহে বীমা পলিচি ক্রয় কৰে :

- পঞ্জীভুক্ত বীমা কোম্পানী
- অনুজ্ঞাপ্রাপ্ত বীমা অভিকর্তা
- অনুজ্ঞাপ্রাপ্ত ইন্ছিওৰেন্স ব্র'কাৰ আৰু কমন চার্ভিচ চেণ্টাৰ্চ (চিএচচি)
- অনুজ্ঞাপ্রাপ্ত ৰেৰ এগ্রিগেটৰ্চ

2. যি কোনো আদায় দিয়াৰ পূর্বে ব্যক্তি আৰু সংস্থাৰ সত্যতা নিৰূপণ কৰি লওক

- বীমা আগবঢ়োৱা ব্যক্তিৰ/সংস্থাৰ পৰিচয়ৰ প্রমাণ বিচাৰক
- এই জড়িত ব্যক্তি জনৰ আৰু সংস্থাৰ ঠিকনাৰ সবিশেষ আৰু টেলিফোন নম্বৰ বিচাৰক, বিশেষকৈ টেলিচে'লৰ ক্ষেত্রত
- বীমা কোম্পানী, ব্র'কাৰ আৰু ৰেৰ এগ্রিগেটৰ সবিশেষ সত্যাপিত কৰিবৰ বাবে আইআৰডিএ ৰেবচাইট চাওক

3) তলত দিয়া সমূহৰ ওপৰত ভিত্তি কৰি আপোনাৰ বাবে উপযুক্ত বীমা উৎপাদন বাছি লওক:

- জীৱনৰ পর্য্যায়, আর্থিক অৱস্থা আৰু আর্থিক আৱশ্যকতা
- ক্রয় কৰিবলগীয়া পলিচিৰ অভিপ্রায়-
  - জীৱন অথবা সম্পত্তিৰ ক্ষতিশংকাৰ ওপৰত বীমা
  - দীর্ঘম্যাদী সঞ্চয় হিচাপে
  - ভৱিষ্যতে চিকৎসালত থকা প্রয়োজন হ'লে
  - বৃদ্ধ কাল/পেঞ্চন/এনুইটি (বাৎসৰিক প্রাপ্তি) ৰ বাবে
  - বাধ্যতামূলক আৱশ্যকৰাত বাবে
- বীমা ৰাশি/বীমাকৃত ব্যক্তি পর্য্যাপ্ত হোৱাৰ ক্ষেত্রত আগবঢ়োৱা লাভসমূহ
- কৰ লাভ, যদি আছে

4) যি কোনো বীমা পলিচি ক্রয় কৰাৰ সময়ত তলত দিয়াসমূহ নিশ্চিত কৰক

- অনুষ্ঠান পত্র আৰু প্রস্তাৱ প্র-পত্র মনোযোগেৰে পঢ়ক
- প্রস্তাৱ প্র-পত্রত চহী কৰাৰ পূর্বে সবিশেষ সমূহ সম্পূর্ণকপে পূৰাওক
- ভৱিষ্যতে চাবৰ বাবে এখন প্রস্তাৱ প্র-পত্র নিজৰ হাতত ৰাখক
- প্রস্তাৱ গ্রহণ কৰাৰ 30 দিনৰ ভিতৰত বীমাকর্তাই বিনামূলীয়াকৈ প্রস্তাৱ প্র-পত্রৰ এটা প্রতিলিপি প্রদান কৰাটো কর্তব্য । অনুগ্রহ কৰি বীমা পলিচিৰ সৈতে ইয়াক সংগ্রহ কৰক
- যদি প্রিমিয়াম চে'কৰ দ্বাৰা আদায় দিয়া হয়, তেন্তে এইটো নিশ্চিত কৰক যে চে'কখন পঞ্জীভুক্ত বীমা কোম্পানীৰ নামত কটা হৈছে; আৰু আদায় দিয়াৰ ৰচিদ সংগ্রহ কৰক
- কোনো ব্যক্তিৰ নামত কোনো ধৰণৰ আদায় নিদিব; বা যদি নগদ ধনৰ দ্বাৰা আদায় দিয়া হয়, এইটো নিশ্চিত কৰক যে এনে আদায় যেন বিশ্বাসযোগ্যতা প্রদান নকৰাকৈ কৰা নহয়
- পলিচি নথিপত্র শীঘ্রে পাবৰ বাবে বীমাকর্তা অথবা অভিকর্তা (এজেণ্ট)/ব্র'কাৰৰ সৈতে যোগাযোগ কৰক

5. জীৱন বীমা পলিচিয়ে প্রধানকৈ জীৱনটোৰ বাবে ক্ষতিশংকা কভাৰ প্রদান কৰে। কিন্তু ই এটা দীর্ঘম্যাদী বিনিয়োগৰ মাধ্যম হিচাপেও কাম কৰে আৰু ইয়াৰ বাবে দীর্ঘ-ম্যাদী প্রতিশ্রুতিৰ আৱশ্যক। জীৱন বীমা পলিচি পোৱাৰ পিছত তলত দিয়া সমূহৰ যত্ন লওক:

- পলিচি নথিপত্র মনোযোগেৰে পঢ়ক
- প্রিমিয়াম আদায়ৰ প্রকাৰ, পলিচি ম্যাদ, আগবঢ়োৱা পৰিপক্কতা লাভ, লক-ইন পিৰিয়ড, সমর্পণ মূল্য ইত্যাদি নিৰীক্ষণ কৰক
- ক্রয় কৰাৰ সময়ত দিয়া প্রতিশ্রুতি অনুসৰি নিয়ম আৰু চর্তসমূহ যেন পলিচি নথিপত্রত একেই সেই কথা নিশ্চিত কৰক
- যদি আপুনি নিয়ম চর্তসমূহৰ সৈতে সম্মত নহয়, তেন্তে পলিচি পোৱাৰ পৰা 15 দিনৰ ভিতৰত আপত্তিৰ কাৰণ দর্শাই বীমাকর্তাক পলিচি ঘূৰাই দিয়ক । সমানুপাতিক ক্ষতিশংকা প্রিমিয়াম, চিকিৎসনীয় পৰীক্ষণৰ বাবে বীমাকর্তাই কৰা ব্যয়, মুদ্রাংক শুল্ক কর্তন কৰি আদায় দিয়া প্রিমিয়াম ঘূৰাই পোৱাৰ বাবে আপুনি স্বত্বৱান
- প্রিমিয়াম নিয়মীয়াকৈ তথা শীঘ্রে আদায় দিয়ক; আৰু পলিচি লেপ্চ হ'বলৈ নিদিব
- বীমা পলিচিৰ পৰা সর্বোচ্চ মূল্য পাবৰ বাবে পলিচিটো বাহাল ৰাখক যিহেতু সঠিক সময়ত প্রিমিয়াম আদায় দিলেহে বীমা কভাৰ উপলব্ধ হয়
- পৰিয়ালৰ সদস্যক বীমা পলিচি ক্রয়ৰ বিষয়ে জনাওক, বিশেষকৈ মনোনীত ব্যক্তিক

6. মিছা ফোন কলৰ দ্বাৰা তথা মনে সজা অফাৰৰ দ্বাৰা প্রতাৰিত নহ'ব । এনে লোকে বীমা পলিচি বা অন্য কোনো বিত্তীয় উৎপাদনত উচ্চ ৰিটার্ন বা অযুক্তিকৰ লাভৰ প্রতিশ্রুতি প্রদান কৰে ।

7. বিনিয়োগত ব'নাচ অথবা লাভসমূহ আগবঢ়াই আইআৰডিএ-ৰ নাম লৈ কোনো লোকে ফোন কৰিলে ইয়াক বিশ্বাস নকৰিব ।

আইআৰডিএ-এ যি কোনো প্রকাৰে বীমা বা বিত্তীয় উৎপাদনৰ বিক্রী বা বীমা কোম্পানীত প্রিমিয়াম বিনিয়োগৰ ক্ষেত্রত জড়িত নহয় ।

8. যদি কোনো পঞ্জীভুক্ত নোহোৱা বীমাকর্তা অথবা বেআইনী মধ্যস্থতাকাৰীয়ে বীমা আগবঢ়ায়, তেন্তে পুলিচত এফআইআৰ দাখিল কৰক আৰু আইআৰডিএ-ক জনাওক ।

এনে কোনো পঞ্জীভুক্ত নোহোৱা বীমাকর্তা বা বেআইনী মধ্যস্থতাকাৰীক আপোনাৰ নিজৰ ক্ষতিশংকাত ধন আদায় দিব ।

দাবী পৰিত্যাগ: ই কেৱল আপোনাক সাধাৰণ জাননী প্রদান কৰে আৰু ই সম্পূর্ণ নহয় । ই হৈছে এক অভিনৱ শিক্ষামূলক পদক্ষেপ আৰু ই আপোনাক কোনো আইনগত পৰামর্শ নিদিয়ে ।

ইনশিয়োরেন্স রেগুলেটোরি অ্যান্ড ডেভেলপমেন্ট অথোরিটি

INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY

বিমার উন্নতিকরণ। বিমাকৃতের সুরক্ষা।

পরিশ্রম ভবন, বশিরবাগ, হায়দ্রাবাদ-500004

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সঠিক ক্রয়ই হল বিমার আসল মূল্য
কিছু টিপ্‌স

1. শুধুমাত্র নিম্নলিখিতদের থেকে বিমা পলিসি ক্রয় সুনিশ্চিত করুন :

- নথিভুক্ত বিমা সংস্থা
- লাইসেন্সধারী বিমা এজেন্ট
- লাইসেন্সধারী বিমা ব্রোকার এবং কমন সার্ভিস সেন্টার (সিএসসি)
- লাইসেন্সধারী ওয়েব অ্যাগ্রিগেটার

2. কোনও টাকা প্রদান করার আগে ব্যক্তিটির যথার্থতা ও সত্তা যাচাই করে নিন

- ব্যক্তিটির পরিচয় প্রমাণপত্র দেখতে চান/প্রার্থিত বিমা সংস্থার সত্তা জানতে চান
- ব্যক্তিটির বিশদ ঠিকানা ও টেলিফোন নং এবং সংশ্লিষ্ট সত্তা জানতে চান, বিশেষ করে টেলিসেলের ক্ষেত্রে
- বিমা সংস্থা, ব্রোকার এবং ওয়েব অ্যাগ্রিগেটারদের সম্বন্ধে বিশদে জানতে আইআরডিএ-র ওয়েবসাইট দেখুন।

3. নিম্নলিখিত বিষয়গুলির ওপর ভিত্তি করে যে বিমাটি চাই তাহা বাছুন :

- জীবনের পর্যায়, আর্থিক পরিস্থিতি আর আর্থিক প্রয়োজন
- পলিসি ক্রয় করার উদ্দেশ্য কি যথা:
  - জীবন অথবা সম্পত্তির সম্ভাব্য বিপদ অথবা ক্ষতির মোকাবিলা করা
  - দীর্ঘমেয়াদি সঞ্চয় করা
  - ভবিষ্যতে হাসপাতালের খরচ মেটানোর জন্য
  - আবশ্যিক চাহিদা মেটানো
  - বার্ধক্য/পেনশন/অ্যানুয়িটির জন্য সঞ্চয় করা
- আশ্বাসিত অর্থরাশি/বিমা-রাশি পর্যাপ্ত কিনা দেখে নেওয়া
- কর ছাড় পাওয়া যায় কিনা দেখা

4. বিমা পলিসি ক্রয় করার সময় নিম্নলিখিত বিষয়গুলি সুনিশ্চিত করুন

- প্রসপেক্টাস (পলিসি বিবরণ) এবং প্রোপোজাল ফর্মটি মনোযোগ সহকারে পড়ুন।
- প্রোপোজাল ফর্মে স্বাক্ষর করার আগে বিবরণগুলি সম্পূর্ণভাবে পূরণ করুন।
- চটজলদি দেখার জন্য প্রোপোজাল ফর্মের একটি কপি নিজের কাছে রাখুন।
- প্রস্তাব গ্রহণ করার 30 দিনের মধ্যে বিনামূল্যে প্রোপোজাল ফর্মের একটি কপি দেওয়া বিমা সংস্থার দায়িত্ব। অনুগ্রহ করে বিমা পলিসির সঙ্গে সেটি সংগ্রহ করুন।
- যদি প্রিমিয়াম চেকের মাধ্যমে দেওয়া হয়, অনুগ্রহ করে নিশ্চিত করুন যে সেটি নথিভুক্ত বিমা সংস্থার নামেই দেওয়া হয়েছে এবং পেমেন্টের রসিদ নিন।
- কোনও ব্যক্তির নামে পেমেন্ট করবেন না, অথবা যদি পেমেন্ট নগদে করা হয়, উপযুক্ত বিশ্বাসযোগ্যতা যাচাই করে তবেই নিশ্চিত হোন।
- বিমা নথিপত্র তাড়াতাড়ি পাওয়ার জন্য বিমা সংস্থা অথবা এজেন্ট/ব্রোকারের সঙ্গে নিয়মিত যোগাযোগ রাখুন।

5. জীবনবিমা পলিসি প্রধানত জীবনের সম্ভাব্য বিপদের বিরুদ্ধে সুরক্ষা জোগায়। কিন্তু এটি দীর্ঘমেয়াদি বিনিয়োগ হিসেবেও কাজ করতে পারে এবং দীর্ঘমেয়াদি অঙ্গীকারগুলির খেয়াল রাখে। জীবনবিমা পলিসিটি পাওয়ার পর নিম্নলিখিত বিষয়গুলি খেয়াল রাখবেন :

- পলিসি নথিপত্র মনোযোগ সহকারে পড়বেন।
- প্রিমিয়াম দেওয়ার ধরন, বিমার মেয়াদ, ম্যাচুরিটি বেনিফিট, লক-ইন পিরিয়ড, সারেন্ডার ভ্যালু ইত্যাদি খতিয়ে দেখুন।
- পলিসি নথিপত্রর নিয়ম ও শর্তাবলি ক্রয়কালীন প্রতিশ্রুতির মতো কিনা সুনিশ্চিত করুন।
- নিয়ম ও শর্তাবলি যদি আপনার পছন্দ না হয়, আপত্তির কারণ দেখিয়ে পলিসি গ্রহণের 15 দিনের মধ্যে বিমা সংস্থাকে পলিসি ফেরত দিন। যে প্রিমিয়াম আপনি দিয়েছেন তার থেকে আনুপাতিক হারে রিস্ক প্রিমিয়াম, ডাক্তারি পরীক্ষার জন্য বিমা সংস্থার খরচ ও স্ট্যাম্প চার্জ বাদ দিয়ে বাকি অর্থরাশি ফেরত পাওয়া আপনার অধিকার।
- নিয়মিতভাবে ও সময়মতো প্রিমিয়াম জমা দিন, এবং পলিসিটিকে অতিপন্ন (ল্যাপ্স) হতে দেবেন না।
- বিমা পলিসিটি থেকে সর্বোচ্চ মূল্য ফেরত পেতে কোনও বিরতি ছাড়াই পলিসিটি বজায় রাখুন; কারণ সময়মতো প্রিমিয়াম জমা দিলে তবেই বিমা সুরক্ষা পাওয়া যায়।
- বিমা পলিসি ক্রয় করার খবর এবং তার সুবিধাগুলি সম্বন্ধে পরিবারের সকলকে জানিয়ে রাখুন, বিশেষ করে নমিনিকে।

6. টেলিফোনের মাধ্যমে বা অন্যভাবে প্রাপ্ত কৃত্রিম আহ্বানের / প্রস্তাবের শিকার কখনও হবেন না। এইগুলিতে বিমা পলিসি অথবা অন্যান্য আর্থিক পণ্যগুলির ওপর খুবই বেশি রিটার্ন অথবা অযৌক্তিক লাভের প্রতিশ্রুতি দেওয়া হয়ে থাকে।

7. ফোনে আইআরডিএ'র নাম করে বিনিয়োগের ওপর বোনাস অথবা লাভের প্রস্তাবের শিকার হবেন না। যে কোনও ধরনের বিমা অথবা আর্থিক পণ্য অথবা বিমা সংস্থার প্রিমিয়ামের বিনিয়োগে আইআরডিএ কোনভাবেই জড়িত থাকে না।

8. যদি কোনও লাইসেন্সবিহীন মধ্যস্থতাকারী অথবা অনথিভুক্ত বিমাকারী বিমা প্রার্থনা করে, পুলিশে এফআইআর ফাইল করুন এবং আইআরডিএ-কে জানান। এরকম লাইসেন্সবিহীন মধ্যস্থতাকারী অথবা অনথিভুক্ত বিমাকারীকে কোনরকম পেমেন্ট করলে সেটি আপনার নিজের দায়িত্বে করবেন।

ઈન્શ્યોરન્સ રેગ્યુલેટરી એન્ડ ડેવલપમેન્ટ ઑથોરિટી

INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY

ઈન્શ્યોરન્સને પ્રોત્સાહન. પૉલિસીધારકોને સુરક્ષા.

પરિશ્રમ ભવન બશીરબાગ હૈદરાબાદ–500004

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યોગ્ય ખરીદી દ્વારા વીમાનું અસલ મૂલ્ય કેટલીક ટિપ્સ

1. આપ માત્ર નિમ્નલિખિત પાસેથી જ વીમો ખરીદો છો એની ખાતરી કરી લોઃ

- નોંધણી થયેલી વીમા કંપનીઓ
- પરવાનાધારક વીમા એજન્ટ
- પરવાનાધારક વીમા દલાલો અને કૉમન સર્વિસ સેન્ટરો (CSC)
- પરવાનો ધારક વેબ ઍગ્રીગેટર્સ

2. કોઈ પણ ચુકવણી કરતા પહેલાં વ્યક્તિ અને સંસ્થાની ખરાઈ કરી લો.

- વીમામાટે સંપર્ક કરનાર વ્યક્તિ/સંસ્થાની ઓળખ માટે પુરાવો માંગવો
- સંબંધિત વ્યક્તિ અને સંસ્થાના, ખાસ કરીને ટેલિફોન દ્વારા વેચાણના કિસ્સામાં સરનામાની વિગતો અને ટેલિફોન નંબર પૂછો
- વીમા કંપનીઓ, દલાલો અને વેબ–ઍગ્રિગેટર્સની વિગતો ચકાસવા માટે ઈરડાની વેબસાઈટ તપાસો.

3. નિમ્નલિખિતના આધાર પર આપને અનુકૂળ હોય એવું વીમા કવચ પસંદ કરોઃ

- ઉંમર, નાણાકીય પરિસ્થિતી તથા આર્થિક જરૂરિયાતો
- વીમો ખરીદવા અંગેનો મુળ હેતુ જેમ કે
  - જીવન અથવા સંપત્તિના જોખમ સામે સુરક્ષા મેળવવા
  - લાંબા ગાળાની બચત માટે
  - ભવિષ્યમાં હૉસ્પિટલાઈઝેશનની જરૂરિયાતોને પૂરી કરવા માટે
  - આવશ્યક જરૂરીયાતોને પૂરી કરવા માટે
  - વૃદ્ધાવસ્થા/પેન્શન/વર્ષાસન હેતુ બચત કરવા માટે
- સુનિશ્ચિત વીમા રકમ ઉપરાંતમેળવવાપાત્ર અન્ય લાભ
- જો ઉપલબ્ધ હોય તો, કર રાહતના લાભ લેવા માટે

4. કોઈ પણ વીમા કવચ ખરીદતી વખતે નિમ્નલિખિતની ખાતરી કરી લો

- માહિતીપત્ર અને દરખાસ્ત ફૉર્મને કાળજીપૂર્વક વાંચી જાઓ
- માહિતીપત્ર ફૉર્મ પર હસ્તાક્ષર કરતા પહેલાં વિગતોને પૂરેપૂરી ભરો
- આપની સુગમતા માટે દરખાસ્ત ફૉર્મની નકલ સાચવી રાખો
- વીમા કંપનીની ફરજના ભાગ પેટે દરખાસ્ત સ્વીકારવાની તારીખથી 30 દિવસની અંદર દરખાસ્ત ફૉર્મની નકલ નિઃશુલ્ક આપવી જરૂરી છે. તેથી કૃપયા વીમા પૉલિસીની સાથે એ મેળવી લો.
- જો પ્રીમિયમની ચુકવણી ચેક દ્વારા કરવામાં આવી હોય તો, કૃપયા ખાતરી કરી લો કે ચેક નોંધાયેલ વીમા કંપનીના નામે છે; અને ચુકવણીની રસીદ મેળવી લો
- કોઈ પણ વ્યક્તિગત નામે ચુકવણી કરશો નહીં; અથવા જો ચુકવણી રોકડેથી કરવામાં આવી હોય તો ખાતરી કરી લો કે પૂરતી ઓળખની ખાતરી કર્યા વગર ચુકવણી કરવામાં નથી આવી
- પૉલિસી દસ્તાવેજની ત્વરિત પ્રાપ્તિ માટે વીમા કંપની, એજન્ટ અથવા દલાલનો સંપર્ક કરવો.

5. જીવન વીમા પૉલિસી મુખ્યત્વે જીવન માટેની જોખમ સુરક્ષા પૂરી પાડે છે. પરંતુ એ લાંબા ગાળાના રોકાણ તરીકે પણ કામ આવી શકે છે અને સાથે એમાં લાંબા ગાળાની વચનબદ્ધતા સંકળાયેલી છે. જીવન વીમા પૉલિસી મેળવ્યા પછી નિમ્ન બાબતોની કાળજી રાખોઃ

- વીમા દસ્તાવેજ કાળજીપૂર્વક વાંચી જાઓ
- પ્રીમિયમ ચૂકવવાની રીત, તથા અવધિ, પાકની મુદતે મળવાપાત્ર લાભો, લૉક–ઈન પીરિયડ, સરેન્ડર વૅલ્યૂ વગેરે ચેક કરી લો.
- ખાતરી કરી લો કે વીમો ખરીદતી વખતે આપવામાં આવેલા વચન અને શરતોતેમ જપૉલિસી દસ્તાવેજ મુજબનાં નિયમો અને શરતો એ જ છે કે નહીં.
- જો આપ વીમા પૉલિસીમાં દર્શાવેલા નિયમો અને શરતો સાથે સંમત ના હો તો, આપના વિરોધનું કારણ જણાવીને વીમા કંપનીને પૉલિસી મળ્યાની તારીખથી 15 દિવસની અંદર પૉલિસી પરત કરી શકો છે. આપ પ્રમાણસર રિસ્ક પ્રીમિયમ, તબીબી પરીક્ષણ માટે વીમા કંપની દ્વારા કરવામાં આવેલા ખર્ચા, સ્ટૅમ્પ ચાર્જીસને કાપી લીધા પછી બાકીનું પ્રીમિયમ પાછું મેળવવાને હકદાર છો.
- પ્રીમિયમ નિયમિતપણે અને અચૂકપણે ચૂકવો; અને પૉલિસીને લૅપ્સ ના થઈ જવા દો.
- વીમા પૉલિસીનો અધિકતમ લાભ મેળવવા માટે કોઈ પણ બ્રેક કર્યા વિના પૉલિસી ચાલુ રાખો કારણ કે વીમા કવર માત્ર પ્રીમિયમની સમયસરની ચુકવણી પર જ ઉપલબ્ધ થશે.
- પરિવારના સભ્યોને અને ખાસ કરીને નિયુક્ત અનુગામીને વીમા પૉલિસીની ખરીદી કર્યાની જાણકારી આપો.

6. ઊંચાં રિટર્ન્સનું વચન આપતાં અથવા વીમા પૉલિસીઓના વેચાણ કે મોચનમાં સંકળાયેલા અયોગ્ય લાભો અથવા અન્ય આર્થિક ઉત્પાદનો વેચતા નકલી કૉલરો દ્વારા કરવામાં આવતી છેતરપિંડીભરી ઑફરોની લાલચમાં કદાપિ ના પડશો.

7. રોકાણ પર બોનસ અથવા નફો ઑફર કરતા, ઈરડાના નામે કૉલ કરતી વ્યક્તિનો વિશ્વાસ ના કરતા.
ઈરડા કોઈ પણ વીમો અથવા નાણાકીય ઉત્પાદનોના વેચાણમાં અથવા કોઈ પણ પ્રકારના વીમા કંપનીઓના પ્રીમિયમના રોકાણમાં સંકળાયેલી નથી.

8. જો કોઈ લાયસંસ વગરનો વચેટિયો અથવા રજિસ્ટર ના થયેલો વીમાકર્તા વીમો લેવાનો આગ્રહ કરે તોપોલિસમાં એફઆઈઆર નોંધાવો અને ઈરડાને આની જાણ કરો.
આવા લાયસંસ વગરના વચેટિયાઓ અથવા નોંધાયેલા ના હોય એવા વીમાકર્તાને કરવામાં આવેલી કોઈ ચુકવણી આપના જોખમે રહેશે.

અસ્વીકૃતિઃ આનો ઈરાદો આપને માત્ર સર્વસાધારણ જાણકારી પૂરી પાડવાનો છે અને આ સંપૂર્ણ નથી. આ શિક્ષણની પહેલ છે અને આપને કોઈ કાયદાની સલાહ આપવાનો ઈરાદો નથી.

ಇನ್ಶೂರೆನ್ಸ್ ರೆಗ್ಯುಲೇಟರಿ ಆ್ಯಂಡ್ ಡೆವಲಪ್‌ಮೆಂಟ್ ಆಥಾರಿಟಿ

INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY

ವಿಮೆಗೆ ಯಾವುದೇ ಎಣೆಯಿಲ್ಲ. ವಿಮೆಗೆ ಅತ್ಯಪೇಕ್ಷೆ, ವಿಮಾದಾರನಿಗೆ ರಕ್ಷಣೆ.

3ನೇ ಫ್ಲೋರ್, ಪರಿಶ್ರಮ ಭವನ, ಬಶೀರ್‌ಬಾಗ್, ಹೈದರಾಬಾದ್ - 500004

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ಯೋಗ್ಯ ಖರೀದಿಯ ಮೂಲಕ ವಿಮೆಯ ನೈಜ ಮೌಲ್ಯ

ಕೆಲವೊಂದು ಕಿವಿಮಾತುಗಳು

1. ಈ ಕೆಳಗಿನವರಿಂದ ಮಾತ್ರವೇ ವಿಮಾ ಪಾಲಿಸಿಗಳನ್ನು ಖರೀದಿಸಿರಿ:

- ನೋಂದಾಯಿತ ವಿಮಾ ಕಂಪನಿಗಳು.
- ಲೈಸೆನ್ಸ್ ಹೊಂದಿರುವ ವಿಮಾ ಏಜೆಂಟರು.
- ಲೈಸೆನ್ಸ್ ಹೊಂದಿರುವ ಇನ್ಶೂರೆನ್ಸ್ ಬ್ರೋಕರ್ಸ್ ಮತ್ತು ಕಾಮನ್ ಸರ್ವಿಸ್ ಸೆಂಟರ್ಸ್ (CSCs).
- ಲೈಸೆನ್ಸ್ ಹೊಂದಿರುವ ವೆಬ್ ಆಗ್ರಿಗೇಟರ್ಸ್.

2. ಯಾವುದೇ ಹಣ ಪಾವತಿಸುವ ಮೊದಲು ವ್ಯಕ್ತಿಯ ಮತ್ತು ಎಂಟಿಟಿಯ ಅಪ್ಪಟತನವನ್ನು ಪರಿಶೀಲಿಸಿರಿ.

- ವಿಮೆ ಕೊಡಿಸುತ್ತೇನೆಂದು ಹೇಳುವ ವ್ಯಕ್ತಿಯ/ಎಂಟಿಟಿಯ ಗುರುತಿನ ಪುರಾವೆಯನ್ನು ಕೇಳಿರಿ.
- ಸಂಬಂಧಿತ ವ್ಯಕ್ತಿ ಮತ್ತು ಎಂಟಿಟಿಯ ವಿಳಾಸದ ವಿವರಗಳನ್ನು ಹಾಗೂ ಟೆಲಿಫೋನ್ ನಂಬರನ್ನು ಕೇಳಿರಿ. ಟೆಲಿಫೋನ್ ಮೂಲಕದ ವ್ಯವಹಾರದಲ್ಲಿ ಇದು ಇನ್ನೂ ಹೆಚ್ಚು ಆಗತ್ಯ.
- ವಿಮಾ ಕಂಪನಿಗಳ, ಬ್ರೋಕರ್‌ಗಳ ಮತ್ತು ವೆಬ್ ಆಗ್ರಿಗೇಟರ್‌ಗಳ ವಿವರಗಳನ್ನು ಪರಿಶೀಲಿಸಲು ಐಆರ್‌ಡಿಎ ವೆಬ್‌ಸೈಟ್ ನೋಡಿರಿ.

3. ಈ ಕೆಳಗಿನವುಗಳನ್ನು ಆವಲಂಬಿಸಿ, ನಿಮಗೆ ಸೂಕ್ತವಾದ ವಿಮಾಪ್ರಾಡಕ್ಟನ್ನು ಆರಿಸಿಕೊಳ್ಳಿ :

- ಜೀವನದ ಹಂತ, ಆರ್ಥಿಕ ಸ್ಥಿತಿ ಮತ್ತು ಆರ್ಥಿಕ ಆವಶ್ಯಕತೆಗಳು.
- ಖರೀದಿಸಬಯಸುವ ಪಾಲಿಸಿಯ ಉದ್ದೇಶ –
  - ಜೀವದ ಆಥವಾ ಆಸ್ತಿಯ ವಿರುದ್ಧ ಆಪತ್ತಿನಿಂದ ರಕ್ಷಣೆಗಾಗಿ.
  - ದೀರ್ಘಕಾಲೀನ ಉಳಿತಾಯಕ್ಕಾಗಿ.
  - ಭವಿಷ್ಯದಲ್ಲಿ ಆಪ್ತೇ ದಾಖಲಾತಿಯ ಆವಶ್ಯಕತೆಗಳ ಪೂರೈಕೆಗಾಗಿ.
  - ಕಡ್ಡಾಯ ಆವಶ್ಯಕತೆಗಳ ಪೂರೈಕೆಗಾಗಿ.
  - ಇಳಿವಯಸ್ಸು /ಪೆನ್ಷನ್/ಯಾನ್ಯುಯಿಟಿಗಳಿಗಾಗಿ ಉಳಿತಾಯ.
- ಆಕ್ಸೂರ್ಡ್ ಮೊತ್ತ /ವಿಮಾಮೊತ್ತದ ತುಲನೆಯಲ್ಲಿ ನೀಡಲಾಗುವ ಸೌಲಭ್ಯಗಳು.
- ಕರಲಾಭಗಳು, ಲಭ್ಯವಿದ್ದಲ್ಲಿ.

4. ಯಾವುದೇ ವಿಮಾ ಪಾಲಿಸಿ ಖರೀದಿಸುವ ಮೊದಲು ಈ ಕೆಳಗಿನ ಕ್ರಮಗಳನ್ನು ಪಾಲಿಸಿರಿ:

- ಪ್ರಾಸ್ಪೆಕ್ಟಸ್ ಮತ್ತು ಪ್ರಪೋಸಲ್ ಫಾರ್ಮನ್ನು ಗಮನವಿಟ್ಟು ಓದಿರಿ.
- ಪ್ರಪೋಸಲ್ ಫಾರ್ಮ್‌ಗೆ ಸಹಿಮಾಡುವ ಮೊದಲು, ವಿವರಗಳನ್ನು ಪೂರ್ಣವಾಗಿ ತುಂಬಿರಿ.
- ನಿಮ್ಮ ಆವಗಾಹನೆಗಾಗಿ ಪ್ರಪೋಸಲ್ ಫಾರ್ಮ್‌ನ ಒಂದು ಪ್ರತಿಯನ್ನು ಇಟ್ಟುಕೊಳ್ಳಿ.
- ಪ್ರಪೋಸಲನ್ನು ಸ್ವೀಕರಿಸಿದ ನಂತರ 30 ದಿನಗಳೊಳಗೆ ಪ್ರಪೋಸಲ್ ಫಾರ್ಮ್‌ನ ಒಂದು ಪ್ರತಿಯನ್ನು ಯಾವುದೇ ಶುಲ್ಕವಿಲ್ಲದೆ ವಿಮಾಕಂಪನಿ ನಿಮಗೆ ನೀಡುವುದು ಆಗತ್ಯ. ವಿಮಾಪಾಲಿಸಿಯೊಂದಿಗೆ ದಯವಿಟ್ಟು ಇದನ್ನು ಕೂಡ ಪಡೆದುಕೊಳ್ಳಿ.
- ನೀವು ಚೆಕ್ಕಿನ ಮೂಲಕ ಪ್ರೀಮಿಯಮ್ ಪಾವತಿಸುವುದಾದಲ್ಲಿ, ಅದನ್ನು ನೋಂದಾಯಿತ ವಿಮಾಕಂಪನಿಯ ಹೆಸರಿಗೇ ಬರೆಯಿರಿ ಮತ್ತು ಆ ಹಣಪಾವತಿಗೆ ರಶೀತಿ ಪಡೆಯಿರಿ.
- ಯಾವುದೇ ವ್ಯಕ್ತಿಯ ಹೆಸರಲ್ಲಿ ಹಣ ಪಾವತಿಸಬೇಡಿ; ಆಥವಾ ನಗದು ಪಾವತಿಸುವುದಾದಲ್ಲಿ, ವ್ಯಕ್ತಿಯ ಪೂರ್ವೋತ್ತರಗಳನ್ನು ತಿಳಿದುಕೊಂಡ ನಂತರವೇ ಪಾವತಿಸಿರಿ.
- ಪಾಲಿಸಿಯನ್ನು ಕೂಡಲೇ ಪಡೆಯಲು, ವಿಮಾಕಂಪನಿಯೊಂದಿಗೆ ಆಥವಾ ಏಜೆಂಟ್/ಬ್ರೋಕರ್‌ರೊಂದಿಗೆ ಫಾಲೊ-ಆಪ್ ಮಾಡಿ.

5. ಜೀವವಿಮಾ ಪಾಲಿಸಿಯು ಮುಖ್ಯವಾಗಿ ಜೀವದ ಆಪತ್ತಿಗೆ ಪ್ರತಿಯಾಗಿ ವಿಮಾರಕ್ಷಣೆ ಒದಗಿಸುತ್ತದೆ. ಆದಾಗ್ಯೂ ಇದನ್ನು ದೀರ್ಘಕಾಲೀನ ವಿನಿಯೋಜನೆಯ ರೂಪದಲ್ಲಿ ಕೂಡ ಬಳಸಬಹುದಾಗಿದ್ದು, ಇದು ದೀರ್ಘಕಾಲೀನ ಬದ್ಧತೆಯನ್ನು ಬಯಸುತ್ತದೆ. ನಿಮಗೆ ಜೀವವಿಮಾ ಪಾಲಿಸಿ ದೊರೆತ ನಂತರ ಈ ಕೆಳಗಿನವುಗಳ ಬಗ್ಗೆ ನಿಗಾವಹಿಸಿರಿ:

- ಪಾಲಿಸಿ ಪ್ರಾಪೋಸಲ್‌ನ್ನು ಗಮನವಿಟ್ಟು ಓದಿರಿ.
- ಪ್ರೀಮಿಯಮ್ ಪಾವತಿ ವಿಧಾನ, ಪಾಲಿಸಿ ಕಾಲಾವಧಿ, ದೊರೆಯುವ ಪರಿಪಕ್ವತಾ ಸೌಲಭ್ಯಗಳು, ಲಾಕ್-ಇನ್ ಆವಧಿ, ಸರೆಂಡರ್ ಮೌಲ್ಯ ಮುಂತಾದವುಗಳನ್ನು ಪರೀಕ್ಷಿಸಿರಿ.
- ಪಾಲಿಸಿ ದಸ್ತಾವೇಜನಲ್ಲಿರುವ ನಿಬಂಧನೆಗಳು ಹಾಗೂ ಷರತ್ತುಗಳು, ಖರೀದಿ ಮಾಡುವಾಗ ಆಶ್ವಾಸನೆ ನೀಡಿರುವ ನಿಬಂಧನೆಗಳು ಹಾಗೂ ಷರತ್ತುಗಳೇ ಆಗಿವೆ ಎಂದು ಖಾತ್ರಿಪಡಿಸಿಕೊಳ್ಳಿ.
- ನಿಬಂಧನೆಗಳು ಹಾಗೂ ಷರತ್ತುಗಳು ನಿಮಗೆ ಒಪ್ಪಿಗೆ ಇಲ್ಲದಿದ್ದಲ್ಲಿ, ಪಾಲಿಸಿ ನಿಮಗೆ ದೊರೆತ 15 ದಿನಗಳೊಳಗೆ, ನಿಮ್ಮ ತಕರಾರುಗಳನ್ನು ನಮೂದಿಸಿ, ಪಾಲಿಸಿಯನ್ನು ವಿಮಾಕಂಪನಿಗೆ ಮರಳಿಸಿರಿ. ನೀವು ಪಾವತಿಸಿರುವ ಪ್ರೀಮಿಯಮ್ ಮೊತ್ತದಿಂದ, ಸೂಕ್ತ ಅನುಪಾತದಲ್ಲಿ ರಿಸ್ಕ್ ಪ್ರೀಮಿಯಮ್ ಮೊತ್ತ, ವೈದ್ಯಕೀಯ ಪರೀಕ್ಷಣೆಗಾಗಿ ವಿಮಾಕಂಪನಿ ವ್ಯಯಿಸಿರುವ ಮೊತ್ತ ಮತ್ತು ಸ್ಟಾಂಪ್ ಶುಲ್ಕಗಳನ್ನು ಕಳೆದು, ಬಾಕಿ ಮೊತ್ತವನ್ನು ಪಡೆಯುವ ಹಕ್ಕು ನಿಮಗಿದೆ.
- ಪ್ರೀಮಿಯಮ್‌ಗಳನ್ನು ನಿಯಮಿತವಾಗಿ ಮತ್ತು ಸಕಾಲಕ್ಕೆ ಕಟ್ಟಿರಿ; ಪಾಲಿಸಿ ಲ್ಯಾಪ್ಸ್ ಆಗಲು ಬಿಡಬೇಡಿ.
- ವಿಮಾ ಪಾಲಿಸಿಯಿಂದ ಗರಿಷ್ಠ ಪ್ರಯೋಜನ ಪಡೆಯಲು ವ್ಯತ್ಯಯವಿಲ್ಲದೆ ಪಾಲಿಸಿಯನ್ನು ಮುಂದುವರಿಸಿರಿ. ಏಕೆಂದರೆ, ಪ್ರೀಮಿಯಮ್ ಆನ್ನು ಸಕಾಲಕ್ಕೆ ಕಟ್ಟಿದರೆ ಮಾತ್ರವೇ ವಿಮಾರಕ್ಷಣೆ ದೊರೆಯುವುದು.
- ವಿಮಾ ಪಾಲಿಸಿ ಖರೀದಿಸಿರುವ ಬಗ್ಗೆ ಮತ್ತು ಅದರ ಸೌಲಭ್ಯಗಳ ಬಗ್ಗೆ, ಕುಟುಂಬದ ಸದಸ್ಯರಿಗೆ – ಅದರಲ್ಲೂ ಮುಖ್ಯವಾಗಿ ನಾಮ ನಿರ್ದೇತಿತ ವ್ಯಕ್ತಿಗೆ – ತಿಳಿಸಿರಿ.

6. ವಿಮಾ ಪಾಲಿಸಿಗಳು ಆಥವಾ ಇತರ ಆರ್ಥಿಕ ಪ್ರಾಡಕ್ಟ್‌ಗಳಿಗೆ ಸಂಬಂಧಪಟ್ಟಂತೆ, ಮಾರಾಟ ಆಥವಾ ರಿಡಂಪ್ಷನ್‌ನಿಂದ ಉಚ್ಚ ಪ್ರತಿಫಲ ಆಥವಾ ಆಪಾರ ಗಳಿಕೆ ದೊರೆಯುವುದೆಂದು, ಚಕಲಿ ಕರೆ ಮಾಡುವವರು ಆಶ್ವಾಸನೆ ನೀಡುವ ಮೋಸದ ಕೊಡುಗೆಗಳಿಗೆ ಎಂದೂ ಬಲಿಬೀಳದಿರಿ.

7. ವಿನಿಯೋಜನೆಯ ಮೇಲೆ ಬೋನಸ್ ಆಥವಾ ಲಾಭ ನೀಡುತ್ತೇವೆಂದು, ಐಆರ್‌ಡಿಎ ಹೆಸರಲ್ಲಿ ಮಾಡುವ ಕರೆಗಳಿಗೆ ಎಂದೂ ಬಲಿಬೀಳದಿರಿ.
ಯಾವುದೇ ಬಗೆಯ ವಿಮೆಯ ಆಥವಾ ಆರ್ಥಿಕ ಪ್ರಾಡಕ್ಟ್‌ಗಳ ಮಾರಾಟದಲ್ಲಿ ಆಥವಾ ವಿಮಾಕಂಪನಿಗಳ ಪ್ರೀಮಿಯಮ್‌ನ ವಿನಿಯೋಜನೆಯಲ್ಲಿ ಐಆರ್‌ಡಿಎ ಎಂದೂ ಒಳಗೊಳ್ಳುವುದಿಲ್ಲ.

8. ಯಾರೇ ಲೈಸೆನ್ಸ್‌ರಹಿತ ಮಧ್ಯಸ್ಥರು ಆಥವಾ ನೋಂದಾವಣೆರಹಿತ ವಿಮಾಕಂಪನಿಗಳು ವಿಮೆ ಕೊಡಿಸುತ್ತೇವೆಂದು ಹೇಳಿದಲ್ಲಿ, ಪೊಲೀಸರ ಬಳಿ ಎಫ್‌ಐಆರ್ ನೋಂದಾಯಿಸಿರಿ ಮತ್ತು ಐಆರ್‌ಡಿಎಗೆ ತಿಳಿಸಿರಿ.
ಇಂತಹ ಲೈಸೆನ್ಸ್‌ರಹಿತ ಮಧ್ಯಸ್ಥರಿಗೆ ಆಥವಾ ನೋಂದಾವಣೆರಹಿತ ವಿಮಾಕಂಪನಿಗಳಿಗೆ ನೀವು ಹಣ ಪಾವತಿಸಿದಲ್ಲಿ, ಅದಕ್ಕೆ ನೀವೇ ಬಾಧ್ಯಸ್ಥರು.

INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY

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योग्य प्रकारे खरेदी करून विम्याचं मोल मिळवा त्यासाठी काही सूचना

1. विम्याची पॉलिसी घेताना फक्त खालील पर्यायांची निवड करा:

- नोंदणीकृत विमा कंपनी
- नोंदणीकृत विमा प्रतिनिधी
- नोंदणीकृत इंशुरन्स ब्रोकर आणि कॉमन सर्व्हिस सेंटर्स (सीएससीज्)
- नोंदणीकृत वेब अॅग्रेगेटर्स

2. पैसे देण्याआधी पैसे घेणाऱ्या व्यक्तीचा आणि संस्थेचा खरेपणा तपासून घ्या

- विमा सेवा देणाऱ्या व्यक्तीचा/संस्थेचा ओळखीचा पुरावा मागा
- खास करुन टेलिसेल्सच्या बाबतीत त्या व्यक्तीचा आणि संबंधितसंस्थेचा पत्ता आणि टेलिफोन नंबर असा तपशील विचारा.
- आयआरडीए वेबसाइटवर जाऊन विमा कंपनी, ब्रोकर्स आणि वेब-अॅग्रेगेटर्सच्या तपशीलाची खात्री करा.

3. खालील गोष्टींच्या आधारे तुमच्यासाठी योग्य असलेलं विमा प्रॉडक्ट निवडा:

- जीवनातील काळ किंवा टप्पा, आर्थिक स्थिती आणि आर्थिक आवश्यकता
- पॉलिसी विकत घेण्याचा हेतू-
  - जीवन किंवा मालमत्तेच्या जोखीमेपासून विमा संरक्षण मिळवणे
  - दीर्घ काळासाठी बचत
  - भावी काळात इस्पितळात दाखल व्हावे लागले तर सोय होणे
  - विम्याची सक्ती पूर्ण करणे
  - वार्धक्य/पेंशन/वार्षिक मिळकत ह्यासाठी बचत
- विम्याची रक्कम/विमा यासाठी पुरेसा लाभ दिला जात आहे
- करमाफी, जर असेल तर.

4. विम्याची कोणतीही पॉलिसी विकत घेताना खालील गोष्टींची खात्री करा

- माहिती पुस्तिका आणि प्रपोजल फॉर्म काळजीपूर्वक वाचा
- प्रपोजल फॉर्मवर सही करण्याआधी विचारलेला तपशील पूर्ण लिहा
- तुमच्या माहितीसाठी प्रपोजल फॉर्मची प्रत जपून ठेवा
- प्रपोजल स्वीकारल्यानंतर 30 दिवसांच्या आधी प्रपोजल फॉर्मची मोफत प्रत देणे ही विमादात्याची जबाबदारी आहे. कृपया विम्याची पॉलिसी घेताना ती प्रतही घ्या.
- जर चेकद्वारे हप्ता भरला तर कृपया तो नोंदणीकृत विमा कंपनीच्या नावे असल्याची खात्री करा; आणि पैसे भरल्याची पावती घ्या
- कोणत्याही व्यक्तीच्या नावे पैसे भरू नका; किंवा रोख पैसे भरताना सदर व्यक्तीकडे अधिकारपत्र असल्याची खात्री करा.
- विमादाता किंवा प्रतिनिधी/ब्रोकर ह्यांच्याकडून पॉलिसी कागदपत्रांची पावती येण्यासाठी त्यांना संपर्क करत राहा.

5. जीवन विमा पॉलिसीमध्ये प्रामुख्याने जीवनाच्या जोखीमेसाठी विमा संरक्षण दिलं जातं. पण दीर्घ काळासाठी गुंतवणूक करण्यासाठी आणि बांधिलकी पाळण्यासाठी तिचा उपयोग करता येतो. जीवन विमा पॉलिसी प्राप्त झाल्यानंतर खालील गोष्टींची काळजी घ्या:

- पॉलिसीची कागदपत्रे काळजीपूर्वक वाचा
- हप्ता भरण्याचे पर्याय, पॉलिसीची मुदत, मुदतपूर्तता लाभ, लॉक इन कालावधी, सरेंडर मूल्य इत्यादी पहा.
- पॉलिसी खरेदी करतेवेळी सांगितलेल्या अटी आणि नियम पॉलिसी कागदपत्रासमान असल्याची खात्री करा.
- जर तुम्हाला अटी आणि नियम मान्य नसतील तर विमादात्याला पॉलिसीच्या पावतीपासून 15 दिवसांच्या आधी पॉलिसी परत द्या आणि पॉलिसी न स्वीकारण्याचं कारण सांगा. प्रमाणानुसार जोखिमेचा प्रीमियम, वैद्यकीय तपासणीसाठी विमादात्याने केलेला खर्च, स्टँप शुल्क वजा करून तुम्ही भरलेला हप्ता परत मिळवण्यासाठी पात्र आहात.
- हप्ते नियमित आणि वेळेवर भरा; आणि पॉलिसी लॅप्स होऊ देऊ नका
- विमा संरक्षण फक्त हप्ते वेळेवर भरल्यामुळेच मिळतं. म्हणून पॉलिसी न थांबता चालू राहू द्या आणि पॉलिसीतून जास्त मोल मिळवा.
- विमा पॉलिसी खरेदी केल्याची माहिती कुटुंबियांना तपशीलवार सांगा. खास करुन पॉलिसीच्या वारसदाराला मिळणारे लाभ सांगा.

6. संशयास्पद कॉलर्सने जास्त परताव्यांची ऑफर दिली किंवा विक्रीतून अकारण लाभ अथवा विमा पॉलिसीचा मोबदला किंवा इतर आर्थिक उत्पादनांची बनावट ऑफर दिली तर त्याला बळी पडू नका

7. आयआरडीए चं नाव घेऊन कोणी संपर्क केला आणि गुंतवणुकीवर बोनस किंवा फायदा देण्याची तयारी दाखवली तर त्याला बळी पडू नका.
आयआरडीए कोणत्याही प्रकारचा विमा किंवा आर्थिक उत्पादने अथवा विमा कंपनीमध्ये हप्त्यांच्या स्वरूपात गुंतवणूक करण्याचं काम करत नाही.

8. जर एखाद्या लायसन्स नसलेल्या उपकंपनीने किंवा नोंदणी नसलेल्या विमादात्याने विमा देण्याचा प्रयत्न केला तर पोलिसांकडे एफआयआर दाखल करा आणि आयआरडीएला कळवा.
अशा लायसन्स नसलेल्या उपकंपनी किंवा नोंदणी नसलेल्या विमादात्याकडे हप्ता भरला तर ती तुमची जबाबदारी राहील.

अस्वीकृती: ह्यातून तुम्हाला फक्त सामान्य माहिती देण्याचा हेतू आहे आणि ती परिपूर्ण नाही. हा शिक्षणाचा उपक्रम आहे आणि ह्यातून कोणताही कायदेशीर सल्ला दिला जात नाही.

ବୀମା ବିନିୟାମକ ଏବଂ ବିକାଶ ପ୍ରାଧିକରଣ
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ସଠିକ୍ କ୍ରୟ ମାଧ୍ୟମରେ ବୀମାର ପ୍ରକୃତ ମୂଲ୍ୟ ନିର୍ଦ୍ଧାରଣ କରିବାର କେତେଗୁଡ଼ିଏ ଟିପ୍ସ୍

1. ନିଶ୍ଚିତ କରନ୍ତୁ ଯେ ଆପଣ କେବଳ ନିମ୍ନଲିଖିତରୁ ବୀମା ପଲିସିଗୁଡ଼ିକୁ କିଣନ୍ତି :
- ରେଜିଷ୍ଟର୍ଡ ବୀମା କମ୍ପାନୀ
- ଲାଇସେନ୍ସ୍ ପ୍ରାପ୍ତ ବୀମା ଏଜେଣ୍ଟସ୍
- ଲାଇସେନ୍ସ୍ ପ୍ରାପ୍ତ ବୀମା ବ୍ରୋକର୍ସ ଏବଂ କମନ୍ ସର୍ଭିସ୍ ସେଣ୍ଟର୍ସଗୁଡ଼ିକ (ସିଏସ୍‌ସିଗୁଡ଼ିକ) ଅର୍ଥାତ୍ ସାଧାରଣ ସେବା କେନ୍ଦ୍ରଗୁଡ଼ିକ
- ଲାଇସେନ୍ସ୍ ପ୍ରାପ୍ତ ୱେବ୍ ଏଗ୍ରିଗେଟର୍ସ

2. କୌଣସି ଟଙ୍କା ଦେବା ପୂର୍ବରୁ ବ୍ୟକ୍ତି ଏବଂ ସଂସ୍ଥାର ଅସଲପଣିଆ ଯାଞ୍ଚ କରନ୍ତୁ :
- ବୀମା ଯାଚନା କରୁଥିବା ବ୍ୟକ୍ତି/ସଂସ୍ଥାର ପରିଚୟ ପ୍ରମାଣ ମାଗନ୍ତୁ
- ବିଶେଷ କରି ଟେଲିସେଲ୍ସ୍ କ୍ଷେତ୍ରରେ, ବ୍ୟକ୍ତି ଏବଂ ସଂସ୍ଥାର ଠିକଣା ଏବଂ ଟେଲିଫୋନ୍ ନମ୍ବରର ବିବରଣୀ ମାଗନ୍ତୁ
- ବୀମା କମ୍ପାନୀ, ବ୍ରୋକର୍ ଏବଂ ୱେବ୍-ଏଗ୍ରିଗେଟରମାନଙ୍କର ବିବରଣୀ ସତ୍ୟାପିତ କରିବା ପାଇଁ ଆଇଆରଡିଏର ୱେବସାଇଟ୍‌କୁ ଯାଞ୍ଚ କରନ୍ତୁ

3. ନିମ୍ନଲିଖିତ ଉପରେ ଆଧାରିତ କରି ଆପଣଙ୍କ ପାଇଁ ଉପଯୁକ୍ତ ବୀମା ଉତ୍ପାଦର ଚୟନ କରନ୍ତୁ :
- ଜୀବନ ଅବସ୍ଥା, ଆର୍ଥିକ ସ୍ଥିତି ଏବଂ ଆର୍ଥିକ ଆବଶ୍ୟକତା
- କିଣିବାକୁ ଥିବା ପଲିସିର ଉଦ୍ଦେଶ୍ୟ –
  - ଜୀବନ କିମ୍ବା ସମ୍ପତ୍ତି ପ୍ରତି ବିପଦ ବିରୁଦ୍ଧରେ ବୀମିତ କରିବା ପାଇଁ
  - ଦୀର୍ଘ-ଅବଧି ସଞ୍ଚୟ ବାବଦରେ
  - ଭବିଷ୍ୟତରେ ହସ୍ପିଟାଲ ଖର୍ଚ୍ଚର ଆବଶ୍ୟକତାର ଯତ୍ନ ନେବା ପାଇଁ
  - ଅନିବାର୍ଯ୍ୟ ଆବଶ୍ୟକତାଗୁଡ଼ିକୁ ପୂରା କରିବା ପାଇଁ
  - ବୃଦ୍ଧାବସ୍ଥା/ପେନ୍‌ସନ୍/ବାର୍ଷିକୀ ପାଇଁ ସଞ୍ଚୟ କରିବାକୁ
- ଆଶ୍ୱାସିତ ରାଶି/ବୀମିତ ରାଶିର ପର୍ଯ୍ୟାପ୍ତତା ସମ୍ବନ୍ଧରେ ଅର୍ପିତ ଲାଭଗୁଡ଼ିକ
- ଇନକମ ଟେକ୍ସ ରିହାତି

4. କୌଣସି ବୀମା ପଲିସି କିଣିବା ବେଳେ, ନିମ୍ନଲିଖିତକୁ ନିଶ୍ଚିତ କରନ୍ତୁ
- ପ୍ରୋସପେକ୍ଟସ୍ ଏବଂ ପ୍ରସ୍ତାବ ପତ୍ରକୁ ଯତ୍ନ ସହକାରେ ପଢନ୍ତୁ
- ପ୍ରସ୍ତାବ ପତ୍ର ଉପରେ ଦସ୍ତଖତ କରିବା ପୂର୍ବରୁ ବିବରଣୀଗୁଡ଼ିକୁ ସମ୍ପୂର୍ଣ୍ଣ ରୂପେ ଭରି କରନ୍ତୁ
- ଭବିଷ୍ୟତ ସନ୍ଦର୍ଭ ପାଇଁ ପ୍ରସ୍ତାବ ପତ୍ରର ଏକ ପ୍ରତିଲିପିକୁ ନିଜ ପାଖରେ ରଖନ୍ତୁ
- ପ୍ରସ୍ତାବ ସ୍ୱୀକୃତିର 30 ଦିନ ଭିତରେ ପ୍ରସ୍ତାବ ପତ୍ରର ଏକ ପ୍ରତିଲିପି ଦେବା ହେଉଛି ବୀମାକର୍ତ୍ତାଙ୍କ କର୍ତ୍ତବ୍ୟ । ଦୟାକରି ବୀମା ପଲିସି ସହ ତାକୁ ସଂଗ୍ରହ କରନ୍ତୁ ।
- ଯଦି ପ୍ରିମିୟମ୍ ଚେକ୍ ଦ୍ୱାରା ପରିଶୋଧ କରାଯାଉଥାଏ, ଦୟାକରି ନିଶ୍ଚିତ କରନ୍ତୁ ଯେ ଏହା ରେଜିଷ୍ଟର୍ଡ ବୀମା କମ୍ପାନୀର ନାଁ'ରେ କରାଯାଇଛି ଏବଂ ଆପଣ ପଇଠର ରସିଦ୍ ପ୍ରାପ୍ତ କରନ୍ତୁ ।
- କୌଣସି ବ୍ୟକ୍ତିଙ୍କ ନାମରେ ପଇଠ କରନ୍ତୁ ନାହିଁ କିମ୍ବା ଯଦି ପଇଠ ନଗଦରେ କରାଯାଉଥାଏ, ନିଶ୍ଚିତ କରନ୍ତୁ ଯେପରି ଏହା ପରିଚୟ ପ୍ରମାଣ ବିନା କରାନଯାଏ ।
- ଶୀଘ୍ର ପଲିସି ଦଲିଲ୍ ପାଇବା ପାଇଁ ବୀମା କମ୍ପାନୀ କିମ୍ବା ଏଜେଣ୍ଟ /ବ୍ରୋକରଙ୍କୁ ଯୋଗାଯୋଗ କରନ୍ତୁ ।

5. ଜୀବନ ବୀମା ମୁଖ୍ୟତଃ ଜୀବନ ପାଇଁ ଥିବା ବିପଦ ଉପରେ ଉପଲବ୍ଧ କରାଏ । ମାତ୍ର ଏହା ଦୀର୍ଘ ଅବଧି ନିବେଶ ପାଇଁ ଏକ ଉପକରଣ ରୂପରେ ମଧ୍ୟ ସେବା କରିପାରିବ ଏବଂ ଦୀର୍ଘକାଳୀନ ପ୍ରତିବଦ୍ଧତା ମଧ୍ୟ ଜଡ଼ିତ କରିପାରିବ । ଜୀବନ ବୀମା ପଲିସି ପାଇବା ପରେ ନିମ୍ନଲିଖିତର ଯତ୍ନ ନିଅନ୍ତୁ ।
- ପଲିସି ଦଲିଲ୍‌କୁ ଯତ୍ନ ସହକାରେ ପଢନ୍ତୁ ।
- ପ୍ରିମିୟମ ପଇଠର ଉପାୟ, ପଲିସିର ଅବଧି, ଦିଆଯାଉଥିବା ପରିପକ୍ୱତା ଲାଭ, ଲକ୍-ଇନ୍ ଅବଧି, ସମର୍ପଣ ମୂଲ୍ୟ ଇତ୍ୟାଦିକୁ ଯାଞ୍ଚ କରନ୍ତୁ ।
- ନିଶ୍ଚିତ କରନ୍ତୁ ଯେ ପଲିସି ଦଲିଲ୍‌ରେ ଦିଆଯାଇଥିବା ନିୟମ ଏବଂ ସର୍ତ୍ତାବଳୀ , କ୍ରୟ ସମୟରେ ପ୍ରତିଶ୍ରୁତି ଦିଆଯାଇଥିବା ସହ ସମାନ ।
- ଯଦି ଆପଣ ନିୟମ ଏବଂ ସର୍ତ୍ତାବଳୀ ସହ ଏକମତ ନହୁଅନ୍ତି, ତେବେ ପ୍ରତିବାଦର କାରଣ ଦର୍ଶାଇ ପଲିସି ପାଇବାର 15 ଦିନ ଭିତରେ ବୀମାକର୍ତ୍ତାଙ୍କୁ ପଲିସି ଫେରାଇ ଦିଅନ୍ତୁ । ଆନୁପାତିକ ବିପଦ ପ୍ରିମିୟମ, ଡାକ୍ତରୀ ଯାଞ୍ଚରେ ବୀମାକର୍ତ୍ତାଙ୍କ ଦ୍ୱାରା ଖର୍ଚ୍ଚ କରାଯାଇଥିବା ରାଶି ଏବଂ ଷ୍ଟାମ୍ପ ଶୁଳ୍କ କାଟିବା ପରେ ପଇଠ କରାଯାଇଥିବା ରାଶି ଫେରସ୍ତ ପାଇବା ପାଇଁ ଆପଣ ହକଦାର ।
- ନିୟମିତ ଭାବେ ଏବଂ ତୁରନ୍ତ ପ୍ରିମିୟମ୍ ପଇଠ କରନ୍ତୁ ଏବଂ ପଲିସିକୁ ଲାପ୍ସ ହେବାକୁ ଦିଅନ୍ତୁ ନାହିଁ ।
- ଯେହେତୁ କେବଳ ଠିକ୍ ସମୟରେ ପ୍ରିମିୟମ୍ ପଇଠ କଲେହିଁ ବୀମା ଏବଂ ବୀମା ପଲିସିରୁ ମିଳୁଥିବା ଲାଭ ଉପଲବ୍ଧ ହେବ ତେଣୁ ବୀମା ପଲିସିରୁ ସର୍ବାଧିକ ଲାଭ ପାଇବା ପାଇଁ କୌଣସି ବ୍ୟତିକ୍ରମ ବିନା ପଲିସିକୁ ଜାରି ରଖନ୍ତୁ ।
- ବୀମା ପଲିସିର କ୍ରୟ ଏବଂ ଏହାର ଲାଭ ବିଷୟରେ ପରିବାରବର୍ଗଙ୍କୁ ସୂଚିତ କରନ୍ତୁ, ବିଶେଷ କରି ନାମାଙ୍କିତଙ୍କୁ ।

6. ବୀମା ପଲିସି କିମ୍ବା ଅନ୍ୟାନ୍ୟ ବିତ୍ତୀୟ ଉତ୍ପାଦର ବିକ୍ରୟ କିମ୍ବା ବିମୋଚନ ସହ ଜଡ଼ିତ ଉଚ୍ଚ ରିଟର୍ଣ୍ଣ କିମ୍ବା ଅନୁଚିତ ଲାଭର ପ୍ରତିଶ୍ରୁତି ଦେଇ **ନକଲି ଫୋନ୍‌କଲ୍ସ୍ କରୁଥିବା ଲୋକଙ୍କ ଅଫରର ଶିକାର କଦାପି ହୁଅନ୍ତୁ ନାହିଁ ।**

7. **ନିବେଶ ଉପରେ ବୋନସ୍ କିମ୍ବା ଲାଭ ଅଫର୍ କରି ଆଇଆରଡିଏ ନାମରେ କରାଯାଉଥିବା ଫୋନ୍ କଲ୍‌ଗୁଡ଼ିକର ଶିକାର କଦାପି ହୁଅନ୍ତୁ ନାହିଁ ।** କୌଣସି ପ୍ରକାରର ବୀମା କିମ୍ବା ବିତ୍ତୀୟ ଉତ୍ପାଦର ବିକ୍ରୟରେ କିମ୍ବା ବୀମା କମ୍ପାନୀଗୁଡ଼ିକର ପ୍ରିମିୟମ୍‌ରେ ନିବେଶ କରିବାରେ ଆଇଆରଡିଏ ଜଡ଼ିତ ହୁଏନି ନାହିଁ ।

8. **ଯଦି କୌଣସି ଲାଇସେନ୍ସ୍ ନଥିବା ମଧ୍ୟସ୍ଥ କିମ୍ବା ରେଜିଷ୍ଟର୍ଡ ହୋଇନଥିବା ବୀମାକର୍ତ୍ତା ବୀମା ଯାଚନା କରନ୍ତି, ତେବେ ସଙ୍ଗେସଙ୍ଗେ ପୋଲିସ୍ ନିକଟରେ ଏଫ୍‌ଆଇଆର୍ ଦାଖଲ କରନ୍ତୁ ଏବଂ ଆଇଆରଡିଏକୁ ସୂଚିତ କରନ୍ତୁ ।** ଏପରି ଲାଇସେନ୍ସ୍ ନଥିବା ମଧ୍ୟସ୍ଥ କିମ୍ବା ରେଜିଷ୍ଟର୍ଡ ହୋଇନଥିବା ବୀମାକର୍ତ୍ତାଙ୍କୁ କରାଯାଇଥିବା ପଇଠ ପାଇଁ ଆପଣ ସ୍ୱୟଂ ଦାୟୀ ହେବେ ।

ଅସ୍ୱୀକାରୋକ୍ତି : ଏହାର ଉଦ୍ଦେଶ୍ୟ ହେଲା ଆପଣଙ୍କୁ କେବଳ ସାଧାରଣ ସୂଚନା ଦେବା ଏବଂ ଏହା ସମ୍ପୂର୍ଣ୍ଣ ନୁହେଁ । ଏହା ହେଉଛି ଏକ ଶିକ୍ଷା ଉପକ୍ରମ ଏବଂ ଆପଣଙ୍କୁ କୌଣସି ଆଇନ୍ ଉପଦେଶ ଦେବା ପାଇଁ ଏହା ଉଦ୍ଦିଷ୍ଟ ନୁହେଁ ।

ਇੰਸ਼ਿਉਰੈਂਸ ਰੈਗੂਲੇਟਰੀ ਐਂਡ ਡਿਵੈਲਪਮੈਂਟ ਅੋਥਾਰਿਟੀ

INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY

ਬੀਮੇ ਨੂੰ ਉਤਸ਼ਾਹ। ਬੀਮੇਦਾਰ ਦੀ ਸੁਰੱਖਿਆ।

ਪਰਿਸ਼ਰਮ ਭਵਨ, ਬਸ਼ੀਰਬਾਗ਼, ਹੈਦਰਾਬਾਦ-500004
www.irda.gov.in www.policyholder.gov.in

ਸਹੀ ਖ਼ਰੀਦਾਰੀ ਰਾਹੀਂ ਬੀਮੇ ਦੀ ਅਸਲੀ ਕੀਮਤ ਕੁਝ ਨੁਸਖੇ

1. ਇਹ ਵੇਖ ਲਓ ਕਿ ਤੁਸੀਂ ਕੇਵਲ ਹੇਠਾਂ ਲਿਖਿਆਂ ਤੋਂ ਹੀ ਬੀਮਾ ਪਾਲਿਸੀਆਂ ਖ਼ਰੀਦਦੇ ਹੋ :

- ਰਜਿਸਟਰਡ ਬੀਮਾ ਕੰਪਨੀਆਂ
- ਲਇਸੰਸਦਾਰ ਬੀਮਾ ਏਜੰਟਾਂ
- ਲਇਸੰਸਦਾਰ ਬੀਮਾ ਬ੍ਰੋਕਰ ਅਤੇ ਸਾਂਝੇ ਸੇਵਾ ਕੇਂਦਰ (ਸੀਐਸਸੀ)
- ਲਇਸੰਸਦਾਰ ਵੈੱਬ ਐਗ੍ਰੀਗੇਟਰ

2. ਕੋਈ ਵੀ ਅਦਾਇਗੀ ਕਰਨ ਤੋਂ ਪਹਿਲਾਂ ਵਿਅਕਤੀ ਅਤੇ ਸੰਸਥਾ ਦੀ ਪ੍ਰਮਾਣਕਤਾ ਦੀ ਜਾਂਚ ਕਰ ਲਓ।

- ਬੀਮੇ ਲਈ ਜ਼ੋਰ ਪਾਉਣ ਵਾਲੇ ਵਿਅਕਤੀ/ਸੰਸਥਾ ਨੂੰ ਉਸ ਦੀ ਪਛਾਣ ਦਾ ਸਬੂਤ ਦੇਣ ਲਈ ਕਹੋ
- ਸਬੰਧਿਤ ਵਿਅਕਤੀ ਅਤੇ ਸੰਸਥਾ ਨੂੰ ਉਸ ਦੇ ਪਤੇ ਦੇ ਵੇਰਵੇ ਅਤੇ ਫ਼ੋਨ ਨੰਬਰ ਦੇਣ ਲਈ ਕਹੋ, ਖ਼ਾਸ ਕਰਕੇ ਟੈਲੀਸੇਲਜ਼ ਦੇ ਮਾਮਲੇ ਵਿੱਚ
- ਬੀਮਾ ਕੰਪਨੀਆਂ, ਬ੍ਰੋਕਰਾਂ ਅਤੇ ਵੈੱਬ ਐਗ੍ਰੀਗੇਟਰਾਂ ਦੇ ਵੇਰਵਿਆਂ ਦੀ ਜਾਂਚ ਲਈ ਆਈਆਰਡੀਏ ਦੀ ਵੈੱਬਸਾਈਟ ਵੇਖੋ

3. ਹੇਠਾਂ ਲਿਖਿਆਂ ਦੇ ਆਧਾਰ ਉੱਤੇ ਆਪਣੇ ਲਈ ਢੁੱਕਵੀਂ ਬੀਮਾ ਪਾਲਿਸੀ ਚੁਣੋ:

- ਉਮਰ ਦਾ ਪੜਾ, ਆਰਥਿਕ ਹਾਲਤ ਅਤੇ ਆਰਥਿਕ ਲੋੜਾਂ
- ਖ਼ਰੀਦੀ ਜਾਣ ਵਾਲੀ ਪਾਲਿਸੀ ਦੀ ਖ਼ਰੀਦਾਰੀ ਇਹਨਾਂ ਮਕਸਦਾਂ ਲਈ ਕਰੋ–
  - ਜੀਵਨ ਜਾਂ ਜਾਇਦਾਦ ਲਈ ਜੋਖਮ ਤੋਂ ਬੀਮਾ ਕਰਵਾਉਣ ਲਈ
  - ਲੰਬੇ ਸਮੇਂ ਦੀ ਬੱਚਤ ਲਈ
  - ਭਵਿੱਖ ਵਿੱਚ ਹਸਪਤਾਲ ਦੀਆਂ ਜ਼ਰੂਰਤਾਂ ਨਾਲ ਨਿਪਟਣ ਲਈ
  - ਲਾਜ਼ਮੀ ਜ਼ਰੂਰਤਾਂ ਪੂਰੀਆਂ ਕਰਨ ਲਈ
  - ਬੁਢਾਪੇ ਲਈ ਬੱਚਤ ਕਰਨ/ਪੈਨਸ਼ਨ/ਅਨਿਊਇਟੀ ਲਈ
- ਉਚਿਤ ਬੀਮੇ ਦੀ ਰਕਮ/ਬੀਮੇ ਦੀ ਰਕਮ ਦੇ ਰੂਪ ਵਿੱਚ ਪੇਸ਼ ਲਾਭ
- ਕਰ ਲਾਭ, ਜੇ ਮੁਹਈਆ ਹੋਣ

4. ਕੋਈ ਵੀ ਬੀਮਾ ਪਾਲਿਸੀ ਖ਼ਰੀਦਣ ਵੇਲੇ ਹੇਠਾਂ ਲਿਖੇ ਕੰਮ ਜ਼ਰੂਰ ਕਰੋ

- ਪ੍ਰਾਸਪੈਕਟਸ ਅਤੇ ਪ੍ਰਸਤਾਵ ਫ਼ਾਰਮ ਧਿਆਨ ਨਾਲ ਪੜ੍ਹੋ
- ਪ੍ਰਸਤਾਵ ਫ਼ਾਰਮ ਉੱਤੇ ਦਸਤਖ਼ਤ ਕਰਨ ਤੋਂ ਪਹਿਲਾਂ ਵੇਰਵੇ ਪੂਰੀ ਤਰ੍ਹਾਂ ਭਰ ਲਓ
- ਤੁਰੰਤ ਪ੍ਰਮਾਣ ਲਈ ਪ੍ਰਸਤਾਵ ਫ਼ਾਰਮ ਦੀ ਨਕਲ ਸੰਭਾਲ ਕੇ ਰੱਖੋ।
- ਬੀਮਾਕਰਤਾ ਦਾ ਇਹ ਫ਼ਰਜ਼ ਹੈ ਕਿ ਉਹ ਪ੍ਰਸਤਾਵ ਸਵੀਕਾਰ ਕਰਨ ਦੇ 30 ਦਿਨਾਂ ਅੰਦਰ ਪ੍ਰਸਤਾਵ ਫ਼ਾਰਮ ਦੀ ਇਕ ਨਕਲ ਮੁਫ਼ਤ ਮੁਹਈਆ ਕਰਾਵੇ। ਕਿਰਪਾ ਕਰਕੇ ਬੀਮਾ ਪਾਲਸੀ ਦੇ ਨਾਲ ਇਹ ਵੀ ਲੈ ਲਓ
- ਜੇਕਰ ਪ੍ਰੀਮੀਅਮ ਚੈੱਕ ਰਾਹੀਂ ਭਰਿਆ ਗਿਆ ਹੈ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਇਹ ਵੇਖ ਲਓ ਕਿ ਇਹ ਰਜਿਸਟਰਡ ਬੀਮਾ ਕੰਪਨੀ ਦੇ ਨਾਂ ਤੇ ਹੈਵੇ; ਅਤੇ ਅਦਾਇਗੀ ਦੀ ਰਸੀਦ ਲੈ ਲਓ
- ਕਿਸੇ ਵੀ ਵਿਅਕਤੀ ਦੇ ਨਾਂ ਤੇ ਅਦਾਇਗੀ ਨਾ ਕਰੋ; ਜਾਂ ਜੇਕਰ ਨਕਦ ਅਦਾਇਗੀ ਕੀਤੀ ਜਾਂਦੀ ਹੈ, ਤਾਂ ਇਹ ਉਸ ਦੇ ਪਿਛੋਕੜ ਬਾਰੇ ਪਤਾ ਲਗਾਉਣ ਤੋਂ ਬਿਨਾਂ ਨਾ ਹੋਵੇ
- ਤੁਰੰਤ ਪਾਲਿਸੀ ਦਸਤਾਵੇਜ਼ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਬੀਮਾਕਰਤਾ ਜਾਂ ਏਜੰਟ/ਬ੍ਰੋਕਰ ਦੀ ਪੈਰਵੀ ਕਰੋ

5. ਜੀਵਨ ਬੀਮਾ ਪਾਲਿਸੀ ਮੁੱਖ ਤੌਰ ਤੇ ਜੀਵਨ ਲਈ ਬੀਮਾ ਸੁਰੱਖਿਆ ਮੁੱਹਈਆ ਕਰਦੀ ਹੈ। ਪਰ ਇਹ ਲੰਬੇ ਸਮੇਂ ਦੇ ਨਿਵੇਸ਼ ਲਈ ਸਾਧਨ ਦੇ ਤੌਰ ਤੇ ਵੀ ਲਾਭਕਾਰੀ ਹੋ ਸਕਦੀ ਹੈ ਅਤੇ ਇਸ ਵਿੱਚ ਲੰਬੇ ਸਮੇਂ ਦਾ ਵਾਅਦਾ ਹੈ। ਜੀਵਨ ਬੀਮਾ ਪਾਲਿਸੀ ਪ੍ਰਾਪਤ ਕਰਨ ਤੋਂ ਬਾਅਦ ਹੇਠਾਂ ਲਿਖੀਆਂ ਗੱਲਾਂ ਦਾ ਧਿਆਨ ਰੱਖੋ:

- ਪਾਲਿਸੀ ਦਸਤਾਵੇਜ਼ ਧਿਆਨ ਨਾਲ ਪੜ੍ਹੋ
- ਪ੍ਰੀਮੀਅਮ ਭਰਨ ਦਾ ਤਰੀਕਾ, ਪਾਲਿਸੀ ਦੀ ਮਿਆਦ, ਮਿਆਦ ਪੂਰੀ ਹੋਣ ਤੇ ਹੱਥ ਆਉਣ ਵਾਲੇ ਲਾਭ, ਲੌਕ-ਇਨ ਸਮਾਂ, ਸਮਰਪਣ ਮੁੱਲ ਆਦਿ ਦੀ ਜਾਂਚ ਕਰੋ
- ਇਹ ਵੇਖ ਲਓ ਕਿ ਪਾਲਸੀ ਦਸਤਾਵੇਜ਼ ਅਨੁਸਾਰ ਨਿਯਮ ਅਤੇ ਸ਼ਰਤਾਂ ਉਹੀ ਹੋਣ, ਜਿਹਨਾਂ ਦਾ ਵਾਅਦਾ ਬੀਮਾ ਲੈਣ ਵੇਲੇ ਕੀਤਾ ਗਿਆ ਸੀ।
- ਜੇਕਰ ਤੁਸੀਂ ਨਿਯਮਾਂ ਅਤੇ ਸ਼ਰਤਾਂ ਨਾਲ ਸਹਿਮਤ ਨਹੀਂ ਹੋ, ਤਾਂ ਪਾਲਸੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦੀ ਮਿਤੀ ਦੇ 15 ਦਿਨਾਂ ਅੰਦਰ ਇਤਰਾਜ਼ਾਂ ਦਾ ਕਾਰਨ ਦੱਸ ਕੇ ਬੀਮਾਕਰਤਾ ਨੂੰ ਪਾਲਿਸੀ ਮੋੜ ਦਿਓ। ਤੁਸੀਂ ਅਨੁਪਾਤ ਅਨੁਸਾਰ ਜੋਖਮ ਪ੍ਰੀਮੀਅਮ, ਬੀਮਾਕਰਤਾ ਦੁਆਰਾ ਡਾਕਟਰੀ ਮੁਆਇਨੇ ਲਈ ਕੀਤੇ ਖ਼ਰਚੇ, ਅਸ਼ਟਾਮ ਦੇ ਖ਼ਰਚੇ ਕੱਟਣ ਬਾਅਦ ਭਰਿਆ ਪ੍ਰੀਮੀਅਮ ਵਾਪਸ ਲੈਣ ਦੇ ਹੱਕਦਾਰ ਹੋ।
- ਪ੍ਰੀਮੀਅਮ ਬਕਾਇਦਾ ਅਤੇ ਤੁਰਤ-ਫੁਰਤ ਭਰੋ; ਅਤੇ ਪਾਲਿਸੀ ਲੈਪਸ ਨਾ ਹੋਣ ਦਿਓ।
- ਬੀਮਾ ਪਾਲਿਸੀ ਦਾ ਵੱਧ ਤੋਂ ਵੱਧ ਮੁੱਲ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਬਿਨਾਂ ਰੁਕਾਵਟ ਪਾਲਿਸੀ ਜਾਰੀ ਰੱਖੋ, ਕਿਉਂਕਿ ਬੀਮਾ ਸੁਰੱਖਿਆ ਕੇਵਲ ਸਮੇਂ ਸਿਰ ਪ੍ਰੀਮੀਅਮ ਭਰਨ ਤੇ ਹੀ ਮਿਲੇਗੀ।
- ਬੀਮਾ ਪਾਲਿਸੀ ਲੈਣ ਅਤੇ ਇਸਦੇ ਡਾਇਦਿਆਂ ਬਾਰੇ ਪਰਿਵਾਰ ਦੇ ਜੀਆਂ ਨੂੰ ਜਾਣਕਾਰੀ ਦਿਓ, ਖ਼ਾਸ ਕਰਕੇ ਨਾਮਜ਼ਦ ਵਿਅਕਤੀ ਨੂੰ।

6. ਬੀਮਾ ਪਾਲਿਸੀਆਂ ਜਾਂ ਦੂਜੇ ਵਿੱਤੀ ਉਤਪਾਦ ਵੇਚਣ ਜਾਂ ਰਿਡੀਮ ਕਰਨ ਲਈ ਜ਼ਿਆਦਾ ਮੁਨਾਫ਼ੇ ਜਾਂ ਅਨੁਚਿਤ ਕਮਾਈ ਦਾ ਵਾਅਦਾ ਕਰਨ ਵਾਲੇ **ਜਾਅਲੀ ਫ਼ੋਨ ਕਰਨ ਵਾਲਿਆਂ ਦੁਆਰਾ ਮਨਘੜਤ ਪੇਸ਼ਕਸ਼ਾਂ ਦੇ ਝਾਂਸੇ ਵਿੱਚ ਕਦੇ ਵੀ ਨਾ ਆਓ।**

7. ਨਿਵੇਸ਼ ਉੱਤੇ ਬੋਨਸ ਜਾਂ ਮੁਨਾਫ਼ੇ ਪੇਸ਼ ਕਰਨ ਵਾਲੀਆਂ ਆਈਆਰਡੀਏ ਦੇ ਨਾਂ ਤੇ ਕੀਤੀਆਂ ਕਾਲਾਂ ਦੇ ਝਾਂਸੇ ਵਿੱਚ ਕਦੇ ਵੀ ਨਾ ਆਓ।

ਆਈਆਰਡੀਏ ਕਿਸੇ ਵੀ ਤਰ੍ਹਾਂ ਦੇ ਬੀਮੇ ਜਾਂ ਵਿੱਤੀ ਪਾਲਿਸੀਆਂ ਦੀ ਵਿੱਕਰੀ ਜਾਂ ਬੀਮਾ ਕੰਪਨੀਆਂ ਦੇ ਪ੍ਰੀਮੀਅਮਾਂ ਦਾ ਨਿਵੇਸ਼, ਜੋ ਵੀ ਹੈ, ਨਹੀਂ ਕਰਦੀ।

8. ਜੇਕਰ ਕੋਈ ਅਣਅਧਿਕ੍ਰਿਤ ਵਿਚੋਲਾ ਜਾਂ ਗੈਰ-ਰਜਿਸਟਰਡ ਬੀਮਾਕਰਤਾ ਬੀਮਾ ਕਰਨ ਲਈ ਕਹਿੰਦਾ ਹੈ, ਤਾਂ ਪੁਲੀਸ ਕੋਲ ਸ਼ਿਕਾਇਤ ਦਰਜ ਕਰਵਾਓ ਅਤੇ ਆਈਆਰਡੀਏ ਨੂੰ ਇਸ ਦੀ ਸੂਚਨਾ ਦਿਓ।

ਅਜਿਹੇ ਕਿਸੇ ਵੀ ਅਣਅਧਿਕ੍ਰਿਤ ਵਿਚੋਲੇ ਜਾਂ ਗੈਰ-ਰਜਿਸਟਰਡ ਬੀਮਾਕਰਤਾ ਨੂੰ ਕੀਤੀ ਗਈ ਅਦਾਇਗੀ ਤੁਹਾਡੇ ਆਪਣੇ ਜੋਖਮ ਤੇ ਹੈ।

ਬੇਦਾਅਵਾ: ਇਸ ਦਾ ਇਰਾਦਾ ਤੁਹਾਨੂੰ ਕੇਵਲ ਆਮ ਜਾਣਕਾਰੀ ਦੇਣਾ ਹੈ ਅਤੇ ਇਹ ਪੂਰੀ ਜਾਣਕਾਰੀ ਨਹੀਂ ਹੈ। ਇਹ ਗਿਆਨ ਦੇਣ ਲਈ ਪਹਿਲ-ਕਦਮੀ ਹੈ ਅਤੇ ਤੁਹਾਨੂੰ ਕੋਈ ਕਾਨੂੰਨੀ ਸਲਾਹ ਦੇਣ ਦੀ ਕੋਸ਼ਿਸ਼ ਨਹੀਂ ਹੈ।

காப்பீடு ஒழுங்குமுறை மற்றும் விரிவாக்க ஆணையம்

INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY

காப்பீட்டை உணர்க்கப்படுத்துவோம், காப்பீடு செய்பவர்களை பாதுகாப்போம்.

3ம் மாடி, பரிஷ்ராம் பவன், பஷீர்பாக், ஹைதராபாத் -500004
www.irda.gov.in www.policyholder.gov.in

சரியானபடி வாங்குவதன் மூலம் காப்பீட்டின் அசல் மதிப்பு ஒரு சில குறிப்புகள் :

1. கீழ்க்கண்ட இடங்களில் மட்டுமே காப்பீடுகளை வாங்குவதை உறுதி செய்து கொள்ளுங்கள்.

- பதிவு செய்துள்ள காப்பீட்டு நிறுவனங்கள்.
- உரிமம் பெற்றுள்ள காப்பீட்டு முகவர்கள்
- உரிமம் பெற்றுள்ள காப்பீட்டு தரகர்கள் மற்றும் பொது சேவை மையங்கள் (சிஎஸ்சிக்கள்)
- உரிமம் பெற்றுள்ள வெப் அக்ரிகேட்டர்கள்

2. ஏதேனும் பணத்தை செலுத்தும் முன்பு நீங்கள் செலுத்தும் நபர் மற்றும் அமைப்பின் உண்மைத் தன்மையை சரிபாருங்கள்.

- காப்பீட்டை கோரும் நபரின்/ அமைப்பின் அடையாளச் சான்றை கேளுங்கள்.
- அந்த நபரின் மற்றும் அமைப்பின் முகவரி மற்றும் தொலைபேசி விபரங்களை முக்கியமாக அவர்கள் தொலைபேசி மூலம் விற்பவர்கள் எனில் கேளுங்கள்.
- காப்பீட்டு நிறுவனங்கள், தரகர்கள் மற்றும் வெப்-அக்ரிகேட்டர்களின் விபரங்களை ஐஆர்டிஏ இணையதளத்தில் சரிபாருங்கள்.

3. கீழ்க்கண்டவற்றின் அடிப்படையில் உங்களுக்கேற்ற காப்பீட்டு திட்டத்தை தேர்ந்தெடுங்கள்:

- தற்போதுள்ள வாழ்க்கை நிலை, நிதி நிலைமை மற்றும் பணத் தேவைகள்
- வாங்கப்பட வேண்டிய பாலிசி-
  - ஆயுள் அல்லது சொத்து மீதான அபாயத்துக்கு எதிராக காப்பீடு செய்ய
  - நீண்ட கால சேமிப்புக்காக
  - வருங்காலத்தில் மருத்துவமனை செலவு தேவைகளை பூர்த்தி செய்ய
  - முதுமை / ஓய்வூதியம்/ ஆன்யூட்டிக்காக சேமிக்க
  - கட்டாயமான தேவைகளைப் பூர்த்தி செய்ய
- உறுதியளிக்கப்படும் தொகை / காப்பீட்டுத் தொகையின் போதிய நிலை மூலம் வழங்கப்படும் நன்மைகள்
- வரி ஊக்கத்தொகை, கிடைக்கும் எனில்

4. எந்த ஒரு காப்பீட்டு பாலிசியையும் வாங்கும் முன்பு, கீழ்க்கண்டவற்றை உறுதி செய்யுங்கள்:

- கையேடு மற்றும் விண்ணப்ப படிவத்தை கவனமாக படியுங்கள்.
- விண்ணப்ப படிவத்தில் கையெழுத்திடும் முன்பு விபரங்களை முழுமையாக பூர்த்தி செய்யுங்கள்.
- உங்களின் உடனடியான தகவலுக்காக விண்ணப்ப படிவத்தின் ஒரு நகலை வைத்துக் கொள்ளுங்கள்.
- விண்ணப்ப படிவம் ஏற்றுக்கொள்ளப்பட்ட 30 நாட்களுக்குள் காப்பீட்டாளர் விண்ணப்ப படிவத்தின் ஒரு நகலை இலவசமாக அளிக்க பொறுப்புடையவர். தயவுசெய்து காப்பீட்டு பாலிசியுடன் அதை சேர்த்து பெற்றுக் கொள்ளுங்கள்.
- ப்ரீமியம் காசோலை மூலம் செலுத்தப்படுகிறது எனில் பதிவு செய்யப்படும் காப்பீட்டு நிறுவனத்தின் பெயரில் செலுத்துவதை உறுதி செய்துகொள்ளுங்கள் மற்றும் இதற்கான ரசீதை பெற்றுக்கொள்ளுங்கள்.
- எந்த ஒரு தனி நபரின் பெயரிலும் பணம் செலுத்தாதீர்கள் அல்லது ரொக்க பணம் மூலம் செலுத்தினால் அந்த நபரின் விபரங்களை உறுதி செய்து கொள்ளாமல் செலுத்தாதீர்கள்.
- பாலிசி ஆவணத்தை உடனடியாக பெறுவதற்கு காப்பீட்டாளர் அல்லது முகவர்/தரகர் முகவரியுடன் தொடர்ந்து தொடர்பு கொள்ளுங்கள்.

5. ஆயுள் காப்பீட்டு பாலிசி முக்கியமாக ஆயுளுக்கான ரிஸ்க் காப்பீட்டை அளிக்கிறது. ஆனால் இது நீண்டகால முதலீட்டுக்கும் மற்றும் நீண்ட கால பொறுப்புக்கும் கூட உதவும். ஆயுள் காப்பீட்டு பாலிசியை பெற்றுக் கொண்ட பின்பு கீழ்கண்டவற்றின் மீது கவனமாக இருங்கள்:

- பாலிசி ஆவணத்தை கவனமாகப் படியுங்கள்
- ப்ரீமியம் செலுத்தும் முறை, பாலிசி காலவரம்பு, வழங்கப்படும் முதிர்வு ஆதாயங்கள், பாலிசி வைத்திருக்கப்படவேண்டிய காலம், சரண்டர் செய்வதால் கிடைக்கும் மதிப்பு முதலியவற்றைச் சரிபாருங்கள்.
- பாலிசி வாங்கும் போது உறுதியளிக்கப்பட்டதுபோல் பாலிசி ஆவணத்திலும் அதே விதிகள் மற்றும் நிபந்தனைகள் உள்ளதா என்று பார்த்து உறுதி செய்து கொள்ளுங்கள்.
- உங்களுக்கு விதிகள் மற்றும் நிபந்தனைகளில் சம்மதம் இல்லாவிட்டால் பாலிசி பெற்றுக்கொண்ட தேதியிலிருந்து 15 நாட்களுக்குள் உங்களின் ஆட்சேபனைக்கான காரணங்களை தெரிவித்து காப்பீட்டாளருக்கு பாலிசியை திருப்பி அனுப்பி விடுங்கள். இந்தக் காலவரம்பிற்குரிய தகுந்த ரிஸ்க் ப்ரீமியம், காப்பீட்டாளர் மருத்துவ பரிசோதனைக்காக செய்த செலவுகள், முத்திரை பத்திரக் கட்டணங்கள் போன்றவை நீங்கள் செலுத்திய ப்ரீமியத்தில் இருந்து கழித்துக்கொள்ளப்பட்டு மீதி தொகையை பெறும் உரிமை உங்களுக்கு உண்டு.
- ப்ரீமியத்தை முறையாக மற்றும் தொடர்ச்சியாக செலுத்துங்கள், பாலிசி காலாவதி ஆக விடாதீர்கள்.
- காப்பீட்டு பாலிசியிலிருந்து அதிகபட்ச மதிப்பை பெற இடைவெளி இன்றி பாலிசியை தொடருங்கள். ஏனெனில், உரிய நேரத்தில் ப்ரீமியம் செலுத்தப்படும்போது மட்டுமே காப்பீட்டு வசதி கிடைக்கும்.
- நீங்கள் காப்பீட்டு பாலிசி வாங்கி இருப்பது பற்றியும் அதன் நன்மைகள் பற்றியும் உங்கள் குடும்பத்தாருக்கு குறிப்பாக வாரிசுக்கு தெரியப்படுத்துங்கள்.

6. போலியான அழைப்புக்கள் மூலம் மோசடி சலுகைகள் அளிப்பதாக கூறுபவரிடம் ஏமாந்துவிடாதீர்கள். இவர்கள் காப்பீட்டு பாலிசிகள் அல்லது இதர திட்டங்கள் போன்றவற்றிற்கு அதிக வருமானங்களை அல்லது நியாயமற்ற லாபங்களை விற்பனை அல்லது சரண்டர் செய்வதன் மூலம் பெற்றுத் தருவதாக வாக்குறுதி அளிப்பார்கள்.

7. முதலீட்டின் மேல் போனஸ் அல்லது லாபங்கள் அளிப்பதாக ஐஆர்டிஏ-ன் பேரில் வரும் அழைப்புக்களில் ஏமாந்து விடாதீர்கள்.

ஐஆர்டிஏ எந்த விதமான காப்பீடு அல்லது நிதித் திட்டங்களை விற்பதிலோ அல்லது காப்பீட்டு நிறுவனங்களின் ப்ரீமியத்தை முதலீடு செய்வதிலோ எந்த விதத்திலும் ஈடுபடுவதில்லை.

8. உரிமம் வாங்கப்படாத இடைத் தரகர்கள் அல்லது பதிவு செய்து கொள்ளாத காப்பீட்டாளர்கள் உங்களிடம் காப்பீடு எடுக்கும்படி கூறினால் காவல் துறைமிடம் எஃப்ஐஆர் தாக்கல் செய்து ஐஆர்டிஏ க்கு தகவல் தெரிவியுங்கள்.

இந்தகைய உரிமம் வாங்கப்படாத இடைத் தரகர்கள் அல்லது பதிவு செய்து கொள்ளாத காப்பீட்டாளர்களிடம் நீங்கள் செலுத்தும் ஏதேனும் பணத்துக்கு நீங்கள்தான் பொறுப்பு.

மறுப்பு: இதன் நோக்கம் உங்களுக்கு பொது தகவல் மட்டும் அளிப்பதே. இது ஒரு முழுமையான தகவல் அல்ல. இது ஒரு தகவலறிவு நடவடிக்கை மற்றும் இது உங்களுக்கு எந்த வித சட்ட ஆலோசனை வழங்கும் நோக்கமுடையதல்ல.

ఇన్స్యూరెన్స్ రెగ్యులేటరీ మరియు డెవలప్‌మెంట్ అథారిటీ

INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY

అసమానమైన బీమా. బీమాకి ప్రోత్సాహం బీమాదారుని సంరక్షణ.

3వ అంతస్తు, పరిశ్రమ్ భవన్, బషీర్‌బాగ్, హైదరాబాద్-500004
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సరైన నిర్ణయం ద్వారా బీమా విలువ అమూల్యం: కొన్ని ముఖ్య సలహాలు

1. మీరు ఈ క్రింది వారినుండి మాత్రమే బీమా పాలసీలను కొనుగోలు చేస్తున్నారా అని నిర్ధారించుకోండి:

- రిజిస్టర్ చేయబడిన బీమా కంపెనీలు
- లైసెన్స్ ఉన్న బీమా ఏజెంట్లు
- లైసెన్స్ ఉన్న బీమా బ్రోకర్లు మరియు కామన్ సర్వీస్ సెంటర్లు (సిఎస్‌సిలు)
- లైసెన్స్ ఉన్న వెబ్ అగ్రిగేటర్లు

2. ఏదైనా పేమెంట్ (చెల్లింపు) చేసేముందు, ఆ వ్యక్తి లేక ఆ సంస్థ సరైనదా కాదా అని తనిఖీ చేసుకోండి:

- బీమా పాలసిని అమ్మజూపు వ్యక్తి/ సంస్థ యొక్క ఐడెంటిటీ (గుర్తింపు) కార్డు గురించి అడగండి
- సదరు వ్యక్తి/ సంస్థయొక్క చిరునామా మరియు టెలిఫోన్ నంబర్లను అడగండి, (టెలిసేల్స్ విషయంలో ఇది ముఖ్యము)
- బీమా కంపెనిలు, బ్రోకర్లు మరియు వెబ్ అగ్రిగేటర్ల వివరాలను ధృవీకరించుకునేందుకు, ఐఆర్‌డిఏ వెబ్‌సైట్‌ని చూడండి

3. ఈ క్రిందివాటి ఆధారంగా మీకు అనువైన బీమా పాలసీని ఎంచుకోండి:

- జీవితపు దశ, ఆర్థిక స్థితి మరియు ఆర్థిక అవసరాలు
- పాలసీ కొనుగోలు చేయడానికి గల కారణాలు:
  - జీవితం లేదా ఆస్తికి కలిగే రిస్క్ (ప్రమాదం)ని బీమా చెయ్యడం
  - దీర్ఘ-కాలిక పొదుపుల నిమిత్తం
  - భవిష్యత్తులో అస్వస్థత వైద్య ఖర్చుల నిమిత్తం
  - విధ్యుక్త (తప్పనిసరి) అవసరార్థం
  - వార్ధక్యం/ పెన్షన్/ అన్యుటీ కోసం ఆదా చెయ్యడం
- హామీ చెయ్యబడిన మొత్తం/బీమా చెయ్యబడిన మొత్తిపు సముచిత ప్రయోజనాలు
- ఆదాయపు పన్ను మినహాయింపు నిమిత్తం (ఒకవేళ వర్తిస్తే)

4. ఒక బీమా పాలిసీని కొంటున్నప్పుడు ఈ క్రింది జాగ్రత్తలు తీసుకోండి

- వివరణ పత్రాన్ని మరియు ప్రతిపాదన పత్రాన్ని (proposal form) జాగ్రత్తగా చదవండి
- ప్రతిపాదన పత్రంపై సంతకం చేసేముందు, వివరాలన్నిటిని పూర్తిగా నింపండి
- ప్రతిపాదన పత్రం యొక్క కాపీని మీ అవసరార్థం ఉంచుకోండి
- బీమా చేస్తున్న సంస్థకి, ప్రతిపాదనని స్వీకరించిన 30 రోజులలోగా, ప్రతిపాదన పత్రం యొక్క కాపీని ఉచితంగా అందజేయవలసిన బాధ్యత ఉంది.
- ప్రీమియంని కనక చెక్కు ద్వారా చెల్లించి ఉంటే, అది రిజిస్టర్డ్ బీమా కంపెని పేరుపై ఉండాలని నిర్ధారించుకోండి, మరియు చెల్లింపునకు రసీదు పొందండి.
- ఏ వ్యక్తిపేరుపైన నగదు చెల్లింపులు చెయ్యకండి; ఒకవేళ కొక్కం రూపంలో చెల్లించాల్సివస్తే, వారి క్రెడెన్షియల్స్ (అధికార పత్రాలు) సరిగ్గా ఉన్నాయా లేదా అని ధృవీకరించుకోకుండా చెల్లింపులు చెయ్యకండి.
- పాలిసీ డాక్యుమెంట్‌ని త్వరితంగా పొందేందుకు, బీమా సంస్థ లేదా ఏజెంట్/బ్రోకర్‌ను సంప్రదించండి.

5. జీవిత బీమా పాలిసీ ముఖ్యంగా అపాయం నుంచి జీవిత బీమా రక్షణ కల్పిస్తుంది. కానీ ఇది దీర్ఘకాలిక పెట్టుబడికి ఒక సాధనంగా కూడా ఉపయోగ పడాలంటే, దీర్ఘకాలిక నిబద్ధత అవసరం. జీవిత బీమా పాలిసీని పొందిన తర్వాత మీరీ క్రిందవాటిని శ్రద్ధగా గమనించండి:

- పాలిసీ డాక్యుమెంట్‌ని చదవండి.
- ప్రీమియం చెల్లింపు విధానం, పాలిసీ అవధి, ఆఫర్ చేస్తున్న పరిపక్వత ప్రయోజనాలు, లాక్-ఇన్ అవధి, సరెండర్ (సమర్పణ) మొత్తం మొదలైనవాటిని పరీక్షించుకోండి.
- పాలిసీ డాక్యుమెంట్‌లో ఉన్న షరతులు, నిబంధనలు, కొనుగోలు సమయంలో చెప్పబడినవే అవి నిర్ధారించుకోండి.
- మీరు కనక షరతులు, నిబంధనలని అంగీకరించకపోతే, పాలిసీ పొందిన తేదీకి 15 రోజుల లోగా, మీకు గల అభ్యంతరాలకి కారణాలను ఇస్తూ, పాలిసీని బీమా సంస్థకి తిరిగి ఇచ్చేయవచ్చు. అనుపాత ప్రీమియం వైద్య పరీక్షలకై బీమా సంస్థ భరించిన ఖర్చులు మరియు స్టాంప్ ఛార్జీల మినహాయింపుల తర్వాత మిగిలిన మీ ప్రీమియంను (రిఫండ్) తిరిగి పొందేందుకు మీరు అర్హులు.
- ప్రీమియంను క్రమబద్ధంగాను, నిర్ణీత సమయానికి కడుతూ ఉండండి; పాలిసీ అంతరించకుండా (లాప్స్ అవకుండా) చూసుకోండి.
- బీమా పాలిసీ నుండి గరిష్ఠమైన మొత్తం పొందేందుకై, ఎటువంటి అంతరాయమూ లేకుండా పాలిసీని కొనసాగనివ్వండి. ఎందుకంటే, ప్రీమియంని సమయానికి కడుతూ వస్తేనే బీమా రక్షణ లభ్యమౌతుంది.
- మీ కుటుంబ సభ్యులకు, ప్రత్యేకించి నామినీలకు, బీమా పాలిసీని కొన్న విషయం మరియు దాని ప్రయోజనాల గురించి తెలియజేయండి.

6. నకిలీ కాల్స్ చేసేవారి ప్రలోభాలకు లొంగి పోకండి. బీమా పాలిసీల అమ్మకం లేదా రిడెంప్షన్ (విడుదల)తో ప్రమేయం ఉన్న అధిక రాబడులు లేదా అకారణమైన లాభాల గురించి చేసే కృత్రిమ ఆఫర్లకు ఎర కాకండి.

7. ఐఆర్‌డిఏ పేరు చెప్పుకొని బోనస్‌ను మరియు పెట్టుబడిపై లాభాల గురించి చెప్పేవారి ప్రలోభాలకు మోసపోవద్దు. ఐఆర్‌డిఏ ఎలాంటి బీమా పథకాలను మరియు ఆర్థిక పథకాలను అమ్మజూపదు మరియు బీమా ప్రీమియం పెట్టుబడులలో జోక్యం చేసుకోదు.

8. ఎవరైనా లైసెన్స్ లేని మధ్యవర్తులు లేదా రిజిస్టర్ చెయ్యని బీమా సంస్థలు బీమాని అభ్యర్థిస్తే, పోలీసు వద్ద ఎఫ్‌ఐఆర్‌ని నమోదు చేసి, ఐఆర్‌డిఏకి తెలియజేయండి.

సదరు లైసెన్స్ లేని మధ్యవర్తులు లేదా రిజిస్టర్ చెయ్యని బీమా సంస్థలకు చేసిన ఏ చెల్లింపులకు, తదుపరి పరిణామాలకు మీరు మాత్రమే బాధ్యులు.

انشورنس ریگیولیٹری اینڈ ڈیولپمنٹ اتھاریٹی

INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY

بیمے کی وسعت. بیمہ شدہ کو محافظت.

تیسرا مذزلہ، پریشرم بھون، بشیر باغ، حیدرآباد ۔ 500004
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صحیح خریداری کے ذریعے انشورنس کی رئیل ویلیو چند اشارات

1. اطمینان کرلیں کہ آپ انشورنس پالیسیاں صرف ذیل سے خرید رہے ہیں:

- رجسٹرڈ انشورنس کمپنیز
- لائسینسڈ انشورنس ایجنٹس
- لائسینسڈ انشورنس بروکرس اور کامن سروس سینٹرس (سی ایس سی)
- لائسینسڈ ویب ایگریگیٹرس

2. فرد اور دیگر موجودات کی اصلیت جانے بغیر کوئی ادائیگی نہ کریں

- انشورنس کیلئے گزارش کرنے والے فرد / موجودات کے شناختی ثبوت کی مانگ کیجئے
- متعلقہ فرد اور موجودات کے پتے اور ٹیلیفون نمبروں کی تفصیل پوچھئے، بہ طور خاص ٹیلی سیلس کے معاملے میں
- انشورنس کمپنیوں، بروکرس اور ویب ایگریگیٹرس کی تصدیق کیلئے آئی آر ڈی اے ویب سائیٹ کی جانچ کیجئے

3. ذیل کی بنیاد پر اپنی ضرورت کے حساب سے انشورنس پروڈکٹ کا انتخاب کیجئے.

- موجودہ عمر، مالی صورت حال اور مالی ضرورتیں
- پالیسی خریدنے کا مقصد۔
  - زندگی یا ملکیت کے جوکھم کا انشورنس
  - طویل مدتی بچتوں کی حیثیت سے
  - مستقبل میں داخل اسپتال ہونے کی ضرورتوں کی تکمیل کی ذمے داری اٹھانے کیلئے
  - لازمی مطالبات کی تکمیل کیلئے
  - بڑھاپے / پینشن / سالانہ وظیفے کی خاطر بچت کیلئے

- اشورڈ رقم / انشورڈ رقم کی موزونیت کی صورت میں پیش کئے جانے والے فائدے
- ٹیکس انسینٹیو، اگر دستیاب ہو

4. کوئی بھی انشورنس پالیسی خریدتے وقت ذیل کا اطمینان کرلیں.

- تفصیل نصاب (پروسپیکٹس) اور پروپوزل (تجویزی) فارم دھیان سے پڑھ لیں.
- پروپوزل فارم پر دستخط کرنے سے پہلے مکمل تفصیلات پُر کریں.
- فوری تیار حوالے کیلئے پروپوزل فارم کی ایک نقل رکھ لیجئے.
- تجویز کی منظوری کے 30 دنوں کے اندر پروپوزل فارم کی ایک کاپی بلامعاوضہ دینے کا فرض انشورر کا ہے. برائے مہربانی انشورنس پالیسی کے ساتھ اسے ضرور حاصل کریں.
- اگر پریمیئم کی ادائیگی چیک کے ذریعے کی گئی ہو تو برائے مہربانی اطمینان کرلیں کہ وہ انشورنس کمپنی کے نام سے رجسٹرڈ ہے، اور ادائیگی کی رسید لے لیں.
- کسی بھی انفرادی حیثیت والے کے نام پر ادائیگی نہ کریں، یا اگر ادائیگی نقدی کی شکل میں ہو، تو مختار نامے کی تصدیق کے بغیر ادائیگی نہ کیجئے.
- انشورر یا ایجنٹ / بروکر سے پالیسی ڈاکیومینٹ کی رسید فوراً حاصل کریں.

5. بنیادی طور پر لائف انشورنس پالیسی زندگی کی خاطر جوکھم کا احاطہ پیش کرتی ہے.

لیکن یہ طویل مدتی سرمایہ کاری کیلئے ایک وسیلے کی حیثیت سے بھی خدمت انجام دیتی ہے اور طویل مدتی تفویض بھی ہے. لائف انشورنس پالیسی لینے کے بعد ذیل کی باتوں کو دھیان میں رکھئے.

- پالیسی ڈاکیومینٹ کو دھیان سے پڑھئے.
- پریمیئم کی ادائیگی کی صورت، پالیسی کی شرط، تکمیل مدت پر پیش کئے جانے والے فائدوں، لاک ۔ ان پیریئڈ، سرینڈر ویلیو وغیرہ کی جانچ کرنا.
- یہ اطمینان کرنا کہ خریداری کے وقت پالیسی ڈاکیومینٹ کے مطابق حسب وعدہ شرائط و ضوابط ہیں.
- اگر آپ شرائط و ضوابط سے متفق نہیں ہیں تو اپنے اعتراضات کی وجوہات بتاتے ہوئے پالیسی کی رسید کی تاریخ سے 15 دنوں کے اندر انشورر کو پالیسی لوٹا دیجئے. تناسب سے رسک پریمیئم، طبی جانچ، اسٹامپ چارجیز جو انشورر نے خرچ کئے، وہ منہا کرنے کے بعد ادا کردہ پریمیئم واپس لینے کے آپ حقدار ہیں.
- پابندی کے ساتھ اور بروقت پریمیئم ادا کریں، پالیسی میں ڈوبنے نہ دیں.
- انشورنس پالیسی کی بدولت زیادہ سے زیادہ حصول کیلئے بغیرناغہ کئے پالیسی جاری رکھئے، کیونکہ وقت پر پریمیئم ادا کرنے پر ہی بیمے کا احاطہ حاصل ہوگا.
- انشور پالیسی کی خریداری اور اس کے فائدوں کے بارے میں اپنے اہل خاندان سے بتلائیں، یہ طور خاص نامزد کردہ کو.

6. بڑے بڑے جھوٹے دعوے کرنے والے غلط لوگوں کے کالز کے بھلاوے میں نہ آئیں جو بیماری ریٹرن یا نامناسب فائدوں، جن میں فروخت یا انشورنس پالیسیوں کی رعایت یا دیگر مالی پروڈکٹس شامل ہوسکتے ہیں، کے سبزباغ دکھاتے ہیں.

7. آئی آر ڈی اے کے نام سے سرمایہ کاری پر بونس یا منافع کی پیشکش کرنے والے غلط لوگوں کا شکار نہ بنیں.

آئی آر ڈی اے کسی بھی قسم کی انشورنس کی فروخت یا فائنینشئل پروڈکٹس یا انشورنس کمپنیز کے پریمیئم کی سرمایہ کاری میں کسی بھی صورت میں ملوث نہیں ہے.

8. کسی بھی غیرلائسینسس یافتہ مصالحت کروانے والے ثالثوں یا غیر رجسٹرڈ انشورر کے دھوکے میں نہ آئیں بلکہ ان کے خلاف پولس میں ایف آئی آر درج کروائیں اور آئی آر ڈی اے کو باخبر کریں. کسی بھی غیرلائسینس یافتہ مصالحت کروانے والے ثالثوں یا غیررجسٹرڈ انشورر کو کسی بھی قسم کی ادائیگی آپ اپنی ذمے داری پر کریں.

Annexure-VI

PUBLIC NOTICE

Ref: IRDA/CAD/PNTC/MISC/197/08/2014
August 26, 2014

IRDA CAUTIONS PUBLIC AGAINST SPURIOUS CALLS AND FICTITIOUS OFFERS

Members of public have been receiving a lot of spurious calls in the name of officials of Insurance Regulatory and Development Authority making fraudulent claims and fictitious offers.

2. IRDA issued a public notice on January 29, 2014 cautioning members of public from falling prey to such offers and issued advertisements in newspapers.

3. In spite of these efforts, it is observed that members of public are still receiving spurious calls in the name of officials of IRDA. The nature of calls are as indicated below:

- Claiming that IRDA is distributing bonus to insurance policy holders out of the funds invested by insurance companies with IRDA.
- Claiming that the policyholder would receive bonuses being distributed by IRDA if they purchase an insurance policy and wait for a few months after which the bonus would be released by IRDA.
- Advising existing policyholders that money in respect of their policy has been fraudulently transferred to someone else and for receiving that money back from IRDA, they have to fulfil certain formalities including payment of money
- Claiming that they are from the Grievance Cell or IGMS Department of IRDA making a call in continuation with a complaint made against an insurer and for resolving the grievance and release of benefit, they have to fulfil certain formalities including payment of money.

4. The other kinds of spurious calls are:

- Advising customers to subscribe to a fresh policy after surrender of the existing policy and wait for a few months after which the fresh policy would be entitled for additional enhanced returns / benefits.
- Informing that 'Survival Benefit or Maturity Proceeds or Bonus' is due under their existing policy and investing in a new insurance policy is mandatory to receive the amounts which are due.
- Advising public to invest in insurance policies to avail gifts, promotional offers, interest free loans, or setting up of Telecom towers or other such offers.

5. The general public is hereby informed that IRDA is a regulatory body established by an Act of Parliament, i.e. the Insurance Regulatory and Development Authority Act 1999, to protect the interests of the policyholders, to regulate, promote and ensure orderly growth of the insurance industry and for matters connected therewith or incidental thereto. Further, IRDA informs the members of public that:

- IRDA does not involve directly or through any representative in sale of any kind of insurance or financial products.
- IRDA does not invest the premium received by insurance companies.
- IRDA does not announce any bonus for policyholders or insurers.
- IRDA has put in place Grievance Redressal Cell in Consumer Affairs Department, Integrated Grievance Management System and IRDA Grievance Call Centre to provide an alternate platform for registering grievances against insurers thereby facilitating resolution of customer grievances by insurers.
- IRDA or its officials dealing with Grievance Management do not make calls in relation to complaints lodged with IRDA as IRDA plays a facilitative role and does not adjudicate upon or investigate into such complaints
- Any person making any kind of transaction with such individuals/agents will be doing the same at their own risk.

6. IRDA hereby urges the public to remain alert and not to fall prey to frauds or scams perpetrated by miscreants who impersonate

to be employees / officers of IRDA or other insurance companies. These miscreants frequently use the names of Shri Rakesh Bajaj, Smt. Manju Arora, Shri R. Srinivasan, Shri Mukesh Sharma, Sri Mukesh Kumar etc. as IRDA officials to give confidence to the customer that they indeed are receiving calls from the IRDA.

7. In order to make the members of public aware of the kind of calls that are being received, one such spurious call indicating the modus operandi adopted to force the gullible customer to fall their prey, is indicated below:

Modus Operandi

- The spurious callers call the victims repeatedly and introduce themselves as employees of IRDA.
- They would inform that proceeds of one's insurance policy are being transferred to some other person.
- They would suggest the policyholder to visit IRDA at Hyderabad / Delhi and meet one particular officer who is responsible for transferring this money. They would give mobile numbers of this officer.
- On being called on the given number the person on the other side would introduce himself/herself as IRDA officer.
- They would inform that IRDA is maintaining money from such accounts where agents had committed frauds and this money is being returned to policy holders.
- The officer would tell that on policyholder's mandate the due from existing policy is being transferred to some other person.
- When informed that no such mandate was given, they would indicate that somebody has committed fraud and that they will file an FIR with police in Hyderabad / Delhi. They would also give details of the FIR filed.
- For further assistance they would give another number. The person on this number would suggest that to get back the money, the policyholder has to engage the services of a particular company. The policyholder has to deposit the following documents:

i) An account payee cheque in the name of the company;

ii) PAN;

iii) First page of the policy document; and

iv) Address proof.

- They would further suggest that these documents be couriered and the details of the despatch including docket number etc be furnished to them.
- They would keep on calling for details of the despatch of cheque and documents and would assure the policyholder that the transfer of dues from the policy to other persons account would be stopped once they receive these documents.

The following are the links to the Audio files which contain the voice recordings of the conversation as made available by one of the complainants

Spurious Call – Audio 1
Spurious Call – Audio 2

8. If any member of the public notices such instances, he or she may lodge a police complaint giving full details, along with the details of the caller and telephone number from which the call was received, in the local police station.

9. As a customer education initiative, on August 15, 2014, IRDA issued an advertisement in English in leading newspapers with the title "Real Value of Insurance through Right Buying – A Few Tips". This advertisement also contained caution to public from falling prey to spurious calls made in the name of IRDA and making payments to unlicensed intermediaries. IRDA would continue its efforts to caution members of public from falling prey to spurious calls and fictitious offers in the name of IRDA or insurance companies or intermediaries.

Consumer Affairs Department
IRDA

Annexure-VII

PRESS RELEASE

No. IRDA/CAD/MISC/PRE/206/08/2014
September 4, 2014

Re: Spurious Phone Calls and Fictitious / Fraudulent Offers – with sample audio of a spurious call

Members of public have been receiving a lot of spurious calls in the name of officials of Insurance Regulatory and Development Authority making fictitious and fraudulent offers. IRDA had issued a public notice on January 29, 2014 cautioning members of public to not fall prey to such offers.

2. Some new patterns of spurious calls are being reported by complainants. Incorporating the new kinds of calls in the name of officials of IRDA received by members of public, IRDA has issued a public notice on August 25, 2014 reiterating its caution to members of public to not fall prey to such spurious calls and fictitious offers.

3. IRDA has also shared the modus operandi used by one such spurious caller based on a complaint and provided links to the audio records of the spurious call to make members of public aware of the practices followed to cheat them (Spurious Call Audio 1, Spurious Call Audio 2)

4. IRDA is a regulatory body established by an Act of Parliament, i.e. the Insurance Regulatory and Development Authority Act 1999, to protect the interests of the policyholders, to regulate, promote and ensure orderly growth of the insurance industry and for matters connected therewith or incidental thereto. Further, IRDA has informed public that:

- IRDA does not involve directly or through any representative in sale of any kind of insurance or financial products.
- IRDA does not invest the premium received by insurance companies.
- IRDA does not announce any bonus for policyholders or insurers.
- IRDA has put in place Grievance Redressal Cell in Consumer Affairs Department, Integrated Grievance Management System and IRDA Grievance Call Centre to provide an alternate platform for registering grievances against insurers thereby facilitating resolution of customer grievances by insurers.
- IRDA or its officials dealing with Grievance Management do not make calls in relation to complaints lodged with IRDA as IRDA plays a facilitative role and does not adjudicate upon or investigate into such complaints
- Any person making any kind of transaction with such individuals/agents will be doing the same at their own risk.

5. IRDA has once again urged the public to remain alert and not to fall prey to frauds or scams perpetrated by miscreants who impersonate to be employees / officers of IRDA or other insurance companies.

6. IRDA advised that if any member of the public notices such instances, he or she may lodge a police complaint giving full details, along with the details of the caller and telephone number from which the call was received, in the local police station.

7. The public notice along with the audio clips has been placed on the web-site of IRDA (www.irda.gov.in) as well as on the consumer education website of IRDA (www.policyholder.gov.in)

Consumer Affairs Department

IRDA

RADIO JINGLES

First Script

टिग टॉग – दरवाजे की घंटी बजती है |

रंजन – कौन है ? अरे ! मोहन तुम सही समय पर आये हो |

मोहन – क्या हुआ रंजन ?

रंजन – यार, कल एक व्यक्ति का आई.आर.डी.ए. से फोन आया था जो बता रहा था कि मेरी पॉलिसी पर बोनस दिया जा रहा है जिसको पाने के लिये मुझे उसकी एक और पॉलिसी खरीदनी होगी |

मोहन - आई.आर.डी.ए. तो ऐसे फोन नहीं करता | आई.आर.डी.ए. बीमा क्षेत्र का रेगुलेटर है जो कि पॉलिसीधारकों के हितों की सुरक्षा और बीमा के व्यवस्थित विकास के लिये कार्य करता है | और ध्यान से सुनो, आई.आर.डी.ए, बीमा या वित्तीय उत्पाद की बिक्री में शामिल नहीं होता और ना ही किसी भी प्रकार के बोनस की घोषणा करता है | यह तो फर्जी कॉल था, इसकी सूचना पुलिस को अवश्य देना |

उपभोक्ता शिक्षा हेतु आई.आर.डी.ए. दवारा जनहित में जारी

Second Script

रंजन – अरे ! मोहन मुझे कुछ समय से लगातार आई.आर.डी.ए. से फोन आ रहे है |

मोहन – कैसे फोन ?

रंजन – आई.आर.डी.ए. के उस व्यक्ति ने बताया कि मेरी बीमा पॉलिसी का पैसा किसी और के पास चला गया है उसे वापस पाने कि लिये मुझे कुछ और पैसा देना होगा |

मोहन –आई.आर.डी.ए. तो ऐसे फोन नहीं करता | ये तो फर्जी कॉल थे | आई.आर.डी.ए. बीमा क्षेत्र का रेगुलेटर है जो कि पॉलिसीधारकों के हितों की सुरक्षा और बीमा के व्यवस्थित विकास के लिये कार्य करता है | रंजन सावधान ! ऐसे झूठे फोन कॉल या फर्जी प्रस्तावों के चंगुल में नहीं फँसना और कोई भी भुगतान करने से पहले उस व्यक्ति की प्रामाणिकता की जॉच अवश्य करना |

उपभोक्ता शिक्षा हेतु आई.आर.डी.ए. दवारा जनहित में जारी

Annexure-IX

PUBLIC NOTICE

Cir. No. IRDA/CAD/CIR/MISC/038/01/2014
27th January 2014

To All the CEOs of Life Insurance Companies

Re: Spurious Phone Calls and Fictitious / Fraudulent Offers

This is with reference to the discussion in the Executive Committee of the Life Insurance Council held at Kolkata on 23 December 2013, which was chaired by Member (Life), IRDA. It was unanimously decided during the meeting that IRDA will create a slide on "Fraudulent Selling of Life Insurance Products" and send it to all life insurers to enable them to insert it at the end of all their product advertisements with a view to educate the customers on the role of regulator and also caution the public on spurious calls. In this regard, please find attached herewith a slide cautioning members of public about IRDA not being involved in sale of financial products or in investing premium.

2. You are advised to include this slide along with voice over of this content in clear terms along with every advertisement/commercial issued in electronic media (TV /cinema halls etc.).

3. Every advertisement / commercial issued from February 1, 2014 should contain this message.

4. Further, you are also advised to incorporate the content in box item prominently in every advertisement in print media including pamphlets, publicity material etc.

5. Please acknowledge receipt and confirm action.

LALIT KUMAR
Financial Advisor

Annexure-X

PUBLIC NOTICE

Cir. No. IRDA/CAD/CIR/MISC/059/02/2014
February 13, 2014

To All the CEOs of Life Insurance Companies

Re: Spurious Phone Calls and Fictitious / Fraudulent Offers

Please refer to the circular IRDA/CAD/CIR/MISC/038/01/2014 dated January 27, 2014 on the captioned subject.

2. Considering a representation from Life Insurance Council and in order to provide sufficient time to insurers to prepare the voice over and reorient their campaign, it has been decided to extend the date of implementation of the contents of circular, insofar as it relates to TV ads I commercials, from February 1, 2014 to March 1, 2014. Please note that no further request for extension of time would be entertained by the Authority. However, other requirements of the circular like incorporating the content in box item prominently in every advertisement in print media including pamphlets, publicity material etc. shall be implemented forthwith.

3. All life insurers shall also flash on their home page of their websites, the public notice No. IRDA/CAD/PNTC/MISC/046/01/2014 dated January 29, 2014 issued by IRDA cautioning general public about spurious calls and fictitious offers. Further, all life insurers shall also send an email I SMS to all their existing customers advising them to not respond to spurious calls in the name of IRDA I other insurance companies asking for changing over to other insurers in the lure of bonus or higher returns.

4. Please acknowledge receipt and confirm action.

LALIT KUMAR
Financial Advisor

Annexure-XI

PUBLIC NOTICE

Cir No. IRDA/Life/Cir/ADV/146/ 06/2014
24th June 2014

To The CEOs of all Life Insurance Companies

Re: IRDA Notice on Spurious Phone calls to be included in all Insurance Advertisements

This has reference to the point 2 of the Cir No. IRDA/CAD/CIR MISC /038/01/2014 dated 27th Jan 2014 and the subsequent discussions in Executive Committee of Life Insurance Council on 28th May 2014 at Hyderabad.

The mandatory inclusion of voice over of the contents of the slide containing IRDA Notice on Spurious Phone Calls along with every advertisement/commercial issued in electronic media (TV/Cinema halls etc.) stands relaxed.

Instead it is now prescribed to include the separate slide as per the enclosed content in Annexure-I at the end of the TV Advertisements / Cinema Hall Advertisements of Insurance with the slide getting displayed continuously for a minimum period of 5 seconds. (Hindi version in Annexure-II is also enclosed).

True Translations in other Indian Languages may also be used as per need with due certification)

All other provisions of the above referred Circular and that of Circular No. IRDA/CAD/CIR/MISC/059/01/2014 dated February 13, 2014 are to be scrupulously complied with from July 2014.

This has the approval of the Competent Authority

Member (Distribution & Life)

DON'T BELIEVE FRAUD PHONE CALLS!!!

IRDA IS NOT INVOLVED IN !

1) ANNOUNCING BONUS IN INSURANCE POLICIES
2) INVESTING PREMIUMS
3) SELLING INSURANCE POLICIES

Issued in Public Interest by
INSURANCE COMPANY, IRDAI

Mis-Selling in Life Insurance Sector

MIS-SELLING IN LIFE INSURANCE SECTOR

I. INTRODUCTION

Mis-selling is the most important issue in the life insurance sector. However, there is no definition of mis-selling in the any legislation regulating insurance business in the country (Insurance Act, 1938 or Insurance Regulatory and Development Authority Act, 1999) or any regulation or guidelines issued by the insurance regulator, Insurance Regulatory and Development Authority of India (IRDAI).

Mis-selling in common parlance refers to unfair or fraudulent practices adopted at the time of soliciting and selling insurance and generally includes selling policies which have not been sought by the customer or which are different from what the customer wanted or was promised or where the product offered for sale is not suitable to the needs of the customer.

Some of the common examples of mis-selling are selling of insurance policies

- with regular premium as single premium policy and the premium is disproportionate to known sources of income
- which are unsuitable based on the profile / requirements of the customer like selling a policy of 15 to 20 years premium paying term to senior citizens
- by agent or intermediary without explaining the product features
- indulging in forgery, tampering of proposal or related papers
- when the customer wanted to invest money in deposits or mutual funds (most common in bancassurance)
- making fictitious offers like huge bonus on poorly performing policies or giving interest free loan, opening ATM, putting up a telecom tower etc.
- after making spurious calls in the guise of IRDAI officials, insurance officials etc.

The list is illustrative and not exhaustive.

Mis-selling is mostly in life insurance sector where there is saving and/or investment along with risk cover. It is also prevalent to an extent in health insurance where misrepresentations about benefits or coverage or both are made to solicit and sell health cover. In pure risk policies like other non-life policies, there is not much of mis-selling as there is no incentive to mis-sell. The focus therefore is on mis-selling by life insurance companies.

II. IMPACT OF MIS-SELLING

Complaints on unfair business practices affect the sentiment about the insurance sector in general and life insurance sector in particular. This would significantly impact the initiatives aimed at enhancing the level of insurance inclusion as measured by indicators such as insurance penetration (measured as ratio of premium to GDP) and insurance density (measured as ratio of premium in USD to population). In the year 2014-15, there has been a sharp decrease in the new business figures of life insurance. Increased incidence of mis-selling can adversely impact growth in the insurance industry which in turn would impact the availability of long term funds for economic development from the insurance sector. Hence, while there is need to assess and reduce the extent of mis-selling, there is also a need to reassure general public that the regulatory framework of life insurance business is sound enough to protect policyholders' interests and grievances, if any, are capable of being resolved by insurers or settled / adjudicated by insurance ombudsmen or consumer fora.

III. COMPLAINTS OF MIS-SELLING

Integrated Grievance Management System (IGMS) introduced by IRDAI in 2011 is a computerized industry-wide grievance repository for the insurance sector. In IGMS, has complaints relating to mis-selling are classified under the broad category of "Unfair Business Practices".

The complaints relating to broad head of 'unfair business practices' consist of complaints falling within the following complaint descriptions:

1. Product differs from what was requested or disclosed.
2. Term(Period) of the policy is different/altered without consent
3. Mode of premium payment differs from requested or disclosed
4. Annuity/Commutation/Cash Option /Rider/ other Options not included as requested
5. Proposed Insurance not in the interest of proposer
6. Intermediary did not provide material information concerning proposed cover
7. Single premium Policy issued as Annual premium policy
8. Tampering, Corrections, forgery of proposal or related papers
9. Credit/Debit card debited without consent of Consumer
10. Premium paying period projected is different from actual
11. False promises made regarding surrender value by intermediaries
12. Free-look refund not paid
13. Cancellation of policy other than Free Look Period not responded.
14. Advice concerning Exclusions/limitations of cover not communicated
15. Illegitimate inducements offered
16. Misappropriation of premiums
17. Malpractices or unfair business practices

The number of complaints relating to unfair business practices has been increasing as can be seen from the table below:

The number of complaints on unfair business practices increased by 63 % in 2012-13 and by 26 % in 2013-14 over previous year's number. However in the current year, there has been a 31 % drop in the number of mis-selling complaints which can be attributed largely to the multi-pronged insurance awareness campaign by IRDAI and also to the sharp drop in the new business mobilized by the life insurance sector. While the number of new life policies issued during the years 2011-12, 2012-13 and 2013-14 was almost stagnant at 4.42 crore policies, the number of policies dropped sharply in the year 2014-15.

The proportion of complaints relating to unfair business practices to total life complaints has increased from 32.55 % in 2011-12 to 56.49 % in 2013-14 with the number of complaints getting doubled. This proportion has reduced marginally to 52.02 % during the current year.

The proportion of complaints of mis-selling to new policies issued rose from 0.23 % in 2011-12 to 0.47

Year	No. of complaints	% increase / decrease compared to last year	Total life complaints	% of mis-selling complaints	No. of new policies	% of complaints n new policies
2011-12	100770	-	309613	32.55	441,60,341	0.23
2012-13	168482	+ 63. 22	341012	49.41	441,55,298	0.38
2013-14	211622	+ 25.60	374620	56.49	441,85,973	0.47
2014-15 (upto 31.3.2015)	145129	- 31.22	278992	52.02	NA	NA
2014-15 (upto 31.12.2014)	112006		208585	53.70	160,35,617	0.69

Source: Integrated Grievance Management System and Business Figures-Life of IRDAI

% in 2013-14 and to 0.69 % in the current year (up to December 31, 2014).

IV. REGULATORY FRAMEWORK

The regulatory framework for preventing mis-selling and ensure right selling is discussed in brief. The basic framework for regulation of insurance business is contained in the Insurance Act, 1938. IRDA Act, 1999 established Insurance Regulatory and Development Authority of India as the regulatory authority to enforce the provisions of Insurance Act so as to ensure which are broadly in the nature of providing a framework for , the following regulations are aimed at ensuring that mis-selling does not take place.

a. IRDA (Protection of Policyholders' Interests) Regulations, 2002

The basic framework for policyholder protection is contained in these regulations.

Procedure to be followed at the 'point of sale', requirements to be complied with at the proposal stage and disclosures to be made in the life insurance policy are clearly stated in these Regulations.

The Regulations contain a provision for free-look cancellation within 15 days of receipt of policy. Every insurer, while forwarding the policy to the insured, should inform by the letter forwarding the policy that he has a period of 15 days from the date of receipt of the policy document to review the terms and conditions of the policy and where the insured disagrees to any of those terms or conditions, he has the option to return the policy stating the reasons for his objection. On availing of the free-look cancellation, the insured would be entitled to a refund of the premium paid, subject only to a deduction of a proportionate risk premium for the period of cover and the expenses incurred by the insurer on medical examination of the proposer and stamp duty charges. In case of ULIPs, the insured would also be entitled to repurchase the units at the price of the units on the date of cancellation

The Regulations clearly indicate that the requirements of disclosure of “material information” regarding a proposal or policy apply both to the insurer and the insured. Further, every insurer is required to have in place proper procedures and effective mechanism to address complaints and grievances of policyholders efficiently and with speed.

Therefore, the regulations ensure that the prospective policyholder is given a thorough understanding of the specific requirements and details required for taking an insurance policy. The insurer, agent or intermediary should enable the prospect to take the best cover that would be in his or her interest.

b. The IRDA (Insurance Advertisements and Disclosure) Regulations, 2000

These regulations require the insurers, agents or intermediaries do not issue "unfair or misleading advertisements" and follow the procedures laid down therein with respect to advertisements (including those on the internet) so that any communication directly or indirectly related to a policy and intended to result in the eventual sale or solicitation of a policy is not misleading or unfair.

Guidelines issued in 2007 on advertisement, promotion and publicity of insurance companies and insurance intermediaries clearly stipulates the details to be made available in the advertisement, which are categorized as "invitation to contract", and also indicates the do's and don’ts amongst other requirements. In 2010, IRDAI issued a circular to life insurers to give fair information to the customers about the product on offer.

c. IRDA (Licensing of Insurance Agents) Regulations, 2000

d. IRDA (Licensing of Corporate Agents) Regulations, 2002

e. IRDA (Insurance Brokers) Regulations, 2002

f. IRDA (Web Aggregators) Regulations, 2013

These regulations mandate compliance of the agents, corporate agents, brokers and web-aggregators with the code of conduct prescribed therein to ensure that the persons soliciting insurance business should be eligible persons and they disseminate the requisite information in respect of insurance products offered for sale, understand the policy being sold and should be capable of

making suitable advice based on the customer needs so that the policy offered / sold meets the requirements of the prospect. Responsibilities are cast upon the agents and other intermediaries in terms of code of conduct, which are mainly aimed at curbing the mis-selling and to promote best practices during solicitation of the business. The training curriculum of these intermediaries is also updated to ensure that the sales force is up to date with all the changes and is capable of providing necessary advice at the time of sale to the prospects.

g. Guidelines on Distance Marketing of Insurance Products, 2011

With the increasing recourse taken by insurers, corporate agents and brokers to solicit policies including lead generation through telecalling, SMS, email, internet, DTH, postal mail and other modes which do not involve communication in person as well as requests from clients seeking information and sale of insurance products in distance mode, IRDAI issued Distance Marketing Guidelines. These guidelines cover not only measures for policyholder protection at the time of offer, negotiation and conclusion of sale but also about preparation of standardized script, training of telecallers, monitoring of calls, preservation of call recordings etc.

h. IRDA (Non-Linked Insurance Products) Regulations, 2013

i. IRDA (Linked Insurance Products) Regulations, 2013

IRDAI had a detailed review of the existing features of the insurance and pension products offered by the life insurers. Based on this review and also taking into account the persistency levels observed in the dynamic changing environment, IRDAI brought out these regulations for protecting the interests of the policyholders, improving the persistency levels and also bringing in value addition to both the insurer and the policyholder.

These regulations ensure that the commission rates are consistent across the industry and have been smoothened with the payments depending on the premium payment term. The benefit illustration requirements have been made applicable not only to linked products but also to all the non-linked products also. The Regulations prohibit certain type of products like highest NAV guarantee, splitting of policies, accepting advance premium for long periods in case of linked products, prohibit mis-leading names so that there is clarity on savings and protection products in case of non-linked products. The regulations also bring in transparency in terms of benefit payouts and enable the customers to choose the right policy.

In case of linked products which are more prone to allegations of mis-sell on account of high charges and risk of investment resting on the policyholder, the regulations for linked products make it mandatory for separate training to all the insurance agents/intermediaries before they are authorized to sell linked insurance products, recommending a suitable product and collecting sufficient information about the potential policyholder as a proof thereof, inform the upfront charges and indicate how premium paid is appropriated towards various charges from the unit fund and the balance of the fund at the end of the first year and subsequent years. An agent/intermediary should obtain a statement of consent (to be furnished along with the documents under File& Use Procedure) signed by the policyholder and countersigned by the person (agent, intermediary etc) himself/herself, along with the proposal form, that he has understood the inbuilt features of the policy and the applicable charges and that he is fully aware of investment risks under the policy to be issued.

j. Grievance Redressal Guidelines for Insurance Sector 2010

In addition to the above regulations, IRDAI has also issued Grievance Redressal Guidelines for insurance sector specifying the timelines for acknowledging, resolving and closing prospect and policyholder grievances. IRDAI has also provided channels for customers to raise grievances with insurers in the form of Integrated Grievance Management System, IRDA Grievance Call Centre and postal, fax and email channels, wherein IRDAI facilitates resolution of grievances by insurers.

Insurance Ombudsman also examine and adjudicate upon complaints relating to mis-selling though the Redressal of Public Grievance Rules,

1998 does not expressly provide mis-selling as a ground of complaint.

Complainants who are not satisfied with the resolution provided by the insurer or decision of the Insurance Ombudsman are free to approach Consumer Fora or Courts.

k. Corporate Governance Guidelines – Policyholder Protection Committee

With a view to addressing the various compliance issues relating to protection of the interests of policyholders, as also relating to keeping the policyholders well informed of and educated about insurance products and complaint-handling procedures, each insurer has been directed set up a Policyholder Protection Committee which shall directly report to the Board. The responsibilities of the Policyholder Protection Committee include putting in place proper procedures and effective mechanism to address complaints and grievances of policyholders including mis-selling by intermediaries and reviewing the mechanism as well as status of complaints at periodic intervals. The Committee is also responsible for ensuring compliance with the statutory requirements as laid down in the regulatory framework and adequacy of disclosure of "material information" to the policyholders.

From the foregoing it is clear that the elaborate regulatory framework is in itself sufficient to ensure that insurers, agents or intermediaries do not resort to mis-selling.

V. MONITORING COMPLIANCE AND REGULATORY ACTION

The compliance with the regulatory framework can be ascertained by way of On-site inspection or off-site monitoring through tools such as complaints, press reports, etc. IRDAI conducts on-site inspection of insurance companies, agents and intermediaries periodically to inspect the books of account, examine the systems and procedures, compliance the regulatory framework, etc. IRDAI also monitors the market conduct of the insurers, agents and intermediaries through complaints, their frequency and severity, press reports etc. Wherever it is found that the entities have not complied with the regulatory framework, IRDAI takes up regulatory action.

VI. CONSUMER EDUCATION

The definitive way of reducing mis-selling is to make the members of public aware of the concept of insurance, kinds of insurance policies, risks covered, benefits offered, exclusions, and conditions etc. This is sought to be achieved through various efforts of financial education to improve financial literacy

- Bima Bemisal campaign through print and electronic media,
- Cautioning public against fictitious offers and spurious calls
- Launching consumer education website www.policyholder.gov.in and its mobile version
- Devising various films, comics, games, handbooks and FAQs relating to insurance and initiatives of IRDAI and publicizing them
- Conducting regular seminars involving customer groups addressing policyholder concerns and policyholder education.
- Introducing mobile application which enables the prospective policyholders to compare insurance products and premium rates in case of unit linked products.

Considering the fact that several complaints were received from members of public relating to spurious calls and fictitious offers involving insurance products, IRDAI launched a multi-pronged campaign to caution members of public through print, electronic and mass media including Internet and by way of specific directions to insurers to incorporate the caution in their publicity material in policy related advertisements as well as advertisements in print, electronic media and TV.

VII. ACTION BY INSURERS

Insurers have also been taking the issue of mis-selling seriously by doing a root cause analysis of mis-selling complaints to identify the major causes and have taken steps to prevent or reduce mis-selling through steps to ascertain suitability of product, place controls on the various channels tuning it based on the vulnerability of the channel and have a strategy on dealing with complaints of mis-selling.

In addition to the action taken by IRDAI based on the examination of complaints by the insurers, they also take up action against the agents or intermediaries in the form of issuing warning letters, terminating employees, filing police complaints and most commonly resort to claw-back of commission wherever the policies have been cancelled as a consequence of proven mis-selling.

Further, every insurer has a Board approved insurance awareness policy containing the strategy and efforts to build awareness among customers.

VIII. INSURANCE LAWS (AMENDMENT) ACT, 2005

The amendments to the Insurance Act, 1938 have been made through the enactment of Insurance Laws (Amendment) Act, 2015. These changes will enable the interests of consumers to be better served through provisions like those enabling penalties on intermediaries / insurance companies for misconduct and disallowing multilevel marketing of insurance products in order to curtail the practice of mis-selling. The amended Law has several provisions for levying higher penalties ranging from up to Rs.1 Crore to Rs. 25 Crore for various violations including mis-selling and misrepresentation by agents / insurance companies.

IX. CONCLUSION

To summarize, the problem of mis-selling of life insurance is a major cause of concern in expansion of life insurance business. The regulatory framework is adequate to prevent mis-selling. However, greater compliance with the relevant regulations, increased insurance awareness, simpler policy terms and conditions, greater adherence to code of conduct by agents and intermediaries, and self-discipline among insurance intermediaries and insurance companies can significantly reduce the mis-selling complaints without affecting the volume of new business. Since mis-selling impacts the trust and confidence on insurance companies, it is time the insurance companies wake up to the challenge and not only take initiatives in educating and empowering consumers leaving them the freedom to exercise an informed choice but also to rein in unscrupulous agents and intermediaries who are bringing business by resorting to cheating through false promises. Putting in place systems to examine complaints from the underwriting perspective and expeditiously redressing them where the policy appears inappropriate can help build trust in the public. The enhanced levels of penalties would also help in deterring insurers and the agents and intermediaries from resorting to mis-selling. However, penalty imposed would in no way compensate for the inconvenience caused to hapless customers subject to mis-selling or rectify the damage caused to the image of the life insurance sector which serves a very important social purpose of providing social security to the insured and mobilise long term funds for investment for economic growth and development of the country.

Data pertaining to Complaints in Life Insurance Sector.
- Information from Life Insurers on Mis-selling and spurious calls"

NAME OF THE INSURER: **AEGON RELIGARE LIFE INSURANCE COMPANY LIMITED**

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	71	5	562	62	13	444	47	12	188	180	30	1194
Bancassurance	20	Nil	258	29	9	241	9	5	115	58	14	614
Other Corporate Agents	362	14	3867	107	100	1941	72	21	644	541	135	6452
Brokers	128	9	1064	182	85	1057	195	63	1102	505	157	3223
Direct selling	27	Nil	75	16	5	81	4	1	57	47	6	213
Microinsurance agents	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Others (to be specified)	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
TOTAL	**608**	**28**	**5826**	**396**	**212**	**3764**	**327**	**102**	**2106**	**1331**	**342**	**11696**

– In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	19103	16042	5729	40874
Bancassurance	38	30	Nil	68
Other Corporate Agents	3798	3323	673	7794
Brokers	2667	4336	4059	11062
Direct selling	38697	40445	10255	89397
Others (to be specified)	Nil	Nil	Nil	Nil
TOTAL	**64303**	**64176**	**20716**	**149195**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	190	139	68	397
Bancassurance	Nil	Nil	Nil	Nil
Other Corporate Agents	308	230	70	608
Brokers	230	372	298	900
Direct selling	239	164	116	519
Others (to be specified)	Nil	Nil	Nil	Nil
TOTAL	**1212**	**866**	**494**	**2424**

4. Root Cause (s) for complaints relating to mis-selling

Customer comes back post expiry of the freelook period stating policy was sold to him:

- As single premium plan
- He will receive high bonus/returns after the policy is purchased
- Product terms and condition explained differs from the terms and condition given in the policy document.
- Promise of loan

5. Steps taken for ascertaining suitability of insurance product at point of sale

Intermediary/agent/sales person is trained to use financial planning tool at the point of sales. This tool helps in ascertaining that the product recommended is suitable to the needs of the customer. In the Agent Confidential Report, the agent/intermediary/sales person has to provide information relating to customer's annual income, assets, liabilities, etc and give confirmation of his financial condition. Underwriter does financial validation while underwriting the policy.

6. Channel-wise controls placed to prevent mis-selling

In all the channels, pre-login call is made to customer before login of the policy. In the call, customer has to validate the information like Name, DOB, address, payment mode, Premium amount and family details as mentioned in the proposal form. In the pre-login call customer is also informed that company does not give any kind of special gifts or bonus on the sale of policy. Customer is briefly informed about product features and benefits including exclusions. Internal campaigns in the form of screen saver, etc are also done in relation to correct selling. After receiving confirmation from the customer the policy is processed for issuance. Training is imparted to the sales force on the importance of right selling and disciplinary actions in case of proven misselling. Agent persistency and Product Churning Policy have been put in place to prevent or curb misselling. Persistency criteria is made part of Sales Force goal sheet. Each Sales person has been mandated to complete yearly online training course on Anti Fraud. Regular campaign are also undertaken to inform the customer about the features of product purchased by him/her.

7. Other Measures taken for addressing mis-selling

In complaint resolution letter, customers are specifically informed that a call was made to the customer at pre issuance stage by AEGON Religare Life Insurance on his/her contact number to reconfirm the details and terms and conditions of the plan mentioned in the Proposal form.

Customer is informed about the premium payment term and also informed that there is no mis commitment given with regards to any discount, bonus, gift and any other benefit.

Further customer is also informed not to believe or accept any commitment of a gift, bonus or discount if it has been offered as it is false and not legal.

Escalation Matrix is clearly mentioned on website which states:

Customer can write to coo.desk@aegonreligare.com if customer fails to get favorable response after writing to grievance.manager@aegonreligare.com

Further if customer is still dissatisfied with the resolution he receives from COO's Desk within 4 days, he may write to gro@aegonreligare.com

8. Procedure adopted for dealing with complaints of mis-selling

Pre- verification call recordings are checked to see if any objection was raised by the customer during the call.

Respective sales person (active) are informed about the complaints which are received. Sales person has to meet the customer and clarify his doubts as mentioned in the complaint and submit the report. In case of intermediary the complaint resolution report is taken from them.

9. Complaints relating to sale of policies after spurious calls (Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	3	0	49	3	0	44	1	0	44	7	0	137
Bancassurance	0	0	0	0	0	0	0	0	0	0	0	0
Other Corporate Agents	81	0	280	13	0	93	1	0	45	95	0	418
Brokers	11	0	53	19	0	117	4	0	96	34	0	266
Direct selling	6	0	50	1	0	152	2	0	114	9	0	316
Microinsurance agents	0	0	0	0	0	0	0	0	0	0	0	0
Others (to be specified)	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	**101**	**0**	**432**	**36**	**0**	**406**	**8**	**0**	**299**	**145**	**0**	**1137**

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

Customers are informed to :

- Ignore such calls
- Register on DNC (Do Not Call)
- To lodge the police complaint along with the details of phone call number etc.

11. Steps taken by the insurer to caution members of public about spurious calls

- To create awareness about Spurious calls SMS / Emails are sent to the customers on Quarterly basis
- On AEGON Religare website customer awareness is created under the tab IRDA Public Notice on Spurious Phone Calls and Fictitious/Fraudulent Offers
- All advertisements issued by AEGON Religare Life Insurance Co. Ltd have Spurious call disclaimer

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs (^)		
	2012 -13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Individual Agents	22	34	30	9	42	49	Nil	Nil	2 (5*)	181	123	55
Bank Assurance Agents/Employees	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Other Corporate Agents	6	6	0	11	17	15	Nil	Nil	2	308	230	69
Brokers	2	0	1	4	12	15	Nil	Nil	1	229	368	280
Employees of Insurer	32	27	9	8	10	28	Nil	Nil	2(5*)	Nil	Nil	Nil
Others (Spurious Tele-callers)	Nil	Nil	Nil	Nil	Nil	Nil	2 (13*)	2(#)	Nil	Nil	Nil	Nil
Total	**62**	**67**	**40**	**32**	**81**	**107**	**2**	**2**	**7**	**718**	**721**	**404**

Note: -

1. ** Number of policies against which FIR is logged.*
2. *# FIR logged for complaints received against non ARLI customer*
3. *^In relation to "Number of commission claw back's", commission reversal date is considered for financial year reporting and not the policy issued date*
4. *Details for FY 2014-15 is for the period April 2014 to Sept 2014*

NAME OF THE INSURER: **AVIVA LIFE INSURANCE COMPANY INDIA LIMITED**

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	249	123	1338	153	100	827	65	37	308	467	260	2473
Bancassurance	333	76	942	200	57	686	124	20	274	657	153	1902
Other Corporate Agents	0	9	7	1	0	6	0	0	3	1	9	16
Brokers	43	23	257	5	24	148	1	5	36	49	52	441
Direct selling	42	24	133	33	42	128	13	22	45	88	88	306
Microinsurance agents	0	0	0	0	0	0	0	0	0	0	0	0
Others (Referral)	124	142	1854	71	92	984	24	33	266	219	267	3104
TOTAL	**791**	**397**	**4531**	**463**	**315**	**2779**	**227**	**117**	**932**	**1481**	**829**	**8242**

– In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	48,265	28,181	9,734	86,180
Bancassurance	56,260	45,412	13,297	1,14,969
Other Corporate Agents	4,981	43	0	5,024
Brokers	2,571	658	77	3,306
Direct selling	27,453	29,481	9,702	66,636
Micro Agents	393	1,675	1	2,069
Others (Referral)	150	499	318	967
TOTAL	**1,40,073**	**1,05,949**	**33,129**	**2,79,151**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	842	1183	524	2549
Banc assurance	1900	2566	1111	5577
Other Corporate Agents	308	926	457	1691
Brokers	78	83	11	172
Direct selling	199	378	234	811
Others (to be specified)	0	0	0	0
TOTAL	**3327**	**5136**	**2337**	**10800**

4. Root Cause (s) for complaints relating to mis-selling

1. Customer's ignorance about the nature of products at the time of sale.
2. Customer lacks knowledge / understanding about the concept of insurance.
3. Unrealistic projection of product details by agent.
4. Lack of product knowledge of the agent/advisor due high attrition rate.
5. Tampering of documents
6. Instigation by Ex-employees and advisors.
7. After thought by customer not being satisfied with the fund performance and ignoring the insurance aspects.

5. Steps taken for ascertaining suitability of insurance product at point of sale

1. Need & Suitability based selling with checks inbuilt at login stage.
2. The Company provides training to the sales force over and above the minimum training stipulated under IRDA Regulations for advisors. Ethical sale, compliance requirements, minimum disclosure at the point of sale is emphasized during the training programs. The Company has a program named ASTRA (Aviva Sales Training and Recruitment Academy) in place with an objective to develop and improve the quality of our sales force through adequate training and regular monitoring

6. Channel-wise controls placed to prevent mis-selling

Controls

1. Proposal stage verification on recorded call
2. 3 Tier most important documents- formulates part of the policy document and is mandatory for customer sign along with the proposal form and is covered as a part of proposal stage verification on recorded call. If summarize key features of a product to ensure that the customer review the key features of the policy purchased, so that he/she can cancel the policy if there is any discrepancy.
3. Identification of Top Branches and Channels from where repeated complaints of Misselling / forgery are coming to ensure corrective measures is taken at Login stage and action thereafter
4. Surprise Visits / Weekly self assessment of documentation correctness of new proposals by Zonal Managers
5. Any new business proposal from a client who has existing policies where premiums are due within the next 45 days is questioned to ensure non diversion of renewal premium as new business premium
6. Orphan Channel Management by allocation of dedicated staff for servicing
7. Training and servicing desks to identify fraudulent documents and sign verification.
8. Signature mapping across all documents at all processing touch points.
9. Identification of negative locations PAN India and preventive quality checks on a case specific basis at login stage.

10. Investigation of customer profile through social sites, credit bureaus, NSDL, external agencies to ensure that information on proposal form is valid and not misrepresented by the sourcing sales.

11. Robust Know your customer process

12. Classification of customer into High, medium, low risk for Anti-Money laundering purposes.

The above controls are in place for agents, corporate agents, Bancassurance channel, brokers, direct selling and all other intermediaries.

7. Other Measures taken for addressing mis-selling

1. Bank account details along with proof mandatory at Login stage for Urban and Rural portfolio

2. Robust customer signature change process

3. Branch Operations & New Business training on fraud detection across PAN India conducted & embedded in performance score cards

4. Active Auto Pay promotion at New Business and Existing Business level to avoid policy lapsation and continuation of policy benefits to customers.

5. 100% check on Renewal Notices to carry Intimation of writing Policy/Proposal Number on Cheques to avoid misappropriation of premium

6. Financial Transactional level SMS (new and old number) at each leg to reduce instances of fraud

7. Customers are required to call / mail from registered contact number(s) / email id only to get the policy details.

8. Mystery shopping at medical centers to check their involvement in fraudulent activities.

8. Procedure adopted for dealing with complaints of mis-selling

1. Detailed discussion with the customer to understand the grievance.

2. Reported Mis-selling Complaint is highlighted to Sales force (Agent / Channel Partner) as per pre-defined grid for their inputs.

3. Sales force (Agent / Channel Partner) is required to touch base with customer and resolve the issues.

4. Legal and audit intervention at appropriate levels of investigation.

5. Basis the investigation findings Warning Letter, Termination, commission claw back is initiated against active agents (Agent / Channel Partner).

6. Orphan agent- clarification letter is sought from the agent.

9. Complaints relating to sale of policies after spurious calls (Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	0	12	14	1	27	25	1	7	12	2	46	51
Bancassurance	0	0	1	0	16	13	0	2	6	0	18	20
Other Corporate Agents	0	0	0	0	0	0	0	0	0	0	0	0
Brokers	0	3	2	0	12	8	0	6	8	0	21	18
Direct selling	0	2	0	0	9	9	0	1	2	0	12	11
Microinsurance agents	0	0	0	0	0	0	0	0	0	0	0	0
Others (to be specified)	0	12	9	0	37	35	0	13	13		62	57
TOTAL	**0**	**29**	**26**	**1**	**101**	**90**	**1**	**29**	**41**	**2**	**159**	**157**

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

Customer is informed to ignore and do not share confidential information or hand over any documents and details related to the Policy or cheque or cash to individual offering attractive reward for surrendering /discontinuing your policy as company shall not be responsible for any loss or damage arising out of any such spurious calls or mails.

All incidents of policy after the spurious call are reported to the Aviva's Complaint team by the customer. The customer complaints team carries out a basic due diligence and if the complaint is accepted the details are shared with Internal Audit team for a detailed investigation.

As per of the investigation, the following procedures are carried out by Internal Audit:

1. Ascertain whether the call was made by Aviva sales employee or agent with the help of employee or agent database maintained by our company.
2. In case the contact details are different from the old proposal with the details entered in new proposal, contact details are verified through the application named "True Caller" or with the help of external empanelled vendor on a case to case basis.
3. If step b results into a finding that the call was made by an Specified person of the Corporate Agent / Broker, the case is then escalated to the Corporate Agent / Broker for further investigations and action
4. Verify with the Aviva Business Protection team to ascertain whether any policy related information including the contact details of the policyholder were sent outside the Aviva domain. If yes, the email communication is retrieved and analyzed for review of the sender, content and recipient of the email.
5. Since new policy has been sourced after spurious calls, the following steps are also carried out
   a. Matching of customer signature in proposal form with the signatures on PQIS and other supporting documents is carried out to ascertain forgeries if any
   b. Proposal stage calling (PSC calls) is also verified to ascertain whether the verification was done by customer or not.

c. Verification of the mode of payment though which the premium has been received on a new policy is also conducted to analyze the trends if any.

d. The option of contacting customer to get further details is also evaluated on a case to case basis

Basis the Investigation and evidences, a show cause notice is issued to the active sales employee / agent of Aviva. Appropriate action is taken basis the facts of the case and revert to the show cause notice.

11. Steps taken by the insurer to caution members of public about spurious calls

1. Public notice released in leading dailies in English and Hindi.
2. Hero area banner with a dedicated page on dos' and don'ts of buying insurance
3. Spurious call awareness emailers were sent to customers periodically on registered email id and will be done going forward as well.
4. Spurious call awareness SMS are sent to customers periodically on registered contact number and will be done going forward as well.
5. The spurious call message is now part of all advertisements – Print/ TV/ BTL

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2012 -13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Individual Agents	0	2	4	25	37	31	0	0	0	83	58	37
Bank assurance Agents/Employees #	0	0	0	0	1	1	0	0	0	106	45	50
Other Corporate Agents	0	0	0	0	0	0	0	0	0	0	1	0
Brokers	0	0	0	0	0	0	0	0	0	17	3	1
Employees of Insurer *	6	4	3	19	12	8	0	1	1	0	0	0
Others (Spurious Tele-callers)	0	0	0	0	1	1	0	0	0	0	0	0
Others (Referral)	-	-	-	-	-	-	-	-	-	68	85	23
Total	6	6	7	44	51	41	0	1	1	274	192	111

- ** In 354 cases across the 3 financial years, no action has been taken by Insurer as the employee was not associated with the Organization at the time of closure of investigation.*
- *# 179 cases across the 3 financial years have been forwarded to Channel partner (Bancassurance). As informed by the Channel Partner, in 49 cases, no action has been taken by the Corporate Agent as the employee was not associated with the Corporate Agent at the time of closure of investigation. Further in 33 cases, channel partner's Investigating team is conducting its investigation and is under work in progress.*

NAME OF THE INSURER: **BAJAJ ALLIANZ LIFE INSURANCE COMPANY LTD**

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	16963	126	1103	31590	1294	3019	6479	499	671	55032	1919	4793
Bancassurance	472	38	192	472	277	336	103	81	118	1047	396	646
Corporate Agents	1781	63	540	2798	910	1499	338	153	305	4917	1126	2344
Brokers	496	6	92	441	236	388	56	50	135	993	292	615
Direct selling	339	10	69	365	57	80	82	13	34	786	80	183
Microinsurance agents	0	0	0	0	0	0	0	0	0	0	0	0
Others	242	7	16	352	242	246	133	79	167	727	328	429
TOTAL	**20293**	**250**	**2012**	**36018**	**3016**	**5568**	**7191**	**875**	**1430**	**63502**	**4141**	**9010**

– In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	464,586	367,973	110,308	942,867
Bancassurance	14,898	9,450	1,185	25,533
Other Corporate Agents	222,774	65,595	3,000	291,369
Brokers	4,144	3,458	796	8,398
Direct selling	24,152	8,244	2,674	35,070
Others (to be specified)	-	-	-	-
TOTAL	**730,554**	**454,720**	**117,963**	**1,303,237**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	5004	3785	1636	10425
Bancassurance	308	175	109	592
Corporate Agents	1643	1531	360	3534
Brokers	624	477	57	1158
Direct selling	20	206	7	233
Others	1154	688	14	1856
TOTAL	**8753**	**6862**	**2183**	**17798**

4. Root Cause (s) for complaints relating to mis-selling

- Incomplete details provided to the customer
- Malpractice

5. Steps taken for ascertaining suitability of insurance product at point of sale

The Company conducts a training program for all the SPs wherein Human Life Value (HLV) calculator to ascertain the gap is covered.

6. Channel-wise controls placed to prevent mis-selling

Steps taken by the Company to mitigate the intensity of mis-selling, inter alia, includes the following:

1. Various documents like pictorial depiction of Key Features, future renewal due dates, etc., have been included in the policy document to sensitize the customer of requirement to make payment of renewal premiums. The information is being provided in vernacular language also.
2. Necessary product training is provided to the insurance agents.
3. We are planning to develop an online training module on AML for all insurance agents and specified persons of corporate agents.
4. The Company is sending a communication "Quality Index Meter" at monthly intervals to corporate agents informing them about the complaints received for the insurance business sourced by them. Similar practice is proposed to be initiated against the insurance agents also wherein allegations of any nature are received from customer regarding insurance business solicited by them.
5. The Company has also initiated Root Cause Analysis for certain complaints depending on the severity of the complaint.
6. Strict monitoring of Fraud / Forgery cases is done and we have also terminated agents wherein the mis-selling ratio was higher and sensitized the Channel Partners by issuing Warning letters.
7. The Company has started verification calling for certain instances. All the alleged mis-selling cases are referred to the sales team for their inputs. Based on the investigation the final decision for CI / FLC is taken. The commission is automatically clawed back for all such cases.

7. Other Measures taken for addressing mis-selling

- Monthly report related to the Complaints including mis-selling region wise and partner wise is shared with the respective HOD.
- All the complaints related to the mis-selling are shared with Sales Admin team.

8. Procedure adopted for dealing with complaints of mis-selling

- Complainant is Acknowledged
- Investigation is done with the help of Sales Admin/ Sales team
- If required support is taken from Legal or Fraud Prevention Unit.
- Individual documents are checked
- Written confirmation on the complaint decision with escalation matrix is shared with the complainant.

9. Complaints relating to sale of policies after spurious calls (Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	56	0	11	90	23	9	10	9	10	156	32	30
Bancassurance	11	1	0	19	10	1	0	0	1	30	11	2
Corporate Agents	34	0	7	71	21	12	9	4	2	114	25	21
Brokers	12	0	0	6	1	7	4	1	0	22	2	7
Direct selling	4	0	0	3	2	0	0	0	0	7	2	0
Microinsurance agents	0	0	0	0	0	0	0	0	0	0	0	0
Others	63	2	0	51	21	9	9	5	15	123	28	24
TOTAL	**180**	**3**	**18**	**240**	**78**	**38**	**32**	**19**	**28**	**452**	**100**	**84**

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

- Investigation is done on the complaints
- On the basis of the investigation action are taken against concerned agents and channel.

11. Steps taken by the insurer to caution members of public about spurious calls

From the date of release of the IRDA Circular on spurious calls, we have ensured that all external communication intended for brand promotion for product and non product, mentions the 'spurious calls disclaimer' in required font size. This includes product/ non-product - literature, promotional collaterals, marketing collaterals for external campaigns etc .

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2012 -13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Individual Agents	43	311	500	44	94	101	-	-	-	1352	1840	405
Bank Assurance Agents/Employees	-	-	-	-	-	-	-	-	-	4803	4598	4203
Other Corporate Agents	-	2	-	-	1	-	-	-	-	1445	990	113
Brokers	-	-	-	-	-	-	-	-	-	628	552	207
Employees of Insurer	-	6	6	-	-	-	-	-	-	-	-	-
Others (Spurious Tele-callers)	-	-	-	-	-	-	-	-	-	-	-	-
Total	43	319	506	44	95	101	-	-	-	8228	7980	4928

**Numbers till 23/12/2014*

NAME OF THE INSURER: **BHARTI-AXA LIFE INSURANCE COMPANY LTD.**

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	266	1	479	369	0	350	1	0	2	636	1	831
Bancassurance	18	0	52	3	0	21	0	0	0	21	0	73
CA	360	0	480	69	0	107	1	0	24	430	0	611
Broker	703	0	615	1176	1	1032	414	2	626	2293	3	2273
Direct Selling	213	1	271	306	0	338	222	0	293	741	1	902
Others	28	0	19	64	0	17	6	0	4	98	0	40
Total	**1588**	**2**	**1916**	**1987**	**1**	**1865**	**644**	**2**	**949**	**4219**	**5**	**4730**

– In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	43352	37429	12538	93319
Bancassurance	0	0	0	0
Other Corporate Agents	2373	1153	516	4042
Brokers	36212	38005	16208	90425
Direct selling	17685	28046	7541	53272
Others (to be specified)	0	0	0	0
TOTAL	**99622**	**104633**	**36803**	**241058**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	811	920	402	2133
Bancassurance	1	1	0	2
Other Corporate Agents	538	148	69	755
Brokers	2118	2434	1130	5682
Direct selling	372	403	167	942
Others (to be specified)	0	0	0	0
TOTAL	**3840**	**3906**	**1768**	**9514**

4. Root Cause (s) for complaints relating to mis-selling

Key Reasons/ root causes for mis-selling include:

Wrong information by the seller (agents/ advisors) mainly in terms of:

a) Policy Tenure

b) Features and benefits of the product being offered

c) Product different than explained

d) Assurances apart from those covered under the product

Root causes of such complaints are:

a) Mal-intention of the agent/ advisor

b) Customer not having gone through the product features/ signing partly filled proposals

c) Improper financial need analysis

5. Steps taken for ascertaining suitability of insurance product at point of sale

- **Training for Distributors:**Agent and Manager training architecture has a module on Need identification and presenting solutions which educate the sales person on identifying and suggesting the best suited product. This module is done to all managers and agents during the induction program.
- **Mobile Training:**One of the key aspects of our training program is the mobile training it offers. Thus, training is offered at the location where the trainees are based. This training is imparted mainly to our partners who are located in far flung areas where we source business. Depending on the profile of the trainees, we can offer customized training to best suit their needs.

In insurance business, the sellers have to constantly reinvent themselves to cater to the changing needs of the customer and changing economic environment of the country.

- **Training for employees:**There are also induction courses across the organization and every new employee goes through these courses. Apart from induction training, there are periodic refresher training programs which are held from time-to-time.
- **Digital empowerment:** Our Digital platform has in place need-based sales which enables sales persons to take the customer through interactive process to identify, prioritize the need of the customer and suggest a product which fits his/her requirement. Currently this Tab based tool is available with 400 selected sales people.
- **Key Features Document:** We have reviewed our KFD and made it simpler for customers to comprehend. This is to ascertain that customer is aware of the product purchased and understand the most important features of the same.
- **Our website is updated** with the latest version of the premium calculator which facilitates need-based assessment of insurance for the customer.

6. Channel-wise controls placed to prevent mis-selling

Agents

- Pre Issuance Verification call to validate customer has been given the correct information about the feature & benefit of product
- Issuance after clearance of fund in the branches with high leakages
- IR penalty on selling another policy to the customer where existing policies are in lapsed mode

Corporate agents/ Brokers

1. Most of the large Brokers/Corporate Agents currently do pre- login verification call; before a proposal is logged in our branches
2. Pre login scrutiny done by dedicated non sales resources at branches and operations team check to reject applications in which discrepancies are found
3. Post login of cases and before issuance pre-issuance verification call is done by Bharti AXA Life to ensure clients are aware of the product details which he/she has bought
4. Regular product refresher training interventions of partner employees is done by the dedicated alternate channel training and sales team.
5. For Corporate Agents specified person signatures are verified in the branches; before login of cases. As SP's are only authorized to sell products
6. Dedicated Sales team managing broking and corporate agency business at branch level and regional level to control/reduce cancellations in the respective regions.
7. Currently Sales KPI has various parameters on business quality, persistency of business and renewals

Banc assurance

Presently Bharti AXA does not have any Banca Channel for sourcing business

Direct selling

- Pre Issuance Verification call to validate customer has been given the correct information about the feature & benefit of product
- IR penalty on selling another policy to the customer where existing policies are in lapsed mode
- Ongoing trainings are conducted on Need-based selling, Product details, risk matrix, relevance of ACR and process of fillupof proposal form, etc, to minimize instances ofmis-selling.

Others

7. Other Measures taken for addressing mis-selling

To address the mis-selling aspect and to control on the complaints that could arise of this nature, below measures are taken by Bharti AXA Life:

- Implementation of Pre- Issuance verification calling for Proprietary & Third party which address issues related to mis-selling & Signature forgery
- Publication of posters, e-mailers, case studies on sales practices risk
- Quarterly visits and written communications to partners(third party) to derive high quality sales
- Discussion with respective Sales Heads on high risk partners to drive quality business
- Market conduct reviews and publication of results of discussions on sales practices issues
- Awareness session in branches on Risk & Compliance during branch visits
- Quarterly publication of Risk dashboard to the respective SalesHeads for necessary action

8. Procedure adopted for dealing with complaints of mis-selling

Various checks are conducted at the centralized Grievance team that has dedicated individuals to handle policyholder complaints.

While the team outcalls the complainants to address their concerns and also provides best options to them to continue the policy, below mandatory checks are conducted to provide a fair decision:

- Vintage of Policy i.e. date of policy issuance versus the first complaint date
- Details of the Plan opted versus policyholder's profile
- Availability of the Pre login Verification call
- Any relevant interactions of the customer recorded with the Company
- Renewal Payment history, alongwith status of the policy
- Policy Bond dispatch/ delivery records
- Inputs from our Sales representatives are taken to understand the pitch done at the sourcing stage

9. Complaints relating to sale of policies after spurious calls (Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2012-13			2013-14			2014 -15			Total
	I	P	R	I	P	R	I	P	R	
Individual Agents	1	0	4	2	0	1	0	0	0	8
Bancassurance	1	0	1	0	0	0	0	0	0	2
CA	2	0	8	3	0	5	0	0	0	18
Broker	4	0	21	11	0	21	0	0	3	60
Direct Selling	5	0	16	1	0	1	0	0	4	27
Others	8	0	24	8	0	4	0	0	0	44
Grand Total	**21**	**0**	**74**	**25**	**0**	**32**	**0**	**0**	**7**	**159**

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

Detailed Process is as attached herewith.

11. Steps taken by the insurer to caution members of public about spurious calls

At Bharti AXA, we respect our customers' privacy and would never compromise on their personal and policy related information.

The theme of spurious calls was also featured in our Customer Education Initiative, wherein we have sensitized all our policyholders on the kind of spurious calls and the action to be taken on occurrence, if any.

We reach out to customers are via Emailers, Letters, SMS and through our website updates.

With this communication, we urge our customers not to fall prey to unsolicited calls from people with vested interests.

We have a robust Risk Control Unit, which is strongly equipped to handle all such spurious call cases.

For all proven cases, strong disciplinary action has beeninitiated against the perpetrators.

As an organization, we have a multi-pronged strategy for sensitization and education of all stakeholders – i.e. employees, associates and policyholders – wherein they are continuously apprised and educated on identification and dealing appropriately with the same.

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2012 -13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Individual Agents	229	302	129	46	91	53	0	0	0	59	21	1
Bank Assurance Agents/Employees	0	0	1	0	0	1	0	0	0	1	0	0
Other Corporate Agents	0	0	0	0	0	0	0	0	0	106	1	0
Brokers	0	0	0	0	0	0	0	0	1	248	102	169
Employees of Insurer	149	173	107	45	55	25	3	4	2	0	0	0
Others (Spurious Tele-callers)	0	0	0	0	0	0	0	2	0	0	0	0
Total	**378**	**475**	**237**	**375**	**146**	**79**	**3**	**6**	**3**	**414**	**124**	**170**

**Number of policies eligible for commission claw back: 708 (Of these in 578 cases, commission was claw backed)*

NAME OF THE INSURER: **BIRLA SUN LIFE INSURANCE COMPANY LIMITED**

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	600	239	4259	484	128	4805	343	82	2572	1427	449	11636
Bancassurance	45	24	596	48	18	679	22	3	349	115	45	1624
Other Corporate Agents	502	202	4015	625	211	5349	242	49	1207	1369	462	10571
Brokers	916	423	9100	891	218	9527	550	108	4283	2357	749	22910
Direct selling	5	1	39	13	6	107	10	8	40	28	15	186
Microinsurance agents	2	2	34	2	0	35	6	1	15	10	3	84
Zero policy	3	10	276	0	0	190	4	0	66	7	10	532
TOTAL	2073	901	18319	2063	581	20692	1177	251	8532	5313	1733	47543

– In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	334426	253631	76841	664898
Bancassurance	24780	15769	6907	47456
Other Corporate Agents	157761	112524	6922	277207
Brokers	28888	24564	7222	60674
Direct selling	9858	7905	1722	19485
Others (to be specified)	2889	1377	14935	19201
TOTAL	**558602**	**415770**	**114549**	**1088921**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	7767	5909	2322	15998
Bancassurance	293	239	101	633
Other Corporate Agents	2789	1718	234	4741
Brokers	2743	2559	1016	6318
Direct selling	117	163	53	333
Others (to be specified)	220	154	56	430
TOTAL	**13929**	**10742**	**3782**	**28453**

4. Root Cause (s) for complaints relating to mis-selling

- Unfair Business Practices
- Freelook opted due to Mis-selling
- Product not as per customers requirement
- Single term policy issued as multiple term
- Misappropriation of premiums

5. Steps taken for ascertaining suitability of insurance product at point of sale

Birla Sun Life has taken several measures to ensure that the Customer is made aware of the product purchased as well as is suitable.

1. For policies sourced by broker business, a Joint Declaration Form (JDF) was introduced to ensure that sales person has explained the product features and customer signs the form confirming the same.
2. PIVC(Pre Issuance Verification Call) initiated to explain product feature and take customer consent before issuance
3. Financial underwriting initiated for Elderly lives to ensure suitable product is sold as per their profile.
6. Channel-wise controls placed to prevent mis-selling

Brokers

- It was noted that incidence of mis-selling from some telesales business partners was very high.
- Established ground rules for tele sales business. To discontinue working with partners who are non compliant.
- The Company has exited all tele channel partner business effective 1st October 2014 where quality of sourcing was found to be concern
- Strict action against the channel partners as defined in the governance framework where misselling is proven
- Cases where complaints are settled favorably, commission claw back is effected
- Pre Issuance Verification Call / Pre Login Verification call & submission of Joint Declaration Form

Agents

- Cases where complaints are settled favorably, commission claw back is effected
- Warning letters / termination of the agents for instances where mis-selling has been proven
- Pre Issuance Verification Call / Welcome Call

Corporate agents : Pre Issuance Verification Call / Pre Login Verification call and submission of Joint Declaration Form

Bancassurance : Welcome call to customers

Direct selling : Welcome call to customers

Others: Welcome call to customers

7. Other Measures taken for addressing mis-selling

- We have made amendments in the underwriting guidelines for Senior citizens.
- PIVC has been introduced for Fund Transfer cases to ensure genuinity .
- Introduced Joint Declaration Form (JDF) which is signed by the client confirming the Policy taken and agreeing to the terms and conditions.
- Investigating all complaints and reaching out the customer to find out root cause and take preventive action to curb mis-selling.

8. Procedure adopted for dealing with complaints of mis-selling

1. BSLI grievance team follows the below Investigation points for resolving misselling complaints:

- All documents viz. application form, illustration, KYC , Joint Declaration form (JDF) submitted at the time of sale are verified to check customer information is correct and consent is provided by the policy owner
- Signatures are verified from external agency for signature forgery cases
- Pre Issuance Verification call (PIVC) referred to check customer's consent on policy issuance
- Sales team inputs taken on the complaints raised against adviser/channel partner
- Customer interaction history with BSLI is checked for tracing any similar concerns/query raised in past
- Policyholder/insured profile is checked for appropriateness of product sold viz age/education/ profession/income/insurance solution offered/earlier policies opted from BSLI

2. BSLI grievance team takes the decision based on the investigation outcome.
3. Outbound call made to the policy owner to intimate the complaint decision and written communication is subsequently sent vide e-mail/letter

9. Complaints relating to sale of policies after spurious calls (Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	3	5	447	1	5	554	11	1	488	15	11	1489
Bancassurance	2	3	59	1		44	2	0	29	5	3	132
Other Corporate Agents	3	1	51	4	1	93	4	0	51	11	2	195
Brokers	15	8	554	20	10	377	32	4	272	67	22	1203
Direct selling	0	0	0	0	0	1	1	0	5	1	0	6
Microinsurance agents	0	0	2	0	0	3	0	0	0	0	0	5
Others (Zero Policy)	2	0	145	0	0	42	0	0	0	2	0	187
TOTAL	**25**	**17**	**1258**	**26**	**16**	**1114**	**50**	**5**	**845**	**101**	**38**	**3217**

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

1. BSLI compliance team Investigates all complaints based on the information provided by the client
2. Investigating team visits the client's locations and also does mystery shopping's on many occasions to nab the culprits
3. Written communication is sent to the complainant educating them of the hoax calls menace with advice to observe caution viz. no payment/documents to be handed over to any person on the basis of such hoax calls, register their contact nos. under DNC registry

11. Steps taken by the insurer to caution members of public about spurious calls

Marketing and customer Service Initiative :

- The customers have been informed through various channels like newspaper advertisements, SMS, e mails and individual letters.
- Marketing has taken an aggressive campaign at Pan India level using all such channels.
- Various cases studies, communication to Sales personnel through online portal and mailers.

Industry Level:

- At an Insurance industry level FIR has been filed at EOW, Delhi to investigate on the errant telemarketers and was also flashed in the newspapers at Delhi.
- Regular meeting with the life council and IRDA to address this concern.

Company Level:

- Many complaints had been filed before the Legal Authorities at various locations, at Delhi and Mumbai;

- Raids had been conducted by Police Authorities basis their investigations and due arrests have been made.
- Investigating all complaints and reaching to the customer to find out root cause and take preventive action
- Mystery shopping done on various occasions to nab the culprits.
- Various other measures initiated by the company to curb Data leakage

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2012 -13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Individual Agents	113	331	203	176	463	218	0	1	0	386	426	351
Bank Assurance Agents/Employees	0	0	0	0	1	0	0	0	0	99	57	19
Other Corporate Agents	5	6	0	29	69	10	0	0	0	324	952	394
Brokers	19	23	4	27	19	4	0	0	0	891	1228	850
Employees of Insurer	2	1	0	1	0	0	0	0	0	0	17	12
Others (Spurious Tele-callers)	0	0	0	0	0	0	0	98	154	0	0	0
Total	**139**	**361**	**207**	**233**	**552**	**232**	**0**	**99**	**154**	**1700**	**2680**	**1626**

**Number of policies eligible for commission claw back: 708 (Of these in 578 cases, commission was claw backed)*

NAME OF THE INSURER: **CANARA HSBC ORIENTAL BANK OF COMMERCE LIFE INSURANCE CO. LTD.**

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	0	0	0	0	0	0	0	0	0	0	0	0
Bancassurance	1033	63	848	993	37	770	296	31	287	2322	131	1905
Other Corporate Agents	1	0	3	2	0	1	0	0	1	3	0	5
Brokers	0	0	0	0	0	0	0	0	0	0	0	0
Direct selling	0	0	0	0	0	0	0	0	0	0	0	0
Microinsurance agents	0	0	0	0	0	0	0	0	0	0	0	0
Others (to be specified)	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	**1034**	**63**	**851**	**995**	**37**	**771**	**296**	**31**	**288**	**2325**	**131**	**1910**

– In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	0	0	0	0
Bancassurance	73310	51262	24915	149487
Other Corporate Agents	33	-2	0	31
Brokers	0	0	0	0
Direct selling	0	112	268	380
Others (to be specified)	0	0	0	0
TOTAL	**73343**	**51372**	**25183**	**149898**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	0	0	0	0
Bancassurance	1341	1110	381	2832
Other Corporate Agents	5	2	0	7
Brokers	0	0	0	0
Direct selling	0	0	1	1
Others (to be specified)	0	0	0	0
TOTAL	**1346**	**1112**	**382**	**2840**

4. Root Cause (s) for complaints relating to mis-selling

There appears an expectation gap between the actual product offered and the understanding of the policyholder. Largely this problem seems to arise as the policyholder does not read the complete proposal form or the product brochure before applying for an insurance policy and many times even after receipt of the policy document they fail to exercise the free look benefit. As a process, the Company makes a validation / welcome call to all the customers subject to contactability to ascertain if they have any concerns with regards to the policy. In all these cases the customers have signed the proposal form, benefit illustration and therefore, it is difficult to establish and identify the correctness of the complaint or if it was only an afterthought to cancel the policy.

5. Steps taken for ascertaining suitability of insurance product at point of sale

Canara HSBC OBC Life Insurance Co Ltd encourages the Specified Persons of its corporate agent to conduct need analysis for all sales solicitations. It has also provided necessary tools e.g "FHC-ALM" document to capture details like, income, risk cover required, expenses, customer's risk appetite etc to arrive the suitability requirements for the customer before suggesting a product plan

6. Channel-wise controls placed to prevent mis-selling

Agents - NA

Corporate agents / Bancassurance : The following measures have been taken to address misselling concerns:-

1) Validation call – Post login of proposal form (and pre issuance of the same), call outs are made to customer to reiterate key product features, benefits etc. This helps in clarifying customer issues/concerns / queries (if any) prior to issuance of policy

2) Key Information Document (KID) – A KID has been introduced which provides key disclosures about the product in simple language to the customer e.g lock in period, premium paying term, policy term, etc. A copy of KID is handed over to the customer also sent along with the policy bond

3) Replacement of old policies – All new proposals sourced are de duped against existing policies and if there are any matches with existing policies which are in 'discontinued' status, then a call out is made mandatorily to the customer to confirm if he has understood the risks associated and new proposal is processed only post receipt of customer confirmation on the same

Brokers - NA

Direct selling - NA

Others - NA

7. Other Measures taken for addressing mis-selling

1) Training- Specific training is imparted to Specified Persons in regions/clusters of the bank which show higher trend for complaints, lapse etc

8. Procedure adopted for dealing with complaints of mis-selling

As part of the company's initiatives to mitigate misspelling, the company has introduced PVC policy (potentially vulnerable customers) to do a suitability analysis and ensure that the product being sold is suitable for the customer based on certain parameters. This policy is based on considering the appropriateness of the product for the target customer, and ensuring that the product has been presented in a manner which increases transparency and helps the customer understand the products. Since, "potential vulnerability" involves a degree of subjectivity, the below key criteria is being used to identify PVC customers;

- Age based criteria: Customers aged 55 and over at the time of taking the policy
- Customers with an annual income of Rs 100,000 or below
- Customers who have lower educational qualification (Class X or below) and who are employed in certain professional activities to earn their living.

Appended are the various modifications which have been implemented in the current procedures as per the PVC policy.

1. In situations where the customer has limited understanding of English language, the sales person speaks and understands the language spoken by the customer. Additionally, the sales literature and brochures used during the sale is in the language that is understood by the customer.
2. While it is the responsibility of the SP to ensure the sale was made in a transparent manner, the Company will be responsible to ensure that suitability was assessed at the time of sale and the right product was offered/ sold to the customer in line with internal procedures. Assessment of suitability will typically involve consideration of customers need for contingency funds, their appetite to risk and their need behind the investment (savings, protection, building a retirement corpus, etc).
3. The Underwriting procedures and new business login procedures have been enhanced to ensure that the requirements under the policy and rules laid out for respective category of PVC customers are complied with.
4. During the validation call to such customers, the company will among other features reiterate the following key terms to enable the customer to understand the product
   (i) customers are aware of the premium payment term,
   (ii) product sold to them is suitable,
   (iii) charges structure including implications for mortality charges(especially for aged customers) is clearly explained.
5. Inaddition to above, the Company works on the principle of TCF (Treating customers fairly) at the time of complaint investigation to ensure that all policy related facts, documentation & communication is reviewed before taking a final decision on the complaint and benefit of doubt is given to the cuistomer.

9. Complaints relating to sale of policies after spurious calls (Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Bancassurance	0	0	0	0	0	0	0	0	0	0	0	0
Other Corporate Agents	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Brokers	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Direct selling	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Microinsurance agents	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Others (to be specified)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
TOTAL	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

The Company investigates all such cases wherein Customer has alleged to have received spurious calls and Company's policy was sold. The Customer is requested to share all relevant details including details of caller, number from which call was made and details of conversation.

Suitable action is taken basis the results of investigation

11. Steps taken by the insurer to caution members of public about spurious calls

- Customers have also been counseled by Company's staff to stay alert from fake offers being made on such calls and have been further reassured that Company takes all such complaints and feedback seriously
- In order to ensure that Customers do not fall prey to offers made through such spurious calls, the Company has put up relevant information about spurious calls on its website. The information is considered to be useful & handy for customers and informs them about what they should do when they receive such calls including some relevant FAQ's
- In line with the circular issued by the authority, all marketing campaigns undertaken by the Company have necessary guidance on spurious calls to enhance Customer awareness & subsequent action to be taken
- The Company has run awareness campaigns through customer touch points like Investment newsletter, E-Mail & SMS campaign etc.
- The Company requests its Customers, who have been impacted as a result of such fake offers, to lodge an FIR with local police and share a copy of the same with the Company. The Company is committed to extend all support to the investigating agency and address Customer's grievance
- The Company continues to work with the industry and regulator to address the issue

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2012 -13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Individual Agents	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Bank Assurance Agents/Employees	0	0	0	0	0	0	0	0	0	189	448	98
Other Corporate Agents	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Brokers	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Employees of Insurer	0	0	0	0	0	0	0	0	0	0	0	0
Others (Spurious Tele-callers)	0	1	0	0	0	0	0	1	0	0	0	0
Total	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**189**	**448**	**98**

NAME OF THE INSURER: **DHFL PRAMERICA LIFE INSURANCE CO. LTD.**

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	227	24	131	170	9	295	61	14	187	458	47	613
Bancassurance	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Other Corporate Agents	5	2	2	13	2	2	19	1	42	37	5	46
Brokers	232	11	122	118	16	268	78	11	181	428	38	571
Direct selling	23	6	18	89	2	98	37	5	73	149	13	189
Microinsurance agents	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Others (Invalid complaints, without application/ policy numbers)	12	1	4	14	2	12	4	2	8	30	5	24
TOTAL	**499**	**44**	**277**	**404**	**31**	**675**	**199**	**33**	**491**	**1102**	**108**	**1443**

– In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	24,618	17,730	5,505	47,853
Bancassurance	506	665	188	1,359
Other Corporate Agents	48,681	11,903	5,737	66,321
Brokers	3,169	2,331	2,052	7,552
Direct selling	25,444	30,112	10,747	66,303
Others (to be specified)	NIL	NIL	NIL	NIL
TOTAL	**102,418**	**62,741**	**24,229**	**189,388**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	772	607	255	1634
Bancassurance	0	0	0	0
Other Corporate Agents	52	39	112	203
Brokers	255	167	128	550
Direct selling	142	293	243	678
Others (to be specified)	0	0	0	0
TOTAL	**1221**	**1106**	**738**	**3065**

4. **Root Cause (s) for complaints relating to mis-selling**

Single premium Policy issued as Annual premium policy -

- Majority cases were related to allegation around term of the policy altered to regular premium paying term instead of single premium. However, it was difficult to establish in cases where there was no overwriting in the proposal form and / or salespersons/agents were no more associated with the company and/or no such grievance was indicated in pre and post issuance verification calls made to the policyholder.

Malpractices and Unfair Business practices -

- Some business complaints pertained to senior citizens who were unable to pay premium for long period of time.
- Some business complaints were due to false/wrong commitments made by business partners/ channel/salespersons.

Tampering, Corrections, Forgery of proposal related papers -

- In some cases above allegations had been proven and grievance redressed through refund of premium as applicable, even though the salespersons/agents were no more associated with the company. However, in many cases such allegations could not be established.

5. **Steps taken for ascertaining suitability of insurance product at point of sale**

- The Company has initiated face to face meeting between the Customer and Senior Company officials prior to proposal login.
- The Company has initiated Pre-Issuance Verification calls to customers to verify proposal information and to detect malpractices/forgery/tampering/miss-selling instance.
- In case of senior citizens as policy holders –
    - o Face to face meeting has been formalized with Proposer/Life Insured and with Parent (in case insured is minor)
    - o For proposer Age & Premium paying term has been capped.
- The company makes Welcome Call to customer post policy issuance mostly within free look period to confirm that customer is aware of key policy features and benefits of the policy and is satisfied with sales person.

6. **Channel-wise controls placed to prevent miss-selling**

Agents

- Welcome call to policyholders done within 1 month of policy dispatch, with 100% call recording.
- PAN , voter ID card verification is done from government websites in all the cases to reduce document forgery complaints.(wherever applicable)
- Face to Face report (FTF) is submitted by Sales person confirming personal meeting with the policy holder and having explained all the features of the product.

Corporate Agents

- Welcome call to policyholders done within 1 month of policy dispatch, with 100% call recording.
- PAN , voter ID card verification is done from government websites in all the cases to reduce document forgery complaints.(wherever applicable)
- Face to Face report (FTF) is submitted by Sales person for premium >50k confirming personal meeting with the policy holder and having explained all the features of the product.

Banc assurance

- Welcome call to policyholders done within 1 month of policy dispatch, with 100% call recording.
- PAN , voter ID card verification is done from government websites in all the cases to reduce document forgery complaints.(wherever applicable)
- Face to Face report (FTF) is submitted by Sales person for premium >50k confirming personal meeting with the policy holder and having explained all the features of the product.

Brokers

- Pre-issuance verification call is made to the policy holder on recorded line at the time of receipt of the application form and KYC. This call helps in confirming documents submitted by the policy holder, contact details and key features of the policy.
- Welcome call done within 1 month of policy dispatch with 100% call recording to policy holders.
- PAN , voter ID card verification is done from government websites in all the cases to reduce document forgery complaints.(wherever applicable)
- Mobile/Landline phone bill is taken as an mandatory proof at the time of application solicitation.

Direct selling – NA

Others

- Welcome call to policyholders done within 1 month of policy dispatch, with 100% call recording.
- PAN , voter ID card verification is done from government websites in all the cases to reduce document forgery complaints.(wherever applicable)
- Face to Face report (FTF) is submitted by Sales person for premium >50k confirming personal meeting with the policy holder and having explained all the features of the product.

7. Other Measures taken for addressing mis-selling

Frequent training sessions organized by Compliance Unit for all employees to sensitize them about the code of conduct and selling ethics

For malpractices/malpractices/forgery/tampering/miss -selling where the Company substantiated misselling by the company sales employees/agents, necessary disciplinary action has been taken by the Company.

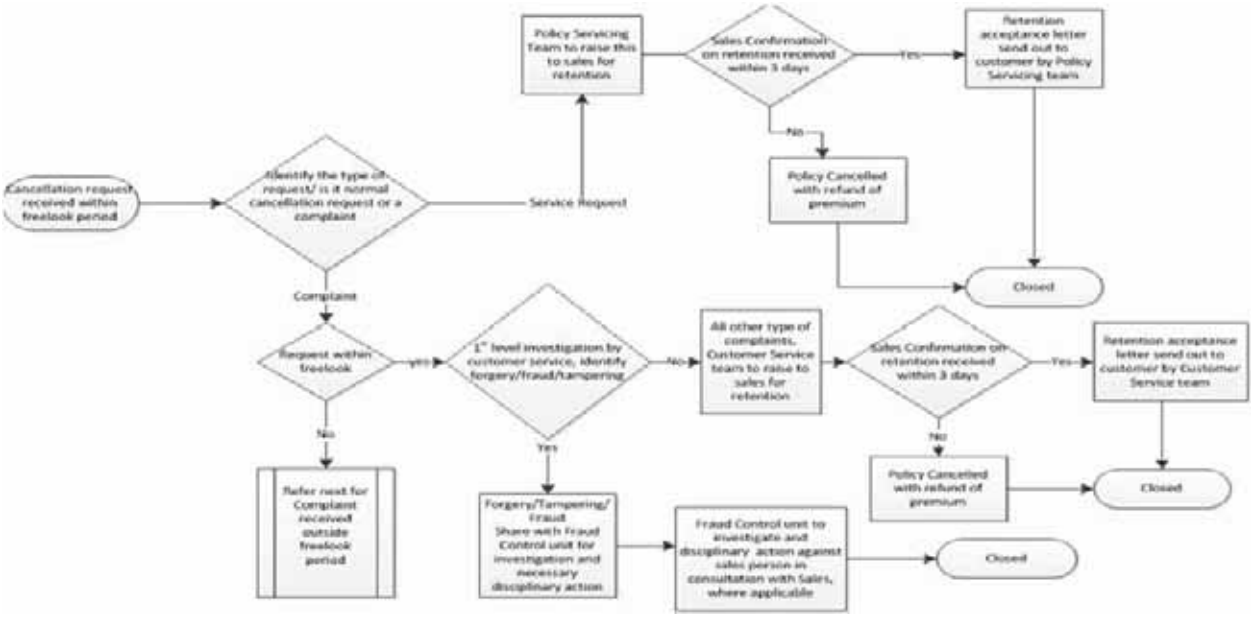
Business relationship ended with some channels where complaints were high.

In case of senior citizens as policy holders –

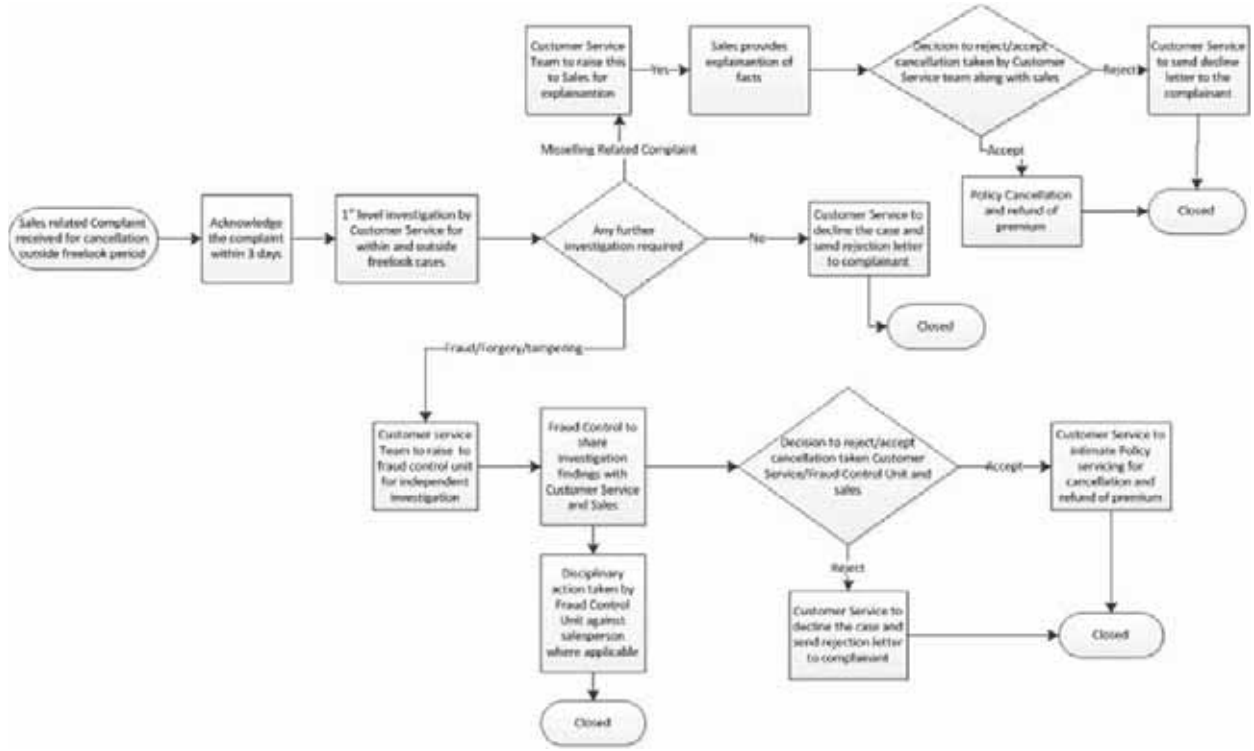
- Face to face meeting has been formalized with Proposer/Life Insured and with Parent (in case insured is minor)
- For proposer Age & Premium paying term has been capped.

8. Procedure adopted for dealing with complaints of mis-selling

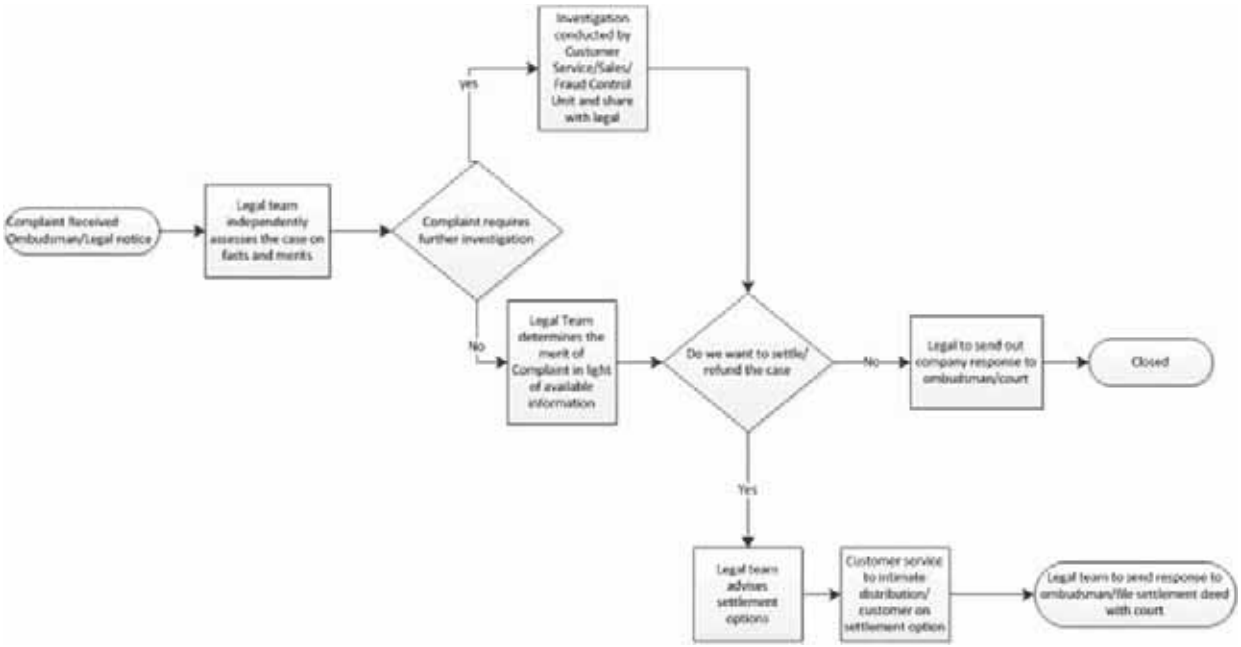
Cancellation Requests/Complaints within Freelook Period



Cancellation Requests/Complaints outside Free look Period



Process Flow: Legal/Ombudsman/Court Cases



9. Complaints relating to sale of policies after spurious calls (Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	4	Nil	4	3	Nil	15	1	1	5	8	1	24
Bancassurance	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Other Corporate Agents	Nil	Nil	Nil	Nil	Nil	Nil	1	Nil	1	1	Nil	1
Brokers	6	Nil	5	4	1	17	3	Nil	6	13	1	28
Direct selling	Nil	Nil	Nil	Nil	Nil	2	Nil	Nil	5	Nil	Nil	7
Micro insurance agents	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Others (Complaints from non policy holders	5	Nil	1	4	2	2	Nil	Nil	Nil	9	2	3
TOTAL	**15**		**10**	**11**	**3**	**36**	**5**	**1**	**17**	**31**	**4**	**63**

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

1. Collection of all the customer complaint letters with mentioned phone numbers along with other contact details
2. Updating Spread Sheet with the necessary information about the customer, policy number if any, spurious tele caller name and other contact details.
3. Filing complaints every Quarter with Economic Offense Wing (New Delhi) and Telephone Regulatory Authority Of India (TRAI).

4. In addition the cases which are investigated and malpractices are identified on the part of our distributor, disciplinary actions are taken.

11. Steps taken by the insurer to caution members of public about spurious calls

(1) IRDA circular no IRDA/CAD/PNTC/MISC/046/01/2014 Dated 29-01-2014, displayed on company website regarding spurious calls to spread awareness and caution to general public and customers.

(2) Customer awareness SMS are sent from time to time to all customers educating them about spurious calls.

(3) Customer awareness E-Mails are sent from time to time to all customers educating them about spurious calls.

(4) All advertisements have warning regarding spurious calls and fictitious/fraudulent offers.

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2012 -13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Individual Agents	35	14	7	12	12	18	3	1	102	73	65	79
Bank Assurance Agents/Employees	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Other Corporate Agents	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	4	3	23
Brokers	Nil	Nil	Nil	Nil	2	8	1	1	12	50	65	78
Employees of Insurer	22	13	14	3	9	11	Nil	1	51	Nil	Nil	Nil
Others (Spurious Tele-callers)	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Total	**57**	**27**	**21**	**15**	**23**	**37**	**4**	**3**	**165**	**127**	**133**	**180**

**The above number of commission claw back may include cases where in commission paid has not yet been recovered from the distributors*

NAME OF THE INSURER: **EDELWEISS TOKIO LIFE INSURANCE CO. LTD.**

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	25	1	5	31	0	39	27	0	49	83	1	93
Bancassurance	0	0	0	1	0	0	0	0	1	1	0	1
Other Corporate Agents	5	0	0	19	0	9	8	0	6	32	0	15
Brokers	9	0	0	19	0	15	14	0	15	42	0	30
Direct selling	1	0	0	6	0	2	12	0	18	19	0	20
Micro insurance agents	0	0	0	0	0	0	0	0	0	0	0	0
Others (to be specified)	3	0	0	0	0	0	0	0	0	3	0	0
TOTAL	**43**	**1**	**5**	**76**	**0**	**65**	**61**	**0**	**89**	**180**	**1**	**159**

– In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	16445	23842	7051	47338
Bancassurance	47	1081	877	2005
Other Corporate Agents	0	1662	621	2283
Brokers	419	1236	573	2228
Direct selling	6044	4800	613	11457
Others (Micro Insurance Agents)	-	230	303	533
TOTAL	**22955**	**32851**	**10038**	**65844**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	221	525	91	837
Bancassurance	0	8	6	14
Other Corporate Agents	0	51	14	65
Brokers	39	56	10	105
Direct selling	157	303	11	471
Others (to be specified)	0	0	0	0
TOTAL	**417**	**943**	**132**	**1492**

4. Root Cause (s) for complaints relating to mis-selling

From the analysis of the past data, the major causes for complaints related to mis-selling shows certain difference in the features explained and actual benefits. It also involves the gap in customer's understanding of the product and difference in premium paying period. The Company has defined a governance matrix to deal with various types of complaints. The complaints are analyzed and appropriate actions are being taken against the concerned sales personnel or agent where over required. The governance action includes, caution, warning letters and termination of agency or employment depending on the nature of complaint.

5. Steps taken for ascertaining suitability of insurance product at point of sale

Vijay Path - Unique Sales Approach - The Company has designed a unique program called 'VIJAYPATH' based on the need based sales approach, which emphasis understanding the customer's needs and suggesting/recommending the solution based on customers need. Our products are designed based on different needs of customers. At all times while designing the process, one thought was kept in mind "Customer Centricity" and as an outcome. Vijay Path educates and helps the customer(s) to know about his present priority and the financial cost associated with it. It helps in finding out how much does he presently has, how much more is needed, and what is the gap? Many times, customer may know their priorities and needs but do not know what will be the cost of it as of today or a few years down the line when it will be time when he requires his needs to be met. This process helps in evaluating the same. Once the thought provoking exercise is completed, the customer knows what he needs to do now. It's like getting out of the state of "I don't know what I don't know". The four steps that we follow in the process are in the order of any professional conversation that one would have with their customers. The 1st step is about introduction of the Company and self and knowing the customer's personal details. The next stage is to understand one's need and help them (Needs are distinguished from Wants because a deficiency would cause a clear negative outcome). So, the 2nd and 3rd step is to explore priority and analyse and prepare and present, respectively. Once the need is established, the solution is presented and thereafter, it's time to take a decision and hence the 4th step is to close and review. Thus we ensure suitability of insurance products at point of sale.

6. Channel-wise controls placed to prevent mis-selling

The Company with an objective of achieving the Vijay Path mantra of listening and understanding the customer needs before providing the solution, and to prevent mis-selling, focuses on mandatory training for all identified distribution channels emphasizing on the adherence to code of conduct and fair practices. In order to prevent mis-selling, various training programs are undertaken at all levels focusing on customer centricity. Customer Centricity training is made mandatory for all direct sales employees. Even various online training modules are introduced and conducted online tests to sales personnel including the agents. As a corrective action, wherever mis-selling and malpractices are seen, appropriate actions are being taken as per the defined governance matrix. The random sampling is also carried out frequently in order to ascertain the mis-selling if any and to curb such malpractices.

7. Other Measures taken for addressing mis-selling

Few other measures adopted by the Company to address the issue of mis-selling includes -

1. Welcome Calls - We make welcome calls to the customer post issuance of the Policy where in addition to getting confirmation on details given by him we also we ask him or her on the product terms and condition are well understood or not.. Further, one of the key initiatives

suggested by the Policyholder Protection Committee (PPC) of the Company was related educating existing and prospective customers on spurious/hoax calls which we do through SMS on regular basis.

2. Pre Login Verfication Call has already been initiated for Term Plan which will in its later phase cover all products and channels

3. Various customer centric campaigns are being conducted across all branches and regions. We have also conducted market research for understanding the consumer's philosophy on insurance, which revealed that most consumers find insurance a too complex product and look for someone who understands their needs and suggest right product. With an objective of bridging this gap, we have launched our brand campaign based on core organizational philosophy of a need based approach in offering insurance solutions. This is done with an objective of ultimately addressing the issues on mis-selling.

4. Customer Relations Programs "Sampark" – In order to understand concerns of the Customers, the company has initiated a unique program called Sampark. These programs focused on reaching out to our customers and understand their experience with the company and also acknowledge them. Under this program, the employees of the company meet the customers.

8. Procedure adopted for dealing with complaints of mis-selling

- Alert is sent to all internally regarding the complaint for immediate attention
- We ensure that our representative meets with the customer in order to resolve their grievance
- All material facts related to the policy are collected to verify key details
- If the decision is in favor of the customer and mis-selling is seen appropriate disciplinary action is taken against the sales person / employee

9. Complaints relating to sale of policies after spurious calls (Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	3	0	0	0	0	2	0	0	2	3	0	4
Bancassurance	0	0	0	0	0	0	0	0	0	0	0	0
Other Corporate Agents	0	0	0	11	0	0	1	0	4	1	0	4
Brokers	3	0	0	0	0	1	4	0	1	18	0	4
Direct selling	1	0	0	0	0	4	0	0	0	1	0	0
Micro insurance agents	0	0	0	0	0	0	0	0	0	0	0	0
Others (to be specified)	1	0	0	0	0	0	0	0	0	1	0	0
TOTAL	**8**	**0**	**0**	**11**	**0**	**5**	**5**	**0**	**7**	**24**	**0**	**12**

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

Upon receiving the complaint related to spurious calls which resulted into sale of policies, the Company as a practice approaches the customer to understand the concern and to gather the information for initiating the investigation. Wherever it was established that policy was given to the customer based on spurious calls received from various unidentified persons, and the complaint is genuine, the policies were cancelled and monies duly returned to the complainant. Even the company has filed the police complaint against the unidentified persons in few cases in order to further investigate and handle the matter.

11. Steps taken by the insurer to caution members of public about spurious calls

In order to create awareness on the spurious calls amongst the customers, the Company has stated sending the communication to customers on regular basis through SMS. Also, in all the advertisement materials (physical, online or video), the mandatory disclaimer on spurious call are incorporated to create and educate the customers about the same.

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2012 -13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Individual Agents	0	6	2	0	4	3	0		0	0	0	0
Bank Assurance Agents/Employees	0	0	0	0	0	0	0	0	0	0	0	0
Other Corporate Agents	0	0	0	0	0	0	0	0	0	0	0	0
Brokers	0	0	0	0	0	0	0	0	0	0	0	0
Employees of Insurer		10	8	0	4	4	0	0	0	0	0	0
Others (Spurious Tele-callers)	0	0	0	0	0	0	2	4	0	0	0	0
Total	**0**	**16**	**10**	**0**	**8**	**7**	**2**	**4**	**0**	**0**	**0**	**0**

**for policies cancelled due to mis- selling/other unfair practices commission is clawed back from intermediary as a process.*

NAME OF THE INSURER: **EXIDE LIFE INSURANCE COMPANY LIMITED**

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	388	125	194	296	183	143	266	195	83	950	503	420
Bancassurance	129	53	92	130	103	94	101	86	47	360	242	233
Other Corporate Agents	65	22	33	53	48	24	36	34	11	154	104	68
Brokers	43	18	24	120	168	176	186	214	122	349	400	322
Direct selling	11	7	6	21	27	15	68	59	26	100	93	47
Microinsurance agents	-	-	-	-	-	-	-	-	-	-	-	-
Others (to be specified)	4	1	-	5	4	-	-	-	-	9	5	-
TOTAL	**640**	**226**	**349**	**625**	**533**	**452**	**657**	**588**	**289**	**1922**	**1347**	**1090**

– In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	701	420	275	1396
Bancassurance	177	135	99	411
Other Corporate Agents	45	29	17	91
Brokers	21	68	55	144
Direct selling	18	10	7	35
Others (to be specified)	1	-	-	1
TOTAL	**963**	**662**	**453**	**2078**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	221	570	511	1302
Bancassurance	59	191	169	419
Other Corporate Agents	6	17	24	47
Brokers	14	234	304	552
Direct selling	2	28	71	101
Others (to be specified)	5	1	1	7
TOTAL	**307**	**1041**	**1080**	**2428**

4. Root Cause (s) for complaints relating to mis-selling

1. Lack of proper communication between the advisor and customer
2. Push of particular products which may not be ideal for the customer
3. Spurious calls
4. Mis-communication on term of policy

5. Steps taken for ascertaining suitability of insurance product at point of sale

1. Customer is contacted, met and taken through a planning exercise to ascertain type of policy and coverage details.
2. Life insurance advisors are licensed and only then authorized to sell insurance products

6. Channel-wise controls placed to prevent mis-selling

1. Welcome calling confirmation on purchase, post policy issuance, prior to dispatch of bond.
2. Pre-login verification calling at partner premises prior to log in of proposal
3. Partner-wise investigation of complaint and action against individual taken if proven as misselling.

7. Other Measures taken for addressing mis-selling

As above

8. Procedure adopted for dealing with complaints of mis-selling

1. Investigation of complaint and action against individual , if proven as mis-selling.
2. Warning or termination letters issued
3. Commission claw-back

9. Complaints relating to sale of policies after spurious calls (Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	6	2	2	12	6	1	12	3	-	30	11	3
Bancassurance	-	-	-	-	-	1	2	1	-	2	1	1
Other Corporate Agents	1	-	-	2	3	-	2	-	-	5	3	-
Brokers	1	-	-	4	2	-	4	3	2	9	5	2
Direct selling	2	-	-	1	-	-	2	-	-	5	-	-
Microinsurance agents	-	-	-	-	-	-	-	-	-	-	-	-
Others (to be specified)	2	1	-	1	1	-	-	-	-	-	-	-
TOTAL	**12**	**3**	**2**	**20**	**13**	**1**	**22**	**7**	**2**	**54**	**23**	**5**

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

1. Customer guidance on toll-free number and advised not to entertain calls from unknown numbers
2. Any such calls received, prior to buying insurance, customer is requested to check directly with the company at the toll-free number or visit branch

11. Steps taken by the insurer to caution members of public about spurious calls

1. Company website is updated with pop up message / flag on hoax and spurious calls
2. SMS triggered to existing customer base on a regular basis on not to entertain calls from unknown sources pertaining to insurance.
3. Email is triggered to customers educating them not to entertain calls from unknown sources pertaining to insurance

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2012 -13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Individual Agents	-	-	-	16	2	-	-	2	-	374	434	238
Bank Assurance Agents/Employees	-	-	-	-	-	-	-	-	-	186	248	135
Other Corporate Agents	-	-	-	1	-	-	2	2	-	31	30	18
Brokers	-	-	4	1	-	-	-	-	-	41	251	184
Employees of Insurer	14	15	23	32	8	14	2	-	-	-	-	-
Others (Spurious Tele-callers)	-	-	-	-	1	-	-	-	-	3	62	93
Total	**14**	**15**	**23**	**50**	**11**	**14**	**4**	**4**	**-**	**635**	**1025**	**668**

NAME OF THE INSURER: **FUTURE GENERALI INDIA LIFE INSURANCE CO LTD.**

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	63	-	214	92	17	340	110	27	234	265	44	788
Bancassurance	-	-	-	-	-	-	-	-	-	-	-	-
Other Corporate Agents	15	-	95	7	-	88	4	2	47	26	2	230
Brokers	89	-	158	50	10	227	230	48	532	369	58	917
Direct selling	62	-	170	125	21	234	110	41	157	297	62	561
Microinsurance agents	-	-	-	-	-	-	-	-	-	-	-	-
Others (to be specified)	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL	**229**	**-**	**637**	**274**	**48**	**889**	**454**	**118**	**970**	**957**	**166**	**2496**

– In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	-	-	-	-
Bancassurance	-	-	-	-
Other Corporate Agents	-	-	-	-
Brokers	-	-	-	-
Direct selling	-	-	-	-
Others (to be specified)	-	-	-	-
TOTAL	**-**	**-**	**-**	**-**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	869	744	316	1929
Bancassurance	-	-	-	-
Other Corporate Agents	249	46	4	299
Brokers	102	185	644	931
Direct selling	238	199	139	576
Others (to be specified)	-	-	-	-
TOTAL	**1458**	**1174**	**1103**	**3735**

4. **Root Cause (s) for complaints relating to mis-selling**

NIL

5. **Steps taken for ascertaining suitability of insurance product at point of sale**

Pre Issuance verification calling done to all customer's before issuance of the policy. Cases issued post receiving confirmation from the customer.

Governance mechanism in place to take action against perpetual defaulters.

6. **Channel-wise controls placed to prevent mis-selling**

Agents : Pre issuance verification calling done to all customer.

Corporate agents: Pre issuance verification calling done to all customer.

Bancassurance: NA

Brokers : Pre Logging verification calling done to all customer. Self declaration taken from the client prior to issuance of the policy.

Direct selling: Pre issuance verification calling done to all customer.

Others: NA

7. **Other Measures taken for addressing mis-selling**

NII

8. **Procedure adopted for dealing with complaints of mis-selling**

NII

9. **Complaints relating to sale of policies after spurious calls(Channel-wise, resolution status-wise number of complaints relating to spurious calls)**

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	1	-	-	-	-	6	-	-	1	1	-	7
Bancassurance	-	-	-	-	-	-	-	-	-	-	-	-
Other Corporate Agents	-	-	-	1	-	2	-	1	1	1	1	3
Brokers	2	-	6	1	-	2	6	1	21	9	1	29
Direct selling	-	-	-	1	-	1	3	-	9	4	-	10
Microinsurance agents	-	-	-	-	-	-	-	-	-	-	-	-
Others (to be specified)	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL	**3**	**-**	**6**	**3**	**-**	**11**	**9**	**2**	**32**	**15**	**2**	**49**

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

Nil

11. Steps taken by the insurer to caution members of public about spurious calls

- Emails and SMS sent to all customers on the awareness of calls received through unverified sources.
- On the website awareness to customers – Beware

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2012 -13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Individual Agents	-	-	-	-	-	-	-	-	-	-	-	-
Bank Assurance Agents/Employees	-	-	-	-	-	-	-	-	-	-	-	-
Other Corporate Agents	-	-	-	-	-	-	-	-	-	-	-	-
Brokers	-	-	-	-	-	-	-	-	-	-	-	-
Employees of Insurer	-	186	51	-	18	34	-	-	01			
Others (Spurious Tele-callers)	-	-	-	-	-	-	-	-	-	-	-	-
Total		**186**	**51**		**18**	**34**			**01**			

NAME OF THE INSURER: **HDFC STANDARD LIFE INSURANCE CO. LTD**

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	224	0	2132	496	0	3981	111	9	1111	831	9	7224
Bancassurance	3162	0	15575	3538	0	12720	991	19	3725	7691	19	32020
Other Corporate Agents	227	0	1697	278	0	1994	46	3	374	551	3	4065
Brokers	2104	0	7837	2560	0	15965	1005	28	8828	5669	28	32630
Direct selling	33		295	186	0	815	35	1	255	254	1	1365
Microinsurance agents	0	0	0	0	0	0	0	0	0	0	0	0
Others (to be specified)	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	**5750**	**0**	**27536**	**7058**	**0**	**35475**	**2188**	**60**	**14293**	**14996**	**60**	**77304**

– In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	374,619	344,166	107681	826,466
Bancassurance	479,640	400,455	159151	1,039,246
Other Corporate Agents	1695	1261	7284	10,240
Brokers	66,214	55274	16527	138,015
Direct selling	103,571	82014	33596	219,181
Others	0	0	0	0
TOTAL	**1,025,739**	**883,170**	**324,239**	**2,233,148**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	252	382	92	726
Bancassurance	990	1803	558	3351
Other Corporate Agents	310	44	21	375
Brokers	1074	499	977	2550
Direct selling	13	63	11	87
Others	0	0	0	0
TOTAL	**2639**	**2791**	**1659**	**7089**

4. Root Cause (s) for complaints relating to mis-selling

1. Mis-representation of facts at the time of sales
2. Customer not following due diligence at the time of purchasing the policy like signing on blank forms
3. Lack of insurance knowledge at the customer's end
4. Forgery /Tampering

5. Steps taken for ascertaining suitability of insurance product at point of sale

1. To improve customer's awareness we have launched a micro site under the head Knowledge Centre for customers to improve/educate customers knowledge.
2. My Mix – A personalized solution through need based product combination offerings has been given to sales team, where they can input customer details and get the products which are relevant and suitable for the customer.
3. Suitability of the product to the customer in terms of income vs premium paying ratio at underwriting stage.

6. Channel-wise controls placed to prevent mis-selling

The following process is followed to all distribution channels :

- On submission of the proposal form at the branch, the contact details are verified by the Manager
- All accompanying documents with the proposal form are verified by the Manager with originals and signed with "Original Seen & Verified" stamp with his employee details.
- Pre conversion call (PCVC) Customer is contacted by a centralized separate team and explained all the features of the plan along with the free look in option. Only on receiving consent from the customer ONLY the proposal is sent for further processing.
- Most Important Document is a one pager which distinctively explains the features of the plan is made to be read and signed by the customer at the time of proposal filling.

Processes specific to channels :

Bancassurance : No cash acceptance or Demand drafts other than HDFC Bank.

Brokers : Random cases, customers are physically met by a separate team to verify the quality of the sale

7. Other Measures taken for addressing mis-selling

1. All the proposals logged in are verified by the audit team for correctness in contact information
2. Distributors whose cases fail to pass through the quality check (PCVC) are updated for necessary action at their end.
3. Missale numbers are part of the monthly reviews with the management at Regional/Zonal & National level.
4. Complaints against any agent/sales managers are adversely considered at the time of promotion.

8. Procedure adopted for dealing with complaints of mis-selling

1. On receipt of a missale complaint, customer is primarily contacted to acknowledge his compliant as well to understand the customer's concern in detail.
2. Details of the complaint are shared with the distributor for their views.
3. Investigation done by looking into all details e.g including the servicing transactions of the customer.
4. Based on our findings and inputs from the distributor a final decision is taken
5. Post final decision is taken, customer is contacted and informed of the decision and the reasons for arriving at the decision are also explained to the customer.

9. Complaints relating to sale of policies after spurious calls (Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	15	0	12	2	8	59	0	0	5	17	8	76
Bancassurance	31	0	35	2	14	74	1	0	14	34	14	123
Other Corporate Agents	25	0	11	0	1	1	0	0	1	25	1	13
Brokers	28	0	170	8	20	195	2	0	136	38	20	501
Direct selling	0	0	1	0	2	9	0	0	1	0	2	11
Microinsurance agents	0	0	0	0	0	0	0	0	0	0	0	0
Others (to be specified)	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	**99**	**0**	**229**	**12**	**45**	**338**	**3**	**0**	**157**	**114**	**45**	**724**

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

1. On receipt of spurious call, customer is contacted initially to understand the complaint better and acknowledge his concerns
2. We check the numbers with our employee and distributor database.
3. Call on the number to establish the identity of the caller.
4. Details are shared with the distributor to also investigate at their end.
5. Based on the inputs from distributor and our findings decision and action taken
6. In case the number is not contactable the details are shared with our Risk monitoring team to further investigate.
7. Where ever identity is established we try to file police FIR

11. Steps taken by the insurer to caution members of public about spurious calls

1. IRDA notice on spurious calls has been uploaded on HDFC Life website
2. Product brochures have a separate section cautioning members of public about various
3. Monthly educative mailers are sent to customers not to fall prey to spurious calls
4. HDFC Life media commercials display a disclaimer about spurious calls as directed by the authority

Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2012 -13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Individual Agents	10	31	16	69	75	45	0	0	0			
Bank Assurance Agents/Employees	8	13	9	42	39	23	0	0	0	0	0	0
Other Corporate Agents		1	0	0	1	0	0	0	0	0	0	0
Brokers		6	2	2	2	0	0	0	0	0	0	0
Employees of Insurer	3	5	2	7	8	6	0	0	0	0	0	0
Others (Spurious Phone numbers , online , distance marketing , Branch sales)	2	4	5	5	12	5	40	181	59	0	0	0
Total	23	60	34	125	137	79	40	181	59	0	0	0

NAME OF THE INSURER: **ICICI PRUDENTIAL LIFE INSURANCE COMPANY**

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	570	87	1,030	530	128	1,096	111	52	548	1,211	267	2,674
Bancassurance	659	76	1,285	727	120	1,585	244	39	860	1,630	235	3,730
Other Corporate Agents	202	51	501	127	45	424	31	20	197	360	116	1,122
Broker	1,434	81	2,976	1,039	290	3,321	78	47	671	2,551	418	6,968
Direct selling	375	34	603	501	83	1,014	108	16	257	984	133	1,874
Micro-insurance agents	0	0	0	0	0	0	0	0	0	0	0	0
Others (Prospect)	5	3	6	7	5	6	1	5	5	13	13	17
TOTAL	**3,245**	**332**	**6,401**	**2,931**	**671**	**7,446**	**573**	**179**	**2,538**	**6,749**	**1,182**	**16,385**

– In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	276,352	202,298	62,633	541,283
Bancassurance	212,327	213,448	107,077	532,852
Other Corporate Agents	148,206	204,884	115,224	468,314
Brokers	88,146	53,925	12,662	154,733
Direct selling	234,927	104,093	32,662	371,682
Others (Prospect)	0	0	0	0
TOTAL	**959,958**	**778,648**	**330,258**	**2,068,864**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	7,964	5,751	1,613	15,328
Bancassurance	11,891	11,655	4,774	28,320
Other Corporate Agents	1,520	1,160	504	3,184
Brokers	7,057	4,881	715	12,653
Direct selling	3,433	2,300	657	6,390
Others (Prospect)	0	0	0	0
TOTAL	**31,865**	**25,747**	**8,263**	**65,875**

4. Root Cause (s) for complaints relating to mis-selling

The broad reasons relating to mis-selling are listed below.

1. Communication and understanding gaps between the sales person and the policyholder
2. Product differs from what was requested or disclosed
3. Proposed insurance not in the interest of proposer
4. Regular premium policy sold as single premium policy
5. Misappropriation of premium
6. Illegitimate inducements offered
7. Malpractices or unfair business practices

5. Steps taken for ascertaining suitability of insurance product at point of sale

We believe that it is extremely important to guide a customer in selecting a product that suits his/ her needs and requirements of life stage. We have various systems and processes to ensure that the customers are well informed about the product that they chose to buy.

Following are some of the measures to ensure that suitable product is offered to the customer:

a. We have a tool called 'What's good for me – Financial planning in 3 easy steps' which asks the customer 3 simple questions pertaining to his life stage, financial goals and risk appetite.

   Based on his/ her responses, the tool suggests one or more suitable product(s). This tool is available directly to customers on our website, as well as to our sales teams, who effectively use as a pre-sales tool to aid customers. Further, we have embarked on a journey of digitisation where the Sales persons are increasingly using tablets or similar online platforms for sale of policies. The work flow has the above mentioned tool built in, and the customer has the visibility and option of the suitability analysis tool prior to filling up the online application form.

b. The Company has a robust induction training module through which our frontline sales force and partners get trained on need analysis and gap analysis, in order to advise and meet the customer needs and suggest right products. Also, most of our product training modules identify the target customer segment for each product in order to help the sales teams sell the right products to customers.

6. Channel-wise controls placed to prevent mis-selling

The Company has put in place the following controls in the process of issuance of a policy.

Agents: The Company is focused at driving the importance of right selling and has also made persistency as one of the key factors in determining the performance of the agent

Corporate agents and Bancassurance:

I. ICICI Bank: Pre–login verification calling is done for all the cases before logging the case to verify the details of the product opted by the customers and explain the policy features. Wherever pre-login is not possible, calling is done by the Company at the pre issuance stage.

II. ICICI Securities: In-house calling is done post policy issuance for all the policies sourced by them

Brokers: Pre-login verification calling is done by brokers for verifying the factual information mentioned in the proposal form and explaining the features of the product

Direct selling: No cash payment accepted at proprietary sales business effective December 1, 2014. ECS mandate is mandatory (with exception) effective December 1, 2014

Others:

Pre-issuance controls:

a. We update the policy status to policyholders through SMS at all the relevant milestones - on receipt of the proposal form, intimation on issuance of policy and dispatch of the policy document.

b. On issuance of policy, we send SMS mentioning key policy details so as to reinforce key aspects of the policy purchased

Post – issuance controls:

a. The Company practices profile based calling that is done to policyholders, based on certain criteria (age etc) to educate on key aspects of the policy purchased, e.g., premium term, lock-in period, etc.

b. Electronic policy documents sent along with product feature videos (selected products) are sent to the policyholders on their registered email ids.

c. We send SMS and emails to all our policyholders, to exercise caution on fake and spurious calls claimed to be made on behalf of the Company, Regulator and other Government agencies.

Policy document:

a. The cover of the policy document clearly mentions the policy term and maturity term for certain segments of products.

b. Know your policy features (policy highlights) is sent long with the policy document. It is a document which explains the key features of the policy in a simple language.

c. The covering letter to policy document mentions the contact details (call centre number, email id) of the Company. It also mentions the freelook option and its time lines.

7. Other Measures taken for addressing mis-selling

Customer Education' initiatives have been taken by the Company through print media, website, social media and other modes of communication. We have communication regarding the below mentioned points in our branches, on social media and product collaterals like brochures, leaflets etc

a. Know your - premium paying term, charges on your policy, life cover and maturity benefit, whether policy is Single Premium or Regular Premium

b. Don't break your old policy for a new one

c. Benefits of ULIPS

d. Fake/ Spurious call alerts

8. Procedure adopted for dealing with complaints of mis-selling

We approach every misselling complaint with high sensitivity and strict actions are taken for all proven cases.

The Company does complete investigations on the complaint by reviewing the facts available and seeking views from the distribution channels. The resolution is conveyed to policyholders through letter/email.

The Company has initiated actions on the intermediaries on the basis of investigation of mis-selling complaints. The Company continues to engage and sensitise brokers and corporate agents regarding mis-selling instances reported from their end. We accordingly engage with the top management of certain distribution partners having high volume of mis-selling complaints and have sensitized them regarding the matter.

9. Complaints relating to sale of policies after spurious calls (Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	3	0	3	23	0	2	1	0	2	27	0	7
Bancassurance	1	0	2	4	0	0	0	0	0	5	0	2
Other Corporate agents	8	0	2	3	0	1	0	0	2	11	0	5
Brokers	91	2	20	126	6	22	6	2	19	223	10	61
Direct selling	10	0	6	20	0	2	1	0	0	31	0	8
Microinsurance agents	0	0	0	0	0	0	0	0	0	0	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0
Total	**113**	**2**	**33**	**176**	**6**	**27**	**8**	**2**	**23**	**297**	**10**	**83**

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

Spurious call complaints are also handled with high sensitivity and actions are taken for all proven cases. The Company does complete investigations on the complaint and resolution is conveyed to policyholders through letter/email.

We have disassociated tele-calling partners involved in spurious calling. The Company has filed police complaints against entities indulged in doing spurious calling. Further, the company has also filed complaints with Economic Offences Wing against certain entities.

The Company has additionally represented 875 numbers to Telecom Enforcement and Resource Monitoring Cell (TERM)- Department of Telecommunication highlighting cases where the calling lines were issued basis fraudulent KYC. This action was taken further to representation to various Tele-calling service providers.

The Company has given 575 numbers to TRAI where 140 series numbers are doing fake calls to our customers.

11. Steps taken by the insurer to caution members of public about spurious calls

The Industry has been facing the menace of spurious calls to misguide policyholders in name of Regulator or advising them to surrender the existing policies and buy new policies under pretext of bonus.

The Company has taken below initiatives to proactively educate our policyholders and safeguard them from such malpractices.

a) Regular policyholder awareness done on spurious calling through periodic emails and SMS, educating them to safeguard their policy information

b) We have a page on the Company website mentioning fraud prevention tips for general public which also educates on spurious calls

c) We have also updated the Authority's public notice in the Company's website

d) "Stay Alert" messages are updated on all letter communications sent to policyholders, such as renewal premium notices, unit statements etc, and audio messages are also played during call hold times at the customer service call centers

e) Social media channels like Facebook is also used to spread awareness about spurious calling

f) Company insurance advertisements carry disclaimer on the spurious calling issue as per the circular issued by the Authority

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2012 -13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Individual Agents	427	283	108	50	353	172	0	2	14	370	438	174
Bank Assurance Agents/Employees	15	3	6	5	9	23	0	0	0	501	623	336
Other Corporate Agents	0	0	0	0	0	0	0	0	0	150	94	34
Brokers	365	291	9	38	22	21	1	5	1	1,133	998	111
Employees of Insurer	49	132	29	7	66	67	3	10	2	0	0	108
Others (Spurious Tele-callers)	0	0	0	0	0	0	11	56	50	0	0	0
Total	**856**	**709**	**152**	**100**	**450**	**283**	**15**	**73**	**67**	**2,154**	**2,153**	**763**

**Data period of FY 2015 is upto November 30, 2014*

NAME OF THE INSURER: **IDBI FEDERAL LIFE INSURANCE CO LTD**

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	109	-	175	51	-	215	19	-	53	179	-	443
Bancassurance	94	-	134	65		208	37	-	94	196	-	436
Other Corporate Agents	-	-	-	-	-	-	-	-	-	-	-	-
Brokers	-	-	-	-	-	-	-	-	-	-	-	-
Direct selling	43		50	15		79	17	-	36	75	-	165
Microinsurance agents	-	-	-	-	-	-	-	-	-	-	-	-
Others (to be specified)	-	-	-	-	-	-	-	-	1		-	1
TOTAL	**246**	**-**	**359**	**131**	**-**	**502**	**73**	**-**	**184**	**450**	**-**	**1045**

– In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	26,475	25,198	10,406	62,079
Bancassurance	79,499	80,273	25,533	185,305
Other Corporate Agents	20	67	-	87
Brokers	2	17	41	60
Direct selling	15,954	4,751	1,952	22,657
Others (to be specified)	-	-	-	-
TOTAL	**121,950**	**110,306**	**37,932**	**270,188**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	1023	780	254	2057
Bancassurance	1226	1188	485	2899
Other Corporate Agents	-	-	-	-
Brokers	-	-	-	-
Direct selling	256	207	113	576
Others (to be specified)	2	2	0	4
TOTAL	**2507**	**2177**	**852**	**5536**

4. **Root Cause (s) for complaints relating to mis-selling**

- The customer complaints are beyond the freelook period.
- Ignorance of preissuance calling/welcome calling confirmation of policy terms.
- Financial Problems/incapacity to pay future premiums
- Change in mind set.
- Misunderstood the product features

5. **Steps taken for ascertaining suitability of insurance product at point of sale**

- Product Training is imparted in detail to all sales persons
- Need based analysis is being done by the customer prior to sale of policy

6. **Channel-wise controls placed to prevent mis-selling (same as point no. 5)**

Agents

Corporate agents

Bancassurance

Brokers-

Direct selling-

Others

7. **Other Measures taken for addressing mis-selling**

- The company has initiated preissuance calling process from 15th May 2012 to confirm the proposal form details with customers before issuance of the policy.
- The company has also initiated Fraud Reporting which is placed to ensure a robust mechanism of reporting of frauds and their investigation process.
- All misselling complaints are evaluated and the company has initiated appropriate actions against the concerned individuals and solutions have been provided to the customers.

8. Procedure adopted for dealing with complaints of mis-selling

- Every complaint that is receive is treated based on its merit
- Every case is properly scrutinized, investigated and the finding is documented by our concerned team based on which decisions pertaining to the complaint are taken by the management basis the evaluation
- In cases where misselling is established appropriate actions is taken against the concerned individuals and resolutions are provided to the customers.
- In cases where misselling allegation is not established the customer request is rejected and the closure letter is sent to the customer.

9. Complaints relating to sale of policies after spurious calls (Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	-	-	-	-	-	-	-	-	-	-	-	-
Bancassurance	-	-	-	-	-	-	-	-	-	-	-	-
Other Corporate Agents	-	-	-	-	-	-	-	-	-	-	-	-
Brokers	-	-	-	-	-	-	-	-	-	-	-	-
Direct selling	-	-	-	-	-	-	-	-	-	-	-	-
Microinsurance agents	-	-	-	-	-	-	-	-	-	-	-	-
Others (to be specified)	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

NA

11. Steps taken by the insurer to caution members of public about spurious calls

- Details are updated on IFLI general public site.
- SMS and Email cautioning the customers on spurious calls are sent on a regular basis to all policy holders.

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2012 -13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Individual Agents	3	5	3	4	-	1	-	-	-	-	-	-
Bank Assurance Agents/Employees					-	-	--	-	-	-	-	-
Other Corporate Agents	-	-		-	-	-	-	-	-	-	-	-
Brokers	-	-	-	-	-	-	-	-	-	-	-	-
Employees of Insurer	1	5	5	2	-	-	-	-	-	-	-	-
Others (Spurious Tele-callers)				-	-	-	-	-	-	-	-	-
Total	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

NAME OF THE INSURER: **INDIAFIRST LIFE INSURANCE CO. LTD.**

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	109	-	175	51	-	215	19	-	53	179	-	443
Bancassurance	94	-	134	65		208	37	-	94	196	-	436
Other Corporate Agents	-	-	-	-	-	-	-	-	-	-	-	-
Brokers	-	-	-	-	-	-	-	-	-	-	-	-
Direct selling	43		50	15		79	17	-	36	75	-	165
Microinsurance agents	-	-	-	-	-	-	-	-	-	-	-	-
Others (to be specified)	-	-	-	-	-	-	-	-	1		-	1
TOTAL	**246**	**-**	**359**	**131**	**-**	**502**	**73**	**-**	**184**	**450**	**-**	**1045**

– In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	26,475	25,198	10,406	62,079
Bancassurance	79,499	80,273	25,533	185,305
Other Corporate Agents	20	67	-	87
Brokers	2	17	41	60
Direct selling	15,954	4,751	1,952	22,657
Others (to be specified)	-	-	-	-
TOTAL	**121,950**	**110,306**	**37,932**	**270,188**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	1023	780	254	2057
Bancassurance	1226	1188	485	2899
Other Corporate Agents	-	-	-	-
Brokers	-	-	-	-
Direct selling	256	207	113	576
Others (to be specified)	2	2	0	4
TOTAL	**2507**	**2177**	**852**	**5536**

4. Root Cause(s) for complaints relating to mis-selling

- Inadequate product knowledge at the point of the sale.
- Not indentifying the need of the customer

5. Steps taken for ascertaining suitability of insurance product at point of sale

- As a part of the on-boarding process for customers we have included the Customer Need Analysis process in our application processing system (Magic Board), which analyses the customer's profile, assets, liabilities and other investment portfolios and recommends insurance plans suitable to the customers.
- The sales executives are also trained on financial management and to understand the need of the customers.
- Audio visual presentation of the product in regional language is part of the sales process.

6. Channel-wise controls placed to prevent mis-selling

Agents/ Corporate agents-

Meetings and trainings conducted for agents by IndiaFirst representative on regular intervals.

Bancassurance- Product training given to the Bank staff on regular intervals. Business Manager to be present in conference on the verification call.

Brokers- Regular updates of the product and visits of a Business Manager to every agency for assistance.

Direct selling- Exclusive team of Trained and Certified personnel to source policies to the customers.

7. Other Measures taken for addressing mis-selling

Apart from the above mentioned measures, we have made Verification Calling mandatory for all applications; have made our sales literature/product audio video available in regional languages.

8. Procedure adopted for dealing with complaints of mis-selling

Complaint acknowledgement email/letter sent to the customer. Complaints investigation process including, customer's profiling, sales feedback, Verification Call recording, Policy document delivery details, Renewal calling remarks and recordings, Correspondence / consent (if any)submitted by the customer while buying the policy, talk to the customer to understand the facts, History of Previous Interactions. Resolution email/letter sent to the customer.

9. Complaints relating to sale of policies after spurious calls (Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	3	-	-	3	-	-	3	-	-	9	-	-
Bancassurance	73	-	1	82	-	3	50	-	3	205	-	7
Other Corporate Agents	-	-	-	-	-	-	-	-	-	-	-	-
Brokers	-	-	-	-	-	-	1	-	-	1	-	-
Direct selling	-	-	-	-	-	-	-	-	-	-	-	-
Microinsurance agents	-	-	-	-	-	-	-	-	-	-	-	-
Others (to be specified)	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL	76	-	1	85	-	3	54	-	3	215	-	7

** - above data is pertaining to those instances where our customers have received spurious calls.*

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

- Call the customer and understand his concern.
- Educate him/her about the spurious activity and advise not to pay heed to such callers.
- Explain the company's background.
- Share the product benefits.

In case customer has already given money, as mentioned by the caller then customer may register a FIR (If required) against the caller at the nearest police station.

11. Steps taken by the insurer to caution members of public about spurious calls

- For awareness a SMS alert has been sent to all our customers on their registered mobile number, informing not to pay heed to such hoax calls.
- IRDA circular on hoax calls is published on IndiaFirst website.
- All hoax call complaints are resolved by calling and informing the customers to be alert. Simultaneously we educate the customers about the product benefits and company's stability.

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2012 -13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Individual Agents	1	-	-	3	-	-	-	-	1	66	61	7
Bank Assurance Agents/Employees	8	2	1	5	3	1	2	1	-	115	104	73
Other Corporate Agents	-	-	-	-	-	-	-	-	-	-	-	-
Brokers	-	-	-	-	-	-	-	-	-	-	-	3
Employees of Insurer	-	-	-	-	-	-	-	-	-	-	-	-
Others (Spurious Tele-callers)	-	-	-	-	-	-	-	-	-	-	-	-
Total	**9**	**2**	**1**	**8**	**3**	**1**	**2**	**1**	**1**	**181**	**165**	**83**

NAME OF THE INSURER: **KOTAK MAHINDRA OLD MUTUAL LIFE INSURANCE LTD.**

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	945	-	374	680	-	526	213	-	367	1,838	-	1,267
Bancassurance	610	-	163	326	-	276	118	-	168	1,054	-	607
Other Corporate Agents	2,039	-	1,158	997	-	1,172	206	-	579	3,242	-	2,909
Brokers	1,218	-	907	612	-	821	155	-	366	1,985	-	2,094
Direct selling	298	-	135	122	-	104	59	-	65	479	-	304
Microinsurance agents	-	-	-	-	-	-	-	-	-	-	-	-
Others – Telesales	518	-	264	284	-	276	41	-	107	843	-	647
Others – Online Sales	12	-	2	6	-	1	3	-	0	21	-	3
Others - No policy	86	-	9	46	-	7	5	-	6	137	-	22
TOTAL	5,726		3,012	3,073		3,183	800		1,658	9,599		7,853

– In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	61284	67054	30086	158424
Bancassurance	39865	38703	11160	89728
Other Corporate Agents	18107	7439	1568	27114
Brokers	21214	15259	5352	41825
Direct selling	29009	31505	4808	65322
Others (to be specified)	0	0	0	0
TOTAL	**169479**	**159960**	**52974**	**382413**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	1348	1902	865	4115
Bancassurance	970	1293	821	3084
Other Corporate Agents	739	557	145	1441
Brokers	1071	1317	484	2872
Direct selling	806	564	206	1576
Others (to be specified)	0	0	0	0
TOTAL	**4934**	**5633**	**2521**	**13088**

4. **Root Cause (s) for complaints relating to mis-selling**

- Low level of understanding of financial products by customers
- Greed of customers coupled with inducements by Agents to increase Sales which results into such grievances when the promised benefits are not received
- Customers treat insurance as short term investments and expect early returns and exits
- Movement of Agents and employees to other companies leading to instigation of clients

5. **Steps taken for ascertaining suitability of insurance product at point of sale**

- Documented Sales Process for need identification.
- Product Suitability Check for all products.
- Pre-issuance calling and welcome calling post issuance to the customers.
- Deploying Technology for sale by launching end to end solutions which includes clients need analysis, clients profiling and product suitability including final recommendation of product and eventually sales fulfillment.
- Regular training to agents on sales process and products.

6. **Channel-wise controls placed to prevent mis-selling**

Agents
- Compulsory training for agents
- Defined selection and recruitment process for all LA.
- Mandatory predefined training on Products and processes given to sales force.
- Implementation of Malpractice Matrix for all channels
- Monthly review by Sr. Management on Mis-selling case & action plan to mitigate it.

Corporate Agents

Bancassurance

Brokers

Direct selling

Others

7. **Other Measures taken for addressing mis-selling**

Proactive / Preventive Measures

- Continuous training of employees
- As a process control any overwriting on proposal forms is not accepted unless the full signature of the client is obtained
- All policy documents are directly sent to clients registered address
- Email alerts and SMS alerts are triggered on every action on proposal/policy
- Customer awareness program has been initiated through emailers and sms alerts in general interest of customers.

- In-house welcome call is done for certain channels and business criterion where incidents of malpractices are high. Various important details in the policy are confirmed to ensure understanding of policy terms
- Pre Conversion Verification Call to clients post login and pre-conversion to verify policy details for certain channels and business criterion to clarify policy details before the proposal is converted.
- High emphasis is given to persistency in rewards for Sales team, this will ensure that the policies are sold on proper and long term advice
- A dedicated unit called the Business Retention and Excellence has been set up for improvement in business quality by way of increasing persistency and client retention thereby emphasizing Protection and Long Term Savings for clients.
- Public Notice released in Hindi in National Daily - DainikJagran PAN India for awareness on spurious calls and renewal cash remittance only at KLIFE branches.
- We have restricted specific mobile numbers enquiring on multiple policies of unrelated customers and blocked them on IVR at the contact center so that confidential information of customer is not available to such customers and customer's interest is safeguarded. We have been continuously alarming customers to beware of such callers recommending pre-mature withdrawals (full/partial) on their policies
- We propose to make signature proof mandatory with application form for verification

Remedial measures (Implemented)

- Policy holders protection committee actively monitors channel wise, region wise complaints and top 5 defaulting areas are taken into discussion and action plan
- Complaints Reduction Committee has been formed in April'12 with stakeholders from Sales, Operations, Customer Care and Compliance to monitor the Sales quality and drive reduction of complaints in terms of miss-selling and forgery. The steering committee brain storms solutions basis root cause analysis of complaints, monitors the action plan, measures progress of implementation and thereby enables reduction in complaints
- Formation of special committee comprising of Sales Head and Ops Head for root cause analysis and implementation of action plans which ensure correct sales and thereby reduction in complaints for new business sourced
- Regular sharing of MIS with Sales Teams to monitor their performance – Daily/Fortnightly
- Accountability brought in for complaints at every level
- Target to Sales teams to reduce complaints for their channel/partners
- Complaints included as a parameter for Sales Scorecards
- Review of complaints as a standing matter at Sales review meetings - Weekly/ Monthly/ Quarterly meeting
- High emphasis is given to persistency in rewards for Sales team
- Customer Care team being empowered to discharge cases in favour of the customer basis merit of the case (post approval from Sales/Ops Head)
- Complaints management team strengthened to discharge cases promptly and aim is to reduce TAT from 15 days to 10 days.
- Stern action against agents/Sales team where miss-selling is proved as per the approved Matrix

- We have stopped sourcing new business from few top agencies in terms of malpractices
- Termination of erring agents, corporate channels and brokers
- Employees involved in such unethical practices are dealt with severely
- Action taken includes the following
- Counselling by Branch Manager and above
- Warning letters
- Stern action including Resignation or Termination
- Punitive action is decided by the fair play committee and depends on case to case basis
- It may also include filing of criminal complaints wherever appropriate

8. Procedure adopted for dealing with complaints of Mis-selling

Complaint receipt	Initiation	Follow up	Closure
Complaint is received in form of email, physical letters at Branch or CPC or call received at contact center.	Complaint is analyzed, snapshot is prepared to cover the availability of verification call, transactions of the customer and other details	Case is followed up for feedback from intermediary and local distribution team to ensure meeting the customer, resolution of grievance and retention	Written resolution via letter and email is sent out to customer
Complaint is registered in KGMS which is linked with IGMS on real time basis	Complaint is sent to sourcing Sales team and their supervisors for end to end resolution	If the customer is retained out calling is done by grievance team to ensure customer is satisfied	Resolution in updated in KGMS / IGMS outlining the concerns, facts and resolution offered to customer. In all interactions, a high focus is maintained on revival and retention by educating customers on long term savings and protection
A call is made to the customer upon receipt of complaint to understand the cause of dissatisfaction, get clarity on facts and seek customer's appointment for a meeting.	Case is assigned to internal departments like internal risk control unit, Underwriting, Servicing teams, Legal for detailed investigation and feedback.	If the grievance is not resolved, it is evaluated by the grievance team in terms of case facts, RCA, need analysis of the product, customer profile, income premium ratio and transactions to assess the	

		complaint in totality with recommendation in keeping with the merit of the case to ensure fair deal to customer	
Acknowledgement is sent within 3 working days via email, sms and letter is couriered to customer	If relevant evidences or documents are not submitted with complaint, requirement letter is issued	If the case facts suggest decision in favor of customer, it is referred to Business Head for review of decision Complaints are also referred to Legal/ GRO where required	

9. Complaints relating to sale of policies after spurious calls(Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	-	-	-	-	-	1	-	-	-	-	-	1
Bancassurance	-	-	-	-	-	-	-	-	-	-	-	-
Other Corporate Agents	-	-	2	-	-	1	-	-	-	-	-	3
Brokers	-	-	1	-	-	3	-	-	-	-	-	4
Direct selling	-	-	-	-	-	-	-	-	-	-	-	-
Microinsurance agents	-	-	-	-	-	-	-	-	-	-	-	-
Others (to be specified)	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL	**-**	**-**	**3**	**-**	**-**	**5**	**-**	**-**	**-**	**-**	**-**	**8**

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

Upon receipt of a complaint case, the contact numbers of callers shared by the customer is traced

We try to trace address of the caller and check if the caller is from Insurance back ground.

Further we match the number with our data base of employees/agents and if found, we take action as per the malpractice matrix.

We explain to the customer about the importance of filing the complaint against the number with TRAI.

Further we also assist the client to file an FIR against the caller.

11. Steps taken by the insurer to caution members of public about spurious calls

Kotak Life Insurance is continuously making attempts to reach out to its customers through different modes of communication like SMS, Emails and the Print Media to prevent customers from falling prey to spurious calls, fictitious offers and cash defalcation.

1. SMS are sent to all customers periodically on their registered mobile numbers
2. As a part of the customer education series, various emails have been sent to customers on their registered email ids, the content of which is available on our website http://insurance.kotak.com/policy_holder/pdf/beware_of_malicious_emails_and_unsolicited_calls.pdf
3. Notices in both English and Hindi have been affixed in each of our branch offices on the customer notice board
4. Public announcement/notice regarding Unsolicited Calls and E mails in DainikJagran - a leading Hindi newspaper with Average Issue Readership (AIR) of 16.429 million, 37 editions and having good penetration in Uttar Pradesh, Madhya Pradesh, Jharkhand, Uttarakhand, Punjab, Haryana, Bihar, Himachal Pradesh, Delhi, West Bengal, Jammu & Kashmir - Date: March 11, 2013
5. Public announcement/notice regarding Unsolicited Calls and E mails in Punjab Kesri - a leading Hindi newspaper having good penetration in Punjab, Haryana, Delhi - Date: February 2, 2014
6. A disclaimer alerting customers regarding spurious calls is incorporated on marketing communication

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Individual Agents	71	99	75	25	9	89	2	1	2	1200	1755	1467
Bank Assurance Agents/Employees	0	0	3	0	0	0	0	0	0	0	0	0
Other Corporate Agents	70	118	81	0	5	3	1	0	0	14	14	7
Brokers	178	214	159	0	0	0	0	1	0	3	4	2
Employees of Insurer	77	95	109	16	7	23	1	1	3	0	0	0
Others (Spurious Tele-callers)	0	0	0	0	0	0	1	9	5	3*	1*	0
Total	**396**	**526**	**427**	**41**	**21**	**115**	**5**	**12**	**10**	**1220**	**1774**	**1476**

**Pertains to Referral commission*

NAME OF THE INSURER: **L I C OF INDIA**

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	271	15	14	287	22	11	113	5	7	671	42	32
Bancassurance	6	-	-	4	2	-	1	-	-	11	2	0
Other Corporate Agents	4	-	-	4	-	-	1	2	-	9	2	0
Brokers	-	-	-	1	-	-	6	-	-	7	0	0
Direct selling	6	-	-	3	-	-	4	-	-	13	0	0
Microinsurance agents		-	-	1	-	03	1	-	-	2		03*
Others (where policy no. not given/wrongly given)	21	2	4	42	-	2	8	1	1	71	3	7
TOTAL	308	17	18	342	24	16	134	8	8	784	49	42

– In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	36075878	33872757	6970203	76918838
Bancassurance	499468	427144	147177	1073789
Other Corporate Agents	74635	57605	16498	148738
Brokers	2266	1822	371	4459
Direct selling	103204	121102	35554	259860
Others (to be specified)				
TOTAL	**36755451**	**34480430**	**7169803**	**78405684**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	43689	50854	2429	96972
Bancassurance	1049	951	91	2091
Other Corporate Agents	194	173	12	379
Brokers	22	9	1	32
Direct selling	382	478	88	948
Others				
TOTAL	**45336**	**52465**	**2621**	**100422**

4. Root Cause (s) for complaints relating to mis-selling

Under Unfair Business Practices category, the following sub categories are considered as mis-selling.

- Product differs from what was required or disclosed.
- Proposed insurance not in the interest of proposer
- Premium payment period projected is different from actual
- Term of the policy is different / altered without consent
- Single Premium issued as Annual premium policy
- Intermediary did not provide material information concerning proposed cover.

During our analysis, we observed that the complaints not falling under the above category / sub-categories are also registerd by the policyholder / complainant.

*There have been allegations, inter alia, of mis-selling from the following Micro Insurance agents –

M/s Oleena Mahila Samajam, Kozhikode, Ag code 83001R012/ 1130107/1130207/1130210, Micro Insurance Agents Welfare Association Kerala and Institute of Education Training and Development, Ag. Code 83010R079.

Under Micro Insurance Plan 182 (Jeevan Madhur) under some of the terms, the maturity benefit was less than the premium paid under the policy. Hence there were allegations that mis-selling was done in view of less maturity benefit given, though LIC did honour its commitments regard to maturity benefits as per terms and conditions laid down in the policy documents.

Returns on ULIP products depends on the performance of the Stock market and if any customer invests money in any ULIP plan and does not get desired returns because of volatility of market, he/she takes it as mis selling which may not actually be termed as mis selling.

Moreover, organization takes care that our field force presents the Illustration benefits as per the guidelines issued by IRDA.

Different mode of payment sold to the customer instead of what was explained by the DSE.

5. Steps taken for ascertaining suitability of insurance product at point of sale

1) Corporation publishes Sales Literature on various schemes to create awareness and educate the customers.

2) Benefit illustrations are provided as per IRDA guidelines to the prospects/policy holders.

3) The Corporation is imparting training to its market intermediaries regularly to sensitize them that the prospective customers are fully informed about unique selling proposition (USPs) of various plans in general & ULIP Plans in particular.

4) There is option of “Cooling Off” period for customers in case of dissatisfaction about the plan.

Suitability, by definition, is the requirement to determine if a life insurance product is appropriate for a given client, based on the client's goals and financial situation. In other words, suitability is a matter of both matching product attributes to client objectives and measuring product qualities against peer-group product alternatives.

Continuous training on product awareness sessions being conducted for Bank officials, Corporate Agents and Brokers.

Continuous training on Products/Services/Business Ethics imparted regularly to DSEs with emphasis on need based selling.

The shortcomings of the said Jeevan Madhur Plan were taken care of and a new plan 819 (New Jeevan Mangal) has been introduced with effect from 09.01.2014.

Following are some of the broad steps for ascertaining suitability of insurance products :

Life Insurance Risk Analysis Before determining the amount of life insurance needed by a client, due care would involve the agent/ intermediary and client in a discussion concerning the various types of life insurance available

Capital needs for family income Most families will be able to maintain their standard of living with about 75% of the former breadwinner's income. Depending on the skills and resources of the surviving spouse, this fund may be large enough to provide lifetime income or for a specified period of transition.

Common Broad Questions :

- What existing death benefit sources does the client have?
- Who is insured? Is someone contributing economically who must be added?
- Do all death benefits, along with available assets, meet client objectives?
- Is waiver of premium available. Is this a desirable benefit for this client?
- Is there accidental death benefit or double indemnity. If so, is this desirable or can it be dropped in favour a lower premium?
- Is coverage decreasing term. Is the balance sufficient?
- Is there a substandard rating that can be removed?

6. Channel-wise controls placed to prevent mis-selling

Agents - Training and information sharing to the Agents/market intermediaries through in house training centers, seminars, meetings etc.

Corporate agents, Bancassurance and Brokers - Continuous training on product awareness sessions being conducted for Bank officials, Corporate Agents and Brokers.

Direct selling - Continuous training on Products/Services/Business Ethics imparted regularly to DSEs with emphasis on need based selling.

Others

7. Other Measures taken for addressing mis-selling

LIC has issued a comprehensive circular Ref. CC/Advt-reg/2014 dated 09.10.2014 regarding norms to be adhered to in regard to our advertisements as per IRDA guidelines.

Issue of instructions/ circulars down the line to make agents aware of the rules laid down by IRDA. The issue is addressed in various meetings, seminars, conventions by way of information sharing. The matter is also included in the appointment letter issued to each Agent.

Disciplinary action is also initiated as per rules if any such incident is found which works as deterrence for future.

Customer survey forms sent to customers after the completion of policies.

8. Procedure adopted for dealing with complaints of mis-selling

Our offices are verifying the complaints registered in Unfair Business Practices under mis-selling category to ascertain whether the complaint is actually related to mis-selling. In all such identified cases, an investigation is instituted to know whether it is case of mis-selling.

On receipt of complaint about mis selling following broad steps are taken :

1) An enquiry is initiated to evaluate the facts of the cases.

2) On the basis of report and fact findings of the reporting /reviewing officer/s the further course of action is decided.

3) If the intermediary/s is found involved, suitable action is initiated as per regulation.

- The outcome/result is conveyed to the complainant in a suitable manner.

9. Complaints relating to sale of policies after spurious calls (Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents												
Bancassurance	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL
Other Corporate Agents	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL
Brokers	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL
Direct selling	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL
Microinsurance agents	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL
Others (to be specified)												
TOTAL	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

Though complaints are reported to our various offices on spurious calls, there are no cases of policies issued after receipt of spurious call.

In case, policy is issued after receipt of the spurious call complaint, a proper investigation is to be done by our Marketing Deptt. and suitable action to be initiated against the erring agent / Development officer.

11. Steps taken by the insurer to caution members of public about spurious calls

In order to bring awareness among our customers and General Public about spurious calls, we have taken the following initiatives:

1 There is running Marquee on our Website www.licindia.in which provides a link to IRDA guidelines regarding spurious call.

2 Published a newspaper advertisement on 31.12.2012 cautioning the policyholders and general public not to entertain calls from unverified sources.

3 Another paper advertisement was published on 09.04.2013 mentioning DOs and Don'ts about spurious calls in all leading newspapers bringing awareness among our policyholders and general public. The same has also been displayed on our website.

4. The third paper advertisement was published on 7.11.2013 about spurious calls and TRAI regulations drawing the attention of general public in the matter.

5. As per the instructions from IRDA vide their letter dated 13.02.2014 regarding spurious calls, SMS/e-mails have been sent to all our existing customers (whose mobile numbers are available in the master) in March 2014.

Thereafter for all spurious call complaints, the policyholders are requested to lodge a Police complaint and to verify with nearest LIC office before divulging any policy details.

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2012 -13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Individual Agents	23	36	11	*87	*72	*18	25	0	1			
Bank Assurance Agents/Employees	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Other Corporate Agents	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Brokers	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Employees of Insurer	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Others (Spurious Tele-callers)												
Total	**23**	**36**	**11**	**87**	**72**	**18**	**25**	**NIL**	**1**	**NIL**	**NIL**	**NIL**

**Also includes cases of action taken against Agents in respect of:*
1 Repudiated claim cases
2 Suppression of Material facts.
3 Fraud cases
4 Black listed
5 Other reasons.

NAME OF THE INSURER: **MAX LIFE INSURANCE COMPANY LIMITED**

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	1352	119	1578	2021	146	1522	798	98	699	4171	363	3799
Bancassurance	568	38	678	1210	59	1101	862	79	835	2640	176	2614
Other Corporate Agents	298	29	608	712	59	681	379	72	488	1389	160	1777
Brokers	153	22	282	235	31	236	89	11	48	477	64	566
Direct selling	104	1	75	194	12	170	69	7	63	367	20	308
Micro insurance agents	-	-	-	-	-	-	-	-	-	-	-	-
Others (to be specified)	55	2	29	63	2	40	15	1	48	133	5	117
TOTAL	**2530**	**211**	**3250**	**4435**	**309**	**3750**	**2212**	**268**	**2181**	**9177**	**788**	**9181**

– In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	216141	193347	81103	490591
Bancassurance	196351	238666	106230	541247
Other Corporate Agents	69663	73997	21934	165594
Brokers	3245	1035	53	4333
Direct selling	18424	18919	13708	51051
Others (to be specified)	426	121	-	547
TOTAL	**504250**	**526085**	**223028**	**1253363**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	1673	1311	589	3573
Bancassurance	3200	3324	2394	8918
Other Corporate Agents	307	368	208	883
Brokers	63	46	1	110
Direct selling	92	87	42	221
Others (to be specified)	-	5(Internet sales)	25(Internet sales)	30
TOTAL	**5335**	**5141**	**3259**	**13735**

4. **Root Cause (s) for complaints relating to mis-selling**

- At an attribute level 57% mis-selling complaints comprise of - incorrect policy benefits (23%) , incorrect premium payment Tenure (17%) and Terms & condition not explained (17%).
- As per the voice captured during various interactions, short term view of customers and sellers seems to be a major reason of customer complaints. Customers with focus on returns, complain more than others.
- Agent attrition seems to be causing complaints. For e.g. 50% of complaints are received on business where sourcing agent has already left Max Life Insurance.
- 58% of complaints are received from policies older than 12 months. And also, Complaint rejection rate continues to be at 59% at Distribution Level .

5. **Steps taken for ascertaining suitability of insurance product at point of sale**

- We have mandated fact finding process in key distribution channels in order to identify /analyze customer's financial needs, goals and to recommend most suitable products. Specifically for ULIP policies, we have mandated the 'Risk profiler' so that the funds opted for by the customer should be in line with their risk appetite.
- We use a pre-issuance verification calling for select customer segments at the time of proposal submission. All cases in which the customer raises concerns with the product are addressed and resolved before the policy is issued. Through the pre -issuance welcome calling the customer's understanding of the product benefits, payment term and risks associated are verified.
- We have launched the Key Feature Document (KFD) for most of the products as a part of the policy pack. It has been prominently visualized in the policy pack. The KFD is a summary of the most important features of the policy and provides information on coverage, benefits, policy details and associated risks. It also highlights the 'freelook' provision.

6. **Channel-wise controls placed to prevent mis-selling**

Agents:

- Management review trends of customer complaints on monthly Functional Working Groups (FWG) and driving focused projects on controlling customer complaint issues.
- Ethical sales has been included across all agent and employee orientation training.
- Strong awareness campaign has been run over emails, articles and SMS to all Agents & Employees
- Branch office level engagements/workshops conducted for driving focused action planning and preventive steps.
- Education letter to agents on misselling complaints.
- Disciplinary action against erring agents, including issuance of warning letters and termination of agent advisors.

Corporate agents / Bancassurance/ Direct Selling/ Brokers:

- Management review trends of customer complaints on monthly basis and driving focused projects on controlling Customer Complaints issues.
- Enforcement of consequence management with third party distributors.

- Branch manager sign-off on Product Suitability Matrix ensuring the product is sold as per the requirements of customer.
- Channel specific workshop for driving focused action planning & preventive steps.
- Customer complaints as a quality parameter in regular discussion with supervisors
- Ethical sales has been included across all Employee New orientation training.

7. Other Measures taken for addressing mis-selling

- Mis-selling is part of Quarterly review Agenda at Board Level (Policyholders Protection Committee)
- "Treat Customer Fairly" framework is initiated to improve organizational drive towards need based selling.

8. Procedure adopted for dealing with complaints of mis-selling

- On receipt of a complaint from the policy holder alleging missale , the same is highlighted to the seller and to our internal investigation team for their necessary investigation and inputs.
- There is an independent investigation unit in Max life named as 'Compliance Investigation Unit' which then investigates the allegation by getting in touch with the customer and the seller, wherever applicable.
- At the time of investigation, all documentation present with Max Life which were submitted at the time of proposing the policy and later are efficiently reviewed.
- Basis the above investigation either the missale gets substantiated or it doesn't.
- In case miselling gets substantiated, in that case the complaint is resolved in favor of the customer i.e. the policy is cancelled and the amount is refunded to the customer.
- Parallely, necessary action is taken against the seller (as per the company's guidelines) who had sold the policy.

9. Complaints relating to sale of policies after spurious calls (Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	547	6	69	1015	16	65	471	15	88	2033	37	222
Bancassurance	95	-	18	301	2	15	234	8	64	630	10	97
Other Corporate Agents	118	3	33	306	5	23	198	8	33	622	16	89
Brokers	38	-	13	131	2	19	73	2	9	242	4	41
Direct selling	23	-	1	50	1	3	22	2	6	95	3	10
Micro Insurance agents	-	-	-	-	-	-	-	-	-	-	-	-
Others (to be specified)	51	-	14	52	1	21	4	-	4	107	1	39
TOTAL	**872**	**9**	**148**	**1855**	**27**	**146**	**1024**	**35**	**200**	**3729**	**71**	**498**

**Please note that these numbers are against the total spurious calls related complaints reported to Max Life.*

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

- On receipt of grievance from the policy holder, the grievance is highlighted to the seller and to the internal investigation team for their necessary investigation and inputs.
- The issue is also highlighted to Fraud Investigation unit for identifying the number from which the customer received the call.
- At the time of investigation all documentation present with Max Life which were submitted at the time of proposing the policy and later are efficiently reviewed.
- In case the grievance raised by the policy holder is substantiated, then in that case the policy is cancelled and the amount is refunded to the customer. Also, a police complaint gets filed against the caller if the evidence of spurious is established.
- In case the grievance raised by the policy holder is not substantiated and in case the policy is outside free look period, then we make the customer understand about the free look period and re-iteration of policy terms and conditions.

11. Steps taken by the insurer to caution members of public about spurious calls

Max Life has taken several initiatives to keep our policy holders updated and aware of the spurious / hoax calls. Details of the initiatives taken by us are as follows :

- Max Life has sent more than 91 lakh SMS till date to our policy holders cautioning them against any such calls. The SMS text is quoted below for your reference:
- Dear customer, please report any communication from unauthorized individuals offering discount on Max Life Insurance/IRDA behalf. Call Max Life at 18001801288 for any service.
- Dear customer, please do not fall prey to unsolicited calls or individuals offering discount on behalf of Max Life/IRDA and report to us at 18002005577.
- Dear Policyholder, Max Life or IRDA, does not CALL/SMS/E-MAIL, asking you to change your policy to other insurers, promising high returns. Stay Alert & Safe!
- Beware of attractive rewards or offers on your policy on behalf of IRDA or other life insurers. If you get such calls or offers, please inform us on 18002005577.
- Do not respond to spurious calls in the name of IRDA/other insurers for change of your policy to other insurers promising high returns. Lodge a police complain.
- We have sent e-mailers to more than 33 lakh customers on the same lines.
- In addition to the SMS and email campaigns, we have also put across posters in all our branch offices. These posters are basically to make our customers aware of the fake calls received from unscrupulous individuals offering false promises of financial gains claiming to be representing IRDA or Max Life, upon surrender of policy or withdrawal of money.
- Apart from this, there is an exclusive page on our corporate website 'www.maxlifeinsurance.com' which educates the policy holders about spurious calls.

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2012 -13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Individual Agents	53	72	33	67	73	26	1	16	12	345	516	262
Bank Assurance Agents/Employees	0	9	8	1	3	28	0	0	0	398	707	661
Other Corporate Agents	2	15	1	0	10	6	0	0	0	106	292	209
Brokers	3	24	0	22	7	0	0	0	0	119	120	23
Employees of Insurer	154	162	76	180	147	151	3	1	3	0	0	0
Others (Spurious Tele-callers)	0	0	0	0	0	0	2	7	7	0	0	0
Total	**212**	**282**	**118**	**270**	**240**	**211**	**6**	**24**	**22**	**968**	**1635**	**1155**

**Please note that out of total number of police complaints some are under filing and only limited number has been converted in to FIR.*

NAME OF THE INSURER: **PNB METLIFE INDIA INSURANCE CO LIMITED**

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	233	0	426	329	0	677	151	0	336	713	0	1439
Bancassurance	231	0	615	371	0	582	159	0	240	761	0	1437
Other Corporate Agents	32	0	130	43	0	109	27	0	32	96	0	277
Brokers	0	0	1	0	0	0	0	0	0	0	0	1
Direct selling	19	0	3	9	0	3	1	0	1	29	0	7
Microinsurance agents	0	0	0	0	0	0	0	0	0	0	0	0
Others (to be specified)	5	0	9	12	0	13	3	0	4	20	0	26
TOTAL	**520**	**0**	**1184**	**764**	**0**	**1384**	**341**	**0**	**613**	**1625**	**0**	**3181**

– In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	60741	38565	13377	112683
Bancassurance	127644	119516	52335	299495
Other Corporate Agents	1067	3494	151	4712
Brokers	200	0	0	182
Direct selling	16940	22462	13448	52850
Others (to be specified)	5264	0	0	5264
TOTAL	**211856**	**184023**	**79307**	**475186**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	2759	1745	618	5122
Bancassurance	2160	2144	1130	5434
Other Corporate Agents	60	21	7	88
Brokers	99	17	4	120
Direct selling	426	1129	444	1999
Others (to be specified)	52	36	22	110
TOTAL	**5556**	**5092**	**2225**	**12873**

4. Root Cause (s) for complaints relating to mis-selling

1) Lack of awareness among the prospects on Insurance product.

2) Customers trust on intermediaries /financial consultant who manage their portfolio.

3) Instigation by Ex-Financial Advisor /Ex-Sales Manager who sourced the products or plan to customers.

4) Inadequate knowledge on product features and benefits in financial advisor and new joinee.

5. Steps taken for ascertaining suitability of insurance product at point of sale

1) Need Analysis to ascertain customer requirement.

2) Financial assessment to judge the premium paying capacity.

3) Regular refresher training for sales /intermediaries.

4) Sales Manager to speak with customer before login and confirm the details.

6. Channel-wise controls placed to prevent mis-selling

Control specific to allchannels(Including Agents & Bancassurance):

1) Disciplinary action against sales based on business quality scores which is monitored &control by compliance function.

2) Mandatory training on product, ethics & compliance.

3) Welcome Call to ascertain customer understanding on product.

Specific for Agents

Mandatory customercontactby Sales Manager beforebusiness is logged to avoid any misselling.

Specific for Bancassurance :

1) Mandatory customer declaration confirming understanding on product features & benefits.

2) Control checklist for Specified Person to ensure all necessary validation during business solicitation to avoid complaints at later stage.

7. Other Measures taken for addressing mis-selling

1) Welcome Calling process to ascertain customer understanding on the product.

2) Dedicated specialized complaint cell to monitor & address Misselling complaints.

3) Key feature section in policy document highlighting critical policy details.

4) Risk investigation for suspicious business before issuance of Policy.

5) Specified Person conversation starter for need based analysis.

6) Simplified product literature in brochure, website and customer documents.

8. Procedure adopted for dealing with complaints of mis-selling

1) Request complaint letter from the customer mentioning details of the matter.

2) Acknowledgement of complaint byGrievance Officer

3) Review of complaint based on:

   a. Available documentary facts and evidence provided by customers.

   b. Feedback in Pre-verification call recording (for cases issued prior to June 2014)

   c. Feedback from Welcome call recording to ascertain the facts and feedback given by customers.

   d. KYC, supporting documents ,application details available with company

4) Case referred to respective sales /intermediaries for their inputs and face to face meeting with complainant.

5) Based on sales inputs and available details decision is taken by Central Grievance Officer.

6) In case of decision in favour of Customer,

   a. full refund is made &

   b. Recommendation madeto compliance for action against the intermediaries/employee found guilty as per malpractice grid.

9. Complaints relating to sale of policies after spurious calls (Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	7	0	6	10	0	10	1	0	3	18	0	19
Bancassurance	5	0	12	12	0	5	0	0	1	17	0	18
Other Corporate Agents	3	0	7	3	0	6	0	0	0	6	0	13
Brokers	0	0	0	0	0	0	0	0	0	0	0	0
Direct selling	0	0	0	0	0	0	0	0	0	0	0	0
Micro insurance agents	0	0	0	0	0	0	0	0	0	0	0	0
Others (to be specified)	0	0	1	0	0	0	0	0	0	0	0	1
TOTAL	**15**	**0**	**26**	**25**	**0**	**21**	**1**	**0**	**4**	**41**	**0**	**52**

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

1) We request for written complaint letter with details of caller from along with the number from where the call/calls were received.

2) Acknowledgement of complaint byGrievance Officer

3) Review of complaint based on:
   a. Available documentary facts and evidence provided by customers.
   b. Feedback in Pre-issuance verification call .
   c. Customer feedback during Welcome call.
   d. KYC, supporting documents, application details available with company.

4) Case referred to respective sales /intermediaries for their inputs and face to face meeting with complainant.

5) Based on sales inputs and investigation available details decision is taken by Central Grievance Officer.

6) In case of decision in favour of Customer,
   a. full refund is made &
   b. Recommendation made to compliance for action against the intermediaries/employee found guilty as per malpractice grid.
   c. Simultaneously action through legal is initiated by issuing legal notice and Police FIR if guilty is identified.

11. Steps taken by the insurer to caution members of public about spurious calls

1) Slide/Voice over incorporated in advertisement and commercials in electronic media.

2) Incorporated the content prominently in every advertisement in print media including pamphlets, publicity material etc.

3) Educating existing customers to avoid such calls through SMS, Letter & Emails

4) Public notice flashed on home page of Website.

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2012 -13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Individual Agents	106	103	116	106	67	35	0	0	0	547	628	363
Bank Assurance Agents/Employees	79	28	35	4	19	11	0	0	0	9	8	9
Other Corporate Agents	0	0	0	0	0	0	0	0	0	4	4	3
Brokers	0	0	0	0	0	0	0	0	0	0	0	0
Employees of Insurer	56	54	34	7	27	13	0	0	0	0	0	0
Others(Online, Direct Selling etc)	0	13	159	0	0	0	0	0	0	4	5	3
Total	**241**	**198**	**344**	**117**	**113**	**59**	**0**	**0**	**0**	**564**	**645**	**378**

NAME OF THE INSURER: **RELIANCE LIFE INSURANCE COMPANY LIMITED**

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	1382	37	2146	1393	116	3093	487	94	1014	3262	247	6253
Bancassurance	-	-	-	-	-	-	-	-	-	-	-	-
Other Corporate Agents	1343	29	3136	2852	220	6378	247	71	1480	4442	320	10994
Brokers	1803	63	3491	1771	173	4843	913	145	3144	4487	381	11478
Direct selling	593	14	1225	1250	100	2111	516	109	1277	2359	223	4613
Microinsurance agents	-	-	-	-	-	-	-	-	-	-	-	-
Others (to be specified)*	257	4	420	131	25	455	27	13	99	415	42	974
TOTAL	**5378**	**147**	**10418**	**7397**	**634**	**16880**	**2190**	**432**	**7014**	**14965**	**1213**	**34312**

– In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	404,596	396,204	129809	930,609
Bancassurance		-	-	-
Other Corporate Agents	194,925	75,911	20316	291,152
Brokers	79,669	58,246	28437	166,352
Direct selling	83,342	56,985	37322	177,649
Others (to be specified)		-	-	-
TOTAL	**762532**	**587346**	**215884**	**1,565,762**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	3455	3308	1292	8055
Bancassurance	-	-	-	-
Other Corporate Agents	3405	1726	26	5157
Brokers	2507	3075	1413	6995
Direct selling	1622	2041	983	4646
Others (to be specified)	-	-	-	-
TOTAL	**10989**	**10150**	**3714**	**24853**

4. Root Cause (s) for complaints relating to mis-selling

- Instances of a few distributors selling insurance policies with a short term view to meet sales targets instead of an adequate focus on long term persistency of the sold policy.
- Complexity of the life insurance product makes it prone to be mis-sold. Often, the distributor does not fully explain the policy details to the customer, coupled with the myopic view of quick returns fabricated by the distributors or their representatives.
- Lack of Consumer awareness – Ever too often, we are faced with a Customer approaching us beyond the policy freelook period as they do not attempt to read and comprehend the complete terms and conditions of the policy purchased.
- Very often, the life insurance product is purchased by the Customer merely as a tax savings tool, rather than the objective of long term savings and protection.

5. Steps taken for ascertaining suitability of insurance product at point of sale

Nil

6. Channel-wise controls placed to prevent mis-selling

Nil

7. Other Measures taken for addressing mis-selling

- Signature of the policyholder on the proposal form, with an explicit consent to purchase a regular premium plan.
- PIVC – probing questions prior to processing the proposal for insurance. Failure to establish contact / critical failure upon contact leads to refund of premium. The prospect is subjected to a standard questionnaire asking pointed questions regarding any promise of gifts or any untoward benefits which are not features of the actual policy.
- Most Important Terms & Conditions document – A welcome letter with the policy bond which specifically highlights the critical policy terms. This document is printed in English as well as 8 regional languages for ease of understanding of the end-user.
- Front-end Sales awareness through a regular email series highlighting instances of action initiated against errant staff indulging in mis-selling. Incidents and Actions taken against the errant employees is tracked in regular Management Reviews.
- Continuous iterations of our 'Zero Tolerance' policy towards those responsible for malpractice through stringent action including termination of top performing distributors irrespective of their contributions in the past

8. Procedure adopted for dealing with complaints of mis-selling

- Mis Selling Complaints, where signature mismatch or tampering is evident on the proposal form or supporting documents, irrespective of the vintage of the policy and availability of PLVC, are treated in favour of the complainant.
- Complaints, where the Suitability of the product sold is questionable (e.g. - senior citizen expected to pay over a continuous term, multiple policies sold successively to the same person) will tend to be favourable to the complainant.

- Mis-selling complaints received within the freelook / extended freelook due to non delivery of the policy (owing to address anomalies), are viewed in favour of the complainant.
- Complaints alleging Mis-Selling received upto a year after issuance of the policy (including those seemingly triggered by a renewal notice) will be evaluated on a case to case basis and the final decision depends on the interaction between the Complaint resolution team and the policyholder.

9. Complaints relating to sale of policies after spurious calls (Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	20		5	22	2	22	123	2	21	165	4	48
Bancassurance	-	-	-	-	-	-	-	-	-	-	-	-
Other Corporate Agents	27		18	38		48	15	2	10	80	2	76
Brokers	36	2	21	36	5	37	31	-	21	103	7	79
Direct selling	21		4	26		10	17	-	7	64	0	21
Microinsurance agents	-	-	-	-	-	-	-	-	-	-	-	-
Others (to be specified)*	285	2	81	326	28	106	146	4	18	757	34	205
TOTAL	**389**	**4**	**129**	**448**	**35**	**223**	**332**	**8**	**77**	**1169**	**47**	**429**

** Note- Others Include instances where complainant has not furnished complete details*

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

- As part of our control measures initiated against Sale of policies through Spurious Calling, our PIVC procedure helps us to probe the sale details with a Customer prior to policy issuance.
- Complaints, where signature mismatch or tampering is evident on the proposal form or supporting documents, irrespective of the vintage of the policy and availability of PLVC, are treated in favour of the complainant.
- Complaints, where the Suitability of the product sold is questionable (e.g. - senior citizen expected to pay over a continuous term, multiple policies sold successively to the same person) will tend to be favourable to the complainant.
- All such Spurious Calling Complaints received within the freelook / extended freelook due to non delivery of the policy (owing to address anomalies), are viewed in favour of the complainant.
- Complaints alleging Mis-Selling received upto a year after issuance of the policy (including those seemingly triggered by a renewal notice) will be evaluated on a case to case basis and the final decision depends on the interaction between the Complaint resolution team and the policyholder

11. Steps taken by the insurer to caution members of public about spurious calls

- Regular Email and SMS campaigns educating Customers against Spurious Calls offering unrealistic gains are sent as part of our drive to curb instances of policies being sourced through Spurious Calls.
- Media Campaign (Television and Radio Spots) to increase awareness and caution the general public regarding Spurious Calling
- Our proposal form carries a warning cautioning prospects against being lured by promises made through Spurious Calls. This effectively helps us to inform policyholders even prior to policy purchase.
- PIVC (Pre Issuance Verification Calling) - We undertook this initiative as a key step towards increasing Customer Awareness. Every proposal from a Customer received at our branches is telephonically verified by a member of our branch operations team. An employee of Reliance Life Insurance speaks to each prospect prior to issuance of the policy explaining the basic policy features and further asks a few probing questions to check and curb any policy issuance which may have been sourced through Spurious Calls.

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2012 -13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Individual Agents	-	-	-	-	-	-	-	-	-	-	-	-
Bank Assurance Agents/Employees	-	-	-	-	-	-	-	-	-	-	-	-
Other Corporate Agents	-	-	-	-	-	-	-	-	-	-	-	-
Brokers	-	-	-	-	-	-	-	-	-	-	-	-
Employees of Insurer	-	-	-	-	-	-	-	-	-	-	-	-
Others (Spurious Tele-callers)	-	-	-	-	-	-	-	-	-	-	-	-
Total												

NAME OF THE INSURER: **SAHARA INDIA LIFE INSURANCE CO. LTD.**

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	1	-	-	-	-	1	-	1	-	1	1	1
Bancassurance	-	-	-	-	-	-	-	-	-	-	-	-
Other Corporate Agents	-	-	-	-	-	-	-	-	-	-	-	-
Brokers	-	-	-	-	-	-	-	-	-	-	-	-
Direct selling	-	-	-	-	-	-	-	-	-	-	-	-
Microinsurance agents	-	-	-	-	-	-	-	-	-	-	-	-
Others (to be specified)	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL	**1**	**-**	**-**	**-**	**-**	**1**	**-**	**1**	**-**	**1**	**1**	**1**

– In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	63870	40512	9342	113724
Bancassurance	-	-	-	-
Other Corporate Agents	978	824	22	1824
Brokers	-	-	-	-
Direct selling	-	-	-	-
Others (to be specified)	-	-	-	-
TOTAL	**64848**	**40976**	**9346**	**115170**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	10	09	08	27
Bancassurance	-	-	-	-
Other Corporate Agents	-	-	-	-
Brokers	-	-	-	-
Direct selling	-	-	-	-
Others (to be specified)	-	-	-	-
TOTAL	**10**	**09**	**08**	**27**

4. Root Cause (s) for complaints relating to mis-selling

- It appeared in the initial investigation that there were problem of perceptions amongst agent and customer regarding product features.

5. Steps taken for ascertaining suitability of insurance product at point of sale

At the very stage of filling up of proposal form, Agent declaration on product suitability is taken.

6. Channel-wise controls placed to prevent mis-selling

- Agents - Agents are supposed to fill product suitability details at the time of proposal submission.
- Corporate agents - Corporate Agents are supposed to fill product suitability details at the time of proposal submission.

Bancassurance

Brokers

Direct selling

Others

7. Other Measures taken for addressing mis-selling

- In addition to regular monitoring by Marketing Executives and LCO heads time to time training is imparted on product features and salesmanship and discussions in routine meetings.

8. Procedure adopted for dealing with complaints of mis-selling

- Whenever a complaint is received against any agent / employee an explanations is called from him with comments of his team senior i.e. Marketing Executive / LCO Heas as the case may be. These explanations and comments are evaluated and further processing is done on the facts emerged in basic investigations.

9. Complaints relating to sale of policies after spurious calls(Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	-	-	-	-	-	-	-	-	-	-	-	-
Bancassurance	-	-	-	-	-	-	-	-	-	-	-	-
Other Corporate Agents	-	-	-	-	-	-	-	-	-	-	-	-
Brokers	-	-	-	-	-	-	-	-	-	-	-	-
Direct selling	-	-	-	-	-	-	-	-	-	-	-	-
Microinsurance agents	-	-	-	-	-	-	-	-	-	-	-	-
Others (to be specified)	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

- We have not received any such complaint as of now. If any such spurious call is reported to us, we shall be informing this immediately to respective telephone service provider, IRDA and lodge a police complaint to initiate necessary action.

11. Steps taken by the insurer to caution members of public about spurious calls

- We have intimated the Sales offices and Teams to inform their esteemed policyholders/ customers to be aware of such mal-practices being done by some spurious callers. We have intimated them to report any such event to HQ immediately quoting the telephone number from which such calls are being made in the name of Sahara Life.

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2012 -13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Individual Agents	-	-	-	-	-	-	-	-	-	-	-	-
Bank Assurance Agents/Employees	-	-	-	-	-	-	-	-	-	-	-	-
Other Corporate Agents	-	-	-	-	-	-	-	-	-	-	-	-
Brokers	-	-	-	-	-	-	-	-	-	-	-	-
Employees of Insurer	-	-	-	-	-	-	-	-	-	-	-	-
Others (Spurious Tele-callers)	-	-	-	-	-	-	-	-	-	-	-	-
Total												

NAME OF THE INSURER: **SBI LIFE INSURANCE COMPANY LIMITED**

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	508	298	2932	675	401	3169	281	165	1179	1464	864	7280
Bancassurance	128	90	733	199	78	913	106	34	392	433	202	2038
Other Corporate Agents	448	206	2746	162	66	814	113	33	341	723	305	3901
Brokers	0	0	0	127	62	942	21	13	244	148	75	1186
Direct selling	0	0	0	0	0	0	5	0	4	5	0	4
Microinsurance agents	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Others (to be specified)	22	20	133	77	32	328	31	9	161	130	61	622
TOTAL	**1106**	**614**	**6544**	**1240**	**639**	**6166**	**557**	**254**	**2321**	**2903**	**1507**	**15031**

– In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	514502	564399	176496	1255397
Bancassurance	350735	452200	196532	999467
Other Corporate Agents	8876	10429	3772	23077
Brokers	11610	2551	348	14509
Direct selling	2947	11543	7604	22094
Others (to be specified)	0	0	0	0
TOTAL	**888670**	**1041122**	**384752**	**2314544**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	5571	5743	2264	13578
Bancassurance	3140	3715	1774	8629
Other Corporate Agents	571	910	355	1836
Brokers	1495	379	25	1899
Direct selling	4	48	47	99
Others (to be specified)	0	0		
TOTAL	**10781**	**10795**	**4465**	**26041**

4. Root Cause (s) for complaints relating to mis-selling

- Unaware of or mis understanding of the Product Features
- Non disclosure of complete product features and conditions
- Products not sold as per the need of the customer.

5. Steps taken for ascertaining suitability of insurance product at point of sale

- Product trainings are imparted to the agents / intermediaries, including the targeted segment of customers for the product.
- We have provided the Need Analysis Calculator, Retirement Calculator, Child Education Calculator and such tools that can be accessed by agents, intermediaries and customers to assess the need and suitability.
- The pre-sales materials / sales collaterals for the products adhere to the advertisements guidelines, prominently disclosing the life cover element and conditions related to the features mentioned therein.

6. Channel-wise controls placed to prevent mis-selling

Agents

Corporate agents

Bancassurance

Brokers

Direct selling

Others

For all channels, we provide regular training, emphasizing on ethical selling.

7. Other Measures taken for addressing mis-selling

- Pre-isssuance welcome calling has been initiated to ensure that the sale is proper and need based. This will also ensure that the address and the contact details captured in our system are correct.
- We have a Sales Quality Score policy in place which addresses any misconduct by sales intermediary leading to penal action, including termination.
- We closely monitor the regions who have higher percentage of mis-selling cases

8. Procedure adopted for dealing with complaints of mis-selling

- On receipt of the complaint, we call the complainant to understand the grievance in detail.
- We also call for clarification from the sales intermediary, based on the grievance received.
- On receipt of the clarification and on the basis of the merit of the complaint, further necessary action is taken.

9. Complaints relating to sale of policies after spurious calls (Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	3	4	31	1	1	4	0	0	0	4	5	35
Bancassurance	1	0	9	0	0	2	0	0	0	1	0	11
Other Corporate Agents	6	2	35	0	0	4	0	0	0	6	2	39
Brokers	0	0	0	0	0	2	0	0	0	0	0	2
Direct selling	0	0	0	0	0	0	0	0	0	0	0	0
Microinsurance agents	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Others (to be specified)	1	5	41	12	13	127	5	3	89	18	21	257
TOTAL	**11**	**11**	**116**	**13**	**14**	**139**	**5**	**3**	**89**	**29**	**28**	**344**

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

It is very difficult to trace the policies which are sourced after receiving spurious calls. However whenever a customer complains about spurious calls, irrespective of, whether the customer is a policyholder or not we follow the following process.

- If the customer's mobile number is registered under DNC, we call for the details of the caller from TRAI and on receipt of the details from TRAI, and we file a FIR against the caller.
- If the customer's mobile number is not registered under DNC, we advise customer to register their number under DNC and to complain to their service provider about receipt of unsolicited calls.

We also inform customer about the IRDA circular regarding spurious calls.

11. Steps taken by the insurer to caution members of public about spurious calls

- An alert message is displayed in the website to beware from spurious calls
- Also a leaflet is sent along with the Original Policy document.
- All our advertisements contain caution for spurious calls

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2012 -13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Individual Agents	400	459	315	32	63	87	-	-	-	-	-	
Bank Assurance Agents/Employees	35	66	53	0	0	-	-	-	-	-	-	-
Other Corporate Agents	38	48	31	0	0	1	-	-	-	-	-	-
Brokers	102	45	10	0	0	-	-	-	-	-	-	-
Employees of Insurer	134	191	158	1	0	0	-	-	-	-	-	-
Others (Spurious Tele-callers)	-	-	-	-	-	-	-	-	-	-	-	-
Total	**709**	**809**	**567**	**33**	**63**	**88**	**-**	**-**	**-**	**-**	**-**	**-**

NAME OF THE INSURER: **SHRIRAM LIFE INSURANCE CO. LTD**

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	13	0	14	13	0	30	10	0	31	36	0	75
Bancassurance	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Other Corporate Agents	3	0	9	0	0	1	5	0	22	8	0	32
Brokers	23	0	60	23	0	80	4	0	10	50	0	150
Direct selling	0	0	0	9	0	20	1	0	7	10	0	27
Micro insurance agents	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Others (to be specified)	19	0	14	5	0	16	0	0	6	24	0	36
TOTAL	**58**	**0**	**97**	**50**	**0**	**147**	**20**	**0**	**76**	**128**	**0**	**320**

– In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	32506	30635	11132	74273
Bancassurance	NA	NA	NA	NA
Other Corporate Agents	12833	80239	21200	114272
Brokers	35706	6344	1028	43078
Direct selling	7883	35997	28525	72405
Others (to be specified)	-	-	-	-
TOTAL	**88928**	**153215**	**61885**	**304028**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	1144	1681	1332	4157
Bancassurance	NA	NA	NA	NA
Other Corporate Agents	671	830	861	2362
Brokers	276	221	58	555
Direct selling	1	0	0	1
Others (to be specified- Employees, Referrals)	4	9	45	58
TOTAL	**2096**	**2741**	**2296**	**7133**

4. Root Cause (s) for complaints relating to mis-selling

1. In Most of the cases, policies sourced based on Fraudulent Calls and over promises were prominent.
2. Customers also believed in these calls without any confirmation or proof check and then later on reached to companies with the kind of activities happened in policy selling.
3. Cases were also indentified where in calls went to customers in the name of IRDA personnel informing on their existing policies with other life insurance companies are performing losses and to cover that they need to invest afresh again.
4. In addition to that, commitments like Loans on Zero percent interest, Fixed deposit schemes; Bonus release etc were also identified.
5. Majority of the complaints came from brokers namely SMC, Safeway Insurance.

5. Steps taken for ascertaining suitability of insurance product at point of sale

1. Customer education was taken on high priority .The company initiated to advertise information in newspapers, Website and News Letter editions warning the general public on the ongoing Fraudulent activities in Insurance selling.
2. Our Website has also been hosted with the information that relates on Spurious/Hoax calls from unknown personnel.
3. Pre Login Verification calling from the company's end has also proved successful in identifying such cases if any and acting towards them as required.
4. Best training to our Marketing staff and field personnel during their orientation program and training sessions conducted.
5. On receiving the complaints through IGMS portal and Grievance Redressal platform's required Investigation is going in to identify the facts and thereon providing a resolution based upon.

6. Channel-wise controls placed to prevent mis-selling

Agents	1. Good Underwriting Procedures
Corporate agents	2. Pre Login Verification Call
Bancassurance	3. Structured Training to Sales force
Brokers	4. Involvement of Managers & Officers in lead
Direct selling	closing wherever applicable
Others	5. Stringent actions if non adhering to P&P's

7. Other Measures taken for addressing mis-selling

- As the severity of Mis selling cases increased, the Company immediately tried to dig the facts.
- Such policies which are Mis sold are segregated and verified with the customer, pertaining to the terms and conditions and information provided. If any minute discrepancy or violation is found, the agent is asked to revisit the customer and make the appropriate amendments to the plan commitments.

- Mis-selling is now being taken seriously by the Company and is trying to take new and innovative steps to reduce the practice of Mis selling. Basis the severity of Mis selling activity that has went into, company has taken a stand either to cancel or reject the complaints lodged in. During the process, people involved in these kinds of instances have been strictly warned from doing such practices.

- We have also revised our understanding and actions from time to time depending on the scenarios of Mis selling cases encountered.

8. Procedure adopted for dealing with complaints of mis-selling

- On receival of the complaint, our Grievance Management Team speaks to the customer and understands his/her concern. Accordingly they also convey the complaint to the concerned channel personnel or the agent from whom the policy has been sourced. This shall also pave a way to retain the customers and make them to be associated with our company with a long term business relationship. In the process scrutiny check on signatures, Medicals done if any, Pre login verification call, etc will also be considered to arrive at a genuine decision. Instances where in a genuine Mis Selling has occurred , we would try to offer options to the customer if still not retainable will do a policy refund. This will not only help to improve customer satisfaction but also develops a trust factor in the customers that company as such does not encourage false practices in procuring business. On the other hand, personnel involved in any kind of unfair business practices have been properly dealt with stringent actions as applicable.

- As a company, we will not leave behind any minute aspect that will hamper or degrade our strong relationships with customer and their continued satisfaction.

9. Complaints relating to sale of policies after spurious calls (Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	0	0	0	0	0	1	0	0	1	0	0	2
Bancassurance	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Other Corporate Agents	0	0	1	1	0	12	0	0	1	1	0	14
Brokers	6	0	9	0	0	5	0	0	2	6	0	16
Direct selling	0	0	0	0	0	1	0	0	0	0	0	1
Micro insurance agents	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Others (to be specified)	13	0	4	0	0	0	0	0	2	13	0	6
TOTAL	**19**	**0**	**14**	**1**	**0**	**19**	**0**	**0**	**6**	**20**	**0**	**39**

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

- A dedicated team was appointed to address these cases and tried to know the exact findings of the mis selling happening.

- Whenever such instances were found, the customers were requested not to go by the false commitments given by the agent and educated them.

- Gave presentations/training to the employees of all cadres/levels regarding the cases and explained them how to prevent and overcome the mis selling cases.
- Company has also taken initiatives to cancel those policies which were sourced on the basis of Spurious/Hoax calls.
- We are still working on the issue (Hoax/Spurious Calls) and trying to get a best and permanent solution and the Company is of the view that we shall overcome and eradicate the same in the near future.

11. Steps taken by the insurer to caution members of public about spurious calls

- As a part of educating the customers, the Company has published many disclaimers in its website and conveyed the message to the customers through all the possible modes of communication.
- Mis-selling can be curbed if there is proper sharing of information about fraudulent activities and instances happened with our neighbors/relatives/friends etc. and hence maintaining a database of all the mis selling cases to lessen the complaints against spurious calls in coming financial year.
- Short movies/videos clippings are telecasted to educate the customers and know the importance of LIFE INSURANCE.

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2012 -13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Individual Agents	0	0	0	0	0	0	0	0	0	0	0	0
Bank Assurance Agents/Employees	0	0	0	0	0	0	0	0	0	0	0	0
Other Corporate Agents	0	0	0	0	0	0	0	0	0	0	0	0
Brokers	0	0	0	0	0	0	0	0	0	0	0	0
Employees of Insurer	0	0	0	0	0	0	0	0	0	0	0	0
Others (Spurious Tele-callers)	0	0	0	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

NAME OF THE INSURER: **STAR UNION DAI-ICHI LIFE INSURANCE CO LTD**

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	-	-	-	35	-	4	39	-	4	74	-	8
Bancassurance	165	-	49	388	4	113	343	2	32	896	6	194
Other Corporate Agents	-	-		-	-	-	-	-	-	-	-	-
Brokers	-	-	-	-	-	-	-	-	-	-	-	-
Direct selling	-	-	-	-	-	-	-	-	-	-	-	-
Microinsurance agents	-	-	-	-	-	-	-	-	-	-	-	-
Others (to be specified)	-	-	-	-	-	-		-	-	-	-	-
Unregistered	7	-	2	13	1	3	8	-	-	28	1	5
TOTAL	**172**	**-**	**51**	**436**	**5**	**120**	**390**	**2**	**36**	**998**	**7**	**207**

– In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	4237	9467	2933	16637
Bancassurance	148290	116251	35112	299653
Other Corporate Agents	0	0	0	0
Brokers	0	1720	95	1815
Direct selling	0	114	70	184
Others (to be specified)	0	0	0	0
TOTAL	**152527**	**127552**	**38210**	**318289**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	11	109	105	225
Bancassurance	527	749	432	1708
Other Corporate Agents	0	0	0	0
Brokers	0	101	26	127
Direct selling	0	0	2	2
Others (to be specified)	0	0	0	0
TOTAL	**538**	**959**	**565**	**2062**

4. Root Cause (s) for complaints relating to mis-selling

- Customer is informed about false returns on investments and incorrect information of the products.
- Payment terms are not clearly explained to the customer.
- Elevated growth on investments promised against insurance products.
- Need based analysis was not done or discussed with the customers.

5. Steps taken for ascertaining suitability of insurance product at point of sale

For Brokers

- Pre issuance login verification call (PLVC) is made to customers for checking amongst other things, whether there was any mis-selling during the sales process.
- Brokers themselves carry out Pre issuance login verification call (PLVC) to check whether there was any mis-selling done by their sales person.
- Claw back of commission is done in case of mis selling by brokers. Also, the same is incorporated as a clause in the agreements with Brokers to deter them from mis-selling.
- Customer awareness modules prepared and uploaded on company websites covering precautions during the purchase and servicing aspects of insurance policy.
- Trainings on mis-selling practices are conducted for sensitising brokers.
- Investigation is carried out for any reported mis-selling case of brokers
- Action is also taken by the broker on proven mis-selling cases.

For Bancassurance

- Pre issuance login verification call (PLVC) is made to customers for checking amongst other things, whether there was any mis-selling during the sales process.
- Trainings are imparted to all employees managing banc assurance business of the company for sensitising them on mis-selling practices and action against it.
- In customer policy documents Grievance Redressal procedures and escalation matrix are mentioned.
- Detailed investigation is done on any reported mis-selling case.
- Wherever mis-selling is proved and employee's involvement is found, action is taken as per the penal matrix.
- Broadcasting of MIS on action taken against employees involved in malpractice. This acts as a deterrent amongst employees against malpractices.

6. Other Measures taken for addressing mis-selling

- Welcome calling is done to all customers post issuance of policies, in which, customers have an opportunity to complain.
- Key Information Document – a single page hand-out is included as a part of the policy document which brings out the key features and benefits of the product the customer has opted for.
- In customer policy documents, Grievance Redressal procedures and escalation matrix are mentioned.
- Grievance cell is in place to receive the customer complaints and suitably resolve and provide the resolution to customers.

- Customer awareness modules prepared and uploaded on company websites covering precautions during the purchase and servicing aspects of insurance policy.
- Penal Matrix implemented for actioning of mis-selling cases if any employee is found involved in mis-selling.

7. Procedure adopted for dealing with complaints of mis-selling

1. Adherence to Grievance Redressal policy in terms of Acknowledging the complaint, Resolution as per the defined TAT.
2. Customer is called on the registered number to seek more inputs and clarification. This helps to investigate and do complete justice to the complaint received and also helps expedite the resolution to be provided to the customer.
3. Feedbacks are given to the Sales personnel involved in the Grievance case received.
4. Root-Cause Analysis is done for every Grievance received.

8. Complaints relating to sale of policies after spurious calls (Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	-	-	-	-	-	-	-	-	-	-	-	-
Bancassurance	-	-	-	20	-	-	27	-	-	47	-	-
Other Corporate Agents	-	-	-	-	-	-	-	-	-	-	-	-
Brokers	-	-	-	-	-	-	-	-	-	-	-	-
Direct selling	-	-	-	-	-	-	-	-	-	-	-	-
Microinsurance agents	-	-	-	-	-	-	-	-	-	-	-	-
Others (to be specified)	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL	**-**	**-**	**-**	**20**	**0**	**0**	**27**	**-**	**-**	**47**	**0**	**0**

9. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

1. Once a complaint about spurious call is received, we ascertain whether the call has been made by any employee/agent/broker of the company.
2. Contact number of the person from which the spurious call is made is obtained.
3. Investigation is conducted to find the details of the Spurious caller.
4. During investigation of such cases, every effort made to obtain the Address, name details etc of the Spurious caller.
5. Once the address, name, etc are obtained then the same is verified with the Insurance advisor/ employee database/brokers to ascertain whether any person associated with the insurance company tried to make such spurious calls to our customers.

6. If the number belongs to any other person than the above, investigation conducted to find out the person firm to whom the spurious call number belongs.

7. Efforts are made to report the matter to police with the investigation details obtained after the receipt of customer complaint.

8. However, it has been observed that police does not entertaining such complaints

9. Details obtained of such spurious callers are maintained and discussed with other companies at Insurance Industry meets and with Life Council

10. Steps taken by the insurer to caution members of public about spurious calls

1. An SMS warning the customers against such types of calls has been sent.

2. A similar SMS has been sent to the employees to ensure that they are aware and can inform customers when approached.

3. A ticker has been put up on the website attracting attention of the customer to such calls. The customer are informed to report such Fraudulent Calls to the Company.

4. A customer awareness initiative is flashed on the opening page of the Website

5. Auto response to email id Customercare@sudlife.in will also highlight this customer awareness note.

6. Additionally, we are working on sending bulk emails to customers

11. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2012 -13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Individual Agents	-	-	-	-	2	-	-	1	-	-	-	-
Bank Assurance Agents/Employees	-	-	-	-	-	-	-	-	-	-	-	-
Other Corporate Agents	-	-	-	-	-	-	-	-	-	-	-	-
Brokers*	-	-	-	-	2	4	-	-	1	-	-	-
Employees of Insurer	-	3	1	1	3	5	-	1	4	1	-	1
Others (Spurious Tele-callers)	-	-	-	-	-	-	-	-	-	-	-	-
Total	**-**	**3**	**1**	**1**	**7**	**9**	**-**	**2**	**5**	**1**	**-**	**1**

**Action is taken by the Broker on the defaulter sales personnel by themselves*

NAME OF THE INSURER: **TATA AIA LIFE INSURANCE COMPANY LIMITED**

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	199	20	1428	160	14	1073	58	7	385	417	41	2886
Bancassurance	106	14	559	73	4	467	24	1	126	203	19	1152
Other Corporate Agents	149	3	436	46	6	318	21	1	66	216	10	820
Brokers	406	27	1524	206	14	970	31	1	262	643	42	2756
Direct selling	53	4	236	18	1	145	8	0	35	79	5	416
Microinsurance agents	0	1	2	1	0	2	0	0	0	1	1	4
Others (No Policy / Group Policy)	15	1	114	6	0	33	0	0	14	21	1	161
TOTAL	**928**	**70**	**4299**	**510**	**39**	**3008**	**142**	**10**	**889**	**1580**	**119**	**8196**

– In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	81,626	72,640	21,117	175,383
Bancassurance	14,108	9,106	770	23,984
Other Corporate Agents	3,723	82	-	3,805
Brokers	21,261	3,941	115	25,317
Direct selling	2,117	4,170	1,011	7,298
Others (Micro Agents)	27,848	27,421	-	55,269
TOTAL	**150,683**	**117,360**	**23,013**	**291,056**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2012-13	2013-14	2014-15 (Upto 30.9.2014)	
Individual Agents	1592	884	281	2757
Bancassurance	452	321	57	830
Other Corporate Agents	329	7	0	336
Brokers	1086	137	1	1224
Direct selling	76	39	7	122
Others **(Micro Insurance Agents)**	1	0	0	1
TOTAL	**3536**	**1388**	**346**	**5270**

4. Root Cause (s) for complaints relating to misselling

- Customer understanding – for e.g. not clear about the various policy charges, other policy features.
- Product differs from what was requested by the customer or disclosed to him / her.
- Tampering / Corrections / Forgery of proposal or related papers by intermediaries
- Other malpractices or unfair business practices like misappropriation, renewal cheques being used for new business
- Policies sourced from customers through the mechanism of spurious / hoax calls with lure of bonus etc.

5. Steps taken for ascertaining suitability of insurance product at point of sale

- The Product is explained in detail to the customer
- Signature taken on the Sales illustration of the product being purchased customer
- Welcome Calling is done to all proposers before issuance of policy to check the understanding of the customer
- We have designed different sales tools to identify the insurance GAP of an individual. These tools also assist sale channel to identify the suitable product for the individual.

6. Channel-wise controls placed to prevent misselling

Agents

- Policy details verified with customer through pre submission calling before accepting new business
- Welcome call post issuance of policy to verify receipt of policy and address queries and explain product features and self service options
- Focus given on quality of agents recruitment
- Training to agents regarding Sales process and need based selling
- Fund transfer restriction between policies
- Action taken against agents by Market Conduct Committee

Corporate agents

- Policy details verified with customer through pre submission calling before accepting new business
- Welcome call post issuance of policy to verify receipt of policy and address queries and explain product features and self service options
- New Business exposure reduced for non compliant Corporate Agency partners
- Fund transfer restriction between policies

Bancassurance

- We do not have a Banca partner now associated with us.

Brokers

- Policy details verified with customer through pre submission calling before accepting new business
- Welcome call post issuance of policy to verify receipt of policy and address queries and explain product features and self service options
- New Business exposure reduced for non compliant Broking partners
- Fund transfer restriction between policies
- The Company submits the list of complaints received against the Broker to IRDA for their reference and action.

Direct selling

- Policy details verified with customer through pre submission calling before accepting new business
- Welcome call post issuance of policy to verify receipt of policy and address queries and explain product features and self service options
- Fund transfer restriction between policies
- Action taken against employees by Market Conduct Committee

Others

7. Other Measures taken for addressing misselling

- Policy details verified with customer through pre submission calling before accepting new business
- Welcome call post issuance of policy to verify receipt of policy and address queries and explain product features and self service options
- Action taken against agents & employee by Market Conduct Committee
- Premium payment certificate is watermark to mitigate risk & fraud
- Face to Face Customer Service Camps are conducted every month wherein customers are invited to visit Company's Branches & are explained the policy features in detail & customer queries are answered
- Inserts added to PIP kit which briefs customers to:
    1. Read policy contract thoroughly
    2. Check if Product features, Charges, Sum Assured, Payment Term, etc are same as explained during sales
    3. How to register Online to Customer Portal
    4. Provides all touch points to contact company

- Periodic SMS and Email communication sent to customers informing them to beware of spurious & hoax communications. Published in local newspapers to customers to beware of such unsolicited calls.

8. Procedure adopted for dealing with complaints of misselling

- Grievance Redressal policy is periodically reviewed & shared with customers
- All complaints are recorded , processed and documented in CRM
- Our grievance Redressal process is a ISO (10002:2004) certified process
- Customer feedback is sought on complaint handling process through outcall post complaint closure for RCA
- Dedicated team conducts RCA on complaints received and implements solutions to minimize complaints
- Market Conduct Committee periodically reviews agent related complaints & action is taken as per Code of Conduct
- An elaborate process of seeking and recording voice of customers (those who have complained and those who do transactions through other touch points) is implemented and monitored.

9. Complaints relating to sale of policies after spurious calls (Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2012-13			2013-14			2014 -15 (Upto 30.09. 2014)			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	2	1	48	6	2	48	4	0	58	12	3	154
Bancassurance	2	0	9	2	1	13	0	0	12	4	1	34
Other Corporate Agents	1	0	5	1	0	8	0	0	6	2	0	19
Brokers	3	0	33	1	0	60	3	0	50	7	0	143
Direct selling	0	0	5	0	0	7	2	0	6	2	0	18
Micro insurance agents	0	0	0	0	0	0	0	0	0	0	0	0
Others (No Policy / Group Policy)	4	0	39	0	0	6	0	0	5	4	0	50
TOTAL	**12**	**1**	**139**	**10**	**3**	**142**	**9**	**0**	**137**	**31**	**4**	**418**

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

- On receipt of information, a detailed investigation is carried out to ascertain the facts and to verify the telephone number through internet or Truecaller.
- We co-relate if any such instances has taken place in the past with any other customer.
- On completing preliminary check, a criminal complaint is filed in the police station against the spurious callers and their units.

- In the past, we have registered a FIR in the police station and have taken criminal action against such callers through police.
- Cancellation of policy where allegation gets established

11. Steps taken by the insurer to caution members of public about spurious calls

- SMS is being sent to the customers to be alert on such calls and to inform us.
- E-mail is sent to the customer on the same.
- We have created an alert in our website which informs the customers to verify the credentials of the agent, and callers and report any unsolicited calls/emails to us.
- We have also published an article in the print and media cautioning on such activity

12. Action taken against intermediaries found engaged in misselling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2012 -13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Individual Agents	198	175	65	127	83	32	4	7	4	341729.72	119859.5	500
Bank Assurance Agents/Employees	0	0	0	0	0	0	0	0	0	0	102750	0
Other Corporate Agents	7	1	0	0	0	0	0	28	20	22000	9500	1068897
Brokers	32	30	14	0	0	0	0	1	0	699166.02	135062.73	89249.72
Employees of Insurer	23	12	9	26	8	2	1	1	0	0	0	142227
Others (Spurious Tele-callers)	0	0	0	0	0	0	23	229	301	0	0	0
Total	**260**	**218**	**88**	**153**	**91**	**34**	**28**	**266**	**325**	**1062895.7**	**367172.23**	**1300873.72**

Claim Handling by Insurance Companies

CLAIM HANDLING BY INSURANCE COMPANIES

I. INTRODUCTION

Claim is a moment of truth as far as an Insurance policy is concerned. It is the culmination of the insurance contract. The expectation of the policyholder taking an insurance policy is that when there is a loss caused to the person or property covered by insurance, the insurer honors the claim and makes the payment of the insured amount at the earliest and with least possible inconvenience. The efficiency of claim handling is a test of the customer service orientation of an insurer.

II. IMPORTANCE OF EFFICIENT CLAIM HANDLING

Claim has a different impact on the policyholder / claimant and the insurer. In case of a claimant, the claim amount is the benefit whereas for an insurer it is expenditure. A claimant would want the sum assured or insured to be paid by the insurer if anything happens to the subject matter of insurance whereas the insurer would want to pay claim only if the loss is caused by the insured event and strictly in accordance with the policy terms and conditions. The information asymmetry insofar as the understanding of the insurer and the policyholder/ claimant and the interpretation of clauses of the insurance contract is one of the main reasons for disputes relating to claims.

Delay in settlement of claims creates undue hardship to the claimants who are already reeling under the impact of the loss caused to the subject matter of insurance. Repudiation of claims either fully or partially makes the claimant feel that the entire exercise of taking an insurance policy was futile and the premium paid was only an item of expenditure without any commensurate benefit. If the reasons for delay in settlement of claims and the reasons for partial or complete repudiation of claims are not informed to the claimant with clarity by the insurer, the claimant is left with no other option but to raise a dispute. Once a dispute is raised and the same is not resolved or explained with reasons, the policyholder/claimant loses trust in the insurer. Thus, there is little possibility that the claimant would take / renew insurance with the insurer, thereby affecting new business or persistency. Further, the negative publicity about the unreasonable rejection of claims also can affect the potential of sourcing of new business or renewals by the insurer.

On the part of insurer, paying of all claims without proper examination can result in a situation where fraudulent claims also get entertained and paid. This would severely impact the financials of the company putting in jeopardy the very solvency of the insurance company.

Therefore, the claim handling is a critical function of an insurer which has to be carried out with diligence and prudence without adversely affecting the customer service.

III. INTERMEDIARIES IN HANDLING OF CLAIMS

Surveyors and loss assessors in non-life and third party administrators in health insurance are the most important intermediaries who have a significant role in claim handling. Ensuring that these intermediaries function properly is the most critical to the discharge of claim related functions by insurers.

Surveyors and loss assessors are appointed by the insurer for surveying and assessing the loss caused when a claim is reported. The report is required to be furnished to the insurer. The insurer would decide upon the claim and may use the report of the surveyors and loss assessors but are not bound by it. The timeliness in appointment and conduct of survey and furnishing a report; thr professionalism displayed in their functioning and the quality of the report determines the speed and quality of settlement of claims by insurers.

In case of health insurance, Third party administrators are the most important intermediaries handling policyholder servicing issues. Providing of cashless facility and settlement of reimbursement claims is done by TPAs. The professionalism in conducting both these functions determines the smoothness of claim handling by insurers.

IV. COMPLAINTS RELATED TO CLAIMS

Once a claim has been unduly delayed or repudiated by the insurer, there is a cause of complaint. The claimant takes up the matter first with the insurer. All the insurers have put in place internal mechanism to deal with such grievances and resolve them. The resolution of claim related complaints also generally includes review of the decision on claims by a Committee. After review, the decision on the claim is conveyed to the complainant.

Once the complaint is not internally redressed, the claimant is forced to seek adjudication of the dispute. For this purpose, he may approach an insurance ombudsman, consumer forum or a civil court and later take it through the appellate channels if redress is not to his satisfaction.

The general perception in respect of claim related grievances is that in the Non-Life Sector, claim related complaints constitute a major area of grievances whereas in case of life insurance sector, the proportion of complaints related to claims is comparatively lower.

The data relating to claim related complaints as obtained from the Integrated Grievance Management System, which reflects this general perception, is as follows:

Claim related complaints constitute less than 15 % of life complaints whereas they constitute nearly 40-45 % of non-life complaints. This clearly shows that claim handling is a serious customer service issue in non-life insurers which needs immediate attention.

There has been a general reduction of claim related complaints in both life and non-life insurers with the rate of reduction being close to 15 % in life insurance claims. Over the three years, the proportion of claim related complaints to total non-life complaints has been on the rise. However, the proportion of claim related complaints to total life complaints has been decreasing.

While the volume of complaints in relation to total number of claims is very small, the problems faced by the complainants cannot be wished away given the inconvenience caused to them.

The major complaint descriptions in claim related complaints as per IGMS are as follows:

1. Claim repudiated without giving reasons
2. Delay in appointment of surveyor
3. Delay in conducing survey.
4. Delay on the part of TPA to provide cashless facility.

Year	No. of Claim complaints	% increase / decrease compared to last year	Total complaints	% of Claim related complaints to total complaints
NON-LIFE COMPLAINTS				
2012-13	30045	NA	78927	38.07
2013-14	27409	(-) 8.77	63335	43.28
2014-15	26467	(-) 3.43	60688	43.61
LIFE COMPLAINTS				
2012-13	43178	NA	341012	12.66
2013-14	36685	(-) 15.04	374620	11.58
2014-15	31076	(-) 15.29	278992	11.14

(Source: Integrated Grievance Management System of IRDAI)

5. Delay on the part of TPA to arrange claim reimbursement.

6. Difference between assessed loss and amount settled by Insurer.

7. Dispute on mode of claim settlement – Total loss / cash loss vis-à-vis repair basis.

8. Claim denied due to alleged non-cooperation of Insured

V. REGULATORY AND SUPERVISORY FRAMEWORK

The regulatory framework and institutional arrangement for processing claims expeditiously and resolving grievances relating to claims is discussed below in brief:

A. Regulations:

• IRDA (Protection of Policyholders' Interest) Regulations, 2002 constitutes the regulatory framework for the protection of policyholders' interests. In terms of Regulation 5, every insurer should have in place proper procedures and effective mechanism to address complaints and grievances of policyholders efficiently and with speed. Regulation 8 and 9 deals with claims procedure in respect of life insurance and general insurance policy respectively.

The Turn Around Time (TAT) for claims related services as per the Regulations are as follows:

CLAIM SERVICE	Turn Around Time
LIFE INSURANCE CLAIM	
1. Surrender Value / Annuity / Pension processing	10 days
2. Maturity claim / survival benefit / penal interest not paid	15 days
3. Raising claim requirements after lodging the claim	15 days
4. Death claim settlement (without investigation requirement)	30 days
5. Death claim settlement / Repudiation (with investigation requirement)	6 months
NON-LIFE INSURANCE CLAIM	
1. Surveyor appointment	72 hours
2. Survey report submission	30 days
3. Insurer seeking addendum report	15 days
4. Additional report submission	3 weeks
5. Offer of settlement / Rejection of claim after receiving 1st / addendum survey report	30 days
6. Payment after acceptance of offer of settlement	7 days

• In terms of Regulation 8(5) and Regulation 9(6), where there is a delay on the part of the insurer in payment of life insurance claims or non-life insurance claims respectively, the insurer is required to pay interest @ bank rate plus two per cent for the delay.

• IRDA (Non-Linked Insurance Products) Regulations, 2013 and IRDA (Linked Insurance Products) Regulations, 2013 contain provisions relating to claim settlement in case of group life insurance policies.

• IRDA (Licensing of Insurance Agents) Regulations, 2000, IRDA (Licensing of Corporate Agents) Regulations, 2002, IRDA (Insurance Brokers) Regulations, 2002, IRDA (Third Party Administrators – Health Services) Regulations, 2001 and Insurance Surveyors and Loss Assessors (Licencing, Professional Requirements and Code of Conduct) Regulations, 2000 stipulate Code of conduct for insurance agents, corporate agents, brokers and TPAs respectively wherein aspects relating to claims are also specified.

• IRDA has issued Circular No IRDA/HLTH/MISC/CIR/216/09/2011 dated 20-9-2011 in respect of delay in claim intimation/document submission with respect to all life insurance contracts and non-life individual and group insurance contracts. IRDA advised all companies to not repudiate delayed claims unless and until the reasons of delay are specifically ascertained, recorded and the insurers should satisfy themselves that the delayed claims would have otherwise been rejected even if reported in time.

B. Grievance Redressal System

- To enable timely resolution of grievances, IRDA has issued Guidelines for Grievance Redressal by insurance companies in 27 July 2010 according to which every insurance company is required to acknowledge grievances within 3 days and resolve complaints within two weeks.
- Grievance cell in the Consumer Affairs Department of IRDA also receives complaints from policyholders which include those relating to claims. The complaints are registered and forwarded to the insurers for resolution and advice to the complainants. The insurers are required to examine the complaints and resolve the same within two weeks.
- Where the complaints are not resolved to the satisfaction of the complainant, the complainant can take up the matter with the Insurance Ombudsman or any other forum.

C. Insurance Ombudsmen in Mediation and Adjudication of Claim related grievances

- In order to provide an expeditious and inexpensive forum for adjudication of matters relating to claims in respect of personal lines of insurance upto a certain limit, Government introduced a system of Ombudsman in the Insurance Sector with effect from 11th November 1998. Currently there are 12 insurance ombudsmen in the country who are allotted to different geographical areas as their areas of jurisdiction (Five more Ombudsman are being appointed to be operating from 5 different cities).
- The grounds relating to claims for which a complaint can be made to the Insurance Ombudsman are as follows:
- Any partial or total repudiation of claims by an insurer.
- Any dispute on the legal construction of the policies in so far as such disputes relate to claims.
- Delay in settlement of claims.
- Each Ombudsman is empowered to redress customer grievances in respect of insurance contracts on personal lines where the insured amount is less than Rs.20 lakhs. The Insurance Ombudsman adjudicates upon the complaint and issues an Award. The insurer shall comply with the award given by the Ombudsman within 15 days of the receipt of the acceptance letter from the complainant and it shall intimate the compliance to the Ombudsman.

D. Supervision and Regulatory action

- IRDA constantly monitors the claims payment position of the insurance companies by collecting the claims payment data quarterly.
- IRDAI monitors the claim handling systems based on the analysis of complaints received based on the date contained in the IGMS.
- IRDA regularly inspects the books of the insurance companies as per Section 33 of the Insurance Act, 1938 which includes the examination of systems and procedures relating to handling of claims, practices of making payment as well as compliance with various regulatory requirements relating to claim handling. Whenever any deviations are noticed regulatory action is initiated.

VI. INITIATIVES BY INSURERS

Insurers themselves also take several steps for better claims handling. The steps include giving the claim related documents and the list of documents to be submitted along with the policy document itself, having a claim review committee headed by independent persons of repute from the industry / judiciary. The monitoring, supervision and constant interaction with the intermediaries like surveyors/ loss assessors, TPAs etc. also enables these intermediaries to perform their responsibilities in accordance with regulations issued by IRDA and the Code of Conduct specified for them.

VII. CLAIMS AND LITIGATION

The basic principle on which insurance operates is 'uberrima fides' i.e. principle of utmost good faith. The good faith is applicable equally to insured as well as the insurer. The insured gives all the information required in the proposal form and the insurer has to give the information about the

products like terms, conditions, warranties and exclusions in documents of offer like prospectus, brochure, advertisement etc. and also make them part of the policy document. The fine print of insurance policy and the legalese in the wording of policy terms and conditions makes it an unequal bargain from the customer's point of view. Since the insurer knows only those things about the insured and the risk as is disclosed by him in the proposal, any failure to disclose renders the position of insurer difficult. The insured has chosen to buy the insurance product and is presumed to have satisfied himself about the product as the principle of 'caveat emptor' of 'buyer beware' applies to insurance as well. However, considering the several terms and conditions in the insurance contract which are presented in highly technical legal terms, literal application of the principle to largely financially illiterate insured persons would shift the balance heavily in the insurer's favour in case of any dispute in enforcing the obligations under the insurance contract. Protection to an extent is provided to the insured through the 'contra proferentem' rule. As the decision to underwrite a policy is supposed to be taken by the insurer after obtaining all information necessary for understanding the risk and the policy terms and conditions being standard forms drafted by the insurer, while interpreting the clauses of contract, any unclear term is interpreted in favour of the insured and against the insurer. The interplay of these principles, provides reason for disputes in insurance. So, over the years, insurance has grown to be not only a subject matter of solicitation but also a fertile ground for litigation.

Disputes in insurance are basically disputes in contract and have to be taken up with civil court. To provide scope for settling the disputes through alternate dispute resolution mechanisms, the institution of Insurance Ombudsmen has been created by Government of India under the Redressal of Public Grievances Rules, 1998. However, only disputes on personal lines of insurance on only 5 grounds of complaint and where compensation sought is less than Rs. 20 lakhs can be taken up with Insurance Ombudsman. Absence of mechanisms of appeal against Awards or for enforcement of Awards make the legal recourse the only alternative for persons or insurers aggrieved by unsatisfactory Awards.

In case of commercial lines of insurance, while resolution through Arbitration and Conciliation is provided for, the Arbitration Awards do not provide finality leaving room for litigation even after arbitration. Further arbitration clause is provide for generally only in case of partial repudiation of claim and not in case of denial of claim.

With the increasing publicity about the recourse to Consumer Fora under the Consumer Protection Act, 1986, the volume of cases before Consumer Fora on matters of insurance has also been increasing with more and more people taking recourse to Consumer Fora alleging deficiency of service. The delay in resolving a case before the District Forum and the several years taken in disposal of appeals by State Forum and National Forum because of the huge volume of cases pending before these fora have rendered the recourse to Consumer Fora ineffective in expeditious resolution of insurance related disputes.

In order to provide a separate forum for dealing with cases relating to third party claims in case of motor accidents, the Motor Accident Claims Tribunals have been set up under the Motor Vehicles Act. Several of these Tribunals are in operation across the country. The number of cases pending before these Tribunals is huge and the delay in decisions by these Tribunals is also substantial. There is no finality to the decisions as cases where the claimants feel that the compensation ordered is too low, they go for Appeal to the High Court and where the insurer feels that the compensation ordered is too high, the insurer goes on an Appeal leading to increased number of appeals before High Court and if further appealed against, before the Supreme Court. The difficulty in resolving disputes about motor accidents arise of the onerous task of assessing the value of human life lost in the accident and there can always be divergence of views of either party leading to litigation and escalations in the form of appeals. A straight jacketed formula is difficult to implement. However, there is sufficient scope of settlement of disputes at the earliest to save the financial burden in the form of absence of any earning of the deceased, cost of filing a case and pursuing it and the consequent time value of the money ordered at some remote time after the loss occurred.

In addition to these, disputes regarding claims in other non-life insurance policies which are not on personal lines are taken up before Civil Courts, where there is substantial delay in deciding the matters. Even after decision of the Court is received, there is the option of Appeal leading to delay in finality of the decision.

VIII.VOLUME OF LITIGATION

The volume of cases pending before various fora / courts as on September 30, 2014 is given below:

COURT / FORUM	LIFE No. of Cases	NON-LIFE No. of Cases
Consumer Forum		
District Level	19237	39567
State Level	1109	16433
National Level	114	1867
Civil Court	13868	9065
High Court	95	17467
Supreme Court	113	2374
MACT Related		
MACT	NA	893124
State Level	NA	16428
National Level	NA	94

(Source – Consolidation of Information furnished by the Insurers)

It is clear from the above that the number of cases relating to life insurance is much less when compared to non-life insurance. There are more than 9 lakh cases relating to motor accident third party claims pending at MACT itself or in appellate courts. Not only is the volume of litigation extremely high, these MACT cases are pending for a number of years.

While delays in litigation and large pendency of cases are a common problem in India, the impact of the delay in decision in matters relating to insurance on the insurers and the insured is significant calling for a new approach for dealing with the problem. Since the liability to honour the decision of the Court which has ordered payment has to be maintained, the cost of engaging counsel and pursuing the matter across different fora is definitely something which affects the financial strength of insurance companies. The occurrence of peril for which insurance was intended to provide cover for puts the claimants in a very difficult position where they have to not only battle the loss / tragedy caused as a consequence of the occurrence of the peril but also spend substantial amounts of money, time and effort to pursue the legal battle with an institution.

Therefore, there is an urgent need to deal with the problem of litigation in insurance by resorting to out-of-court settlements, taking up the cases through Lok Adalats, etc.

IX. INSURANCE AWARENESS

Insurance awareness can help persons taking insurance to be more aware about the nuances of insurance, what to disclose and what to look for in an insurance product, how to understand the insurance product and comprehend the terms, conditions, exclusions and warranties in the insurance policy. When this meeting of minds of insurer and the policyholder/claimant about mutual rights and obligations is there, disputes warranting litigation would not arise. In non-life insurance, underwriting includes risk assessment. Therefore, suggesting the suitable insurance policy and also mechanisms of mitigating risks can be an important service provided by the insurer to the policyholder. Building insurance awareness and bringing in more transparency in policy terms and conditions through simplification of language can help in interpretational problems in claim handling, avoiding an important reason for a lot of litigation in claims.

X. CONCLUSION

Insurers should have proper systems in place for quick and proper handling of claims. Providing a reasoned and timely decision about the claim can help mitigate the agony of the claimant in approaching various channels only to understand why there is a delay and what is the reason for repudiation of claim in full or in part. A suitable mechanism at insurer's level to ensure that this information would be provided promptly would reduce the number of complaints relating to claims.If the suitable policy is issued and the policyholder has fulfilled the obligation of payment of premium regularly, there should not be a cause for rejection of genuine claims in case of loss to the subject matter of insurance. If the insurers and the intermediaries adopt such an approach, the benefits of insurance can be realized by the policyholders/claimants. This would in turn build confidence in the insurance sector thereby promoting greater insurance inclusion.

- Information from Life insurers on Handling of Claims and Court cases

NAME OF THE INSURER: **AEGON RELIGARE LIFE INSURANCE COMPANY LIMITED**

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	1	0	0	228	226	132	115	164	88	114	62	23	0	0	21
ULIP	3	0	0	166	149	69	143	135	61	26	14	4	0	0	4
Pension	0	0	0	24	25	10	24	25	9	0	0	0	0	0	1
Health Insurance	32	5	10	689	428	148	460	292	105	256	131	30	5	10	23
Others (pl specify)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**36**	**5**	**10**	**1107**	**828**	**359**	**742**	**616**	**263**	**396**	**207**	**57**	**5**	**10**	**49**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	100	157	88	15	7	0	0	0	0	0	0	0	0	0	0
ULIP	124	129	61	19	6	0	0	0	0	0	0	0	0	0	0
Pension	24	25	9	0	0	0	0	0	0	0	0	0	0	0	0
Health Insurance	455	291	100	5	1	5	0	0	0	0	0	0	0	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**703**	**602**	**258**	**39**	**14**	**5**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	0	0	12	0	0	8	0	0	1	0	0	0	0	0	0
ULIP	0	0	2	0	0	2	0	0	0	0	0	0	0	0	0
Pension	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Health Insurance	5	10	21	0	0	2	0	0	0	0	0	0	0	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**5**	**10**	**36**	**0**	**0**	**12**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	0	0	0	0	0	0
ULIP	0	0	0	0	0	0
Pension	0	0	0	0	0	0
Health Insurance	0	0	0	0	0	0
Others	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**

5. Constraints which cause delay in settlement of claims

Company settles claims as per the defined TAT's; further acceleration in settlement is constraint by:

a. Lack of cooperation by hospitals, government agencies etc in cases where treatment papers and/or documents are required to decision the claim

b. Incomplete documents received from the Claimant (mainly on account of reasons stated under 'point a' herein above E.g. obtaining postmortem report, FIR etc in case of accidental deaths)

c. Nominee not having a bank account

6. Initiatives taken by the company to ensure expeditious settlement of claims

Some of the key initiatives taken by the Company to expedite settlement of genuine claims are as follows:-

a. Claims assistance services where ARLI appointed representatives assist claimants to file a claim and procure documents. This comes at no extra cost to the claimant and helps fast track the claims decision process (especially helps to circumvent delays on account of points stated under '4.a' and '4.b' hereinabove)

b. Claims Hotline to provide telephonic assistance to the claimants

c. Online Claim intimation where claimant can register a claim on AEGON Religare website

d. We have aggressive internal TAT's along with well defined escalation matrix to drive speedy decision making for early settlement of claims.

7. Institutional Framework for review of repudiated claims

AEGON Religare has put in place a 2 tier framework for review of all repudiated claims. Every claim rejection is based on concrete evidences and the decision to reject is made by a high level committee of experts (the "Claims Committee") in the field of Claims, Operations, Legal and Underwriting.

Despite this, ARLI believes in providing a fair and unbiased opportunity to the claimants to make a representation against its decision. Such representation can be made by the Claimant by making a written representation to the Claims Review Committee of the Company.

The Claims Review Committee is headed by an eminent external member, Mr R.L.Narasimhan. Mr R.L.Narasimhan was Managing Director & CEO of IDBI Trusteeship Services Ltd. Prior to this, he was the Executive Director (Legal) in LIC of India.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	62
State Commission	13
National Commission	00
Other Courts	
Civil Courts	01
High Courts @	01
Supreme Court	00
Total	77
@ of these, the number of appeals against orders of Insurance Ombudsman	None

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

Post intimation of Court/For a notice, cases are reviewed internally to see if it can be resolved at our end.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	Nil	Nil	Nil	Nil	Nil	Nil
Camps	Nil	Nil	Nil	Nil	Nil	Nil
Others (give details)	Nil	Nil	Nil	Nil	Nil	Nil
TOTAL	Nil	Nil	Nil	Nil	Nil	Nil

NAME OF THE INSURER: **AVIVA LIFE INSURANCE COMPANY INDIA LIMITED**

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	17	8	2	893	986	406	665	717	317	237	284	36	8	2	55
ULIP	3	0	1	1115	817	328	1068	772	300	50	35	2	0	1	27
Pension	0	0	0	396	211	70	396	211	70	0	0	1	0	0	0
Health Insurance	0	0	0	9	11	9	5	8	8	4	3	0	0	0	0
Others (pl specify)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**20**	**8**	**3**	**2413**	**2025**	**813**	**2134**	**1708**	**695**	**291**	**322**	**39**	**8**	**3**	**82**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	447	442	232	195	221	80	21	54	5	0	0	0	2	0	0
ULIP	990	711	267	75	53	29	2	8	4	0	0	0	1	0	0
Pension	387	200	69	9	9	1	0	2	0	0	0	0	0	0	0
Health Insurance	1	4	7	4	3	1	0	1	0	0	0	0	0	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**1825**	**1357**	**575**	**283**	**286**	**111**	**23**	**65**	**9**	**0**	**0**	**0**	**3***	**0**	**0**

**3 claims are those which were approved as open title within 6 months but amount was released after 1 year, post receipt of documents necessary to establish the legal heir ship of the claimant(s)*

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	8	0	34	0	2	21	0	0	0	0	0	0	0	0	0
ULIP	0	0	19	0	1	8	0	0	0	0	0	0	0	0	0
Pension	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Health Insurance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**8**	**0**	**53**	**0**	**3**	**29**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	0	0	0	0	0	0
ULIP	0	0	0	0	0	0
Pension	0	0	1	1872	0	0
Health Insurance	0	0	0	0	0	0
Others	0	0	0	0	0	0
Total	**0**	**0**	**1**	**1872**	**0**	**0**

5. Constraints which cause delay in settlement of claims

As an organization, AVIVA is committed to provide hassle free and speedy claims settlement to the claimants and at the same time ensure that only valid claims are paid keeping the interest of both – Policy Holder and the Company in perspective. The primary concern that prevents fast settlement of claims is increasing trend of fraudulent claims from certain geographical pockets. Non co operation from claimants and relevant institutions like hospitals, other govt/quasi govt authorities also to some extent delay the closure of case.

6. Initiatives taken by the company to ensure expeditious settlement of claims

The very first step that AVIVA undertook in this regard was to enhance training program for its advisors and sales force, reiterating the importance of need based selling and correct product being offered to the correct segment.

Some of the important initiatives taken by company for speedier claim settlement are:

1. The claimant is involved and informed at every claim stage through letters, calls and SMS. (Giving sympathy call on intimation of claim, explaining requirements, following up, providing help in obtaining documents from hospitals, Dispatch of Claims cheques etc.)

2. Involvement of Branch personnel-Branch operations team is well versed with the documents that are required for processing a claim. Branch Ops do the initial screening of the claims at the time of submission by the claimant.

3. Pro active Document collection through Aviva personnel and Investigators- Claimant is guided for Documentation and in case claimant is unable to procure the same, Branch Ops / Investigators are roped in for the Document collection

5. Introduction of Net Promoter Score (NPS), a customer loyalty metric which is clear measure of an organization's performance through its customers' eyes. A sample of settled claims cases are picked monthly and feedback is taken from the claimants about the delivery process and their experience of claims settlement. The feedbacks received are analyzed and if required, the claims process is redesigned.

6. Claim Review Committee-To be more customers friendly and to provide claimant an opportunity to present his case, we have Claims Review Committee and in the communication of declining claim, we intimate claimant about the option of CRC

7. Institutional Framework for review of repudiated claims

The claim is denied only in cases of fraudulent suppression of material information. This ensures that claims are not paid to fraudulent persons at the cost of honest policyholders.

Each decision of repudiation is reviewed by two senior claims assessors, including, but not limited to Head of claims. Any representation made against any decision is reviewed by an internal committee including senior members of legal, complaints, policy servicing, underwriting, risk, audit and claims teams. Any further scope of re-evaluation or re-investigation is clearly envisaged so as to ensure that customer is given a fair chance to put forward facts in his favour.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	182
District Forum	127
State Commission	47
National Commission	8
Other Courts	
Civil Courts	22
High Courts @	4
Supreme Court	0
Total	**26**
@ of these, the number of appeals against orders of Insurance Ombudsman	NA

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

All claim cases in litigation are reviewed jointly by the Internal Claims & legal teams. The cases are reviewed keeping in mind the insurance principles & established provisions of law; to determine whether a case is to be contested or taken up for settlement. Cases marked as fit for settlement our taken up for compromise before the courts, lok adalats etc accordingly. Since April 2012 total 13 court cases have been closed as settled.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	0	0	2	240000	0	0
Camps	0	0	0	0	0	0
Others (settlement before the respective courts where case is filed)	4	1235290	2	276333	5	6396544
TOTAL	**0**	**1235290**	**0**	**516333**	**5**	**6396544**

NAME OF THE INSURER: **BAJAJ ALLIANZ LIFE INSURANCE COMPANY LTD**

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	472	738	441	8752	9731	4932	6867	8652	3884	1619	1376	444	738	441	1045
ULIP	374	365	131	17921	12813	5455	17310	12760	5197	620	287	68	365	131	321
Pension	0	15	0	194	368	176	179	383	169	0	0	0	15	0	7
Health Insurance	444	383	296	10820	10281	4024	7777	8184	3173	3104	2184	816	383	296	331
Others (pl specify)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**1290**	**1501**	**868**	**37687**	**33193**	**14587**	**32133**	**29979**	**12423**	**5343**	**3847**	**1328**	**1501**	**868**	**1704**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	3761	5562	2619	3276	3036	1316	1441	1430	393	8	0	0	0	0	0
ULIP	14531	11808	4919	2836	957	312	561	282	34	2	0	0	0	0	0
Pension	146	359	155	26	20	14	7	4	0	0	0	0	0	0	0
Health Insurance	10872	10345	3984	11	6	5	1	4	0	0	0	0	0	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**29310**	**28074**	**11677**	**6149**	**4019**	**1647**	**2010**	**1720**	**427**	**10**	**0**	**0**	**0**	**0**	**0**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	457	312	496	235	112	415	48	17	134	0	0	0	0	0	0
ULIP	307	117	265	49	12	45	9	2	11	0	0	0	0	0	0
Pension	15	0	5	0	0	2	0	0	0	0	0	0	0	0	0
Health Insurance	381	296	330	0	0	1	0	0	0	0	0	0	0	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**1160**	**725**	**1096**	**284**	**124**	**463**	**57**	**19**	**145**	**0**	**0**	**0**	**0**	**0**	**0**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	40	224978	6	51790	38	728300
ULIP	65	2373738	18	829233	37	1640812
Pension	2	2453	0	0	1	414
Health Insurance	0	0	3	36074	1	523
Others	0	0	0	0	0	0
Total	**107**	**2601169**	**27**	**917097**	**77**	**2370049**

5. Constraints which cause delay in settlement of claims

1) Non co-operation from hospital authorities (private/government) for procuring treatment records, medical cause of death certifications(including post mortem, chemical analysis findings) even with reliable information/details of past treatment history.

2) Non co-operation from government authorities like Registrar of Births & Deaths, Courts(for procuring Judicial Magistrate's Final Verdict documents for unnatural deaths- falling under Sec 174 of IPC), Police Authorities(FIR, PIR and B-Final Reports) and other government/quasi government authorities.

6. Initiatives taken by the company to ensure expeditious settlement of claims

1) Reduced claim documentation facilitated through system during claim intimation by graded reduction of requirements for policies with higher duration, bar-coded claim forms (with claim notification reference mentioned therein) issued to ensure easy linking of documents to earlier set of documents submitted to minimise loss of time due to non-linking of documents.

2) Customer calling on registration of claims for handholding through our call centres to help nominees/claimants understand nuances of claim documentation.

3) We offer document pickup from customer and/or other location/s wherever he/she has expressed inability to procure or submit a document or set of documents.

4) Effective use of MIS to track claim ageing on regular basis, encouraging Neft transactions to reduce turnaround time and transaction failures.

7. Institutional Framework for review of repudiated claims

1) Claims Review Committee is with 7 members .

2) Inducted one Retired Civil Judge in June 2014 with additional experience of representing Insurance related Consumer Forum disputes.

3) Customer calls/mails/enquiries received at our call centres/branches with regard to repudiated/ rejected claims are automatically registered as Claim Review Committee requests for further processing.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	755
State Commission	301
National Commission	45
Other Courts	
Civil Courts	123
High Courts @	12
Supreme Court	45
Total	
@ of these, the number of appeals against orders of Insurance Ombudsman	0

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like LokAdalat, Settlement camps etc.)

We take extra initiatives to review and recommend cases whenever Lok Adalats, Settlement Camps are being organised by focussing on pendency ageing, sustainability of evidences and providing benefit of doubt to customers wherever deemed fit.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
LokAdalat	0		0		0	
Camps	0		0		0	
Others (give details)	0		0		0	
TOTAL	**0**		**0**		**0**	

NAME OF THE INSURER: **BHARTI-AXA LIFE INSURANCE COMPANY LTD.**

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	10	4	13	299	418	288	305	336	189	42	73	41	4	13	68
ULIP	4	5	10	509	506	185	508	465	169	62	36	11	5	10	15
Pension	-	-	-	234	168	60	234	168	60	-	-	-	-	-	-
Health Insurance	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Others (pl specify)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	**14**	**9**	**23**	**1042**	**1092**	**533**	**1047**	**969**	**418**	**104**	**109**	**52**	**9**	**23**	**83**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	113	194	111	133	156	98	59	59	21	-	-	-	-	-	-
ULIP	347	405	405	128	73	10	33	23	8	-	-	-	-	-	-
Pension	230	168	168	-	-	-	4	-	-	-	-	-	-	-	-
Health Insurance	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Others	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	**690**	**767**	**333**	**261**	**229**	**108**	**96**	**82**	**29**	**-**	**-**	**-**	**-**	**-**	**-**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	3	5	38		4	26	1	4	4	-	-	-	-	-	-
ULIP	2	5	8	3	2	3	-	3	4	-	-	-	-	-	-
Pension	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Health Insurance	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Others	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	**5**	**10**	**46**	**3**	**6**	**29**	**1**	**7**	**8**	**-**	**-**	**-**	**-**	**-**	**-**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	1	3939.03	-	-	-	-
ULIP	1	9931	-	-	-	-
Pension	-	-	-	-	-	-
Health Insurance	-	-	-	-	-	-
Others	-	-	-	-	-	-
Total	**-**	**-**	**-**	**-**	**-**	**-**

5. Constraints which cause delay in settlement of claims

In majority of the cases, getting medical records from the hospital for cases where the insured was treated in hospital was the major constraint.

6. Initiatives taken by the company to ensure expeditious settlement of claims

The Company offers services of Dedicated Claims Handler (DCH)to claimants to help them throughout the claim process. DCH helps claimant in filling up the claim forms & submission of claim documents.

7. Institutional Framework for review of repudiated claims

Claims are repudiated only if there is material non-disclosure or mis-representation made by the Insured while opting for the policy. The reasons for such repudiation are detailed in the letter which is sent to the nominee informing him / her about the repudiation of claim. The repudiation letter also informs the nominee about representation procedure / grievance redressal procedure and details of Ombudsman.Cases where there is representation form the nominee on repudiated claim, are reviewed by the Committee and then decision is taken.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	21
State Commission	8
National Commission	1
Other Courts	
Civil Courts	-
High Courts @	1
Supreme Court	-
Total	
@ of these, the number of appeals against orders of Insurance Ombudsman	NIL

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like LokAdalat, Settlement camps etc.)

We are perusing each case carefully with a view point of settlement and after taking into consideration various norms of the Company, product terms and conditions and applicable laws rules and regulations, out of court case settlement are initiated by the Company for maximum policyholder's satisfaction.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
LokAdalat	-	-	-	-	-	-
Camps	-	-	-	-	-	-
Others (give details)	2	10,00,000	2	5,00,000	1	8,500
TOTAL	**2**	**10,00,000**	**2**	**5,00,000**	**1**	**8,500**

NAME OF THE INSURER: **BIRLA SUN LIFE INSURANCE COMPANY LTD**

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	16	362	219	6787	6737	3054	5377	6146	2876	1064	734	129	362	219	268
ULIP	7030	6169	8211	287199	268895	99186	287845	266711	103927	215	142	15	6169	8211	3455
Pension	443	361	517	17076	16006	6765	17157	15846	7050	1	4	0	361	517	232
Health Insurance	78	230	305	1403	1192	460	662	742	369	226	290	112	230	305	233
Others (Rider, Immediate Annuity)	0	25	6	1102	3398	19510	1077	3417	19513	0	0	0	25	6	3
Total	**7567**	**7147**	**9258**	**313567**	**296228**	**128974**	**312118**	**292862**	**133735**	**1506**	**1170**	**256**	**7147**	**9258**	**4191**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	4348	3815	2387	1560	1382	477	440	1402	116	92	248	18	3	33	7
ULIP	287131	265628	103519	772	736	345	139	433	49	12	46	18	6	10	11
Pension	17108	15790	7000	43	31	32	7	12	17	0	17	0	0	0	1
Health Insurance	730	677	304	81	163	48	53	87	39	21	77	29	3	28	61
Others ((Rider, Immediate Annuity)	1063	3377	19502	8	22	8	6	13	3	0	5	0	0	0	0
Total	**310380**	**289287**	**132712**	**2464**	**2334**	**910**	**645**	**1947**	**224**	**125**	**393**	**65**	**12**	**71**	**80**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	198	143	151	112	50	64	33	7	31	13	9	6	6	10	16
ULIP	6105	8116	3221	23	20	168	9	14	9	14	20	11	18	41	46
Pension	357	502	196	1	7	19	1	0	8	1	1	2	1	7	7
Health Insurance	67	43	37	52	56	38	65	32	20	46	76	42	0	98	96
Others (Rider, Immediate Annuity	25	6	1	0	0	1	0	0	1	0	0	0	0	0	0
Total	**6752**	**8810**	**3606**	**188**	**133**	**290**	**108**	**53**	**69**	**74**	**106**	**61**	**25**	**156**	**165**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	7	86675.40	43	790035.30	102	327457.64
ULIP	3	16675.77	19	263886.32	10	15447.12
Pension	0	0	0	0	3	2035.03
Health Insurance	0	0	0	0	1	304
Others (Rider, Immediate Annuaity	0	0	27	12913.74	0	0
Total	**10**	**103351.17**	**89**	**1066835.36**	**116**	**345243.79**

5. Constraints which cause delay in settlement of claims

The endeavor of BSLI has always been to settle claims faster. However there a quite number of constraints leading to delay in settlement of claims which are listed below:

- Claims from identified industry wide negative locations. Insurance frauds are seen in cartel operating in such locations who are insuring lives on already dead people, terminally ill, uninsurable older lives using forged identity, age proofs & financial documents. Hence most of these cases are investigated hence leading to delay in settlement of clams.
- A large chunk of fraudulent cases come to the forefront only at claims stage rather than the proposal stage hence establishing fraudulent intent with concrete evidences is a challenge which leads to exhaustive investigation resulting in delay in claim settlement.
- Also there is delay in the claim settlement for cases where the title to Policy monies are not clear & we are unable to disburse the claim in view of want of legal requirements to establish the rightful beneficiary.

Another factor attributing to delay in claim settlement is customer requirement wherein claim gets intimated however claimants are not traceable or uninterested in submitting claim requirements.

6. Initiatives taken by the company to ensure expeditious settlement of claims

At BSLI Claims we believe in enhancing the Customer experience at every possible touch point. Settling Claims on time and speedily is one of our core deliverable. Hence following best practices are carried out:

- Non-early claims, claims under non risk plans & Claims for inactive Policies as on date of event are treated as “Straight through Cases” and are processed swiftly by a specific team.
- Early claims are handled separately by team with the aim of settling genuine/ valid claims by assigning the cases for investigation & effectively guiding them and mitigating the risk associated with fraud claims.
- Further we ensure that the claim requirements raised & received are first time right resulting in faster settlement of claims.
- Majority of the claim payouts are processed thru NEFT thereby resulting in faster payments and credit to the Claimant’s Bank account.
- Claims which require cursory checks or wherein claim requirement is pending are assigned to Third Party agency as “Claims Assistance” / “Documentation Pickup“ wherein they carryout basic verification and assists the claimants in arranging the pending claim requirements. This facility is only to assist the claimant and as a customer experience of BSLI being with them in their hour of grief.

BSLI also has designated Claims Service Ambassadors within the organization, wherein the Ambassadors visit the claimant as an emotional support to them and assist in collecting pending claim requirements. This again is a gesture of service to claimants in their need and facilitating swifter claim settlement which is the ultimate Moments of Truth.

7. Institutional Framework for review of repudiated claims

- As a claims philosophy, Birla Sun Life Insurance Company Ltd repudiates claim only on the basis of strong documentary evidence establishing material suppression / misstatement of facts which would have impacted the risk assessment at application stage.

- Further specific cases are also routed through Legal team for their consensus who represents the cases in litigation.
- We have internal Committees comprising of Functional Heads called as "Claims Committee" who decides cases that are complex in nature or beyond specific value.

Representation which merit reconsideration is tabled before Claims Review Committee comprising Chief Operating Officer, Chief Financial Officer and Chief Actuary.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	489
State Commission	146
National Commission	25
Other Courts	
Civil Courts	34
High Courts @	5
Supreme Court	1
Total	**700**
@ of these, the number of appeals against orders of Insurance Ombudsman	* From the 2 cases wherein which appeal has been filed against Ombudsman orders. One case was preferred by BSLI before the HC OF has been preferred by BSLI and another by the policy holder

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

BSLI has taken various steps for settlement of old pending cases. As a part of settlement strategy BSLI has identified cases for settlement based on past experience and precedents for eg: cases based on Non standard age proof (NSAP). Recently, we have identified all such pending matters and took one time approval for settlement of these cases. The matters are under final stages of out of court settlement.

Similarly, cases of weak medical evidences have also been evaluated and being proposed for settlement. The Company has proactively now looking into all cases which are pending beyond 3 years and above and are revisiting the same as a continuous activity and proposing for settlement.

BSLI had taken the opportunity of placing the cases for settlement before the mega lokadalat which recently took place. These cases are in the process of settlement.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	-	-	-	-	-	-
Camps	-	-	-	-	-	-
Others (give details)	10	2081000	16	4930500	11	3823854
TOTAL	**10**	**2081000**	**16**	**4930500**	**11**	**3823854**

NOTE : The information presented excludes the Rural policies data.

NAME OF THE INSURER: **CANARA HSBC ORIENTAL BANK OF COMMERCE LIFE INSURANCE CO. LTD.**

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	05	02	01	255	509	356	239	474	299	20	36	03	02	01	54
ULIP	15	11	15	481	460	215	443	412	145	42	44	11	11	15	75
Pension	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Health Insurance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Others (pl specify)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**20**	**13**	**16**	**736**	**969**	**571**	**682**	**886**	**444**	**62**	**80**	**14**	**13**	**16**	**129**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	156	365	277	58	97	20	43	48	05	01	0	0	01	0	0
ULIP	205	277	111	166	103	30	110	73	10	04	0 2	0	0	01	05
Pension	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Health Insurance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**361**	**642**	**388**	**224**	**200**	**50**	**153**	**121**	**15**	**05**	**02**	**0**	**01**	**01**	**0 5**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	02	01	25	0	0	17	0	0	12	0	0	0	0	0	0
ULIP	03	02	27	03	0 2	27	02	01	15	02	07	01	01	0 3	05
Pension	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Health Insurance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**05**	**03**	**52**	**03**	**02**	**44**	**02**	**01**	**27**	**02**	**07**	**01**	**01**	**03**	**05**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	02	3870.62	0	0	0	0
ULIP	04	188389.46	02	25005.86	0	0
Pension	0	0	0	0	0	0
Health Insurance	0	0	0	0	0	0
Others	0	0	0	0	0	0
Total	**06**	**192260.08**	**02**	**25005.86**	**0**	

Note: Penal Interest is for the cases paid during the above FY

5. Constraints which cause delay in settlement of claims

Following are the chief factors that might delay the claim settlements:

- **Medical documents:**

  The Authorities like private doctors, private hospitals, government doctors, government hospitals, clinics and even the big corporate hospitals do not co-operate and many a times deny providing the required medical documents. These documents are critical for the prudent claim evaluation and the authorities do not share it even after sharing the consent of the life assured & claimant. This problem arises as there is no statute / mandate / rule or act that makes it their duty to share these medical records with the insurers.

- Medico-Legal / Police Records: Police authorities and Govt. hospitals and the forensic officials (working for the govt.) do not co-operate in providing the documents such as FIR, Inquest Report, Panchanama, Final Police Investigation Report, Post-mortem examination report and viscera report. Viscera reports as it is take months to year and half to be available. These documents are critical for evaluation of the un-natural death claims (to determine whether Accident, Suicide or Homicide) and even after filing a request under Right To Information (RTI) Act, the authorities do not respond.

- **Employers:**

  Lack of co-operation from the employers delays the claim settlement as well. Leave records (such as leaves taken on medical grounds and the medical certificates submitted for the same or any hospitalization related claims submitted by an employee) are not provided by the employers, be it govt. or semi govt. or private. Same concern is seen here that they are not under any obligation to share these records with the insurers.

- **KYC documents:**

  Basic KYC documents of the claimant (such as Photo ID proof and address proof of the claimant) are required to be submitted at claims stage. Unavailability of these documents or miss-outs in self attestation / attestation by the competent authorities could delay the claim settlement.

- **Bank Account details / details required for NEFT:**

  Unavailability / delayed submission of the required details may delay the claim settlement.

- **Legal / Judicial System Issues:**

  Certain claim scenarios (rival claims, open title cases, litigations etc) require certain specific legal documents such as Succession Certificates, Guardianship Certificates, Legal Heirship Certificates to be issued from the courts. Also the final police investigation reports take a long time to be available post the routine legal / judicial procedures. Claims involving such scenarios take long time for settlement.

6. Initiatives taken by the company to ensure expeditious settlement of claims

Following are the major initiatives that our company has taken to facilitate the settlement of the claims:

- **Various Touch Points:**

  Claim can be informed through all possible channels - Call, Informing the bank person (SP) / RM / Hub , Email, Website, letter etc.

- **Dedicated Case Manager:**

  To a large extend, a dedicated case manager is provided for every claim and not a generic email id is dealing with the claimant.

- **Claimant Assistance:**

  The case manager at claims unit calls up the claimant and explains the claims process and the pending documents. The case manager is approachable throughout the claims process and assists the claimant on any queries that they may have.

- **Document Procurement:**

  In case there is difficulty in submitting the documents by the claimant or if specifically requested, the required claim documents are even procured on behalf of the claimant.

- **Continuous support:**

  There is a continuous support extended from the respective Hub / Branch / Claim Examiner during the evaluation so that the claimant's queries are addressed promptly and satisfactorily.

- **Customer Education:**

  We have published the articles in the newspapers for the awareness of our customers in order to facilitate an easy and smooth settlement of claims.

- **Proactive Investigation**

  As a company, we trigger the claim investigation without waiting for formal intimation (on receipt of any information of death of LA) to facilitate the speedy claim process.

7. Institutional Framework for review of repudiated claims

Following is the framework where a repudiated claim can be requested for a review:

- **Complaint Redressal Unit (CRU):**

  In every claim repudiation case, the claimant is given the contact details of the company's Complaint Redressal Unit which is headed by the Grievance Redressal Officer (GRO), where the claimant should first write / raise concerns regarding the claim decision.

- **Claims Review Group (CRG):**

  The represented claim repudiation case may also be reviewed in CRG, the group that involves Head of Service Delivery, Director Operations, Legal and Sales representatives along with the Head Claims.

- **Insurance Ombudsman:**

  In every claim repudiation case, the claimant is given the contact details of the respective ombudsman office. This guides the claimant to represent in Ombudsman if they do not receive the satisfying revert from the CRU.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	18
State Commission	07
National Commission	01
Other Courts	
Civil Courts	01
High Courts @	NIL
Supreme Court	NIL
Total	
@ of these, the number of appeals against orders of Insurance Ombudsman	NIL, We have not challenged any order passed by Ombudsman.

Note: The data provide above is as on December 16, 2014.

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

Claims are repudiated after a close scrutiny and only when we are fully satisfied that the documents are available to prove that the repudiation is justified and within the ambit of applicable insurance laws. As a result, the Company has very low number of claims repudiation cases filed before various Fora. As of now the Company has not initiated any settlement for claim cases before Lok Adalat or settlement camps as the Company anyways take proactive steps to settle cases where merits permit. Similarly, in future , if any case comes in which demands settlement based on its facts, the Company shall take all necessary steps to initiate settlement and early resolution of Complaint.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	NIL	NIL	NIL	NIL	NIL	NIL
Camps	NIL	NIL	NIL	NIL	NIL	NIL
Others (give details)	NIL	NIL	NIL	NIL	NIL	NIL
TOTAL	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**

NAME OF THE INSURER: **DHFL PRAMERICA LIFE INSURANCE CO. LTD.**

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	102	283	427	407	463	218	119	132	214	107	187	159	283	427	272
ULIP	34	57	52	77	70	35	37	56	52	17	19	21	57	52	14
Pension	4	2	1	12	10	6	14	9	5	0	2	0	2	1	2
Health Insurance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Others (pl specify)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**140**	**342**	**480**	**496**	**543**	**259**	**170**	**197**	**271**	**124**	**208**	**180**	**342**	**480**	**288**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	24	35	37	33	41	30	56	74	74	103	107	101	10	62	131
ULIP	3	4	15	4	9	17	15	18	10	26	17	17	6	27	14
Pension	2	4	4	5	5	0	4	1	1	3	0	0	0	1	0
Health Insurance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**29**	**43**	**56**	**42**	**55**	**47**	**75**	**93**	**85**	**132**	**124**	**118**	**16**	**90**	**145**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	49	51	33	72	60	53	71	82	68	77	121	54	14	113	64
ULIP	10	2	3	16	10	3	11	9	2	16	14	1	4	17	5
Pension	0	0	1	2	1	0	0	0	1	0	0	0	0	0	0
Health Insurance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**59**	**53**	**37**	**90**	**71**	**56**	**82**	**91**	**71**	**93**	**135**	**55**	**18**	**130**	**69**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	14	37517.2	9	19044	19	560254
ULIP	4	10372.6	6	15016	7	134165
Pension	0	0	0	0	0	0
Health Insurance	0	0	0	0	0	0
Others	0	0	0	0	0	0
Total	**18**	**47890**	**15**	**34059**	**26**	**694418**

5. Constraints which cause delay in settlement of claims

We are a young company in our 6th year of operations. A significant part of our business has been built over sourcing from widely spread rural belt. Consequently, a sizeable portion of our claims are from rural/interior areas where we have to rely on external investigators and distribution partners to support us in getting complete claims documents which takes time, for us to settle our claims fairly. Many a times the claimants are not even aware of the insurance policy and hence delay in the submission of relevant claims documents. This impacts the settlement, though our endeavor continues to be fair with our decision.

Being a young company, as compared to a long tenured organization, a fairly significant percentage (over 90%) of our claims portfolio includes early death claims, which are prima facie suspicious, hence require detailed and stringent investigations before they can be decisioned & settled in a fair manner. As we grow our other business lines and mature as an organization, we would for sure be favorably moving towards much faster settlement as non early claims would come down significantly.

Single premium and Pension portfolio also influences the settlement turnaround timelines. We have a very insignificant business from single premium & pension product lines as compared the overall product mix in the industry. Since the risk cover is minimal in single premium products or nil in the case of pension products, the claims are settled fast without much documentary requirements.

6. Initiatives taken by the company to ensure expeditious settlement of claims

As an organization, we have made substantial investments in necessary people, process and technology platforms to improve our overall claims experience.

Some of which are mentioned below:

- Online Claim Intimation enabled on our company website (https://dhflpramerica.com/Claims/Claim) for easy and real-time accessibility to policyholders and their kin
- Audio video of our claim process put up on Company website for creating awareness among claimants
- Claims timelines put up on website and monthly tracking of adherence of the claim settlement ratios
- Multilingual Claim forms available for claimants
- Claims Helpdesk set up at Head Office for assistance to claimants
- Tie up with Investigators having Pan India Presence, for investigation and document collection
- Outbound calling thru Contact Center to claimants to inform them of pending requirements
- Claims process is covered in Internal training programs to increase awareness
- Seeking support from Zonal teams, local branch/office personnel for procuring documents from claimant

We are also in transition phase of launching new “Policy administration system” along with “Imaging and Workflow” systems which will further improve our overall servicing capabilities.

7. Institutional Framework for review of repudiated claims

We have institutionalized an internal review committee known as CRC (Claims Review Committee) which constitutes of representatives from Senior Management.

All repudiation claims come under CRC preview and discussion before any decision is taken to repudiate.

As a process we seek opinions from two CRC members.

We have also taken a conscious call in lot of cases where we have paid ex-gratia if we see no deliberate intent to commit fraud against our Company. This is also done to improve market sentiment in general and a good will gesture by DHFL Pramerica in particular.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	21
State Commission	5
National Commission	0
Other Courts	26
Civil Courts	0
High Courts @	0
Supreme Court	0
Total	52
@ of these, the number of appeals against orders of Insurance Ombudsman	NIL

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

The Company has initiated a process wherein the Pending Legal cases before various Forums/ Court/ Lok Adalats / Ombudsman are periodically evaluated and the settlement proceedings are taken up in deserving cases.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	NIL	NIL	NIL	NIL	NIL	NIL
Camps	0	0	0	0	0	0
Others (give details)	Ombudsman Cases 8 Matters	657148	0	0	Ombudsman Cases 15 Matters	2396116
TOTAL	**8**	**657148**	**0**	**0**	**15**	**2396116**

NAME OF THE INSURER: **EDELWEISS TOKIO LIFE INSURANCE CO. LTD.**

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	0	4	20	42	258	316	30	222	237	8	20	16	4	20	81
ULIP	0	0	0	2	2	2	1	2	1	1	0	0	0	0	1
Pension	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Health Insurance	0	0	2	2	17	6	2	14	5	0	1	0	0	2	2
Others (pl specify)	0	0	0	0	32	85	0	32	85	0	0	0	0	0	0
Total	**0**	**4**	**22**	**46**	**309**	**409**	**118**	**270**	**328**	**9**	**21**	**16**	**4**	**22**	**84**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	15	160	213	18	61	18	5	21	21	0	0	1	0	0	0
ULIP	1	1	1	1	1	0	0	0	0	0	0	0	0	0	0
Pension	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Health Insurance	0	8	3	2	6	2	0	1	1	0	0	0	0	0	0
Others	0	30	85	0	2	0	0	0	0	0	0	0	0	0	0
Total	**16**	**199**	**302**	**21**	**70**	**20**	**5**	**22**	**22**	**0**	**0**	**1**	**0**	**0**	**0**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	1	7	61	3	9	9	0	4	10	0	0	1	0	0	0
ULIP	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
Pension	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Health Insurance	0	2	1	0	0	1	0	0	0	0	0	0	0	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**1**	**9**	**62**	**3**	**9**	**11**	**0**	**4**	**10**	**0**	**0**	**1**	**0**	**0**	**0**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	0	0	2*	561	0	0
ULIP	0	0	0	0	0	0
Pension	0	0	0	0	0	0
Health Insurance	0	0	0	0	0	0
Others	0	0	0	0	0	0
Total	**0**	**0**	**2**	**561**	**0**	**0**

5. Constraints which cause delay in settlement of claims

The Company is in its third year of operations and hence most of the claims are early claims which in most cases warrant detailed claims investigation which increase the timelines for settlement of claims.

6. Initiatives taken by the company to ensure expeditious settlement of claims

- The claims management is currently centralized and handled by HO. There is a two level committee, which is empowered to decide on claims based on the financial matrix. All claims are assessed and presented before the respective committee for the decisions.
- In case of early claims which warrant investigation, stringent TATs are agreed with third party investigation agencies.
- Facilitate extended support to beneficiary by arranging collection of documents wherever circumstances so warrants.
- In case of group policies suitable training/awareness session is conducted for policyholders explaining them the documentation requirements which would facilitate faster submission of documents and in turn early settlement of claims

7. Institutional Framework for review of repudiated claims

- Two tier committee in place whereby cases are reviewed and decided based on the assigned financial Authorities.
- Expert legal /medical opinion is sought on a case to case basis depending on the complexity of claim.
- The detailed analysis is presented to Policyholder Protection Committee and the committee deliberates the same in detail. The action points arising from the committee meeting is monitored and closed in a time bound manner by the claims team.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	2
State Commission	-
National Commission	2
Other Courts	-
Civil Courts	-
High Courts @	-
Supreme Court	-
Total	**4**
@ of these, the number of appeals against orders of Insurance Ombudsman	-

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

Company proactively takes various initiatives to keep the litigation under control. Whenever any lawyer notice/ complaint is received through ombudsman office, company assess the case completely based on merits. Wherever the genuine case is established, the Company settles the matter in favour of the customer so that it does not lead to litigation.

The numbers of litigations are insignificant and hence currently no case is settled through Lok Adalats & other foras.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	-	-	-	-	-	-
Camps	-	-	-	-	-	-
Others (give details)	-	-	-	-	-	-
TOTAL	**-**	**-**	**-**	**-**	**-**	**-**

NAME OF THE INSURER: **EXIDE LIFE INSURANCE CO. LTD.**

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	123	155	199	1736	2442	1076	1389	1988	939	299	372	171	157	199	155
ULIP	28	22	6	867	630	230	833	634	233	34	7	0	22	6	3
Pension	2	2	2	556	490	273	558	489	274	0	0	0	0	2	1
Health Insurance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Others (pl specify)	0	9	20	0	528	898	0	509	906	0	8	5	0	20	9
Total	**153**	**188**	**227**	**3159**	**4090**	**2477**	**2780**	**3620**	**2352**	**333**	**387**	**176**	**179**	**227**	**168**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	975	1557	646	218	214	160	186	175	122	6	25	7	4	17	4
ULIP	743	568	219	56	35	10	25	23	4	3	6	0	6	2	0
Pension	523	475	261	18	11	12	14	3	1	2	0	0	1	0	0
Health Insurance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Others	0	479	874	0	11	13	0	7	16	0	9	2	0	3	1
Total	**2241**	**3079**	**2000**	**292**	**271**	**195**	**225**	**208**	**143**	**11**	**40**	**9**	**11**	**22**	**5**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	70	67	54	58	92	65	29	40	34	0	0	2	0	0	0
ULIP	14	4	1	4	1	1	4	1	1	0	0	0	0	0	0
Pension	0	1	1	0	1	0	0	0	0	0	0	0	0	0	0
Health Insurance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Others	0	7	0	0	8	6	0	3	3	0	2	0	0	0	0
Total	**84**	**79**	**56**	**62**	**102**	**72**	**33**	**44**	**38**	**0**	**2**	**2**	**0**	**0**	**0**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	10	6522	42	218490	11	71440
ULIP	9	12470	8	37068	0	0
Pension	3	60524	0	0	0	0
Health Insurance	0	0	0	0	0	0
Others	0	0	0	0	0	0
Total	**22**	**79516**	**50**	**255558**	**11**	**71440**

5. Constraints which cause delay in settlement of claims

- Delayed reporting of claim by the claimant especially claims that occur within 2 years of policy commencement.
- Non submission of minimum required mandatory documents for settlement of claim.
- Noncooperation by government agencies and hospital in providing records required for adjudicating a claim.
- Interference of Organized Syndicate frauds in document collection and investigations

6. Initiatives taken by the company to ensure expeditious settlement of claims

- Strict monitoring of claims settlement TAT and reduction of TAT's internally for speedier settlement of claims.
- Assignment of cases for document collection to external agencies.
- Rigorous follow up with claimants for documents required for settlement of claims.
- Claims underwriting rules and red flags simplified basis the claims experience of policies sourced by the agent and location
- Periodic review of Claims and underwriting guidelines basis the Sum at risk, tenure of the policy, customer profile and claims experience.

7. Institutional Framework for review of repudiated claims

- The case with inputs from the claims team is sent to underwriting team for their review and opinion that if the policy can be issued with revised terms considering the findings of the claims team.
- Legal team opines if the findings of the claim investigation and documents are substantial for the claim to be repudiated
- Repudiated claims are reviewed independently by Senior Vice President Customer Services and his recommendations are placed before the claims committee for consideration
- Claims committee consisting of COO, Appointed Actuary and Legal head reviews the claims that are repudiatedand provides feedback to other functions to mitigate operational risk and ensure preventive action.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	134
State Commission	35
National Commission	1
Other Courts	
Civil Courts	16
High Courts @	2
Supreme Court	0
Total	188
@ of these, the number of appeals against orders of Insurance Ombudsman	0

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

The Company as a practice on settlement: Decide on the merits of the case before filing written statement and if case merits so then immediately settlement is initiated with complainant. If complainant agrees, without any delay the case is closed in terms of settlement memo filed before the court.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	-	-	-	-	-	-
Camps	-	-	-	-	-	--
Others (give details)	3	38614	4	105016	5	504316
TOTAL	**3**	**38614**	**4**	**105016**	**5**	**504316**

NAME OF THE INSURER: **FUTURE GENERALI INDIA LIFE INSURANCE CO LTD.**

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	82	62	209	1288	1601	751	863	1136	592	445	318	128	62	209	240
ULIP	13	7	30	407	446	201	342	403	184	71	20	11	7	30	36
Pension	3	1	0	145	91	48	147	92	48	0	0	0	1	0	0
Health Insurance	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Others (pl specify)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Total	**98**	**70**	**239**	**1840**	**2138**	**1000**	**1352**	**1631**	**824**	**516**	**338**	**139**	**70**	**239**	**276**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	640	662	273	506	602	256	122	160	177	37	25	14	3	5	0
ULIP	278	298	132	115	99	37	13	23	26	5	1	0	2	2	0
Pension	135	82	38	11	9	4	1	1	6	0	0	0	0	0	0
Health Insurance	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Others	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Total	**1053**	**1042**	**443**	**632**	**710**	**297**	**136**	**184**	**209**	**42**	**26**	**14**	**5**	**7**	**0**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	44	86	103	7	82	90	9	38	39	0	3	5	2	0	3
ULIP	5	12	10	0	10	17	2	8	6	0	0	3	0	0	0
Pension	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Health Insurance	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Others	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Total	**50**	**98**	**113**	**7**	**92**	**107**	**11**	**46**	**45**	**0**	**3**	**8**	**2**	**0**	**3**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	4	24665	9	799358	1	6049
ULIP	0	0	0	0	0	0
Pension	0	0	0	0	0	0
Health Insurance	0	0	0	0	0	0
Others	0	0	0	0	0	0
Total	**4**	**24665**	**9**	**799358**	**1**	**6049**

5. Constraints which cause delay in settlement of claims

1 Primarily, the claims outstanding are due to documents awaited from claimants

2 Delay in investigation as its consume time to procure evidences for non disclosure.

6. Initiatives taken by the company to ensure expeditious settlement of claims

1 It is our endeavor to pay all genuine claims in a timely manner.

2 Claims are processed in a prudent manner on receipt of documents and investigation findings as may be required as per guidelines.

7. Institutional Framework for review of repudiated claims

In case the claimant is not satisfied with the decision of the Company, they can approach to Independent Review Committee.

Independent Claims Review Committee is headed by Retired Justice of Mumbai High Court and senior representatives of Future Generali Life Insurance Management team

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	95
State Commission	21
National Commission	00
Other Courts	
Civil Courts**	08
High Courts @	02
Supreme Court	00
Total	126
@ of these, the number of appeals against orders of Insurance Ombudsman	01

** Data upto 16.12.2014*

*** Includes cases pending before various Lok Adalats*

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

The cases are considered on case to case basis for settlement.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	NIL	NIL	NIL	NIL	NIL	NIL
Camps	NIL	NIL	NIL	NIL	NIL	NIL
Others (give details)***	01	1, 00, 000	04	26, 69, 197	NIL	NIL
TOTAL	**01**	**1, 00, 000**	**04**	**26, 69, 197**	**NIL**	**NIL**

**** Cases settled while pending before District Consumer Forums.*

NAME OF THE INSURER: **HDFC LIFE INSURANCE CO. LTD.**

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	4	60	83	2220	3141	1792	2100	2918	1308	64	200	104	60	83	463
ULIP	6	41	12	2514	2651	1433	2376	2539	1200	103	141	41	41	12	204
Pension	0	0	0	1605	1434	748	1605	1434	737	0	0	0	0	0	11
Health Insurance	0	0	0	10	8	5	10	7	5	0	1	0	0	0	0
Others (pl specify)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**10**	**101**	**95**	**6349**	**7234**	**3978**	**6091**	**6898**	**3250**	**167**	**342**	**145**	**101**	**95**	**678**

**Invalid cases are removed from intimation as there is not separate field for claim invalidation provided.*
Also the micro insurance claims are not included

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	1865	2312	1154	272	607	202	27	199	56	0	0	0	0	0	0
ULIP	2002	2127	1087	434	458	138	43	95	16	0	0	0	0	0	0
Pension	1588	1412	735	14	18	2	3	4	0	0	0	0	0	0	0
Health Insurance	10	7	5	0	1	0	0	0	0	0	0	0	0	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**5465**	**5858**	**2981**	**720**	**1084**	**342**	**73**	**298**	**72**	**0**	**0**	**0**	**0**	**0**	**0**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	37	62	186	22	17	206	1	4	71	0	0	0	0	0	0
ULIP	27	9	105	12	2	73	2	1	26	0	0	0	0	0	0
Pension	0	0	11	0	0	0	0	0	0	0	0	0	0	0	0
Health Insurance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**64**	**71**	**302**	**34**	**19**	**279**	**3**	**5**	**97**	**0**	**0**	**0**	**0**	**0**	**0**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	1	344	5	63200.2	0	0
ULIP	1	69	1	1071	0	0
Pension	1	366	2	27093	0	0
Health Insurance	1	24669	0	0	0	0
Others	0	0	0	0	0	0
Total	**4**	**25448**	**8**	**91364.2**	**0**	**0**

5. Constraints which cause delay in settlement of claims

1. Non receipt of the documents from customer
2. Non receipt of the documents from medical authorities
3. Non receipt of the documents from the police authorities

6. Initiatives taken by the company to ensure expeditious settlement of claims

1. Regular follow ups done by the Branch operations officer and claims team
2. Document procurement done through empanelled vendors

7. Institutional Framework for review of repudiated claims

Grievance mechanism via claims review committee through which we review the repudiated claims

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	101
State Commission	50
National Commission	4
Other Courts	
Civil Courts	0
High Courts @	4
Supreme Court	0
Total	159
@ of these, the number of appeals against orders of Insurance Ombudsman	4

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

Nil

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	0	0	0	0	0	0
Camps	0	0	0	0	0	0
Others (give details)	0	0	0	0	0	0
TOTAL	**0**	**0**	**0**	**0**	**0**	**0**

NAME OF THE INSURER: **ICICI PRUDENTIAL LIFE INSURANCE**

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	15	0	50	1,739	2,331	1,388	1,536	1,932	1,052	218	349	156	0	50	230
ULIP	21	8	31	5,512	5,113	2,588	5,249	4,832	2,300	276	258	133	8	31	186
Pension	9	1	0	6,511	4,955	2,200	6,510	4,953	2,164	9	3	0	1	0	36
Health Insurance	252	426	411	22,550	24,591	13,322	18,486	20,455	11,022	198	304	76	426	411	1,011
Others (Term)	2	3	40	1,052	928	286	1,023	834	217	28	57	59	3	40	50
Others (Annuity)	0	0	0	28	36	27	28	36	27	0	0	0	0	0	0
Total	**299**	**438**	**532**	**37,392**	**37,954**	**19,811**	**32,832**	**33,042**	**16,782**	**729**	**971**	**424**	**438**	**532**	**1,513**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	1,345	1,514	962	115	186	41	71	229	49	3	3	0	2	0	0
ULIP	4,906	4,265	2,190	188	287	80	148	277	30	3	3	0	4	0	0
Pension	6,449	4,889	2,151	41	34	12	12	27	1	3	3	0	5	0	0
Health Insurance	18,261	20,198	10,820	149	131	121	76	125	81	0	1	0	0	0	0
Others (Term)	974	779	198	12	17	9	15	35	10	0	3	0	22	0	0
Others (Annuity)	28	34	27	0	2	0	0	0	0	0	0	0	0	0	0
Total	**31,963**	**31,679**	**16,348**	**505**	**657**	**263**	**322**	**693**	**171**	**9**	**13**	**0**	**33**	**0**	**0**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	0	6	77	0	27	97	0	17	56	0	0	0	0	0	0
ULIP	4	10	78	3	11	73	0	9	33	0	0	1	1	1	1
Pension	1	0	31	0	0	2	0	0	3	0	0	0	0	0	0
Health Insurance	317	312	784	95	68	153	14	31	74	0	0	0	0	0	0
Others (Term)	0	4	16	2	26	22	1	9	10	0	1	2	0	0	0
Others (Annuity)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**322**	**332**	**986**	**100**	**132**	**347**	**15**	**66**	**176**	**0**	**1**	**3**	**1**	**1**	**1**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	24	47,978.29	3	72,488.50	0	0
ULIP	21	56,956.85	4	1,450.95	0	0
Pension	0	0	0	0	0	0
Health Insurance	84	6,278.42	11	2,172.61	22	1,389.75
Others	0	0	0	0	0	0
Total	**129**	**111,213.56**	**18**	**76,112.06**	**22**	**1,389.75**

5. Constraints which cause delay in settlement of claims

- Incorrect or incomplete contact details given by the claimant causes delay in processing of a claim as company faces difficulties in establishing contact with the claimant for any requirement or clarifications.
- Delay in submission of additional documents like hospital/medical records, KYC documents or electronic pay out mandate details
- Sometimes certain claims needs viscera report and/or final police report to conclude on exact cause of death. Such reports usually takes long time to issue which is beyond the control of the claimant and the company.
- In certain claims though the decision has been taken to pay the claim however payment is kept on hold as matter may be pending in the court to decide right beneficiary to whom payment is to be made.

6. Initiatives taken by the company to ensure expeditious settlement of claims

The Company continuously reviews its claims philosophy & processes to make it in line with the customers' expectations. Company has taken various initiatives in order to facilitate faster claim settlement & to enhance overall customer satisfaction.

- Online claim intimation & documents upload facility: Claimant can initiate a claim by using company's online claim intimation along with document upload facility. Thus claimant need not visit company branch and can initiate a claim from one's home/office.
- Dedicated claims hotline: Company's claim process is centralized and thus claim experts are located centrally. Considering this, company has set up a dedicated "Claims hotline" which connects customer touch points like branch and call centre directly with claim expert. With this unique initiative, claimant can directly speak to claim experts through local branch or call centre and get the first hand resolution on claim related queries. This initiative has helped to get all case related requirements at one go.
- Dedicated claim assessor: In case any additional requirements are triggered then dedicated claim assessor is assigned to that particular claim. Name and contact number is shared with claimant. Assessor assists & guides claimant to submit the additional requirements.
- Document procurement: Wherever claimant is unable to collect the documents due to any constraints at his end, company deploys procurement agencies to collect the required documents on behalf of the claimant.
- 24X7 Call centre: A dedicated 24X7 call centre has been set up to provide information related to claims procedure, documents required or status of a claim. Thus claimant can contact call centre any time to seek clarifications or to know the status of the claim.
- Electronic pay outs for claim payments: Company ensures that maximum claim payouts are processed through electronic mode which is safe, convenient and faster. Currently more than 95% of claim payouts are processed through electronic mode.

7. Institutional Framework for review of repudiated claims

- The Claim assessor reviews the documents received and refers the claim to be repudiated to a specialised "Repudiation team". "Repudiation team "is a dedicated team comprising of officials from different backgrounds like Legal, Medicine, etc. and having extensive industry experience.

This team reviews each and every repudiation, referred to them. They examine the case facts and evidences and only in cases where evidences are strong and sustainable in the Court of law, refer the claim for repudiation to the senior most members of the team. The claim is repudiated only after the final signoff is provided by the senior most member of the above team.

- To review all representations received on repudiated claims, Grievance Redressal Committee (GRC) has been constituted. The GRC comprises of two external members, who are eminent persons from the industry and three internal members from the senior management. This Committee independently reviews the case facts and provides its decision. The final decision given by the committee is communicated to the Claimant within 15 calendar days from the date of receipt of the representation. The GRC members also meet quarterly to review overall claims performance and the claim repudiations.
- The Company has also established a quarterly Claim Committee meeting which comprises of various functional heads from Actuary, Legal, Risk Control, Sales, Customer Service, etc. which review the overall Claims experience and repudiations.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	432
State Commission	113
National Commission	23
Other Courts	
Lok Adalat	23
Civil Courts	74
High Courts @	6
Supreme Court	0
Total	671
@ of these, the number of appeals against orders of Insurance Ombudsman	NIL

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

Nil

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	0	0	0	0	1	3,00,000
Camps	0	0	0	0	0	0
Others (give details)	0	0	0	0	0	0
TOTAL	**0**	**0**	**0**	**0**	**1**	**3,00,000**

NAME OF THE INSURER: **IDBI FEDERAL LIFE INSURANCE CO LTD**

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	21	22	35	402	655	343	304	593	253	95	49	61	22	35	45
ULIP	10	4	4	218	229	104	206	227	90	15	2	1	4	4	6
Pension	0	0	0	36	22	12	36	22	12	0	0	0	0	0	0
Health Insurance	0	2	0	35	23	6	20	21	3	13	4	1	2	0	1
Rider	1	4	1	66	57	31	45	51	16	21	9	2	4	1	5
Total	**32**	**32**	**40**	**757**	**986**	**496**	**611**	**914**	**374**	**144**	**64**	**0**	**32**	**40**	**57**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	122	242	124	157	336	129	25	15	0	0	0	0	0	0	0
ULIP	157	187	75	43	36	15	6	4	0	0	0	0	0	0	0
Pension	33	17	9	3	5	3	0	0	0	0	0	0	0	0	0
Health Insurance	11	12	3	8	9	0	1	0	0	0	0	0	0	0	0
Rider	23	24	7	19	27	8	3	0	1	0	0	0	0	0	0
Total	**346**	**482**	**218**	**230**	**413**	**155**	**35**	**19**	**1**	**0**	**0**	**0**	**0**	**0**	**0**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	18	26	35	4	9	9	0	0	1	0	0	0	0	0	0
ULIP	3	3	4	0	0	1	0	0	0	0	0	0	1	1	1
Pension	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Health Insurance	0	0	1	2	0	0	0	0	0	0	0	0	0	0	0
Rider	2	0	3	2	1	2	0	0	0	0	0	0	0	0	0
Total	**23**	**29**	**43**	**8**	**10**	**12**	**0**	**0**	**1**	**0**	**0**	**0**	**1**	**1**	**1**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	NA	NA	NA	NA	NA	NA
ULIP	NA	NA	NA	NA	NA	NA
Pension	NA	NA	NA	NA	NA	NA
Health Insurance	NA	NA	NA	NA	NA	NA
Others	NA	NA	NA	NA	NA	NA
Total	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**

5. Constraints which cause delay in settlement of claims

- Claimants don't submit complete claim form and all mandatory documents especially bank statement and KYC documents .
- Delay in submission of pending requirements by claimants especially FIR , Post mortem reports etc
- Delay in procurement of medical records from hospitals /Medical centres.
- In case of certain areas where syndicates are operational , investigators find it difficult to procure documents leading to delay.

6. Initiatives taken by the company to ensure expeditious settlement of claims

- There is a dedicated claims helpdesk to revert to customer queries on claims. The TAT for this is 48 hours .
- The company has put in a process of having investigators to procure documents on behalf of claimants in some cases.
- There is a process to follow up with claimants at periodic intervals by letters, emails and telecalling of the claimants for pending requirements.
- In case of Non early claims where complete documentation is received & no further investigation are required , the company has put a claims settlement guarantee of 8 working days or payment of 8% interest
- The TAT & Ageing of pending claims is monitored daily by the Claims Head and COO and on monthly basis by Claims Review committee .

7. Institutional Framework for review of repudiated claims

- Repudiated claims are presented before the Claims Review Committee with details including: reason for repudiation, channel details, client details, sum assured, early or non early.
- The Claims Review Committee is held every month;
- Any representation made against claim repudiation is reviewed by Legal team, in consultation with GRO;
- Claims data is shared with RCU for analysis of trends, patterns;
- Action is taken against Advisors, in accordance with the grid.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	78
State Commission	4
National Commission	1
Other Courts	
Civil Courts	2
High Courts @	1
Supreme Court	0
Total	**86**
@ of these, the number of appeals against orders of Insurance Ombudsman	NIL

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

- Matters are evaluated and classified into settleable and non-settleable matters basis internal parameters;
- The customer/Advocate are contacted for initiation of settlement process in settleable complaints;
- The settlement terms are deliberated with the customer/advocates and finalised;
- Finalised terms of settlement are intimated to the court for closure.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	Nil	Nil	Nil	Nil	Nil	Nil
Camps	Nil	Nil	Nil	Nil	Nil	Nil
Others (give details)	2	2,05,000	2	1,69,103	17	12,41,175
TOTAL	2	2,05,000	2	1,69,103	17	12,41,175

NAME OF THE INSURER: **INDIAFIRST LIFE INSURANCE CO. LTD.:**

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	1	24	90	2652	3088	1709	2419	2550	1364	210	472	275	24	90	160
ULIP	0	8	15	749	801	374	575	666	298	166	128	42	8	15	49
Pension	0	0	0	117	75	47	104	75	43	13	0	0	0	0	4
Health Insurance	63	16	56	594	817	488	265	476	305	376	301	136	16	56	103
Others (pl specify)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**64**	**48**	**161**	**4112**	**4781**	**2618**	**3363**	**3767**	**2010**	**765**	**901**	**453**	**48**	**161**	**316**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	2416	2498	1263	63	163	133	1	38	24	0	12	3	0	0	0
ULIP	704	691	271	36	86	60	1	16	9	0	1	0	0	0	0
Pension	117	73	42	0	2	1	0	0	0	0	0	0	0	0	0
Health Insurance	272	506	278	175	188	125	183	80	38	11	3	0	0	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**3509**	**3768**	**1854**	**274**	**439**	**319**	**185**	**134**	**71**	**11**	**16**	**3**	**0**	**0**	**0**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	14	71	83	7	18	42	2	0	19	1	1	15	0	0	1
ULIP	4	12	32	4	2	13	0	0	3	0	1	0	0	0	1
Pension	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0
Health Insurance	14	28	57	1	23	38	1	5	8	0	0	0	0	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**32**	**111**	**176**	**12**	**43**	**93**	**3**	**5**	**30**	**1**	**2**	**15**	**0**	**0**	**2**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	6	648	3	133523	2	63613.09
ULIP	0	0	0	0	0	0
Pension	0	0	0	0	0	0
Health Insurance	0	0	0	0	0	0
Others	0	0	0	0	0	0
Total	**6**	**648**	**3**	**133523**	**2**	**63613.00**

5. Constraints which cause delay in settlement of claims

a. Non submission of basic claim requirements and additional requirements (called, if any) despite various follow ups

b. Non co-operation from the Hospital Authorities / Govt. Authorities in getting records related to LA which delays the investigation process

c. Since the past medical history in most of the cases are older records it gets difficult for the hospital authorities to retrieve

d. There has been a steep rise in fraudulent claims (like Death before issuance, policy deliberately taken on older age lives by misrepresenting the actual age, impersonation, etc.) and as a result it becomes extremely difficult to get evidences in such types of cases.

e. Many a times we come across cases where there is a Rival claimant approaching for the claim money / Nominee has predeceased the LA / Multiple nominations etc. These cases take a legal route in which getting the legal documents is difficult.

6. Initiatives taken by the company to ensure expeditious settlement of claims

a. We carry out telephonic follow ups with the claimant and make them understand the pending requirements

b. We also ask the field investigator to assist the claimants in arranging the pending claim requirements including legal documents

c. For the rural area claims where the claimants are illiterate, we arrange for our Sales support team to make the claimants aware of the pending requirements and help them in arranging for those requirements

d. We share the soft copies of all the pending requirements to our sales support team, so that they personally follow up with the claimants in getting the requirements fulfilled.

7. Institutional Framework for review of repudiated claims

a. Prior to repudiation of any claim, we seek the Re-underwriting opinion on the adversities noted to understand whether the non-disclosure/misrepresentation would have any bearing on the underwriting decision at the proposal stage

b. We also seek the opinion of the Claims Review Committee comprising of Director & CEO, Appointed Actuary, Head of Governance & Company Secretary, Head of Operations, & Chief Financial Officer who provide their views on sustainability of our decision

c. For the cases where we get adversities related to LA's medical history, we seek Chief Medical Officer's opinion

d. Reinsurer's opinion is sought for complex cases and the cases which fall under the treaty

e. In case of Health Claims TPA has not been given authority to reject claims. All recommendations to reject claim is reviewed by the IndiaFirst claims team.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	74
State Commission	3
National Commission	1
Other Courts	
Civil Courts	6
High Courts @	-
Supreme Court	-
Total	**84**
@ of these, the number of appeals against orders of Insurance Ombudsman	NIL

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

Two cases were settled in the year 2013-2014 which were filed with the District consumer forums.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	NA	NA	NA	NA	NA	NA
Camps	NA	NA	NA	NA	NA	NA
Others (give details)	NA	NA	NA	NA	2	219013.70
TOTAL	**NA**	**NA**	**NA**	**NA**	**2**	**219013.70**

NAME OF THE INSURER: **KOTAK MAHINDRA OLD MUTUAL LIFE INSURANCE LTD.**

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	127	46	49	9429	14867	8614	9303	14563	7072	207	301	60	46	49	1531
ULIP	58	30	19	1779	1519	626	1755	1507	564	52	23	1	30	19	80
Pension	10	6	5	519	389	189	523	390	178	0	0	0	6	5	16
Annuity	0	0	0	0	4	3	0	4	3	0	0	0	0	0	0
Health Insurance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**195**	**82**	**73**	**11727**	**16779**	**9432**	**11581**	**16464**	**7817**	**259**	**324**	**61**	**82**	**73**	**1627**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	8515	14112	4891	761	569	1698	223	169	538	5	8	3	6	6	2
ULIP	1525	1392	536	203	88	28	61	33	1	5	3	0	13	14	0
Pension	490	361	169	26	11	9	6	5	0	1	12	0	0	1	0
Annuity	0	4	3	0	0	0	0	0	0	0	0	0	0	0	0
Health Insurance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**10530**	**15869**	**5599**	**990**	**668**	**1735**	**290**	**207**	**539**	**11**	**23**	**3**	**19**	**21**	**2**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	13	6	686	9	11	639	4	3	172	3	12	9	17	17	25
ULIP	1	0	34	3	2	15	1	3	12	7		5	18	14	14
Pension	0	0	6	1	0	4	1	1	1			1	4	4	4
Annuity	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Health Insurance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**14**	**6**	**726**	**13**	**13**	**658**	**6**	**7**	**185**	**10**	**12**	**15**	**39**	**35**	**43**

Note: All the claims amounts above pertains to death claims and Critical Illness

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	NA	NA	NA	NA	NA	NA
ULIP	NA	NA	NA	NA	NA	NA
Pension	NA	NA	NA	NA	NA	NA
Health Insurance	NA	NA	NA	NA	NA	NA
Others	NA	NA	NA	NA	NA	NA
Total	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**

5. Constraints which cause delay in settlement of claims

- There are cases wherein the nominee expires and there is no clear title of the legal heir, thus procuring those documents takes time.
- There are cases in rural areas wherein the claimants do not have the required mandatory documents and hence assisting them to get the requisite documents takes time.
- Waiting for Viscera and Chemical analysis report which is essential in cases wherein there is a decision to rule out suicide.

6. Initiatives taken by the company to ensure expeditious settlement of claims

- Hand holding drive wherein our 3rd party vendors would assist the customer in procuring legal documents and mandatory documents as an additional service for hassle free and faster closure of Claims.
- Training front desk officials in branches to ensure all mandatory documents are informed to the customer and explanation and handholding for all required documents.

7. Institutional Framework for review of repudiated claims

In cases of Frank Repudiations, the principle of Utmost Good faith and the provisions of section 45 of the Insurance Act are taken into consideration.In cases of Frank repudiations, the opinion of Legal team is mandatorily sought and as per the approval matrix or in case of discrepancy in opinion it may be referred to the Claims Review Committee for further opinion.On receipt of the Legal opinion the repudiation letters are sent to the Legal team for checking post which they are dispatched to the client.

Review of Repudiated claims on receipt of complaints / Grievance

A 'Grievance' or 'Complaint' may be defined as any communication that expresses dissatisfaction about an action or lack of action, about the standard of service/deficiency of service of an insurance company and/or any intermediary or asks for remedial action. The grievance and complaint management is based on the regulatory directions of the circular issued by IRDA. The complaints which qualify the categories as defined by the regulator are registered in the Kotak Grievance Management System either by the CSD/ Claims Team.

Step-wise process is as follows :

- The registration of the complaints is done in Kotak Grievance Management System as per the categories defined by IRDA and an acknowledgement with the stipulated time frame for the same is sent by CSD to the complainant.
- The facts of the case are analyzed and if the complaint cannot be reconsidered as per the opinion of the Claims teams of the grade L6 & above, then a communication to that effect is sent to the client.
- In case if the facts of the case and the information submitted by the claimant warrants a payment in any form then the opinion of the Internal Ombudsman or the Claims review Committee is taken as the case may be.
- When the final decision is taken a communication to that effect is given to the client with the time as stipulated by the regulator.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	128
State Commission	40
National Commission	2
Other Courts	
Civil Courts	17
High Courts @	6
Supreme Court	0
Total	193
@ of these, the number of appeals against orders of Insurance Ombudsman	NIL

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

After receipt of customer-related litigations, the Legal Team assesses the grievance of the customers and the past communications, if any, between the customer and the Insurer, to find out the possibility of a settlement. At this very stage, many litigants are called up and possibility of settlement is explored. However, the experience so far is that most of the customers say that they need to speak to their lawyer. Ultimately, very few settlements actually materialize.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	-	-	-	-	-	-
Camps	-	-	-	-	-	-
Others (give details)	-	-	1 (out of court settlement)	275000/-	2 (out of court settlement)	
TOTAL	**-**	**-**	**1**	**275000/-**	**2**	**1357000/-**

NAME OF THE INSURER: **LIC OF INDIA**

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	98475	99391	87276	17771719	25306724	8082493	17762363	25310452	7809210	8440	8387	1634	99391	87276	358925
ULIP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pension	115591	82484	42536	102293	95489	40204	135400	134823	51518	0	0	0	82484	43150	31222
Health Insurance	1252	93	0	17153	18630	10143	16879	17177	8870	1433	1546	974	93	0	299
Others (Micro Insurance)	17	36	34	11736	12100	5103	11650	12050	5021	67	52	74	36	34	42
Total	**215335**	**182004**	**129846**	**17902901**	**25432943**	**8137943**	**17956292**	**25474502**	**7874619**	**9940**	**9985**	**2682**	**182004**	**130460**	**390488**

Claims O/s: Opening balance at the beginning of the financial year is shown in this column.*

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	14131971	21324820	6530144	2189252	2494434	608231	792472	683748	295121	361003	309548	150034	284993	311905	166586
ULIP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pension**	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Health Insurance	17616	18414	9739	469	202	105	179	67	0	38	31	0	10	9	0
Others (Micro Insurance)	11650	12050	5021	0	0	0	0	0	0	0	0	0	0	0	0
Total	**14161237**	**21355284**	**6544904**	**2189721**	**2494636**	**608336**	**792651**	**683815**	**295121**	**361003**	**309579**	**150034**	**285003**	**311914**	**166586**

*Pension**: data not available*

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	50630	42864	133148	33317	30026	131645	10505	10124	70863	2723	2095	18182	2216	2167	5087
ULIP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pension**	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Health Insurance	93	0	260	0	0	31	0	0	8	0	0	0	0	0	0
Others (Micro Insurance)	0	0	0	21	30	15	15	2	5	0	1	3	0	1	19
Total	**50723**	**42864**	**133408**	**33338**	**30056**	**131691**	**10520**	**10126**	**70868**	**2723**	**2096**	**18185**	**2216**	**2168**	**5106**

*Pension**: data not available*

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	12435	89023823.59	10532	87263118.82	NA	NA
ULIP	0	0	0	0	0	0
Pension	506	1593136.03	383	2001423.27	NA	NA
Health Insurance	0	0	0	0	0	0
Others (Micro Insurance)	NA	NA	NA	NA	NA	NA
Total	**12941**	**90616959.62**	**10915**	**89264542.09**	**0**	**0**

5. Constraints which cause delay in settlement of claims

- Basic constraint is non receipt of requirements from policyholder such as policy bond, discharge form.
- Other mandatory requirements such as KYC documents and NEFT mandate etc.
- Unable to establish contact with policy holder where contact details such as address/email/ mobile number are not updated in our records.

6. Initiatives taken by the company to ensure expeditious settlement of claims

- Survival Benefit intimation three months in advance from due date alongwith discharge voucher are sent by speed post/registered post and by SMS, email (wherever details available).
- Maturity intimation for paid up cases are sent 6 months in advance from due date alongwith discharge voucher and for in force cases 3 months in advance from due date alongwith discharge voucher-by speed post/ registered post and by SMS, email (wherever details available)
- Review of responses of intimations is taken two months in advance.
- Advance intimation of all NRI cases of the year –yearly in advance, follow up every quarter via email (where details available)
- Constant monitoring is done to ensure that no SB, maturity claim of in force policies is pending beyond due date and no maturity claim of paid up policies is pending beyond one month from due date.
- Death claims is booked immediately on receipt of intimation letter with death certificate.
- All requirements are called for in one instance via SMS, email, written communication.
- Follow up is done to ensure that investigation is completed within 30 days from the date of allotment.
- Also, follow up is done for non early death claim to ensure no claim is pending beyond one month from date of intimation.
- No early death claim to be pending beyond 3 months from date of intimation is also ensured.
- On weekly basis, Information regarding pending Claims for want of requirements is put on our website.
- Letters to Policyholders through emails and phone, Call Centres by TPAs as well as Divisions.
- Follow up through agents and development officers.
- Follow up by Divisions/Branches.

7. Institutional Framework for review of repudiated claims

LIC of India has adopted fair practices in the matter of settlement of claims by explicitly citing the grounds of repudiation in the letter conveying the decision to repudiate a death claim. A write up on why a death claim is repudiated with the copy of the proposal form is provided to the claimant with this letter.

Further, an opportunity of review of the repudiated clam within the organization is provided to the claimant and after having exhausted all avenues of review within the organization, the address of

the Insurance Ombudsman is also provided in cases where the net claim amount is up to Rs. 20 lacs.

For the purpose, when a claim is repudiated, the claimant is provided with the address of Zonal Office Claims Disputes Redressal Committee to prefer his / her appeal.

Zonal Office Claims Disputes Redressal Committee [ZO CDRC] consists of senior officials of the Zonal Office and a retired District or High Court Judge who has been inducted to bring in transparency in the process of review vis-a-vis the claimant. Such Committees are functioning in all our 8 Zonal Offices at Mumbai. Kolkata, Patna, Chennai, Hyderabad, Bhopal, New Delhi and Kanpur. On receipt of appeal from the claimant, ZO CDRC reviews the case. If the decision to repudiate the claim is upheld by the said Committee and if the net claim amount is less than the prescribed net claim amount, the claimant is provided with the address of the Insurance Ombudsman. In respect of cases where net claim amount exceeds such stipulated amount, the claimant is provided with the address of the Central Office Claims Disputes Redressal Committee.

Central Office Claims Disputes Redressal Committee [CO CDRC] consists of senior officials of the Central Office and a retired High Court Judge. On receipt of appeal from the claimant, the case is reviewed by CO CDRC, which is again a fresh assessment. If the decision to repudiate the claim is upheld by CO CDRC, the claimant is provided with the address of the Insurance Ombudsman in case where the net claim amount is up to Rs. 20 lacs.

1. Review of repudiated claims by Divisional office through DODRC(Divisional office dispute redressal committee) consisting of, among others, Manager (NB) and Manager (Legal).

2. Review by Appellate authorities within our Organisation at Zonal and CO levels.

3. Insurance ombudsman.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	8103
State Commission	2923
National Commission	215
Other Courts	
Civil Courts	6422
High Courts @	1294
Supreme Court	96
Total	
@ of these, the number of appeals against orders of Insurance Ombudsman	14

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

We normally do not submit to the jurisdiction of the Lok Adalat as there may be questions involving facts and law which needs detailed adjudication and cannot be achieved in a conciliation proceeding in Permanent Lok Adalats/Camps.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	NIL	NIL	NIL	NIL	NIL	NIL
Camps	NIL	NIL	NIL	NIL	NIL	NIL
Others (give details)	NIL	NIL	NIL	NIL	NIL	NIL
TOTAL	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**

NAME OF THE INSURER: **MAX LIFE INSURANCE CO LTD.**

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	122	8	4	5572	6280	3120	5264	5740	2685	422	544	106	8	4	333
ULIP	25	0	0	3535	3046	1418	3460	2988	1277	100	58	41	0	0	100
Pension	0	0	0	30	277	152	29	276	137	1	1	1	0	0	14
Health Insurance	1	0	0	259	236	99	203	214	92	57	22	2	0	0	5
Others (pl specify)	0	0	0	0	0	0	0	0	0		0	0	0	0	
Total	**148**	**8**	**4**	**9396**	**9839**	**4789**	**8956**	**9218**	**4191**	**580**	**625**	**150**	**8**	**4**	**452**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	4118	4804	2156	1022	837	486	101	98	43	0	1	0	23	0	0
ULIP	3165	2782	1173	249	187	95	15	19	9	1	0	0	30	0	0
Pension	24	262	127	5	14	10	0	0	0	0	0	0	0	0	0
Health Insurance	181	191	81	20	19	11	0	4	0	0	0	0	2	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**7488**	**8039**	**3537**	**1296**	**1057**	**602**	**116**	**121**	**52**	**1**	**1**	**0**	**55**	**0**	**0**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	7	4	298	1	0	35	0	0	0	0	0	0	0	0	0
ULIP	0	0	93	0	0	7	0	0	0	0	0	0	0	0	0
Pension	0	0	13	0	0	1	0	0	0	0	0	0	0	0	0
Health Insurance	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0
Others	0	0		0	0	0	0	0	0	0	0	0	0	0	0
Total	**7**	**4**	**409**	**1**	**0**	**43**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	175	802,240	67	128,928	14	32,979
ULIP	53	301,823	8	141,558	10	29,669
Pension	5	11,474	1	12,679	3	72
Health Insurance	1	24,658	1	1,208	1	1,266
Others	0	-	0	-	0	-
Total	**234**	**1,140,194**	**77**	**284,374**	**28**	**63,985**

5. Constraints which cause delay in settlement of claims

1. Non- cooperation by claimant/family in the claim documentation process.
2. Non-submission of requisite medical records from hospitals/clinics.
3. Non-availability/non-cooperation from Government authorities like Police, Hospitals etc.

6. Initiatives taken by the company to ensure expeditious settlement of claims

At Max Life Insurance Claims Unit, we follow the principle of Treating Customers Fairly. Our mission and guiding principle at Claims is to be the 'Fairest, Fastest and Friendliest' in Claims processing.

Our processes are designed to provide a hassle-free claims experience and we are committed to providing the best in class service experience. Some of the initiatives taken by us to expedite claim settlement are as below-

1. Use of automated end to end workflow for faster claims processing.
2. Electronic fund transfer of claim proceeds resulting in faster claim settlement.
3. Extensive training of claims assessors. We train our assessors to approach every claim with 'Intent to Pay' unless fraud is established.
4. Enrolment of Investigation agencies with wide geographic reach resulting in fast track investigation closures. Smart categorization of investigation assignments based on various factors like degree of suspicion, claim amount etc.
5. Continuous education of Distributors and customers on claims process & documentation.

7. Institutional Framework for review of repudiated claims

At grievance/litigation stage, we continue to abide by the principle of Treating Customers Fairly. We have grievance redressal policy in place which is in compliance with the Regulation 5 of IRDA (Protection of Policyholders' Interest, 2002) and Guidelines For Grievance Redressal, 2010. For repudiated claims we have a robust mechanism in place :

1. We have an independent body- Claims Council in place that constitutes of following members- Director & Head- Legal & Compliance, Chief Operations Officer, Appointed Actuary, Head- Operations and Head- Claims.
2. All reconsideration requests/grievances are thoroughly reviewed by Senior Claims Management and Claims Council members (wherever required).
3. Any fresh information received at grievance/litigation stage is thoroughly reviewed. All cases are re-reviewed as fresh cases.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	192
State Commission	53
National Commission	6
Other Courts	
Civil Courts	37
High Courts @	1
Supreme Court	2
Total	**291**
@ of these, the number of appeals against orders of Insurance Ombudsman	

** Data is as on 30.Sep.2014*

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

1. Reconsideration of cases basis change in laws by way of recent pronouncements and filing settlement application suo moto;
2. By paying requisite compensation, in certain cases;
3. By directly approaching the customer in cases where the opposite counsel representing the claimant is hindering the settlement process.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	0	0	0	0	1	1.08
Camps	0	0	0	0	0	0
Others:						
District Consumer forum	22	73.20	57	200.04	17	97.96
Ombudsman	7	14.90	5	23.40	10	43.28
Civil Court	0	0	2	14.46	1	1.20
Criminal Court	0	0	1	10.00	0	0
National commission	0	0	2	3.00	0	0
State Commission	0	0	8	20.66	0	0
High Court	0	0	0	0	1	5.00
TOTAL	**29**	**88.10**	**75**	**271.56**	**30**	**148.52**

NAME OF THE INSURER: **PNB METLIFE INSURANCE CO. LTD.**

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	90	42	5	908	1138	649	646	941	539	310	234	75	42	5	40
ULIP	94	25	3	1219	1240	553	1282	1260	539	6	2	1	25	3	16
Pension	3	0	0	87	63	22	89	63	22	1	0	0	0	0	0
Health Insurance	49	16	3	265	94	19	132	75	17	166	32	1	16	3	4
Others (pl specify) Group claims	9	7	1	2196	1356	676	2115	1358	665	83	4	1	7	1	11
Total	**245**	**90**	**12**	**4675**	**3891**	**1919**	**4264**	**3697**	**1782**	**566**	**272**	**78**	**90**	**12**	**71**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	566	941	538	70	0	1	21	0	0	5	0	0	0	0	0
ULIP	1096	1253	538	132	7	1	30	0	0	8	0	0	0	0	0
Pension	85	63	22	2	0	0	1	0	0	0	0	0	1	0	0
Health Insurance	132	74	16	0	1	1	0	0	0	0	0	0	0	0	0
Others(Group claims)	1809	1353	665	288	5	0	18	0	0	0	0	0	0	0	0
Total	**3688**	**3684**	**1779**	**492**	**13**	**3**	**70**	**0**	**0**	**13**	**0**	**0**	**1**	**0**	**0**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	41	4	22	1	1	18	0	0	0	0	0	0	0	0	0
ULIP	23	1	6	2	2	10	0	0	0	0	0	0	0	0	0
Pension	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Health Insurance	8	3	3	7	0	1	1	0	0	0	0	0	0	0	0
Others (Group claims)	2	1	2	5	0	6	0	0	3	0	0	0	0	0	0
Total	**74**	**9**	**33**	**15**	**3**	**35**	**1**	**0**	**3**	**0**	**0**	**0**	**0**	**0**	**0**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	4	394690	19	21259	0	0
ULIP	3	27173	30	450108	0	0
Pension	0	0	1	824	0	0
Health Insurance	0	0	0	0	0	0
Others	0	0	0	0	0	0
Total	**7**	**421863**	**50**	**472191**	**0**	**0**

5. Constraints which cause delay in settlement of claims

1. Submission of incomplete documents at the time of claim intimation.
2. Fraud claims.

6. Initiatives taken by the company to ensure expeditious settlement of claims

1. Arranging for document pick-up from the claimants.
2. Focus on prompt investigation and report submission.

7. Institutional Framework for review of repudiated claims

The claimant may submit a written request for review of the claim decision. Which would be independently review by claims committee comprising various functional heads. The review decision is sign-off by two members other than those who were part original decision. The review committee also has an external member to provide objective opinion on the case.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	116
State Commission	44
National Commission	8
Other Courts	
Civil Courts	20
High Courts @	2
Supreme Court	Nil
Total	190
@ of these, the number of appeals against orders of Insurance Ombudsman	NIL

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like LokAdalat, Settlement camps etc.)

We provide the details of cases to our empanelled counsels to explore all the possibilities of settlements in the court of law and also have instructed to refer the same before the LokAdalat if there is a possibility for settlement.

Our claim cases undergo a multi layered review mechanism wherein opinions are sought from various functions such as CMO, Underwriters, Legal, etc., Our claims committee also consist of an external member who reviews the claim decisions.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
LokAdalat	0	0	1	145000	0	0
Camps	0	0	0	0	0	0
Others (give details)	0	0	0	0	0	0
TOTAL	**0**	**0**	**1**	**145000**	**0**	**0**

NAME OF THE INSURER: **RELIANCE LIFE INSURANCE COMPANY LIMITED**

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	610	1036	1091	9508	10756	5587	7568	9482	4451	1358	1891	330	1036	1091	739
ULIP	286	298	381	9411	7785	2866	8994	7489	2459	268	245	68	298	381	253
Pension	14	22	33	1651	804	213	1642	810	173	0	0	0	22	33	20
Health Insurance	249	172	140	3306	3699	1587	1529	1490	406	1854	2241	1024	172	140	297
Others (pl specify)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	1159	1528	1645	23876	23044	10253	19733	9789	7489	3480	4377	1422	1528	1645	1309

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	3366	5198	3057	3627	3322	1293	496	812	91	34	76	2	45	74	8
ULIP	7791	6503	2275	989	622	160	130	185	16	15	125	0	69	54	8
Pension	1616	722	0	18	37	0	6	7		2	43	0	0	1	0
Health Insurance	3383	3728	1430	0	3	0	0	0	0	0	0	0	0	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**16156**	**16151**	**6762**	**4634**	**3984**	**1453**	**632**	**1004**	**107**	**51**	**244**	**2**	**114**	**129**	**16**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	661	778	482	326	290	175	12	10	16	20	12	17	17	1	49
ULIP	145	312	96	69	50	29	13	5	13	31	8	29	40	6	86
Pension	8	32	7	4	0	2	6	1	1	2	0	3	2	0	7
Health Insurance	172	140	297	0	0	0	0	0	0	0	0	0	0	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**986**	**1262**	**882**	**399**	**340**	**206**	**31**	**16**	**30**	**53**	**20**	**49**	**59**	**7**	**142**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	160	99754.11	197	351246.06	168	273653.59
ULIP	41	39513.06	478	425210.22	91	50808.63
Pension	12	4180.46	71	53515.26	6	4270.78
Health Insurance	0	0	0	0	0	0
Others	0	0	0	0	0	0
Total	**213**	**143447.63**	**746**	**829971.54**	**265**	**328733.00**

5. Constraints which cause delay in settlement of claims

The delays have been very negligible and largely restricted to early claims where due to late reporting of claim investigation takes longer time and where claimants do not respond fast for requirements notified to them.

6. Initiatives taken by the company to ensure expeditious settlement of claims

1. Follow-up with customers including calling up the claimant pending for requirements/ documentation.

2. Payment is being done through NEFT since FY 13-14

7. Institutional Framework for review of repudiated claims

Depending on the sum assured of the death claim case, the recommended decision to repudiate is reviewed as per delegation of authority matrix of the organization. Legal and Chief Medical Officer input is also taken as per the process defined. Similar process has also been put for reconsideration of repudiated cases.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	406
Permanent Lok Adalat	36
State Commission	94
National Commission	05
Other Courts	
Civil Courts	10
High Courts @	04
Supreme Court	0
Total	
@ of these, the number of appeals against orders of Insurance Ombudsman	02

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

Depending on merit of case, we initiate for out of court settlement option.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	-	-	-	-	-	-
Camps	-	-	-	-	-	-
DCF	01	120000	12	7287904	-	-
TOTAL	**01**	**120000**	**12**	**7287904**	**-**	**-**

NAME OF THE INSURER: **SAHARA INDIA LIFE INSURANCE CO. LTD.**

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	84	48	9	376	458	259	364	439	208	39	51	8	48	9	52
ULIP	86	21	7	408	327	135	444	328	117	25	15	5	21	7	20
Pension	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0
Health Insurance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Others (pl specify)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**170**	**69**	**16**	**785**	**785**	**394**	**809**	**767**	**325**	**64**	**66**	**13**	**69**	**16**	**72**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	104	320	159	125	74	36	105	27	5	28	9	0	2	0	0
ULIP	165	272	107	174	36	6	84	11	1	17	5	0	4	0	0
Pension	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Health Insurance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**270**	**592**	**266**	**299**	**110**	**42**	**189**	**38**	**6**	**45**	**14**	**0**	**6**	**0**	**0**

3. **Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014**

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	6	5	30	26	2	17	16	2	5	0	0	0	0	0	0
ULIP	3	7	20	9	0	0	9	0	0	0	0	0	0	0	0
Pension	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Health Insurance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**9**	**12**	**50**	**35**	**2**	**17**	**25**	**2**	**5**	**0**	**0**	**0**	**0**	**0**	**0**

4. **Statistics of instances and quantum of penal interest paid for delayed payment of claims:**

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	09	28931.60	14	10201.39	0	0
ULIP	08	19560.28	04	7047.59	0	0
Pension	0	0	0	0	0	0
Health Insurance	0	0	0	0	0	0
Others	0	0	0	0	0	0
Total	**17**	**48491.88**	**18**	**17248.98**	**0**	**0**

5. Constraints which cause delay in settlement of claims

Most of our insured population are from rural areas. One of the main constraints is that claimant does not provide medical documents citing the reason that no medical intervention has taken place. We usually ask for previous medical documents to ascertain the disease which is usually not provided. Some times it is informed that they follow a custom of burning all the belongings in the funeral pyre. The cause of death in most of the cases is mentioned such as "fever" / Stomach Pain" which is actually the symptom of a disease. Investigating such cases take unusually more time.

The claimant (female) have problem in opening bank accounts. They usually do not have a bank account. In few cases where are impropriety is observed, it becomes difficult to get the age supporting documents which could be accepted by court of law.

An important point needs to be mentioned is that the Death Certificate which is an extract of Register of Birth& Death, however forms are quite different in different states. For example, death certificate issued in the state of west Bengal mentions age at death. In Uttar Predesh, Death certificate issued from panchayat secretary in some cases do not contain registration no.

6. Initiatives taken by the company to ensure expeditious settlement of claims

Since January, we have been issuing bilingual claim forms (English and Hindi). Our Branch Heads take care in filling up the claim form and for expeditious settlement of claims we have instructed to send fully completed claim forms. Check points form part of the claim form.

7. Institutional Framework for review of repudiated claims

There is a claim review committee headed by Justice (Retd.) S.C.Verma, Allahabad High Court and Ex-Lokayukt, Govt. of U.P.

Other members are the C.E.O. and the appointed actuary.

Meetings are usually held every 3-4 months for review of repudiated claims

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	19
State Commission	06
National Commission	02
Other Courts	
Civil Courts	01
High Courts @	
Supreme Court	01
Total	
@ of these, the number of appeals against orders of Insurance Ombudsman	None

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like LokAdalat, Settlement camps etc.)

Contact some complainants (cases pending with District Forums) were made but Complainants are not willing.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
LokAdalat	0	0	0	0	0	0
Camps	0	0	0	0	0	0
Others (give details)	0	0	0	0	0	0
TOTAL	**0**	**0**	**0**	**0**	**0**	**0**

NAME OF THE INSURER: **SBI LIFE INSURANCE COMPANY LIMITED**

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	146	158	441	14883	17506	7840	14345	16465	6844	526	758	518	158	441	919
ULIP	93	121	172	6983	6679	2954	6742	6420	2746	213	208	122	121	172	258
Pension	16	38	41	2781	2165	771	2754	2156	776	5	6	1	38	41	35
Health Insurance	425	170	106	3246	1471	335	918	518	130	2583	1017	200	170	106	111
Others (Annuity Plus death)	1	9	13	102	119	93	94	115	79	0	0	0	9	13	27
Total	**681**	**496**	**773**	**27995**	**27940**	**11993**	**24853**	**25674**	**10575**	**3327**	**1989**	**841**	**496**	**773**	**1350**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	13171	15142	6483	1617	1967	834	75	94	43	8	17	2	0	3	0
ULIP	6137	6137	2738	753	436	119	49	36	10	14	6	1	2	13	0
Pension	2659	2100	763	88	44	13	10	6	0	2	7	0	0	5	1
Health Insurance	2925	864	198	421	319	77	147	255	54	8	86	1	0	11	0
Others (Annuity Plus death)	73	106	67	19	8	11	2	1	1	0	0	0	0	0	0
Total	**24965**	**24349**	**10249**	**2898**	**2774**	**1054**	**283**	**392**	**108**	**32**	**116**	**4**	**2**	**32**	**1**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	95	243	495	27	90	253	14	54	86	4	26	45	18	28	40
ULIP	53	86	136	20	21	50	9	15	9	12	15	16	27	35	47
Pension	15	13	11	1	5	1	2	4	3	10	4	4	10	15	16
Health Insurance	81	46	24	49	55	63	31	4	18	8	1	6	1	0	0
Others	5	5	12	1	1	9	2	7	6	1	0	0	0	0	0
Total	**249**	**393**	**678**	**98**	**172**	**376**	**58**	**84**	**122**	**35**	**46**	**71**	**56**	**78**	**103**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	795	939173	540	2178555	332	817843
ULIP	241	356252	230	1351335	129	114897
Pension	80	74417	100	81171	171	121065
Health Insurance	25	9397	276	191232	0	0
Others	2	16356	7	13736	1	1
Total	**1143**	**1395595**	**1153**	**3816030**	**633**	**1053806**

5. Constraints which cause delay in settlement of claims

- Difficulty in procuring papers from Hospitals, Police authorities or any other agencies
- Admitted claims where the title is not clear.
- Increase in suspicious/fraudulent claims requiring extra efforts and time in investigation.

6. Initiatives taken by the company to ensure expeditious settlement of claims

- Involving our local branch offices in collection of requirements.
- Entrusting procurement of documents in non-investigated cases to outside agencies

7. Institutional Framework for review of repudiated claims

Whenever a Claim is Repudiated/Rejected, the claimant is communicated about the claim decision and an option is provided to appeal against the claim decision to the Claims Review Committee.

The Claims Review Committee (CRC) of SBI Life meets once in a month. The CRC consists of the following members:

- Retired High Court Judge (Chair Person)
- Deputy CEO
- ED –Actuarial & Risk
- ED – Operations & IT
- Head -Legal
- Head- Underwriting

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	377
State Commission	127
National Commission	23
Other Courts	
Civil Courts	115
High Courts @	30
Supreme Court	Nil
Total	
@ of these, the number of appeals against orders of Insurance Ombudsman	Appeals against awards of Ins Ombudsman -1 Total Open cases wrt Ins Ombudsman-126

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

13 Notices were received for hearing before the National Lok Adalat held in December 2014. We had proposed to settle 12 cases during the hearing. Total 6 cases were settled amounting to Rs. 12,27,175/-.

During the FY 13-14 we have settled one case each in District Forum and Insurance Ombudsman.

Further, 1 case has been settled during FY 14-15 pending before the District Forum.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	0	0	0	0	6	12,27,175/-
Camps	0	0	0	0	0	0
Others (give details)	0	0	0	0	0	0
TOTAL	0	0	0	0	6	12,27,175/-

NAME OF THE INSURER: **SHRIRAM LIFE INSURANCE COMPANY LTD.**

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	124	57	168	554	804	595	326	423	381	295	270	153	57	168	229
ULIP	173	24	22	734	526	207	736	527	205	147	1	3	24	22	21
Pension	0	0	0	17	16	9	17	16	8	0	0	0	0	0	1
Health Insurance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Others (pl specify)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**297**	**81**	**190**	**1305**	**1346**	**811**	**1079**	**966**	**594**	**442**	**271**	**156**	**81**	**190**	**251**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	174	232	156	245	288	227	89	127	96	72	43	53	41	3	2
ULIP	460	396	159	212	100	32	63	18	13	58	9	4	90	5	0
Pension	10	15	8	7	1	0	0	0	0	0	0	0	0	0	0
Health Insurance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**644**	**643**	**323**	**464**	**389**	**259**	**152**	**145**	**109**	**130**	**52**	**57**	**131**	**8**	**2**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	20	29	59	25	65	80	4	52	58	0	17	15	8	5	17
ULIP	7	6	5	6	5	7	1	3	2	2	3	1	8	5	6
Pension	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
Health Insurance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**27**	**35**	**64**	**31**	**70**	**88**	**5**	**55**	**60**	**2**	**20**	**16**	**16**	**10**	**23**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	49	95259	4	5394	4	14136
ULIP	60	320147	5	37983	0	0
Pension	7	5505	0	0	0	0
Health Insurance	0	0	0	0	0	0
Others	0	0	0	0	0	0
Total	**116**	**420911**	**9**	**43377**	**4**	**14136**

5. Constraints which cause delay in settlement of claims

1) During investigation the claimant/nominee's does not co-operate and give proper information of the deceased life assured for verification of the details filled in the proposal form like age, medical reports etc.....Even the identification of the deceased life assured is not given at times.

2) The claimants does not send the claim forms completely filled at a time and this also causes delay for getting the completely filled in claim forms.

6. Initiatives taken by the company to ensure expeditious settlement of claims

1) The Company takes the help of marketing executives and agents to help the claimant/nominee getting the claim forms filled.

2) There are situations where if the claim is found to be genuine on investigation the claim form related to medical questionnaire is exempted and claim is settled.

3) Where the nominee predeceases the policy holder and subsequently does not nominate any body and if the claim is less than 1.5 lakhs the family members certificate and a affidavit from other family members of the claimant is taken to settle the claim instead of insisting for a legal heir certificate from the competent court of law.

7. Institutional Framework for review of repudiated claims

1) On repudiation of claim an opportunity is given to the claimant to approach the internal claims review committee to review the repudiation.

2) The internal claims review committee reviews the claim and if the claim repudiation is upheld the same is informed to the claimant and suggest them to approach Ombudsman under their jurisdiction as per policy holder's protection act if not satisfied with the internal claims review committee's decision.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	NA
State Commission	NA
National Commission	NA
Other Courts	
Civil Courts	NA
High Courts @	NA
Supreme Court	NA
Total	**NA**
@ of these, the number of appeals against orders of Insurance Ombudsman	NA

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

NA

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	NA	NA	NA	NA	NA	NA
Camps	NA	NA	NA	NA	NA	NA
Others (give details)	NA	NA	NA	NA	NA	NA
TOTAL	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**

NAME OF THE INSURER: **STAR UNION DAI-ICHI LIFE INSURANCE CO LTD**

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	10	15	7	165	321	268	154	294	235	6	35	19	15	7	21
ULIP	38	36	2	343	492	304	331	497	288	14	29	14	36	2	4
Pension	7	5	0	175	153	68	177	158	67	0	0	0	5	0	1
Health Insurance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Others (Group Death)	8	33	0	729	1531	445	697	1555	433	7	9	1	33	0	11
Total	**63**	**89**	**9**	**1412**	**2497**	**1085**	**1359**	**2504**	**1023**	**27**	**73**	**34**	**89**	**9**	**37**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	46	223	234	55	86	19	47	16	1	10	4	0	2	0	0
ULIP	91	370	288	125	122	13	75	22	0	45	11	0	9	1	1
Pension	111	144	66	52	13	1	9	1	0	5	0	0	0	0	0
Health Insurance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Others (Group Death)	409	1417	431	185	70	3	104	77	0	6	0	0	0	0	0
Total	**657**	**2154**	**1019**	**417**	**291**	**36**	**235**	**116**	**1**	**66**	**15**	**0**	**11**	**1**	**1**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	12	5	16	1	1	4	1	0	0	1	1	0	0	0	1
ULIP	20	0	4	4	1	0	6	0	0	6	0	0	0	1	0
Pension	5	0	0	0	0	1	0	0	0	0	0	0	0	0	0
Health Insurance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Others (Group Death)	33	0	11	0	0	0	0	0	0	0	0	0	0	0	0
Total	**70**	**5**	**31**	**5**	**2**	**5**	**7**	**0**	**0**	**7**	**1**	**0**	**0**	**1**	**1**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	7	1950.40	0	0.00	9	39302.75
ULIP	22	165745.76	7	237042.72	57	380697.34
Pension	39	58800.71	1	638.54	6	6386.51
Health Insurance	0	0.00	0	0.00	0	0.00
Others (Group Death)	7	35657.87	0	0.00	0	0.00
Total	**75**	**262154.74**	**8**	**237681.26**	**72**	**426386.60**

5. Constraints which cause delay in settlement of claims

a. Non-receipt of claim documents (mandatory and medical documents) from the claimant

b. Open Title cases where nominee has pre-deceased the Life Assured. In such cases, procuring Joint Indemnity from Class I legal heirs / Succession Certificate from Class II legal heirs, causes delay in claim settlement

6. Initiatives taken by the company to ensure expeditious settlement of claims

a. Robust follow up mechanism is in place. Claimants are sent Requirement letter and the Reminder letters to submit pending claim documents

b. Claim Assistance is provided to illiterate / rural claimants. Through this Assistance, documents are procured from Hospitals / Doctors, etc, by the Agency, on behalf of the Claimant and submitted to SUD Life

c. Decentralized follow up done by Regional Offices & Branch Offices with the Claimant, to submit pending documents

7. Institutional Framework for review of repudiated claims

a. Claims Review Committee comprising of Senior Management and external member (Retired Justice of Mumbai High Court) is formed to review the representations of the claimants. Claimant's representation along with Case Facts is reviewed independently by the Committee. An unbiased decision is arrived at by the Committee, by taking the joint consensus of each and every member of the Committee. The decision taken by Claims Review Committee is communicated to the Claimant.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	26
District Forum	2
State Commission	NA
National Commission	
Other Courts	NA
Civil Courts	NA
High Courts @	NA
Supreme Court	
Total	**28**
@ of these, the number of appeals against orders of Insurance Ombudsman	NA

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

NA

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	NA	NA	NA	NA	NA	NA
Camps	NA	NA	NA	NA	NA	NA
Others (give details)	NA	NA	NA	NA	NA	NA
TOTAL	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**

NAME OF THE INSURER: **TATA AIG LIFE INSURANCE COMPANY LTD**

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	31	230	164	3676	3112	1395	3101	2886	1229	376	292	75	230	164	255
ULIP	17	69	58	2620	2353	974	2286	2236	931	282	128	23	69	58	78
Pension	1	6	6	288	357	118	281	356	113	2	1	1	6	6	10
Health Insurance	3	12	3	793	522	175	706	491	169	78	40	7	12	3	2
Others (pl specify)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**52**	**317**	**231**	**7377**	**6344**	**2662**	**6374**	**5969**	**2442**	**738**	**461**	**106**	**317**	**231**	**345**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	2571	2031	897	516	673	274	339	408	113	51	56	10	0	10	10
ULIP	1960	2047	849	431	236	87	157	71	17	19	7	1	1	3	0
Pension	278	342	103	3	12	10	2	1	1	0	0	0	0	2	0
Health Insurance	695	450	176	79	72	0	9	8	0	1	1	0	0	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**5504**	**4870**	**2025**	**1029**	**993**	**371**	**507**	**488**	**131**	**71**	**64**	**11**	**1**	**15**	**10**

• Disposal claims ageing is from claim intimation date to claim decision date

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Conventional	84	65	99	75	52	71	51	16	46	21	9	18	1	22	21
ULIP	30	26	26	29	8	11	1	8	11	9	1	14	0	15	16
Pension	1	1	3	1	1	3	1	1	0	1	0	1	0	3	3
Health Insurance	8	3	2	3	0	0	1	0	0	0	0	0	0	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**123**	**95**	**130**	**108**	**61**	**85**	**54**	**25**	**57**	**31**	**10**	**33**	**1**	**40**	**40**

- *Pending claims aging is from claims intimation date to last day of the respective period.*

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	26	1248012.2	68	314763	6	27472.6
ULIP	29	907468.37	5	61881.5	4	28176.2
Pension	0	0	0	0	1	14.77
Health Insurance	5	11048.89	0	0	2	8272.51
Others	0	0	0	0	0	0
Total	**60**	**2166529.4**	**73**	**376645**	**13**	**63936**

5. Constraints which cause delay in settlement of claims

1. Sometimes claimants do not readily share the required documents despite sending pending letters and follow-up over phone.
2. Procuring medical treatment records from hospitals / health centres generally causes a lot of delay. In the absence of any law / guidelines, hospitals sometimes refuse to share information or provide the required information / documents after a lot of follow up causing significant delays in claim settlement.
3. Verification of forged documents with Government authorities sometimes takes up a lot of time.
4. In cases where the cause of death is accident (to rule out whether insured was under the influence of alcohol or responsible for the accident)/suicide (in first year) we await the Final Police report and the Chemical Viscera Report to ascertain the exact cause. These 2 documents holdup claims decision.
5. In Open Title cases where we are not able to establish the payee because of various reasons (no nomination/nominee dead/ appointee dead) we await the succession certificate/legal heir certificate/ legal guardianship certificate. The procurement of these documents delays the settlement of claims.

6. Initiatives taken by the company to ensure expeditious settlement of claims

1. We send SMS communication to the claimants at intimation & requirement stage informing them about the requirements pending for claim settlement. This is in addition to the letters sent by post / courier.
2. We have simplified claim process for non-early claims by reducing documentation.
3. We have an Online Claim Intimation Process whereby the claimant can lodge the claim intimation through TALIC website and can also upload the documents
4. We regularly engage with our advisors to train them and reiterate to them about the Claim process/requirements so that they can assist the claimants on the queries/documentation.
5. We have a process of Condolence Calling whereby claims team calls up the customer within 2 days of claim intimation. During this call we offer condolence and acknowledge the claim lodged. We also convey the claim requirements to the claimant. We offer all support in arranging for the Claim documentation through investigators/employees. This in turn speeds up the entire claim settlement process.
6. In cases of undelivered/stale cheque we call up the customers to get the correct address and necessary documentation (KYC /NEFT details) so that the claim proceeds can be paid to the customers at the earliest. We also engages with investigators/employees to visit the claimants' place of residence for procurement of the above documentation in case claimants are not contactable over phone.

7. Institutional Framework for review of repudiated claims

Tata AIA Life has a robust process for review of repudiated claims and any grievances or representations regarding the claims repudiation decisions. A claim cannot be repudiated unless it is reviewed by the Head of Claims (function head). The authority of repudiation of claims, irrespective of the amount involved, is with the Head of Claims. If an aggrieved or dissatisfied claimant represents against a repudiation decision, the case has to be necessarily put up to the Claims Review Committee.

This Committee is made up of select heads of departments / functions including Legal or their representatives and an independent member with experience of the insurance industry as well as of arbitration / legal matters. The Committee reviews all the representation cases and communicates their decision to the Claims department. The Committee may agree with claims department decision, may advice the claims department to settle the claim or recommend that the claim may be paid as ex-gratia.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	410
State Commission	86
National Commission	12
Other Courts	**0**
Civil Courts	16
High Courts @	4
Supreme Court	0
Total	**528**
@ of these, the number of appeals against orders of Insurance Ombudsman	1

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

We only repudiate the cases where we have strong documentary evidences hence no settlement has been done so far. However we encourage the dispute settlement through Lok Adalat/Settlement camps etc. If we will come across any such case which we may settle through Lok Adalat/Settlement camps etc, we will do so.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	0	0	0	0	0	0
Camps	0	0	0	0	0	0
Others (give details)	0	0	0	0	0	0
TOTAL	**0**	**0**	**0**	**0**	**0**	**0**

- Information from Non-Life insurers on Handling of Claims and Court cases

Bajaj Allianz General Insurance Co. Ltd. and
The New India Assurance Co. Ltd. have not submitted the information

NAME OF THE INSURER: **AGRICULTURE INSURANCE COMPANY OF INDIA LIMITED**

1 Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Marine	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Motor	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Health	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Miscellaneous	5200261	9131408	15447468	11839322	15381717	4056239	4782358	9056170	3937587	4815	7876	85	10326089	15447468	15560804
Total	5200261	9131408	15447468	11839322	15381717	4056239	4782358	9056170	3937587	4815	7876	85	10326089	15447468	15560804

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Marine	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Motor	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Health	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Miscellaneous	0	0	0	2141608	5228393	518083	2353453	2443813	2905914	125289	1129063	355756	166823	262776	157918
Total	**0**	**0**	**0**	**2141608**	**5228393**	**518083**	**2353453**	**2443813**	**2905914**	**125289**	**1129063**	**355756**	**166823**	**262776**	**157918**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Marine	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Motor	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Health	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Miscellaneous	0	0	0	6776347	11479130	9438988	3415516	1085305	558998	39826	648273	1866019	94400	2234759	3696798
Total	**0**	**0**	**0**	**6776347**	**11479130**	**9438988**	**3415516**	**1085305**	**558998**	**39826**	**648273**	**1866019**	**94400**	**2234759**	**3696798**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	NIL	NIL	NIL	NIL	NIL	NIL
Marine	NIL	NIL	NIL	NIL	NIL	NIL
Motor	NIL	NIL	NIL	NIL	NIL	NIL
Health	NIL	NIL	NIL	NIL	NIL	NIL
Miscellaneous	NIL	NIL	NIL	NIL	NIL	NIL
Total	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**

5 Constraints which cause delay in settlement of claims

- delay in receipt of yield data
- delay in receipt of share of Govt. towards their liability in premium subsidy and/or claims
- delay in receipt of area sown data from State Govt.
- delay in receipt of consent for application of area reduction factor
- inaccurate bank account details

6 Initiatives taken by the company to ensure expeditious settlement of claims

- follow up with Govts. for release of their share in liabilities
- follow up with State Govt. to provide upfront premium subsidy and make adequate budgetary provision

7 Institutional Framework for review of repudiated claims

- there is a committee formed by MOA , GOI to consider additional claims i.e. claims reported after settlement of claims under Govt. formulated schemes mainly due to banks 'errors , which are not normally accepted as per scheme provisions.
- for other products , Technical committee considers such claims

8 Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	2664
State Commission	702
National Commission	505
Motor Claims related	
MACT	NA
Appeals with High Court	NA
Appeals before Supreme Court	NA
Other policyholder related cases	
Civil Courts	18
High Courts @	350
Supreme Court	536
Total	4775
@ of these, the number of appeals against orders of Insurance Ombudsman	NIL

9 Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like LokAdalat, Settlement camps etc.)

NIL (since the claims are under various Govt. sponsored schemes, where area approach is adopted and claims are not settled on individual basis and hence individual cases are not eligible to be placed before LokAdalatand other such forums.)

10 Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
LokAdalat	NIL	NIL	NIL	NIL	NIL	NIL
Camps	NIL	NIL	NIL	NIL	NIL	NIL
Others (give details)	NIL	NIL	NIL	NIL	NIL	NIL
TOTAL	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**

NAME OF THE INSURER: **APOLLO MUNICH HEALTH INSURANCE CO LTD**

1 Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Marine	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Motor	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Health	4436	6224	10143	127259	145988	66023	115074	121585	56468	8040	15402	5012	6224	10143	12184
Miscellaneous	131	177	204	904	1348	686	461	751	351	127	141	75	177	204	324
Total	**4567**	**6401**	**10347**	**128163**	**147336**	**66709**	**115535**	**122336**	**56819**	**8167**	**15543**	**5087**	**6401**	**10347**	**12508**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Marine	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Motor	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Health	102863	103620	44805	10693	10887	9746	1211	5652	1704	252	1093	183	55	333	30
Miscellaneous	178	281	58	206	264	205	44	146	54	24	49	28	9	11	6
Total	**103041**	**103901**	**44863**	**10899**	**11151**	**9951**	**1255**	**5798**	**1758**	**276**	**1142**	**211**	**64**	**344**	**36**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Marine	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Motor	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Health	5534	3463	8224	488	3007	3065	30	3008	564	33	409	107	139	256	224
Miscellaneous	72	64	139	28	12	80	58	92	54	5	11	28	14	25	23
Total	**5606**	**3527**	**8363**	**516**	**3019**	**3145**	**88**	**3100**	**618**	**38**	**420**	**135**	**153**	**281**	**247**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	-	-	-	-	-	-
Marine	-	-	-	-	-	-
Motor	-	-	-	-	-	-
Health	-	-	-	-	-	-
Miscellaneous	-	-	-	-	-	-
Total	**-**	**-**	**-**	**-**	**-**	**-**

5. Constraints which cause delay in settlement of claims

Non-submission of complete documents by the customer

Delay in receipt of query documents

Claim Investigation – Field verification

Non-cooperation during an investigation

Incomplete communication details - address for sending communication, phone number, etc

6. Initiatives taken by the company to ensure expeditious settlement of claims

Strict TATs with monitoring

Part of the teams KRAs and performance evaluation

Proactive approach – outbound calling for query cases,

Expert review panel

7. Institutional Framework for review of repudiated claims

All rejections have to be approved by the team at AMHI which ensures a maker and checker for reducing errors

We have a senior member at HO who reviews the disputed claims including repudiated claims

We have a panel of experts to whom we refer complicates cases for an opinion

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	184 (UP TO 30-SEP-14)
State Commission*	24 (UP TO 30-SEP-14)
National Commission	1 (UP TO 30-SEP-14)
Motor Claims related	
MACT	NA
Appeals with High Court	NA
Appeals before Supreme Court	NA
Other policyholder related cases	
Civil Courts	5
High Courts @*	4
Supreme Court	0
Total	**218**
@ of these, the number of appeals against orders of Insurance Ombudsman	0

**This report also contains such cases which have been filed by Apollo Munich Health Insurance Company Limited before the respective State Commissions / High Court.*

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

Whenever we receive any case before various Fora and Court, we thoroughly review the merits of the case and also seek counsel opinion if required, considering the legal implication and intricacies. We also explore the possibility of out of court settlement with the customer or even before the Original Court with the help of Presiding Officer.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat*	0	0	3	72223	1	25400
Camps	0	0	0	0	0	0
Others (give details)*	6	448222	18	1561408	3	273238
TOTAL	**6**	**448222**	**21**	**1633631**	**4**	**298638**

**This report does not contain Ombudsman Cases. In case any such detail is required to be reported we may be instructed accordingly.*

NAME OF THE INSURER: **BHARTI AXA GENERAL INSURANCE COMPANY LIMITED**

1 Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	137	169	291	316	496	366	259	345	202	9	13	13	169	291	413
Marine	273	290	461	912	1176	636	796	921	462	67	29	12	290	461	595
Motor	11553	18861	22472	144075	179785	106662	130371	168868	97891	1187	1154	650	18861	22472	27040
Health	3307	3762	3034	48718	55410	33077	39615	46450	25256	3541	7912	4186	3762	3034	5174
Miscellaneous	724	1118	1526	3141	4387	3065	2104	3159	2058	252	165	141	1118	1526	2065
Total	**15994**	**24200**	**27784**	**197162**	**241254**	**143806**	**173145**	**219743**	**125869**	**5056**	**9273**	**5002**	**24200**	**27784**	**35287**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	41	46	13	75	79	32	40	67	58	48	94	43	55	59	56
Marine	41	75	35	209	195	81	261	283	161	253	303	143	32	65	42
Motor	41708	97293	80527	64386	49906	12801	18675	13797	2614	3999	4374	1255	1603	3498	694
Health	39615	46290	25256	0	160	0	0	0	0	0	0	0	0	0	0
Miscellaneous	97	116	172	605	664	562	876	1398	782	424	802	413	102	179	129
Total	**81502**	**143820**	**106003**	**65275**	**51004**	**13476**	**19852**	**15545**	**3615**	**4724**	**5573**	**1854**	**1792**	**3801**	**921**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	-	-	-	54	83	114	25	38	101	32	94	78	58	76	120
Marine	-	-	-	168	213	274	60	136	127	33	81	146	29	31	48
Motor	-	-	-	9784	11329	12972	2358	2475	3736	2972	2647	3036	3747	6021	7296
Health	-	-	-	2926	2919	4847	782	39	208	51	56	95	3	20	24
Miscellaneous	-	-	-	592	787	1038	182	307	461	156	232	312	145	200	254
Total	**-**	**-**	**-**	**13524**	**15331**	**19245**	**3407**	**2995**	**4633**	**3244**	**3110**	**3667**	**3982**	**6348**	**7742**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	-	-	-	-	-	-
Marine	-	-	-	-	-	-
Motor	-	-	-	-	-	-
Health	1	2,830	-	-	1	5,872
Miscellaneous	3	1,710	46	754,293	8	30,537
Total	**4**	**4,540**	**46**	**754,293**	**9**	**36,409**

5. Constraints which cause delay in settlement of claims

1. Wrong NEFT details by the insured
2. Incomplete documentation
3. Wrong address given in the proposal form – deficiency letter does not reach insured

6. Initiatives taken by the company to ensure expeditious settlement of claims

1. Hand Holding – customers are contacted by our team and helping in deficiency retrieval
2. Maximize NEFT Payments

7. Institutional Framework for review of repudiated claims

- Repudiation/Denial claims are reviewed by the qualified medical team
- Benefit of doubt claims will be honored to settlement as
- All the repudiated/denied claim are certified by the insurer before sharing the denial/repudiation letter to the client
- We have dedicated team & system for "Closed files review", which contains repudiated claims as well.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	432
State Commission	77
National Commission	4
Motor Claims related	
MACT	11140
Appeals with High Court	334
Appeals before Supreme Court	1
Other policyholder related cases	
Civil Courts	7
High Courts @	3
Supreme Court	0
Total	**11998**
@ of these, the number of appeals against orders of Insurance Ombudsman	0

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

Company has taken initiatives in bringing compromisable cases into notice of our panel advocates and regularly follows up with them to discuss with claimants for compromise of cases. Company officials often go on tour to various locations for adducing evidence and compromise of cases. We

have given list of compromisable cases to the Registrar of courts and showed our willingness to compromise in these cases. We also request the court to fix a day for our company where our company officials will be present in the court and discuss with claimants for negotiation. Settlement of cases is done regularly on monthly basis and is recorded in Lok Adalat, Conciliation and camps. We have taken above initiatives to close maximum number of compromisable cases in Lok Adalat conducted on 6th and 13th of December.

As a result of which we have compromised 1015 cases in various Lok Adalats from January to November and in Lok Adalat conducted on 6th and 13th we have negotiated 793 cases pan India.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	470	107,376,212	1416	302,631,669	618	141,299,199
Camps	-	-	-	-	-	-
Others (give details)	809	201,708,712	1250	433,920,817	855	345,515,262
TOTAL	**1279**	**309,084,924**	**2666**	**736,552,486**	**1473**	**486,814,461**

NAME OF THE INSURER: **CHOLAMANDALAM MS GENERAL INSURANCE CO. LTD.**

1 Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	1646	837	304	969	1034	624	618	573	253	188	181	82	837	304	436
Marine	1645	1250	1544	17254	18921	10112	14941	15684	8621	643	791	205	1250	1544	2087
Motor	23145	26895	28508	113366	109310	50758	97437	93446	39355	4512	3929	1728	26895	28508	33418
Health	22607	21297	13743	170153	134526	33911	159387	133508	31207	8374	5606	2862	21297	13743	12373
Miscellaneous	1505	1226	1126	6340	5642	2625	4080	4037	1733	1005	520	257	1226	1126	1356
Total	**50548**	**51505**	**45225**	**308082**	**269433**	**98030**	**276463**	**247248**	**81169**	**14722**	**11027**	**5134**	**51505**	**45225**	**49670**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	122	102	33	107	132	73	193	149	70	129	139	53	67	51	24
Marine	9611	9289	6529	2976	4068	1301	1318	1540	476	790	556	224	246	231	91
Motor	43393	53016	24084	30448	20126	8392	13364	8142	2625	5637	4815	1509	4595	7347	2745
Health	158986	133489	31147	397	19	60	4	0	0	0	0	0	0	0	0
Miscellaneous	1308	2890	1187	1416	645	307	728	272	135	327	156	77	301	74	27
Total	**213420**	**198786**	**62980**	**35344**	**24990**	**10133**	**15607**	**10103**	**3306**	**6883**	**5666**	**1863**	**5209**	**7703**	**2887**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	54	58	86	75	55	133	50	66	99	49	62	47	609	63	71
Marine	297	553	719	400	369	675	257	277	360	217	238	215	79	107	118
Motor	2845	3130	4009	4481	3605	4221	3878	3094	3856	4476	5261	6084	11215	13418	15248
Health	19116	9379	916	2110	3000	7660	7	207	1308	5	640	2219	59	517	270
Miscellaneous	290	240	346	270	245	258	121	168	261	141	164	175	404	309	316
Total	**22602**	**13360**	**6076**	**7336**	**7274**	**12947**	**4313**	**3812**	**5884**	**4888**	**6365**	**8740**	**12366**	**14414**	**16023**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	0	0	0	0	0	0
Marine	0	0	0	0	0	0
Motor	0	0	0	0	0	0
Health	0	0	0	0	0	0
Miscellaneous	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**

5. Constraints which cause delay in settlement of claims

"1. High demands by petitioner advocates""""

2. Non co operation petitioner advocates in providing the required and vital documents

3. Disability certificates with high percentage of disability

4. Motor OD - Most of the Commercial Veh claims are repaired at various local garages across various parts of the country, which impacts overall TAT

5. Some customers are not supporting by providing the valid documents for processing the claim, which also increases the TAT

6. Initiatives taken by the company to ensure expeditious settlement of claims

1. speedy investigation

2. fixing monthly target to the legal officers

3. Periodic travel to MACT certres for compromise settlement

4. Attending Lok Adalats

5. Provided TABs to surveyors to carry out surveys and get the approvals in time

6. Implemented workflow system across organization for smoother processing of claims

7. Institutional Framework for review of repudiated claims

1. All Repudiations are handled centrally by Head Office to ensure that, no eligible claims are repudiated.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	1008
State Commission	92
National Commission	15
Motor Claims related	
MACT	26933
Appeals with High Court	507
Appeals before Supreme Court	2
Other policyholder related cases	
Civil Courts	32
High Courts @	0
Supreme Court	0
Total	28589
@ of these, the number of appeals against orders of Insurance Ombudsman	0

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

"1. Head office officials visit MACT Centres and assist Legal officers in the region in compromise talks.“"

" 2. Whenever Lok adalat is arranged by the Legal services authority the list of fit cases for compromise has been furnished to the department for negotiation talks“"

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	8038	1560613117	10625	2033752557	3709	856047486
Camps	0	0	0	0	0	0
Others (give details)	0	0	0	0	0	0
TOTAL	**8038**	**1560613117**	**10625**	**2033752557**	**3709**	**856047486**

NAME OF THE INSURER: **CIGNATTK HEALTH INSURANCE COMPANY LIMITED**

1 Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Marine	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Motor	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Health	NA	NA	0	NA	NA	80	NA	NA	42	NA	NA	22	NA	NA	16
Miscellaneous	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Total	**NA**	**NA**	**0**	**NA**	**NA**	**80**	**NA**	**NA**	**42**	**NA**	**NA**	**22**	**NA**	**NA**	**16**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Marine	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Motor	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Health	NA	NA	64	NA	NA	0	NA	NA	0	NA	NA	0	NA	NA	0
Miscellaneous	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Total	**NA**	**NA**	**64**	**NA**	**NA**	**0**	**NA**	**NA**	**0**	**NA**	**NA**	**0**	**NA**	**NA**	**0**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Marine	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Motor	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Health	NA	NA	10	NA	NA	6	NA	NA	0	NA	NA	0	NA	NA	0
Miscellaneous	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Total	**NA**	**NA**	**10**	**NA**	**NA**	**6**	**NA**	**NA**	**0**	**NA**	**NA**	**0**	**NA**	**NA**	**0**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	NA	NA	NA	NA	NA	NA
Marine	NA	NA	NA	NA	NA	NA
Motor	NA	NA	NA	NA	NA	NA
Health	NA	NA	NA	NA	0	0
Miscellaneous	NA	NA	NA	NA	NA	NA
Total	**NA**	**NA**	**NA**	**NA**	**0**	**0**

5. Constraints which cause delay in settlement of claims

- Partial and inadequate documents submitted by customer leading to additional document requirements.
- NEFT details given by customers in claim form are not supported by cancelledcheque leading to additional document requirement.
- Investigation of suspicious and fraudulent claims.

6. Initiatives taken by the company to ensure expeditious settlement of claims

- Our approach is to process all claims in a time bound manner from the point of receipt of claim intimation to conclusion.
- Claims process Info graphic is included in the welcome kit.
- Reiteration of cashless process in welcome call to help the customer understand cashless process.
- Contact touch points are highlighted in all communication.
- Aggressive TAT's for cashless processing and reimbursement claim settlement.
- Proactive communication- Emails, SMS and outbound calling to explain computation of settled claim and deduction reason through customer service managers.
- Telephonic and request based onsite claims assistance is provided to customers through customer service managers.
- Empowerment of Branch operations and Customer service team through technology.

7. Institutional Framework for review of repudiated claims

Claim Repudiation Process:

- Preliminary assessment of cashless and reimbursement claims is done by TPA.
- TPA recommends decision of rejection to CignaTTK claims team.
- Final assessment and rejection of claim is done by CignaTTK.
- Review of claims referred to claims committee is done as per the internal claims committee and authority matrix.

Scope of CignaTTK Claims Committee-

- Decide on cases which have been referred by the individual approving authority.
- Review Representation & Grievance received against claims which have been primarily adjudicated by the individual authorities other than the Claims Committee. This review is irrespective of the sum assured under the policy.
- Post review of the cases following decision to be made
- Stand by the original decision
- Revoke the original decision
- Suggest additional actionable

Composition of Claims Committee-

Claims Committee	**Department**
Head – Products & Underwriting	Marketing
Head- Service Delivery	Operations
Chief Compliance Officer	Legal & Compliance
Chief Executive Officer	NA
Chief Financial Officer	Finance
Head - Claims	Operations
Appointed Actuary	Actuary

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	**NO. OF PENDING CASES**
Consumer Courts	
District Forum	0
State Commission	0
National Commission	0
Motor Claims related	
MACT	NA
Appeals with High Court	NA
Appeals before Supreme Court	NA
Other policyholder related cases	
Civil Courts	0
High Courts @	0
Supreme Court	0
Total	**0**
@ of these, the number of appeals against orders of Insurance Ombudsman	

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like LokAdalat, Settlement camps etc.)

No cases pending with various courts and forums.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	**YR(2012-13)**		**YR(2013-14)**		**(01 APR 14 to 30 SEP 2014)**	
	No. of claims	**Amount**	**No. of claims**	**Amount**	**No. of claims**	**Amount**
LokAdalat	NA	NA	NA	NA	0	0
Camps	NA	NA	NA	NA	0	0
Others (give details)	NA	NA	NA	NA	0	0
TOTAL	**NA**	**NA**	**NA**	**NA**	**0**	**0**

NAME OF THE INSURER: **EXPORT CREDIT GUARANTEE CORPORATION OF INDIA LTD**

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Year	No	Amount
2012-13	1140	579,90,63,572
2013-14	1004	567,40,62,255
2014-15	450	276,88,56,717

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

	F Y 2012-13		F Y 2013-14		F Y 2014-15	
Period	**No.**	**Amount**	**No.**	**Amount**	**No.**	**Amount**
30 days	219	29,42,66.70	157	23,90,01.39	26	3,97,43,471
30 days to 6 months	246	74,36,73.77	211	77,23,78.49	29	4,89,36,765
6 months to 1 year	12	9,90,21.58	13	8,15,34,63	31	8,90,03,826
1 year to 5 years	NIL	NIL	2	148,65,43.11	39	7,94,56,446
5 years & above	NIL	NIL	NIL	NIL	21	5,02,87,446
Total	**477**	**113,69,62.05**	**383**	**257,94,57.62**	**146**	**30,74,27,954**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

	F Y 2012-13		F Y 2013-14		F Y 2014-15	
Period	**No.**	**Amount**	**No.**	**Amount**	**No.**	**Amount**
30 days	108	75,82,88.94	77	49,55,05.46	61	34,16,98,367
30 days to 6 months	68	32,23,25.20	100	44,67,88.32	44	24,37,77,139
6 months to 1 year	10	152,18,20.48	12	6,43,09.17	45	28,31,42,143
1 year to 5 years	NIL	NIL	2	3,97,34.57	52	46,39,20,708
5 years & above	NIL	NIL	NIL	NIL	20	23,53,40,767
Total	**186**	**260,24,34.62**	**191**	**104,63,37.52**	**222**	**156,78,79,126**

4. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	No. of Pending Cases
Consumer Courts	
District Forum	38
State Commission	48
National Commission	24
Motor Claims related	
MACT	NA
Appeals with High Court	NA
Appeals before Supreme Court	NA
Other Courts	
Civil Courts	36
High Courts @	108
Supreme Court	4
Total	**258**
@ of these, the number of appeals against orders of Insurance Ombudsman	0

5. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	0	0	0	0	0	0
Camps	0	0	0	0	0	0
State Commission	0	0	1	22,68,764	0	0
TOTAL	**0**	**0**	**1**	**22,68,764**	**0**	**0**

NAME OF THE INSURER: **FUTURE GENERALI INDIA INSURANCE COMPANY LIMITED**

1 Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	185	179	285	689	1694	910	527	1376	623	179	225	125	179	285	467
Marine	304	495	1269	4858	7685	5095	3650	5667	2825	1155	1399	984	495	1269	2641
Motor	8622	11108	10693	85535	100917	60021	76047	95154	53005	7600	6985	2949	11108	10693	15375
Health	837	1525	1026	42367	37591	21626	41051	38077	19770	1127	1039	628	1525	1026	2254
Miscellaneous	975	1346	2437	7996	10009	4573	5555	6396	2852	2320	2824	1001	1346	2437	3420
Total	**10923**	**14653**	**15710**	**139870**	**164391**	**91094**	**126830**	**146670**	**79075**	**1127**	**1039**	**628**	**14653**	**15710**	**24157**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	312	1048	220	82	170	279	106	216	161	132	109	54	74	58	34
Marine	2326	3822	1930	1364	1772	903	651	830	596	361	496	325	103	146	55
Motor	58269	76459	42817	16307	15675	9299	4976	4451	1875	2441	2589	849	1654	2965	1114
Health	41860	36536	20293	304	2551	85	11	20	16	3	9	3	0	0	1
Miscellaneous	2947	3620	1125	2463	2450	1110	1617	2090	737	614	802	725	230	258	156
Total	**105714**	**121485**	**66385**	**20520**	**22618**	**11676**	**7361**	**7607**	**3385**	**3551**	**4005**	**1956**	**2061**	**3427**	**1360**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	49	53	73	33	51	113	31	79	126	39	59	96	27	43	59
Marine	187	254	412	126	703	529	102	173	1245	60	92	383	20	47	72
Motor	2299	2098	4426	1742	1529	2608	1405	998	1775	1901	1450	1441	3761	4618	5125
Health	1213	958	1862	303	66	334	3	2	28	0	0	20	6	0	10
Miscellaneous	382	515	625	486	652	917	221	730	858	157	276	580	100	264	440
Total	**4247**	**3825**	**7157**	**2628**	**3028**	**4566**	**1769**	**1992**	**4056**	**2162**	**1880**	**2517**	**3919**	**4985**	**5710**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	0	0	0	0	0	0
Marine	0	0	0	0	0	0
Motor	0	0	0	0	0	0
Health	0	0	0	0	0	0
Miscellaneous	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**

5. Constraints which cause delay in settlement of claims

1. Delayed submission of deficient documents
2. Non co-operation of insured/providers during investigation of suspected fraud claims
3. Investigation process – sometimes due to the complex nature of case and unavailability of all concerned parties at a time, it takes long to complete the investigation.
4. Unavailability of complete Member Data – for new policies it takes long time for HR/Broker to collate the member data and provide to us till then the claims lies in Orphan status.
5. Dependency from third party such as confirmation from RTO & Police Authorities especially in motor claims

6. Initiatives taken by the company to ensure expeditious settlement of claims

1. In case of returned letters claimant is contacted by the claim official to confirm the address before dispatch of the reminder letter.
2. Wherever, there are processing gaps identified, real-time feedback is provided to the processing employee and their reporting manager. Quarterly RCA report is discussed with HODs for action planning.
3. Outbound calling, post claim registration to confirm address and contact details, so that customer receives the information of the pending requirements to be fulfilled.
4. Outbound calls to claimants whose claim cheques are issued & dispatched but not realized.
5. Periodic audits are done to track the delivery of pendency letters dispatched to fool-proof the process
6. Telephonic follow-up of deficient documents in addition to hard/soft copy reminders
7. Daily mailers to Branch/Regional offices regarding Claims which are deficient and Claims which are under Investigation, so that they can also update the Intermediaries to get the quick response.
8. Launch of E enrolment process where employees can add their dependants online instead of depending on HR/Broker to collate.
9. “Did You Know” Weekly Tips circulation to all customers to educate about the requirements which helps in faster settlement of claim.
10. Green channel system for faster settlement of senior citizens claims.

7. Institutional Framework for review of repudiated claims

All Health Claims are reviewed at 3 levels before the final repudiation.

In some cases even a Pre Repudiation Letter is sent to Insured to clarify the grounds on which the claim is getting repudiated.

In case of repudiation of all Non-Health claims the claim file is reviewed by the Zonal/HO claims Manager before the final repudiation.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	613
State Commission	68
National Commission	5
Motor Claims related	
MACT	6891
Appeals with High Court	424
Appeals before Supreme Court	4
Other policyholder related cases	
Civil Courts	0
High Courts @	0
Supreme Court	0
Total	
@ of these, the number of appeals against orders of Insurance Ombudsman	0

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

- All the claims where there is no defense available to us are put up for compromise in Lok Adalats, Settlements camps etc.
- Serious efforts are put in by is to invite claimants to the negotiating table by contacting claimants &their advocates. We also take help of the Judiciary in compromising the case by making them send notices to the claimants to come forward for compromises.

The above initiatives have helped to close maximum number of claims in these forums. The judiciary all over India has appreciated our effort to compromise the cases.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	617	132491374	1402	326997266	382	91099002
Camps	0	0	0	0	0	0
Others (give details) Compromise	1008	239743157	1856	465477637	620	179549806
TOTAL	**1625**	**372234531**	**3258**	**792474903**	**1002**	**270648808**

NAME OF THE INSURER: **HDFC ERGO GENERAL INSURANCE CO. LTD**

1 Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	271	199	189	760	1309	957	580	1017	679	252	302	20	199	189	447
Marine	1493	1776	1444	18603	22851	15196	16977	22552	13779	1343	631	367	1776	1444	2494
Motor	17789	20524	21820	116679	127008	72261	109908	122768	68246	4036	2944	1681	20524	21820	24154
Health	3011	4744	7472	93806	219314	71258	80588	206765	67161	11485	9821	4710	4744	7472	6859
Miscellaneous	1673	2857	2928	44714	35721	17679	38614	33359	15447	4916	2291	216	2857	2928	4944
Total	**24237**	**30100**	**33853**	**274562**	**406203**	**177351**	**246667**	**386461**	**165312**	**22032**	**15989**	**6994**	**30100**	**33853**	**38898**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	26	59	29	84	162	90	109	156	56	130	98	31	40	66	23
Marine	6260	7351	4566	6261	5775	3925	1746	2709	1514	600	1527	1289	82	137	63
Motor	80436	88279	49735	13289	13189	7497	3755	4022	1626	2015	2349	663	2529	3512	1194
Health	61323	144572	40204	15353	26128	16785	2766	4326	1802	645	892	310	87	270	75
Miscellaneous	17696	16653	8210	3831	4062	1787	11991	1438	513	2332	546	217	109	165	75
Total	**165741**	**256914**	**102744**	**38818**	**49316**	**30084**	**20367**	**12651**	**5511**	**5722**	**5412**	**2510**	**2847**	**4150**	**1430**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	37	60	199	49	39	102	35	30	82	62	43	45	16	17	19
Marine	929	992	1660	519	332	664	236	63	108	76	41	47	16	16	15
Motor	4443	4720	4870	2826	2580	3152	2377	1956	2712	2950	2823	3169	7928	9741	10251
Health	3770	6340	5729	754	972	1076	113	121	45	104	39	8	3	0	1
Miscellaneous	1168	1141	1894	663	628	1430	305	138	327	567	325	322	154	696	971
Total	**10347**	**13253**	**14352**	**4811**	**4551**	**6424**	**3066**	**2308**	**3274**	**3759**	**3271**	**3591**	**8117**	**10470**	**11257**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	0	0	0	0	0	0
Marine	0	0	0	0	0	0
Motor	0	0	0	0	0	0
Health	0	0	0	0	0	0
Miscellaneous	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**

5. Constraints which cause delay in settlement of claims

Delay in submission of required documents/information from the claimants.

6. Initiatives taken by the company to ensure expeditious settlement of claims

Regular follow up and reminders for the pending documents/information from the claimants.

7. Institutional Framework for review of repudiated claims

Repudiation of claims is done by designated financial authority who reviews each claim before repudiation.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	778
State Commission	118
National Commission	19
Motor Claims related	
MACT	16835
Appeals with High Court	909
Appeals before Supreme Court	5
Other policyholder related cases	
Civil Courts	31
High Courts @	
Supreme Court	
Total	
@ of these, the number of appeals against orders of Insurance Ombudsman	1

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

The core objective of the Company is the ensure that just and reasonable compensation reaches to the victims and as fast as possible. Initiatives by the Company are as below :

- Maximum participation in the Lok-Adalats.
- Initiated for permanent weekly Lok-Adalat with the due intervention and directions from the Judiciary.
- In the recent Mega Lok-Adalat, Company has been able to close about 1200 claims in December-2014.
- Conciliation camps are organized at Courts and at office of the Company. These settlement counts are reflected in the Lok-Adalat by the Court.

- With respect to consumer cases, considering all legal aspects, if the case is found to be in favour of the customer, an attempt is made to compromise the same

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	2,667	451,361,595	4,269	937,956,458	1,284	310,148,104
Camps						
Others - Consumer Court Cases	15	7,056,999	16	4,974,605	5	620,155
TOTAL	**2,682**	**458,418,594**	**4,285**	**942,931,063**	**1,289**	**310,768,259**

NAME OF THE INSURER: **ICICI LOMBARD GENERAL INSURANCE COMPANY LTD**

1 Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	1,696	2,332	2,230	2,473	2,485	1,153	1,684	2,499	1,568	153	88	55	2,332	2,230	1,760
Marine	3,826	2,403	3,570	22,691	27,495	13,313	22,789	25,844	11,237	1,325	484	502	2,403	3,570	5,144
Motor	87,234	91,858	96,177	568,306	687,351	385,808	554,575	673,328	373,156	9,107	9,704	4,821	91,858	96,177	104,008
Health	1,450,847	729,686	512,584	3,722,718	5,481,221	1,784,210	4,390,948	5,610,410	1,818,564	52,931	87,913	35,803	729,686	512,584	442,427
Miscellaneous	9,191	9,474	10,016	36,620	31,404	18,041	34,426	23,539	16,634	1,911	7,323	1,283	9,474	10,016	10,140
Total	**1,552,794**	**835,753**	**624,577**	**4,352,808**	**6,229,956**	**2,202,525**	**5,004,422**	**6,335,620**	**2,221,159**	**65,427**	**105,512**	**42,464**	**835,753**	**624,577**	**563,479**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	485	615	669	289	472	157	190	204	36	263	203	28	119	142	69
Marine	9,732	15,628	4,523	6,237	5,088	3,916	3,829	1,368	1,003	688	506	198	165	271	113
Motor	467,877	567,740	314,665	29,034	37,482	20,805	11,575	12,663	7,492	4,791	5,862	2,245	10,449	12,557	4,881
Health	4,268,817	5,446,653	1,755,806	56,870	78,050	23,447	2,982	2,122	2,402	1,015	184	109	1,239	15	9
Miscellaneous	14,175	15,417	9,850	4,175	2,953	1,240	2,292	984	292	1,408	495	197	637	277	266
Total	**4,761,086**	**6,046,053**	**2,085,513**	**96,605**	**124,045**	**49,565**	**20,868**	**17,341**	**11,225**	**8,165**	**7,250**	**2,777**	**12,609**	**13,262**	**5,338**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	560	227	151	129	219	103	120	98	101	231	297	372	1292	1389	1033
Marine	835	1515	1367	358	952	1669	195	325	973	136	242	594	879	536	541
Motor	23683	27083	31711	7538	9294	9967	5722	6574	7123	8072	7324	8327	46843	45902	46880
Health	724369	504168	433758	2719	6294	5438	659	1607	1698	241	149	1187	1698	366	346
Miscellaneous	3759	3420	3448	2163	2237	2260	1567	1245	895	825	1317	1351	1160	1797	2186
Total	**753206**	**536413**	**470435**	**12907**	**18996**	**19437**	**8263**	**9849**	**10790**	**9505**	**9329**	**11831**	**51872**	**49990**	**50986**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	0	0	0	0	0	0
Marine	0	0	0	0	0	0
Motor	0	0	0	0	0	0
Health	0	0	0	0	0	0
Miscellaneous	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**

5. Constraints which cause delay in settlement of claims

1. Incomplete details provided by insured at the time of claim intimation
2. Incomplete/wrong documents submission
3. Non-submission/delay in submission of required documents
4. Verification of pre-existing conditions and/or ailments in case of health claims
5. Verification of genuineness of claim through investigation getting delayed due to non cooperation of insured/providers/TPA
6. Delay in reporting of Vehicle by insured for survey in case of own damage cases
7. Delay in repair of vehicle due to un-availability of parts own damage cases

6. Initiatives taken by the company to ensure expeditious settlement of claims

1. Frequent email are sent to insured explaining claim settlement process
2. intimation of claim by calling at call centre, through SMS and email
3. Communication for deficient documents through email and letters
4. Separate calling is done to insured explain a complicated query (if any) raised in the claim
5. The list of documents required is mentioned in the claim form to make it easy for insured to submit all documents at once
6. Trained Customer care executives at the very first level of customer touch point to guide the insured properly
7. In-house team of Claims surveyor is built for expeditious survey of claims
8. Empanelled Surveyors are assigned for locations/situations where inhouse team is not available
9. Mobile application provided to both Internal and external Surveyors with integrated Claims module for immediate upload of survey photographs and other inputs of survey
10. Access to Claims module provided to Investigators for seamless submission of reports
11. Extensive network of Cashless service providers all across India
12. Special arrangements are made for Catastrophic claims
13. System triggered SMS to insured at various stages of the claim, like – surveyor assignment (with surveyor details), post survey completion, post payment, etc
14. Payment of claim amount through electronic mode, ensuring quick and hassle free settlement

7. Institutional Framework for review of repudiated claims

1. A senior level claims team is there to review any repudiated claim represented by the insured
2. Grievance redressal details available on Website

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	4653
State Commission	1554
National Commission	91
Motor Claims related	
MACT	53931
Appeals with High Court	9532
Appeals before Supreme Court	31
Other policyholder related cases	
Civil Courts	121
High Courts @	102
Supreme Court	1
Other cases (Arbitration, PLA, Labour Court etc.)	400
Total	70416
@ of these, the number of appeals against orders of Insurance Ombudsman	0

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

1. Review of cases on the basis of new documents if any produced by the customer before court of law
2. Review of cases earlier closed for want of documents if customer agrees to submit pending documents before court of law
3. Review of TP cases as per evidence produced by the claimant and offer for settlement as per M V Act

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	4	364,824	16	2,366,218	22	3,123,614
Camps	0	0	0	0	0	0
Others (Consumer Forum)	374	65,032,241	600	139,390,696	360	58,419,240
TOTAL	**378**	**65,397,065**	**616**	**141,756,914**	**382**	**61,542,854**

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	1,645	30,47,71,665	3,556	76,78,80,406	1,544	39,98,39,110
Camps	0	0	0	0	0	0
Others (MACT)	2,605	41,89,94,348	5,266	97,07,26,490	1,745	38,09,38,860
TOTAL	**4,250**	**723,766,013**	**8,822**	**1,738,606,896**	**3,289**	**780,777,970**

NAME OF THE INSURER: **IFFCO TOKIO GENERAL INSURANCE CO. LTD.**

1 Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	833	936	1163	1387	1149	435	1230	980	322	54	0	0	936	1163	1292
Marine	1576	964	958	15601	15128	7739	15990	16122	7195	223	0	0	964	958	1803
Motor	53986	52928	49774	281105	320455	182200	278145	327648	163117	4018	1202	384	52928	49774	71401
Health*	1664	2954	2585	21211	30108	39922	19921	31050	35799	0	0	0	2954	1682	7225
Miscellaneous	3419	3417	4204	10073	10977	5258	9829	10739	4230	246	2	0	3417	5107	5520
Total	61478	61199	58684	329377	377817	235554	325115	386539	210663	4541	1204	384	61199	58684	87241

**Health including Overseas Travel*

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	3	289	73	97	161	56	156	178	78	317	168	48	626	169	65
Marine	114	9639	4606	5705	3375	1604	5826	1368	527	2419	752	203	2133	709	242
Motor	23346	190406	105680	190500	85739	38867	30688	22780	9364	14325	12955	3894	17602	15541	4995
Health*	222	11783	12204	10643	15565	17810	6862	1699	4389	2772	977	764	2364	743	254
Miscellaneous	74	2496	1035	2238	2955	1391	2939	1939	690	2513	1989	588	2393	1214	496
Total	23759	214613	123598	209183	107795	59728	46471	27964	15048	22346	16841	5497	25118	18376	6052

**Health including Overseas Travel*

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	41	72	46	54	70	111	127	105	113	154	191	179	560	725	843
Marine	277	289	471	171	209	556	110	122	308	134	128	221	272	210	247
Motor	9324	8584	16485	7035	6160	11866	5277	4443	9314	6126	6528	7671	25166	24059	26065
Health*	1903	438	2573	242	174	2580	177	348	1180	547	391	632	85	331	260
Miscellaneous	442	1946	652	649	638	954	522	457	930	587	866	1047	1217	1200	1937
Total	**11987**	**11329**	**20227**	**8151**	**7251**	**16067**	**6213**	**5475**	**11845**	**7548**	**8104**	**9750**	**27300**	**26525**	**29352**

**Health including Overseas Travel*

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	0	0	0	0	0	0
Marine	0	0	0	0	0	0
Motor	0	0	0	0	0	0
Health	0	0	0	0	0	0
Miscellaneous	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**

** No Penal interest on account of delay in payment of claim amount, as stipulated under clause 9(6) of IRDA (Protection of Policyholders' Interest) Regulations, 2002, was made during the reported periods.*

5. Constraints which cause delay in settlement of claims

Normally, following factors cause delay in settlement of claims:

- Non submission of necessary claim documents/clarifications/information from Insured especially in commercial vehicles. Ex. copy of FIR, Repair Bills, Permit, Fitness.
- Wrong address of Insured resulting into lack of communication, delay in registration of FIR, Financier NOC, Final report, transferred Registration Certificate in case of Theft Claims,
- Delay in reinstatement of damaged property

6. Initiatives taken by the company to ensure expeditious settlement of claims

- Periodic review of outstanding claims.
- Compromised settlement of contentious matters.
- Introduction of E Survey module.
- Introduction of In-house surveyors for losses up to Rs. 20,000/-
- Introduction of Preferred Garages and Special Service Providers like Windshield Experts, etc.
- Regular rotation of surveyors to ensure maximum efficiency.
- Waiver of spot survey for selected categories of commercial vehicles.

Regular interactions and meetings are arranged with insured/surveyors. Wherever necessary,

Specialist is also introduced /engaged.

- We have developed a review mechanism in system wherein we can fix the review date based on the merit of the claim/development. Said claim shall appear in review list on review date fixed and claim officer can accordingly take action e.g. chase the insured/surveyors etc. This review mechanism has helped to have a better control on claim progress and ultimate helped for speedy processing of claim.

7. Institutional Framework for review of repudiated claims

- Standardised guidelines for claim settlement to ensure better understanding amongst claim officers & transparency in claim settlement.
- Before repudiation, legal opinion is sought from the legal department.
- Regular training on nuances of Motor & Non Motor Insurance to fresher & experienced claim officers.
- Authority to Repudiate claims is given one step higher than the delegated financial authority for approval of claims, thus obviating the need for review.
- Post repudiation representations made either directly to the company or through the Grievance Redressal mechanism of IRDA is given due consideration and decided on merits.
- We have Grievance Redressal System (Online) in place and customer can lodge their grievance on that system. In case of repudiation of claim, we close the claim immediately in our system as liability has been denied. Wherein, customer goes for litigation, then we follow same process as above for review/monitoring the claim progress.

8. Statistics of cases of policyholders / claimants before Consumer Forum /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	1646
State Commission	223
National Commission	36
Motor Claims related	
MACT	35390
Appeals with High Court	1104
Appeals before Supreme Court	3
Other policyholder related cases	
Civil Courts	22
High Courts @	9
Supreme Court	3
Ombudsman	27
Arbitration	2
Others (PLA)	6
Total	**38471**
@ of these, the number of appeals against orders of Insurance Ombudsman	0

9. Initiatives taken by the company for settlement of cases pending before various Forum and Courts (like Lok Adalat, Settlement camps etc.)

- Participation in Lok Adalat organized under Legal Services Act, 1987.
- Settlement of cases before permanent Lok Adalats exists at various State levels.
- Settlement of cases before Ombudsman.
- Settlement through alternative disputes resolution mechanism like conciliation, mediation etc.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	1386	207582725	2030	334293377	509	125883987
Camps	0	0	0	0	0	0
Others (Out of Court settlement)	2638	418637449	5374	918851409	1483	332752547
TOTAL	4024	626220174	7404	1253144786	1992	458636534

NAME OF THE INSURER: **LIBERTY VIDEOCON GENERAL INSURANCE CO. LTD.**

1 Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	0	11	79	0	27	95	0	6	17	0	8	10	0	11	79
Marine	0	14	57	0	31	104	0	15	34	0	1	27	0	14	57
Motor	11	589	802	25	6135	9878	12	5061	8974	2	494	691	11	589	802
Health	0	16	1101	0	40	4362	0	24	3109	0	0	168	0	16	1101
Miscellaneous	0	238	447	0	597	711	0	267	397	0	85	105	0	238	447
Total	**11**	**868**	**2486**	**25**	**6830**	**15150**	**12**	**5373**	**12531**	**2**	**588**	**1001**	**11**	**868**	**2486**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	0	5	12	0	7	9	0	1	4	0	1	2	0	0	0
Marine	0	14	38	0	2	11	0	0	11	0	0	1	0	0	0
Motor	14	4776	8274	0	723	1192	0	54	170	0	2	26	0	0	3
Health	0	17	2221	0	7	1023	0	0	32	0	0	1	0	0	0
Miscellaneous	0	154	159	0	117	193	0	69	119	0	12	31	0	0	0
Total	**14**	**4966**	**10704**	**0**	**856**	**2428**	**0**	**124**	**336**	**0**	**15**	**61**	**0**	**0**	**3**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	0	4	9	0	2	23	0	4	42	0	1	5	0	0	0
Marine	0	4	14	0	4	26	0	6	12	0	0	5	0	0	0
Motor	10	432	610	1	130	142	0	24	39	0	3	8	0	0	3
Health	0	13	560	0	3	189	0		352	0	0	0	0	0	0
Miscellaneous	0	85	80	0	72	164	0	59	103	0	22	88	0	0	12
Total	**10**	**538**	**1273**	**1**	**211**	**544**	**0**	**93**	**548**	**0**	**26**	**106**	**0**	**0**	**15**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	0	0	0	0	0	0
Marine	0	0	0	0	0	0
Motor	0	0	0	0	0	0
Health	0	0	0	0	0	0
Miscellaneous	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**

5. Constraints which cause delay in settlement of claims

- Delayed or non-submission of documents by the insured/claimant (inspite of follow up and reminders from our side) is primary reason for delay in settlement of claims.
- In some cases, spare part availability is low in market, especially for vehicle models which are obsolete (e.g. Matiz) – lead to delay in getting the vehicle repaired.
- In court cases, non-appearance of claimant and/or witness leads to shifting of hearing to next dates leading to delays.
- In some catastrophic losses, due to damage to approach paths, it becomes difficult to reach the loss location for survey quickly, leading to slight delays sometimes.

6. Initiatives taken by the company to ensure expeditious settlement of claims

- Automation of processes for quick processing of claims.
- Building pan-India claim servicing capabilities (e.g. Surveyor, Garages, Hospitals in our servicing network) to ensure timely, quickly claim processing anywhere in India.
- Use of Mobility Solutions (e.g. Tab Applications) for claims managers and/or surveyors to enable them process most part of the claim on the spot.
- Encouraging NEFT processing to be able to reduce the payment time which in case of cheques is higher to to courier and clearance time taken.
- Use of technology to closely monitor processing of each claim and ensuring timely servicing.
- Encouraging out-of-court settlement for Motor-Third Party claims to save time and harassment of the insured/claimant, in case the admissibility of the claim is beyond reasonable doubt.

7. Institutional Framework for review of repudiated claims

- Internal review mechanism in claims function
- Centralized Processing of repudiated claims – to ensure better control and fair processing
- Claims beyond a certain loss limit reviewed by senior persons within claims team before repudiation
- Grievance Redressal Mechanism

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	07
State Commission	01
National Commission	00
Motor Claims related	
MACT	86
Appeals with High Court	01

Appeals before Supreme Court	00
Other policyholder related cases	
Civil Courts	00
High Courts @	00
Supreme Court	00
Total	95
@ of these, the number of appeals against orders of Insurance Ombudsman	00

Note: Data for point no 8 is as on 12 Dec 2014 since no period is mentioned here.

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

- Upfront written offer submitted before Tribunals in the cases wherein all documents are available and liability is admitted under the Policy
- Appointed external investigators to collect necessary documents in the pending cases to assess admissibility of liability under the policy
- Constant persuasion with Claimants and / or our lawyer for conclusion in comprisable cases

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	00	00	00	00	00	00
Camps	00	00	00	00	00	00
Others (give details)– Compromised	00	00	02	28000	02	115000
TOTAL	00	00	02	28000	02	115000

NAME OF THE INSURER: **L AND T GENERAL INSURANCE COMPANY LIMITED**

1 Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	50	133	238	341	369	260	254	267	189	4	1		133	238	308
Marine	201	155	282	1137	813	263	1168	685	276	11	2	1	155	282	272
Motor	902	705	837	7925	12239	9700	7946	11840	8242	176	267	76	705	837	2219
Health	10	320	646	3,321	11,579	3,997	2,216	9,682	2,933	795	1,571	892	320	646	818
Miscellaneous	49	92	159	184	264	171	139	198	192	1		6	92	159	133
Total	**1202**	**705**	**837**	**9587**	**25264**	**10394**	**11723**	**22672**	**8899**	**987**	**1841**	**83**	**1405**	**2162**	**2932**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	94	49	48	44	55	59	53	64	36	59	62	34	8	38	10
Marine	714	247	65	213	115	45	172	207	69	74	110	85	6	7	12
Motor	2348	3943	2344	4970	7041	5553	1214	704	310	560	338	102	30	81	9
Health	2,713	10,376	3,337	241	813	414	57	54	0	0	10	0	0	0	0
Miscellaneous	52	42	58	41	52	47	21	43	46	19	53	32	7	7	13
Total	**3208**	**4281**	**2515**	**5268**	**7263**	**5704**	**1517**	**1018**	**461**	**712**	**563**	**253**	**51**	**133**	**44**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	24	27	33	42	59	66	24	36	61	34	57	59	9	59	89
Marine	50	24	31	72	81	63	21	97	54	6	45	81	6	35	43
Motor	102	273	506	375	389	1099	108	98	383	114	56	179	6	21	52
Health	220	418	447	69	228	290	18	0	78	13	0	3	0	0	0
Miscellaneous	10	23	12	29	38	28	19	29	19	3	29	30	31	40	44
Total	**186**	**347**	**1029**	**518**	**567**	**1546**	**172**	**260**	**595**	**157**	**187**	**349**	**52**	**155**	**228**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	NIL	NIL	NIL	NIL	NIL	NIL
Marine	NIL	NIL	NIL	NIL	NIL	NIL
Motor	NIL	NIL	NIL	NIL	NIL	NIL
Health	NIL	NIL	1	1,000.00	NIL	NIL
Miscellaneous	NIL	NIL	NIL	NIL	NIL	NIL
Total	**NIL**	**NIL**	**1**	**1,000.00**	**NIL**	**NIL**

5. Constraints which cause delay in settlement of claims

1. In motor theft claims there is a delay in getting non traceable report from the court
2. Delay in procuring vehicular verification reports from concerned RTO
3. Non Submissions of Documents
4. Time required for reinstatement of the affected property
5. Delay in submission of documents by customer

6. Initiatives taken by the company to ensure expeditious settlement of claims

1. In motor claim continues follow up with the insured to get the vehicle repaired and submit the documents
2. NEFT payments to the customers
3. On account payment for claim above 1lac.
4. Rigorous follow up with the parties concerned during the currency of the claim.
5. Customer is contacted over phone to explain the documents to be submitted for specific claim.
6. Rigorous follow up process of reminders at regular intervals to the insured and intermediaries.
7. In all cases we request the insured to submit the NEFT details along with the claim documents for direct transfer of claim amount to their accounts, avoiding delays in payments. Till now we have able to achieve 56% payment through NEFT for health claims.

7. Institutional Framework for review of repudiated claims

1. Before giving final repudiation to the customer we give a chance to a customer to represent the facts.
2. While sending repudiation letter we request insured to represent the case making submissions to support contrary to the stand conveyed. The Letter is sent by Registered post A/d. This is to ensure that proper opportunity is given to insured to represent their case.
3. On receipt of representation the same is forwarded to the surveyor and the case is reviewed light of the advice of surveyor and the policy terms and conditions. The decision is accordingly conveyed to insured in writing.
4. If no representations are received, the closure of case is conveyed in writing to the insured by Registered Post A/D.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	36
State Commission	7
National Commission	0
Motor Claims related	
MACT	1325
Appeals with High Court	31
Appeals before Supreme Court	0
Other policyholder related cases	
Civil Courts	1
High Courts @	0
Supreme Court	0
Total	**1400**
@ of these, the number of appeals against orders of Insurance Ombudsman	0

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

Actively participating in Lok Adalat and compromising the matters through conciliation and pre-litigation.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	0	0	37	99.42	0	0
Camps	0	0	0	0	0	0
Others (Compromised + Settlement)	36	71.13	68	95.90	16	24.45
TOTAL	**36**	**71.13**	**105**	**195.32**	**16**	**24.45**

NAME OF THE INSURER: **MAGMA HDI GENERAL INSURANCE COMPANY LTD.**

1 Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	0	1	4	2	18	23	1	13	4	0	2	3	1	4	20
Marine	0	0	24	0	67	334	0	43	239	0	0	31	0	24	88
Motor	0	303	2107	786	12068	12190	438	9815	10394	45	449	310	303	2107	3593
Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Miscellaneous	0	0	11	0	25	186	0	14	111	0	0	10	0	11	76
Total	**0**	**304**	**2146**	**788**	**12178**	**12733**	**439**	**9885**	**10748**	**45**	**451**	**354**	**304**	**2146**	**3777**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	0	0	0	1	5	1	0	4	2	0	0	1	0	0	0
Marine	0	0	97		29	58	0	2	26	0	0	55	0	0	0
Motor	292	1580	5924	191	5815	2135	0	588	687	0	114	227	0	0	13
Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Miscellaneous	0	0	4		7	92	0	1	8	0			0	0	
Total	**292**	**1580**	**6025**	**192**	**5856**	**2286**	**0**	**595**	**723**	**0**	**114**	**283**	**0**	**0**	**13**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	0	0	0	1	3	14	0	1	5	0	0	1	0	0	0
Marine	0	0	0		22	65	0	1	18	0	1	4	0	0	1
Motor	0	0	0	298	1546	1979	5	353	829	0	195	636	0	13	149
Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Miscellaneous	0	0	0	0	9	49	0	2	24	0	0	3	0	0	0
Total	**0**	**0**	**0**	**299**	**1580**	**2107**	**5**	**357**	**876**	**0**	**196**	**644**	**0**	**13**	**0**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	0	0	0	0	0	0
Marine	0	0	0	0	0	0
Motor	0	0	0	0	0	0
Health	0	0	0	0	0	0
Miscellaneous	0	0	0	0	0	0
Total	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**

5. Constraints which cause delay in settlement of claims

1. Required documents not submitted in time.
2. Repair & reinstatement not completed.
3. Delay in verification of vehicular documents from Authority.
4. Delay in receipt of criminal documents.

6. Initiatives taken by the company to ensure expeditious settlement of claims

1. Prompt deputation of surveyors & receipt of reports within stipulated time.
2. TATs defined for claim settlements.
3. Decentralised claim settlement authority at the Branches.
4. Bill less settlements upto defined limits.

7. Institutional Framework for review of repudiated claims

1. Repudiation authority for claims vesting only with HO.
2. Registered postal queries & reminders sent to insured prior to closure.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	98
State Commission	2
National Commission	0
Motor Claims related	
MACT	1930
Appeals with High Court	5
Appeals before Supreme Court	0
Other policyholder related cases	
Civil Courts	0
High Courts @	0
Supreme Court	0
Total	2035
@ of these, the number of appeals against orders of Insurance Ombudsman	0

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like LokAdalat, Settlement camps etc.)

1. Participation in all LokAdalats .
2. Extensively participated in National LokAdalat.
3. Compromise settlement process initiated in pending cases.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
LokAdalat	0	0	153	369.78 lacs	187	676.14 lacs
Camps	0	0	0	0	0	0
Others (give details)	0	0	0	0	0	0
TOTAL	**0**	**0**	**153**	**369.78 lacs**	**187**	**676.14 lacs**

NAME OF THE INSURER: **MAX BUPA HEALTH INSURANCE LTD.**

1 Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Marine	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Motor	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Health	869	1761	3560	23813	49747	34942	20719	41530	29049	2202	6418	4524	1761	3560	4929
Miscellaneous	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	**869**	**1761**	**3560**	**23813**	**49747**	**34942**	**20719**	**41530**	**29049**	**2202**	**6418**	**4524**	**1761**	**3560**	**4929**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Marine	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Motor	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Health	16465	35486	25239	3634	3592	962	125	270	95	28	40	25	0	0	0
Miscellaneous	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	**16465**	**35486**	**25239**	**3634**	**3592**	**962**	**125**	**270**	**95**	**28**	**40**	**25**	**0**	**0**	**0**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Marine	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Motor	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Health	1367	2231	4699	362	1246	185	32	83	42	0	0	3	0	0	0
Miscellaneous	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	**1367**	**2231**	**4699**	**362**	**1246**	**185**	**32**	**83**	**42**	**0**	**0**	**3**	**0**	**0**	**0**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	-	-	-	-	-	-
Marine	-	-	-	-	-	-
Motor	-	-	-	-	-	-
Health	0	0	0	0	717	2,14,590
Miscellaneous	-	-	-	-	-	-
Total	**0**	**0**	**0**	**0**	**0**	**0**

5. Constraints which cause delay in settlement of claims

1. Non receiving of mandatory documents
2. Delay in receipt of additional information
3. Complete information/history about the previous policy claim history in case of portability
4. On site verification in remote locations (Non Metro)

6. Initiatives taken by the company to ensure expeditious settlement of claims

1. Pro active communication/updates given to the customer and provider
2. Follow up(s) and assistance to the customer in regards to the missing information seeked from the customer
3. Completion of investigation in time and customer facilitation during the same process
4. Formation of in house “Medical Advisory Team” for fast, fair and hassle free settlement
5. Process Re-engineering to make the claim process more convenient and faster for the customer

7. Institutional Framework for review of repudiated claims

1. A dedicated customer redressal team for assisting customers in case of any disconnects/ appeals for reconsiderations
2. Medical Advisory Team acting as customer advocates in case of any doubts or customer disputes for claims team
3. Clear Matrix for time bound resolution of escalated claims
4. Settlement TAT are well defined and adhered to with spirit

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	195
State Commission	6
National Commission	Nil
Motor Claims related	
MACT	-
Appeals with High Court	-
Appeals before Supreme Court	-
Other policyholder related cases	

Civil Courts	Nil
High Courts @	Nil
Supreme Court	Nil
Total	201
@ of these, the number of appeals against orders of Insurance Ombudsman	Nil

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

The cases under litigation are evaluated on merits and in line with our customer centricity approach, cases are identified and discussed internally. Basis that, such matters are further discussed with claimants with a view to find an amicable solution. Once a common ground is reached for settlement, the conciliation officer/ hon'ble ombudsman is informed of the settlement and requested to pass a settlement order in the matter.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	-	-	-	-	-	-
Camps	-	-	-	-	-	-
Others (give details) - Ombudsman	-	-	2	72305	3	62936
Total	**-**	**-**	**2**	**72305**	**3**	**62936**

NAME OF THE INSURER: **NATIONAL INSURANCE COMPANY LIMITED**

1 Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	3331	2634	3222	5157	5362	2871	3296	2912	1219	2558	1862	732	2634	3222	4142
Marine	2715	2772	2722	14299	12424	5970	11646	10680	4718	2596	1794	730	2772	2722	3244
Motor	320928	290980	240101	697394	643810	299495	667045	659635	278171	60297	35054	9294	290980	240101	252131
Health	33636	32220	31551	460554	467861	209374	381712	392373	178868	80258	76157	29408	32220	31551	32649
Miscellaneous	26193	23691	22616	66652	63495	29684	49733	49548	20862	19421	15022	6406	23691	22616	25032
Total	**386803**	**352297**	**300212**	**1244056**	**1192952**	**547393**	**1113432**	**1115148**	**483838**	**165130**	**129889**	**46569**	**352297**	**300212**	**317198**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	260	145	68	147	145	70	513	637	275	1189	1011	417	1187	974	389
Marine	2541	1814	708	775	831	322	3337	3039	1709	3326	3262	1234	1667	1734	745
Motor	229034	240412	96477	132617	109757	69213	149403	216331	82101	78642	37878	11951	77350	55257	18429
Health	165154	136334	65976	8691	34080	16494	145079	165178	78179	56068	49616	16009	6720	7165	2210
Miscellaneous	10031	9730	4763	5847	3937	1926	15190	16100	6827	11406	12021	3881	7259	7760	3465
Total	**407020**	**388435**	**167992**	**148076**	**148750**	**88025**	**313522**	**401285**	**169091**	**150631**	**103788**	**33492**	**94183**	**72890**	**25238**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	164	172	383	327	343	767	363	622	780	677	863	846	1103	1222	1366
Marine	198	191	239	396	382	477	501	497	727	896	773	755	781	879	1046
Motor	33277	12978	18085	66553	25957	36170	15384	28286	34519	22315	26034	22375	153451	146846	140982
Health	6866	5683	4285	13732	11366	8569	5453	5719	7009	3531	3895	8228	2638	4888	4558
Miscellaneous	1691	1220	1684	3383	2440	3367	3574	3099	3995	4678	4369	4180	10365	11488	11806
Total	**42196**	**20244**	**24676**	**84391**	**40488**	**49350**	**25275**	**38223**	**47030**	**32097**	**35934**	**36384**	**168338**	**165323**	**159758**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	NIL	NIL	NIL	NIL	NIL	NIL
Marine	NIL	NIL	NIL	NIL	NIL	NIL
Motor	NIL	NIL	NIL	NIL	NIL	NIL
Health	NIL	NIL	NIL	NIL	NIL	NIL
Miscellaneous	NIL	NIL	NIL	NIL	NIL	NIL
Total	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**

5. Constraints which cause delay in settlement of claims

Sometimes the delay takes place in settlement of non-suit claims on account of following reasons.

1. Policyholders taking pretty long time in submission of requisite claims documents
2. Delay in repairing of the vehicles by the insured, especially in case of extensive damages to commercial heavy vehicles
3. Delay of a few weeks in submission of duly discharged loss voucher
4. Delay in receiving survey reports from surveyors in case of large losses
5. Delay in settlement of motor vehicles theft cases due to delay to non-submission / issue of Final Report by police authorities

6. Initiatives taken by the company to ensure expeditious settlement of claims

1. Deputation of surveyors within 24 hours and subsequently following them for release of their reports within 30 days
2. Creation of claims Hubs for exclusive handling of claims for a cluster of offices with focused attention to achieve optimum Turn Around Time(TAT)
3. Presently 54 Motor Own Damage claims and 16 Motor TP Claims Hubs are functioning at different centers all over India. More such Hubs are planned in near future.
4. Cashless settlement through National & Local Tie-Ups with authorized automobile dealers are being done extensively all over India providing thereby, a single window to the Motor Insurance Customers for expeditious settlement of their claims.
5. Specialist officers in the cadre of Administrative Officers with specialization in Automobile Engineering, Legal and Medical Professionals have been recruited during last 4 years to improve the efficacy of the claims handling system of the company.
6. Presently the company is moving over to Core Insurance Solution (EASI) to bring the settlement of claims under the ambit of IT enabled services, thereby improving the TAT.
7. Utilisation of Third Party Administrators (TPA) for quick administration & processing of claims for expeditious settlement of Health Insurance Claims
8. Regular monitoring the performance of the TPAs from the angle of TAT agreed upon and review of the pending hospitalization claims
9. Creation of claims disposal task force at the time of catastrophic losses, such as, Kashmir Floods & Hudhud cyclone

7. Institutional Framework for review of repudiated claims

Complaints related to repudiation of claims and quantum dispute would now are being addressed by regional Customer Reationship Committee (RCRC) in following manner. Maximum time schedule for disposal of such cases will be two weeks from the date of receipt at RO.

1. Concerned office/ claim hub on receiving these types of complaints will send the complete file along with a speaking note to RCRC of Regional Office (RO) through Customer Relationship Management Department (CRM dept.) Respective RO Tech Dept. would assist the RCRC in this regard.

2. These cases would be taken up immediately in the meeting of RCRC and wherever feasible and practical an attempt should be made to involve customers in the proceedings of grievance redressal with an aim of customer relationship building and also of transparency.

3. Appeal against the decision of RCRC shall lie to the Deputy General Manager(DGM) at RO level and time required for disposal will not be more than 15 working days.

4. Where DGM is not posted such appeal would be placed before a committee consisting of all the three members of RCRC and RO in-charge. Time schedule will remain unchanged.

5. One-step higher authority will undertake review of claims those approved by RCC/ DGM/ GM.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts (as at 31/03/ 2014)

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	8549
State Commission	3353
National Commission	684
Motor Claims related	
MACT	105749
Appeals with High Court	42529
Appeals before Supreme Court	477
Other policyholder related cases	
Civil Courts	128
High Courts @	262
Supreme Court	2
Total	161733
@ of these, the number of appeals against orders of Insurance Ombudsman	162

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

1. COMMON MECHANISM FOR COMPROMISE SETTLEMENT OF MOTOR TP CASES (CMCSTPC)

1.1 The governing Board of GIPSA had decided to setup an alternative conciliatory forum i.e. CMCSTPC, to provide opportunity to the innocent victims of the road accidents to enable them in getting their due of just compensation at an early date without going through a prolonged litigation process.

1.2 As the flag company in Eastern India, we have opened 8 such conciliatory centers at Cuttack, Rourkela, Guwahati, Patna, Kolkata, Midnapore, Tamluk and Durgapur in the states of Odisha, Bengal, Bihar and Assam during the last 2 years for the benefit of the claimants. The process of compromise is facilitated through mediation done by an independent and respectable

committee consisting of a retired judge, practicing orthopadesian and a senior retired officer from the insurance company.

1.3 So far, 57 monthly sittings have been held in these centers wherein 2,035 no. of cases stand compromised.

1.4 We have planned to open two more centers in the north-eastern part of India at Agartala and Silchar shortly.

2. SETTLEMENT OF CASES THROUGH LOK ADALAT

2.1 As per Legal Services Authority Act, 1987, Lok Adalats have been set up by all the State/ District Authorities under the aegis of State/District Legal Services Authority for the purpose of mediation and disposal of MACT cases pending before the Tribunals.

2.2 Apart from regular participation by our dealing offices and settlement of cases on compromise basis thereof, MACT cases are also being settled in other in-house alternative forum, such as, Divisional In-house Conciliatory Committee (DICC) / Regional In-house Conciliatory Committee (RICC).

2.3 All our Regional Offices are also participating in Lok Adalats being held every month by various High Court Legal Services Committees and settling appeal cases pending before High Courts on compromise basis.

2.4 Due to the above mentioned pro-active measures by our operating offices, 140000 numbers of cases have been settled in various Conciliation forums and Lok Adalats during the last 10 years.

2.1 We also participate in National Lok Adalats by deploying our workforce in all the MACTS, High Courts & Supreme Court. Our company has settled 10,337 & 13121 no. of cases in National Lok-Adalat held on 23/11/2013 & 06/12/2014, which are record settlement of Motor TP claims in a single a day.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	11062	126.13	18069	260.28	5902	84.39
Camps	NIL	NIL	NIL	NIL	NIL	NIL
Others (give details)	NIL	NIL	NIL	NIL	NIL	NIL
TOTAL	**11062**	**126.13**	**18069**	**260.28**	**5902**	**84.39**

NAME OF THE INSURER: **RAHEJA QBE GENERAL INSURANCE COMPANY LIMITED**

1 Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	2	3	4	4	4	4	2	1	3	0	0	0	2	3	4
Marine	1	0	0	2	0	0	3	1	0	0	0	0	1	0	0
Motor	8	6	10	9	10	5	15	9	1	0	0	0	8	6	10
Health	9	7	14	35	35	19	44	37	15	0	0	0	9	7	14
Miscellaneous	34	78	69	45	70	48	30	8	56	0	2	0	34	78	69
Total	**49**	**94**	**97**	**95**	**119**	**76**	**94**	**56**	**75**	**0**	**2**	**0**	**49**	**94**	**97**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	0	0	0	0	0	3	0	0	0	2	1	0	0	0	0
Marine	0	0	0	0	0	0	0	0	0	3	0	0	0	1	0
Motor	0	0	0	0	0	0	0	0	1	7	6		8	3	0
Health	0	0	0	20	0	15	11	37	0	10	0	0	3	0	0
Miscellaneous	0	0	0	0	0	0	26	8	56	4	0	0	0	0	0
Total	**0**	**0**	**0**	**20**	**0**	**18**	**37**	**45**	**57**	**26**	**7**	**0**	**11**	**4**	**0**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	0	0	0	0	0	1	0	0	1	2	2	0	0	1	2
Marine	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
Motor	1	0	1	0	2	0	0	1	2	1	2	4	1	1	3
Health	4	0	3	2	2	3	1	1	4	1	4	2	1		2
Miscellaneous	1	6	4	11	16	6	5	11	18	12	16	15	4	29	26
Total	**6**	**6**	**8**	**13**	**20**	**10**	**6**	**13**	**25**	**16**	**24**	**21**	**8**	**31**	**33**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	0	0	0	0	0	0
Marine	0	0	0	0	0	0
Motor	0	0	0	0	0	0
Health	0	0	0	0	0	0
Miscellaneous	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**

5. Constraints which cause delay in settlement of claims

Late submission of documents by the Insured.

6. Initiatives taken by the company to ensure expeditious settlement of claims

Nil

7. Institutional Framework for review of repudiated claims

Nil

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	Nil
State Commission	Nil
National Commission	Nil
Motor Claims related	
MACT	8
Appeals with High Court	Nil
Appeals before Supreme Court	Nil
Other policyholder related cases	
Civil Courts	Nil
High Courts @	Nil
Supreme Court	Nil
Total	**8**
@ of these, the number of appeals against orders of Insurance Ombudsman	Nil

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

Nil

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	Nil		Nil		Nil	
Camps	Nil		Nil		Nil	
Others (give details) - MACT	8	1941104	4	333300	1	1330000
TOTAL	**8**	**1941104**	**4**	**333300**	**1**	**1330000**

NAME OF THE INSURER: **RELIANCE GENERAL INSURANCE CO LTD**

1 Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	316	358	457	1,197	1,161	706	1,102	1,061	578	46	-	1	365	457	583
Marine	382	367	463	1,505	1,808	990	1,430	1,713	964	85	-	-	372	463	498
Motor	34,570	82,859	84,347	158,603	174,453	91,777	150,909	172,714	90,816	4,481	-	-	37,783	84,347	85,403
Health	160,266	295,291	67,058	1,099,837	1,078,231	311,169	922,015	1,236,352	329,441	42,742	70,210	15,195	295,346	67,058	33,540
Miscellaneous	2,007	4,081	4,992	7,981	6,089	3,298	5,328	5,321	2,438	455	-	-	4,205	4,992	5,803
Total	197,541	382,956	157,317	1,269,123	1,261,742	407,940	1,08,0784	1,417,161	424,237	47,809	70,210	15,196	338,071	157,317	125,817

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	379	263	116	153	170	129	112	125	58	90	86	29	74	50	38
Marine	491	587	251	201	296	223	103	142	61	67	53	27	26	21	15
Motor	84,840	101,141	55,290	26,430	25,155	12,201	8,843	8,265	3,728	4,279	3,972	1,619	3,966	10,035	5,613
Health	484,678	302,908	72,732	194,020	379,374	241,609	180,965	283,020	3,368	35,392	204,545	1,643	1,635	25,038	1,216
Miscellaneous	1,244	1,095	547	967	1,014	566	669	663	317	438	397	163	448	455	196
Total	**571,632**	**405,994**	**128,936**	**221,771**	**406,009**	**254,728**	**190,692**	**292,215**	**7,532**	**402,66**	**209,053**	**3,481**	**61,49**	**35,599**	**7,078**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	102	89	101	46	75	111	49	79	103	58	76	112	110	138	156
Marine	82	117	85	77	68	108	51	54	50	49	51	74	113	173	171
Motor	6,325	6,542	6,858	4,308	6,616	5,806	4,154	5,367	5,653	4,479	8,837	8,427	18,517	56,985	58,659
Health	54,922	42,061	7,077	107,572	12,001	6,813	103,196	3,347	6,498	28,729	8,222	4,909	927	1,427	8,243
Miscellaneous	349	416	482	600	583	731	604	616	626	938	790	990	1,714	2,583	2,974
Total	61,780	49,225	14,603	112,603	19,343	13,569	108,054	9,463	12,930	34,253	17,980	14,512	21,381	61,306	70,203

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	0	0	0	0	0	0
Marine	0	0	0	0	0	0
Motor	0	0	0	0	53	34786
Health	0	0	0	0	133	6576
Miscellaneous	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**186**	**41362**

5. Constraints which cause delay in settlement of claims

Motor Claims:

1. Repair time taken.
2. Non availability of spare parts
3. Document verification from RTO which are not computerized takes time.
4. NEFT documents especially insured from rural areas.

Health Claims:

1. Delay in submission of claim documents by the insured.
2. Submission of incomplete claim documents by the insured.
3. Claim document submission at location other than claim processing office.
4. Incorrect claim form / no intimation of change in communication details of customers.
5. Difficulty in availing NEFT details.

6. Initiatives taken by the company to ensure expeditious settlement of claims

Motor Claims:

1. Online submission of loss assessment report avoiding delay in manual preparation of report.
2. We had adopted the NEFT instead of cheques for expeditious settlement since year 2010 to avoid delay in preparation and dispatch of cheques.
3. Automated messages at various stages in the lifecycle of a claim to make insured aware of the status and also requirements pending from his side.
4. Enhancing cashless network based on volume of claims received so that insured does not have to pay upfront and wait for reimbursement.

Health Claims:

1. Increased customer awareness on claim document requirement & overall claims process through website, requirement letters, claim forms etc.
2. Guided claim processing for the customers to aid completeness of documentation.
3. Making customer contact details mandatory at policy sourcing & claims.

Commercial Claims:

Structured Monthly review of by Top Management through Dashboard Meetings of

1. Outstanding claim count/ Disposal of claims
2. Ageing of claims & analysis of increase in ageing of claims
3. Periodic meetings with clients for submission of documents as applicable
4. Review with surveyors for submission of survey reports
5. Turn Around Time for claim settlement
6. Automation built in for indicating ageing of claims

7. Institutional Framework for review of repudiated claims

Motor Claims:

Claims where discrepancies are observed are thoroughly investigated and a careful evaluation of the documentary evidence is made. All the repudiated claims are verified at Corporate office by a team with adequate technical and legal expertise and the final decision is taken based on merits of the case. Post such evaluation and review the claims are repudiated and a written communication detailing the grounds of repudiation is sent to the customer.

Health Claims:

1. All claim repudiations are closely supplemented with due remarks and reasons along with reference clause for repudiation.
2. Workflow based claim processing leading to additional layer of QC for claim repudiation of critical claims.
3. Detailed explanation on rejection grounds to the customer through letters and calls.

Commercial Claims:

All cases requiring repudiation would need to be put up one step up higher than approval authority. This will ensure that the grounds of repudiation are fair and the repudiation is strictly as per policy terms.

If any claim repudiated is put up for for consideration by the client on some specific technical or interpretation grounds or if any new fact is brought to light, such justification is placed on record. If on technical grounds, the matter is placed before the surveyor for his technical inputs.

Review of any repudiated claim is centralized at Corporate Office and is done, if at all, on the grounds of merit and with all facts and figures on record.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	4063
State Commission	798
National Commission	44
Motor Claims related	
MACT	59288
Appeals with High Court	7435
Appeals before Supreme Court	48
Other policyholder related cases	
Civil Courts	94
High Courts @	
Supreme Court	
Total	**71770**
@ of these, the number of appeals against orders of Insurance Ombudsman	0

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

The company is participating in the Lok Adalats, apart is also settling claims in usual course as and when an agreement is arrived with the claimants. The company is taking due care of all requirements in the claims and accordingly proceeding for the settlements. The company has been also proactively involved in the adjudication of claims through Court process as well by avoiding unnecessary adjournments and there has been a substantial disposal of cases through court proceedings as well. Recently National Lok Adalat was scheduled in Dec 2014 and the company has participated in the same and settled cases in agreement with claimants.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	390	48,737,695	1395	1,81,557,669	688	92,252,955
Camps	0	0	0	0	0	0
Others(give details)	0	0	0	0	0	0
TOTAL	**390**	**48,737,695**	**1395**	**1,81,557,669**	**688**	**92,252,955**

NAME OF THE INSURER: **RELIGARE HEALTH INSURANCE COMPANY LIMITED**

1 Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Marine	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Motor	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Health	0	637	15630	5881	69858	38801	4897	49243	37240	347	5622	6359	637	15630	10832
Miscellaneous	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Total	**0**	**637**	**15630**	**5881**	**69858**	**38801**	**4897**	**49243**	**37240**	**347**	**5622**	**6359**	**637**	**15630**	**10832**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Marine	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Motor	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Health	4897	45396	34790	0	3282	2227	0	565	209	0	0	14	0	0	0
Miscellaneous	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Total	**4897**	**45396**	**34790**	**0**	**3282**	**2227**	**0**	**565**	**209**	**0**	**0**	**14**	**0**	**0**	**0**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Marine	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Motor	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Health	637	15147	10222	0	381	451	0	102	141	0	0	18	0	0	0
Miscellaneous	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Total	**637**	**15147**	**10222**	**0**	**381**	**451**	**0**	**102**	**141**	**0**	**0**	**18**	**0**	**0**	**0**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	NA	NA	NA	NA	NA	NA
Marine	NA	NA	NA	NA	NA	NA
Motor	NA	NA	NA	NA	NA	NA
Health	Nil	Nil	Nil	Nil	Nil	Nil
Miscellaneous	NA	NA	NA	NA	NA	NA
Total	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**

5. Constraints which cause delay in settlement of claims

i) Incomplete document submission by leading to deficiency.

ii) Delay in submission of deficiency documents.

iii) Claim verification

6. Initiatives taken by the company to ensure expeditious settlement of claims

i) Corporate Training.

ii) Broker / Agent Training.

iii) Detailed Claim procedure in company website.

iv) Proactive Customer calling for claim deficiency resolution.

v) Campaign to reduce deficiency through Email/Camps at Corporates

7. Institutional Framework for review of repudiated claims

i) Client can approach for review of claims through Call centre/Email

ii) Claims reviewed by Claims Head/Customer Service Head independently of decision taken earlier

iii) Expert Medical opinion sought if requirement seen

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	18
State Commission	0
National Commission	0
Motor Claims related	NA
MACT	
Appeals with High Court	
Appeals before Supreme Court	
Other policyholder related cases	NA
Civil Courts	
High Courts @	
Supreme Court	
Total	18
@ of these, the number of appeals against orders of Insurance Ombudsman	-

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like LokAdalat, Settlement camps etc.)

We would like to state that Company commenced its operations in July 2012 and till November 30, 2014 only 18 cases are pending before various District Consumer Forums across India. Out of 18 Cases, notices have been received in 16 cases in this financial year. In most of the cases, Company believes that it has strong supporting documents and reasons to substantiate Company's decision and thus it is judiciously viable to defend the matter in courts.

Further, we would also like to highlight that till date respected District Consumer Forms have passed judgment in 3 cases and all have been decided in Company's favour.

Further, Company again reviewed all the pending cases as mentioned above and reached to a conclusion that Company has sufficient supporting documents to support its decision and hence it would not be viable to place the matter before National LokAdalat for amicable settlement.

However, it will be our endeavor to settle any matter which can be resolved amicably in future.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
LokAdalat	NA	NA	NA	NA	NA	NA
Camps	NA	NA	NA	NA	NA	NA
Others (give details)	NA	NA	NA	NA	NA	NA
TOTAL	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**

NAME OF THE INSURER: **ROYAL SUNDARAM ALLIANCE INSURANCE CO.LTD**

1 Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	321	393	51	1079	926	515	615	1212	226	70	183	81	393	51	440
Marine	1149	1270	756	4739	8381	3422	3953	7269	2359	153	585	262	1270	756	1775
Motor	18798	24865	26904	251906	411474	107156	247165	393540	103042	4473	3164	570	24865	26904	30504
Health	2015	8014	18116	39364	266228	69186	33970	234161	58007	4902	13974	3836	2367	18116	23340
Miscellaneous	530	411	518	1068	1455	481	860	1159	287	81	278	38	411	518	426
Total	**22813**	**34953**	**46345**	**298156**	**688464**	**180760**	**286563**	**637341**	**163921**	**9679**	**18184**	**4787**	**29306**	**46345**	**56485**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	127	226	48	178	390	72	107	239	48	120	253	40	83	117	18
Marine	867	3480	736	2835	3262	1308	118	463	221	90	244	99	43	97	-5
Motor	175572	292163	88217	49627	64140	1804	7406	19474	3560	6565	11170	3247	7995	16588	6214
Health	27827	121807	23461	4358	81047	33649	879	5144	753	716	2749	120	190	682	24
Miscellaneous	226	640	156	318	162	53	123	154	35	90	167	24	103	76	19
Total	**204619**	**418316**	**112618**	**57316**	**149001**	**36886**	**8633**	**25474**	**4617**	**7581**	**14583**	**3530**	**8414**	**17560**	**6270**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	0	0	0	158	22	205	76	11	114	93	9	60	66	9	61
Marine	0	0	0	510	235	896	82	66	156	99	98	154	579	357	569
Motor	0	0	0	5580	7513	8607	2516	2276	3128	3518	3348	3994	13251	13767	14775
Health	0	0	0	1754	12639	22083	159	2457	702	92	1300	190	362	1720	365
Miscellaneous	0	0	0	119	140	158	60	78	77	103	109	68	129	191	123
Total	**0**	**0**	**0**	**8121**	**20549**	**31949**	**2893**	**4888**	**4177**	**3905**	**4864**	**4466**	**14387**	**16044**	**15893**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	NA	NA	NA	NA	NA	NA
Marine	NA	NA	NA	NA	NA	NA
Motor	NA	NA	NA	NA	NA	NA
Health	Nil	Nil	Nil	Nil	Nil	Nil
Miscellaneous	NA	NA	NA	NA	NA	NA
Total	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**

5. Constraints which cause delay in settlement of claims

Health:

- Establishing the duration of ailments/diseases is vital to adjudication of liability in health claims in view of the waiting periods and exclusions on pre-existing diseases. Hence, we seek documents like indoor case records/previous consultation papers/first prescription of diagnosis etc which causes delay in disposal of the claims
- Many hospitals refuse to share or cause delay in sharing of indoor case records which eventually leads to customer inconvenience.

Motor Own Damage:

- Delay in leaving the vehicle for repairs
- Delayed submission of claim documents like claim form etc from the insured
- Delay in getting survey reports from independent surveyors.
- Delay due to validation in break n and close proximity.
- Delay due to investigation of potential frauds.
- Delay due to receipt of bills from the repairers after delivery of the vehicle.
- Process Delays

Property/Marine:

1. Property claims, reinstatement of loss is delayed and consequently claim settlement is also delayed
2. Marine claims – Non submission of original documents

Commercial – Agency

- We get small claims from far-flung places. Finding out surveyors and obtaining documents is often a challenge. Again, when the claim amounts are not big - the expectations are to settle with very less of documents.

Motor TP Claims:

- Non co-operation of Insured, non availability of insured in the available policy copy address and non availability of police & other related documents.

6. Initiatives taken by the company to ensure expeditious settlement of claims

Health:

- We appoint our service providers to visit the hospitals for procuring indoor case records (which may involve multiple visits to the various departments in a hospital)
- Cashless approvals done by the TPA is closely monitored by us. For cases where cashless approval is kept on hold for want of documents, we co-ordinate with the hospital and the customer directly for obtaining the same to ensure seamless cashless administration process.

- Instances where the hospital does not provide break-up of certain bill-heads or do not provide the invoices or stickers for implants, depending on the merits of the claim, we waive submission of the same, if the claim is otherwise payable.

Motor Own Damage:

- Decentralization of claim settlement authority (97% of claims are handled at the location)
- Software application with laptop connectivity for all the field staff across the country to assess losses, approve settlements and activate claims disbursement.
- Keep reminding the insured for repairs.
- Send a detail communication immediately after intimation to the insured regarding insured role in settlement (theft claims)
- Demand only essential documents like claim form, RC and DL. Avoid documents like police report, port mortem report, goods related documents.
- To have more in house surveyors to ensure speed of handling the survey, assessment and achieve concurrent processing of claims as well.
- Have a centralized support desk to address issues relating to close proximity, break n cases , fraud claims etc
- Brief the investigators on the scope of investigation and have a monthly review of the investigation.
- Monthly MIS to key dealers / repairers regarding outstanding claims giving the reasons for outstanding.
- Work flow based application, digitalization and dynamic integration of field and office for speedy processing of claims

Property:

- Close monitoring of outstanding claims and reminders to the client and surveyors on minimum one touch a month basis.

Commercial – Agency

- We have a fast-track claim procedure in place, where claims of lesser magnitude are considered for settlement with survey (when losses are clearly established) and documentary requirements are kept to barest minimum

Motor TP Claims:

- Wherever the documents are found fit, the cases are referred to lok adalat and compromise settlements arranged.

7. Institutional Framework for review of repudiated claims

Health:

- All requests for reconsideration (of rejected claims) are reviewed by a panel of doctors and a senior claim sanctioning authority.
- Where there is an element of doubt involving medical admissibility, we seek specialist opinion from neutral panel of doctors and claim admissibility is reviewed fairly.

- All reconsideration requests routed through Grievance Redressal are handled directly by the Head of Claims from the Corporate Office.

Motor Own Damage:

- Repudiation of an own damage claim is centralized at the corporate office. Hence each denial is carried out after a wider analysis.
- However, if there is a complaint / dissatisfaction over claims denial, the same is reviewed at Chief Operating Officer level duly involving the legal team.
- 0.76% of claims were denied during 2013 2014. Such a percentage confirms that the Royal Sundaram does the review even before repudiating a claim.

Property:

- Quarterly review of closed/repudiated claims

Commercial – Agency:

- This being a small vertical, representations is considered by the Claims Head, in discussion with portfolio head and COO.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	836
State Commission	139
National Commission	44
Motor Claims related	
MACT	19770
Appeals with High Court	1152
Appeals before Supreme Court	3
Other policyholder related cases	
Civil Courts	32
High Courts @	02
Supreme Court	02
Total	
@ of these, the number of appeals against orders of Insurance Ombudsman	NIL

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

List of cases fit for compromise settlement are duly forwarded to our panel advocates and specific letter is sent to the petitioners and their counsel intimating our willingness for settlement of their cases through compromise.

As far as Consumer and ombudsman cases are concerned, we don't settle those cases through lok Adalats or Settlement camps."

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	3398	596437585	3456	639561600	978	198327388
Camps	0	0	0	0	0	0
Others (give details)	3235	596481577	2721	569405726	1116	310681459
TOTAL	**6633**	**1192919162**	**6177**	**1208967326**	**2094**	**509008847**

NAME OF THE INSURER: **SBI GENERAL INSURANCE COMPANY LIMITED**

1 Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	1	4	6	1	5	6	-	1	-	NA	NA	NA	1	4	6
Marine	-	1	-	-	1	-	-	-	-	NA	NA	NA	-	1	-
Motor	4	34	39	9	41	42	5	7	3	NA	NA	NA	4	34	39
Health	-	5	17	-	13	22	-	8	5	NA	NA	NA	-	5	17
Miscellaneous	-	10	32	1	14	35	1	4	3	NA	NA	NA	0	10	32
Total	**5**	**54**	**94**	**11**	**74**	**105**	**6**	**20**	**11**	**NA**	**NA**	**NA**	**5**	**54**	**94**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-
Marine	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Motor	-	1	1	-	1	1	2	2	1	2	3	-	1	-	-
Health	-	1	1	-	1	2	-	2	2	-	4	-	-	-	-
Miscellaneous	-	-	-	-	1	1	-	2	2	1	1	-	-	-	-
Total	**-**	**2**	**2**	**-**	**3**	**4**	**2**	**6**	**5**	**3**	**9**	**-**	**1**	**-**	**-**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	-	-	-	-		1	-	-	2	-	2	3	1	2	-
Marine	-	-	-	-		-	-	-	-	-	-	-	-	1	-
Motor	-	-	-	-		5	-	-	20	-	10	14	4	24	-
Health	-	-	-	-		3	-	-	9	-	4	5	-	1	-
Miscellaneous	-	-	-	-		10	-	-	13	-	7	9	-	3	-
Total	**-**	**-**	**-**	**-**		**19**	**-**	**-**	**44**	**-**	**23**	**31**	**5**	**31**	**-**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	-	-	-	-	-	-
Marine	-	-	-	-	-	-
Motor	-	-	-	-	-	-
Health	-	-	-	-	-	-
Miscellaneous	-	-	-	-	-	-
Total	**-**	**-**	**-**	**-**	**-**	**-**

5. Constraints which cause delay in settlement of claims

Non Support of insured for submission of documents& non agreement of surveyor report.

6. Initiatives taken by the company to ensure expeditious settlement of claims

Placing cases before National LokAdalat& attending Conciliations.

7. Institutional Framework for review of repudiated claims

Strong GRC intervention and systematic review of claim files and documents & defined SOP and Manual in place.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	136
State Commission	18
National Commission	2
Motor Claims related	
MACT	2917
Appeals with High Court	4
Appeals before Supreme Court	-
Other policyholder related cases	
Civil Courts	13
High Courts @	1
Supreme Court	-
Total	14
@ of these, the number of appeals against orders of Insurance Ombudsman	

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like LokAdalat, Settlement camps etc.)

Negotiation with the claimant advocates and convincing the claimants on quantum for amicable settlement out of court.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
LokAdalat	29	51,07,000	294	5,65,85,533	290	7,59,00,422
Camps	-	-	-	-	-	-
Others (give details)	-	-	-	-	-	-
TOTAL	**29**	**51,07,000**	**294**	**5,65,85,533**	**290**	**7,59,00,422**

NAME OF THE INSURER: **SHRIRAM GENERAL INSURANCE COMPANY LIMITED**

1 Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	56	26	21	67	65	53	97	70	22	0	0	4	26	21	48
Marine	5	9	4	21	10	4	17	15	4	0	0	2	9	4	2
Motor	12523	16151	27632	78404	79307	40176	69895	63948	32497	4881	3878	2543	16151	27632	32768
Health	6	17	21	57	78	50	46	74	50	0	0	3	17	21	18
Miscellaneous	20	65	86	96	172	84	51	146	83	0	5	25	65	86	62
Total	**12610**	**16268**	**27764**	**78645**	**79632**	**40367**	**70106**	**64253**	**32656**	**4881**	**3883**	**2577**	**16268**	**27764**	**32898**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	5	4	5	10	14	2	36	27	8	40	20	5	6	5	2
Marine	3	5	0	2	4	1	6	4	2	4	2	0	2	0	1
Motor	18213	14366	9862	38028	30236	15240	8879	9961	4175	3447	6079	1483	1328	3306	1737
Health	5	26	9	21	24	22	18	15	14	2	7	5	0	2	0
Miscellaneous	8	13	2	10	42	18	12	39	24	14	33	20	7	19	19
Total	**18234**	**14414**	**9878**	**38071**	**30320**	**15283**	**8951**	**10046**	**4223**	**3507**	**6141**	**1513**	**1343**	**3332**	**1759**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	3	7	33	7	3	5	3	3	3	10	6	3	3	2	4
Marine	1	0	0	1	0	0	0	0	0	3	1		4	3	2
Motor	4556	4921	4609	4119	5515	4752	2054	4030	4101	1961	5982	7438	3461	7184	11868
Health	5	6	3	4	5	4	4	4	3	1	1	1	3	5	7
Miscellaneous	6	16	17	17	13	10	12	15	4	12	19	13	18	23	18
Total	**4571**	**4950**	**4662**	**4148**	**5536**	**4771**	**2073**	**4052**	**4111**	**1987**	**6009**	**7455**	**3489**	**7217**	**11899**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	NA	NA	NA	NA	NA	NA
Marine	NA	NA	NA	NA	NA	NA
Motor	NA	NA	NA	NA	NA	NA
Health	NA	NA	NA	NA	NA	NA
Miscellaneous	NA	NA	NA	NA	NA	NA
Total	NA	NA	NA	NA	NA	NA

5. Constraints which cause delay in settlement of claim

Delay in survey report submission, Late submission of claim documents by insured, Delay in repairs by insured, Surveyors are not guiding insured about required documents

6. Initiatives taken by the company to ensure expeditious settlement of claims

Implemented online submission of survey report, offering customers for Cash loss settlement, Guidance to insured through call center, claim team & surveyors, formation of Help Desk SATHI who interact with customer after registration of claim

7. Institutional Framework for review of repudiated claims

We have proper system and process in place for claim settlement. We have separate claim Audit team who verify claims before settlement.

8. Statistics of cases of policyholders / claimants before Consumer Forum /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	1624
State Commission	221
National Commission	17
High Courts	2
Motor Claims related	
MACT	51371
Appeals with High Court	4655
Appeals before Supreme Court	28
WCC	3186
Other policyholder related cases	
Civil Courts	15
High Courts @	0
Supreme Court	0
Total	**61119**
@ of these, the number of appeals against orders of Insurance Ombudsman	

9. Initiatives taken by the company for settlement of cases pending before various Foram and Courts (like Lok Adalat, Settlement camps etc.)

Active Participation in Lok Adalat, out of Court settlement with claimants on Mutual understanding, inquiry about TP claim from insured at the time of registration of OD claim and initiate process to settle such TP claim

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	837	83514655	2792	453833196	1376	312181747
Compromised through TP-CHD in Court	45	10744886	120	61188907	90	67602609
TOTAL	**882**	**94259541**	**2912**	**515022103**	**1466**	**379784356**

NAME OF THE INSURER: **STAR HEALTH AND ALLIED INSURANCE COMPANY LTD**

1 Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Marine	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Motor	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Health	26709	27448	30507	250338	321400	167626	183527	248363	119629	66072	69978	52090	27448	30507	26414
Miscellaneous	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**26709**	**27448**	**30507**	**250338**	**321400**	**167626**	**183527**	**248363**	**119629**	**66072**	**69978**	**52090**	**27448**	**30507**	**26414**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Marine	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Motor	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Health	159663	228095	113330	22007	19077	6063	1397	937	183	376	169	37	84	85	16
Miscellaneous	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**159663**	**228095**	**113330**	**22007**	**19077**	**6063**	**1397**	**937**	**183**	**376**	**169**	**37**	**84**	**85**	**16**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Marine	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Motor	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Health	15990	19809	17206	8349	7696	6283	1831	1965	1743	667	754	694	611	283	488
Miscellaneous	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**15990**	**19809**	**17206**	**8349**	**7696**	**6283**	**1831**	**1965**	**1743**	**667**	**754**	**694**	**611**	**283**	**488**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	NIL	NIL	NIL	NIL	NIL	NIL
Marine	NIL	NIL	NIL	NIL	NIL	NIL
Motor	NIL	NIL	NIL	NIL	NIL	NIL
Health	NIL	NIL	NIL	NIL	NIL	NIL
Miscellaneous	NIL	NIL	NIL	NIL	NIL	NIL
Total	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**

5. Constraints which cause delay in settlement of claims

We have not encountered any constraints with respect to Retail and Market business.

With respect to Overseas Travel Policies:

1. Delay in receipt of the medical records and bills by the overseas hospital in case of cashless claims.
2. Delay in receipt of the claim documents by the customer in case of reimbursement claims since the customer waits to complete his trip and the documents are submitted upon arrival to India.
3. Improper claim documents.

6. Initiatives taken by the company to ensure expeditious settlement of claims

1) 24*7 customer care centre to address the need of customers.
2) Cashless handling through Medical personnel within two hours.
3) 6640 Network Hospitals to render cashless settlement.
4) Network hospitals with agreed package rates.
5) Team of Field Visit personnel to visit patients at hospitals which help the patients to get better attention by network hospitals.
6) Payment of claims through NEFT mode.
7) Addressing the grievance of customers on real time basis.
8) Providing claim procedure sheet along with the policy documents, the list of documents to be submitted.
9) Regular follow up with the overseas hospital for medical records and bills.

7. Institutional Framework for review of repudiated claims

We have a dedicated team consisting of Insurance Medical Legal professionals to review repudiated claims and to take appropriate decision.

After repudiation ,if the customer represents then Grievance Department will review the claim

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	747
State Commission	47
National Commission	2
Motor Claims related	
MACT	**
Appeals with High Court	1
Appeals before Supreme Court	1
Other policyholder related cases	
Civil Courts	25
High Courts @	**
Supreme Court	**
Total	**823**
@ of these, the number of appeals against orders of Insurance Ombudsman	10

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

With respect to retail and market business the cases pending before the Consumer Forum are further reviewed by the Company in consultation with the Doctors and wherever it is feasible within the terms and conditions of the Policy, we are taking all the steps to negotiate, compromise and settle the cases amicably.

Settlements are made within 7 working days from the date of receipt of the order/award/any consent letter from the complainant.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	122	6423665	118	5608864	65	4723996
Camps	0	0	0	0	0	0
Others (give details)	0	0	0	0	0	0
TOTAL	**122**	**6423665**	**118**	**5608864**	**65**	**4723996**

NAME OF THE INSURER: **TATA AIG GENERAL INSURANCE CO LTD**

1 Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	2207	2154	2523	20689	25784	8551	13737	16208	7157	1195	1617	638	2154	2523	1635
Marine	3766	3321	2965	15752	16119	13351	10319	10565	7907	1891	2108	1126	3321	2965	4990
Motor	10283	11240	9647	255626	243356	119594	231356	220444	106693	1683	2456	1217	11240	9647	11398
Health	304	389	3044	8221	83244	30056	5654	72310	24236	1023	2775	1767	389	3044	4035
Miscellaneous	9121	7023	4773	47974	54697	26496	42920	45486	20296	616	435	177	7023	4773	6399
Total	**25681**	**24127**	**22952**	**348262**	**423200**	**198048**	**303986**	**365013**	**166289**	**6408**	**9391**	**4925**	**24127**	**22952**	**28457**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	8250	9230	3596	3670	4880	2413	1014	1149	651	545	632	314	258	317	183
Marine	2982	3283	3778	3864	4037	2721	2080	1983	816	1043	940	415	350	322	177
Motor	134364	135785	69637	83951	72261	32760	10049	8995	3153	2588	2785	911	404	618	232
Health	2813	67063	21312	2330	4157	2240	394	836	507	101	221	147	16	33	30
Miscellaneous	12920	13378	7360	23662	25453	11242	4316	4842	1131	1661	1505	467	361	308	96
Total	**161329**	**228739**	**105683**	**117477**	**110788**	**51376**	**17853**	**17805**	**6258**	**5938**	**6083**	**2254**	**1389**	**1598**	**718**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	921	1059	315	248	239	323	362	503	334	323	403	354	300	319	309
Marine	1297	1006	2737	544	312	662	617	593	669	463	540	379	400	514	543
Motor	7078	6563	7963	1812	799	1016	1303	1042	1169	636	686	590	411	557	660
Health	183	2263	3093	86	371	547	64	244	250	20	120	66	36	46	79
Miscellaneous	2115	2639	3807	827	310	556	1634	585	733	1145	450	289	1302	789	1014
Total	**11594**	**13530**	**17915**	**3517**	**2031**	**3104**	**3980**	**2967**	**3155**	**2587**	**2199**	**1678**	**2449**	**2225**	**2605**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	0	0	0	0	0	0
Marine	0	0	0	0	0	0
Motor	0	0	0	0	0	0
Health	0	0	0	0	0	0
Miscellaneous	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**

5. Constraints which cause delay in settlement of claims

- Delay in reporting Claims
- Non submission / Delayed submission of requested documents/reports by insured
- Repair/reinstatement happens over a period of time

6. Initiatives taken by the company to ensure expeditious settlement of claims

- Robust monitoring system in place for speedy settlement of claims
  - o Weekly report
  - o LOB wise monthly report
  - o Monthly Benchmark report
  - o Claim handler wise monthly No activity report
- Quarterly review of all claims pending over 90 days is mandatory
- Frequent follow up mails/letter sent to insured for documents submission
- Frequent follow up with surveyor for survey report submission
- Service level agreement with corporate clients / affinity partners on claim process protocol and documentation
- Proactive release of on account payment where repair / reinstatement is taking time

7. Institutional Framework for review of repudiated claims

- All claim repudiations are done at the level of Line head in Corporate Office.
- All customer grievances / litigations including Consumer Fora & Ombudsman cases, pertaining to repudiation of claim, are reviewed by the Line Head and Claims Legal Head.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	608
State Commission	106
National Commission	25
Motor Claims related	
MACT	8,388
Appeals with High Court	287
Appeals before Supreme Court	1
Other policyholder related cases	
Civil Courts	69
High Courts @	7
Supreme Court	1
Total	**9,492**
@ of these, the number of appeals against orders of Insurance Ombudsman	No appeals from order of Ombudsman

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

- Where any new evidence is brought out by the Insured / Complainant – the claim is reviewed and settled, if the claim is in order.
- Where the claim is pending for documentation, a specific stand is taken in the written statement stating the requirement of the documents.
- Our Advocates are specifically instructed to report the evidence before the Consumer Foras and inform us where they feel the need to review our decision.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat/ consent Award	1,656	27,69,47,297	2,514	40,60,89,046	1,105	20,95,71,268
Camps	0	0	0	0	0	0
Others (give details) JRY	64	83,53,893	30	92,77,950	9	17,54,337
TOTAL	1,720	28,53,01,190	2,544	41,53,66,996	1,114	21,13,25,605
TOTAL INCL. AWARDS	**2,203**	**43,15,67,564**	**3,152**	**64,35,13,135**	**1,487**	**38,02,74,393**

NAME OF THE INSURER: **THE ORIENTAL INSURANCE COMPANY LTD.**

1 Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire															
Marine	5262	3806	3908	4756	7024	5350	6136	6813	3422	76	109	35	3806	3908	5801
Motor															
Health	53460	52966	59923	518162	620182	319538	502747	594311	287418	15083	18914	16207	53792	59923	75836
Miscellaneous -Aviation	155	133	214	97	192	68	119	111	88	0	0	0	133	214	194
Total															

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire															
Marine	3441	4029	2235	241	523	234	707	742	348	1048	987	326	775	641	314
Motor															
Health Insurance	325494	494381	251538	121181	82900	31987	47071	12631	3422	8941	4024	402	60	375	69
Miscellaneous-Aviation	14	55	26	4	2	2	9	4	3	36	15	10	56	35	47
Total															

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	Not Received														
Marine	652	667	3079	526	498	536	672	801	623	960	967	769	996	975	794
Motor	Not Received														
Health Insurance	34361	45363	46313	13513	9553	19860	4956	2672	5948	861	1346	2780	101	989	935
Miscel-Aviation	32	95	36	2	4	13	9	11	54	17	23	40	73	81	51
Total															

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	Not Received					
Marine						
Motor						
Health						
Miscellaneous						
Total						

5. Constraints which cause delay in settlement of claims

- Delay of Survey Reports submission
- Delay of submission of documents by the insured
- GA & Salvage claims take longer to finalise settlement
- Repairing of Ships & Aircraft take longer time.
- Disposal of salvage takes time specially for bulk cargo
- Export claim take longer for finalize settlement."

6. Initiatives taken by the company to ensure expeditious settlement of claims

- Quick submission of survey repots
- Resolution of disputes through negotiation.
- Regular review of pending claims
- Counseling /Followup with clients for documents submission"

7. Institutional Framework for review of repudiated claims

- Repudiated claim are reviewed by Higher office as and when complaints are received.
- Grievance redressal mechanism at RO/HO level including through company's portal.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	6425
State Commission	2968
National Commission	475
Motor Claims related	
MACT	137341
Appeals with High Court	37736
Appeals before Supreme Court	1175
Other Courts	
Civil Courts	449
High Courts @	0
Supreme Court	0
Total	
@ of these, the number of appeals against orders of Insurance Ombudsman	7

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

1. Financial Authority of our officers has been enhanced considerably due to which number of cases settled in Lok Adalats has increased substantially even at district level.

2. Compromise manual has been issued by the dept in 2014 for giving clear and simpler guidelines for easier settlement of MACT claims.

3. Opening of Common Mechanism for compromise settlement at state level wef 2011 .The common mechanism Committee comprise of a Retired District Judge, a retired Scale V or higher ranked Officer (from GIPSA Member Companies / GIC) and an orthopaedic surgeon, either serving or retired Civil Surgeon. This process has helped in speedy settlement small cases, specially injury cases."

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	11611	NA	15741	NA	1755	NA
Camps	NA	NA	NA	NA	NA	NA
Others (give details)	NA	NA	NA	NA	NA	NA
TOTAL	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**

NAME OF THE INSURER: **UNITED INDIA INSURANCE COMPANY LIMITED**

1 Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	2886	2780	3175	5858	6627	3324	5551	5697	2220	413	535	138	2780	3175	4141
Marine	5462	5184	4804	16955	16453	7880	16273	15587	6731	960	1246	548	5184	4804	5405
Motor	220420	253372	226672	395455	354229	176995	340510	377609	144308	21993	3320	1850	253372	226672	257509
Health	45128	122538	74064	1885905	963586	749015	1786515	992441	595194	21980	19619	43498	122538	74064	184387
Miscellaneous	23929	23678	25330	130392	131715	47941	124866	122838	41337	5777	7225	2842	23678	25330	29092
Total	**297825**	**407552**	**334045**	**2434565**	**1472610**	**985155**	**2273715**	**1514172**	**789790**	**51123**	**31945**	**48876**	**407552**	**334045**	**480534**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	187	160	75	278	266	132	1096	982	417	1585	1234	468	1252	1328	514
Marine	1229	1010	565	1825	1698	988	4293	4022	1930	4703	3645	1458	2981	3064	1057
Motor	93505	117370	21855	70547	88501	52422	41920	38080	13847	28002	22175	9182	84633	72455	36708
Health	534835	227149	33885	207545	79869	131606	724090	465930	185694	296009	169260	233126	11374	27522	3864
Miscellaneous	22468	23731	3688	15851	12759	9563	44220	34506	14336	25613	25995	6236	9822	14137	4044
Total	**652224**	**369420**	**60068**	**296046**	**183093**	**194711**	**815619**	**543520**	**216224**	**355912**	**222309**	**250470**	**110062**	**118506**	**46187**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	372	477	531	281	118	221	458	456	1032	748	893	952	921	1231	1405
Marine	682	672	376	685	248	459	866	821	966	1494	1183	1286	1457	1880	2318
Motor	11171	10783	12180	17377	9182	25750	23536	13545	26207	31365	29001	24449	169923	164161	168923
Health	63991	7711	10169	52356	1612	103813	1872	9367	15811	2140	28353	23886	2179	27021	30708
Miscellaneous	4014	3990	3996	3973	2790	1885	4001	3651	5065	5364	4558	6646	6326	10341	11500
Total	**80230**	**23633**	**27252**	**74672**	**13950**	**132128**	**30733**	**27840**	**49081**	**41111**	**63988**	**57219**	**180806**	**204634**	**214854**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	NIL	NIL	NIL	NIL	NIL	NIL
Marine	NIL	NIL	NIL	NIL	NIL	NIL
Motor	NIL	NIL	NIL	NIL	NIL	NIL
Health	NIL	NIL	NIL	NIL	NIL	NIL
Miscellaneous	NIL	NIL	NIL	NIL	NIL	NIL
Total	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**

5. Constraints which cause delay in settlement of claims

1. Delay in getting the required documentation from the insured.
2. Complex nature of claims requiring detailed study and investigation.
3. Claims on Reinstatement value basis of settlement take longer time since the property has to be reinstated.
4. Surveyor's, investigator's reports requiring detailed clarifications.

6. Initiatives taken by the company to ensure expedious settlement of claims

1. Specialised service hubs have been started and functioning in 25 centres across the country which has got the expertise in quicker settlement of claims.
2. Claims disposal ratio is a key result area for performance appraisal of all offices.
3. Special drives are undertaken at Head Office/Regional Office level to ensure speedy disposal of claims.
4. Customer sensitisation programme are conducted for frontline officers at all operating offices for spreading awareness on customer needs, PPI regulations and Citizen's charter .

7. Institutional Framework for review of repudiated claims

The Company has adopted a Board approved Customer Grievance Redressal System (CGRS) for dealing with grievances against repudiation of claims and on policy/claims related issues. Accordingly, complaints against a claim repudiated at BO will be reopened & reviewed by DO, Claims repudiated at DO will be reviewed by RO Technical Department, Claims repudiated at RO will be reviewed by HO Technical Department respectively. All health claims are referred to the respective policy issuing office for approval/repudiation by the TPA concerned. Total Loss and Theft claims are referred to RO for approval/repudiation by the operating office.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts as on 30/09/2014

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	8079
State Commission	3351
National Commission	524
Motor Claims related	
MACT	203212
Appeals with High Court	47195
Appeals before Supreme Court	210
Other policyholder related cases	
Civil Courts	155
High Courts @	843 - (NIL against Ombudsman Order)
Supreme Court	39
Total	
@ of these, the number of appeals against orders of Insurance Ombudsman	

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

The Company is laying great emphasis on settlement of claims through Lok Adalats. Various circulars and directions are being issued from time to time and the progress is monitored from Head Office. Great importance was given to Mega Lok Adalat held in December, 2014 which was a great success (The figures are not included in the statistics given below)

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	8146	125.96	21093	326.15	5713	88.34
Camps	0	0	0	0	0	0
Others (give details)	1083	17.87	0	0	0	0
TOTAL	**9229**	**143.83**	**21093**	**326.15**	**5713**	**88.34**

NAME OF THE INSURER: **UNIVERSAL SOMPO GENERAL INSURANCE CO.LTD.**

1 Statistics of Number of Claims received, disposed, pending for the category wise for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	192	193	191	839	1069	602	680	922	464	158	149	84	193	191	245
Marine	167	140	113	1955	2486	1466	1958	2477	1405	24	36	19	140	113	155
Motor - OD	2606	3157	2059	33126	30855	17433	31893	31464	16822	682	489	330	3157	2059	2340
Motor - TP	1819	3358	5093	2459	3087	1591	904	1352	886	16	0	0	3358	5093	5798
Motor - (OD+TP)	4425	6515	7152	35585	33942	19024	32797	32816	17708	698	489	330	6515	7152	8138
Health	1564	1707	2117	18433	28082	18631	16944	25242	16004	1346	2430	1693	1707	2117	3051
Miscellaneous	730	805	795	5316	6551	3410	4798	6012	2550	443	549	799	805	795	856
Total	**7078**	**9360**	**10368**	**62128**	**72130**	**43133**	**57177**	**67469**	**38131**	**2669**	**3653**	**2925**	**9360**	**10368**	**12445**

2. Statistics of time taken for disposal of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	168	197	214	193	304	118	232	336	134	211	207	65	34	27	17
Marine	1337	1909	1106	311	266	207	212	224	90	110	108	16	12	6	5
Motor - OD	17382	16375	10313	10334	10332	5316	3322	3689	1345	1420	1452	177	117	105	1
Motor - TP	87	104	40	71	57	51	110	148	53	231	435	161	421	608	581
Motor - (OD+TP)	17469	16479	10353	10405	10389	5367	3432	3837	1398	1651	1887	338	538	713	582
Health	9131	16908	11269	6854	9024	5396	1877	1533	976	374	207	56	54		
Miscellaneous	2473	3144	1630	1536	2117	1123	728	737	435	415	468	107	89	95	54
Total	**30578**	**38637**	**24572**	**19299**	**22100**	**12211**	**6481**	**6667**	**3033**	**2761**	**2877**	**582**	**727**	**841**	**658**

3. Statistics of age-wise pendency of claims for 2012-13, 2013-14 and 2014-15 up to Sep 30, 2014

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15	2012-13	2013-14	2014-15
Fire	34	37	69	65	49	71	38	56	59	38	28	24	18	21	22
Marine	57	51	66	57	33	55	19	22	26	6	5	6	1	2	2
Motor - OD	1408	1157	1552	1022	618	600	531	283	186	184	1	2	12		
Motor - TP	255	73	175	555	380	496	888	646	825	461	1594	1000	1199	2400	3302
Motor - (OD+TP)	1663	1230	1727	1577	998	1096	1419	929	1011	645	1595	1002	1211	2400	3302
Health	1207	1532	1952	454	486	971	44	98	127	2	1	1			
Miscellaneous	249	246	316	229	210	240	144	113	90	84	85	61	99	141	149
Total	3210	3096	4130	2382	1776	2433	1664	1218	1313	775	1714	1094	1329	2564	3475

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		(01 APR 2014 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	Nil	Nil	Nil	Nil	Nil	Nil
Marine	Nil	Nil	Nil	Nil	Nil	Nil
Motor	Nil	Nil	Nil	Nil	Nil	Nil
Health	Nil	Nil	Nil	Nil	Nil	Nil
Miscellaneous	Nil	Nil	Nil	Nil	Nil	Nil
Total	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**

NB: The above summary excludes claims of Motor TP / MACT .

5. Constraints which cause delay in settlement of claims

The main constraints which cause delay in settlement of claims are

- Delay in reinstatement / repairs of vehicles / property
- Delay in carrying out repairs associated with unavailability of spares.
- Delay in issuance of Final Police report.
- Non Compliance of documentation to establish liability and assessment by insured
- Long time taken in courts for MACT TP/legal claims

6. Initiatives taken by the company to ensure expeditious settlement of claims

Proactive initiatives have been taken towards expeditious settlement of claims

a) Decentralization of claims settlement at Zonal Offices. This has resulted in settlement of more than 90 % claims at local level.

b) Online motor surveyor assessment module implemented for quicker submission of reports and monitoring

c) Online processing and approval of claims, thus reducing TAT as physical movement of claim files is reduced.

d) Strict monitoring of health claims through TPA for quicker settlement.

e) Regular proactive follow up is done and reminders by way of letter, mails and phones calls are made to insured keeping the concerned marketing personnel in loop for better coordination and communication. Wherever required meetings are arranged with insured to explain and clarify the requirements. In case of difficulty in compliance alternative means are suggested for adoption in consultation with the surveyor to take the claim forward. Insured is also persuade to complete repairs quickly in cases where policy is on reinstatement / replacement basis.

7. Institutional Framework for review of repudiated claims

a) All repudiations go through rigorous process of thorough scrutiny at the Zonal and Corporate Office levels involving Claims Department , Underwriting and Marketing Department. No Claim would be declined without Corporate Office Approval

b) The Zonal Claims team based on survey / investigation / relevant papers thoroughly scrutinize claims considered for declinature. The Zonal Underwriter and Branch Manager is also informed for their opinion.

c) In case of agreement on declinature at Zonal level the complete file is dispatched to Corporate Claims Office recommending repudiation where the file is again thoroughly scrutinized to check if grounds of declinature are in order.

d) Thereafter the matter is referred to respective Underwriting and Marketing Heads for their opinion.

In case grounds of declinature are not found sound the same is referred back to Zone for taking the claim forward for settlement on merits.

e) In case of concurrence on the grounds of declinature being justified, the declinature of the claim is approved at Corporate Office which is conveyed to insured in writing detailing the grounds of declinature.

f) Insured is also given an opportunity to represent their case against declinature which if received is again scrutinized in detail on points raised and reverted depending on the outcome.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	371
State Commission	81
National Commission	3
Total Consumer Courts	455
Motor Claims related	
MACT	5994
Appeals with High Court	89
Appeals before Supreme Court	NIL
Total Motor Claims related	6083
Other policyholder related cases	
Civil Courts	2
High Courts @	NIL
Supreme Court	NIL
Grand Total	**6540**
@ of these, the number of appeals against orders of Insurance Ombudsman	NIL

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

a) On receipt of a claim, its genuinity is established , and where found in order ,the advocate is instructed to initiate steps for settlement.

b) Depending on the volume in the States ;Monthly Camps are initiated to settle and conclude the fit claims

c) The Company is actively involved in the participation in the Mega Lok Adalats and Lok Adalats initiated by the respective State Legal Authorities.

d) Where the claims are directly reported to the Company and the same is found to be genuine, efforts are made to settle the claim even before these are filed in Court.

10. Statistics of cases settled out of court (specify other mechanisms)

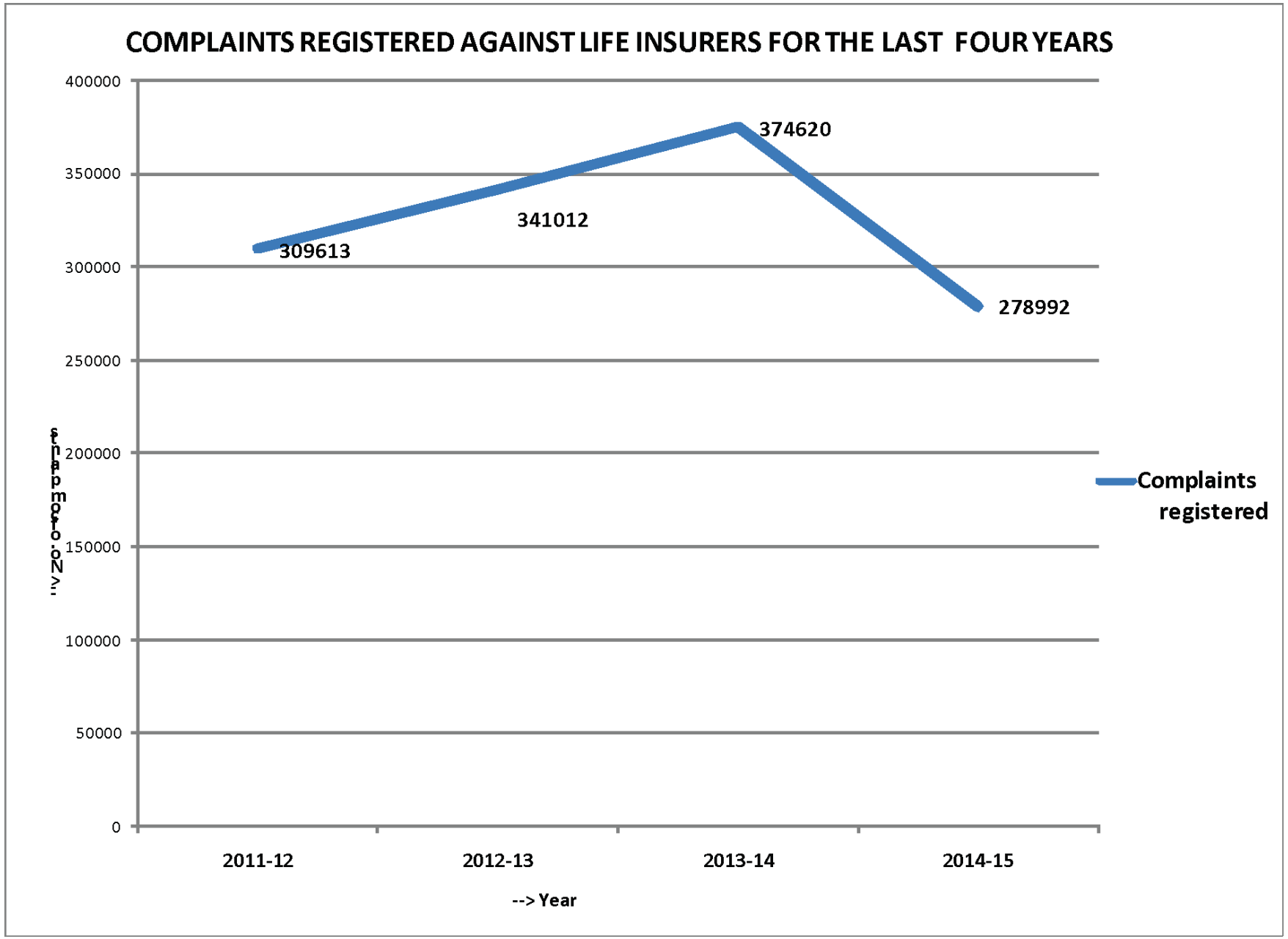
Category	YR(2012-13)		YR(2013-14)		(01 APR 14 to 30 SEP 2014)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	58	1,59,77,715	261	4,95,27,443	229	4,85,20,104
Camps	87	93,57,842	215	3,60,23,444	153	3,57,16,639
Others (give details)	-	-	-	-	-	-
TOTAL	**145**	**2,53,35,557**	**476**	**8,55,50,887**	**382**	**8,42,36,743**

Data on Grievances - Life Insurers

1. Cursory glance of registered & 'attended to' Life Complaints
2. Complaints registered against Life Insurers - Graphical Presentation
3. Movement of Complaints
4. Analysis of registered Life Complaints
5. Classification of Life Complaints - Graphical Presentation
6. Analysis of Unfair Business Practice Complaints
7. ULIP Complaints - Graphical Presentation
8. State-wise Distribution of Complaints

CURSORY GLANCE OF COMPLAINTS REGISTERED AND ATTENDED TO LIFE INSURERS

S. No.	Description	2011-12		2012-13		2013-14		2014-15	
		Registered	Attended to	Registered	Attended to	Registered	Attended to	Registered	Attended to
1	Complaints registered by Policyholders directly online in IGMS	4871	4686	7472	7383	14472	14183	4903	4423
2	Complaints registered through IRDA	7292	7137	16520	16485	17333	17113	16462	15359
3	Compliants registered by Life Insurers	297450	296508	317020	317202	342815	342186	257627	253729
	Total:	**309613**	**308331**	**341012**	**341070**	**374620**	**373482**	**278992**	**273511**


COMPLAINTS REGISTERED AGAINST LIFE INSURERS FOR THE LAST FOUR YEARS
400000
350000
300000
250000
200000
150000
100000
50000
0
309613
341012
374620
278992
2011-12
2012-13
2013-14
2014-15
--> Year
Complaints registered

MOVEMENT OF COMPLAINTS - LIFE INSURERS

S. No	Insurer	2013-14			2014-15			
		Reported during the year	Attended to during the year	Pending at the end of the year	Opening Balance year	Reported during the year	Attended to during the the year	Pending at the end of
1	LIC	85284	85828	0	0	80944	80944	0
(i)	Public total:	85284	85828	0	0	80944	80944	0
1	Aegon Religare	6826	6775	76	76	6897	6602	371
2	Aviva	6606	6606	0	0	4185	4185	0
3	Bajaj Allianz	52314	52308	10	10	19795	19530	275
4	Bharti Axa	7365	7402	16	16	5642	5307	351
5	Birla Sun Life	30825	30917	40	40	23629	23658	11
6	Canara HSBC	4351	4353	0	0	4559	4500	59
7	DHFL Pramerica	1392	1383	42	42	1593	982	653
8	Edleweiss Tokio	232	233	0	0	514	481	33
9	Exide Life	6459	6459	13	13	9488	8867	634
10	Future Generali	11676	11632	101	101	5390	5110	381
11	HDFC Standard	52402	51882	666	666	32214	30582	2298
12	ICICI Prudential	19697	19677	33	33	11801	11775	59
13	IDBI Federal	864	865	2	2	771	773	0
14	India First	1500	1461	47	47	1287	1216	118
15	Kotak Mahindra	6165	6169	8	8	4616	4496	128
16	Max Life	19389	19395	0	0	16553	16549	4
17	PNB MetLife	4362	4365	4	4	4820	4817	7
18	Reliance	30659	30748	45	45	24763	24318	490
19	Sahara	24	25	0	0	27	27	0
20	SBI Life	16061	16067	5	5	12273	12263	15
21	Shri Ram	287	279	8	8	240	234	14
22	Star Union Daichi	1319	1314	9	9	2301	2215	95
23	Tata AIA	8561	8521	55	55	4690	4632	113
(ii)	Private Total:	289336	288836	1180	1180	198048	193119	6109
	Grand total:	**374620**	**374664**	**1180**	**1180**	**278992**	**274063**	**6109**

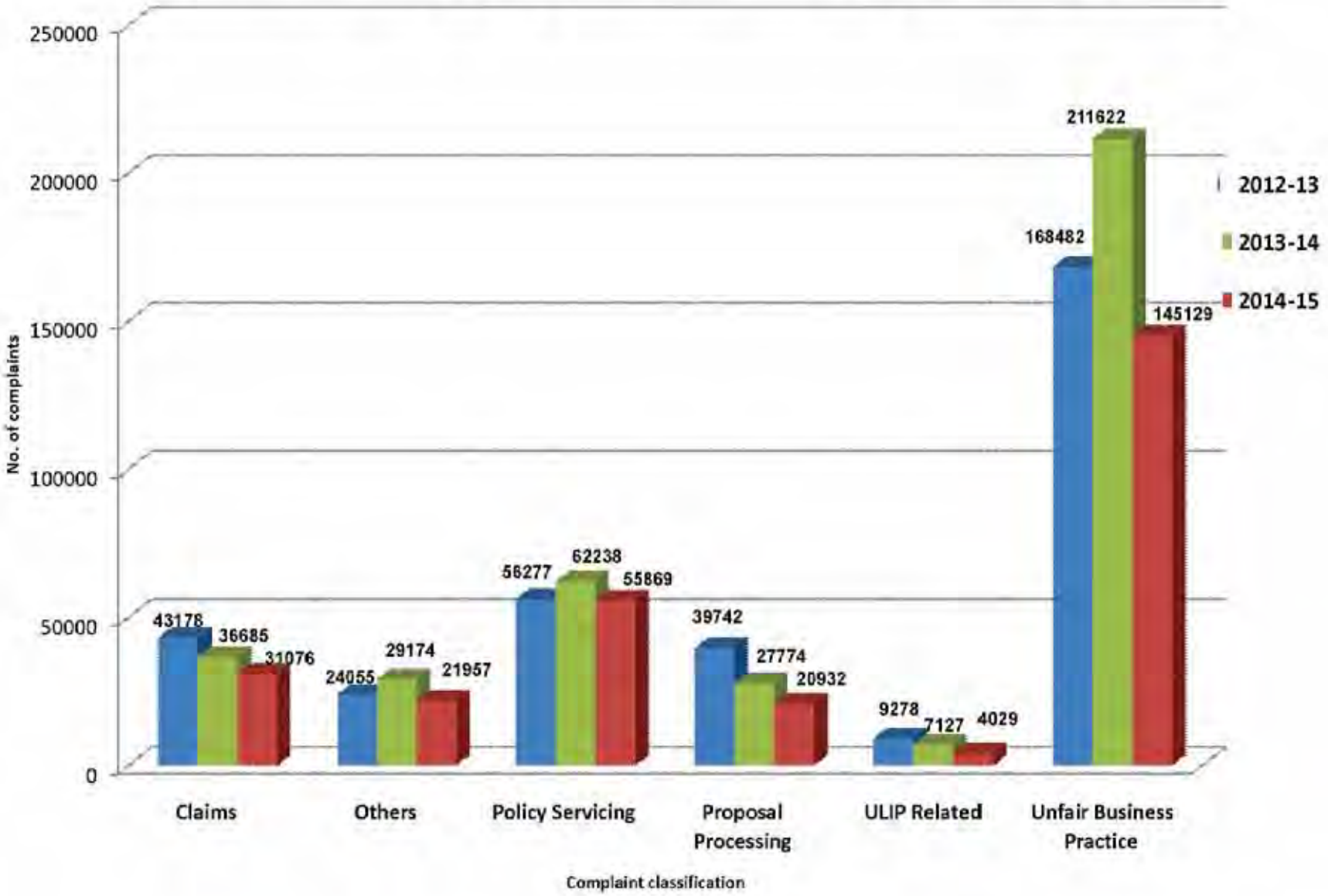
ANALYSIS OF REGISTERED LIFE COMPLAINTS (2013-14)

S. No	Name of the Insurer	Death Claims		Others		Policy Servicing		Proposal Processing		Survival Claims		ULIP Related	Unfair Business Practice		Total		
		Non-Linked	ULIP	Non-Linked	ULIP	Non-Linked	ULIP	Non-Linked	ULIP	Non-Linked	ULIP		Non-Linked	ULIP	Non-Linked	ULIP	Total (A+B)
1	LIC	2176	68	16761	1144	39014	1433	4823	217	15194	989	965	2458	42	**80426**	**4858**	**85284**
(i)	**Public total:**	**2176**	**68**	**16761**	**1144**	**39014**	**1433**	**4823**	**217**	**15194**	**989**	**965**	**2458**	**42**	80426	4858	85284
1	Aegon Religare	11	4	39	6	484	383	112	20	114	202	4	4517	930	**5277**	**1549**	**6826**
2	Aviva	31	5	407	85	1077	258	209	56	200	140	438	3619	81	**5543**	**1063**	**6606**
3	Bajaj Allianz	637	140	326	94	825	282	424	146	2753	940	1817	43820	110	**48785**	**3529**	**52314**
4	Bharti AXA	23	0	85	11	608	6	847	1	182	4	273	2711	2614	**4456**	**2909**	**7365**
5	Birla Sunlife	296	41	2076	183	1446	498	852	169	1053	462	375	22264	1110	**27987**	**2838**	**30825**
6	Canara HSBC	4	15	3	1	119	803	384	958	10	128	291	377	1258	**897**	**3454**	**4351**
7	DHFL Pramerica	36	4	32	7	38	16	117	12	15	47	2	1007	59	**1245**	**147**	**1392**
8	Edleweiss Tokio	0	0	3	0	18	0	23	0	0	0	0	182	6	**226**	**6**	**232**
9	Future Generali	18	10	4267	17	12	6	2554	991	17	24	8	3405	347	**10273**	**1403**	**11676**
10	HDFC Standard	173	125	655	286	1852	1416	1811	887	1946	942	637	28974	12698	**35411**	**16991**	**52402**
11	ICICI Prudential	114	86	327	50	115	46	192	46	214	29	768	14970	2740	**15932**	**3765**	**19697**
12	IDBI Federal	14	1	30	2	8	1	12	0	7	6	6	526	251	**597**	**267**	**864**
13	IndiaFirst	47	5	14	1	122	29	127	13	120	19	58	932	13	**1362**	**138**	**1500**
14	ING Vysya	37	1	318	81	823	175	531	60	981	429	171	2852	0	**5542**	**917**	**6459**
15	Kotak Mahindra	31	1	218	54	140	103	91	17	130	16	119	3088	2157	**3698**	**2467**	**6165**
16	Max Life	113	23	401	169	2255	3161	2477	1087	288	718	210	6390	2097	**11924**	**7465**	**19389**
17	PNB MetLife	112	33	9	4	122	255	83	67	53	144	188	1885	1407	**2264**	**2098**	**4362**
18	Reliance	448	90	471	63	497	382	1732	29	398	267	283	24222	1777	**27768**	**2891**	**30659**
19	Sahara	2	0	2	0	1	2	0	0	6	7	0	3	1	**14**	**10**	**24**
20	SBI Life	74	15	186	77	636	400	3479	1255	535	888	231	6223	2062	**11133**	**4928**	**16061**
21	Shri Ram	11	0	26	15	9	6	15	1	12	4	6	171	11	**244**	**43**	**287**
22	Star Union Daichi	6	4	29	20	122	182	111	116	29	129	11	261	299	**558**	**761**	**1319**
23	Tata AIA	100	76	87	32	1311	741	525	95	300	333	266	2822	1873	**5145**	**3416**	**8561**
(ii)	Private Total:	2338	679	10011	1258	12640	9151	16708	6026	9363	5878	6162	175221	33901	**226281**	**63055**	**289336**
	Total [(i) + (ii)]	4514	747	26772	2402	51654	10584	21531	6243	24557	6867	7127	177679	33943	**306707**	**67913**	**374620**
	Grand Total	**5261**		**29174**		**62238**		**27774**		**31424**		**7127**	**211622**		**374620**		

ANALYSIS OF REGISTERED LIFE COMPLAINTS (2014-15)

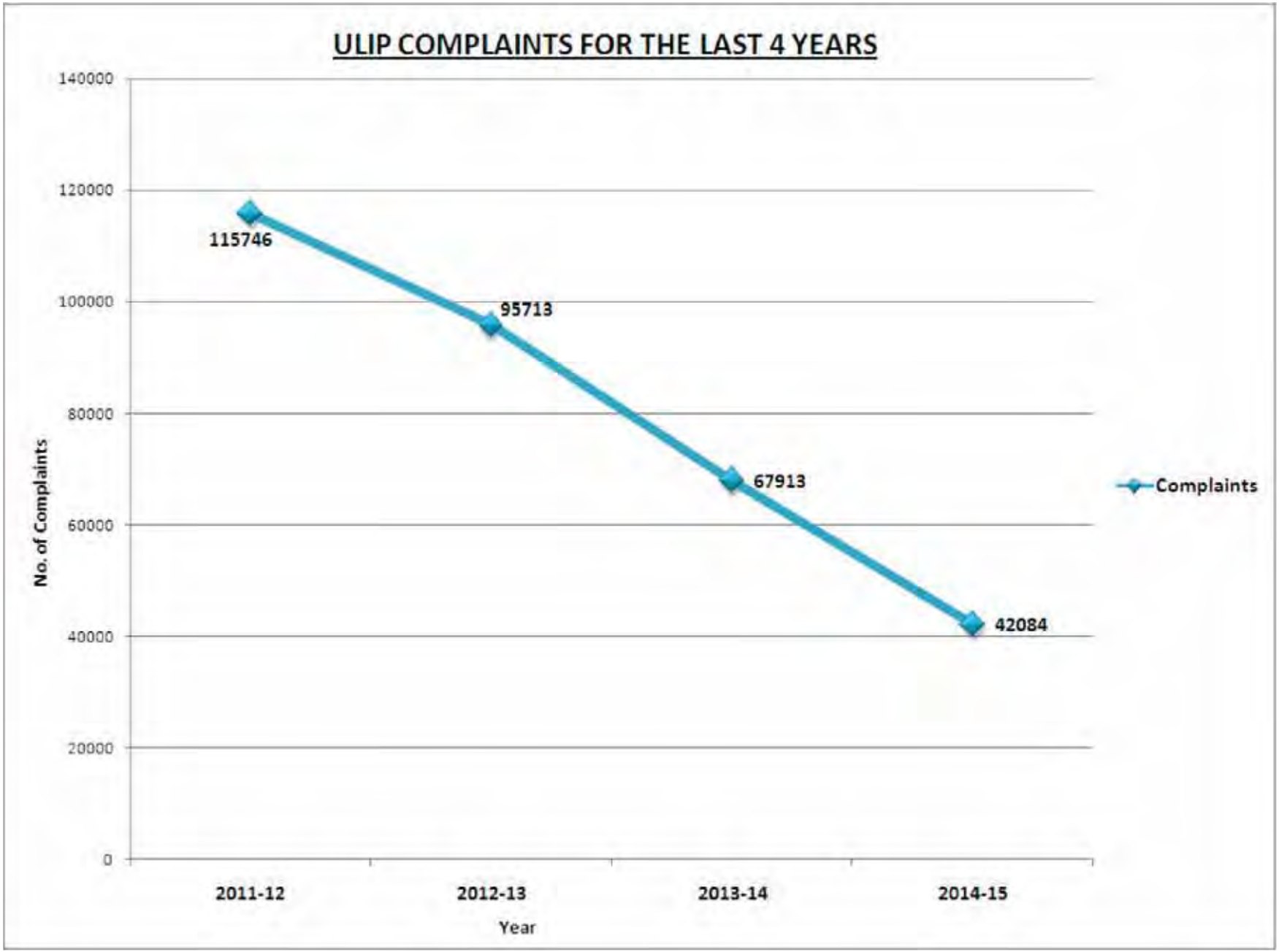
S. No	Name of the Insurer	Death Claims		Others		Policy Servicing		Proposal Processing		Survival Claims		ULIP Related	Unfair Business Practice		Total		
		Non-Linked	ULIP	Non-Linked	ULIP	Non-Linked	ULIP	Non-Linked	ULIP	Non-Linked	ULIP		Non-Linked	ULIP	Non-Linked	ULIP	Total (A+B)
1	LIC	1653	53	15741	940	39086	1182	4046	128	14267	796	689	2340	23	**77133**	**3811**	**80944**
(i)	**Public total:**	**1653**	**53**	**15741**	**940**	**39086**	**1182**	**4046**	**128**	**14267**	**796**	**689**	**2340**	**23**	77133	3811	80944
1	Aegon Religare	9	2	33	1	456	292	95	5	84	139	5	5441	335	**6118**	**779**	**6897**
2	Aviva	25	1	120	39	805	99	128	40	110	51	150	2579	38	**3767**	**418**	**4185**
3	Bajaj Allianz	100	8	180	60	365	52	165	20	750	121	831	17064	79	**18624**	**1171**	**19795**
4	Bharti AXA	22	0	75	17	334	4	364	11	198	3	195	2021	2398	**3014**	**2628**	**5642**
5	Birla Sunlife	207	25	1145	147	1281	359	613	76	824	291	210	17797	654	**21867**	**1762**	**23629**
6	Canara HSBC	5	10	1	0	210	892	510	868	11	301	266	498	987	**1235**	**3324**	**4559**
7	DHFL Pramerica	18	5	22	5	52	16	109	13	33	53	4	1197	66	**1431**	**162**	**1593**
8	Edleweiss Tokio	3	0	2	0	25	0	144	1	0	0	0	329	10	**503**	**11**	**514**
9	Exide Life	46	2	233	32	948	105	635	47	1622	232	168	5418	0	**8902**	**586**	**9488**
10	Future Generali	32	10	271	13	16	8	977	258	50	30	8	3472	245	**4818**	**572**	**5390**
11	HDFC Standard	315	62	421	136	1136	512	1328	455	1367	518	267	20377	5320	**24944**	**7270**	**32214**
12	ICICI Prudential	128	36	226	29	95	25	106	8	219	24	317	8187	2401	**8961**	**2840**	**11801**
13	IDBI Federal	21	0	13	2	8	0	12	0	18	3	0	547	147	**619**	**152**	**771**
14	IndiaFirst	26	1	12	0	110	19	48	5	99	22	17	921	7	**1216**	**71**	**1287**
15	Kotak Mahindra	74	3	172	52	188	102	82	17	95	22	104	2486	1219	**3097**	**1519**	**4616**
16	Max Life	187	31	446	136	1316	1337	2560	1247	672	266	94	6647	1614	**11828**	**4725**	**16553**
17	PNB MetLife	78	18	14	2	293	301	107	142	225	422	209	2267	742	**2984**	**1836**	**4820**
18	Reliance	382	73	708	106	852	319	1097	54	720	407	146	18829	1070	**22588**	**2175**	**24763**
19	Sahara	3	0	3	0	0	1	0	0	9	4	0	6	1	**21**	**6**	**27**
20	SBI Life	127	23	219	68	612	318	2955	987	569	485	145	4647	1118	**9129**	**3144**	**12273**
21	Shri Ram	16	0	17	1	7	2	14	3	13	3	8	153	3	**220**	**20**	**240**
22	Star Union Daichi	11	7	33	16	307	429	106	91	78	421	16	385	401	**920**	**1381**	**2301**
23	Tata AIA	66	29	30	18	637	356	213	42	223	253	180	1800	843	**2969**	**1721**	**4690**
24	**Private Total:**	**1901**	**346**	**4396**	**880**	**10053**	**5548**	**12368**	**4390**	**7989**	**4071**	**3340**	**123068**	**19698**	159775	38273	198048
	Total [(i) + (ii)]	**3554**	**399**	**20137**	**1820**	**49139**	**6730**	**16414**	**4518**	**22256**	**4867**	**4029**	**125408**	**19721**	236908	42084	278992
	Grand Total	**3953**		**21957**		**55869**		**20932**		**27123**		**4029**	**145129**		**278992**		

CLASSIFICATION OF LIFE COMPLAINTS FOR THE LAST THREE YEARS

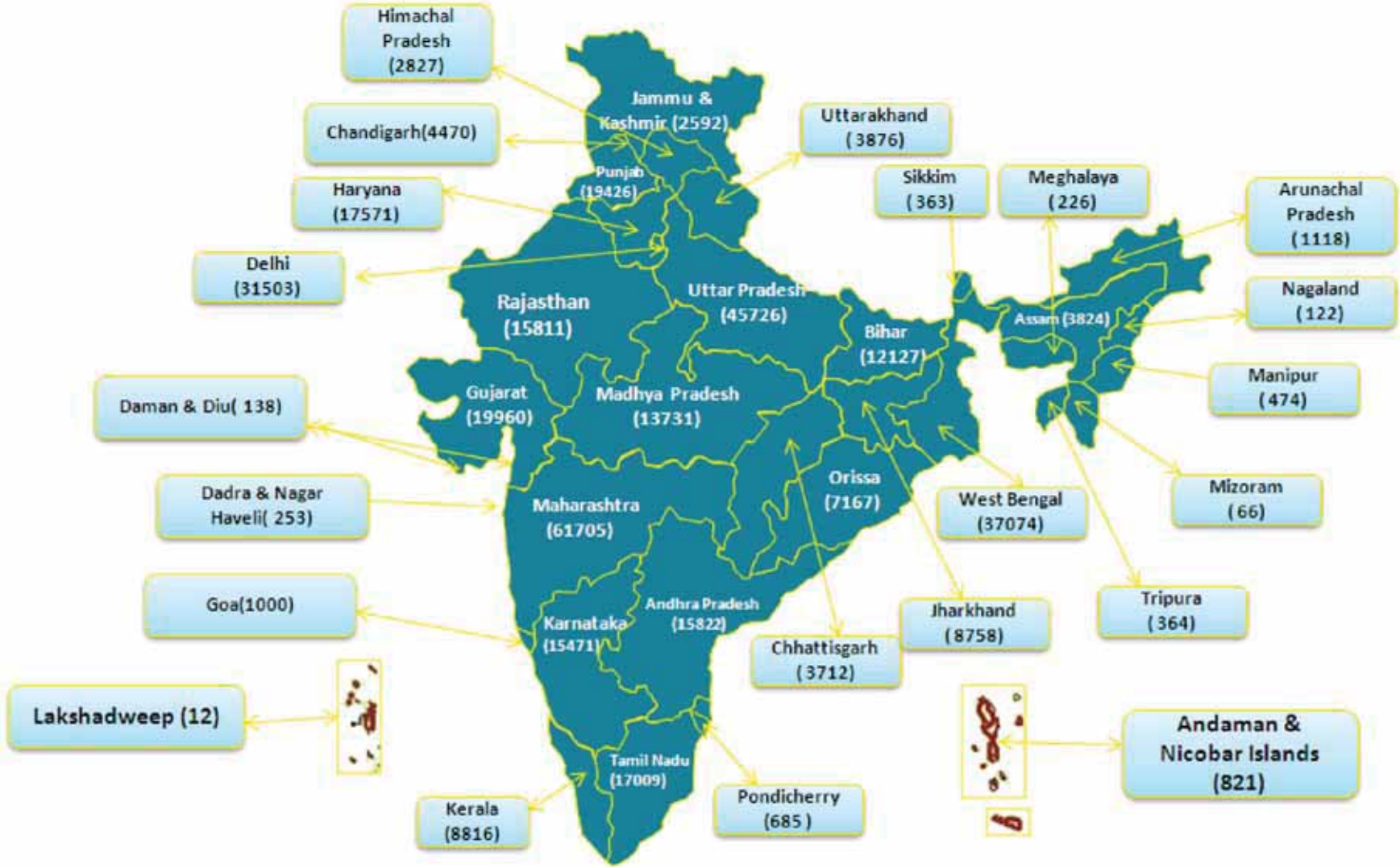


ANALYSIS OF 'UNFAIR BUSINESS PRACTICE' COMPLAINTS FOR THE LAST 3 YEARS

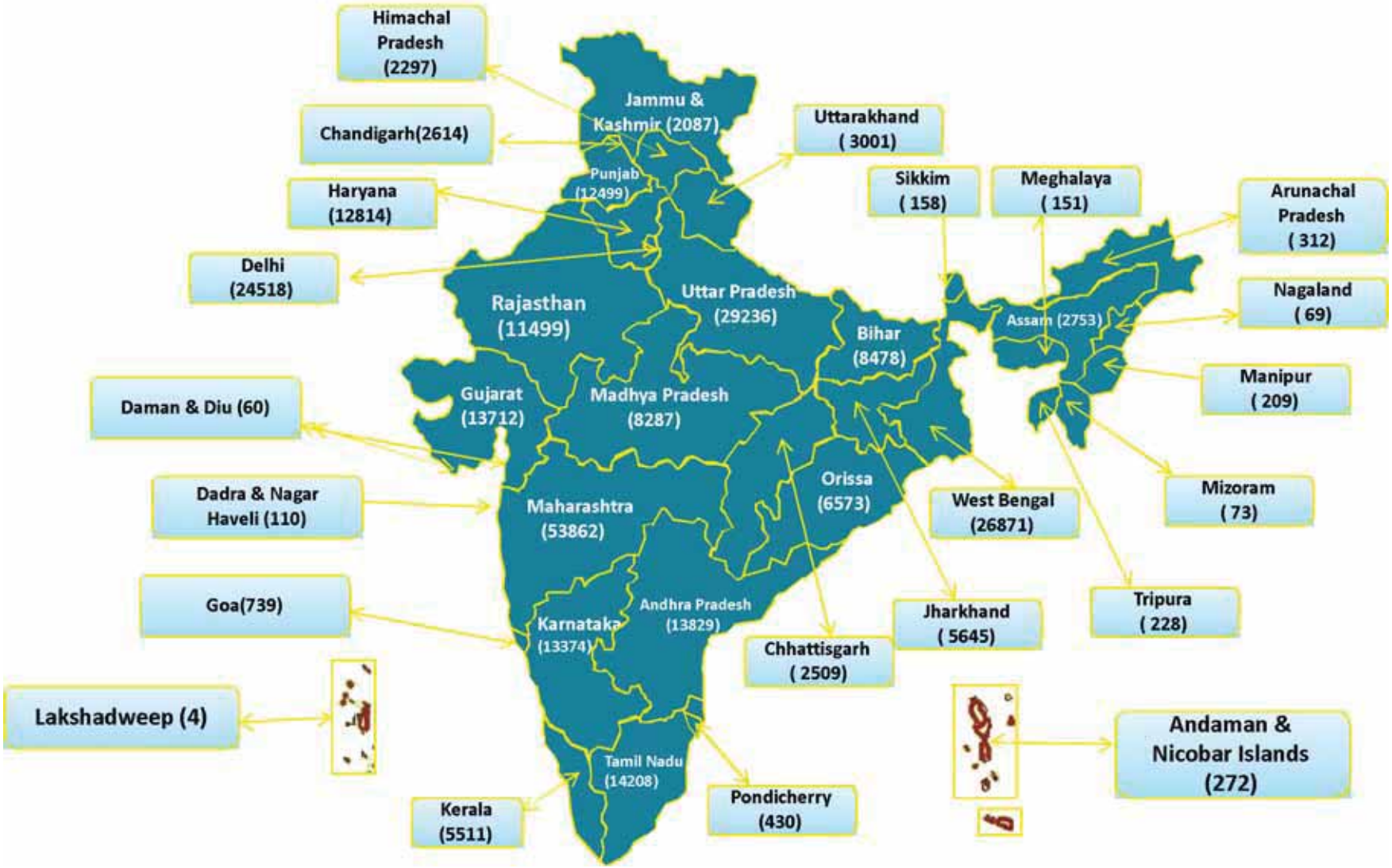
S. No.	Complaint Description	Conventional			Health			Pension			ULIP			Others			Total		
		2014-15	2013-14	2012-13	2014-15	2013-14	2012-13	2014-15	2013-14	2012-13	2014-15	2013-14	2012-13	2014-15	2013-14	2012-13	2014-15	2013-14	2012-13
1	Advice concerning Exclusions/limitations of cover not communicated	101	77	46	4	6	7	4	2	5	36	98	114	24	18	16	169	201	188
2	Annuity/Commutation/Cash Option / Rider/other Options not included as requested	74	90	125	2	1	1	40	27	41	16	22	53	23	25	21	155	165	241
3	Credit/Debit card debited without consent of Consumer	321	314	263	8	8	7	4	7	10	45	156	111	19	22	16	397	507	407
4	Do Not Call Registry	93	215	244		5	7	3	14	11	117	193	342	65	86	68	278	513	672
5	Free-look refund not paid	4340	7421	5080	54	36	33	86	78	85	997	1677	4038	983	2345	1327	6460	11557	10563
6	Illegitimate inducements offered	5030	5485	2277	13	10	7	38	29	11	877	1180	779	812	616	286	6770	7320	3360
7	Intermediary did not provide material information concerning proposed cover	2936	2604	928	29	17	30	51	49	38	812	1229	575	2868	1842	614	6696	5741	2185
8	Malpractices	35619	45577	39062	338	339	270	484	758	780	9001	14389	19916	17393	18915	8095	62835	79978	68123
9	Misappropriation of premiums	2929	4543	4154	28	42	51	40	50	96	1057	1454	1760	617	896	646	4671	6985	6707
10	Mode of premium payment differs from requested or disclosed	574	764	698	12	7	9	12	27	15	131	281	371	119	130	120	848	1209	1213
11	Premium paying period projected is different from actual	1224	1920	2080	6	6	7	13	33	29	668	1268	1170	278	458	326	2189	3685	3612
12	Product differs from what was requested or disclosed.	4373	8882	12082	62	107	146	78	162	214	1053	3334	5961	526	923	881	6092	13408	19284
13	Proposed Insurance not in the interest of proposer	5102	7065	3980	50	43	23	53	44	15	1263	1585	574	153	163	68	6621	8900	4660
14	Single premium Policy issued as Annual premium policy	4564	6707	8014	11	14	21	58	115	142	1377	2403	2805	10260	33360	14429	16270	42599	25411
15	Spurious Calls		0	0		0	0		0	0		0	0	9994	7359	6339	9994	7359	6339
16	Surrender value projected is different from actual	516	687	559	1	7	7	17	38	35	417	900	819	88	142	113	1039	1774	1533
17	Tampering, Corrections, forgery of proposal or related papers	9825	13013	8649	48	80	56	84	147	84	1550	3110	2730	862	1039	682	12369	17389	12201
18	Term(Period) of the policy is different/ altered without consent	843	1516	1143	4	1	9	13	30	24	304	664	480	112	121	127	1276	2332	1783
	Total	**78464**	**106880**	**89384**	**670**	**729**	**691**	**1078**	**1610**	**1635**	**19721**	**33943**	**42598**	**45196**	**68460**	**34174**	**145129**	**211622**	**168482**


ULIP COMPLAINTS FOR THE LAST 4 YEARS
140000
120000
100000
80000
60000
40000
20000
0
No. of Complaints
115746
95713
67913
42084
2011-12
2012-13
2013-14
2014-15
Year
Complaints

STATE WISE DISTRIBUTION OF COMPLAINTS - LIFE (2013-14)



STATE WISE DISTRIBUTION OF COMPLAINTS - LIFE - 2014-15

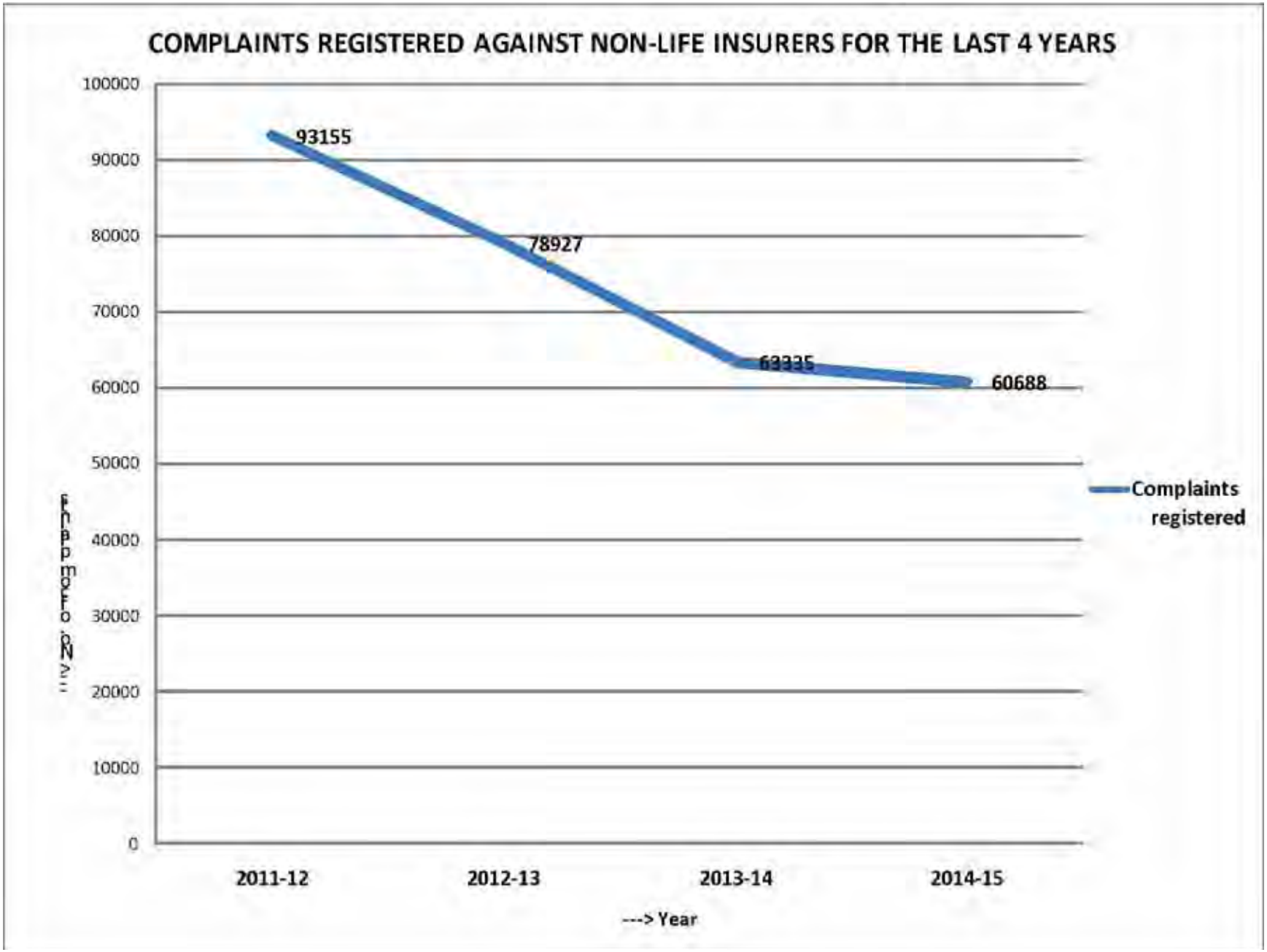


Data on Grievances - Non-Life Insurers

1. Cursory glance of registered & 'attended to' Non-Life Complaints
2. Complaints registered against Non-Life Insurers - Graphical Presentation
3. Movement of Complaints
4. Analysis of registered Non-Life Complaints
5. Classification of Non-Life Complaints - Graphical Presentation
6. Class-wise Non-Life Industry Complaints
7. Class-wise Non-Life Complaints - Graphical Presentation
8. Analysis of Health Insurance Complaints
9. Analysis of Motor Insurance Complaints
10. State-wise Distribution of Complaints

CURSORY GLANCE OF COMPLAINTS REGISTERED AND ATTENDED TO NON-LIFE INSURER

S. No.	Description	2011-12		2012-13		2013-14		2014-15	
		Registered	Attended to	Registered	Attended to	Registered	Attended to	Registered	Attended to
1	Complaints registered by Policyholders directly online in IGMS	3070	2740	4305	4387	4181	4031	2787	2612
2	Complaints registered through IRDA	4861	4448	6486	6761	6697	6540	7260	6816
3	Complaints registered by Non-Life Insurers	85224	84372	68136	68139	52457	52096	50640	49352
	Total:	**93155**	**91560**	**78927**	**79287**	**63335**	**62667**	**60687**	**58780**

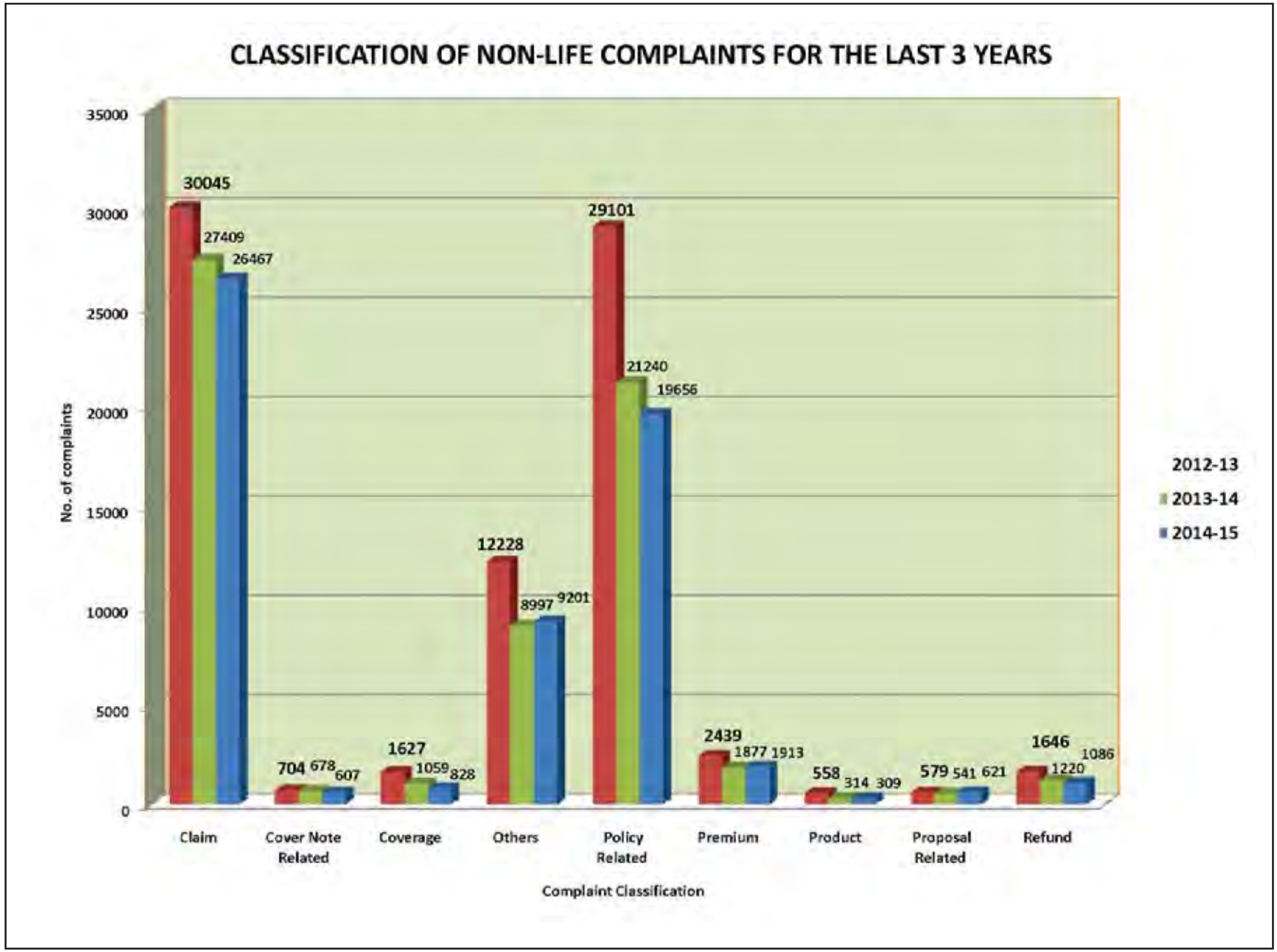

COMPLAINTS REGISTERED AGAINST NON-LIFE INSURERS FOR THE LAST 4 YEARS
100000
90000
80000
70000
60000
50000
40000
30000
20000
10000
0
93155
78927
62335
60688
2011-12
2012-13
2013-14
2014-15
---> Year
Complaints registered

MOVEMENT OF COMPLAINTS - NON-LIFE INSURERS

S. No	Insurer	2013-14			2014-15			
		Reported during the year	Attended to during the year	Pending at the end of the year	Opening Balance year	Reported during the year	Attended to during the the year	Pending at the end of
1	Agriculture Insurance*	-	-	-	-	-	-	-
2	ECGC of India	108	77	43	43	46	43	46
3	National Insurance	4954	5068	256	256	4740	4821	175
4	The New India Assurance	3610	3613	99	99	3204	3201	102
5	The Oriental Insurance	2789	3004	66	66	2165	2172	59
6	United India Insurance	6197	6321	218	218	5705	5868	55
(i)	**Total - PSU insurers**	**17658**	**18083**	**682**	**682**	**15860**	**16105**	**437**
1	Apollo MUNICH Health Insurace	1761	1760	3	3	2061	1815	13
2	Bajaj Allianz General Insurance	6361	6358	5	5	4770	4199	204
3	Bharati Axa General Insurance	5356	5356	0	0	4586	3347	105
4	Cholamandalam MS General Insurance	2847	2842	10	10	2508	1849	103
5	CignaTTK Health Insurance	0	0	0	0	75	40	4
6	Future Generali India Ins.	4229	4229	0	0	3727	2832	0
7	HDFC ERGO General Insurance	1173	1172	2	2	2086	1435	23
8	ICICI Lombard General Insurance	6854	6855	24	24	5930	4415	372
9	IFFCO Tokio General Insurance	3373	3368	9	9	2043	1679	163
10	L&T General. Insurance	148	148	1	1	431	329	5
11	Liberty Videocon Genral Insurance	88	88	0	0	356	226	6
12	Magma HDI General Insurance	43	43	0	0	101	76	9
13	Max Bupa Health Insurance	613	618	2	2	427	338	0
14	Raheja QBE	0	0	0	0	0	0	0
15	Reliance General Insurance	2598	2618	40	40	1762	1344	67
16	Religare Health Insurance	184	185	0	0	423	303	2
17	Royal Sundaram Alliance General Insurance	2915	2917	2	2	4976	3475	66
18	SBI General Insurance	881	849	42	42	1325	823	317
19	Shriram General Insurance	210	212	0	0	135	106	0
20	Star Health and Allied Insurance	577	567	12	12	2785	1552	166
21	Tata- AIG General Insurance	4947	4948	0	0	3963	3016	37
22	Universal Sompo							
	General Ins	**519**	**520**	**0**	**0**	**358**	**279**	**0**
	Total Private Insurers	**45677**	**45653**	**152**	**152**	**44828**	**33478**	**1662**
	Grand Total [(i)+(ii)]	**63335**	**63736**	**834**	**834**	**60688**	**49583**	**2099**

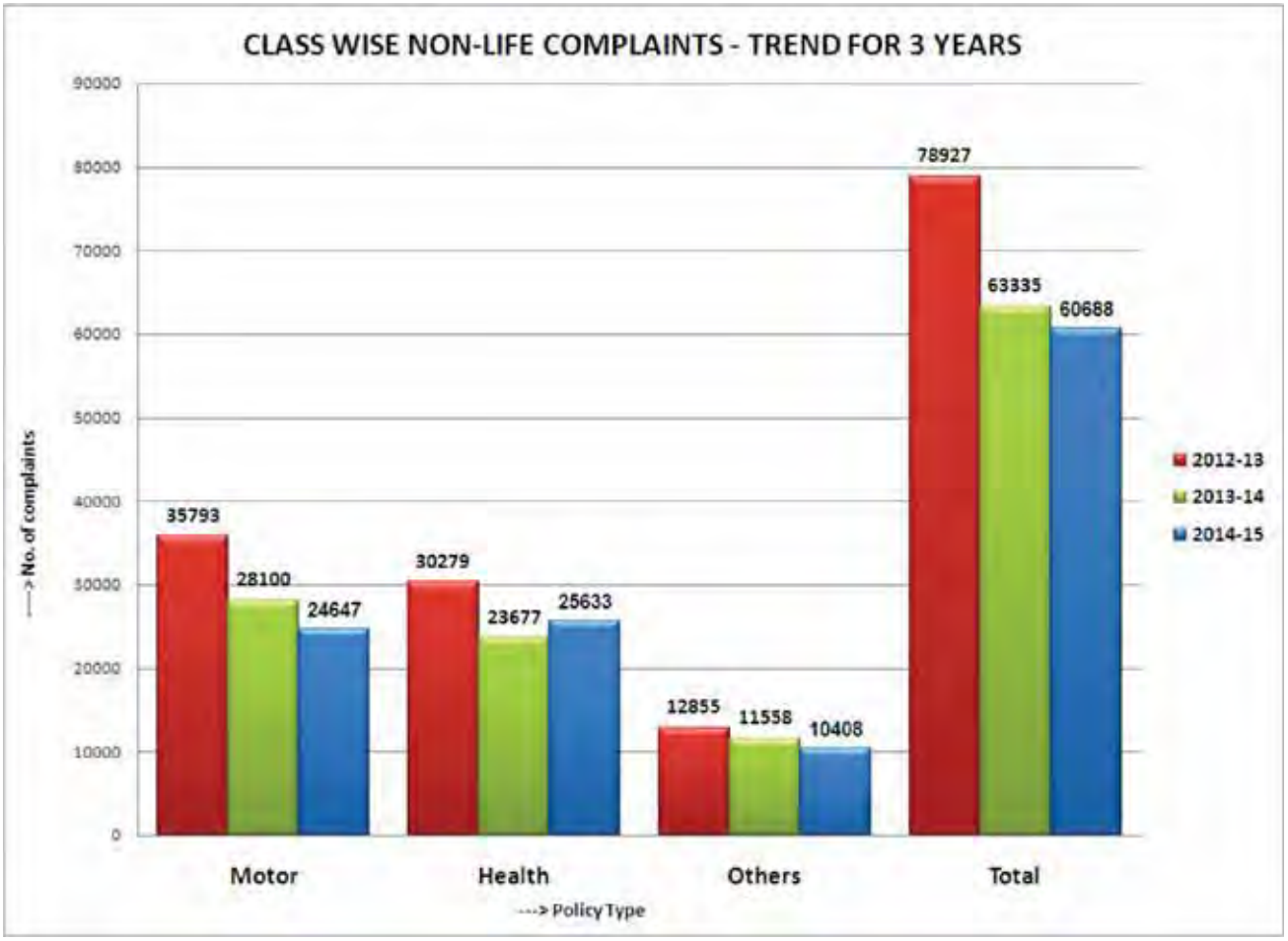
ANALYSIS OF REGISTERED NON-LIFE COMPLAINTS

S. No	Name of the Insurer	Claim		Cover Note Related		Coverage		Others		Policy Related		Premium		Product		Proposal Related		Refund		Total	
		2013-14	2014-15	2013-14	2014-15	2013-14	2014-15	2013-14	2014-15	2013-14	2014-15	2013-14	2014-15	2013-14	2014-15	2013-14	2014-15	2013-14	2014-15	2013-14	2014-15
1	Agriculture Insurance	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
2	ECGC of India	103	38	0	0	0	2	1	1	3	0	1	0	0	0	0	4	0	1	108	46
3	National Insurance	2672	2549	74	47	38	22	1442	1410	536	527	120	103	11	18	8	11	53	53	4954	4740
4	The New India Assurance	2898	2506	3	3	10	9	225	198	321	370	92	63	6	4	3	3	52	48	3610	3204
5	The Oriental Insurance	1735	1378	22	17	25	12	341	274	454	317	162	138	3	1	8	8	39	20	2789	2165
6	United India Insurance	3833	3245	78	52	56	56	697	695	1111	1248	261	260	12	12	21	24	128	113	6197	5705
(i)	Total - PSU insurers	11241	9716	177	119	129	101	2706	2578	2425	2462	636	564	32	35	40	50	272	235	17658	15860
1	Apollo MUNICH Health Insurace	722	1152	0	0	41	12	217	213	594	453	24	74	6	13	112	93	45	51	1761	2061
2	Bajaj Allianz General Insurance	847	684	161	130	31	24	2028	1735	2763	1762	159	83	11	13	150	261	211	78	6361	4770
3	Bharati Axa General Insurance	2141	2335	97	30	30	35	162	114	2694	1841	78	56	27	13	23	13	104	149	5356	4586
4	Cholamandalam MS Gen. Ins.	1126	752	40	54	0	2	41	154	1616	1499	0	2	13	12	1	1	10	32	2847	2508
5	CignaTTK Health	0	7	0	2	0	4	0	39	0	6	0	2	0	0	0	7	0	8	0	75
6	Future Generali India Ins.	2157	1797	117	125	4	3	255	169	1510	1433	27	15	82	107	67	71	10	7	4229	3727
7	HDFC ERGO General Insurance	668	1008	64	129	4	2	118	128	287	799	5	3	3	10	13	1	11	6	1173	2086
8	ICICI Lombard General Insurance	1547	1991	3	1	6	13	1175	1284	3218	1652	694	845	10	12	8	12	193	120	6854	5930
9	IFFCO Tokio General Insurance	2043	1401	7	0	4	3	116	197	1168	409	17	17	1	4	6	3	11	9	3373	2043
10	L&T General. Insurance	33	99	0	0	0	1	27	98	72	167	0	7	1	3	2	10	13	46	148	431
11	Liberty Videocon General Ins.	30	234	0	2	1	1	6	11	47	93	2	3	2	2	0	2	0	8	88	356
12	Magma HDI General Insurance	15	62	2	0	2	0	8	10	14	21	1	3	0	1	0	1	1	3	43	101
13	Max Bupa Health Insurance	319	286	0	0	15	2	99	60	60	28	7	23	74	8	19	10	20	10	613	427
14	Raheja QBE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
15	Reliance General Insurance	1355	577	5	2	5	7	672	898	500	222	20	21	18	19	6	7	17	9	2598	1762
16	Religare Health Insurance	85	209	0	0	1	6	41	109	12	32	7	10	1	1	29	23	8	33	184	423
17	Royal Sundaram Alliance Gen. Ins.	801	1146	0	2	7	14	405	493	1527	3146	64	75	22	37	7	10	82	53	2915	4976
18	SBI General Insurance	193	312	1	3	2	5	170	352	479	575	16	16	2	8	4	8	14	46	881	1325
19	Shriram General Insurance	188	102	0	0	1	0	9	9	7	21	0	1	0	0	2	1	3	1	210	135
20	Star Health and Allied Insurance	371	1224	0	0	4	5	61	128	46	1346	75	43	0	3	10	15	10	21	577	2785
21	Tata- AIG General Insurance	1133	1071	4	7	772	588	667	413	2098	1646	44	48	9	8	40	22	180	160	4947	3963
22	Universal Sompo General Ins	394	302	0	1	0	0	14	9	103	43	1	2	0	0	2	0	5	1	519	358
	Total Private Insurers	**16168**	**16751**	**501**	**488**	**930**	**727**	**6291**	**6623**	**18815**	**17194**	**1241**	**1349**	**282**	**274**	**501**	**571**	**948**	**851**	**45677**	**44828**
	Grand Total [(i)+(ii)]	**27409**	**26467**	**678**	**607**	**1059**	**828**	**8997**	**9201**	**21240**	**19656**	**1877**	**1913**	**314**	**309**	**541**	**621**	**1220**	**1086**	**63335**	**60688**


CLASSIFICATION OF NON-LIFE COMPLAINTS FOR THE LAST 3 YEARS
No. of complaints
35000
30000
25000
20000
15000
10000
5000
0
30045
27409
26467
704
678
607
1627
1059
828
12228
8997
9201
29101
21240
19656
2439
1877
1913
558
314
309
579
541
621
1646
1220
1086
Claim
Cover Note Related
Coverage
Others
Policy Related
Premium
Product
Proposal Related
Refund
Complaint Classification
2012-13
2013-14
2014-15

CLASS-WISE NON-LIFE INDUSTRY COMPLAINTS FOR THREE YEARS

S.No.	Sector of Insurnace	2012-13	2013-14	2014-15
1	Motor	35793	28100	24647
2	Health	30279	23677	25633
3	Others	12855	11558	10408
	Total:	**78927**	**63335**	**60688**



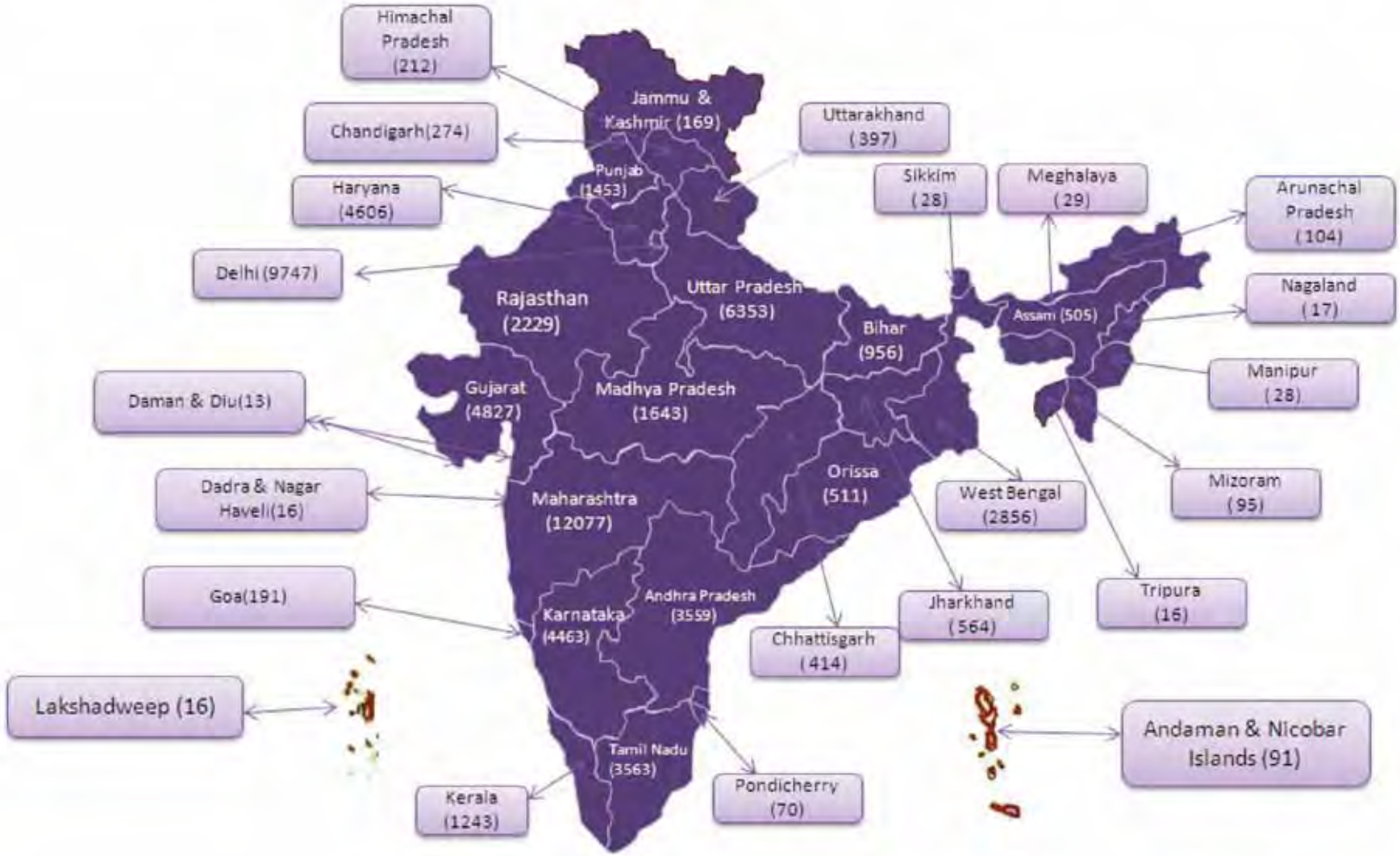
ANALYSIS OF HEALTH INSURANCE COMPLAINTS FOR THE LAST THREE FINANCIAL YEARS

S.No	Complaint Type	2014-15	2013-14	2012-13
1	Claim	11184	10309	11249
2	Coverage	152	179	298
3	Others	4877	5078	7403
4	Policy Related	7455	6165	8883
5	Premium	1071	1045	1163
6	Product	111	142	404
7	Proposal Related	362	291	269
8	Refund	421	468	610
	Total	**25633**	**23677**	**30279**

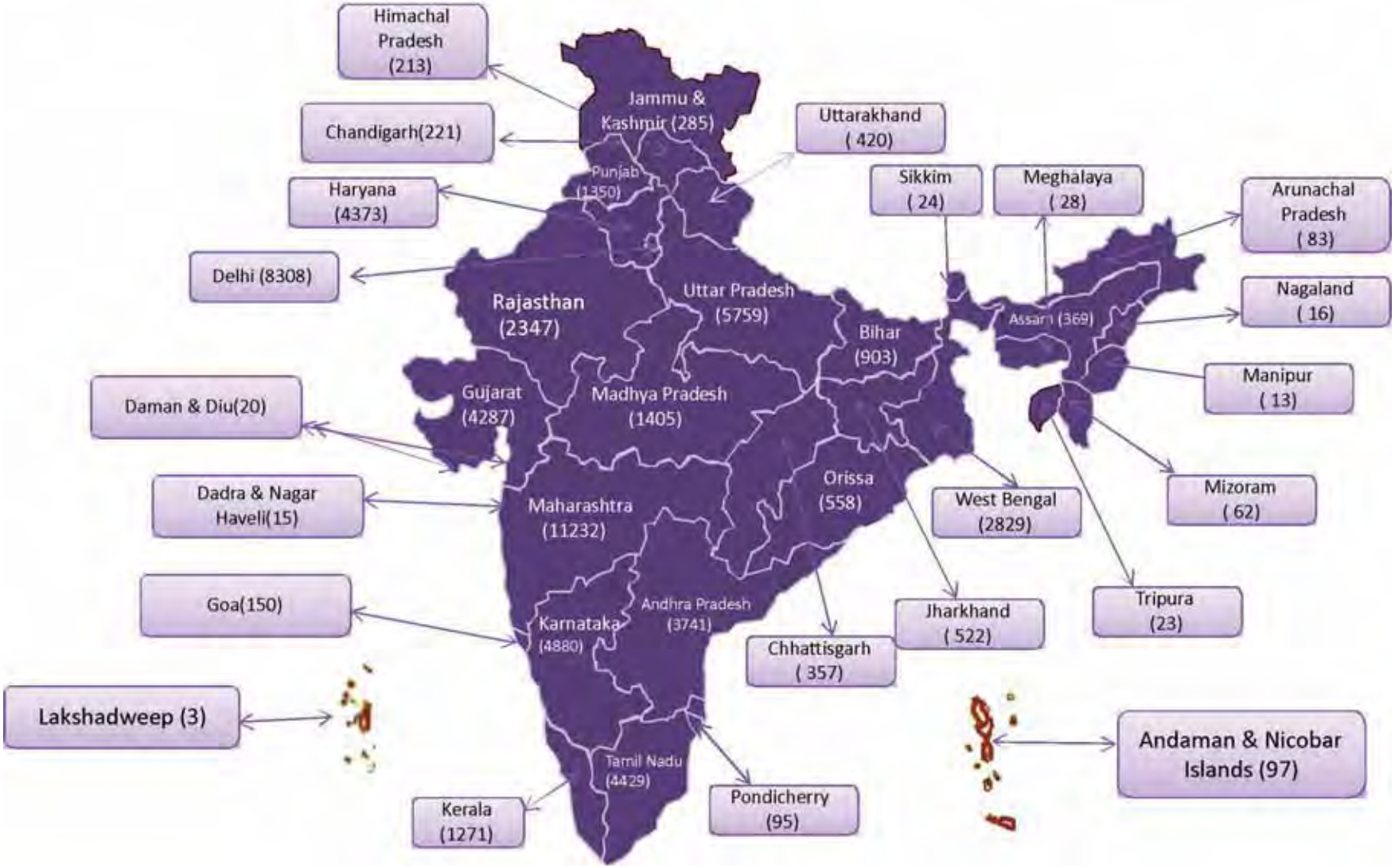
ANALYSIS OF MOTOR INSURANCE COMPLAINTS FOR THE LAST THREE FINANCIAL YEARS

S.No	Complaint Type	2014-15	2013-14	2012-13
1	Claim	11641	13183	15235
2	Cover Note Related	553	589	586
3	Coverage	74	80	241
4	Others	3027	2508	3214
5	Policy Related	8177	10440	14546
6	Premium	525	599	941
7	Product	143	115	101
8	Proposal Related	193	183	251
9	Refund	314	403	678
	Total	**24647**	**28100**	**35793**

STATE WISE DISTRIBUTION OF COMPLAINTS – NON LIFE (2013-14)



STATE WISE DISTRIBUTION OF COMPLAINTS– NON LIFE (2014-15)

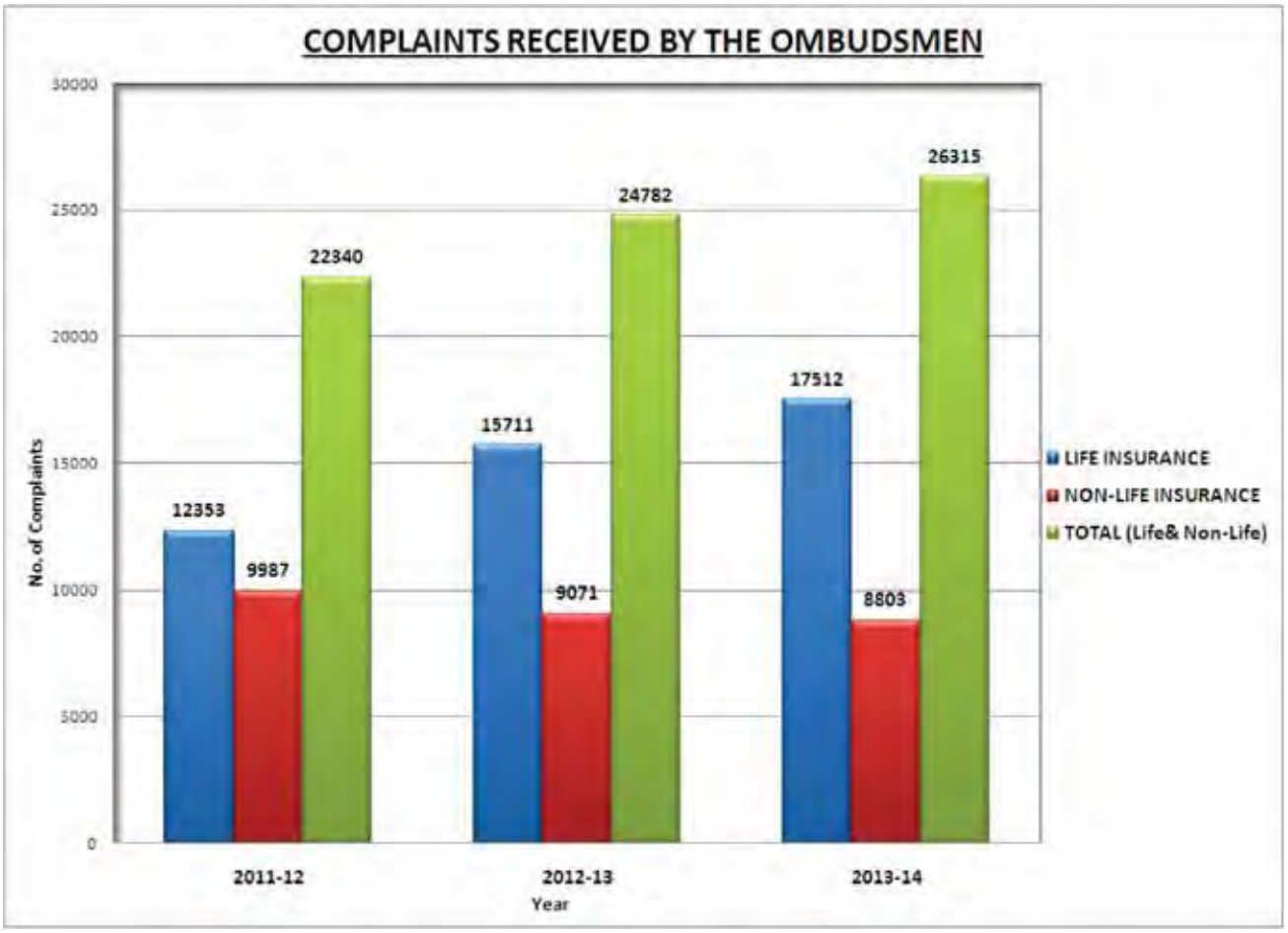


Data on Grievances
- Insurance Ombudsman

1. Cursory glance of Complaints received for the last 3 years
2. Complaints received for the last 3 years - Graphical Presentation
3. Disposal of Complaints for 2012-13 and 2013-14
4. Classification for Complaints received for 2012-13 and 2013-14

COMPLAINTS RECEIVED BY THE INSURANCE OMBUDSMEN
CURSORY GLANCE

Insurace Type	2011-12	2012-13	2013-14
LIFE INSURANCE	12353	15711	17512
NON-LIFE INSURANCE	9987	9071	8803
TOTAL (Life& Non-Life)	**22340**	**24782**	**26315**

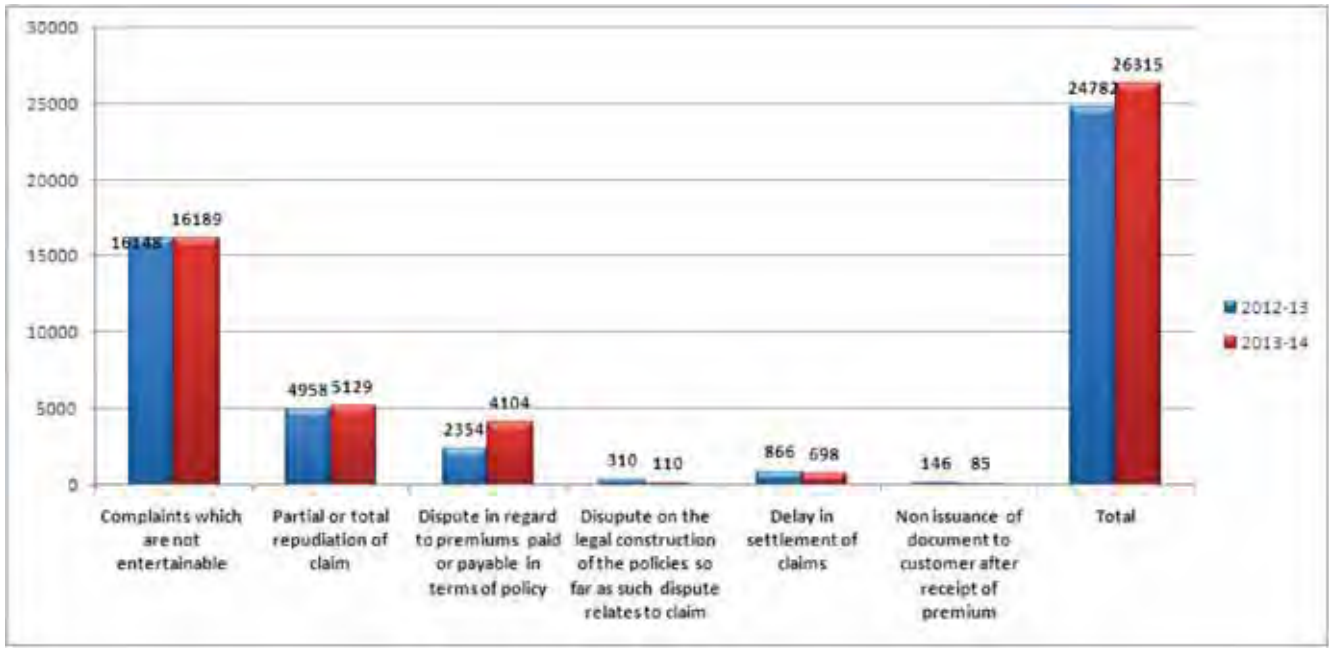


DISPOSAL OF COMPLAINTS BY THE INSURNACE OMBUDSMEN

	Particulars	2012-13				2013-14			
		O/S as on 01.04.2012	Received	Disposed	O/s as on 31.03.2013	O/S as on 01.04.2013	Received	Disposed	O/s as on 31.03.2014
1.	**Against Life & General Insurers**	**7176**	**24782**	**23357**	**8601**	**8601**	**26315**	**25299**	**9617**
2.	Against Life Insurers	2846	15711	14673	3884	3884	17512	15672	5724
3.	Against General Insurers	4330	9071	8684	4717	4717	8803	9627	3893

CLASSIFICATION OF COMPLAINTS RECEIVED BY THE INSURANCE OMBUDSMEN
(Life & General Insurers)

Year	Complaints which are not entertainable	Partial or total repudiation of claim	Dispute in regard to premiums paid or payable in terms of policy	Disupute on the legal construction of the policies so far as such dispute relates to claim	Delay in settlement of claims	Non issuance of document to customer after receipt of premium	Total
2012-13	16148	4958	2354	310	866	146	**24782**
2013-14	16189	5129	4104	110	698	85	**26315**



Data on Grievances – 2013-14
Summary of complaints, Disposal & Resolution - Industry wise

1. Total Industry (Life & Non Life)
2. Life Industry
3. Non Life Industry

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Industry (Life & NonLife)
01-Apr-2013 TO 31-Mar-2014

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	2459	
Received during the period	437955	
Attended to during the period	438400	99.54%
Pending as at the end of the period	2014	0.46%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	211622	48.32%
Policy Servicing	62238	14.21%
Others	38171	8.72%
Survival Claims	31424	7.18%
Proposal Processing	27774	6.34%
Claim	27409	6.26%
Policy Related	21240	4.85%
ULIP Related	7127	1.63%
Death Claims	5261	1.20%
Premium	1877	0.43%
Refund	1220	0.28%
Coverage	1059	0.24%
Cover Note Related	678	0.15%
Proposal Related	541	0.12%
Product	314	0.07%
TOTAL	**437955**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	12.13	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
• Telephone	5054	1.15%
• Email	12242	2.80%
• Letter	6705	1.53%
• Fax	28	0.01%
• walk In	1	0.00%
IGMS portal	18653	4.26%
Insurer's portal	395272	90.25%
TOTAL	**437955**	

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	569	28.25%
16 – 30 days	204	10.13%
More than 30 days	1241	61.62%
Total Pending	**2014**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	Complaint Type	No. of Complaints	%
Malpractices or unfair business practices	UBP	79978	18.26%
Single premium Policy issued as Annual premium policy	UBP	42599	9.73%
Complaint raised with Insurer not addressed	O	21363	4.88%
Policy bond not received.	PP	17962	4.10%
Tampering, Corrections, forgery of proposal or related papers	UBP	17389	3.97%
Payment of premium not acted upon or wrongly acted upon	PS	14010	3.20%
Product differs from what was			
requested or disclosed.	UBP	13408	3.06%
Free-look refund not paid	UBP	11557	2.64%
Certificate of Insurance / Policy not received by the Insured	Policy Related	10516	2.40%
Insurer not disposed of the claim	Claim	9777	2.23%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	215756	49.26%
Partially in favour	21823	4.98%
Reject	158626	36.22%

POLICY TYPE CLASSIFICATION		
Policy Type	No. of Complaints	%
Conventional Life Insurance Policy	218784	49.96%
Others	88274	20.16%
Unit Linked Insurance Policy	67913	15.51%
Motor Insurance	28100	6.42%
Health Insurance	23677	5.41%
Pension Policy (other than Unit Linked)	6159	1.41%
Health Insurance Policy	3498	0.80%
Fire	890	0.20%
Marine Cargo	375	0.09%
Engineering	120	0.03%
Credit	110	0.03%
Marine Hull	33	0.01%
Crop	22	0.01%
TOTAL	**437955**	

RECEIPT OF COMPLAINTS		
Top 5 companies		%
Life Insurance Corporation of India	85284	19.47%
HDFC Standard Life Insurance Co. Ltd	52402	11.97%
Bajaj Allianz Life Insurance Company Ltd	52314	11.95%
Birla SunLife Insurance Company Limited	30825	7.04%
Reliance Life Insurance Company Limited	30659	7.00%
TOTAL	**251484**	**57.42%**

COMPLAINTS AGAINST TYPE OF ENTITY		
Insurer	423555	96.71%
Broker	1335	0.30%
TPA	3880	0.89%
Surveyor	39	0.01%
Agent	9146	2.09%
TOTAL	**437955**	
Unregistered entities	101	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Death Claims	2634	518	1529
Others	25201	2928	8639
Policy Servicing	46822	3400	10033
Proposal Processing	17672	984	7112
Survival Claims	20025	1962	7262
ULIP Related	2723	616	3042
Unfair Business Practices	65773	7925	110324
Claim	13323	2417	8485
Cover Note Related	511	14	110
Coverage	517	255	267
Policy Related	17833	582	1135
Premium	1327	120	253
Product	164	18	121
Proposal Related	321	20	166
Refund	910	64	148
TOTAL	**215756**	**21823**	**158626**

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Life Insurer
01-Apr-2013 TO 31-Mar-2014

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	1224	
Received during the period	374620	
Attended to during the period	374664	99.7%
Pending as at the end of the period	1180	0.3%

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	358	30.34%
16 – 30 days	116	9.83%
More than 30 days	706	59.83%
Total Pending	**1180**	

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices (UBP)	211622	56.49%
Policy Servicing (PS)	62238	16.61%
Survival Claims (SC)	31424	8.39%
Others (O)	29174	7.79%
Proposal Processing (PP)	27774	7.41%
ULIP Related (UR)	7127	1.90%
Death Claims (DC)	5261	1.40%
TOTAL	**374620**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	Complaint Type	No. of Complaints	%
Malpractices or unfair business practices	UBP	79978	21.35%
Single premium Policy issued as Annual premium policy	UBP	42599	11.37%
Complaint raised with Insurer not addressed	O	21363	5.70%
Policy bond not received.	PP	17962	4.79%
Tampering, Corrections, forgery of proposal or related papers	UBP	17389	4.64%
Payment of premium not acted upon or wrongly acted upon	PS	14010	3.74%
Product differs from what was requested or disclosed.	UBP	13408	3.58%
Free-look refund not paid	UBP	11557	3.08%
Non-receipt of Premium receipt	PS	9434	2.52%
Survival Benefit is not paid	SC	8941	2.39%

AVERAGE RESOLUTION RATE		
Average Resolution Rate	11.26	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	174285	46.52%
Partially in favour	17919	4.78%
Reject	146751	39.17%

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
• Telephone	3863	1.03%
• Email	8520	2.27%
• Letter	4930	1.32%
• Fax	19	0.01%
• walk In	1	0.00%
IGMS portal	14472	3.86%
Insurer's portal	342815	91.51%
TOTAL	**374620**	

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	218784	58.40%
Others	78266	20.89%
Unit Linked Insurance Policy	67913	18.13%
Pension Policy (other than Unit Linked)	6159	1.64%
Health Insurance Policy	3498	0.93%
TOTAL	**374620**	

RECEIPT OF COMPLAINTS		
Top 5 companies		%
Life Insurance Corporation of India	85284	22.77%
HDFC Standard Life Insurance Co. Ltd	52402	13.99%
Bajaj Allianz Life Insurance Company Ltd	52314	13.96%
Birla SunLife Insurance Company Limited	30825	8.23%
Reliance Life Insurance Company Limited	30659	8.18%
TOTAL	**251484**	**67.13%**

COMPLAINTS AGAINST TYPE OF ENTITY		
Insurer	364466	97.29%
Broker	1269	0.34%
TPA	29	0.01%
Surveyor	10	0.00%
Agent	8846	2.36%
TOTAL	**374620**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Death Claims	2634	518	1529
Others	18636	2514	7449
Policy Servicing	46822	3400	10033
Proposal Processing	17672	984	7112
Survival Claims	20025	1962	7262
ULIP Related	2723	616	3042
Unfair Business Practices	65773	7925	110324
TOTAL	**174285**	**17919**	**146751**

Complaint Type - Others in Description Type

1. Complaint raised with Insurer not addressed
2. Violation of other IRDA regulations
3. Advertisements regulations violation

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - NonLife Insurer
01-Apr-2013 TO 31-Mar-2014

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	1235	
Received during the period	63335	
Attended to during the period	63736	98.71%
Pending as at the end of the period	834	1.29%

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	211	25.30%
16 – 30 days	88	10.55%
More than 30 days	535	64.15%
Total Pending	**834**	

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	27409	43.28%
Policy Related	21240	33.54%
Others	8997	14.21%
Premium	1877	2.96%
Refund	1220	1.93%
Coverage	1059	1.67%
Cover Note Related	678	1.07%
Proposal Related	541	0.85%
Product	314	0.50%
TOTAL	**63335**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	Complaint Type	No. of Complaints	%
Certificate of Insurance / Policy not received by the Insured	Policy Related	10516	16.60%
Insurer not disposed of the claim	Claim	9777	15.44%
Difference between assessed loss and amount settled by Insurer.	Claim	2589	4.09%
Insurer failed to clarify the queries raised by Insured.	Others	2427	3.83%
Insurer not issued claim cheque inspite of offer of settlement.	Claim	2359	3.72%
TPA not sent ID card to Insured.	Others	2313	3.65%
Details shown in policy or Add-on are incorrect.	Policy Related	1946	3.07%
Insurer reduced the Quantum of claim for reasons not indicated in the policy.	Claim	1740	2.75%
Insured asked for issue of a duplicate policy – Insurer failed to issue	Policy Related	1685	2.66%
Insurer failed to make offer of settlement to Insured after receipt of survey report.	Claim	1608	2.54%

AVERAGE RESOLUTION RATE		
Average Resolution Rate	17.27	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
• Telephone	1191	1.88%
• Email	3722	5.88%
• Letter	1775	2.80%
• Fax	9	0.01%
• walk In		0.00%
IGMS portal	4181	6.60%
Insurer's portal	52457	82.82%
TOTAL	**63335**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	41471	65.48%
Partially in favour	3904	6.16%
Reject	11875	18.75%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Motor Insurance	28100	44.37%
Health Insurance	23677	37.38%
Others	10008	15.80%
Fire	890	1.41%
Marine Cargo	375	0.59%
Engineering	120	0.19%
Credit	110	0.17%
Marine Hull	33	0.05%
Crop	22	0.03%
TOTAL	**63335**	

RECEIPT OF COMPLAINTS		
Top 5 companies		%
ICICI Lombard General Insurance	6854	10.82%
Bajaj Allianz General Insurance	6361	10.04%
United India Insurance	6197	9.78%
Bharti AXA General Insurance	5356	8.46%
National Insurance Company Limited	4954	7.82%
TOTAL	**29722**	**46.93%**

COMPLAINTS AGAINST TYPE OF ENTITY		
Insurer	59089	93.30%
Broker	66	0.10%
TPA	3851	6.08%
Surveyor	29	0.05%
Agent	300	0.47%
TOTAL	**63335**	

"RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED "(Complaint Type wise)"			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	13323	2417	8485
Cover Note Related	511	14	110
Coverage	517	255	267
Others	6565	414	1190
Policy Related	17833	582	1135
Premium	1327	120	253
Product	164	18	121
Proposal Related	321	20	166
Refund	910	64	148
TOTAL	**41471**	**3904**	**11875**

Data on Grievances – 2014-15
Summary of complaints, Disposal & Resolution - Industry wise

1. Total Industry (Life & Non Life)
2. Life Industry
3. Non Life Industry

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Industry (Life & NonLife)
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	2014	
Received during the period	339680	
Attended to during the period	333408	97.6%
Pending as at the end of the period	8286	2.4%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	145129	42.73%
Policy Servicing	55869	16.45%
Survival Claims	27123	7.98%
Others	21957	6.46%
Proposal Processing	20932	6.16%
ULIP Related	4029	1.19%
Death Claims	3953	1.16%
Claim	26467	7.79%
Policy Related	19656	5.79%
Others	9201	2.71%
Premium	1913	0.56%
Refund	1086	0.32%
Coverage	828	0.24%
Proposal Related	621	0.18%
Cover Note Related	607	0.18%
Product	309	0.09%
TOTAL	**339680**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	11.8	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
• Telephone	7297	2.15%
• Email	10658	3.14%
• Letter	5763	1.70%
• Fax	0	0.00%
• walk In	0	0.00%
IGMS portal	7692	2.26%
Insurer's portal	308270	90.75%
TOTAL	**339680**	

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	2872	34.99%
16 – 30 days	527	6.42%
More than 30 days	4809	58.59%
Total Pending	**8208**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	Complaint Type	No. of Complaints	%
Malpractices or unfair business practices	UBP	62835	18.50%
Complaint raised with Insurer not addressed	O	18230	5.37%
Single premium Policy issued as Annual premium policy	UBP	16270	4.79%
Policy bond not received.	PP	12641	3.72%
Tampering, Corrections, forgery of proposal or related papers	UBP	12369	3.64%
Certificate of Insurance / Policy not received by the Insured	Policy Related	11216	3.30%
Payment of premium not acted upon or wrongly acted upon	PS	10960	3.23%
Non-receipt of Premium receipt	PS	10210	3.01%
Spurious calls or Hoax Calls	UBP	9994	2.94%
Insurer not disposed of the claim	Claim	9421	2.77%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	184634	54.36%
Partially in favour	21426	6.31%
Reject	127381	37.50%

POLICY TYPE CLASSIFICATION		
Policy Type	No. of Complaints	%
Conventional Life Insurance Policy	177192	52.164%
Others	51589	15.188%
Unit Linked Insurance Policy	42084	12.389%
Pension Policy (other than Unit Linked)	4999	1.472%
Health Insurance Policy	3128	0.921%
Health Insurance	25633	7.546%
Motor Insurance	24647	7.256%
Others	9119	2.685%
Fire	804	0.237%
Marine Cargo	310	0.091%
Engineering	118	0.035%
Marine Hull	29	0.009%
Credit	20	0.006%
Crop	8	0.002%
TOTAL	**339680**	

RECEIPT OF COMPLAINTS		
Top 5 companies		%
Life Insurance Corporation of India	80944	23.83%
HDFC Standard Life Insurance Co. Ltd	32214	9.48%
Reliance Life Insurance Company Ltd	24763	7.29%
Birla SunLife Insurance Company Ltd	23629	6.96%
Bajaj Allianz Life Insurance Company Ltd	19795	5.83%
TOTAL	**181345**	**53.39%**

COMPLAINTS AGAINST TYPE OF ENTITY		
Insurer	327058	96.28%
Broker	438	0.13%
TPA	3530	1.04%
Surveyor	26	0.01%
Agent	8628	2.54%
TOTAL	**339680**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	45264	7254	89421
Policy Servicing	45392	3143	6987
Survival Claims	18569	1975	6195
Others	17102	1160	3527
Proposal Processing	15532	975	4138
ULIP Related	1627	400	1928
Death Claims	1787	385	1715
Claim	11350	4389	10040
Policy Related	17067	820	1191
Others	7118	570	1226
Premium	1433	101	289
Refund	866	69	117
Coverage	446	132	234
Proposal Related	423	17	169
Cover Note Related	486	13	98
Product	172	23	106
TOTAL	**184634**	**21426**	**127381**

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Life Insurer
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	1180	
Received during the period	278992	
Attended to during the period	274063	97.8%
Pending as at the end of the period	6109	2.2%

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	2105	34.46%
16 – 30 days	407	6.66%
More than 30 days	3597	58.88%
Total Pending	**6109**	

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	145129	52.02%
Policy Servicing	55869	20.03%
Survival Claims	27123	9.72%
Others	21957	7.87%
Proposal Processing	20932	7.50%
ULIP Related	4029	1.44%
Death Claims	3953	1.42%
TOTAL	**278992**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	Complaint Type	No. of Complaints	%
Malpractices or unfair business practices	UBP	62835	22.52%
Complaint raised with Insurer not addressed	O	18230	6.53%
Single premium Policy issued as Annual premium policy	UBP	16270	5.83%
Policy bond not received.	PP	12641	4.53%
Tampering, Corrections, forgery of proposal or related papers	UBP	12369	4.43%
Payment of premium not acted upon or wrongly acted upon	PS	10960	3.93%
Non-receipt of Premium receipt	PS	10210	3.66%
Spurious calls or Hoax Calls	UBP	9994	3.58%
Survival Benefit is not paid	SC	8746	3.13%
Surrender Value not paid	SC	6774	2.43%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	145273	52.07%
Partially in favour	15292	5.48%
Reject	113911	40.83%

AVERAGE RESOLUTION RATE		
Average Resolution Rate	10.99	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
• Telephone	5184	1.86%
• Email	7189	2.58%
• Letter	4085	1.46%
• Fax	0	0.00%
• walk In	0	0.00%
IGMS portal	4904	1.76%
Insurer's portal	257630	92.34%
TOTAL	**278992**	

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	177192	63.51%
Others	51589	18.49%
Unit Linked Insurance Policy	42084	15.08%
Pension Policy (other than Unit Linked)	4999	1.79%
Health Insurance Policy	3128	1.12%
TOTAL	**278992**	

RECEIPT OF COMPLAINTS		
Top 5 companies		%
Life Insurance Corporation of India	80944	29.01%
HDFC Standard Life Insurance Co. Ltd	32214	11.55%
Reliance Life Insurance Company Limited	24763	8.88%
Birla SunLife Insurance Company Limited	23629	8.47%
Bajaj Allianz Life Insurance Company Ltd	19795	7.10%
TOTAL	**181345**	**65.00%**

COMPLAINTS AGAINST TYPE OF ENTITY		
Insurer	270367	96.91%
Broker	374	0.13%
Surveyor	3	0.00%
TPA	14	0.01%
Agent	8234	2.95%
TOTAL	**278992**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	45264	7254	89421
Policy Servicing	45392	3143	6987
Survival Claims	18569	1975	6195
Others	17102	1160	3527
Proposal Processing	15532	975	4138
ULIP Related	1627	400	1928
Death Claims	1787	385	1715
TOTAL	**145273**	**15292**	**113911**

Complaint Type - Others in Description Type

1. Complaint raised with Insurer not addressed
2. Violation of other IRDA regulations
3. Advertisements regulations violation

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - NonLife Insurer
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	834	
Received during the period	60688	
Attended to during the period	59345	96.5%
Pending as at the end of the period	2177	3.5%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	26467	43.61%
Policy Related	19656	32.39%
Others	9201	15.16%
Premium	1913	3.15%
Refund	1086	1.79%
Coverage	828	1.36%
Proposal Related	621	1.02%
Cover Note Related	607	1.00%
Product	309	0.51%
TOTAL	**60688**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	15.58	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
• Telephone	2113	3.48%
• Email	3469	5.72%
• Letter	1678	2.76%
• Fax	0	0.00%
• walk In	0	0.00%
IGMS portal	2788	4.59%
Insurer's portal	50640	83.44%
TOTAL	**60688**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	39361	64.86%
Partially in favour	6134	10.11%
Reject	13470	22.20%

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	767	36.54%
16 – 30 days	120	5.72%
More than 30 days	1212	57.74%
Total Pending	**2099**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	Complaint Type	No. of Complaints	%
Certificate of Insurance / Policy not received by the Insured	Policy Related	11216	18.48%
Insurer not disposed of the claim	Claim	9421	15.52%
Difference between assessed loss and amount settled by Insurer.	Claim	2464	4.06%
Insurer failed to clarify the queries raised by Insured.	Others	2370	3.91%
Insurer not issued claim cheque inspite of offer of settlement.	Claim	2224	3.66%
TPA not sent ID card to Insured.	Others	2148	3.54%
Details shown in policy or Add-on are incorrect.	Policy Related	1771	2.92%
Insurer reduced the Quantum of claim for reasons not indicated in the policy.	Claim	1621	2.67%
Delay on the part of TPA to arrange claim reimbursement.	Claim	1336	2.20%
Insurer failed to make offer of settlement to Insured after receipt of survey report.	Claim	1325	2.18%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Health Insurance	25633	42.24%
Motor Insurance	24647	40.61%
Others	9119	15.03%
Fire	804	1.32%
Marine Cargo	310	0.51%
Engineering	118	0.19%
Marine Hull	29	0.05%
Credit	20	0.03%
Crop	8	0.01%
TOTAL	**60688**	

RECEIPT OF COMPLAINTS		
Top 5 companies		%
ICICI Lombard General Insurance	5930	9.77%
United India Insurance Company	5705	9.40%
Royal Sundaram Alliance Insurance	4976	8.20%
Bajaj Allianz General Insurance	4770	7.86%
National Insurance Company	4740	7.81%
TOTAL	**26121**	**43.04%**

COMPLAINTS AGAINST TYPE OF ENTITY		
Insurer	56691	93.41%
Broker	64	0.11%
Surveyor	23	0.04%
TPA	3516	5.79%
Agent	394	0.65%
TOTAL	**60688**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	11350	4389	10040
Policy Related	17067	820	1191
Others	7118	570	1226
Premium	1433	101	289
Refund	866	69	117
Coverage	446	132	234
Proposal Related	423	17	169
Cover Note Related	486	13	98
Product	172	23	106
TOTAL	**39361**	**6134**	**13470**

Data on Grievances – 2014-15
Summary of complaints, disposal & Resolution
- Life - Insurer wise

1. AEGON Religare Life Insurance Company Limited
2. Aviva Life Insurance Company India Limited
3. Bajaj Allianz Life Insurance Company Ltd
4. Bharti-Axa Life Insurance Company LTD
5. Birla SunLife Insurance Company Limited
6. Canara HSBC Oriental Bank of Commerce Life
7. DHFL Pramerica Life Insurance Company Limited
8. Edelweiss Tokio Life Insurance Company Limited
9. Exide Life Insurance Company Limited
10. Future Generali India Life Insurance Co Ltd
11. HDFC Standard Life Insurance Co. Ltd
12. ICICI Prudential Life Insurance Company Ltd
13. IDBI Federal Life Insurance Co Ltd
14. IndiaFirst Life Insurance Company Limited
15. Kotak Mahindra Old Mutual Life Insurance Ltd.
16. Life Insurance Corporation of India
17. Max Life Insuarnce Company Limited
18. PNB MetLife India Insurance Company Ltd.
19. Reliance Life Insurance Company Limited
20. Sahara India Life Insurance Co. Ltd.
21. SBI Life Insurance Co. Ltd.
22. Shriram Life Insurance Company Ltd.
23. Star Union Dai-ichi Life Insurance Co Ltd
24. Tata AIG Life Insurance Company LTD

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Aegon Religare Life
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	76	
Received during the period	6897	
Attended to during the period	6602	94.68%
Pending as at the end of the period	371	5.32%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	5776	83.75%
Policy Servicing	748	10.85%
Survival Claims	223	3.23%
Proposal Processing	100	1.45%
Others	34	0.49%
Death Claims	11	0.16%
ULIP Related	5	0.07%
TOTAL	**6897**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	10.53	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	80	1.16%
o Email	158	2.29%
o Letter	123	1.78%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	78	1.13%
Insurer's portal	6458	93.63%
TOTAL	**6897**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	763	131	4564
Policy Servicing	239	1	503
Survival Claims	57	3	161
Proposal Processing	17	4	79
Others	1	3	29
Death Claims	3	1	7
ULIP Related			5
TOTAL	**1080**	**143**	**5348**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	256	69.00%
16 – 30 days	9	2.43%
More than 30 days	106	28.57%
Total Pending	**371**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	Complaint Type	No. of Complaints	%
Malpractices or unfair business practices	UBP	3308	47.96%
Spurious calls or Hoax Calls	UBP	793	11.50%
Tampering, Corrections, forgery of proposal or related papers	UBP	763	11.06%
Illegitimate inducements offered	UBP	385	5.58%
Payment of premium not acted upon or wrongly acted upon	PS	375	5.44%
Single premium Policy issued as Annual premium policy	UBP	265	3.84%
Alteration in policy not effected.	PS	181	2.62%
Surrender Value not paid	SC	151	2.19%
Dispute concerning statement of account or premium position statement	PS	91	1.32%
Product differs from what was requested or disclosed.	UBP	68	0.99%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	1080	15.66%
Partially in favour	143	2.07%
Reject	5348	77.54%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Others	4782	69.33%
Conventional Life Insurance Policy	1152	16.70%
Unit Linked Insurance Policy	779	11.29%
Health Insurance Policy	105	1.52%
Pension Policy (other than Unit Linked)	79	1.15%
TOTAL	**6897**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Aviva Life
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	0	
Received during the period	4185	
Attended to during the period	4185	100.00%
Pending as at the end of the period	0	0.00%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	2617	62.53%
Policy Servicing	904	21.60%
Proposal Processing	168	4.01%
Survival Claims	161	3.85%
Others	159	3.80%
ULIP Related	150	3.58%
Death Claims	26	0.62%
TOTAL	**4185**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	8.93	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	98	2.34%
o Email	215	5.14%
o Letter	87	2.08%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	130	3.11%
Insurer's portal	3655	87.34%
TOTAL	**4185**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	173	227	2215
Policy Servicing	167	366	368
Proposal Processing	26	47	95
Survival Claims	10	32	119
Others	3	9	147
ULIP Related	3	29	118
Death Claims	2	3	21
TOTAL	**384**	**713**	**3083**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	0	
16 – 30 days	0	
More than 30 days	0	
Total Pending	**0**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	Complaint Type	No. of Complaints	%
Malpractices or unfair business practices	UBP	1964	46.93%
Policy Benefit option not effected	PS	635	15.17%
Tampering, Corrections, forgery of proposal or related papers	UBP	150	3.58%
Product differs from what was requested or disclosed.	UBP	148	3.54%
Complaint raised with Insurer not addressed	O	131	3.13%
Single premium Policy issued as Annual premium policy	PP	94	2.25%
Payment of premium not acted upon or wrongly acted upon	UBP	89	2.13%
Policy bond not received.	PS	85	2.03%
Surrender Value not paid	SC	77	1.84%
Premium paying period projected is different from actual	UBP	66	1.58%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	384	9.18%
Partially in favour	713	17.04%
Reject	3083	73.67%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	3233	77.25%
Others	447	10.68%
Unit Linked Insurance Policy	418	9.99%
Pension Policy (other than Unit Linked)	52	1.24%
Health Insurance Policy	35	0.84%
TOTAL	**4185**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Bajaj Allianz Life
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	10	
Received during the period	19795	
Attended to during the period	19530	98.61%
Pending as at the end of the period	275	1.39%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	17143	86.60%
Survival Claims	871	4.40%
ULIP Related	831	4.20%
Policy Servicing	417	2.11%
Others	240	1.21%
Proposal Processing	185	0.93%
Death Claims	108	0.55%
TOTAL	**19795**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	4.3	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	245	1.24%
o Email	138	0.70%
o Letter	220	1.11%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	282	1.42%
Insurer's portal	18910	95.53%
TOTAL	**19795**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	12537	1150	3300
Survival Claims	272	185	400
ULIP Related	175	180	454
Policy Servicing	131	106	172
Others	70	62	105
Proposal Processing	77	46	60
Death Claims	30	22	52
TOTAL	**13292**	**1751**	**4543**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	115	41.82%
16 – 30 days	76	27.64%
More than 30 days	84	30.55%
Total Pending	**275**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Single premium Policy issued as Annual premium policy	UBP	9863	49.83%
Malpractices or unfair business practices	UBP	3477	17.57%
Intermediary did not provide material information concerning proposed cover	UBP	2904	14.67%
Foreclosure notice not given to policyholder	ULIP	341	1.72%
Spurious calls or Hoax Calls	UBP	254	1.28%
Surrender Value not paid	SC	209	1.06%
Disputes concerning correctness of surrender value	SC	201	1.02%
Complaint raised with Insurer not addressed	O	194	0.98%
Survival Benefit is not paid	SC	180	0.91%
Maturity claim is not paid	SC	150	0.76%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	13292	67.15%
Partially in favour	1751	8.85%
Reject	4543	22.95%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Others	16135	81.51%
Conventional Life Insurance Policy	2349	11.87%
Unit Linked Insurance Policy	1171	5.92%
Health Insurance Policy	96	0.48%
Pension Policy (other than Unit Linked)	44	0.22%
TOTAL	**19795**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Bharti Axa Life
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	16	
Received during the period	5642	
Attended to during the period	5307	93.80%
Pending as at the end of the period	351	6.20%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	4419	78.32%
Proposal Processing	375	6.65%
Policy Servicing	338	5.99%
Survival Claims	201	3.56%
ULIP Related	195	3.46%
Others	92	1.63%
Death Claims	22	0.39%
TOTAL	**5642**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	10.22	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	457	8.10%
o Email	315	5.58%
o Letter	165	2.92%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	159	2.82%
Insurer's portal	4546	80.57%
TOTAL	**5642**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	1845	2	2469
Proposal Processing	150		217
Policy Servicing	169		164
Survival Claims	86		108
ULIP Related	57		129
Others	30		61
Death Claims	13		8
TOTAL	**2350**	**2**	**3156**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	54	15.38%
16 – 30 days	11	3.13%
More than 30 days	286	81.48%
Total Pending	351	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Malpractices or unfair business practices	UBP	2222	39.38%
Tampering, Corrections, forgery of proposal or related papers	UBP	477	8.45%
Product differs from what was requested or disclosed.	UBP	345	6.11%
Illegitimate inducements offered	UBP	325	5.76%
Policy bond not received.	PP	297	5.26%
Single premium Policy issued as Annual premium policy	UBP	193	3.42%
Free-look refund not paid	UBP	164	2.91%
Misappropriation of premiums	UBP	143	2.53%
Surrender Value not paid	SC	129	2.29%
Premium paying period projected is different from actual	UBP	122	2.16%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	2350	41.65%
Partially in favour	2	0.04%
Reject	3156	55.94%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	2858	50.66%
Unit Linked Insurance Policy	2628	46.58%
Others	128	2.27%
Health Insurance Policy	22	0.39%
Pension Policy (other than Unit Linked)	6	0.11%
TOTAL	**5642**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Birla Sun Life
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	40	
Received during the period	23629	
Attended to during the period	23658	99.95%
Pending as at the end of the period	11	0.05%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	18451	78.09%
Policy Servicing	1640	6.94%
Others	1292	5.47%
Survival Claims	1115	4.72%
Proposal Processing	689	2.92%
Death Claims	232	0.98%
ULIP Related	210	0.89%
TOTAL	**23629**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	10.62	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	350	1.48%
o Email	528	2.23%
o Letter	326	1.38%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	321	1.36%
Insurer's portal	22104	93.55%
TOTAL	**23629**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	2077	539	15816
Policy Servicing	208	138	1287
Others	132	78	1082
Survival Claims	125	50	938
Proposal Processing	127	45	515
Death Claims	24	7	200
ULIP Related	11	10	189
TOTAL	**2704**	**867**	**20027**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	1	9.09%
16 – 30 days	1	9.09%
More than 30 days	9	81.82%
Total Pending	**11**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Malpractices or unfair business practices	UBP	12680	53.66%
Spurious calls or Hoax Calls	UBP	1801	7.62%
Complaint raised with Insurer not addressed	O	1258	5.32%
Free-look refund not paid	UBP	985	4.17%
Product differs from what was requested or disclosed.	UBP	622	2.63%
Misappropriation of premiums	UBP	569	2.41%
Payment of premium not acted upon or wrongly acted upon	PS	531	2.25%
Policy bond not received.	PP	504	2.13%
Illegitimate inducements offered	UBP	491	2.08%
Surrender Value not paid	SC	398	1.68%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	2704	11.44%
Partially in favour	867	3.67%
Reject	20027	84.76%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Others	15977	67.62%
Conventional Life Insurance Policy	5668	23.99%
Unit Linked Insurance Policy	1762	7.46%
Health Insurance Policy	114	0.48%
Pension Policy (other than Unit Linked)	108	0.46%
TOTAL	**23629**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Canara HSBC
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	0	
Received during the period	4559	
Attended to during the period	4500	98.71%
Pending as at the end of the period	59	1.29%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	1485	32.57%
Proposal Processing	1378	30.23%
Policy Servicing	1102	24.17%
Survival Claims	312	6.84%
ULIP Related	266	5.83%
Death Claims	15	0.33%
Others	1	0.02%
TOTAL	**4559**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	9.15	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	5	0.11%
o Email	22	0.48%
o Letter	12	0.26%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	7	0.15%
Insurer's portal	4513	98.99%
TOTAL	**4559**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	804	95	560
Proposal Processing	1269	35	50
Policy Servicing	857	119	122
Survival Claims	212	30	68
ULIP Related	157	15	91
Death Claims	6	2	7
Others	1		
TOTAL	**3306**	**296**	**898**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	59	100.00%
16 – 30 days	0	0.00%
More than 30 days	0	0.00%
Total Pending	**59**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Policy bond not received.	PP	1236	27.11%
Malpractices or unfair business practices	UBP	699	15.33%
Payment of premium not acted upon or wrongly acted upon	PS	395	8.66%
Policy Benefit option not effected	PS	263	5.77%
Surrender Value not paid	SC	245	5.37%
Insurer failed to send lapse intimation	PS	198	4.34%
Poor disclosures of various Charges	ULIP	167	3.66%
Illegitimate inducements offered	UBP	161	3.53%
Premium paying period projected is different from actual	UBP	150	3.29%
Spurious calls or Hoax Calls	UBP	120	2.63%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	3306	72.52%
Partially in favour	296	6.49%
Reject	898	19.70%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Unit Linked Insurance Policy	3324	72.91%
Conventional Life Insurance Policy	1113	24.41%
Others	122	2.68%
TOTAL	**4559**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - DHFL Pramerica Life
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	42	
Received during the period	1593	
Attended to during the period	982	60.06%
Pending as at the end of the period	653	39.94%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	1263	79.28%
Proposal Processing	122	7.66%
Survival Claims	86	5.40%
Policy Servicing	68	4.27%
Others	27	1.69%
Death Claims	23	1.44%
ULIP Related	4	0.25%
TOTAL	**1593**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	13.35	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	97	6.09%
o Email	110	6.91%
o Letter	62	3.89%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	35	2.20%
Insurer's portal	1289	80.92%
TOTAL	**1593**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	135	67	654
Proposal Processing	44	4	37
Survival Claims	13	3	11
Policy Servicing	17	16	10
Others	3	4	9
Death Claims		3	9
ULIP Related	4		
TOTAL	**216**	**97**	**730**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	37	5.67%
16 – 30 days	14	2.14%
More than 30 days	602	92.19%
Total Pending	**653**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Malpractices or unfair business practices	UBP	660	41.43%
Tampering, Corrections, forgery of proposal or related papers	UBP	171	10.73%
Free-look refund not paid	UBP	100	6.28%
Single premium Policy issued as Annual premium policy	UBP	90	5.65%
Spurious calls or Hoax Calls	UBP	73	4.58%
Surrender Value not paid	SC	55	3.45%
Illegitimate inducements offered	UBP	52	3.26%
Policy bond not received.	PS	48	3.01%
Payment of premium not acted upon or wrongly acted upon	PP	47	2.95%
Mistakes in the name and address of the insured.	PS	40	2.51%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	216	13.56%
Partially in favour	97	6.09%
Reject	730	45.83%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	1353	84.93%
Unit Linked Insurance Policy	162	10.17%
Others	78	4.90%
TOTAL	**1593**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Edleweiss Tokio Life
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	0	
Received during the period	514	
Attended to during the period	481	93.58%
Pending as at the end of the period	33	6.42%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	339	65.95%
Proposal Processing	145	28.21%
Policy Servicing	25	4.86%
Death Claims	3	0.58%
Others	2	0.39%
TOTAL	**514**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	14.32	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	3	0.58%
o Email	9	1.75%
o Letter	0	0.00%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	6	1.17%
Insurer's portal	496	96.50%
TOTAL	**514**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	132		192
Proposal Processing	101		32
Policy Servicing	19		4
Death Claims			3
Others			2
TOTAL	**252**		**233**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	27	90.00%
16 – 30 days	0	0.00%
More than 30 days	3	10.00%
Total Pending	**30**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Malpractices or unfair business practices	UBP	158	30.74%
After submission of all requirements, no communication was received.	PP	59	11.48%
Policy bond not received.	PP	52	10.12%
Premium paying period projected is different from actual	UBP	40	7.78%
Product differs from what was requested or disclosed.	UBP	33	6.42%
Tampering, Corrections, forgery of proposal or related papers	UBP	31	6.03%
Wrong Policy Bond is issued	PP	26	5.06%
Free-look refund not paid	UBP	22	4.28%
Payment of premium not acted upon or wrongly acted upon	PS	17	3.31%
Spurious calls or Hoax Calls	UBP	16	3.11%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	252	49.03%
Partially in favour	0	0.00%
Reject	233	45.33%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	484	94.16%
Others	18	3.50%
Unit Linked Insurance Policy	11	2.14%
Health Insurance Policy	1	0.19%
TOTAL	**514**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Exide Life
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	13	
Received during the period	9488	
Attended to during the period	8867	93.33%
Pending as at the end of the period	634	6.67%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	5418	57.10%
Survival Claims	1854	19.54%
Policy Servicing	1053	11.10%
Proposal Processing	682	7.19%
Others	265	2.79%
ULIP Related	168	1.77%
Death Claims	48	0.51%
TOTAL	**9488**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	11.56	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	162	1.71%
o Email	237	2.50%
o Letter	87	0.92%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	90	0.95%
Insurer's portal	8912	93.93%
TOTAL	**9488**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	2204	1374	1462
Survival Claims	1174	489	72
Policy Servicing	642	286	58
Proposal Processing	445	179	30
Others	127	82	32
ULIP Related	78	58	20
Death Claims	13	21	12
TOTAL	**4683**	**2489**	**1686**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	292	46.06%
16 – 30 days	192	30.28%
More than 30 days	150	23.66%
Total Pending	**634**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Malpractices or unfair business practices	UBP	3222	33.96%
Free-look refund not paid	UBP	1513	15.95%
Survival Benefit is not paid	SC	844	8.90%
Surrender Value not paid	SC	596	6.28%
Policy bond not received.	PP	510	5.38%
Payment of premium not acted upon or wrongly acted upon	PS	270	2.85%
Policy Benefit option not effected	PS	230	2.42%
Product differs from what was requested or disclosed.	UBP	206	2.17%
Maturity claim is not paid	SC	206	2.17%
Complaint raised with Insurer not addressed	O	194	2.04%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	4683	49.36%
Partially in favour	2489	26.23%
Reject	1686	17.77%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	7954	83.83%
Unit Linked Insurance Policy	586	6.18%
Pension Policy (other than Unit Linked)	524	5.52%
Others	350	3.69%
Health Insurance Policy	74	0.78%
TOTAL	**9488**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Future Generali Life
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	101	
Received during the period	5390	
Attended to during the period	5110	93.06%
Pending as at the end of the period	381	6.94%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	3717	68.96%
Proposal Processing	1235	22.91%
Others	284	5.27%
Survival Claims	80	1.48%
Death Claims	42	0.78%
Policy Servicing	24	0.45%
ULIP Related	8	0.15%
TOTAL	**5390**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	12.05	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	219	4.06%
o Email	184	3.41%
o Letter	107	1.99%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal*	379	7.03%
Insurer's portal	4501	83.51%
TOTAL	**5390**	

** 1 Complaint registered in 244 times*

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	1116	534	1790
Proposal Processing	846	70	289
Others	245	1	32
Survival Claims	34	3	41
Death Claims	14	11	13
Policy Servicing	14	3	7
ULIP Related	3	2	3
TOTAL	**2272**	**624**	**2175**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	300	78.74%
16 – 30 days	4	1.05%
More than 30 days	77	20.21%
Total Pending	**381**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Malpractices or unfair business practices	UBP	2977	55.23%
Policy bond not received.	PP	1216	22.56%
Tampering, Corrections, forgery of proposal or related papers	UBP	250	4.64%
Violation of other IRDA regulations	O	233	4.32%
Spurious calls or Hoax Calls	UBP	106	1.97%
Single premium Policy issued as Annual premium policy	UBP	94	1.74%
Free-look refund not paid	UBP	92	1.71%
Misappropriation of premiums	UBP	88	1.63%
Complaint raised with Insurer not addressed	O	47	0.87%
Illegitimate inducements offered	UBP	37	0.69%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	2272	42.15%
Partially in favour	624	11.58%
Reject	2175	40.35%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	4691	87.03%
Unit Linked Insurance Policy	572	10.61%
Others	117	2.17%
Pension Policy (other than Unit Linked)	10	0.19%
TOTAL	**5390**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - HDFC Standard Life
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	666	
Received during the period	32214	
Attended to during the period	30582	93.01%
Pending as at the end of the period	2298	6.99%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	25697	79.77%
Survival Claims	1885	5.85%
Proposal Processing	1783	5.53%
Policy Servicing	1648	5.12%
Others	557	1.73%
Death Claims	377	1.17%
ULIP Related	267	0.83%
TOTAL	**32214**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	19.79	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	595	1.85%
o Email	1091	3.39%
o Letter	465	1.44%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	626	1.94%
Insurer's portal	29437	91.38%
TOTAL	**32214**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	4569	55	20245
Survival Claims	248		1527
Proposal Processing	460	4	1209
Policy Servicing	394	2	1139
Others	63	4	388
Death Claims	17		340
ULIP Related	28	1	221
TOTAL	**5779**	**66**	**25069**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	229	9.97%
16 – 30 days	44	1.91%
More than 30 days	2025	88.12%
Total Pending	**2298**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Tampering, Corrections, forgery of proposal or related papers	UBP	5519	17.13%
Illegitimate inducements offered	UBP	4273	13.26%
Proposed Insurance not in the interest of proposer	UBP	4143	12.86%
Intermediary did not provide material information concerning proposed cover	UBP	2917	9.06%
Single premium Policy issued as Annual premium policy	UBP	2721	8.45%
Free-look refund not paid	UBP	2222	6.90%
Misappropriation of premiums	UBP	1251	3.88%
Term(Period) of the policy is different/altered without consent	UBP	744	2.31%
Policy bond not received.	PP	661	2.05%
Surrender Value not paid	SC	549	1.70%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	5779	17.94%
Partially in favour	66	0.20%
Reject	25069	77.82%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	23301	72.33%
Unit Linked Insurance Policy	7270	22.57%
Others	858	2.66%
Pension Policy (other than Unit Linked)	488	1.51%
Health Insurance Policy	297	0.92%
TOTAL	**32214**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - ICICI Prudential Life
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	33	
Received during the period	11801	
Attended to during the period	11775	99.50%
Pending as at the end of the period	59	0.50%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	10588	89.72%
ULIP Related	317	2.69%
Others	255	2.16%
Survival Claims	243	2.06%
Death Claims	164	1.39%
Policy Servicing	120	1.02%
Proposal Processing	114	0.97%
TOTAL	**11801**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	31.62	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	393	3.33%
o Email	699	5.92%
o Letter	413	3.50%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	368	3.12%
Insurer's portal	9928	84.13%
TOTAL	**11801**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	1808	710	8034
ULIP Related	51	25	239
Others	72	47	136
Survival Claims	50	48	144
Death Claims	23	18	120
Policy Servicing	54	32	33
Proposal Processing	57	20	36
TOTAL	**2115**	**900**	**8742**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	39	66.10%
16 – 30 days	10	16.95%
More than 30 days	10	16.95%
Total Pending	**59**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Malpractices or unfair business practices	UBP	3987	33.79%
Proposed Insurance not in the interest of proposer	UBP	1742	14.76%
Product differs from what was requested or disclosed.	UBP	1295	10.97%
Spurious calls or Hoax Calls	UBP	1073	9.09%
Tampering, Corrections, forgery of proposal or related papers	UBP	1022	8.66%
Single premium Policy issued as Annual premium policy	UBP	995	8.43%
Misappropriation of premiums	UBP	350	2.97%
Complaint raised with Insurer not addressed	O	243	2.06%
Poor disclosures of various Charges	ULIP	196	1.66%
Repudiation of Claim	DC	131	1.11%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	2115	17.92%
Partially in favour	900	7.63%
Reject	8742	74.08%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	7486	63.44%
Unit Linked Insurance Policy	2840	24.07%
Others	1180	10.00%
Health Insurance Policy	205	1.74%
Pension Policy (other than Unit Linked)	90	0.76%
TOTAL	**11801**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - IDBI Federal Life
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	2	
Received during the period	771	
Attended to during the period	773	100.00%
Pending as at the end of the period	0	0.00%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	694	90.01%
Survival Claims	21	2.72%
Death Claims	21	2.72%
Others	15	1.95%
Proposal Processing	12	1.56%
Policy Servicing	8	1.04%
TOTAL	**771**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	11.51	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	38	4.93%
o Email	76	9.86%
o Letter	29	3.76%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	28	3.63%
Insurer's portal	600	77.82%
TOTAL	**771**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	199		494
Survival Claims	3		18
Death Claims			21
Others	2		13
Proposal Processing	5		7
Policy Servicing	5		3
TOTAL	**214**	**0**	**556**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	0	
16 – 30 days	0	
More than 30 days	0	
Total Pending	**0**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Intermediary did not provide material information concerning proposed cover	UBP	205	12.58%
Tampering, Corrections, forgery of proposal or related papers	UBP	152	8.43%
Single premium Policy issued as Annual premium policy	UBP	120	8.43%
Malpractices or unfair business practices	UBP	73	5.71%
Premium paying period projected is different from actual	UBP	52	3.24%
Illegitimate inducements offered	UBP	19	2.33%
Term(Period) of the policy is different/altered without consent	UBP	19	2.08%
Repudiation of Claim	DC	18	1.82%
Free-look refund not paid	UBP	17	1.30%
Misappropriation of premiums	UBP	17	1.04%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	214	27.76%
Partially in favour	0	0.00%
Reject	556	72.11%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	600	77.82%
Unit Linked Insurance Policy	152	19.71%
Others	13	1.69%
Health Insurance Policy	4	0.52%
Pension Policy (other than Unit Linked)	2	0.26%
TOTAL	**771**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - India First Life
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	47	
Received during the period	1287	
Attended to during the period	1216	91.15%
Pending as at the end of the period	118	8.85%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	928	72.11%
Policy Servicing	129	10.02%
Survival Claims	121	9.40%
Proposal Processing	53	4.12%
Death Claims	27	2.10%
ULIP Related	17	1.32%
Others	12	0.93%
TOTAL	**1287**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	10.7	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	16	1.24%
o Email	17	1.32%
o Letter	7	0.54%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	20	1.55%
Insurer's portal	1227	95.34%
TOTAL	**1287**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	488	68	328
Policy Servicing	94	17	12
Survival Claims	64	6	41
Proposal Processing	38	6	8
Death Claims	3	2	22
ULIP Related	13	2	1
Others	5	2	4
TOTAL	**705**	**103**	**416**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	46	38.98%
16 – 30 days	1	0.85%
More than 30 days	71	60.17%
Total Pending	**118**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Malpractices or unfair business practices	UBP	423	32.87%
Spurious calls or Hoax Calls	UBP	184	14.30%
Product differs from what was requested or disclosed.	UBP	166	12.90%
Payment of premium not acted upon or wrongly acted upon	PS	93	7.23%
Surrender Value not paid	SC	58	4.51%
Misappropriation of premiums	UBP	52	4.04%
Single premium Policy issued as Annual premium policy	UBP	44	3.42%
Survival Benefit is not paid	SC	36	2.80%
After submission of all requirements, no communication was received.	PP	21	1.63%
Disputes concerning correctness of surrender value	SC	20	1.55%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	705	54.78%
Partially in favour	103	8.00%
Reject	416	32.32%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	788	61.23%
Others	378	29.37%
Unit Linked Insurance Policy	71	5.52%
Health Insurance Policy	47	3.65%
Pension Policy (other than Unit Linked)	3	0.23%
TOTAL	**1287**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Kotak Mahindra Life
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	8	
Received during the period	4616	
Attended to during the period	4496	97.23%
Pending as at the end of the period	128	2.77%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	3705	80.26%
Policy Servicing	290	6.28%
Others	224	4.85%
Survival Claims	117	2.53%
ULIP Related	104	2.25%
Proposal Processing	99	2.14%
Death Claims	77	1.67%
TOTAL	**4616**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	26.69	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	153	3.31%
o Email	282	6.11%
o Letter	187	4.05%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	150	3.25%
Insurer's portal	3844	83.28%
TOTAL	**4616**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	883	136	2581
Policy Servicing	97	5	180
Others	66	15	138
Survival Claims	45	1	70
ULIP Related	28	3	70
Proposal Processing	43		53
Death Claims	25		49
TOTAL	**1187**	**160**	**3141**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	126	98.44%
16 – 30 days	0	0.00%
More than 30 days	2	1.56%
Total Pending	128	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Malpractices or unfair business practices	UBP	2562	55.50%
Product differs from what was requested or disclosed.	UBP	234	5.07%
Complaint raised with Insurer not addressed	O	183	3.96%
Tampering, Corrections, forgery of proposal or related papers	UBP	176	3.81%
Premium paying period projected is different from actual	UBP	129	2.79%
Misappropriation of premiums	UBP	121	2.62%
Single premium Policy issued as Annual premium policy	UBP	104	2.25%
Surrender value projected is different from actual	UBP	72	1.56%
Illegitimate inducements offered	UBP	66	1.43%
Policy bond not received.	PP	63	1.36%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	1187	25.71%
Partially in favour	160	3.47%
Reject	3141	68.05%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	2371	51.36%
Unit Linked Insurance Policy	1519	32.91%
Others	607	13.15%
Pension Policy (other than Unit Linked)	100	2.17%
Health Insurance Policy	19	0.41%
TOTAL	**4616**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - LIC
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	0	
Received during the period	80944	
Attended to during the period	80944	100.00%
Pending as at the end of the period	0	0.00%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Policy Servicing	40268	49.75%
Others	16681	20.61%
Survival Claims	15063	18.61%
Proposal Processing	4174	5.16%
Unfair Business Practices	2363	2.92%
Death Claims	1706	2.11%
ULIP Related	689	0.85%
TOTAL	**80944**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	3.82	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	1042	1.29%
o Email	1019	1.26%
o Letter	596	0.74%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	1134	1.40%
Insurer's portal	77153	95.32%
TOTAL	**80944**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Policy Servicing	37314	1628	1321
Others	15334	741	605
Survival Claims	13683	808	568
Proposal Processing	3866	191	116
Unfair Business Practices	2150	121	92
Death Claims	1361	229	115
ULIP Related	621	40	28
TOTAL	**74329**	**3758**	**2845**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	0	
16 – 30 days	0	
More than 30 days	0	
Total Pending	**0**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Complaint raised with Insurer not addressed	O	13583	16.78%
Non-receipt of Premium receipt	PS	9406	11.62%
Survival Benefit is not paid	PS	6621	8.18%
No Response for recording Change of address	PS	6579	8.13%
Payment of premium not acted upon or wrongly acted upon	PS	4881	6.03%
Premium payment position statement not received	PS	4815	5.95%
Maturity claim is not paid	SC	3899	4.82%
Surrender Value not paid	SC	2411	2.98%
Request for Servicing Branch transfer is not effected	PS	2407	2.97%
Statement of account not received	PS	2325	2.87%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	74329	91.83%
Partially in favour	3758	4.64%
Reject	2845	3.51%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	72150	89.14%
Unit Linked Insurance Policy	3811	4.71%
Pension Policy (other than Unit Linked)	2923	3.61%
Health Insurance Policy	1708	2.11%
Others	352	0.43%
TOTAL	**80944**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Max Life
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	0	
Received during the period	16553	
Attended to during the period	16549	99.98%
Pending as at the end of the period	4	0.02%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	8261	49.91%
Proposal Processing	3807	23.00%
Policy Servicing	2653	16.03%
Survival Claims	938	5.67%
Others	582	3.52%
Death Claims	218	1.32%
ULIP Related	94	0.57%
TOTAL	**16553**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	7.68	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	221	1.34%
o Email	381	2.30%
o Letter	175	1.06%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	251	1.52%
Insurer's portal	15525	93.79%
TOTAL	**16553**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	4042	497	3720
Proposal Processing	3591	93	122
Policy Servicing	2338	132	176
Survival Claims	695	49	193
Others	431	21	129
Death Claims	32	2	184
ULIP Related	76	4	14
TOTAL	**11205**	**798**	**4538**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	4	100.00%
16 – 30 days	0	0.00%
More than 30 days	0	0.00%
Total Pending	**4**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Spurious calls or Hoax Calls	UBP	2633	15.91%
Malpractices or unfair business practices	UBP	2610	15.77%
Payment of premium not acted upon or wrongly acted upon	PS	1357	8.20%
Policy bond not received.	PP	1166	7.04%
Alteration in policy not effected.	PS	1033	6.24%
Product differs from what was requested or disclosed.	UBP	1031	6.23%
Mistakes in the name and address of the insured.	PP	951	5.75%
Mistakes in any other policy schedule item.	PP	817	4.94%
Complaint raised with Insurer not addressed	O	563	3.40%
Tampering, Corrections, forgery of proposal or related papers	UBP	555	3.35%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	11205	67.69%
Partially in favour	798	4.82%
Reject	4538	27.41%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	9036	54.59%
Unit Linked Insurance Policy	4725	28.54%
Others	2674	16.15%
Health Insurance Policy	88	0.53%
Pension Policy (other than Unit Linked)	30	0.18%
TOTAL	**16553**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - PNB MetLife
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	4	
Received during the period	4820	
Attended to during the period	4817	99.85%
Pending as at the end of the period	7	0.15%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	3009	62.43%
Survival Claims	647	13.42%
Policy Servicing	594	12.32%
Proposal Processing	249	5.17%
ULIP Related	209	4.34%
Death Claims	96	1.99%
Others	16	0.33%
TOTAL	**4820**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	6.08	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	181	3.76%
o Email	218	4.52%
o Letter	181	3.76%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	118	2.45%
Insurer's portal	4122	85.52%
TOTAL	**4820**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	885	8	2109
Survival Claims	474	15	157
Policy Servicing	466	16	112
Proposal Processing	207	2	40
ULIP Related	169	5	35
Death Claims	15	8	73
Others	2		14
TOTAL	**2218**	**54**	**2540**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	6	85.71%
16 – 30 days	0	0.00%
More than 30 days	1	14.29%
Total Pending	**7**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Malpractices or unfair business practices	UBP	1373	28.49%
Tampering, Corrections, forgery of proposal or related papers	UBP	600	12.45%
Spurious calls or Hoax Calls	UBP	522	10.83%
Surrender Value not paid	SC	379	7.86%
Payment of premium not acted upon or wrongly acted upon	PS	298	6.18%
Survival Benefit is not paid	SC	171	3.55%
Policy bond not received.	PP	138	2.86%
Free-look refund not paid	UBP	127	2.63%
Product differs from what was requested or disclosed.	UBP	113	2.34%
Single premium Policy issued as Annual premium policy	UBP	99	2.05%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	2218	46.02%
Partially in favour	54	1.12%
Reject	2540	52.70%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	2405	49.90%
Unit Linked Insurance Policy	1836	38.09%
Others	553	11.47%
Health Insurance Policy	16	0.33%
Pension Policy (other than Unit Linked)	10	0.21%
TOTAL	**4820**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Reliance Life
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	45	
Received during the period	24763	
Attended to during the period	24318	98.02%
Pending as at the end of the period	490	1.98%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	19899	80.36%
Policy Servicing	1171	4.73%
Proposal Processing	1151	4.65%
Survival Claims	1127	4.55%
Others	814	3.29%
Death Claims	455	1.84%
ULIP Related	146	0.59%
TOTAL	**24763**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	21.41	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	761	3.07%
o Email	794	3.21%
o Letter	518	2.09%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	401	1.62%
Insurer's portal	22289	90.01%
TOTAL	**24763**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	5969	968	12572
Policy Servicing	881	64	178
Proposal Processing	1047	34	60
Survival Claims	562	121	414
Others	423	67	318
Death Claims	167	45	230
ULIP Related	83	3	58
TOTAL	**9132**	**1302**	**13830**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	452	92.24%
16 – 30 days	25	5.10%
More than 30 days	13	2.65%
Total Pending	**490**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Malpractices or unfair business practices	UBP	15432	62.32%
Policy bond not received.	PP	1009	4.07%
Spurious calls or Hoax Calls	UBP	924	3.73%
Complaint raised with Insurer not addressed	O	781	3.15%
Tampering, Corrections, forgery of proposal or related papers	UBP	775	3.13%
Misappropriation of premiums	UBP	736	2.97%
Payment of premium not acted upon or wrongly acted upon	PS	713	2.88%
Illegitimate inducements offered	UBP	499	2.02%
Surrender Value not paid	SC	447	1.81%
Single premium Policy issued as Annual premium policy	UBP	440	1.78%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	9132	36.88%
Partially in favour	1302	5.26%
Reject	13830	55.85%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	17271	69.75%
Others	4935	19.93%
Unit Linked Insurance Policy	2175	8.78%
Health Insurance Policy	200	0.81%
Pension Policy (other than Unit Linked)	182	0.73%
TOTAL	**24763**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Sahara Life
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	0	
Received during the period	27	
Attended to during the period	27	100.00%
Pending as at the end of the period	0	0.00%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Survival Claims	13	48.15%
Unfair Business Practices	7	25.93%
Death Claims	3	11.11%
Others	3	11.11%
Policy Servicing	1	3.70%
TOTAL	**27**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	10.87	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	7	25.93%
o Email	3	11.11%
o Letter	2	7.41%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	4	14.81%
Insurer's portal	11	40.74%
TOTAL	**27**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Survival Claims	1	2	10
Unfair Business Practices		3	4
Death Claims			3
Others			3
Policy Servicing		1	
TOTAL	**1**	**6**	**20**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	0	
16 – 30 days	0	
More than 30 days	0	
Total Pending	**0**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Surrender Value not paid	SC	6	22.22%
Malpractices or unfair business practices	UBP	4	14.81%
Death claim not paid	DC	3	11.11%
Complaint raised with Insurer not addressed	O	3	11.11%
Disputes concerning correctness of surrender value	SC	2	7.41%
Survival Benefit is not paid	SC	2	7.41%
Dispute concerning claim value	SC	2	7.41%
Misappropriation of premiums	UBP	2	7.41%
Spurious calls or Hoax Calls	UBP	1	3.70%
Statement of account not received	PS	1	3.70%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	1	3.70%
Partially in favour	6	22.22%
Reject	20	74.07%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	15	55.56%
Unit Linked Insurance Policy	6	22.22%
Others	4	14.81%
Health Insurance Policy	2	7.41%
TOTAL	**27**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - SBI Life
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	5	
Received during the period	12273	
Attended to during the period	12263	99.88%
Pending as at the end of the period	15	0.12%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	5765	46.97%
Proposal Processing	3942	32.12%
Survival Claims	1054	8.59%
Policy Servicing	930	7.58%
Others	287	2.34%
Death Claims	150	1.22%
ULIP Related	145	1.18%
TOTAL	**12273**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	7.33	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	182	1.48%
o Email	244	1.99%
o Letter	163	1.33%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	137	1.12%
Insurer's portal	11547	94.08%
TOTAL	**12273**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	1057	526	4173
Proposal Processing	2832	182	927
Survival Claims	210	100	742
Policy Servicing	268	133	529
Others	50	19	216
Death Claims	21	5	123
ULIP Related	17	15	113
TOTAL	**4455**	**980**	**6823**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	12	80.00%
16 – 30 days	0	0.00%
More than 30 days	3	20.00%
Total Pending	**15**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Policy bond not received.	PP	3583	29.19%
Malpractices or unfair business practices	UBP	2758	22.47%
Tampering, Corrections, forgery of proposal or related papers	UBP	555	4.52%
Product differs from what was requested or disclosed.	UBP	390	3.18%
Payment of premium not acted upon or wrongly acted upon	PS	362	2.95%
Intermediary did not provide material information concerning proposed cover	UBP	345	2.81%
Single premium Policy issued as Annual premium policy	UBP	300	2.44%
Illegitimate inducements offered	UBP	275	2.24%
Complaint raised with Insurer not addressed	O	256	2.09%
Dispute concerning claim value	SC	244	1.99%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	4455	36.30%
Partially in favour	980	7.99%
Reject	6823	55.59%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	7689	62.65%
Unit Linked Insurance Policy	3144	25.62%
Others	1133	9.23%
Pension Policy (other than Unit Linked)	282	2.30%
Health Insurance Policy	25	0.20%
TOTAL	**12273**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - ShriRam Life
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	8	
Received during the period	240	
Attended to during the period	234	94.35%
Pending as at the end of the period	14	5.65%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	156	65.00%
Others	18	7.50%
Proposal Processing	17	7.08%
Death Claims	16	6.67%
Survival Claims	16	6.67%
Policy Servicing	9	3.75%
ULIP Related	8	3.33%
TOTAL	**240**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	14.33	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	43	17.92%
o Email	61	25.42%
o Letter	51	21.25%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	24	10.00%
Insurer's portal	61	25.42%
TOTAL	**240**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	12		140
Others			18
Proposal Processing	1		16
Death Claims	2		14
Survival Claims	2		14
Policy Servicing			9
ULIP Related	3		5
TOTAL	**20**	**0**	**216**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	4	28.57%
16 – 30 days	1	7.14%
More than 30 days	9	64.29%
Total Pending	**14**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Malpractices or unfair business practices	UBP	95	39.58%
Spurious calls or Hoax Calls	UBP	19	7.92%
Complaint raised with Insurer not addressed	UBP	17	7.08%
Death claim not paid	DC	12	5.00%
Free-look refund not paid	UBP	11	4.58%
Product differs from what was requested or disclosed.	UBP	10	4.17%
Policy bond not received.	PP	9	3.75%
Tampering, Corrections, forgery of proposal or related papers	UBP	9	3.75%
Surrender Value not paid	SC	8	3.33%
Premium payment position statement not received	PS	4	1.67%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	20	8.33%
Partially in favour	0	0.00%
Reject	216	90.00%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	175	72.92%
Others	42	17.50%
Unit Linked Insurance Policy	20	8.33%
Health Insurance Policy	3	1.25%
TOTAL	**240**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Star Union Daichi Life
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	9	
Received during the period	2301	
Attended to during the period	2215	95.89%
Pending as at the end of the period	95	4.11%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	786	34.16%
Policy Servicing	736	31.99%
Survival Claims	499	21.69%
Proposal Processing	197	8.56%
Others	49	2.13%
Death Claims	18	0.78%
ULIP Related	16	0.70%
TOTAL	**2301**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	12.5	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	19	0.83%
o Email	44	1.91%
o Letter	16	0.70%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	29	1.26%
Insurer's portal	2193	95.31%
TOTAL	**2301**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	533	23	206
Policy Servicing	595	53	69
Survival Claims	413	21	54
Proposal Processing	175	5	6
Others	39	3	6
Death Claims	12	4	2
ULIP Related	11	1	4
TOTAL	**1778**	**110**	**347**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	26	27.37%
16 – 30 days	10	10.53%
More than 30 days	59	62.11%
Total Pending	**95**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Payment of premium not acted upon or wrongly acted upon	PS	487	21.16%
Malpractices or unfair business practices	UBP	261	11.34%
Policy bond not received.	PP	169	7.34%
Maturity claim is not paid	SC	158	6.87%
Product differs from what was requested or disclosed.	UBP	155	6.74%
Surrender Value not paid	SC	155	6.74%
Premium payment position statement not received	PS	108	4.69%
Free-look refund not paid	UBP	85	3.69%
Single premium Policy issued as Annual premium policy	UBP	84	3.65%
Survival Benefit is not paid	SC	75	3.26%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	1778	77.27%
Partially in favour	110	4.78%
Reject	347	15.08%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Unit Linked Insurance Policy	1381	60.02%
Conventional Life Insurance Policy	858	37.29%
Others	60	2.61%
Health Insurance Policy	2	0.09%
TOTAL	**2301**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Tata AIA Life
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	55	
Received during the period	4690	
Attended to during the period	4632	97.62%
Pending as at the end of the period	113	2.38%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	2643	56.35%
Policy Servicing	993	21.17%
Survival Claims	476	10.15%
Proposal Processing	255	5.44%
ULIP Related	180	3.84%
Death Claims	95	2.03%
Others	48	1.02%
TOTAL	**4690**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	11.59	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	90	1.92%
o Email	164	3.50%
o Letter	97	2.07%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	128	2.73%
Insurer's portal	4211	89.79%
TOTAL	**4690**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	883	20	1701
Policy Servicing	423	25	531
Survival Claims	136	9	325
Proposal Processing	108	8	134
ULIP Related	39	7	131
Death Claims	4	2	87
Others	3	2	40
TOTAL	**1596**	**73**	**2949**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	20	17.70%
16 – 30 days	9	7.96%
More than 30 days	84	74.34%
Total Pending	**113**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Product differs from what was requested or disclosed.	UBP	624	13.30%
Spurious calls or Hoax Calls	UBP	614	13.09%
Tampering, Corrections, forgery of proposal or related papers	UBP	441	9.40%
Payment of premium not acted upon or wrongly acted upon	PS	324	6.91%
Misappropriation of premiums	UBP	291	6.20%
Malpractices or unfair business practices	UBP	278	5.93%
Policy Benefit option not effected	PS	161	3.43%
Policy bond not received.	PP	153	3.26%
Disputes concerning correctness of surrender value	SC	121	2.58%
Surrender Value not paid	SC	112	2.39%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	1596	34.03%
Partially in favour	73	1.56%
Reject	2949	62.88%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	2192	46.74%
Unit Linked Insurance Policy	1721	36.70%
Others	646	13.77%
Pension Policy (other than Unit Linked)	66	1.41%
Health Insurance Policy	65	1.39%
TOTAL	**4690**	

Data on Grievances – 2014-15
Summary of complaints, disposal & Resolution
- Non Life - Insurer wise

1. Apollo Munich Health Insurance Co Ltd
2. Bajaj Allianz General Insurance Company Ltd
3. Bharti AXA General Insurance Company Limited
4. Cholamandalam MS General Insurance Co. Ltd.
5. Cigna TTK Health Insurance Co. Ltd.
6. Export Credit Guarantee Corporation of India Ltd
7. Future Generali India Insurance Company limited
8. HDFC Ergo General Insurance Company Ltd.
9. ICICI Lombard General Insurance Company Ltd
10. IFFCO TOKIO General Insurance Co. Ltd.
11. L And T General Insurance Company Limited
12. Liberty Videocon General Insurance Co. Ltd
13. Magma HDI General Insurance Company Ltd.
14. Max Bupa Health Insurance Company Limited
15. National Insurance Company Limited
16. Reliance General Insurance Co Ltd
17. Religare Health Insurance Company Limited
18. Royal Sundaram Alliance Insurance Co. Ltd
19. SBI General Insurance Co. Ltd.
20. Shriram General Insurance Co. LTD.
21. Star Health And Allied Insurance Company Ltd
22. TATA AIG General Insurance Company Ltd.
23. The New India Assurance Co. Ltd.
24. The Oriental Insurance Company Ltd.
25. United India Insurance Company Limited
26. Universal Sompo General Insurance Co Ltd

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Apollo Munich Health
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	3	
Received during the period	2061	
Attended to during the period	2051	99.37%
Pending as at the end of the period	13	0.63%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	1152	55.90%
Policy Related	453	21.98%
Others	213	10.33%
Proposal Related	93	4.51%
Premium	74	3.59%
Refund	51	2.47%
Product	13	0.63%
Coverage	12	0.58%
TOTAL	**2061**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	8.5	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	121	5.87%
o Email	149	7.23%
o Letter	32	1.55%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	109	5.29%
Insurer's portal	1650	80.06%
TOTAL	**2061**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	278	16	853
Policy Related	362	3	86
Others	99	4	108
Proposal Related	36	4	51
Premium	32		42
Refund	39		12
Product	5		8
Coverage	6		6
TOTAL	**857**	**27**	**1166**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	12	92.31%
16 – 30 days	0	0.00%
More than 30 days	1	7.69%
Total Pending	**13**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Insurer not disposed of the claim	Claim	365	17.71%
Certificate of Insurance / Policy not received by the Insured	Policy Related	327	15.87%
Insurer asking for claim documents on a piecemeal basis.	Claim	149	7.23%
Insurer failed to clarify the queries raised by Insured.	Others	145	7.04%
Insurer asking for irrelevant claim documents	Claim	144	6.99%
Delay on the part of TPA to arrange claim reimbursement.	Claim	118	5.73%
Claim repudiated without giving reasons	Claim	89	4.32%
Difference between assessed loss and amount settled by Insurer.	Claim	59	2.86%
Claim denied due to alleged non-cooperation of Insured	Claim	57	2.77%
Insurer accepted premium and then rejected the proposal	Proposal Related	55	2.67%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	857	41.58%
Partially in favour	27	1.31%
Reject	1166	56.57%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Health Insurance	2061	100.00%
TOTAL	**2061**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Bajaj Allianz General
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	5	
Received during the period	4770	
Attended to during the period	4571	95.73%
Pending as at the end of the period	204	4.27%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Policy Related	1762	36.94%
Others	1735	36.37%
Claim	684	14.34%
Proposal Related	261	5.47%
Cover Note Related	130	2.73%
Premium	83	1.74%
Refund	78	1.64%
Coverage	24	0.50%
Product	13	0.27%
TOTAL	**4770**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	1.77	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	95	1.99%
o Email	149	3.12%
o Letter	57	1.19%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	129	2.70%
Insurer's portal	4340	90.99%
TOTAL	**4770**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Policy Related	1678	10	23
Others	1700	1	4
Claim	560	30	55
Proposal Related	252		8
Cover Note Related	122	1	4
Premium	77	2	2
Refund	72	2	1
Coverage	23		1
Product	11		
TOTAL	**4495**	**46**	**98**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	14	6.86%
16 – 30 days	7	3.43%
More than 30 days	183	89.71%
Total Pending	**204**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
TPA not sent ID card to Insured.	Others	1579	33.10%
Certificate of Insurance / Policy not received by the Insured	Policy Related	482	10.10%
Insurer not disposed of the claim	Claim	367	7.69%
Details shown in policy or Add-on are incorrect.	Policy Related	321	6.73%
Insured asked for issue of a duplicate policy – Insurer failed to issue	Policy Related	291	6.10%
Insurer collected premium – Issued policy without any proposal or confirmation in writing from Insured	Proposa l Related	236	4.95%
Endorsement for modification of policy/add on not issued by the Insurer	Policy Related	228	4.78%
Product no longer available with Insurer	Policy Related	184	3.86%
Cover Note not received	Cover Note Related	123	2.58%
Delay in appointment of surveyor	Claim	85	1.78%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	4495	94.23%
Partially in favour	46	0.96%
Reject	98	2.05%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Health Insurance	2683	56.25%
Motor Insurance	1933	40.52%
Others	126	2.64%
Fire	20	0.42%
Crop	3	0.06%
Marine Cargo	3	0.06%
Marine Hull	1	0.02%
Engineering	1	0.02%
TOTAL	**4770**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Bharati Axa General
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	0	
Received during the period	4586	
Attended to during the period	4481	97.71%
Pending as at the end of the period	105	2.29%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	2335	50.92%
Policy Related	1841	40.14%
Refund	149	3.25%
Others	114	2.49%
Premium	56	1.22%
Coverage	35	0.76%
Cover Note Related	30	0.65%
Proposal Related	13	0.28%
Product	13	0.28%
TOTAL	**4586**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	6.37	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	85	1.85%
o Email	91	1.98%
o Letter	25	0.55%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	120	2.62%
Insurer's portal	4265	93.00%
TOTAL	**4586**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	100	2017	179
Policy Related	1726	81	10
Refund	136	6	
Others	85	18	5
Premium	54	2	
Coverage	29	5	
Cover Note Related	29	1	
Proposal Related	13		
Product	11	1	1
TOTAL	**2183**	**2131**	**195**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	49	46.67%
16 – 30 days	7	6.67%
More than 30 days	49	46.67%
Total Pending	**105**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Certificate of Insurance / Policy not received by the Insured	Policy Related	811	17.68%
Surveyor delayed issue of his report.	Claim	497	10.84%
Insurer not disposed of the claim	Claim	280	6.11%
Insurer failed to make offer of settlement to Insured after receipt of survey report.	Claim	235	5.12%
Details shown in policy or Add-on are incorrect.	Policy Related	227	4.95%
Endorsement for modification of policy/add on not issued by the Insurer	Policy Related	211	4.60%
Difference between assessed loss and amount settled by Insurer.	Claim	193	4.21%
Survey report copy not issued to the Insured by the surveyor.	Claim	176	3.84%
Insurer refusing to register claim	Claim	175	3.82%
Insured asked for issue of a duplicate policy – Insurer failed to issue	Policy Related	175	3.82%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	2183	47.60%
Partially in favour	2131	46.47%
Reject	195	4.25%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Motor Insurance	3947	86.07%
Health Insurance	505	11.01%
Others	119	2.59%
Fire	7	0.15%
Marine Cargo	5	0.11%
Marine Hull	1	0.02%
Crop	1	0.02%
Engineering	1	0.02%
TOTAL	**4586**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Cholamandalam MS General
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	10	
Received during the period	2508	
Attended to during the period	2415	95.91%
Pending as at the end of the period	103	4.09%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Policy Related	1499	59.77%
Claim	752	29.98%
Others	154	6.14%
Cover Note Related	54	2.15%
Refund	32	1.28%
Product	12	0.48%
Coverage	2	0.08%
Premium	2	0.08%
Proposal Related	1	0.04%
TOTAL	**2508**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	4.7	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	20	0.80%
o Email	20	0.80%
o Letter	26	1.04%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	14	0.56%
Insurer's portal	2428	96.81%
TOTAL	**2508**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Policy Related	1406		35
Claim	482		252
Others	134		6
Cover Note Related	35		14
Refund	30		1
Product	9		3
Coverage	1		1
Premium	1		1
Proposal Related	1		
TOTAL	**2099**	**0**	**313**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	25	24.27%
16 – 30 days	2	1.94%
More than 30 days	76	73.79%
Total Pending	**103**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Certificate of Insurance / Policy not received by the Insured	Policy Related	1369	54.59%
Insurer not disposed of the claim	Claim	433	17.26%
Insurer not issued claim cheque inspite of offer of settlement.	Claim	179	7.14%
TPA not sent ID card to Insured.	Others	130	5.18%
Delay on the part of TPA to arrange claim reimbursement.	Claim	108	4.31%
Details shown in policy or Add-on are incorrect.	Policy Related	83	3.31%
Cover Note not received	Cover Note Related	54	2.15%
Refund of premium due under policy not received by Insured.	Refund	18	0.72%
Endorsement for modification of policy/add on not issued by the Insurer	Policy Related	18	0.72%
Dispute regarding quantum of premium refund.	Refund	14	0.56%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	2099	83.69%
Partially in favour	0	0.00%
Reject	313	12.48%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Motor Insurance	1659	66.15%
Health Insurance	581	23.17%
Fire	226	9.01%
Others	38	1.52%
Engineering	3	0.12%
Marine Cargo	1	0.04%
TOTAL	**2508**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Cigna TTK Health
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	0	
Received during the period	75	
Attended to during the period	71	94.67%
Pending as at the end of the period	4	5.33%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Others	39	52.00%
Refund	8	10.67%
Proposal Related	7	9.33%
Claim	7	9.33%
Policy Related	6	8.00%
Coverage	4	5.33%
Cover Note Related	2	2.67%
Premium	2	2.67%
TOTAL	**75**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	8.27	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	3	4.00%
o Email	2	2.67%
o Letter	0	0.00%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	8	10.67%
Insurer's portal	62	82.67%
TOTAL	**75**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Others	31		4
Refund	5		3
Proposal Related	4		3
Claim			7
Policy Related	5		1
Coverage	3		1
Cover Note Related	2		
Premium	2		
TOTAL	**52**		**19**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	4	100.00%
16 – 30 days	0	0.00%
More than 30 days	0	0.00%
Total Pending	**4**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Alleged misconduct of officials of Insurer.	Others	34	45.33%
Insurer accepted premium and then rejected the proposal	Proposal Related	7	9.33%
Refund of premium due under policy not received by Insured.	Refund	6	8.00%
Insurer failed to clarify the queries raised by Insured.	Others	5	6.67%
Delay on the part of TPA to arrange claim reimbursement.	Claim	4	5.33%
Dispute relating to Interpretation of perils/exclusions/conditions/ warranties	Coverage	3	4.00%
Cover Note not received	Cover Note Related	2	2.67%
Dispute regarding quantum of premium refund.	Refund	2	2.67%
Certificate of Insurance / Policy not received by the Insured	Policy Related	2	2.67%
Insurer refused to accept Insured's request to enhance coverage mid-term.	Policy Related	1	1.33%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	52	69.33%
Partially in favour	0	0.00%
Reject	19	25.33%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Health Insurance	73	97.33%
Others	2	2.67%
TOTAL	**75**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - ECGC of India
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	43	
Received during the period	46	
Attended to during the period	43	48.31%
Pending as at the end of the period	46	51.69%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	38	82.61%
Proposal Related	4	8.70%
Coverage	2	4.35%
Refund	1	2.17%
Others	1	2.17%
TOTAL	**46**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	98.76	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	1	2.17%
o Email	2	4.35%
o Letter	6	13.04%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	4	8.70%
Insurer's portal	33	71.74%
TOTAL	**46**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	2		24
Proposal Related			1
Coverage	1		
Refund			
Others			
TOTAL	**3**		**25**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	0	0.00%
16 – 30 days	0	0.00%
More than 30 days	46	100.00%
Total Pending	46	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Insurer repudiated the claim due to alleged breach of policy condition / warranty.	Claim	19	41.30%
Insurer not disposed of the claim	Claim	7	15.22%
Insurer asking for claim documents on a piecemeal basis.	Claim	6	13.04%
Insurer accepted premium and then rejected the proposal	Proposal Related	3	6.52%
Insurer refusing to register claim	Claim	2	4.35%
Dispute relating to Interpretation of perils/exclusions/conditions/ warranties	Coverage	2	4.35%
Difference between assessed loss and amount settled by Insurer.	Claim	2	4.35%
Proposal form given by Insured was tampered by Agent / Insurer	Proposal Related	1	2.17%
Claim denied due to alleged non-cooperation of Insured	Claim	1	2.17%
Refund of premium due under policy not received by Insured.	Refund	1	2.17%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	3	6.52%
Partially in favour	0	0.00%
Reject	25	54.35%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Others	26	56.52%
Credit	18	39.13%
Marine Cargo	2	4.35%
TOTAL	**46**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Future Generali India
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	0	
Received during the period	3727	
Attended to during the period	3727	100.00%
Pending as at the end of the period	0	0.00%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	1797	48.22%
Policy Related	1433	38.45%
Others	169	4.53%
Cover Note Related	125	3.35%
Product	107	2.87%
Proposal Related	71	1.91%
Premium	15	0.40%
Refund	7	0.19%
Coverage	3	0.08%
TOTAL	**3727**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	4.8	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	28	0.75%
o Email	36	0.97%
o Letter	12	0.32%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	33	0.89%
Insurer's portal	3618	97.08%
TOTAL	**3727**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	634	41	1121
Policy Related	1310	1	121
Others	95		74
Cover Note Related	82		43
Product	43	2	62
Proposal Related	35		35
Premium	7		8
Refund	3		4
Coverage	2		1
TOTAL	**2211**	**44**	**1469**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	0	
16 – 30 days	0	
More than 30 days	0	
Total Pending	**0**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Certificate of Insurance / Policy not received by the Insured	Policy Related	1107	29.70%
Insurer not disposed of the claim	Claim	551	14.78%
Difference between assessed loss and amount settled by Insurer.	Claim	548	14.70%
Delay in appointment of surveyor	Claim	167	4.48%
Details shown in policy or Add-on are incorrect.	Policy Related	161	4.32%
Delay in conducing survey.	Claim	120	3.22%
Cover Note not received	Cover Note Related	118	3.17%
Product (policy) received by insured is not what it was negotiated at the time of sale.	Product	107	2.87%
Insurer failed to make offer of settlement to Insured after receipt of survey report.	Claim	93	2.50%
Insurer not issued claim cheque inspite of offer of settlement.	Claim	79	2.12%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	2211	59.32%
Partially in favour	44	1.18%
Reject	1469	39.42%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Motor Insurance	3137	84.17%
Others	423	11.35%
Health Insurance	112	3.01%
Marine Cargo	25	0.67%
Fire	20	0.54%
Engineering	10	0.27%
TOTAL	**3727**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - HDFC ERGO General
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	2	
Received during the period	2086	
Attended to during the period	2065	98.90%
Pending as at the end of the period	23	1.10%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	1008	48.32%
Policy Related	799	38.30%
Cover Note Related	129	6.18%
Others	128	6.14%
Product	10	0.48%
Refund	6	0.29%
Premium	3	0.14%
Coverage	2	0.10%
Proposal Related	1	0.05%
TOTAL	**2086**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	5.38	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	66	3.16%
o Email	118	5.66%
o Letter	34	1.63%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	85	4.07%
Insurer's portal	1783	85.47%
TOTAL	**2086**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	237	2	754
Policy Related	732		61
Cover Note Related	124		5
Others	30		96
Product	3		7
Refund	2		4
Premium	1		2
Coverage	1		1
Proposal Related			1
TOTAL	**1130**	**2**	**931**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	23	100.00%
16 – 30 days	0	0.00%
More than 30 days	0	0.00%
Total Pending	**23**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Certificate of Insurance / Policy not received by the Insured	Policy Rel	762	36.53%
Insurer not disposed of the claim	Claim	508	24.35%
Insurer repudiated the claim due to alleged breach of policy condition / warranty.	Claim	160	7.67%
Cover Note not received	C N R	129	6.18%
Insurer reduced the Quantum of claim for reasons not indicated in the policy.	Claim	108	5.18%
Insurer repudiated claim due to "pre-existing disease exclusion"	Claim	46	2.21%
Insurer failed to clarify the queries raised by Insured.	Others	45	2.16%
Claim repudiated without giving reasons	Claim	29	1.39%
Insurer asking for irrelevant claim documents	Claim	23	1.10%
Difference between assessed loss and amount settled by Insurer.	Claim	21	1.01%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	1130	54.17%
Partially in favour	2	0.10%
Reject	931	44.63%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Motor Insurance	1162	55.70%
Health Insurance	713	34.18%
Others	201	9.64%
Fire	7	0.34%
Marine Cargo	2	0.10%
Engineering	1	0.05%
TOTAL	**2086**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - ICICI Lombard General
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	24	
Received during the period	5930	
Attended to during the period	5582	93.75%
Pending as at the end of the period	372	6.25%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	1991	33.58%
Policy Related	1652	27.86%
Others	1284	21.65%
Premium	845	14.25%
Refund	120	2.02%
Coverage	13	0.22%
Proposal Related	12	0.20%
Product	12	0.20%
Cover Note Related	1	
TOTAL	**5930**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	14.29	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	274	4.62%
o Email	411	6.93%
o Letter	125	2.11%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	250	4.22%
Insurer's portal	4870	82.12%
TOTAL	5930	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	1738		165
Policy Related	1505		1
Others	1232		2
Premium	781		1
Refund	119		
Coverage	8		3
Proposal Related	11		
Product	11		1
Cover Note Related	1		
TOTAL	**5406**		**173**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	252	67.74%
16 – 30 days	36	9.68%
More than 30 days	84	22.58%
Total Pending	372	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Insurer not issued claim cheque inspite of offer of settlement.	Claim	1250	21.08%
Insured asked for cancellation of policy, Insurer failed to respond	Policy Related	725	12.23%
Insurer calculated premium wrongly and over charged the Insured.	Premium	483	8.15%
Alleged misconduct of surveyor / investigator.	Others	376	6.34%
Rebating resorted to by Agent.	Others	298	5.03%
Insurer not disposed of the claim	Claim	291	4.91%
Alleged misconduct of officials of Insurer.	Others	251	4.23%
Insured asked for issue of a duplicate policy – Insurer failed to issue	Policy Related	222	3.74%
Certificate of Insurance / Policy not received by the Insured	Policy Related	208	3.51%
Important clauses deliberately shown in small print	Policy Related	188	3.17%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	5406	91.16%
Partially in favour	0	0.00%
Reject	173	2.92%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Motor Insurance	3238	54.60%
Health Insurance	1605	27.07%
Others	1075	18.13%
Fire	7	0.12%
Marine Hull	3	0.05%
Marine Cargo	2	0.03%
TOTAL	**5930**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - IFFCO Tokio General
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	9	
Received during the period	2043	
Attended to during the period	1889	92.06%
Pending as at the end of the period	163	7.94%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	1401	68.58%
Policy Related	409	20.02%
Others	197	9.64%
Premium	17	0.83%
Refund	9	0.44%
Product	4	0.20%
Coverage	3	0.15%
Proposal Related	3	0.15%
TOTAL	**2043**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	21.68	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	109	5.34%
o Email	158	7.73%
o Letter	54	2.64%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	99	4.85%
Insurer's portal	1623	79.44%
TOTAL	**2043**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	1073	122	143
Policy Related	316	67	8
Others	102	39	38
Premium	8	3	1
Refund	3	3	
Product	2		2
Coverage	2		1
Proposal Related		1	1
TOTAL	**1506**	**235**	**194**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	19	11.66%
16 – 30 days	20	12.27%
More than 30 days	124	76.07%
Total Pending	**163**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Insurer not disposed of the claim	Claim	1230	60.21%
Certificate of Insurance / Policy not received by the Insured	Policy Rel	343	16.79%
Alleged misconduct of surveyor / investigator.	Others	82	4.01%
Insurer failed to clarify the queries raised by Insured.	Others	37	1.81%
Difference between assessed loss and amount settled by Insurer.	Claim	30	1.47%
Endorsement for modification of policy/add on not issued by the Insurer	Policy Rel	29	1.42%
Insurer reduced the Quantum of claim for reasons not indicated in the policy.	Claim	23	1.13%
Misbehavior of surveyor towards the Insured	Others	21	1.03%
Claim repudiated without giving reasons	Claim	15	0.73%
Insurer closed the claim without advising the Insured any reasons.	Claim	13	0.64%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	1506	73.72%
Partially in favour	235	11.50%
Reject	194	9.50%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Motor Insurance	1861	91.09%
Health Insurance	138	6.75%
Others	33	1.62%
Fire	6	0.29%
Marine Cargo	4	0.20%
Engineering	1	0.05%
TOTAL	**2043**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - L&T General
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	1	
Received during the period	431	
Attended to during the period	427	98.84%
Pending as at the end of the period	5	1.16%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Policy Related	167	38.75%
Claim	99	22.97%
Others	98	22.74%
Refund	46	10.67%
Proposal Related	10	2.32%
Premium	7	1.62%
Product	3	0.70%
Coverage	1	0.23%
TOTAL	**431**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	6.8	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	18	4.18%
o Email	28	6.50%
o Letter	8	1.86%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	21	4.87%
Insurer's portal	356	82.60%
TOTAL	**431**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Policy Related	147		20
Claim	45		54
Others	64	1	32
Refund	37		7
Proposal Related	1		9
Premium	6		1
Product	2		1
Coverage	1		
TOTAL	**303**	**1**	**124**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	4	80.00%
16 – 30 days	1	20.00%
More than 30 days	0	0.00%
Total Pending	**5**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Certificate of Insurance / Policy not received by the Insured	Policy Rel	101	23.43%
Insurer not disposed of the claim	Claim	84	19.49%
Insurer failed to clarify the queries raised by Insured.	Others	67	15.55%
Endorsement for modification of policy/add on not issued by the Insurer	Policy Rel	56	12.99%
Refund of premium due under policy not received by Insured.	Refund	44	10.21%
No response from TPA / Insurer for queries raised / clarifications sought by Insured.	Others	24	5.57%
Insurer accepted premium and then rejected the proposal	Proposal Rel	10	2.32%
Insurer calculated premium wrongly and over charged the Insured.	Premium	6	1.39%
Insured asked for cancellation of policy, Insurer failed to respond	Policy Rel	6	1.39%
Difference between assessed loss and amount settled by Insurer.	Others	4	0.93%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	303	70.30%
Partially in favour	1	0.23%
Reject	124	28.77%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Health Insurance	250	58.00%
Others	92	21.35%
Motor Insurance	83	19.26%
Fire	3	0.70%
Marine Hull	1	0.23%
Engineering	1	0.23%
Marine Cargo	1	0.23%
TOTAL	**431**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Liberty Videocon
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	0	
Received during the period	356	
Attended to during the period	350	98.31%
Pending as at the end of the period	6	1.69%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	234	65.73%
Policy Related	93	26.12%
Others	11	3.09%
Refund	8	2.25%
Premium	3	0.84%
Proposal Related	2	0.56%
Cover Note Related	2	0.56%
Product	2	0.56%
Coverage	1	0.28%
TOTAL	**356**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	3.55	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	7	1.97%
o Email	3	0.84%
o Letter	1	0.28%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	6	1.69%
Insurer's portal	339	95.22%
TOTAL	**356**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	86	4	141
Policy Related	73		18
Others	4		7
Refund	7		
Premium	3		
Proposal Related	2		
Cover Note Related	1		1
Product	1		1
Coverage			1
TOTAL	**177**	**4**	**169**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	4	66.67%
16 – 30 days	0	0.00%
More than 30 days	2	33.33%
Total Pending	**6**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Dispute on obsolete factor.	Claim	153	42.98%
Insurer not disposed of the claim	Claim	55	15.45%
Certificate of Insurance / Policy not received by the Insured	Policy Rel	52	14.61%
Endorsement for modification of policy/add on not issued by the Insurer	Policy Rel	16	4.49%
Details shown in policy or Add-on are incorrect.	Policy Rel	14	3.93%
Details shown in policy different from the Cover Note.	Policy Rel	10	2.81%
Delay in appointment of surveyor	Claim	9	2.53%
Refund of premium due under policy not received by Insured.	Refund	5	1.40%
Delay in conducing survey.	Claim	5	1.40%
Insurer repudiated the claim due to alleged breach of policy condition / warranty.	Claim	3	0.84%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	177	49.72%
Partially in favour	4	1.12%
Reject	169	47.47%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Motor Insurance	347	97.47%
Health Insurance	7	1.97%
Others	1	0.28%
Engineering	1	0.28%
TOTAL	**356**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Magma HDI General
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	0	
Received during the period	101	
Attended to during the period	92	91.09%
Pending as at the end of the period	9	8.91%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	62	61.39%
Policy Related	21	20.79%
Others	10	9.90%
Refund	3	2.97%
Premium	3	2.97%
Product	1	0.99%
Proposal Related	1	0.99%
TOTAL	**101**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	17.06	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	16	15.84%
o Email	6	5.94%
o Letter	6	5.94%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	5	4.95%
Insurer's portal	68	67.33%
TOTAL	**101**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	25	4	24
Policy Related	18		3
Others	5	3	1
Refund	2		1
Premium	2		1
Product			1
Proposal Related			1
TOTAL	**52**	**7**	**32**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	4	44.44%
16 – 30 days	1	11.11%
More than 30 days	4	44.44%
Total Pending	**9**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Insurer not disposed of the claim	Claim	39	38.61%
Certificate of Insurance / Policy not received by the Insured	Policy Rel	13	12.87%
Insurer failed to clarify the queries raised by Insured.	Others	5	4.95%
Details shown in policy or Add-on are incorrect.	Policy Rel	4	3.96%
Difference between assessed loss and amount settled by Insurer.	Claim	3	2.97%
Endorsement for modification of policy/add on not issued by the Insurer	Policy Rel	3	2.97%
Dispute regarding quantum of premium refund.	Refund	3	2.97%
Surveyor delayed issue of his report.	Claim	2	1.98%
Insurer refusing to register claim	Claim	2	1.98%
Insurer reduced the Quantum of claim for reasons not indicated in the policy.	Claim	2	1.98%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	52	51.49%
Partially in favour	7	6.93%
Reject	32	31.68%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Motor Insurance	95	94.06%
Health Insurance	5	4.95%
Others	1	0.99%
TOTAL	**101**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Max Bupa Health
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	2	
Received during the period	427	
Attended to during the period	429	100.00%
Pending as at the end of the period	0	0.00%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	286	66.98%
Others	60	14.05%
Policy Related	28	6.56%
Premium	23	5.39%
Proposal Related	10	2.34%
Refund	10	2.34%
Product	8	1.87%
Coverage	2	0.47%
TOTAL	**427**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	6.61	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	91	21.31%
o Email	126	29.51%
o Letter	28	6.56%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	130	30.44%
Insurer's portal	52	12.18%
TOTAL	**427**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	35	49	202
Others	32	11	17
Policy Related	9	10	9
Premium	5	17	1
Proposal Related	1	1	8
Refund	5	4	1
Product	1	5	2
Coverage			2
TOTAL	**88**	**97**	**242**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	0	
16 – 30 days	0	
More than 30 days	0	
Total Pending	**0**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Insurer not disposed of the claim	Claim	139	32.55%
Insurer failed to clarify the queries raised by Insured.	Others	50	11.71%
Insurer repudiated claim due to "pre-existing disease exclusion"	Claim	30	7.03%
Claim repudiated without giving reasons	Claim	26	6.09%
Insurer repudiated the claim due to alleged breach of policy condition / warranty.	Claim	24	5.62%
Insurer loaded premium arbitrarily	Premium	21	4.92%
Insurer refusing to register claim	Claim	10	2.34%
Insurer asking for irrelevant claim documents	Claim	9	2.11%
TPA refuses to extend cashless facility to the Insured.	Claim	8	1.87%
Product (policy) received by insured is not what it was negotiated at the time of sale.	Product	7	1.64%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	88	20.61%
Partially in favour	97	22.72%
Reject	242	56.67%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Health Insurance	419	98.13%
Others	7	1.64%
Motor Insurance	1	0.23%
TOTAL	**427**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - National Insurance
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	256	
Received during the period	4740	
Attended to during the period	4821	96.50%
Pending as at the end of the period	175	3.50%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	2549	53.78%
Others	1410	29.75%
Policy Related	527	11.12%
Premium	103	2.17%
Refund	53	1.12%
Cover Note Related	47	0.99%
Coverage	22	0.46%
Product	18	0.38%
Proposal Related	11	0.23%
TOTAL	**4740**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	34.03	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	215	4.54%
o Email	411	8.67%
o Letter	225	4.75%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	370	7.81%
Insurer's portal	3519	74.24%
TOTAL	**4740**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	1053	252	1140
Others	861	224	313
Policy Related	329	71	121
Premium	52	12	38
Refund	35	4	11
Cover Note Related	20	6	21
Coverage	13	2	7
Product	16		2
Proposal Related	7	2	2
TOTAL	**2386**	**573**	**1655**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	31	17.71%
16 – 30 days	15	8.57%
More than 30 days	129	73.71%
Total Pending	**175**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Insurer failed to make offer of settlement to Insured after receipt of survey report.	Claim	804	16.96%
Insurer failed to clarify the queries raised by Insured.	Others	690	14.56%
Insurer not disposed of the claim	Claim	551	11.62%
Refusal to renew Insurance	Others	387	8.16%
Difference between assessed loss and amount settled by Insurer.	Claim	188	3.97%
Insurer reduced the Quantum of claim for reasons not indicated in the policy.	Claim	176	3.71%
Certificate of Insurance / Policy not received by the Insured	Policy Rel	158	3.33%
Claim repudiated without giving reasons	Claim	130	2.74%
Insurer not issued claim cheque inspite of offer of settlement.	Claim	112	2.36%
TPA not sent ID card to Insured.	Others	106	2.24%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	2386	50.34%
Partially in favour	573	12.09%
Reject	1655	34.92%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Health Insurance	2901	61.20%
Motor Insurance	1285	27.11%
Others	369	7.78%
Fire	93	1.96%
Marine Cargo	67	1.41%
Engineering	16	0.34%
Marine Hull	8	0.17%
Credit	1	0.02%
TOTAL	**4740**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Reliance General
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	40	
Received during the period	1762	
Attended to during the period	1735	96.28%
Pending as at the end of the period	67	3.72%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Others	898	50.96%
Claim	577	32.75%
Policy Related	222	12.60%
Premium	21	1.19%
Product	19	1.08%
Refund	9	0.51%
Proposal Related	7	0.40%
Coverage	7	0.40%
Cover Note Related	2	0.11%
TOTAL	**1762**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	15.46	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	113	6.41%
o Email	95	5.39%
o Letter	64	3.63%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	147	8.34%
Insurer's portal	1343	76.22%
TOTAL	**1762**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Others	821	16	34
Claim	346	4	211
Policy Related	192	3	21
Premium	20		1
Product	17		2
Refund	7		1
Proposal Related	4	1	2
Coverage	5		2
Cover Note Related	2		
TOTAL	**1414**	**24**	**274**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	40	59.70%
16 – 30 days	5	7.46%
More than 30 days	22	32.84%
Total Pending	**67**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Failure of online transaction though premium was deducted through credit card.	Others	755	42.85%
Insurer not disposed of the claim	Claim	253	14.36%
Difference between assessed loss and amount settled by Insurer.	Claim	94	5.33%
Certificate of Insurance / Policy not received by the Insured	Policy Rel	82	4.65%
Delay on the part of TPA to arrange claim reimbursement.	Claim	64	3.63%
Details shown in policy different from the Cover Note.	Policy Rel	52	2.95%
Alleged misconduct of officials of Insurer.	Others	42	2.38%
Surveyor delayed issue of his report.	Claim	41	2.33%
Insurer failed to clarify the queries raised by Insured.	Others	38	2.16%
Claim repudiated without giving reasons	Claim	33	1.87%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	1414	80.25%
Partially in favour	24	1.36%
Reject	274	15.55%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Motor Insurance	1274	72.30%
Health Insurance	430	24.40%
Others	48	2.72%
Fire	6	0.34%
Marine Cargo	2	0.11%
Marine Hull	1	0.06%
Engineering	1	0.06%
TOTAL	**1762**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Religare Health
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	0	
Received during the period	423	
Attended to during the period	421	99.53%
Pending as at the end of the period	2	0.47%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	209	49.41%
Others	109	25.77%
Refund	33	7.80%
Policy Related	32	7.57%
Proposal Related	23	5.44%
Premium	10	2.36%
Coverage	6	1.42%
Product	1	0.24%
TOTAL	**423**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	9.09	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	28	6.62%
o Email	52	12.29%
o Letter	4	0.95%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	43	10.17%
Insurer's portal	296	69.98%
TOTAL	**423**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	38	3	168
Others	71	2	34
Refund	23	1	9
Policy Related	27		5
Proposal Related	10		13
Premium	3		7
Coverage	3		3
Product	1		
TOTAL	**176**	**6**	**239**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	0	0.00%
16 – 30 days	0	0.00%
More than 30 days	2	100.00%
Total Pending	**2**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Insurer not disposed of the claim	Claim	129	30.50%
Insurer failed to clarify the queries raised by Insured.	Others	99	23.40%
Insurer repudiated the claim due to alleged breach of policy condition / warranty.	Claim	25	5.91%
Dispute regarding quantum of premium refund.	Refund	22	5.20%
Insurer repudiated claim due to "pre-existing disease exclusion"	Claim	21	4.96%
Insurer accepted premium and then rejected the proposal	Proposal Related	21	4.96%
Certificate of Insurance / Policy not received by the Insured	Policy Related	20	4.73%
Difference between assessed loss and amount settled by Insurer.	Claim	19	4.49%
Refund of premium due under policy not received by Insured.	Refund	11	2.60%
Insurer loaded premium arbitrarily	Premium	10	2.36%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	176	41.61%
Partially in favour	6	1.42%
Reject	239	56.50%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Health Insurance	420	99.29%
Others	3	0.71%
TOTAL	**423**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Royal Sundaram Alliance General 01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	2	
Received during the period	4976	
Attended to during the period	4912	98.67%
Pending as at the end of the period	66	1.33%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Policy Related	3146	63.22%
Claim	1146	23.03%
Others	493	9.91%
Premium	75	1.51%
Refund	53	1.07%
Product	37	0.74%
Coverage	14	0.28%
Proposal Related	10	0.20%
Cover Note Related	2	0.04%
TOTAL	**4976**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	6.76	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	46	0.92%
o Email	78	1.57%
o Letter	25	0.50%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	64	1.29%
Insurer's portal	4763	95.72%
TOTAL	**4976**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Policy Related	3056	39	27
Claim	488	370	267
Others	357	81	38
Premium	61	10	3
Refund	40	7	6
Product	17	11	8
Coverage	9	3	1
Proposal Related	9		1
Cover Note Related	2		
TOTAL	**4039**	**521**	**351**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	64	96.97%
16 – 30 days	0	0.00%
More than 30 days	2	3.03%
Total Pending	66	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Certificate of Insurance / Policy not received by the Insured	Policy Related	2506	50.36%
Insurer not disposed of the claim	Claim	530	10.65%
Details shown in policy or Add-on are incorrect.	Policy Related	256	5.14%
Insurer failed to clarify the queries raised by Insured.	Others	180	3.62%
Difference between assessed loss and amount settled by Insurer.	Claim	130	2.61%
TPA not sent ID card to Insured.	Others	96	1.93%
Insurer not issued claim cheque inspite of offer of settlement.	Claim	87	1.75%
Change of address not noted	Policy Related	82	1.65%
Insurer repudiated claim due to "pre-existing disease exclusion"	Claim	78	1.57%
Refusal to renew Insurance	Others	73	1.47%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	4039	81.17%
Partially in favour	521	10.47%
Reject	351	7.05%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Health Insurance	3141	63.12%
Motor Insurance	1384	27.81%
Others	446	8.96%
Engineering	3	0.06%
Fire	1	0.02%
Marine Cargo	1	0.02%
TOTAL	**4976**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - SBI General
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	42	
Received during the period	1325	
Attended to during the period	1050	76.81%
Pending as at the end of the period	317	23.19%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Policy Related	575	43.40%
Others	352	26.57%
Claim	312	23.55%
Refund	46	3.47%
Premium	16	1.21%
Proposal Related	8	0.60%
Product	8	0.60%
Coverage	5	0.38%
Cover Note Related	3	0.23%
TOTAL	**1325**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	19.99	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	40	3.02%
o Email	34	2.57%
o Letter	15	1.13%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	36	2.72%
Insurer's portal	1200	90.57%
TOTAL	**1325**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Policy Related	399		60
Others	254	1	25
Claim	116	1	114
Refund	35		3
Premium	6		2
Proposal Related	4		2
Product	5		
Coverage	4		
Cover Note Related			1
TOTAL	**823**	**2**	**207**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	16	5.05%
16 – 30 days	11	3.47%
More than 30 days	290	91.48%
Total Pending	**317**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Certificate of Insurance / Policy not received by the Insured	Policy Related	245	18.49%
Failure of online transaction though premium was deducted through credit card.	Others	234	17.66%
Insurer not disposed of the claim	Claim	138	10.42%
Without the consent of Insured Insurer debited customer bank A/c / credit card and issued policy.	Policy Related	134	10.11%
Insurer repudiated the claim due to alleged breach of policy condition / warranty.	Claim	97	7.32%
Endorsement for modification of policy/add on not issued by the Insurer	Policy Related	90	6.79%
Insurer failed to clarify the queries raised by Insured.	Others	67	5.06%
Details shown in policy or Add-on are incorrect.	Policy Related	46	3.47%
Refund of premium due under policy not received by Insured.	Refund	38	2.87%
Difference between assessed loss and amount settled by Insurer.	Claim	27	2.04%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	823	62.11%
Partially in favour	2	0.15%
Reject	207	15.62%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Others	1280	96.60%
Motor Insurance	26	1.96%
Health Insurance	15	1.13%
Fire	4	0.30%
TOTAL	**1325**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Shriram General
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	0	
Received during the period	135	
Attended to during the period	135	100.00%
Pending as at the end of the period	0	0.00%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	102	75.56%
Policy Related	21	15.56%
Others	9	6.67%
Proposal Related	1	0.74%
Refund	1	0.74%
Premium	1	0.74%
TOTAL	**135**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	28.26	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	27	20.00%
o Email	23	17.04%
o Letter	26	19.26%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	35	25.93%
Insurer's portal	24	17.78%
TOTAL	**135**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	20	15	67
Policy Related	17		4
Others	3		6
Proposal Related			1
Refund	1		
Premium	1		
TOTAL	**42**	**15**	**78**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	0	
16 – 30 days	0	
More than 30 days	0	
Total Pending	**0**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Insurer not disposed of the claim	Claim	65	48.15%
Certificate of Insurance / Policy not received by the Insured	Policy Related	21	15.56%
Insurer failed to clarify the queries raised by Insured.	Others	9	6.67%
Difference between assessed loss and amount settled by Insurer.	Claim	8	5.93%
Claim repudiated without giving reasons	Claim	6	4.44%
Survey report copy not issued to the Insured by the surveyor.	Claim	6	4.44%
Insurer repudiated claim due to delay in intimation of claim by Insured.	Claim	2	1.48%
Insurer refusing to register claim	Claim	2	1.48%
Insurer failed to make offer of settlement to Insured after receipt of survey report.	Claim	2	1.48%
Insurer closed the claim without advising the Insured any reasons.	Claim	2	1.48%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	42	31.11%
Partially in favour	15	11.11%
Reject	78	57.78%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Motor Insurance	124	91.85%
Others	4	2.96%
Fire	4	2.96%
Health Insurance	3	2.22%
TOTAL	**135**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Star Health and Allied
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	12	
Received during the period	2785	
Attended to during the period	2631	94.07%
Pending as at the end of the period	166	5.93%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Policy Related	1346	48.33%
Claim	1224	43.95%
Others	128	4.60%
Premium	43	1.54%
Refund	21	0.75%
Proposal Related	15	0.54%
Coverage	5	0.18%
Product	3	0.11%
TOTAL	**2785**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	12.03	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	102	3.66%
o Email	210	7.54%
o Letter	85	3.05%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	143	5.13%
Insurer's portal	2245	80.61%
TOTAL	**2785**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Policy Related	845	310	104
Claim	230	495	468
Others	49	23	53
Premium	7	7	28
Refund	13	6	2
Proposal Related	7	3	5
Coverage	1	1	3
Product	3		
TOTAL	**1155**	**845**	**663**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	110	66.27%
16 – 30 days	1	0.60%
More than 30 days	55	33.13%
Total Pending	**166**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Certificate of Insurance / Policy not received by the Insured	Policy Related	692	24.85%
Delay on the part of TPA to arrange claim reimbursement.	Claim	373	13.39%
Claim repudiated without giving reasons	Claim	229	8.22%
Insured asked for cancellation of policy, Insurer failed to respond	Policy Related	199	7.15%
Insurer not disposed of the claim	Claim	152	5.46%
Insurer repudiated claim due to delay in submission of claim documents by the Insured.	Claim	121	4.34%
Details shown in policy or Add-on are incorrect.	Policy Related	96	3.45%
Insurer refused to renew the policy without giving any reasons.	Policy Related	90	3.23%
Insurer failed to clarify the queries raised by Insured.	Others	71	2.55%
Insurer asking for claim documents on a piecemeal basis.	Claim	68	2.44%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	1155	41.47%
Partially in favour	845	30.34%
Reject	663	23.81%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Health Insurance	2740	98.38%
Others	44	1.58%
Motor Insurance	1	0.04%
TOTAL	**2785**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Tata-AIG General
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	0	
Received during the period	3963	
Attended to during the period	3926	99.07%
Pending as at the end of the period	37	0.93%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Policy Related	1646	41.53%
Claim	1071	27.02%
Coverage	588	14.84%
Others	413	10.42%
Refund	160	4.04%
Premium	48	1.21%
Proposal Related	22	0.56%
Product	8	0.20%
Cover Note Related	7	0.18%
TOTAL	**3963**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	6.44	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	60	1.51%
o Email	101	2.55%
o Letter	35	0.88%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	74	1.87%
Insurer's portal	3693	93.19%
TOTAL	**3963**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Policy Related	1370	100	163
Claim	479	291	296
Coverage	293	107	179
Others	303	39	65
Refund	122	14	23
Premium	32	5	10
Proposal Related	8	4	9
Product	4	2	2
Cover Note Related	6		1
TOTAL	**2617**	**562**	**748**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	36	97.30%
16 – 30 days	0	0.00%
More than 30 days	1	2.70%
Total Pending	37	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Certificate of Insurance / Policy not received by the Insured	Policy Related	1111	28.03%
Insurer reduced the Quantum of claim for reasons not indicated in the policy.	Claim	622	15.70%
Dispute relating to Interpretation of perils/exclusions/conditions/ warranties	Coverage	569	14.36%
Insurer not disposed of the claim	Claim	333	8.40%
Endorsement for modification of policy/add on not issued by the Insurer	Policy Related	284	7.17%
Insurer failed to clarify the queries raised by Insured.	Others	239	6.03%
Refund of premium due under policy not received by Insured.	Refund	140	3.53%
Details shown in policy or Add-on are incorrect.	Policy Related	93	2.35%
Failure of online transaction though premium was deducted through credit card.	Others	84	2.12%
Insured asked for cancellation of policy, Insurer failed to respond	Policy Related	64	1.61%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	2617	66.04%
Partially in favour	562	14.18%
Reject	748	18.87%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Others	3647	92.03%
Health Insurance	175	4.42%
Motor Insurance	134	3.38%
Marine Cargo	4	0.10%
Fire	3	0.08%
TOTAL	**3963**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - The New India Assurance
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	99	
Received during the period	3204	
Attended to during the period	3201	96.91%
Pending as at the end of the period	102	3.09%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	2506	78.21%
Policy Related	370	11.55%
Others	198	6.18%
Premium	63	1.97%
Refund	48	1.50%
Coverage	9	0.28%
Product	4	0.12%
Cover Note Related	3	0.09%
Proposal Related	3	0.09%
TOTAL	**3204**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	50.29	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	128	4.00%
o Email	335	10.46%
o Letter	269	8.40%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	232	7.24%
Insurer's portal	2240	69.91%
TOTAL	**3204**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	932	235	1249
Policy Related	261	34	62
Others	107	22	56
Premium	27	2	30
Refund	31	6	10
Coverage	2	3	3
Product	1	1	
Cover Note Related	2		1
Proposal Related	2		1
TOTAL	**1365**	**303**	**1412**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	26	25.49%
16 – 30 days	11	10.78%
More than 30 days	65	63.73%
Total Pending	**102**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Insurer not disposed of the claim	Claim	841	26.25%
Difference between assessed loss and amount settled by Insurer.	Claim	518	16.17%
Insurer not issued claim cheque inspite of offer of settlement.	Claim	180	5.62%
Insurer reduced the Quantum of claim for reasons not indicated in the policy.	Claim	166	5.18%
Insurer asking for irrelevant claim documents	Claim	161	5.02%
Delay on the part of TPA to arrange claim reimbursement.	Claim	160	4.99%
Insurer repudiated claim due to "pre-existing disease exclusion"	Claim	99	3.09%
Insurer failed to clarify the queries raised by Insured.	Others	91	2.84%
Insurer refused to renew the policy without giving any reasons.	Policy Rel	75	2.34%
Claim repudiated without giving reasons	Claim	72	2.25%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	1365	42.60%
Partially in favour	303	9.46%
Reject	1412	44.07%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Health Insurance	2028	63.30%
Motor Insurance	649	20.26%
Others	315	9.83%
Fire	138	4.31%
Marine Cargo	54	1.69%
Engineering	14	0.44%
Marine Hull	6	0.19%
TOTAL	**3204**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - The Oriental Insurance
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	66	
Received during the period	2165	
Attended to during the period	2172	97.36%
Pending as at the end of the period	59	2.64%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	1378	63.65%
Policy Related	317	14.64%
Others	274	12.66%
Premium	138	6.37%
Refund	20	0.92%
Cover Note Related	17	0.79%
Coverage	12	0.55%
Proposal Related	8	0.37%
Product	1	0.05%
TOTAL	**2165**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	30.18	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	211	9.75%
o Email	422	19.49%
o Letter	222	10.25%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	358	16.54%
Insurer's portal	952	43.97%
TOTAL	**2165**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	388	120	858
Policy Related	238	16	63
Others	167	26	80
Premium	60	16	62
Refund	10	5	4
Cover Note Related	15		2
Coverage	4	1	7
Proposal Related	2		6
Product			1
TOTAL	**884**	**184**	**1083**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	8	13.56%
16 – 30 days	1	1.69%
More than 30 days	50	84.75%
Total Pending	**59**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Insurer not disposed of the claim	Claim	712	32.89%
Certificate of Insurance / Policy not received by the Insured	Policy Related	134	6.19%
Delay on the part of TPA to arrange claim reimbursement.	Claim	107	4.94%
Insurer reduced the Quantum of claim for reasons not indicated in the policy.	Claim	102	4.71%
Insurer failed to clarify the queries raised by Insured.	Others	100	4.62%
Difference between assessed loss and amount settled by Insurer.	Claim	82	3.79%
Claim repudiated without giving reasons	Claim	70	3.23%
Insurer repudiated claim due to "pre-existing disease exclusion"	Claim	51	2.36%
Details shown in policy or Add-on are incorrect.	Policy Related	51	2.36%
TPA not sent ID card to Insured.	Others	49	2.26%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	884	40.83%
Partially in favour	184	8.50%
Reject	1083	50.02%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Health Insurance	1441	66.56%
Motor Insurance	394	18.20%
Others	204	9.42%
Fire	77	3.56%
Marine Cargo	29	1.34%
Engineering	17	0.79%
Crop	2	0.09%
Marine Hull	1	
TOTAL	**2165**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - United India Insurance
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	218	
Received during the period	5705	
Attended to during the period	5868	99.07%
Pending as at the end of the period	55	0.93%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	3245	56.88%
Policy Related	1248	21.88%
Others	695	12.18%
Premium	260	4.56%
Refund	113	1.98%
Coverage	56	0.98%
Cover Note Related	52	0.91%
Proposal Related	24	0.42%
Product	12	0.21%
TOTAL	**5705**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	29	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	187	3.28%
o Email	350	6.13%
o Letter	268	4.70%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	228	4.00%
Insurer's portal	4672	81.89%
TOTAL	**5705**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	1754	314	1142
Policy Related	1044	75	124
Others	509	59	122
Premium	183	25	48
Refund	88	11	14
Coverage	35	10	11
Cover Note Related	42	5	5
Proposal Related	14	1	9
Product	9	1	2
TOTAL	**3678**	**501**	**1477**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	26	47.27%
16 – 30 days	2	3.64%
More than 30 days	27	49.09%
Total Pending	**55**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Insurer not disposed of the claim	Claim	1109	26.05%
Certificate of Insurance / Policy not received by the Insured	Policy Related	571	13.41%
Difference between assessed loss and amount settled by Insurer.	Claim	318	7.47%
Delay on the part of TPA to arrange claim reimbursement.	Claim	266	6.25%
Details shown in policy or Add-on are incorrect.	Policy Related	229	5.38%
Insurer reduced the Quantum of claim for reasons not indicated in the policy.	Claim	219	5.14%
TPA reduces estimate given by the hospital without any reason.	Claim	189	4.44%
TPA not sent ID card to Insured.	Others	144	3.38%
Insurer repudiated the claim due to alleged breach of policy condition / warranty.	Claim	113	2.65%
Insurer failed to clarify the queries raised by Insured.	Others	107	2.51%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	3678	64.47%
Partially in favour	501	8.78%
Reject	1477	25.89%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Health Insurance	3083	54.04%
Motor Insurance	1710	29.97%
Others	578	10.13%
Fire	172	3.01%
Marine Cargo	108	1.89%
Engineering	44	0.77%
Marine Hull	7	0.12%
Crop	2	0.04%
Credit	1	0.02%
TOTAL	**5705**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Universal Sompo General
01-Apr-2014 TO 31-Mar-2015

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	0	
Received during the period	358	
Attended to during the period	358	100.00%
Pending as at the end of the period	0	0.00%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	302	84.36%
Policy Related	43	12.01%
Others	9	2.51%
Premium	2	0.56%
Refund	1	0.28%
Cover Note Related	1	0.28%
TOTAL	**358**	

AVERAGE RESOLUTION RATE		
Average Resolution Rate	13.38	

MODE OF RECEIPT OF COMPLAINTS		
IRDA		
o Telephone	22	6.15%
o Email	26	7.26%
o Letter	26	7.26%
o Fax	0	0.00%
o walk In	0	0.00%
IGMS portal	45	12.57%
Insurer's portal	239	66.76%
TOTAL	**358**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	211	4	86
Policy Related	2		41
Others	3		6
Premium	2		
Refund	1		
Cover Note Related	1		
TOTAL	**220**	**4**	**133**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	0	
16 – 30 days	0	
More than 30 days	0	
Total Pending	**0**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Insurer not disposed of the claim	Claim	259	72.35%
Certificate of Insurance / Policy not received by the Insured	Policy Related	41	11.45%
Insurer repudiated claim due to alleged fraud.	Claim	8	2.23%
Delay on the part of TPA to arrange claim reimbursement.	Claim	6	1.68%
Difference between assessed loss and amount settled by Insurer.	Claim	5	1.40%
Insurer failed to clarify the queries raised by Insured.	Others	5	1.40%
Insurer not issued claim cheque inspite of offer of settlement.	Claim	4	1.12%
Insurer asking for irrelevant claim documents	Claim	3	0.84%
Insurer reduced the Quantum of claim for reasons not indicated in the policy.	Claim	3	0.84%
Claim repudiated without giving reasons	Claim	3	0.84%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED		
In favour	220	61.45%
Partially in favour	4	1.12%
Reject	133	37.15%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Motor Insurance	203	56.70%
Health Insurance	104	29.05%
Others	37	10.34%
Fire	10	2.79%
Engineering	4	1.12%
TOTAL	**358**	

Important Regulations / Instructions

a) IRDA (Health Insurance) Regulations 2013

b) Guidelines on Standardization in Health Insurance 2013

c) IRDA (Linked Insurance Product) Regulations 2013

d) IRDA (Non-Linked Insurance Product) Regulations 2013

e) Premium rates for
Motor Third Party Liability Insurance Covers for 2015-16

a) IRDA (Health Insurance) Regulations 2013

INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY

NOTIFICATION

Hyderabad, the 16th February, 2013

Insurance Regulatory and Development Authority (Health Insurance) Regulations, 2013

F. No. IRDA/Reg./14/72/2013.—In exercise of the powers conferred under Section 114A of the Insurance Act 1938 and Section 14 read with section 26 of the IRDA Act 1999 and in consultation with the Insurance Advisory Committee, the Authority hereby makes the following regulations, namely:-

1. **Short title and commencement.**

   a. These Regulations may be called Insurance Regulatory and Development Authority (Health Insurance) Regulations, 2013

   b. They shall come into force from the date of their publication in the Official Gazette of the Government of India.

   c. Unless otherwise provided by this Regulation, nothing in this Regulation shall deem to invalidate the health insurance contracts entered prior to these Regulations coming into force

   d. These Regulations are applicable to all licensed life insurers, non-life insurers and health insurers, conducting health insurance business as defined under these regulations in India.

2. **Definitions.** In these Regulations, unless the context otherwise requires,--

   a. "Act" means the Insurance Act, 1938.
   b. "Agreement" means an agreement prescribing the terms and conditions of services, which may be rendered to the holders of health policies of an Insurance Company entered into between
      i. a Third Party Administrator (TPA) and an insurance company ; or
      ii. a Network provider and an Insurance Company, which may include a TPA as a third party.
      iii. a Network provider, a TPA, and the insurer.
   c. "Authority" means the Insurance Regulatory and Development Authority established under sub section 1 of section 3 of the IRDA Act 1999.
   d. "Break in policy" occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.
   e. "Cashless facility" means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization approved.
   f. "File and Use Procedure" means a procedure to be followed for health insurance product approval by the insurers in accordance with guidelines/circular issued by the Authority.
   g. "Health insurance business" or "health cover" means the effecting of insurance contracts which provide for sickness benefits or medical, surgical or hospital expense benefits, including assured benefits and long-term care, travel insurance and personal accident cover.

h. "Health Services by TPA" means the services rendered by a TPA to an insurer under an agreement in connection with health insurance business but does not include the business of an insurance company or the soliciting either directly or indirectly, of health insurance business or deciding on the admissibility of a claim or its rejection.

i. "Health plus Life Combi Products" mean products which offer the combination of a Pure Term Life Insurance cover of a life insurance companies and a Health Insurance cover offered by non-life and/or standalone health insurance companies.

j. "Network Provider" means hospitals or health care providers enlisted by an insurer or by a TPA and insurer together to provide medical services to an insured on payment by a cashless facility.

k. "Portability" means the right accorded to an individual health insurance policyholder (including family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer or from one plan to another plan of the same insurer, provided the previous policy has been maintained without any break.

l. "Senior citizen" means any person who has completed sixty or more years of age as on the date of commencement or renewal of a health insurance policy.

m. "Third Party Administrators or TPA means any person who is licensed under the IRDA (Third Party Administrators – Health Services) Regulations,2001 by the Authority, and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing health services.

n. All words or expressions not defined in these Regulations but defined in the Insurance Act 1938 or Insurance Regulatory and Development Authority Act 1999 shall have the same meanings respectively assigned to them in those Acts.

3. Registration and Scope of Health Business

a. Health Insurance products may be offered only by entities with a valid registration under the Insurance Regulatory and Development Authority (Registration of Indian Insurance Companies) Regulations 2001.

b. Life Insurance Companies may offer long term health products but the premium for such products shall remain unchanged for at least a period of every block of three years, thereafter the premium may be reviewed and modified as necessary.

c. Non-Life and Standalone Health insurance companies may offer individual health products with a minimum tenure of one year and a maximum tenure of three years, provided that the premium shall remain unchanged for the tenure.

d. Group Health Insurance Policies may be offered by any insurance company, provided that all such products shall only be one year renewable contracts. However, the non-life and standalone health insurers may offer group personal accident products with term less than one year also to provide coverage to any specific events.

e. Overseas or Domestic Travel Insurance policies may only be offered by non-life and standalone health insurance companies, either as a standalone product or as an add-on cover to an existing health policy, provided that the premium for the add-on cover is approved by the Authority under File And Use Procedure.

4. File and Use Procedure for health insurance products

a. No health insurance product shall be marketed by any insurer unless it has the prior clearance of the Authority accorded as per the File and Use Procedure.

b. Any subsequent revision or modification of any approved health insurance product shall also require the prior clearance of the Authority as per the guidelines issued from time to time.

i. Any revision or modification in a policy which is approved by the Authority shall be notified to each policy holder at least three months prior to the date when such revision or modification comes into effect. The notice shall set out the reasons for such revision or modification, in particular the reason for an increase in premium and the quantum of such increase.

ii. The possibility a revision or modification of the terms of the policy including the premium must be disclosed in the prospectus.

c. File & Use application for the prior approval of the Authority shall be certified by the Appointed Actuary and the CEO of the insurance company and shall be in such formats and accompanied by such documentation as may be stipulated by the Authority from time to time.

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d. **Withdrawal of Health Insurance Product**

i. To withdraw a health insurance product, the insurer shall take prior approval of the Authority by giving reasons for withdrawal and complete details of the treatment to the existing policyholders.

ii. The policy document shall clearly indicate the possibility of withdrawal of the products in the future and the options that would be available to the policyholder on withdrawal of the products.

iii. If the existing customer does not respond to the insurer's intimation, the policy shall be withdrawn on the renewal date and the insured shall have to take a new policy available with the insurer, subject to portability conditions.

iv. The withdrawn product shall not be offered to the prospective customers.

e. All particulars of any product shall after introduction be reviewed by the Appointed Actuary at least once a year. If the product is found to be financial unviable, or is deficient in any particular the Appointed Actuary may revise the product appropriately and apply for revision under File and Use procedure.

f. Five years after a product has been accorded File and Use approval, the Appointed Actuary shall review the performance of the product in terms of morbidity, lapse, interest rates, inflation, expenses and other relevant particulars as compared to the original assumptions made while designing such product and seek fresh approval with suitable justifications or modifications of the earlier assumptions made.

5. **General Provisions relating to Health Policies**

a. Health insurance product may be designed to offer various covers

i. To specified age or gender groups

ii. To different age groups

iii. To treatment in all hospitals throughout the country, provided the definition of hospital is met

iv. To treatment in specified hospitals only, provided the morbidity rates used are representative

v. To treatment in specified geographies only, provided the morbidity rates used are representative etc

provided, such specifications are disclosed upfront and clearly in the product prospectus, documents and sale process.

b. Insurer shall not compel the insured to migrate to other health insurance products, if it is to the disadvantage of insured.

c. Insurers shall ensure adequate dissemination of product information on all their health insurance products on their websites. This information shall include a description of the product, copies of the prospectus as approved under the File and Use Procedure, proposal form, policy document wordings and premium rates inclusive and exclusive of Service Tax as applicable.

d. **Nomination and Assignment**

i. All health insurance policies shall provide for a nomination registered at the time of the proposal in accordance with Section 39 of the Insurance Act, 1938.

ii. No assignment of health insurance policies shall be allowed irrespective of whether the coverage provided under such policies are indemnity based or benefit based. Provided that, in Life-Health Combi products, assignment may be allowed only for the life insurance component of the product in accordance with Section 38 of the Insurance Act, 1938.

e. **Entry and Exit Age**

i. Except as provided for in regulation j, all health insurance policies shall ordinarily provide for an entry age of at least up to 65 years.

ii. Except travel insurance products and for products in accordance with Regulation j and 4 (d) herein, once a proposal is accepted and a policy is issued which is thereafter renewed periodically without any break, further renewal shall not be denied on grounds of the age of the insured.

f. Renewal of Policies

i. A health insurance policy shall ordinarily be renewable except on grounds of fraud, moral hazard or misrepresentation or non-cooperation by the insured.

ii. The renewal of a health insurance policy sought by the insured shall not be denied arbitrarily. If denied, the insurer shall provide the policyholder with cogent reasons for such denial of renewal.

iii. A insurer shall not deny the renewal of a health insurance policy on the ground that the insured had made a claim or claims in the previous or earlier years, except for benefit based policies where the policy terminates following payment of the benefit covered under the policy like critical illness policy following payment of the critical illness benefit, the policy terminates.

iv. The insurer shall provide for a mechanism to condone a delay in renewal up to 30 days from the due date of renewal without deeming such condonation as a break in policy. However coverage need not be available for such period.

v. The promotion material and the policy document shall explicitly state the conditions under which a policy terminates, such as on the payment of the benefit in case of critical illness benefits policies.

g. Free Look Period

i. All Health insurance Policies shall have a free look period. The free look period shall be applicable at the inception of the policy and:

1. The insured will be allowed a period of at least 15 days from the date of receipt of the policy to review the terms and conditions of the policy and to return the same if not acceptable

2. If the insured has not made any claim during the free look period, the insured shall be entitled to-

a. A refund of the premium paid less any expenses incurred by the insurer on medical examination of the insured persons and the stamp duty charges or;

b. where the risk has already commenced and the option of return of the policy is exercised by the policyholder, a deduction towards the proportionate risk premium for period on cover or;

c. Where only a part of the risk has commenced, such proportionate risk premium commensurate with the risk covered during such period.

d. In respect of unit linked policy, in addition to the above deductions, the insurer shall also be entitled to repurchase the unit at the price of the units as on the date of the return of the policy.

h. Cost of pre-insurance health check up

i. The cost of any pre-insurance medical examination shall generally form part of the expenses allowed in arriving at the premium. However in case of products with term of one year and less, if such cost is to be incurred by the insured, not less than 50% of such cost shall be borne by the insurer once the proposal is accepted, except in travel insurance policies where such costs need not be reimbursed.

ii. Insurers shall maintain a list of, and the fees chargeable by, institutions where such pre-insurance medical examination may be conducted, the reports from which will be accepted by them. Such list shall be furnished to the prospective policyholder at the time of pre-insurance medical examination.

i. Cumulative bonus

i. Insurers may offer cumulative bonuses on indemnity based health insurance policies, which shall be stated explicitly in the prospectus and the policy document.

ii. If a claim is made in any particular year, the cumulative bonus accrued may be reduced at the same rate at which it is accrued;

iii. Cumulative bonus shall not be allowed on benefit based policies.

j. Option to migrate to suitable health insurance policy

i. Insurers offering health covers specific to age groups such as maternity covers, children under family floater policies, students etc, shall offer an option to migrate to a suitable health insurance policy at the end of the specified exit age or at the renewal of the policy by providing suitable credits for all the previous policy years, provided the policy has been maintained without a break.

k. All health insurance policies shall allow the portability of any policy in accordance with Schedule:I

l. **AYUSH Coverage**:

i. Insurers may provide coverage to non-allopathic treatments provided the treatment has been undergone in a government hospital or in any institute recognized by government and/or accredited by Quality Council of India/National Accreditation Board on Health or any other suitable institutions.

ii. For benefit based products, (i) shall not be applicable.

m. Disclosures/Declarations:

i. Subject to the provisions of these regulations, prospectus of health insurance policy shall mandatorily contain all the information regarding:

1. disclosures about the terms of its renewal.
2. coverage and premium applicable as per the age progression
3. disclosure of the maximum age up to when the renewal would be available, if product is offered to specified age groups and the option available to migrate to other policies in all such cases.
4. any changes in the scope of the cover after certain duration of the policy or after a certain age- such as including but not limited to coverage for pre-existing diseases;
5. whether renewal premium would be guaranteed or subject to revision;
6. details of specific circumstances, if any, where premium could be loaded (or discount withdrawn) by the insurer and also to the extent to which it could be done;
7. procedure and terms for enhancing the sum insured or scope of cover , if any;
8. all the exclusions, cancellation conditions and
9. other aspects in accordance with the extant regulations, guidelines, circulars etc on advertisements and disclosure requirements.

ii. Declarations shall only form part of the proposal form and shall not be included in the policy document. The standard declarations in the proposal form shall be:

1. "I/We hereby declare, on my behalf and on behalf of all persons proposed to be insured, that the above statements, answers and/or particulars given by me are true and complete in all respects to the best of my knowledge and that I/We am/are authorized to propose on behalf of these other persons.

2. I understand that the information provided by me will form the basis of the insurance policy, is subject to the Board approved underwriting policy of the insurance company and that the policy will come into force only after full receipt of the premium chargeable.

3. I/We further declare that I/we will notify in writing any change occurring in the occupation or general health of the life to be insured/proposer after the proposal has been submitted but before communication of the risk acceptance by the company.

4. I/We declare and consent to the company seeking medical information from any doctor or from a hospital who at anytime has attended on the life to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the life to be assured/proposer and seeking information from any insurance company to which an application for insurance on the life to be assured/proposer has been made for the purpose of underwriting the proposal and/or claim settlement.

5. I/We authorize the company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwriting and/or claims settlement and with any Governmental and/or Regulatory authority."

n. **Standard Definition of terms in health insurance policies**

i. Phrases and terms used in all health insurance policies shall carry the meaning attached to them as set out in 'Standard Definitions', if any, issued by the Authority from time to time.

o. **Standard Nomenclature and Procedures for Critical Illnesses**

i. The nomenclature and procedures incorporated into policies offering 'critical illness cover' shall be as defined by the Authority from time to time.

p. **Standard List of Excluded Expenses in Hospitalization Indemnity policies**

i. Hospitalization indemnity policies shall generally exclude from cover the Standard list of excluded items as may be stipulated by the Authority from time to time.

ii. However insurers may offer to cover as part of hospitalization expenses, items in the Standard excluded list or exclude items not in the list, provided that such modification is shall clearly stated and such modified list is annexed to the policy document.

q. **Special Provisions for Insured Persons who are Senior Citizens**

i. The premium charged for health insurance products offered to senior citizens shall be fair, justified, transparent and duly disclosed upfront. The insured shall be informed in writing of any underwriting loading charged over and above the premium and the specific consent of the policyholder for such loadings shall be obtained before issuance of a policy.

ii. All health insurers and TPAs, as the case may be, shall establish a separate channel to address the health insurance related claims and grievances of senior citizens.

r. **Multiple Policies**

i. If two or more policies are taken by an insured during a period from one or more insurers, the contribution clause shall not be applicable where the cover/benefit offered:

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1. is fixed in nature;

2. does not have any relation to the treatment costs;

ii. In case of multiple policies which provide fixed benefits, on the occurrence of the insured event in accordance with the terms and conditions of the policies, the insurer shall make the claim payments independent of payments received under other similar polices.

iii. If two or more policies are taken by an insured during a period from one or more insurers to indemnify treatment costs, the insurer shall not apply the contribution clause, but the policyholder shall have the right to require a settlement of his claim in terms of any of his policies.

1. In all such cases the insurer who has issued the chosen policy shall be obliged to settle the claim without insisting on the contribution clause as long as the claim is within the limits of and according to the terms of the chosen policy.

2. If the amount to be claimed exceeds the sum insured under a single policy after considering the deductibles or co-pay, the policy holder shall have the right to choose insurers by whom the claim to be settled. In such cases, the insurer may settle the claim with contribution clause.

3. Except in benefit policies, in cases where an insured has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the policy.

6. Underwriting

a. All Insurance Company's shall evolve a Health Insurance Underwriting Policy which shall be approved by the Board of the Company. The policy should among other matters prescribe the proposal form in which prospects may apply for purchasing a Health Policy. Such form should capture all the information necessary to underwrite a proposal in accordance with the stated Policy of the Company.

b. The Underwriting Policy shall be filed with the Authority. The Company retains the right to modify the Policy as it deems necessary, but every modification shall also be filed with the Authority.

c. Any proposal for health insurance may be accepted or denied wholly based on the Board approved underwriting policy. A denial of a proposal shall be communicated to the prospect in writing, recording the reasons for denial.

d. The insured shall be informed of any underwriting loading charged over and above the premium and the specific consent of the policyholder for such loadings shall be obtained before issuance of a policy.

e. If an insurance company requires any further information, such as change of occupation, at any subsequent stage of a policy or at the time of its renewal, it shall

i. prescribe standard forms to be filled up by the insured and shall make these forms part of the policy document

ii. Clearly state the events which will require the submission of such information.

iii. Clearly state the conditions applicable in such event.

f. Insurers may devise mechanisms or incentives to reward policyholders for early entry, continued renewals, favourable claims experience etc with the same insurer and disclose upfront such mechanism or incentives in the prospectus and the policy document, as approved under File and Use.

7. Principles of Pricing of Health Insurance Products

a. The premium for a health insurance policy shall be based on,

i. for individual policies, the completed age of the prospect on the date of inception of the policy or on the date of its renewal..

ii. for provision of cover under family floater, the impact of the multiple incidence rates of all family members proposed to be covered.

b. . The policy premiums shall be unchanged

i. for all group products and travel insurance products, for the entire period of cover.

ii. for all individual and family floater products, other than travel insurance products, for at least:

1. a period of one year in case of one year renewable policies and

2. for the period of the tenure as stipulated in Regulations 3 (b) and 3(c) herein in the case of multi-year policies..

c. For a period of three years after a product has been cleared under File and Use Procedure the premiums filed shall ordinarily not be changed. Thereafter the insurer may vary the premium rates depending on the experience, such rate shall not be changed for a period of at least one year from the date of clearance from the Authority.

d. Changes in rates will be applicable from the date of approval by the Authority and shall be applied only prospectively thereafter for new policies and at the date of renewal for renewals.

e. The reasonableness of the pricing as arrived at by the insurer will be assessed having regard to the financial sustainability and viability of the product with respect to the rates, loadings, guarantees and discounts, and the accuracy of the assumptions underlying the pricing model adopted.

f. At the time of filing the product under the File and Use procedure, the insurer shall provide:

i. complete pricing details including the methodology adopted to arrive at the premiums, together with the data sources utilized;

ii. assumptions made shall include the expected claim frequency and claim severities across age bands, expected expenses, lapse rates etc;

iii. specific loadings, if any, allowed;

iv. the profit margin at various model points or the expected loss ratios and the expected combined ratios across various model points across the entire portfolio;

v. the underwriting capacity required for the product and the actual capacity available with the insurer;

vi. the retention capacity to manage the business

vii. internal capacity building measures, if any, required to offer the proposed product and

viii. any other relevant metric for the product proposed.

g. Applications for revision of premium rates shall be filed before the Authority for approval under the File and Use Procedure and shall encompass

i. the justification for the revision in price;

ii. the claims experience of the three immediately preceding years compared to the expected experience duly explaining the variations, and the experience of any similar product.

iii. the expected claims experience, the assumptions underlying the proposed pricing along with an analysis of how the proposed pricing would address the adversities experienced sustainably.

h. **Loadings on Renewals:**

i. The loadings on renewals shall be in terms of increase or decrease in premiums offered for the entire portfolio and shall not be based on any individual policy claim experience.

ii. The discounts and loadings offered shall:

1. not be at the discretion of the insurer;

2. be based on an objective criteria;

3. be disclosed upfront in the prospectus and policy document along with the objective criteria, and shall be as approved under the File and Use.

i. **Upper Limit/Maximum Cover offered under a contract:**

i. If in a benefit based health insurance policy the insurer has prescribed any upper limit for any specified benefit or cover, the insurer shall not accept any proposal for a cover beyond such upper limit, unless the premium for such cover is separately charged.

ii. Complete pricing details on how such inbuilt limits are considered in arriving at the total premium shall be provided under the File and Use.

iii. If any proposal is accepted beyond such upper limit, the insurer shall not deny a claim on the ground that the policy exceeds the upper limit prescribed for that policy.

iv. However, the insurer may cancel the cover beyond such upper limit and shall return the proportionate premium, provided that

1. the policyholder, at the time of proposal, has not disclosed the existing and simultaneous policy details in the proposal form and

2. the existence of such policy is revealed only subsequently resulting in the cover accepted beyond the upper limit, and

3. Such other policy has been underwritten by another insurance company.

8. Protection of Policyholders' Interest

a. Unless otherwise provided, the IRDA (Policyholder Protection of Interest) Regulation, 2002 is applicable to all health insurance policies.

b. Every insured shall be provided with a Key Information Sheet setting out in simple language briefly but clearly all the important features of the policy, its claim limits, disallowances. The authority may prescribe such document.

c. The insurer shall establish necessary systems, procedures, offices and infrastructure to enable efficient issuance of pre-authorisations on a 24 hour basis and the prompt settlement of claims and grievances.

d. **Settlement/Rejection of claim by insurer:**

i. An insurer shall settle claims, including its rejection, within thirty days of the receipt of the last 'necessary' document.

ii. Except in cases where a fraud is suspected, ordinarily no document not listed in the policy terms and conditions shall be deemed 'necessary'. The insurer shall ensure that all the documents required for claims processing are called for at one time and shall not call for the documents in a piece meal manner.

iii. The information that the insurer has captured in the proposal form at the time of accepting the proposal, the terms & conditions offered under the policy, the medical history as revealed by earlier claims, if any, and the prior claims experience shall all be maintained by the insurer as an electronic record and shall not be called for again from the policyholder/insured at the time of subsequent claim settlements. If called, for such information will not be deemed 'necessary.'

iv. If the claim event falls within two policy periods, the claims shall be paid taking into

consideration the available sum insured in the two policy periods, including the deductibles for each policy period. Such eligible claim amount to be payable to the insured shall be reduced to the extent of premium to be received for the renewal/due date of premium of health insurance policy, if not received earlier.

v. Insurer may stipulate a period within which all necessary claim documents should be furnished by the policyholder/insured to make a claim. However, claims filed even beyond such period should be considered if there are valid reasons for any delay.

e. **Minimum Disclosures in Policy Document**: In addition to the requirements stipulated in IRDA (Protection of Policyholders' Interest) Regulations, 2000 the policy document shall contain:

i. List of disclosures required as per this regulation.

ii. Procedure for claims submission, time lines and possible course of action, if time lines for claim submission are not adhered to along with all the claims documents required for claim processing.

iii. Sub-limits applicable on any of the covers offered in the health insurance product and the impact of such sub-limits on other covers provided in the product, if any, shall be clearly spelt out.

iv. Penal interest provision shall invariably be incorporated in the policy document as per Regulation 9(6) of (Protection of Policyholders' Interests) Regulations, 2002.

v. The TPA(s) details, if any along with complete address and contact numbers shall be attached to the policy document and shall be updated as and when there is a change in the TPA (s).

9. Administration of Health Policies

a. Subject to the terms of a policy, insurers shall extend to all policy holders a cashless facility for treatment at specified establishments or the reimbursement of the costs of medical and health treatments or services availed at any medical establishment.

b. Cashless facility shall be offered only at establishments which have entered into an Agreement with the insurer to extend such services. Such establishments will be termed as Network Providers. Reimbursement shall be allowed at any medical establishment. All such establishments must be licensed or registered as may be required by any Local, State or National Law as applicable.

c. The administration of all health plus life-combi products shall be in accordance with the provisions of Schedule II to this Regulation as may be amended from time to time by the Authority.

d. Except in emergencies a cashless facility may require a Pre-Authorisation to be issued by the Insurer or an appointed TPA to the Network Provider where the treatment is to be undergone. The Authority may prescribe a Standard Pre-Authorisation form and standard reimbursement claims forms which shall be used for this purpose, as applicable.

e. To avail the benefit of cashless facility, insurers shall issue an Identification Card to the insured within 15 days from the date of issue of a policy, either through a TPA or directly.

f. The identification card shall, at the minimum, carry details of the policyholder and the logo of the insurer. The validity of card shall coincide with the term of the policy and mayas renewed from time to time. Insures may issue a Smart Card instead of an Identity Card.

g. Where a policyholder has been issued a pre-authorisation for the conduct of a given procedure in a given hospital or if the policyholder is already undergoing such treatment at a hospital, and such hospital is proposed to be removed from the list of Network Provider, then insurers shall provide the benefits of cashless facility to such policy holder as if such hospital continues to be on the Network Provider list.

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h. Insurer shall keep the insured informed of the list of Network Providers and display the same on their website and the appointed TPA's office. Such list shall be updated as and when there is any change in the Network providers.

i. The insured shall have access to all the Network Providers of an insurer to avail cashless facility as long as the insurer has a valid service agreement with the Network Provider and such Network Providers shall remain unchanged irrespective of change in TPAs.

j. An insurance company may enter into arrangement with other insurance companies for sharing of Network Providers, transfer of claim & transaction data arising in areas beyond their service areas.

10. **Agreement between Insurers, Network Providers and TPAs**

a. Insurance companies may offer policies providing cashless services to the policyholders provided:

i. The services are offered in network providers who have been enlisted to provide medical services either directly under an agreement with the insurer or by an agreement between health services provider, the TPA and the insurer.

ii. The Authority may, from time to time, prescribe clauses to be included in such agreements as stipulated in (b).

iii. the Agreements which shall be entered into between insurers, network providers/TPAs shall cover the following amongst others:

1. the tariff applicable with respect to various kinds of healthcare services being provided by the network provider.
2. a clause empowering the insurer to cancel or otherwise modify the agreement in case of any fraud, misrepresentation, inadequacy of service or other non-compliance or default on the part of TPA or network provider; provided no such cancellation or modification shall be done by the insurer unless the concerned TPA/ network provider is given an opportunity of being heard.
3. a standard clause providing for continuance of services by a network provider to the insurance company if the TPA is changed or the agreement with TPA is terminated.
4. a clause providing for opting out of network provider from a given TPA for reasons of inadequacy of service rendered by the TPA to the network provider.
5. a clause specifying the fees and other charges leviable by an insurance company to the TPA for services rendered.
6. a clause specifically requiring only the insurance company the power to deny a claim.
7. a clause enabling insurer to inspect the premises of the network provider at any time without prior intimation.

b. The Authority may from time to time prescribe standard clauses to be included in such agreements.

c. The insurance company shall endeavour to enter into Agreements with adequate number of both public and private sector providers with adequate geographical spread.

11. **Payments to Network Providers and Settlement of Claims of Policyholders**:

a. For the purpose of claim settlement, insurer shall make direct payments to the Network provider and to the policyholders by integrating their banking system platform with the network provider or the insured,

as the case may be. Provided that, if a claimant opts for payment through a cheque or Demand Draft, the insurer shall not deny such request.

12. **Services offered by TPA in relation to Health Insurance Policies**

a. The insurer may enter into an Agreement for the provision of defined services with a TPA holding a valid license issued in accordance with the IRDA (Third Party Administrators) Regulations, 2001 as may be amended from time to time.

b. **The services offered by a TPA shall not include**

i. Claim settlements and rejections with respect to the health insurance policies; However, TPA may handle claims admissions and recommend to the insurer for the payment of the claim settlement, provided a detailed guideline is prescribed by the insurer to the TPA for claims assessments & admissions in terms of capacity requirements, internal control requirements, claim assessment & admissions procedure requirements etc under the agreement.

ii. Any services directly to the policyholder or insured or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the insurer.

c. The TPA shall have in place the infrastructure necessary to extend the health services as required to the policyholders at all times.

d. **Settlement and Denial of Claims:**

i. All documents submitted to TPA shall be electronically collected and shall be forwarded to the Insurers for taking a decision on the claim settlements or claim rejections.

ii. TPA shall, in the correspondence to the policyholder with respect to settlement/denial of the claims, state clearly the following:

"As per the instructions of the insurer <Name of the Insurer>, the claim is being settled/denied for Rs. <amount> on account of <specifics of treatment/grounds of denial>. For any further clarifications, you may directly contact the insurer."

iii. The above statement shall form the mandatory part of the communication to be sent to the policyholder in every case of settlement or denial of the claims.

iv. The insurer and the TPA shall be responsible for the proper and prompt service to the policyholders at all times.

e. **Bar on Non-insurance healthcare schemes**

i. The TPA shall offer health services only in accordance with the IRDA (Third Party Administrators) Regulations, 2001 and shall not provide any services:

1. directly or indirectly to non-insurance healthcare schemes or

2. directly to health insurance schemes promoted, sponsored or approved by entities not being insurance companies, such as Governments, PSU's etc.

3. directly or indirectly to the policyholder or insured, except the health services as per the agreement with the insurer.

13. **Agreement between a TPA and an Insurance company**

a. The insurer and the TPA shall themselves define the scope of the Agreement, the health and related services that may be provided by the TPA and the remuneration therefor. Provided that there shall be a clause in the Agreement for its termination by either party on grounds of mutual consent or any fraud, misrepresentation, inadequacy of service or other non-compliance or default fraud. Provided further that, there shall be no element in the Agreement which dilutes, restricts or otherwise modifies the

stipulations of the IRDA in respect of Policy Holder welfare, protection, service standards and turn-around-time parameters.

b. The remuneration to the TPA shall be based on the services rendered to the insurer and shall not be related to the product/policy experience or the reduction of claim costs or loss ratios of the insurer.

c. A copy of the Agreement entered into between the TPA and the Insurance Company or any modification thereof, shall be filed, within 15 days of its execution or modification, as the case may be, with the Authority.

d. More than one TPA may be engaged by an insurance company and, similarly, a TPA can serve more than one insurance company.

e. The Authority from time to time may prescribe minimum standard clauses to be included in the agreement between insurer and TPA.

14. Change of TPAs for servicing of Health Insurance Policies

a. A change in the TPA by the insurer shall be communicated to the policyholders 30 days before giving effect to the change.

b. The contact details like helpline numbers, addresses, etc. of the new TPA shall be made immediately available to all the policyholders in case of change of TPA.

c. The insurers shall take over all the data in respect of the policies serviced by the earlier TPA and make sure that the same is transferred seamlessly to the newly assigned TPA, if any. It shall be ensured that no inconvenience or hardship is caused to the policyholders as a result of the change. In this regard, the following aspects shall receive special attention:

i. Status of cases where pre-authorization has already been issued by existing TPA.

ii. Status of cases where claim documents have been submitted to the existing TPA for processing.

iii. Status of claims where processing has been completed by the TPA and payment is pending with the insurer/ TPA.

15. Data and related issues:

a. The TPA and the insurer shall establish a seamless flow of data transfer for all the claims.

b. The respective files shall be handed over to the insurer within 15 days of the claim settlement or rejection.

16. Submission of Returns to the Authority

a. All insurance companies carrying on health insurance business shall furnish the Returns to the Authority in accordance with Schedule-III.

17. Transitory Provisions

a. Withdrawal of Products

i. The Appointed Actuary shall examine every Health product, Group and Individual, in the Company's portfolio and list out those products which are not in compliance with the provisions in every particular of these Regulations. Such list shall be certified by the Appointed Actuary, counter signed by the CEO and submitted to the Authority on or before 30.06.2013.

ii. Products not in compliance with this Regulation shall all stand withdrawn and shall not be sold

1. In the case of Group Products, from 1st July 2013
2. In the case of Individual Products, from 1st October 2013

iii. No new members shall be enrolled into the existing group policies once the product stands withdrawn.

iv. Products which have been filed and are awaiting the approval of the Authority shall all be returned to the applicant to be refilled afresh after due examination for compliance

b. Remedial Measures

i. Insurers may on their own modify product features other than those relating to any benefits offered, premium bases, loading levied or discounts offered in the products. If such modifications suffice to render the product compliant in every particular of this Regulation, then on the basis of a certificate to that effect by the Appointed Actuary and the CEO, the Authority will record such change and allot the unique identification number where after such product may be introduced. The Authority reserves the right, in such cases to take appropriate action if it is established that this assertion of the Company was not well founded.

ii. Products which cannot be covered under the provisions of (i) above shall be appropriately modified and filed for a fresh approval under the File and Use. Such application shall be in a tabular format setting out the current provision and the revised provisions to render the product in compliance with this Regulation together with an analysis of the implications on pricing, reserving, profit margin and other relevant metrics.

iii. At renewal, all Group Policies shall be given an option
   1. to switch over to a modified approved version of the group product, or
   2. to continue to be renewed under the extant policy, provided that in such case no new members shall be enrolled after 1st June 2013 and the specific written consent is obtained by the group policyholder to continue in the old policy.

c. All the insurers shall inform the prospective policyholders about the possible changes in the products being sold during the transition period and give an option to the existing policyholders including prospective policyholders to switch over to the modified version if any, once introduced.

18. Repeal and Savings:

a. All the guidelines/clarifications/circulars/letters issued earlier in respect of the health insurance products shall abate from the date this regulation comes into force.

b. Unless otherwise provided by these regulations, nothing in these regulations shall deem to invalidate the health insurance contracts entered prior to these regulations coming into force.

Schedule: I

Portability of Health Insurance Policies offered by Life and General Insurers:

1. A policyholder desirous of porting his policy to another insurance company shall apply to such insurance company, to port the entire policy along with all the members of the family, if any, at least 45 days before the premium renewal date of his/her existing policy.

2. Insurer may not be liable to offer portability if policyholder fails to approach the new insurer at least 45 days before the premium renewal date.

3. Portability shall be opted by the policyholder only as stated in (1) above and not during the currency of the policy.

4. In case insurer is willing to consider the proposal for portability even if the policyholder fails to approach insurer at least 45 days before the renewal date, it may be free to do so.

5. Where the outcome of acceptance of portability is still waiting from the new insurer on the date of renewal

   a. the existing policy shall be allowed to extend, if requested by the policyholder, for the short period by accepting a pro- rate premium for such short period, which shall be of at least one month and

   b. shall not cancel existing policy until such time a confirmed policy from new insurer is received or at the specific written request of the insured

   c. the new insurer, in all such cases, shall reckon the date of the commencement of risk to match with date of expiry of the short period, wherever relevant.

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d. if for any reason the insured intends to continue the policy further with the existing insurer, it shall be allowed to continue by charging a regular premium and without imposing any new condition.

6. In case the policyholder has opted as in 5 (a), and there is a claim, then existing insurer may charge the balance premium for remaining part of the policy year provided the claims is accepted by the existing insurer. In such cases, policyholder shall be liable to pay the premium for the balance period and continue with existing insurer for that policy year.

7. On receipt of such intimation, the insurance company shall furnish the applicant, the Portability Form as set out in Annexure 'I' to these guidelines together with a proposal form and relevant product literature on the various health insurance products which could be offered.

8. The policyholder shall fill in the portability form along with proposal form and submit the same to the insurance company.

9. On receipt of the Portability Form, the insurance company shall address the existing insurance company seeking necessary details of medical history and claim history of the concerned policyholder. This shall be done through the web portal of the IRDA.

10. The insurance company receiving such a request on portability shall furnish the requisite data in the data format for porting insurance policies prescribed in the web portal of IRDA within 7 working days of the receipt of the request.

11. In case the existing insurer fails to provide the requisite data in the data format to the new insurance company within the specified time frame, it shall be viewed as violation of directions issued by the IRDA and the insurer shall be subject to penal provisions under the Insurance Act, 1938.

12. On receipt of the data from the existing insurance company, the new insurance company may underwrite the proposal and convey its decision to the policyholder in accordance with the Regulation 4 (6) of the IRDA (Protection of Policyholders' interest) Regulations, 2002.

13. If on receipt of data within the above time frame, the insurance company does not communicate its decision to the requesting policyholder within 15 days in accordance with its underwriting policy as filed by the company with the Authority, then the insurance company shall not retain the right to reject such proposal and shall have to accept the proposal.

14. In order to accept a policy which is porting-in, insurer shall not levy any additional loading or charges exclusively for the purpose of porting.

15. No commission shall be payable to any intermediary on the acceptance of a ported policy.

16. Portability shall be allowed in the following cases:

a. All individual health insurance policies issued by non-life insurance companies including family floater policies

b. Individual members, including the family members covered under any group health insurance policy of a non-life insurance company shall have the right to migrate from such a group policy to an individual health insurance policy or a family floater policy with the same insurer. Thereafter, he/she shall be accorded the right mentioned in 1 above.

17. For any health insurance policy, waiting period with respect to pre-existing diseases and time bound exclusions shall be taken into account as follows:-

S. No	No of years of continuous insurance cover with previous insurer (s)	Waiting period to be served with new insurer in number of days/years				
		YY Days	1 Year	2 years	3 years	4 years
I.	XX Days at inception (XX-no of days as per the policy document)	(YY-XX) Days	N/A	N/A	N/A	N/A
II.	**For 1 year period exclusion:**					
	1 year	N/A	Nil	1 Year	2 Years	3 Years
III.	**For 2 year period exclusion:**					
	1 year	N/A	Nil	1 Year	2 Years	3Years
	2 years	N/A	Nil	Nil	1 Year	2 Years
IV.	**For 3 year period exclusion:**					
	1 year	N/A	Nil	1 Year	2 Years	3 Years
	2 years	N/A	Nil	Nil	1 Year	2 Years
	3 years	N/A	Nil	Nil	Nil	1 Year
V.	**For 4 year period exclusion:**					
	1 year	N/A	Nil	1 Year	2 Years	3 Years
	2 years	N/A	Nil	Nil	1 Year	2 Years
	3 years	N/A	Nil	Nil	Nil	1 Year
	4 years	N/A	Nil	Nil	Nil	Nil

Note 1: In case the waiting period for a certain disease or treatment in the new policy is longer than that in the earlier policy for the same disease or treatment, the additional waiting period should be clearly explained to the incoming policy holder in the portability form to be submitted by the porting policyholder.

Note 2: For group health insurance policies, the individual member's shall be given credit as per the table above based on the number of years of continuous insurance cover, irrespective of, whether the previous policy had any pre-existing disease exclusion/time bound exclusions.

18. The portability shall be applicable to the sum insured under the previous policy and also to an enhanced sum insured, if requested by the insured, to the extent of cumulative bonus acquired from the previous insurer(s) under the previous policies.

For e.g. - If a person had a SI of RS 2lakhs and accrued bonus of Rs 50, 000 with insurer A; when he shifts to insurer B and the proposal is accepted, insurer B has to offer him SI of Rs 2.50lakhs by charging the premium applicable for Rs 2.50lakhs. If insurer B has no product for Rs 2.50lakhs, insurer B would offer the nearest higher slab say Rs 3lakhs to insured by charging premium applicable for Rs 3lakhs SI .However, portability would be available only up to Rs 2.50lakhs.

19. Insurers shall clearly draw the attention of the policyholder in the policy contract and the promotional material like prospectus, sales literature or any other documents in any form whatsoever, that:

a. all health insurance policies are portable;

b. policyholder should initiate action to approach another insurer, to take advantage of portability, well before the renewal date to avoid any break in the policy coverage due to delays in acceptance of the proposal by the other insurer.

Annexure-I

Portability Form

PART-I

1)	Name of the Policyholder / insured (s)	
2)	Date of Birth/Age	
3)	Address of the policyholder/insured	
4)	Details of existing insurer	
	i. Name of the product	
	ii. Sum Insured	
	iii. Cumulative Bonus	
	iv. Add-ons/riders taken	
	v. Policy number	
5)	Details of the proposed insurance	
	i. Name of the product proposed/intend to take	
	ii. Sum Insured Proposed	
	iii. Whether Cumulative Bonus to be converted to an enhanced sum insured	
6)	Reason(s) for portability	

7)	No. of family member to be included i the policy to be ported.	
Enclosure: Photocopy of the existing policy documents		
Date:		Signature of the policyholder

PART –II

1. Whether the PED exclusions / time bound exclusion have longer exclusion period than the existing policy: (Please indicate Yes / NO):
2. If yes, please give written consent to the declaration below:

"I am aware that the waiting period for the following disease(s)/treatment(s) is ..... days/years more than the previous policy terms. I hereby agree to observe the additional waiting period for the following disease(s)/treatment(s)

Signature of the policyholder

Schedule: II

Administration of Health Plus Life Combi Products

1. The product of this class shall be named as **'Health plus Life Combi Products'** referred as 'Combi Products' hereinafter in this schedule.

2. This schedule does not apply to Micro Insurance Products which are governed by IRDA (Micro Insurance) Regulations, 2005.

3. All insurance companies that promote 'Health plus Life Combi products' shall adhere to the following:

   a. **Scope of Combi Product Class:**

      i) The 'Combi Products' may be promoted by all Life Insurance and Non-Life Insurance Companies.

      ii) The 'Combi Product' shall be the combination of Pure Term Life Insurance cover offered by life insurance companies and Health Insurance cover offered by non life insurance companies/stand alone health insurance companies.

      iii) The Products offered under the combi products shall be individually cleared under the File and Use procedure.

      iv) Riders / Add-on covers may be offered subject to File and Use clearance.

      v) The premium components of both risks are to be separately identifiable and disclosed to the policyholders at both pre-sale stage and post-sale stage and in all documents like policy document, sales literature.

      vi) The product may be offered both as individual insurance policy and on group insurance basis. However in respect of health insurance floater policies, the pure term life insurance coverage is allowed on the life of one of the earning members of the family who is also the proposer on health insurance policy subject to insurable interest and other applicable underwriting norms of respective insurers.

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vii) The integrated premium amount of the 'Combi Product' shall be basis for reckoning the threshold limit / applicability of extant Regulations, guidelines and circulars etc. issued by the Authority or any other statutory body.

viii) Commission and Claim payouts in respect of 'Combi Products' shall be by respective insurers only.

ix) 'Combi product' shall have a free look option as outlined in IRDA (Health Insurance Regulations) 2010. Free Look option is to be applied to the 'Combi Product' as a whole.

x) The Health portion of the 'Combi Product' shall entitle its renewability at the option of policy holder from the respective Non-Life / standalone health Insurance Company

b. **Tie up between insurers:**

i) It is mandatory that insurance companies offering the 'Combi Product' shall have in place a Memorandum of Understanding covering the modus operandi of marketing, policy service and sharing of common expenses.

ii) Insurers forming the tie-up shall obtain prior approval of IRDA by duly filing the copy of the agreement entered in this regard. Approval may be obtained by any one of insurers.

iii) A tie up is permitted between one life insurer and one non-life insurer only. Thus a life insurer is permitted to tie up with only one non-life insurer and vice-versa.

iv) Between these two Insurers any number of 'Combi Products' may be promoted.

v) Insurance companies shall carry out an appropriate due diligence before establishing the business relationship for the purpose of promoting 'Combi Products'. Insurers are also expected to have a long-term understanding for effective policy service of the proposed 'Combi Products'.

vi) Withdrawal from the tie-up is generally not desirable. However, in exceptional cases where insurers desire to withdraw from MOU they shall obtain prior permission of the Authority.

vii) There shall be specific time frames / Turn around Times (TAT) to be agreed between the insurance companies as part of MOU for effective policy service, transmission of premiums received etc. at various stages of policy i.e., at pre-sale stage and post-sale stage.

viii) Filing the advertisements in accordance with IRDA (Insurance Advertisements and Disclosures) Regulations, 2000 within 30 days from the date of issuing the advertisement with Authority.

ix) Proposed procedures for obtaining the prior approval of IRDA for issuing Joint Sale Advertisements along with the common corporate agents.

x) The modus operandi of proposed policy service at various stages of the policy viz., proposal stage, policy servicing, premium collection arrangements and claims service etc.

xi) The Information Technology systems put in place for supporting the sale and policy service of the 'Combi Products'.

xii) Agreement on reimbursement of expenses in consideration of common services rendered by each other of insurance companies.

xiii) Distribution Channel wise maximum commission allowed under the 'Combi Products'.

xiv) The manner in which premium is proposed to be collected subject to provisions of Section 64 VB of Insurance Act, 1938.

xv) The procedures put in place for expeditious transfer of the portion of premium that pertains to the other insurer of the product.

xvi) Operational procedures put in place for updating premium on policy data base on a real time basis.

xvii) Options available to policyholders of 'Combi Products' to discontinue either portion of risk coverage while continuing with the other portion, subject to the extant law, regulations, guidelines etc.

xviii) Copy of proposed common Sales Literature / Sales Illustrations, proposal form to be issued by both the insurers in respect of 'Combi Products', subject to the conditions that these documents cleared under File and Use procedure are not modified.

xix) Common Advertisements of 'Combi Products', subject to the condition that this shall be restricted to the features, terms and conditions of the 'Combi Product'.

c. **Lead Insurer**:

i) As two insurance companies are involved in offering the 'Combi Product' one of the insurance companies may be mutually agreed to act as a lead insurer in respect of each 'Combi Product' marketed with agreed terms, conditions and considerations.

ii) The Lead Insurer for this purpose is the insurance company mutually agreed by both the insurers to play a critical role in facilitating the policy service as a contact point for rendering various services as required for combi products. The lead insurer may play a major role in facilitating underwriting and policy service.

iii) The role of lead insurer shall not deter in relying upon the existing operational infrastructure of the partner-insurance company for effective policy servicing of 'Combi Products'.

iv) Either of the insurers shall not be absolved of their responsibility of proactive settlement of claims and other obligations in accordance with the terms and conditions of their respective policies.

4. **Underwriting:** Under the 'Combi Product', underwriting of respective portion of risk shall be carried out by respective insurance companies, that is; Life Insurance risk shall be underwritten by Life Insurance Company and the Health Insurance portion of risk shall be underwritten by Non-Life/stand-alone health Insurance Company.

5. **File and Use:**

a. The life insurance product and the health insurance product to be offered as a combi product shall have prior approval under File and Use procedure.

b. Both the independent approved products shall be integrated as a single product and shall be filed with a common brand name.

c. The single product shall be offered without making any modifications to the cleared products.

d. 'Combi Product' is to be filed at the stage of integrating for getting File and Use approval irrespective of the earlier approval to either of products.

e. 'Combi Product' filing shall follow the File and Use guidelines in vogue and all such guidelines that would be issued from time to time.

f. Combi Product' is to be filed with Actuarial Department of Authority in File and Use formats that are in vogue.

g. The Combi Product shall be approved by the Authority at File and Use.

h. The File and Use application of the 'Combi Product' shall also specify the following:-

i) Lead Insurer for the 'Combi Product' and demarcation of functions between insurers for carrying out activities

ii) Procedures proposed for issuance of the premium notices, where applicable and final lapse notices in terms of Section 50 of the Insurance Act, 1938.

iii) Where the servicing is to be necessarily attended by the original insurer, the lead insurer shall facilitate the policy servicing. As far as the policyholder is concerned lead insurer shall be made as the single nodal point for receiving the servicing requests, fulfilling the services and issuing acknowledgements.

iv) Results of feasibility study, if any, in giving a limited access to the policy data base of policies for effecting over-the-counter policy service requests to the lead insurer.

v) The results of the cost benefit analysis carried out by both the insurers and the possibility of offering any discounts on the premium in the combi product.

vi)

6. Lead insurer in settlement of claims shall ensure:-

a. Based on the type of claim, the other insurer shall also take proactive measures for settlement of claims. In no case, the Lead insurer shall guarantee the settlement of claim on behalf of the other insurer.

b. The risks accepted by one insurer under 'Combi Product' shall not affect the business of other insurance company.

c. As far as health portion of 'Combi Policies' are concerned, the extant regulations and guidelines shall apply.

d. Where the policies are serviceable directly, the lead insurer shall play a facilitative role.

e. The operational procedures proposed to be put in place for timely dispatch of the policy bond of 'Combi Products'.

7. **Distribution Channel**:

a. The sale of 'Combi Product' shall be solicited through:-

i) Direct Marketing channels

ii) Brokers and

iii) Composite Individual and Corporate Agents, common to both insurers

b. 'Combi Products' shall not be marketed through 'Bank Referral' arrangements.

c. Insurers shall ensure that the 'Combi Product' is not marketed by those insurance intermediaries who are not authorized to market either of the products of either of the insurers.

Mandatory Minimum Disclosures:

a. The mandatory minimum disclosures for a Combi Product shall be:

i) The product is jointly offered by "abc insurance company" (specify non-life/ stand-alone health insurer name) and "xyz insurance company" (specify life insurer name).

ii) The risks of this 'Combi Product' are distinct and are assumed / accepted by respective insurance companies.

iii) The liability to settle the claim vests with respective insurers that is for health insurance benefits "abc insurance company" (specify non-life/ stand-alone health insurer name) and for life insurance benefits "xyz insurance company" (Specify life insurer name).

iv) The legal/quasi legal disputes, if any, shall be dealt with the respective insurers for respective benefits.

v) The policy holders of the 'Combi Product' under reference shall be eligible to continue with either part of the policy, discontinuing the other during the policy term.

vi) Where guaranteed renewability of health insurance plan is allowed, the health insurance portion of this 'Combi Product' is entitled to that facility.

vii) Specific Disclosures on the available premium payment options on these 'Combi Products'.

viii) Specific Disclosures about the available Policy Servicing facilities for these 'Combi Products'.

ix) Specific Disclosures about the proposed claims service of these policies under both the risks.

x) Specific Disclosures on the availability of services of 'Third Party Administrators (TPAs)' for health insurance portion of risk, if available.

xi) Specific Disclosures on the available Grievances Redressal Options including particulars of Ombudsman under these 'Combi products'.

xii) Policyholders are to be advised to familiarize themselves with the policy benefits and policy service structure of the 'Combi Product' before deciding to purchase the policy.

b. Policy documents of 'Combi Products' shall contain the above referred points (iii) to, (xi) as minimum disclosures.

c. Declaration from the prospect shall be obtained and attached to proposal form that he / she has understood the disclosures mentioned above.

9. In respect of 'Combi Products' both the insurers shall comply with the provisions Insurance Act, 1938 and Regulations notified there under and other guidelines, circulars that are applicable to health insurance business and life insurance business respectively.

10. For the purpose of these guidelines non-life insurance company includes standalone health insurance Company also.

11. In order to monitor the progress of the penetration of the product class before enlarging the scope of the same all insurance companies that are marketing 'Combi Products' shall submit the information that is required by the Authority from time to time.

12. The Authority may stipulate such other terms and conditions from time to time for monitoring activities of insurance companies offering 'Combi Products'.

Schedule: III

Health Insurance Returns to be submitted by Insurance Companies

J. HARI NARAYAN, Chairman

[ADVT. III/4/161/12/Exty.]

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ALL NON-LIFE AND STAND-ALONE HEALTH INSURANCE COMPANIES

Ref: IRDA/HL T/REG/CIR/191 /09/2013

25th September, 2013

Re: IRDA Health Insurance Regulations, 2013

Reference is drawn to the captioned Regulations notified on 15th February, 2013. In response to representations received from the industry, a re-examination of some of the provisions has been carried out. Now, in exercise of powers under Section 14(2) of the IRDA Act, 1999, the following amendments are being carried out and may be noted:

A. Regulation 5: General Provisions relating to Health Policies:

1. Free look period:

Existing provision: Regulation 5(g): 'All health insurance policies shall have a free look period. The free look period shall be applicable at the inception of the policy ... '

Modification: Regulation 5(g): All new individual health insurance policies except those with tenure of less than a year shall have a free look period. The free look period shall be applicable at the inception of the policy ..... '

2. Cumulative Bonus:

Existing provision: Regulation 5 (i) (iii): 'Cumulative bonus may not be allowed on benefit based policies.'

Modification: Regulation 5 (i)(iii): Cumulative bonus may not be allowed on benefit based policies with the exception of Personal Accident cover.

3. AYUSH coverage:

Existing provision: Regulation 5 (I) (i), 'Insurers may provide coverage to nonallopathic treatments provided the treatment has been undergone in a government hospital or in any institute recognized by government and/or accredited by Quality Council of India/National Accreditation Board on Health or any other suitable institutions.'

Modification: Regulation 5 (I) (i), 'Insurers may provide coverage to non-allopathic treatments provided the treatment has been undergone in a government hospital or in any institute recognized by government and/or accredited by Quality Council of India/National Accreditation Board on Health.'

Insurers and Third Party Administrators are advised to make a note of the amendments and ensure necessary compliance.

T.S.Vijayan
Chairman

b) Guidelines on Standardization in Health Insurance 2013

LIFE INSURERS, NON-LIFE INSURERS, STANDALONE HEALTH INSURERS AND TPAs

IRDA/HLT/CIR/036/02/2013, dt.: 20-02-2013

Re: Guidelines on Standardization in Health Insurance

Health insurance addresses a major area o f public concern. Although it is rapidly growing, access to health insurance still remains limited and add to it complaints especially due to variable interpretations of key policy terms are enormous. In order to address the expectation of public more effectively, the Authority propose to stipulate the following in respect of all health insurance policies issued by life and general insurers in the country.

1. Standard Definition for 46 commonly used terms in health insurance policies:

Standard terms would reduce ambiguity, enable all stakeholders to provide better services and enable customers to interact more effectively with insurers, TPAs and providers. All insurers shall adhere to the stipulated definitions, annexed at Annexure I, while defining these 46 core terms in all health insurance policies.

2. Standard Nomenclature and Procedures for Critical Illnesses:

In view of resolving the differences in the definitions of terms on Critical Illnesses adopted by the different insurers which are creating confusion in the minds o f consumers and the industry especially at the time when insurers and re-insurers have to arrive at a point where lump sum payment is made, 11 Critical Illness terms have been standardized to be adopted uniformly across industry, if offered under the product. All products offering the 11 critical illness coverage shall ensure that definitions o f the stated 11 terms are in line with the stipulated definitions annexed at **Annexure II.**

3. Standard Pre-authorization and Claim form:

A common industry wide pre-authorization and claim form will significantly streamline processes at all stages. This will enhance the ability o f providers to obtain a timely prior authorization. By implementing it in an optical character recognition (OCR) format, the ability to transfer data from a handwritten paper based form to IT systems has been enhanced thus reducing the data entry issues for TPAs and insurers. Every company shall attach set of claim forms along with policy terms and conditions to the policyholder. The forms are attached at **Annexure III.**

4. Standard List of Excluded Expenses in Hospitalization Indemnity policies:

Hospitalization indemnity products are the commonest products in the Indian market and account for most o f the health insurance sold in the country. The standard listing of 199 excluded items, an area which has otherwise been fairly variable in its interpretation and implementation, has been finalized. The same is annexed at **Annexure IV.** However, Insurers may include these exclusions, if the product design allows for, or if the insurer wants to include these as part of hospitalization expenses.

5. Standard File and Use Application Form, Database Sheet and Customer Information Sheet:

The existing F&U form used by the non-life insurers is designed keeping in view largely the characteristics of Non Life products other than Health. With this, the essential information like the sum insured, the minimum and maximum age, term o f the product etc that gets captured in the F&U form is very minimal. In order to capture the relevant product design information, the modified File and Use Application form along with the Database sheet and Customer information sheet as annexed in the **Annexure: V, VI and VII** respectively shall be submitted under File and Use procedure by the insurers.

This circular supersedes all the existing circulars / guidelines on File and Use Procedure for health insurance products offered by life insurers/non-life insurers/health insurers. All the insurers shall comply with the File and Use procedure specified in this circular.

6. Standard agreement between TPA & Insurer and Provider (Hospital) & Insurer:

The insurers enter into agreements with the TPAs for health services under health insurance contracts and with the Providers (Hospitals) for health care services under health insurance contracts. The Service Level Agreement shall include the minimum standard clauses as annexed in **Annexure: VIII and IX,** as applicable.

This is issued under section 14(2) o f IRDA Act, 1999 and shall be effective from 1st July 2013 for group products and l sl October 2013 for other products.

J. Harinarayan
Chairman

c) IRDA (Linked Insurance Product) Regulations 2013

THE GAZETTE OF INDIA
EXTRAORDINARY
PART III SECTION IV
PUBLISHED BY AUTHORITY
INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY
NOTIFICATION
HYDERABAD, the 11th FEBRUARY, 2013

Insurance Regulatory and Development Authority (Linked Insurance Products) Regulations, 2013

F. No. IRDA/Reg/15/73/2013 :- In exercise of the powers conferred under Section 114A of the Insurance Act, 1938(4 of 1938) read with Sections 14 and 26 of the Insurance Regulatory and Development Authority, Act 1999, the Authority in consultation with the Insurance Advisory Committee, hereby makes the following regulations, namely:-

CHAPTER I

Preliminary

1. Short title and commencement.

a. These regulations may be called Insurance Regulatory and Development Authority (Linked Insurance Products) Regulations, 2013.

b. They shall come into force on the date of their publication in the Official Gazette.

c. These regulations shall be applicable to all linked insurance products offered by life insurance companies.

d. Unless otherwise provided by these regulations, nothing in these regulations shall deem to invalidate the linked insurance policies entered prior to these regulations coming into force.

e. Regulations shall mean Insurance Regulatory and Development Authority (Linked Insurance Products) Regulations, 2013.

f. For the purpose of this Regulation, the unit fund shall be read as the policy account unless otherwise specified in case of variable insurance products.

1A. Definitions: In these Regulations, unless the context otherwise requires,—

a) "**Act"** means the Insurance Act, 1938 (4 of 1938).

b) "**Authority"** means the Insurance Regulatory and Development Authority established under sub-section (1) of section 3 of the Insurance Regulatory and Development Authority Act, 1999 (41 of 1999)

c) "Allocation" means the process of creating the units at the prevailing unit price offered by the life insurer like when the premiums are received or when switches are made.

d) "**Date of payment of premium"** means the date on which premium payment is received by the insurer in accordance with the provisions of Section 64 VB (2) of the Act.

e) "**Date of discontinuance of the policy"** means, for the purpose of these regulations, the date on which the insurer receives the intimation from the insured or policyholder about discontinuance of the policy or surrender of the policy or on the expiry of the notice period provided for in the sub-regulation (i) of Regulation 13 (a) herein, whichever is earlier.

f) **"Discontinuance"** means the state of a policy that could arise on account of surrender of the policy or non-payment of the contractual premium due before the expiry of the notice period provided for stipulated in sub regulation (i) of Regulation 13 (a) herein.

Provided that no policy shall be treated as discontinued on non-payment of the said premium if, within the grace period, the premium has not been paid due to the death of the insured or upon the happening of any other contingency covered under the policy.

g) **"Death benefit"** means the benefit, agreed at the inception of the contract, which is payable on death as specified in the policy document.

h) "**Discontinued Policy Fund / Discontinued Policy Account Value"** means the segregated fund/policy account of the insurer that is set aside and is constituted by the fund value/policy account value, as applicable, of all the discontinued policies determined in accordance with this Regulation.

i) "**Discontinuance charge"** means a charge that does not exceed the limits stipulated in sub-regulation (vi) of regulation 13 (a) herein, expressed as a percentage of one annualized level premium or the single premium or fund value/policy account value, as applicable, that can be levied upon discontinuance of a policy.

j) **"Employer-Employee group"** means groups where an employer-employee relationship exists between the master policyholder and the member in accordance with the relevant laws.

k) **"Fund value or Unit Fund value"** means the total value of the units at that point of time in a segregated fund i.e. total number of units under a policy multiplied by the Net Asset Value (NAV) per unit of that fund.

l) "**Free-look**" period shall be as stipulated in sub-regulation 2 of Regulation 6 of Insurance Regulatory and Development Authority (Protection of Policyholders' Interests) Regulations, 2002.

m) "**Grace Period"** means the time granted by the insurer from the due date for the payment of premium, without any penalty/late fee, during which time the policy is considered to be in-force with the risk cover without any interruption as per the terms of the policy.

n) **"Limited premium payment products"** means the linked insurance products where the premium payment period is limited compared to the policy term and are paid at regular intervals like yearly, half-yearly etc.

o) "**Lock-in-period"** means the period of five consecutive years from the date of commencement of the policy, during which period the proceeds of the discontinued policies cannot be paid by the insurer to the policyholder or to the insured, as the case may be, except in the case of death or upon the happening of any other contingency covered under the policy.

p) **"Maturity benefit"** means the benefit which is payable on maturity i.e. at the end of the term, as specified in the policy document and is stated at the inception of the contract.

q) **"Net Asset Value (NAV)"** means the price per unit **of the Segregated Fund.**

r) **"Partial Withdrawals"** means any part of fund/ partial withdrawal that is encashed/ withdrawn by the policyholder during the period of contract.

s) **"Premium re-direction"** means an option which allows the policyholder to modify the allocation of amount of renewal premium to various segregated funds, under a unit linked policy, offered through a different investment pattern from the option exercised at the inception of the contract.

t) **"Redemption"** means cancellation of the units at the prevailing unit price of the segregated funds offered in the products, in case of partial withdrawals, switches, surrender, maturity etc.

u) **"Regular Premium Products"** means linked insurance products where the premium payment is throughout the term of the product and are paid in regular intervals like yearly, half-yearly etc.

v) "**Rider benefits**" means an amount of benefit payable on a specified event offered under the rider, and is allowed as add-on benefit to main benefit.

w) "**Revival of a policy"** means restoration of the policy, which was discontinued due to the non-payment of premium, by the insurer with all the benefits mentioned in the policy document, with or without rider benefits if any, upon the receipt of all the premiums due and other charges if any, as per the terms and conditions of the policy, upon being satisfied as to the

continued insurability of the insured on the basis of the information, documents and reports furnished by the policyholder, in accordance with their Board approved Underwriting guidelines.

x) "**Revival Period**" means the period of two consecutive years from the date of discontinuance of the policy, during which period the policyholder is entitled to revive the policy which was discontinued due to the non-payment of premium.

y) "**Segregated fund"** means the funds as referred to in Schedule II-A of the IRDA (Assets, Liabilities and Solvency Margin of the Insurers) Regulations, 2000.

z) "Sales illustrations" means a document furnished in accordance with life insurance council circular number LC/SP/Ver 1.0 dated 3rd February, 2004, which depicts the effect of charges on the value of benefits at various stages of a linked contract. The illustrations furnished for these contracts shall inter alia furnish the yield, net of charges, corresponding to both the higher and lower interest rate scenario.

aa) "Settlement options" means a facility made available to the policyholder under the unit linked products to receive the maturity proceeds in installments in accordance with the terms and conditions specified in advance at the inception of the contract.

bb) "Single premium products" means linked insurance products, where the premium payment is made by a single payment at the inception of the policy.

cc) "Sum Assured" means an absolute amount of benefit which is guaranteed to become payable on death of the life assured in accordance with the terms and conditions of the policy or an absolute amount of benefit which is available to meet the health cover.

dd) "Surrender" means complete withdrawal/ termination of the entire policy.

ee) "Surrender Value" means an amount, if any, that becomes payable in case of surrender in accordance with the terms and conditions of the policy.

ff) "Switches" means a facility allowing the policyholder to change the investment pattern by moving from one segregated fund, either wholly or in part, to other segregated fund(s) amongst the segregated funds offered under the underlying unit linked product of the insurer.

gg) "Top-up premium" means an additional amount (s) of premium paid, if any, over and above the contractual basic premiums stipulated in the terms and conditions, at irregular intervals during the period of contract

hh) "Units" means a specific portion or part of the underlying segregated unit linked fund which is representative of the policyholder's entitlement in such funds.

ii) "Linked Whole Life products" means linked insurance products which do not have a definite policy term and the policy terminates on death of the life assured. This can be issued with item (n) or (u) or (bb) stated above.

jj) All words or expressions not defined in these regulations but defined in the Insurance Act 1938 or Insurance Regulatory and Development Authority Act 1999 shall have the same meanings respectively assigned to them in those Acts.

Chapter-II

Linked Insurance Products

2. Linked insurance products:

a. Linked insurance products shall be offered only under non-par individual products and non-par fund based group products in any of the following manner:

i) Unit Linked Products and

ii) Variable Linked Products.

3. Unit Linked Insurance Products (ULIP):

a. Unit Linked insurance products shall be offered in any of the following manner:

i) Linked Individual Non-par;

(ii) Linked Fund based Group Non-par;

b. These are the products where the benefits are partially or wholly dependent on the performance of the underlying assets under each of the segregated fund offered and shall be operated as follows:

i) The premiums shall be allocated to such segregated funds, otherwise called as unit funds, as per its net asset value and the benefits shall be determined based on the performance of the underlying assets of such segregated funds.

ii) The insurers may levy charges as stipulated in Regulation 35 herein applicable to the unit linked products.

iii) The products shall comply with the maximum reduction in yield requirements as referred stipulated in Regulation 37 herein.

c. A unit linked policy may only offer the following death benefits:

i) The sum assured as agreed in the policy plus the balance in the unit fund or

ii) Higher of the sum assured as agreed in the policy or the balance in the unit fund.

In either case, the sum assured shall be at a minimum consistent with the provision stipulated in Regulation 5 herein.

d. A minimum maturity benefit which shall be at least equal to the balance in the unit fund on the date of maturity.

4. Variable Linked Insurance Products (VLIP):

a. Variable insurance products shall be offered in any of the following manner:

i) Linked Individual Non-par;

ii) Linked Fund based Group Non-par;

b. These are the products where the benefits are partially or wholly dependent on the performance of an approved external index/ benchmark which is linked to the product and shall be operated as follows:

i) The Variable insurance products shall have a:

(1) Guaranteed non-negative interest rate, referred as minimum floor rate and

(2) Non-negative variable interest rate of not less than quarterly frequency, which shall be directly linked to the performance of the approved external index or the external benchmark.

(3) Non- negative residual additions, if any, shall be credited to the policy account in order to meet the maximum reduction in yield as stipulated in Regulation 37 at the end of each year starting from policy year 5. Such non-negative residual additions shall be determined as:

(a) Gross Investment Yield earned in the shadow account at the end of each policy year less

(b) Actual yield earned in the policy account value, at the end of each policy year less

(c) Yield referred in the reduction in yield at that duration as per Regulation 37

(d) For the purpose of this regulation, the yield earned on each of the Policy account shall be calculated using the money weighted rate of return method at end of each policy year.

ii) This minimum floor rate, as approved in the File and Use clearance accorded by the Authority, shall be:

(1) Guaranteed for the entire term of the policy accumulating on the balance of the policy account;

(2) Such accumulation shall be at a frequency of not less than quarterly on the balance of the policy account at the beginning of each such quarter.

iii) At each interval, after the minimum floor rate is credited, the non-negative variable interest rate, as applicable, in accordance with the external index or external benchmark, as approved in the File and Use clearance accorded by the Authority, shall be credited to the balance of the policy account value and

iv) At the end of each policy year, in order to comply with maximum reduction in yield as stipulated in Regulation 37 herein, after minimum floor rate and non-negative variable interest rate are credited, non-negative residual additions, if any shall be credited to the policy account value.

c. Variable linked policy may only offer the following death benefits:

i) The sum assured as agreed in the policy plus the balance in the policy account or

ii) Higher of the sum assured as agreed in the policy or the balance in the policy account.

In either case, the sum assured shall be at a minimum consistent with the provision stipulated in Regulation 5 herein and

iii) A minimum maturity benefit which shall be at least equal to the balance in the policy account.

iv) **Policy Account Value**:

(1) Every variable linked insurance policy shall have a corresponding policy account whose balance shall depict the accrual to the policyholder. The policy account shall be credited with premium net of charges as stipulated in Regulation 35 herein, as applicable to variable insurance products. The guaranteed rate and variable interest rate shall be applicable to the balance of the policy account.

(2) Shadow policy account value shall be maintained on a daily basis. Such shadow policy account shall be computed based on the actual accruals of all income elements like premiums, top-up premiums, income from investments as and when received and all actual debits i.e. partial withdrawals to the policy account value as and when debited, to arrive at the actual gross investment return and reduction in yield to the policy account value, at the end of each year starting from policy year 5.

(3) The policy account value shall comply with the maximum reduction in yield requirements as referred stipulated in Regulation 37 herein.

v) **Frequency of accrual of non-negative variable interest rate**: For all modes of premium payment (viz., single premium, annual, half-yearly, quarterly and monthly) the non-negative variable interest rate to be credited shall not be less than quarterly frequency.

vi) **Separation of assets:**

(1) The insurer shall keep a separate account of all receipts and payments in respect of this product. The valuation of assets and liabilities shall be in accordance with the IRDA (Assets, Liabilities and Solvency Margin) Regulations, 2000 and all other relevant regulations.

(2) The insurer shall earmark assets for each product separately and the policy account value of each of the product shall be disclosed on a daily basis in the website through a specifically assigned identification number called "SAIN" where the SAIN shall start with the unique identification number assigned to the product followed by a three digit running number to be assigned to such products.

(3) The insurer shall prepare the financial statements separately in addition to the businesses mentioned in Part V of the Schedule-A of the Insurance Regulatory and Development Authority (Preparation of Financial Statements and Auditor's Report of Insurance Companies) Regulations, 2002.

vii) **Furnishing Statements of Accounts:**

(1) The statement of policy account shall be sent to the policyholder at least once a year.

(2) Policy account statement shall be issued at the end of each financial year to the policyholder giving the breakup of the Opening balance, premium received, deductions towards charges, minimum floor interest earned, variable interest earned, non-negative residual interest rate credited and closing balance in the manner prescribed in the **Annexure - I**.

viii) **Approved External Index**: The external index so linked may be allowed to be changed only on approval under File and Use under the following circumstances:

(1) Such changes shall be allowed only in case of non-availability of the existing index or disruption of existing index.

(2) Any such subsequent changes shall be informed to the policyholder at least with 1 month's notice and shall provide the policyholder/insured the information about another approved external index, which shall be linked to the product.

Chapter-III

Benefits Payable on Death, Benefits payable under Health cover and Guarantees

5. Benefit payable on death/ Benefits offered under the Health Cover:

a. From inception of the policy, all individual linked insurance products shall offer at least the minimum sum assured as specified in the Table 5.c that becomes payable:

i) on death or

ii) to make benefits payments under the health cover, as applicable.

b. The table 5.c below specifies the minimum sum assured under linked insurance products where:

i) T is Policy Term chosen by the policyholder for any product except for whole life products.

ii) For whole life products, T shall be taken as 70 minus age at entry.

iii) AP is Annualized Premium selected by the policyholder at the inception of the policy excluding the service tax.

iv) SP is the Single Premium which is chosen by the policyholder at the inception of the policy, excluding the service tax.

c. The minimum sum assured shall be at least equal to:

d. In respect of pension products and immediate annuity products, the minimum sum assured as in Table 5.c is not mandatory.

e. Single premium health insurance products shall not be offered under unit linked insurance products.

f. Other Conditions:

i) In case of unit linked insurance products as stipulated in Regulation 3 (c)(ii) herein, on death during the term of the policy, the sum assured payable on death shall not be reduced, except to the extent of the partial withdrawals made during the two year period immediately preceding the death of the life assured. However, on attainment of 60 years of age of the life assured, all the partial withdrawals made within two years before attaining age 60 and all the partial withdrawals made after

Table 5.c

Type of Products	Minimum Sum assured for age at entry below 45 years	Minimum Sum assured for age at entry of 45 years and above
Life Single Premium (SP) Products	125 percent of single premium.	110 percent of single premium
Life Regular Premium (RP) including Limited Premium Paying (LPP) Products	10 times the annualized premiums or (0.5 X T X annualized premium) whichever is higher.	7 times the annualized premiums or (0.25 X T X annualized premium) whichever is higher.
Health Regular Premium (RP) including Limited Premium Paying (LPP) products	5 times the annualized premium or Rs.100,000 per annum whichever is higher.	5 times the annualized premium or Rs.100,000 per annum whichever is higher.

attaining age 60 may be reckoned for adjusting out of the sum assured to determine actual sum payable on death.

ii) No cover shall be extended after the expiry of the policy term and only settlement options under unit linked products, which are clearly outlined at the commencement of the contract, may be allowed.

iii) In case of death due to suicide, within 12 months from the date of inception of the policy or from the date of revival of the policy, the nominee of the policyholder shall be entitled to the fund value / policy account value, as available on the date of death.

iv) In case fraud or misrepresentation, the policy shall be cancelled immediately by paying the surrender value, subject to the fraud or misrepresentation being established by the insurer in accordance with Section 45 of the Insurance Act, 1938.

v) For policies issued on minor life, the date of commencement of policy and date of commencement of risk shall be same.

g. At no time the death benefit under a life insurance product or a benefit assured under a pension product on death or a health related benefit under a health insurance product shall be less than 105 percent of the total premiums including top-ups paid, excluding the service tax.

6. Guarantees on policy benefits:

a. Subject to provisions stipulated in Regulations 5, 26 and 33 herein, all individual linked products shall have either a guaranteed sum assured payable on death or a guaranteed sum assured to meet the health cover, as applicable and may have a guaranteed maturity value.

b. General aspects on any investment guarantees provided under linked products:

i) Guarantees provided shall be reasonable, consistent in relation to the current and long term interest rate scenario and priced appropriately.

ii) In case of unit linked products where guarantee charge is levied: If a guarantee charge is levied for the guarantees offered, the insurer shall submit a comprehensive documentation on such guarantee charge and demonstrate in their application under the File and Use:

(1) the purpose of such charge,

(2) the pricing methodology adopted and reserving methodology proposed to be adopted,

(3) the appropriateness of proper pricing and reserving through sensitivity and scenario testing for all the guarantees provided for,

(4) the possible asset allocations envisaged in arriving at the guarantee and the corresponding charge,

(5) whether such asset allocations envisaged as in (4) above and the actual assets allocations underlying the fund could be different,

(6) how the objective of the fund would be achieved in such scenario etc.,

iii) In case of variable insurance products, the insurer shall not levy any guarantee charge.

Chapter-IV

Policy Term, Premium Paying Term & Commission

7. Minimum Policy Term: The minimum policy term:

a. For individual products, shall be at least five years and

b. For fund based group linked products, shall be on annually renewable basis.

8. Premium Payment Term:

a. Premium Payment Term of Policies: Irrespective of the policy term, all individual linked products, shall have the minimum features as stated below:

i) Except for single premium payment products, no product shall have a minimum premium payment term (PPT) of 5 years.

ii) Insurers may design products which offer a range of premium paying terms and policy terms within a product.

iii) Insurers may extend an option to a policyholder to alter the premium payment term or policy terms provided that such alteration is in accordance with their Board approved underwriting policy.

9. Commissions or remuneration in any form:

a. Commission or remuneration in any form for the procurement of all individual policies in respect of all the Distribution Channels except the Direct Marketing shall not exceed the following:

i) Other than Pension Products:

(1) In case of single premium, 2% of the single premium;

(2) In case of other than single premium, the Table 9 (a) shall apply.

Table 9 (a)

Premium paying terms	Maximum Commission or remuneration in any form as % of premium		
	1st year	2 & 3 year	Subsequent years
5	15	7.5/5(*)	5
6	18	7.5/5(*)	5
7	21	7.5/5(*)	5
8	24	7.5/5(*)	5
9	27	7.5/5(*)	5
10	30	7.5/5(*)	5
11	33/30(*)	7.5/5(*)	5
12 years or more	35/30(*)	7.5/5(*)	5

Note – (*)
The maximum commission or remuneration:
a) For brokers shall be:

i. 30% in the first year for policies with premium paying term 10 and above; and

ii. 5% in the subsequent years for all premium paying terms.

b) During the first ten years of a life insurer's business for all intermediaries, except for brokers, shall be 40% in the first year for policies with premium paying term 12 and above.

ii) Pension Products:

(1) In case of single premium, 2 per cent of single premium.

(2) In case of other than single premium:

(a) 7½ per cent of the first year's premium, and.

(b) 2% per cent of each renewal premium.

b. For all distribution channels, except direct marketing, the maximum commission or remuneration in any form with respect to fund based group products as stipulated in Regulation 41 (a) herein, with respect to all premium payment modes, shall be:

i) 2 per cent of the premiums paid during the year with a ceiling of rupees one lakh per scheme for the entire year.

ii) At subsequent renewal, 2 per cent of the premiums paid during the year with a ceiling of rupees one lakh per scheme for the entire year.

c. If the commission or remuneration in any form offered in a product is substantially different between the distribution channels, the AA shall justify.

i) The reasons for the difference;

ii) How the difference is allowed in the pricing (i.e. charging structure) along with the volumes projected for each distribution channel;

d. Provided where the policies are procured by Direct marketing, no commission shall be payable.

Chapter-V

Discontinuance Terms

10. Grace Period: The grace period for payment of the premium for all types of linked insurance policies, except single premium policies shall be:

a. Fifteen days, where the policyholder pays the premium on a monthly basis;

b. Thirty days, in all other cases.

11. Lock-in Period: All linked insurance products shall have a lock-in period of five years from the date of inception of the policy.

12. Options of a policyholder upon discontinuance of the policy during the first five years:

a. For other than single premium policies, a policyholder shall be entitled to exercise one of the following options upon the discontinuance of the policy:

i) Revive the policy within a period of two years, or

ii) Complete withdrawal from the policy without any risk cover.

b. For single premium policies, the policyholder shall be entitled to exercise the option stipulated in sub-regulation a (ii) above.

13. Obligations of an insurer upon discontinuance of a policy before lock-in-period.

a. Where a policy is discontinued, the insurer shall take the following steps to enable the policyholder to exercise the option as stipulated in Regulation 12 herein:

i) Send a notice within a period of fifteen days from the date of expiry of grace period to such a policyholder to exercise the said options within a period of thirty days of receipt of such notice:

Provided that where the policyholder does not exercise the option within the notice period of thirty days, the treatment of such policy shall be subject to provisions stipulated in Regulation 15 herein.

Explanation.—The fund value/policy account value of the policy shall be part of the segregated fund chosen/total policy account till the policyholder exercises his/her option or till the expiry of thirty days of notice period whichever is earlier. During this period the

Where the policy is discontinued during the policy year	Maximum Discontinuance Charges for the policies having annualized premium up to Rs.25,000/-	Maximum Discontinuance Charges for the policies having annualized premium above Rs. 25,000/-
1	Lower of 20% * (AP or FV/policy account value) subject to a maximum of Rs. 3000	Lower of 6% * (AP or FV/policy account value) subject to a maximum of Rs. 6000
2	Lower of 15% * (AP or FV/policy account value) subject to a maximum of Rs. 2000	Lower of 4% * (AP or FV/policy account value) subject to a maximum of Rs. 5000
3	Lower of 10% * (AP or FV/policy account value) subject to a maximum of Rs. 1500	Lower of 3% * (AP or FV/policy account value) subject to a maximum of Rs. 4000
4	Lower of 5% * (AP or FV/policy account value) subject to a maximum of Rs. 1000	Lower of 2% * (AP or FV/policy account value) subject to a maximum of Rs. 2000
5 and onwards	Nil	Nil

policy is deemed to be in force with risk cover as per terms and conditions of the policy.

ii) To impose discontinuance charges only to recoup expenses incurred towards procurement, administration of the policy and incidental thereto;

iii) To design the discontinuance charges to encourage the policyholder to continue with the contract for the full term;

iv) To ensure that the discontinuance charges reflect the actual expenses incurred;

v) To structure the discontinuance charges within the statutory ceilings on commissions and expenses; and

vi) To ensure that the charges levied on the date of discontinuance (as a percentage of one annualized premium or a percentage of single premium) do not exceed the limits specified below:—

(1) For annual premiums:

(2) **For Single premium policies:**

b. Provided that where a policy is discontinued, only discontinuance charge and Fund management charge, which shall not exceed 50 bps per annum on discontinuance fund/ policy account value**,** as applicable, may be levied by the insurer and no other charges by whatsoever name shall be levied.

c. Provided that no discontinuance charges shall be imposed on top-ups premiums.

14. Obligations of an insurer on revival of a discontinued policy:

a. Where the policyholder exercises the option to revive the policy, the policy shall be revived restoring the risk cover along with the investments made in the segregated funds as chosen by the policyholder, out of the

Where the policy is discontinued during the policy year	**Maximum Discontinuance Charges for the policies having Single Premium up to Rs.25,000/-**	**Maximum Discontinuance Charges for the policies having Single Premium above Rs.25,000/-**
1	Lower of 2% *(SP or FV/policy account value) subject to a maximum of Rs.3000/-	Lower of 1% *(SP or FV/policy account value) subject to a maximum of Rs.6000/-
2	Lower of 1.5% *(SP or FV/policy account value) subject to a maximum of Rs.2000/-	Lower of 0.5% *(SP or FV/policy account value) subject to a maximum of Rs.5000/-
3	Lower of 1% *(SP or FV/policy account value) subject to a maximum of Rs.1500/-	Lower of 0.25% *(SP or FV/policy account value) subject to a maximum of Rs.4000/-
4	Lower of 0.5% *(SP or FV/policy account value) subject to a maximum of Rs.1000/-	Lower of 0.1% *(SP or FV/policy account value) subject to a maximum of Rs.2000/-
5 and onwards	Nil	Nil

AP- Annualised Premium
SP-Single Premium
FV- Fund Value

discontinued fund/policy account value, less the applicable charges as in sub-Regulation (b) in accordance with the terms and conditions of the policy.

b. The insurer, at the time of revival:

i) shall collect all due and unpaid premiums without charging any interest or fee.

ii) may levy policy administration charge and premium allocation charge as applicable during the discontinuance period. No other charges shall be levied.

iii) Shall add back to the fund, the discontinuance charges deducted at the time of discontinuance of the policy.

15. Obligations of the insurer upon surrender of the policy:

a. Where the policyholder exercises the option stipulated in sub-Regulation (ii) of Regulation 12 (a) herein or does not exercise the option available in terms of the proviso to sub-Regulation (i) of Regulation 13 (a), the fund value/policy account value of the policy shall be credited to the discontinued policy fund/ policy account value. The proceeds of the discontinued policy shall be refunded only upon completion of the lock-in period. The income earned on such fund/ policy account value shall be apportioned to the discontinued policy fund/discontinued policy account value and shall not be made available to the shareholders.

b. The insurer shall refund the amount by means of a cheque or demand draft, to be delivered to the insured, at his last known address or through any other electronic mode of payment to the specific bank account of the insured. However, the insurer may deduct discontinuance charges on the date of discontinuance on such policies, which shall not exceed the charges stipulated in sub-Regulation (vi) of Regulation 13 (a) herein:

Provided that in case of linked pension products, the insurer shall not refund more than one-third of the proceeds of the discontinued policy or as per the extant income tax provisions while the remaining amount shall be used to purchase an annuity with the same insurer, subject to the provisions of section 4 of the Act.

Explanation:(i) “Proceeds of the discontinued policies” means the fund value/policy account value as on the date the policy has discontinued, after addition of interest computed at the interest rate stipulated in Regulation 19 herein.

16. Obligations of the insurer, where the insured or the nominee is not traced:

a. Where the insured or his nominee, as applicable cannot be traced, the said proceeds shall be set aside and shown separately in the annual report of the insurer with its age wise break-up. The insurer shall not write back or apportion the said proceeds to the income of the shareholders or to that of any other policyholder. The proceeds so set aside shall be dealt with in such manner as may be specified by the Authority from time to time. A separate statement shall be furnished to the Authority on a half-yearly basis as stipulated in Regulation 62(b) herein.

17. Obligations of the insurer where two year revival period is not completed at the end of the lock-in period:

a. For policies which have not completed two years of revival period at the end of the lock-in-period, the insurer shall take the following steps to enable the policyholder to exercise the options available at the end of lock-in-period.

i) Where a policy is discontinued, the insurer shall take the following steps to enable the policyholder to exercise the options:

(1) as stipulated in Regulation 12 herein or

(2) Payout the proceeds at the end of the lock-in-period or revival period whichever is later.

ii) Send a notice within a period of fifteen days from the date of expiry of grace period to such a policyholder to exercise the said options within a period of thirty days of receipt of such notice:

Provided that where the policyholder does not exercise the option within the notice period of thirty days, the treatment of such policy shall be subject to provisions stipulated in Regulation 15 herein.

Explanation.—The fund value/policy account value of the policy shall be part of the segregated fund chosen/total policy account till the policyholder exercises his/her option or till the expiry of thirty days of notice period whichever is earlier. During this period the policy is deemed to be in force with risk cover as per terms and conditions of the policy.

b. If sub-regulation a (i) of Regulation 12 or a(i)(2) above is opted, the fund shall continue to remain in the discontinued policy fund/policy account value till the policy is revived or up to the end of the revival period whichever is earlier. If the policy is not revived within two years of the revival period, the proceeds of the discontinued policy fund/discontinued policy account value shall be paid out to the policyholder in accordance with Regulation 15.

18. Segregated Discontinued Policy Fund/ Discontinued policy account:

a. Each insurer shall have one discontinued policy fund/discontinued policy account for all the pension products, one for all life insurance products and one for all health insurance products. Each of these funds/policy accounts shall comprise of all the discontinued policy funds/discontinued policy account values of all the policies offered under the respective linked insurance products.

b. In case of unit linked products, the discontinued policy fund shall be a unit fund with the following asset categories:

i) Money market instruments: 0% to 40%;

ii) Government securities: 60% to 100%.

19. Minimum Guaranteed Interest Rate:

a. The minimum guaranteed interest rate applicable to the discontinued fund/ discontinued policy account shall be at an interest rate of 4 per cent per annum.

b. The excess income earned in the discontinued fund/discontinued policy account over and above the minimum guaranteed interest rate shall also be apportioned to the discontinued policy fund/discontinued policy account value in arriving at the proceeds of the discontinued policies and shall not be made available to the shareholders.

20. Obligations of the insurer in case of discontinuance of policy after the lock-in-period:

a. In case of discontinuance of policy after the lock-in-period, the insurer shall offer a revival period of two years from the date of discontinuance of premium. During this period the policy is deemed to be in force with risk cover as per terms and conditions of the policy.

i) Where a policy is discontinued, the insurer shall take the following steps to enable the policyholder to exercise the options:

(1) Revive the policy within a period of two years, or

(2) Complete withdrawal from the policy without any risk cover.

(3) Convert the policy into paid-up policy, with the paid-up sum assured in accordance with Section 113 (2) of the Insurance Act, 1938 i.e. sum assured multiplied by the total number of premiums paid to the original number of premiums payable as per the terms and conditions of the policy.

ii) Send a notice within a period of fifteen days from the date of expiry of grace period to such a policyholder to exercise the said options within a period of thirty days of receipt of such notice:

Provided that where the policyholder does not exercise the option within the notice period of thirty days, the treatment of such policy shall be, by default, in accordance with (2) above.

Explanation.—The fund value/policy account value of the policy shall be part of the segregated fund chosen/total policy account till the policyholder exercises his/her option or

till the expiry of thirty days of notice period whichever is earlier. During this period the policy is deemed to be in force with risk cover as per terms and conditions of the policy.

Chapter: VI

Free Look Period, Surrender Value, Top-up Premium, Partial Withdrawals and Settlement Options

21. Return of Policy during the Free-look period:

a. In case of unit linked products, the policyholder shall be entitled to an amount which shall at least be equal to non-allocated premium plus charges levied by cancellation of units plus fund value at the date of cancellation less expenses in accordance with the IRDA (Protection Of Policyholders' Interests) Regulations 2000, if the policyholder returns the policy.

b. In case of variable insurance products, the policyholder shall be entitled to an amount in accordance with the IRDA (Protection Of Policyholders' Interests) Regulations 2000, if the policyholder returns the policy.

22. Surrender Value:

a. Surrender Value: All individual linked insurance and pension products shall acquire surrender value in the following manner:

i) Linked Products other than linked pension products shall acquire surrender value stipulated in Regulations 15 herein.

ii) Linked Pension Products shall acquire surrender value stipulated in Regulation 27 herein.

b. Where a linked insurance product acquires a surrender value during the first five years, it shall become payable only after the completion of the lock-in-period. After the lock-in period, the surrender value shall be at least equal to the fund value/policy account value as on the date of surrender.

c. The "Surrender Value" or the "surrender value formula" shall be published in the policy document and all other promotional materials of the policy.

23. Top-up Premium:

a. A top-up premium is an amount of premium that is paid by the policyholders at irregular intervals besides basic regular premium payments specified in the contract and is treated as single premium for all purposes.

b. Top-up premiums can be remitted to the insurer during the period of contract only, where due basic regular premiums are paid up to date and if expressly allowed in the terms and conditions of the policy.

c. All top-up premiums made during the currency of the contract, except for pension products, shall have insurance cover treating them as single premium, as per the table 5.c.

d. Top-up premiums once paid cannot be withdrawn from the fund/policy account value for a period of 5 years from the date of payment of the 'Top-up' premium, except in case of complete surrender of the policy.

e. Except for pension products, top-up premiums are not permitted during the last 5 years of the contract.

f. For pension products, top-up premiums may be allowed unlimitedly, subject to providing the assured benefits on each of the top-up premiums paid.

g. For all other products other than pension products, at any point of time during the currency of the contract, the total top-up premiums paid shall not exceed the sum total of the regular premiums paid at that point of time/single premium paid.

h. The minimum sum assured on top-up premium shall be based on the age at payment of top-up premium but not on entry age.

24. Partial Withdrawals:

a. Partial withdrawal shall be allowed only after fifth policy anniversary.

b. In the case of child policies, partial withdrawals shall not be allowed until the minor life insured attains majority i.e. on or after attainment of age 18.

c. No partial withdrawal shall be allowed in case of –

i) Linked pension products

ii) Fund based Group linked products.

d. Partial withdrawals made shall be allowed from the fund/policy account value built up on from the top-up premiums, if any, as long as such fund/policy account value supports the partial withdrawal and subsequently, the partial withdrawals may be allowed from the fund/policy account value built up from the base premium. The insurer shall have the necessary systems built to identify the funds/policy account values from the base premiums and funds/policy account values from top-up premiums.

e. The partial withdrawals with respect to the funds/policy account values from the base premiums shall only be counted for the purpose of adjusting the sum assured to be payable on death for the purposes of sub-Regulation 5 (f)(i) herein. Partial withdrawals made from the top-up premiums shall not be deducted for this purpose.

f. The partial withdrawals shall not be allowed which would result in termination of a contract.

25. Settlement Options under unit linked products:

a. The insurer may provide settlement options at the maturity providing only periodical payments, in the contract so as to avoid the possibility of fluctuations affecting the maturity value under linked life insurance products and linked health insurance products.

b. Settlement options shall clearly indicate in the promotional material, the inherent risk being borne by the policyholder during the period and shall be explicitly understood by the policyholder.

c. The period of settlement shall not, in any case, be extended beyond a period of five years from the date of maturity.

d. The insurer may levy fund management charge during the settlement period and no other charges shall be levied.

e. Partial withdrawals and switches shall not be allowed during the settlement period.

f. Complete withdrawal may be allowed at any time during the settlement period without levying any charge.

g. The provisions of this Regulation shall not apply to linked pension products and all variable insurance products.

Chapter VII

Pension Products

26. General Provisions with respect to Pension and annuity products :

a. Pension products may be offered on any of the following platforms:

i) Individual linked pension products;

ii) Fund based Group linked pension products;

b. **Defined Assured Benefits**:

i) All individual pension products shall have explicitly defined assured benefit that is payable on:

(1) Death and;

(2) Vesting.

ii) The defined assured benefit shall be disclosed at the time of sale.

iii) The assured benefit shall be utilized on the vesting date or on date of death stipulated in sub-Regulations 28 and 29 herein, as applicable.

c. Pension products offered by the insurers may have a sum assured payable on death throughout the deferment period or may offer riders. The sum of all the rider premiums attached to the pension product shall not

exceed 15% of the premium paid for the pension policy. Such rider premiums shall be separately accounted for and shall not be included in arriving at the assured benefit as referred stipulated in Regulation (b) above.

27. Surrender Value and Options on Surrender:

a. On the date of surrender during the lock-in-period, the provisions stipulated in Regulation 15 herein shall be applicable. For the individual linked pension products, the extant Income Tax Rules shall be complied with at the time of closure of the contract at the end of the lock-in-period.

b. On the date of surrender after the lock-in period, the surrender value shall not be less than the fund value/policy account value as on the date of such surrender and the policyholder shall exercise one of the following options:

i) To commute to the extent allowed under Income Tax Act and to utilize the balance amount to purchase immediate annuity from the same insurer, which shall be guaranteed for life, at the then prevailing annuity/pension rate, or

ii) To utilize the entire proceeds to purchase the single premium deferred pension product from the same insurer

28. Options on Vesting: On the date of vesting, the policyholder shall exercise one of the following options:

a. To commute to the extent allowed under Income Tax Act and to utilize the balance amount to purchase immediate annuity with the same insurer, which shall be guaranteed for life, at the then prevailing annuity/pension rate, or

b. To utilize the entire proceeds to purchase the single premium deferred pension product with the same insurer; or

c. To extend the accumulation period / deferment period within the same policy with the same terms and conditions as the original policy provided the policyholder is below an age of 55 years.

29. Options to the Nominee on death of the policyholder: If the policyholder dies during the deferment period, the nominee shall exercise one of the following options:

a. To utilize the entire proceeds of the policy or part thereof for purchasing an annuity at the then prevailing rate from the same insurer; or

b. Withdraw the entire proceeds of the policy;

30. Financial Planning: For the purpose of financial planning, any pension product offered by the insurer shall comply with the sales literature guidelines issued by the life insurance Council circular number LC/SP/Ver. 1.0 dated 3rd February, 2004 and shall also necessarily disclose:

a. An illustrative target purchase price for each policyholder considering the premium payment capacity, age, vesting age and the future expected conditions.

b. Possible risks involved, if any, including the targeted pension rate in meeting the targeted purchase price.

c. Possible risks involved, if any, in purchasing the targeted pension rate/annuity rate.

d. An illustrative target annuity/pension rates for the illustrative target purchase price.

e. For the purpose of providing benefit illustration, in addition to the benefit illustration requirement stipulated in Regulation 40 herein, additional benefit illustration shall be disclosed to the prospective policyholder as in **Annexure II.**

31. In addition to the regular yearly statement to be sent to the policyholder in accordance with Regulation 60 (d) herein, a yearly disclosure shall be sent to each policyholder in **Annexure-III,** on 1st April indicating:

a. The current accumulated/available amount;

b. The expected accumulated/available amount on the date of vesting on the basis of the then prevailing and the likely assumed economic & demographic environment, as relevant with the caveat, that the projected rates shall not reflect any guarantee;

c. Likely annuity amounts based on the then prevailing annuity rates and on assumed interest rates of 4% p.a. and 8% p.a. with the caveat, that the projected rates shall not reflect any guarantee;

32. Fund Based Groups Linked Pension Products:

a. For all fund based group linked pension products with the defined benefits subscribed to by an employer, where the scheme does not maintain individual member accounts and only maintains a superannuation fund:

i) There shall be an assured benefit that shall be applicable on the entire superannuation fund available with the insurer.

ii) For exits such as death/retirement etc which are in accordance with the scheme rules as agreed at the inception of the contract with group policyholder, the insurer shall make payments from such funds only subject to the availability of funds in the respective unit fund or policy account value of the respective group policyholder's superannuation fund.

iii) Except for exits as per the scheme rules, no other withdrawals shall be allowed.

b. For all fund based group linked pension products with the defined contributions subscribed to by an employer, where the scheme maintain individual member accounts:

i) There shall be an assured benefit that shall be applicable on each of such individual accounts.

ii) For exits such as death/retirement/termination etc which are in accordance with the scheme rules as agreed at the inception of the contract with group policyholder, the insurer shall make payments from such individual member funds only subject to the availability of funds in the respective unit fund or policy account value of the respective member of the group policyholder's.

iii) Except for exits as per the scheme rules, no other withdrawals shall be allowed.

c. Provisions stipulated in Regulations 27, 28 and 29 herein shall not be applicable to fund based group linked pension products; however the benefits shall be subject to the scheme rules.

d. Provisions stipulated in Regulation 41 (e) herein shall apply in case of complete surrender of the policy.

e. Where the group policyholder maintains superannuation funds with more than one insurer, the group policyholder shall have the option to choose the insurer to purchase the immediate annuity.

33. For the purpose of this Regulation:

a. Target purchase price shall mean an absolute amount guaranteed at the outset of the contract or the accumulated value of the premiums/contributions accumulating at an illustrative rate of 4% p.a. and 8% p.a., which is expected to meet the policyholder's pension needs after allowing for commutation.

b. Targeted pension rate shall mean the pension that a policyholder expects to receive at the date of vesting at an illustrative assumed rate of interest of 4% p.a. and 8% p.a. allowed in pricing the annuity

c. "Guaranteed for life" shall mean:

i) an amount of annuity is guaranteed, in absolute terms, at the time of vesting or at the time of surrender or at the time of sale and

ii) Such guaranteed amount shall become payable as long as the policyholder survives.

d. An assured benefit means at least one of the guarantees from the following options of providing either:

(1) non-zero positive rate of return on the premiums paid, excluding service tax, from the date of payment to date of vesting or

(2) an absolute amount to be paid on death or maturity (which shall result in non-zero positive return).

ii) In both the above cases, the amount of such guarantee shall be disclosed at the time of purchase of contract.

iii) The non-zero positive return on death may be more than the non-zero positive return on maturity/vesting.

iv) A guaranteed maturity benefit (in absolute amounts) which shall be utilized at the vesting date or guaranteed death benefit (in absolute amounts) payable on death shall be disclosed at the time of purchase of contract.

e. The prevailing annuity rate shall mean the annuity rates that are approved by the authority as per the file and use procedure and are attached to the pension products.

f. Commutation shall mean the giving up of a part or all of the annuity payable from vesting/ surrender for an immediate lump sum.

Chapter VIII

Charges & Reduction in Yield for all Linked Products

34. Charges:

a. The life insurers shall use uniform definitions for charges under all the linked products in accordance with this regulation.

b. The insurers shall distribute the overall charges, in all linked products, in an even fashion during the lock-in period such that the:

i) premium allocation charge and policy administration charge shall be spread evenly during first 5 years of the policy contract, without wide fluctuations;

ii) charges could change from year to year in a reasonably orderly manner so that the difference between the maximum and minimum charges during first 5 years shall not vary by more than 1.5 times.

c. For the purpose of this Regulation, the unit fund shall be read as the policy account, in case of variable insurance products and the charges shall be levied to the policy account, wherever applicable.

35. The charges levied under the linked insurance products shall be:

a. **Premium Allocation Charge**: This is a percentage of the premium appropriated towards charges from the premium received. For unit linked products, the balance amount known as allocation rate constitutes that part of premium which is utilized to purchase the units of the fund in the policy. For variable insurance products, the balance amount shall be credited to the policy account. The percentage shall be explicitly stated and could vary by the policy year in which the premium is paid, the premium size and the premium type (regular, single or top-up premium).

i) This is a charge levied at the time of receipt of premium.

ii) **Example:** If premium = Rs.1000 & Premium Allocation Charge: 10% of the premium; then the charge: Rs.100 and Balance amount of premium is Rs.900.

b. **Fund Management Charge (FMC):**

i) For unit linked products, this is a charge levied as a percentage of the value of assets and shall be appropriated by adjusting the Net Asset Value. This is a charge levied at the time of computation of NAV, which is usually done on daily basis

ii) For variable insurance products, this is a charge levied as a percentage of the policy account value and shall be appropriated to the policy account value.

iii) **Example:** If Fund Management charge (FMC) is 1% p.a. payable annually; Fund before FMC is Rs.100/- and Fund after this charge is Rs.99/ -.

c. **Guarantee Charge:**

i) For unit linked products, this is a charge levied as a percentage of the value of assets and shall be appropriated by adjusting the Net Asset Value.

ii) This is a charge levied at the time of computation of NAV, which is usually done on daily basis.

iii) In case of variable insurance products, the insurer shall not levy any guarantee charge.

d. **Policy Administration Charge**: This charge shall represent the expenses other than those covered by premium allocation charges and the fund management expenses. This is a charge which may be expressed as a fixed amount or a percentage of the premium or a percentage of sum assured.

i) For unit fund, this charge is levied at the beginning of each policy month from the unit fund by canceling units for equivalent amount.

ii) For variable insurance products, this charge is levied at the beginning of each policy month from the policy account value.

iii) This charge could be flat throughout the policy term or vary at a pre-determined rate, subject to an upper limit. The pre-determined rate shall preferably be say an x% per annum, where x shall not exceed 5.

iv) Example: Rs.40/- per month increased by 2%p.a. on every policy anniversary.

e. **Surrender Charge or Discontinuance charge**

i) This is a charge levied on the unit fund/policy account value where the policyholder opts for complete withdrawal of the contract as stipulated in Regulation 12 a (ii) herein.

ii) This charge is usually expressed either as a percentage of the fund or as a percentage of the annualized premiums (for regular premium contracts).

f. **Switching Charge**: For unit linked products, this is a charge levied on switching of monies from one fund to another available within the product. The charge per each switch, if any, shall be levied at the time of effecting the switch and it shall be either a flat amount **or** lower of {a flat amount or percentage of the fund value}.

g. **Mortality /Morbidity charge:** This is the cost of life/health insurance cover. It is exclusive of any expense loadings levied by cancellation of units. This charge, if any, shall be levied at the beginning of each policy month from the fund.

i) The method of computation shall be explicitly specified in the policy document. The mortality/ morbidity charge table shall form part of the policy document.

ii) Mortality/morbidity charge table shall be guaranteed during the contract period.

iii) The mortality/morbidity charge for the mortality/morbidity risk covered shall:

(1) only reflect the pure risk charges for the cover offered and shall not include any allowance for expenses or any other parameters.

(2) be reasonable and consistent with the prescribed mortality tables or morbidity tables, if any.

(3) be demonstrated with the support of insurer's own experience, wherever applicable.

(4) be expressed as per Rs.1000 Sum at risk for each age.

h. **Rider charge**: This is the rider charge which is exclusive of expense loadings and levied separately to cover the cost of rider cover. The rider charge, if any, shall be levied by cancellation of units. This charge is levied at the beginning of each policy month from the fund.

i) The rider charge table shall be form part of the policy document.

ii) The rider charge shall:

(1) only reflect the pure risk charges for the cover offered and shall not include any allowance for expenses or any other parameters.

(2) be reasonable and consistent with the prescribed mortality/morbidity tables

(3) be demonstrated with the support of insurer's own experience, wherever applicable.

(4) be expressed as per Rs.1000 Sum Assured for each age

iii) Only linked riders approved by the Authority shall be attached to linked products.

i. **Partial withdrawal charge:** For unit linked products, this is a charge levied on the unit

fund at the time of part withdrawal of the fund during the contract period.

j. **Miscellaneous charge:**

i) This is a charge levied for any alterations within the contract, such as, increase in sum assured, premium redirection, change in policy term etc. The charge is expressed as a flat amount. For unit linked products, this shall be levied by cancellation of units.

ii) This charge is levied only at the time of alteration.

iii) **Example:** Rs.100/- for any alteration such as increase in sum assured, change in premium mode etc.

36. Other conditions on Charges:

a. The charges as filed under the File and Use and approved by the IRDA shall not be modified or changed without obtaining the prior approval of the IRDA.

b. All the charges other than premium allocation charge and mortality charge shall have an upper limit, if any, specified in all the promotional material and policy document.

c. All the charges, where upper limit is allowed, may be modified with supporting data within the upper limits with prior clearance from the Authority.

d. The cap on Fund Management Charges in respect of each of the segregated fund shall be 135 basis points and cap on guarantee charge shall be 50 basis points.

37. Difference between Gross Yield and Net Yield for all linked products:

a. Subject to sub-regulation (b), the maximum reduction in yield for policies from the fifth policy anniversary shall be in accordance with the Table 37 a.

Table: 37 a.

Number of years elapsed since inception	Maximum Reduction in Yield (Difference between Gross and Net Yield (% p.a.)
5	4.00%
6	3.75%
7	3.50%
8	3.30%
9	3.15%
10	3.00%
11 and 12	2.75%
13 and 14	2.50%
15 and thereafter	2.25%

b. The net reduction in yield at maturity for policies with term:

i) less than or equal to 10 years shall not be more than 3.00% and

ii) above 10 years shall not be more than 2.25%.

c. The insurer shall ensure that the reduction in yield in (a) and (b) is complied for all gross investment returns. However, only for the purpose of demonstration, the insurer shall demonstrate in the File and Use Application the compliance of reduction in yield in (a) and (b) for gross investment returns of 6% p.a., 8%, 10%p.a, 15%p.a., 20% p.a., 25%p.a.

d. In the process to comply with the reduction in yield, the insurer may arrive at specific non-negative additions, if any, to be added to the unit fund/policy account value, as applicable, at various durations of time. In case of unit linked products, such specific non-negative additions shall be called non-negative claw-back additions and shall be filed in the file and use procedure for approval.

38. At the time of Maturity, the insurer shall issue the policyholder a certificate showing year-wise contributions, charges deducted, fund value and final payment made to the policyholder taking into account partial withdrawals, if any. This certificate shall confirm adherence of above prescription.

39. Computation of Net Yield:

a. Mortality and Morbidity charges may be excluded in the calculation of the net yield.

b. Extra premium due to underwriting emanating from extraordinary health conditions, cost of all rider benefits, service tax on charges (as applicable) and any explicit cost of investment guarantee shall be excluded in the calculation of net yield. The calculation of all charges shall be as per 'File and Use' document as approved by the IRDA.

c. The net yield shall be calculated based on the projection of end fund on monthly basis at a specified gross rate of return assuming the mortality and morbidity charges as zero throughout the term of the contract and premiums are paid as and when due. The equation of value concerning the gross premium paid by the policyholder and the maturity fund value shall give the effective net yield per annum expected to be earned on the contract at the point of sale.

d. As the policyholders' behavior with regard to options under Linked products, for example, partial withdrawals, premium redirection etc. affect the net yield; such options may be ignored throughout the term of the contract of demonstrating the net yield.

e. A sample calculation of net yield is given in **Annexure IV.**

40. Customized Benefit Illustration:

a. The benefit illustrations shall be shown as per the gross investment returns prescribed by the Life Insurance Council which are currently 4% and 8% and the corresponding net yield shall be demonstrated only with respect to gross investment return of 8% p.a

b. The customized benefit illustration shall include all charges as applicable, service tax and fund values including commission/brokerage payable.

c. The net yield and hence reduction in net yield as calculated, shall be disclosed in the benefit illustration indicating the corresponding gross yield figures.

d. The benefit illustration shall be as prescribed in **Annexure V_A for Unit Linked Products and V_B for Variable Linked Products**.

Chapter: IX

Fund Based Group Linked Products

41. Fund Based Group Linked Products

a. Except for fund based group linked products, no other group linked product shall be offered under linked platform, where fund based group linked products are those which are offered to Employer-Employee groups and consists of:

i) Group Linked Superannuation Product;

ii) Group Linked Gratuity Product;

iii) Group Leave Encashment Product;

b. Provisions stipulated in Regulations 5, 10 to 20, 23, 24 and 25 shall not be applicable to fund based group linked products. However, the group linked policies in (a) (ii) & (a) (iii) above shall have life cover depending on the needs of the group.

c. The premium with respect to group schemes shall be made in accordance with the Actuary's certificate submitted by the employer in accordance with the AS15 (Revised). Where the fund is overfunded/in surplus as per such certificate, the insurer may allow "nil contributions/premiums" under the policy and in all such cases, the policy shall not be treated as discontinued.

d. The fund based group linked products shall not allow any top-ups, unless required as per the actuary's certificate in accordance with the AS 15 (Revised), to address the underfunding of the scheme.

e. The fund based group linked products may levy a surrender charge not exceeding 0.05 per cent of the fund/policy account value, with a maximum of Rs. 500, 000/-, if the policy is surrendered within the third renewal of the policy.

f. Fund based group linked products may offer life insurance cover with an explicit mortality charge levied.

g. Provisions stipulated in Regulations 34, 35, 36 and 37 herein shall be applicable to fund based group linked products:

i) At each individual account level, if individual accounts are maintained;

ii) At each policyholder fund level, if individual accounts are not maintained and only one fund is maintained.

For the purpose of this Regulation, "number of years elapsed since inception" stipulated in Regulation 37 herein shall be read as "number of years elapsed since renewal of the policy".

42. Fund Based Group Linked Products Administration:

a. The premium charged and benefits admissible to each member of the group shall be clearly specified in the group policy and the group policyholder shall not have the liberty to vary the premium or benefits with regard to the individual members.

b. Group discounts on premium are given for the benefit of the insured members of the group and shall not be appropriated as additional remuneration by the agent or corporate agent or broker or group policyholder. Such discounts shall be based on valid underwriting considerations such as the group size and shall be passed on to the members.

c. Where a part or whole of the premium is paid by the group policyholder, for example, the employer in respect of insurance of his employees, the discounts may be shared by those who paid the premium in proportion to the premium paid by them.

d. There shall be no other payment whether as management expenses or documentation expenses or profit commission or bulk discount or payment of any other description, to the agent or corporate agent or group policyholder. The group policyholder shall be specifically prohibited from collecting by way of premium from the members of a group, any amount higher than the amount charged by or paid to the insurer for such insurance.

e. The insurer, under an agreement with the group policyholder, may leverage on the existing infrastructure, if any, for better administration of the scheme with respect to the following services:

i) Data management – Documenting the list of the persons insured under the group policy from time to time and supporting the insurer with quality data on all members of the scheme and Know Your Customer requirements. The data management shall enable seamless transfer of data to insurer at regular intervals of each month or at short intervals as decided between the insurer and the group policyholder, to ensure efficient claims handling and establishing accurate reserving and pricing.

ii) Collection of Premium — Group policyholder may support the insurer through prompt premium collections under contributory schemes and its remittance to the insurer on a timely manner for better cash flow management.

iii) Issuance of Certificate of Insurance –The insurer shall be responsible to issue certificate of insurance to each group member of the policy where individual accounts are maintained. However, the insurer may provide the facility to the group policyholder to issue certificates of insurance to persons insured under the group, provided the underwriting guidelines for acceptance or rejection of such a risk do not require use of subjective judgment and can be easily programmed into a computer that will review acceptance and print the certificate of insurance. The procedure to be followed include:

(1) The certificate shall contain information on the schedule of benefits, the premium to be paid and important terms and conditions of the insurance contract.

(2) The certificate shall also state the procedure to be followed to register a claim with the insurer including the full address of the office of the insurer where the claim should be registered.

(3) The certificate forms shall be supplied by the insurer with in-built security features and in pre-numbered lots to the group policyholder. Before furnishing a fresh lot of forms, insurer shall personally verify the previous issue of certificate of insurers.

(4) Under any circumstances the insurer shall be responsible for the certificate of insurance issued by a group policyholder, in certificate forms provided by the insurer.

(5) The insurer shall be held responsible to the group members insured, in respect of the group policy in case of failure of the group policyholder to account for the business to the insurer, if the group member insured can prove that he had paid the premium and secured a proper receipt leading him to believe that he was duly insured.

iv) Claims settlement – The insurer may take the services of the group policyholder in facilitating the registering and settlement of a claim, however, the insurer is totally responsible to ensure that the claim payment is made in the name of the insured member, with respect to the life cover available in the group linked products, even if the cheque is sent to the group manager for administrative convenience. For other claim payments, the payment shall be made in accordance with the scheme rules. This payment shall be made only when the service is rendered.

f. The insurer may make payments directly to the group policyholder for the services rendered as in (e) under an agreement. The Authority may prescribe such remuneration to be paid to the Group Policyholder from time to time for each of the services rendered as in (e) and the current limits shall not be more than:

i) For data management: Rs.15/- per member per annum;

ii) Premium collection: Rs.10/- per member per annum;

iii) Issuance and delivery of certificate of Insurance: Rs.10/- per member subject to a minimum of Rs. 500/-. Issue of duplicate certificate of insurance shall not be done by the group policyholder;

iv) Claims settlement: Rs.10/- per claim;

g. If the business is procured through an intermediary, the remuneration with respect to the functions referred in (e) (i), (ii) and (iv) shall not be paid to the group policyholder, as these functions are part of obligations of an intermediary. However, with respect to the services referred in e (iii), the services of a group policyholder may be utilized and payment may be made as stipulated in f (iii).

h. If the business is procured directly, the remuneration with respect to the functions referred in (e) (i), (ii) and (iv) may be paid to the group policyholder, only if the group policyholder has provided all the services in accordance with the agreement. The payments to the group policyholder:

i) all put together shall not in any case exceed 20% of the commission payable as stipulated in Regulation 9 herein in case of both Single premium products and other than single premium products.

ii) shall ensure that for each of the services individually, the payments shall not exceed the rated proportion to the overall limit of 20% of the commission payable as stipulated in Regulation 9 herein in case of both Single premium products and other than single premium products

Chapter X

Computation of Net Asset Value (NAV) for Unit Linked Products

43. Computation of NAV:

a. The NAV of the Segregated FUND [SFIN] shall be computed as:

Market value of investment held by the fund + value of current assets – (value of current liabilities and provisions, if any)

Number of units existing on Valuation Date (before creation / redemption of units)

b. The NAV computed as above, in respect of 'each' Segregated Fund, shall be Audited by the Concurrent Auditor on a day-to-day basis.

c. The NAV calculated as above, in respect of 'each' Segregated fund, shall be declared daily on the Insurer's Website and at the **Life Insurance Council's** Website, as and when the same is ready

d. The sale or purchase shall be on a net basis.

Note:

i) Market value of investment, held by the fund.

ii) Value of Current Assets represents Accrued interest, Dividend Receivable, Bank Balance, Receivable for Sale of Investments and Other Current Assets (for Investments)

iii) Value of current liabilities represents Payable for Investments

iv) Number of units derived from the investment accounting system shall be reconciled on a day to day basis with the policy administration system

v) Provisions shall include expenses for brokerage and transaction cost, NPA, Fund Management Charges (FMC) and any other charges approved by the Authority.

44. Segregated funds:

a. Each Segregated Fund shall have:

i) A 'single' NAV, declared on a day-to-day basis and

ii) Fund management charge, if any, shall be specific to each segregated fund.

b. Each segregated fund shall have identified assets representing the investments of such segregated funds.

c. The Internal / Concurrent Auditor shall certify that such segregation had not resulted in enrichment of one set of policyholders from others due to change in the units or the NAV.

d. The implication, to the policyholder of such change, if any, shall be put on the insurer's website along with the rationale of making such change.

e. The concurrent Auditor shall confirm the Insurer's adherence to these requirements.

45. Asset Allocation under each fund:

a. The asset allocation range for each asset category shall be separate and explicitly stated.

b. Within a fund, no asset category shall have the asset allocation of "0%-100%", if more than one asset category is represented in the fund.

c. The asset allocation range shall reflect the investment objectives of the underlying fund.

Chapter XI

Administration of Linked Insurance Products

46. Administration of linked insurance products:

a. The insurers shall not launch any product, unless all the processes are lay down and suitable infrastructure requirements on an ongoing basis for the products to be launched are established and enable the insurer to perform all the day-to-day operations, computation of NAV on a daily basis, determination of the reserves and solvency margin from day of launch of such products, and as required under the legislation, regulation etc.

b. Where policies may be credited with additional benefits during the term of the contract or where the benefits are complexly designed and deviates from the simple insurance product structured, the insurer shall demonstrate to the Authority that it has established all the systems required to manage the day to day operations of the portfolio and shall enable the Appointed Actuary to determine the reserves and solvency margin calculations as required.

c. The Board or its delegated risk committee shall certify that "all the system requirements on an ongoing basis for the product……..(product

name) to be launched are established and the systems enable the insurer from day of launch of the product, to perform seamlessly all the day-to-day operations, computation of NAV on a daily basis and enables to submit all the necessary reports and returns as required under the legislation, regulation etc". The certificate shall be submitted before the launch of the product.

d. With regard to the existing products, the insurer shall submit the certificate to the Authority within 30 days from the date of this regulation.

Chapter XII

Miscellaneous Provisions

47. Level Premiums:

a. Except for group products, the premium chosen at the outset shall become payable throughout the premium paying term of the policy and shall not be altered during the term of the policy. Such premium shall be level / uniform and shall not vary over the term of the policy.

b. The insurer shall not accept any amounts less than the due stipulated regular premium payable as stated in the policy.

c. Any additional payments made on ad hoc basis shall be considered as top-up premium and treated as single premium for the purpose of providing insurance cover.

d. Service tax, if any, shall not be included in the contractual premium and shall be collected from the policyholder separately as over and above such premium.

48. Allotment of Units under unit linked products:

a. Units shall only be allocated on the day the proposal is accepted and results into a policy by adjustment of application money towards premium.

b. The premium shall be adjusted on the due date even if it has been received in advance and the status of the premium received in advance shall be communicated to the policyholder. This shall be disclosed in all literatures/documents furnished to the policyholders.

49. Loans:

a. Loans shall not be allowed under the Linked Insurance Products.

b. The promotion material shall display prominently in a bold font in the front page that "the Linked Insurance Products do not offer any liquidity during the first five years of the contract. The policyholder will not be able to surrender/withdraw the monies invested in Linked Insurance Products completely or partially till the end of the fifth year".

50. Series/Tranche of Funds under unit linked products:

a. Products with "highest NAV guaranteed" shall not be allowed.

b. Any guarantee offered in the benefits under a linked product shall be at the product level and shall not be related to any of the underlying funds.

c. The opening of series of closed ended funds shall not be allowed within a product.

51. Market Value adjustment:

a. Market value adjustment shall not be allowed under:

i) Individual products

ii) Non-par fund based group products where the product has no investment guarantees.

b. Market value adjustment may be allowed for non-par fund based Group products for bulk exits and complete surrender, where the bulk exits are clearly defined in the contract and provided there is an investment guarantee assured throughout the policy period.

c. Market value adjustment shall be defined explicitly & objectively and approved under File and Use. There shall not be any discretion left to the insurer in arriving at the market value adjustment.

d. Market value adjustment shall not be applicable for the amounts below the amount which represents the bulk exits and shall be applied only to the amount which is over and above the amount representing bulk exit.

e. For the purpose of this regulation:

i) If the amount to be paid on total exits in any event exceeds 25% of the total fund of the scheme at the beginning of the year, such transactions shall be treated as bulk exits, where exit shall be as per the scheme rules.

ii) "Exit" shall mean exit of the member from the group.

52. Advance Premium:

a. Collection of advance premium under individual linked products shall not be allowed except in the following cases:

i) The premium due may be accepted 30 days before the date of due of payment of premium. However, the commission shall only be paid on the premium due date

ii) For monthly premium payment mode, the insurer may accept three months' premiums in advance only on the date of commencement of policy, if it is a prerequisite to allow monthly mode of premium payment and is allowed under File and Use.

53. Splitting of Policies:

a. Splitting of policies shall not result into any increase, directly or indirectly to the policyholder by way of fees or charges in whatsoever name at any time during the term of the policies and not just at the inception.

b. A policy will be deemed to be split, if multiple policies of the same nature are sold to a prospect at the same time which results into a situation defined in (a) above.

54. Linked Health Insurance Products:

All the health insurance products under linked platform shall comply with the extant regulations, guidelines and circulars applicable for unit linked insurance products.

55. Approval of Innovative products:

a. Innovative products can be defined as the products which are uncommon in the market. Any product design, which is not approved so far by the Authority, shall be treated as innovative product.

b. The innovativeness in product design shall result in meeting customer needs, better customer understanding and satisfaction and shall not result in complexity of understanding the product, additional strain on the company's infrastructure, which may result in increased cost to the customer.

c. The insurer shall discuss with the Authority, the product design concept of the proposed innovative product along with:

i) Market research inputs which identify the specific needs of customer or meeting the existing needs in innovative manner through the proposed product design.

ii) A separate note on how such new product will enhance the satisfaction of customer and of any other stakeholder.

iii) Details on systems support that is being envisaged for execution of the proposed product.

iv) Details on underwriting, claims settlement, investment strategies for such new products.

v) Treatment for arriving at the reserves, solvency margin required for such products.

vi) Market conduct requirements for such products.

d. Whether any such products are available elsewhere in other markets. If available, the general structure of such products, the valuation requirements, market conducts and specific regulations on such products.

56. Financial Viability of the Products:

a. All the products once approved shall be reviewed by the Appointed Actuary at least once a year on the financial viability of the product. If the product is found to be financial

unviable, the Appointed Actuary shall revise the product under File and Use procedure. After 5 years of File and Use approval, the Appointed Actuary shall re-file the product along with the past five years experience in terms of mortality, lapse, interest rates, inflation, expenses etc. and seek fresh approval with suitable justifications for the assumptions made.

b. If the pricing assumptions for mortality is less than 50% of the prescribed table, the Appointed Actuary shall justify such assumptions with the actual claims experience for similar products for the past 3 years

Chapter XIII

Market Conduct

57. Market Conduct:

a. All Life Insurers shall give a periodical in house training to the persons involved in soliciting or procuring the business (agents/intermediaries) of their respective companies. A statement indicating the number of agents trained shall be furnished to the Authority which shall be appended to AAAR.

b. The Insurers shall impart this as a separate training to all the insurance agents/ intermediaries before they are authorized to sell linked insurance products to ensure required expertise.

c. The curriculum for this in-house training should inter alia contain;

i) The developments of the capital market,

ii) The basic knowledge of concept and working of the Linked Insurance Products,

iii) Risks in investing in Linked Insurance Products with reference to different funds,

iv) The developments in other similar type of financial products, the concept of equity market, debt market and the overall economic scenario as affecting the capital market in general and the features of the linked products.

v) This shall be a separate training in addition to the mandatory hours training for issuing and renewing the license respectively. The training shall be on a continuous basis.

d. Every life insurer shall maintain a register of such persons (agent/intermediaries), who have undergone this specific training. Insurers need to make sure that their insurance advisors selling the linked life insurance products render unbiased advice to enable the policyholders recognizes whether the recommended product is suitable.

e. An agent/intermediary shall maintain the records pertaining to the policyholder to demonstrate that sufficient information has been collected about the potential policyholder to enable a suitable product to be recommended. The agent/intermediary shall prepare a needs assessment form and enclose it to the proposal giving his recommendations of the appropriateness of the product recommended by him. This will form part of the policy file of the individual. These records shall be made available to the Authority, whenever called for.

f. Further, an agent/intermediary shall provide the sales illustration statement as prescribed to the potential policyholder. He/she shall clearly indicate how premium paid is appropriated towards various charges from the unit fund and the balance of the fund at the end of the first year and subsequent years. The upfront charges in the initial years have to be brought to the knowledge of the policyholders.

g. An agent/intermediary shall obtain a statement of consent (to be furnished along with the documents under F & U Procedure) signed by the policyholder and countersigned by the person (agent, intermediary etc) himself/ herself, along with the proposal form, that he has understood the inbuilt features of the policy and the applicable charges and that he is fully aware of investment risks under the policy to be issued. A copy of the illustration explained to the proponent duly countersigned by the agent/intermediary and the proponent shall also form part of the proposal papers.

h. An Insurer or its agent/intermediary shall not make any exaggerated statement, whether oral or written, either about their qualifications or capability to render investment management services or their achievements.

i. Appropriate documentation forming part of the proposal papers to demonstrate informed decision making on the part of the proponent in deciding a particular insurance product.

j. Life insurance Council shall issue guidelines on:

i) "Code of conduct" to be followed by all the insurers and the intermediaries selling linked products to ensure no mis-sale takes place.

ii) Uniform practice for rounding off the **unit prices**.

58. **Policyholder Education:** The insurers and life insurance council shall actively promote education of the policyholders on the Linked Products on an ongoing basis to guide them in taking appropriate decisions in terms of the features, risk factors including the terminology and the definitions of charges under these products.

59. **Uniform cut-off timings for applicability of Net Asset Value in case of unit linked products :** The allotment of units to the policyholder shall be done only after the receipt of premium proceeds as stated below:

(i) Allocations (premium allocations, switch in):

a. In respect of premiums/funds switched received up to 3 p.m. by the insurer along with a local cheque or a demand draft payable at par at the place where the premium is received, the closing NAV of the day on which premium is received shall be applicable.

b. In respect of premiums/funds switched received after 3 p.m. by the insurer along with a local cheque or a demand draft payable at par at the place where the premium is received, the closing NAV of the next business day shall be applicable.

c. In respect of premiums received with outstation cheques/demand drafts at the place where the premium is received, the closing NAV of the day on which cheques/demand draft is credited shall be applicable.

d. Having regard to the above, insurer shall ensure that each and every payment instrument is banked with utmost expedition at the first opportunity, given the constraints of banking hours, prudently utilizing every available banking facility (e.g. high value clearing, account transfer etc.) Any loss in NAV incurred on account of delays, shall be made good by the insurer.

(ii) Redemptions:

a. In respect of valid applications received (e.g. surrender, maturity claim, switch out etc) up to 3 p.m. by the insurer, the same day's closing NAV shall be applicable.

b. In respect of valid applications received (e.g. surrender, maturity claim, switch etc) after 3 p.m. by the insurer, the closing NAV of the next business day shall be applicable.

Chapter: XIV

Disclosure Norms under

60. **Disclosure Norms:**

a. For all unit linked products, all Life Insurers shall necessarily and explicitly mention, **using the same font size**, in all the sales brochures, prospectus of Insurance products, in all promotional material and in policy documents:

i) On top of each document including the proposal form mention, **"In this policy, the investment risk in investment portfolio is borne by the policyholder"**.

ii) The various funds offered along with the details and objective of the fund.

iii) The minimum and maximum percentage of the Investments in different types (like equities, debt etc.), investment strategy so as to enable the policyholder to make an informed investment decision. **"No statement of opinion as to the performance of the fund shall be made anywhere."**

iv) The definition of all applicable charges, method of appropriation of these charges and the quantum of charges that are levied under the terms and conditions of the policy.

v) The maximum limit up to which the insurer reserves the right to increase the charges subject to prior clearance of the Authority.

vi) The fundamental attributes and the risk profile (low, medium or high) of different types of investments that are offered under various funds of each linked product**.**

b. For all unit linked products, the policyholder shall be given the full details, **using the same font**, related to the investments, as an annual report, covering the fund performance during the preceding financial year in relation to the economic scenario, market developments etc. which should including particulars like.

i) The investment strategies and Risk Control measures adopted.

ii) The changes in fundamentals, such as interest rates, tax rates, etc., affecting the investment portfolio.

iii) The composition of the fund (debt, equity etc.), analysis within various classes of investment, investment portfolio details, sectoral exposure of the underlying funds and the ratings of investments made.

iv) Analysis according to the duration of the investments held.

v) Performance of the various funds over different periods like 1 year, 2 years, 3years, 4 years, 5 years and since inception along with comparative benchmark index.

c. A copy of such annual report referred in (b) above shall be appended to the Appointed Actuary Annual Report (AAAR) and shall be submitted along with the AAAR.

d. All the Life Insurers are required to issue the periodical statements of accounts to policyholders each year disclosing the actual charges levied and the fund/policy account value at the beginning and end of the year.

i) Unit statement account /Policy account value shall form a part of the policy document

ii) Unit statement account /Policy account value shall make a reference to the terms and conditions applicable under the respective policy document.

iii) Unit statement account /Policy account value shall be issued on every policy anniversary and also as and when a transaction takes place.

e. No unit statements/ Policy account value shall be required to be sent to the policyholder in respect of transactions related to monthly debit of mortality and other charges specified in the contract.

f. All the insurers shall submit the disclosures relating to discontinued policies as specified below:

i) The funds arising from discontinuance policies shall be shown under a separate head in the Balance Sheet in the following manner:

(1) Funds for discontinued policies

(a) Discontinued on account of non-payment of premium;

(b) Others

(2) The amount refunded to the policyholders and amount transferred to the "Funds for discontinued policies**"** during the financial year shall be shown under a separate head.

ii) The following disclosures shall be made in the notes of the accounts

(1) Number of policies discontinued during the financial year;

(2) Percentage of discontinued to total policies (product wise) during the year;

(3) Number and percentage of the policies revived during the year;

(4) Charges imposed on account of discontinued policies.

Chapter: XV

Advertisements

61. Advertisements:

a. An advertisement shall ensure the dissemination to all policyholders of adequate, accurate, explicit and timely information fairly printed in a simple language about:

i) A factual picture of inherent risks involved.

ii) Shall clearly distinguish the fact that the Linked products are different from the traditional Life Insurance products so that at no point of time the prospective policy holders will be misled while choosing the Unit Linked products.

iii) The risk factors associated with specific reference to fluctuations in investment returns and the possibility of increase in charges.

iv) The premiums and funds are subject to certain charges related to the fund or to the premium paid.

v) The contingency on which the guarantee, if any, is payable and the exact quantum of such guarantee.

b. The terminology used in all the advertisements shall be simple, concise and understandable to convey the exact meaning to the policyholders as all of them may not be sophisticated in legal or financial matters and shall avoid the usage of technical jargon and also terms which can have different interpretations or detract the policyholders**.**

c. Care should be taken while reporting the past performance of the funds in advertisements, as well as in any other promotional material like sales illustrations, sales brochures etc. It should contain only the results of the funds and be duly supported by related figures. The emphasis on past performance must be reduced in the advertisements, however, past performance, wherever intended to be reported, shall contain:

i) Compound annual returns (shall adopt standardized computations) for the previous five calendar years, expressed as a percentage rounded to the nearest 0.1%.

ii) Where last five calendar years data are not available, as many years as possible must be shown.

iii) Where data is not available for at least one calendar year, past performance shall not be shown.

iv) The life insurers shall not be permitted to demonstrate a link between the past performance and the future.

v) It shall clearly state, in the same font, that the past performance is not indicative of future performance.

vi) Corresponding benchmark index performance, if any, shall be included.

d. All the advertisements of Linked Insurance products shall disclose the risk factors as stated in the policy document along with the following warning statements:

i) Linked Insurance products are different from the traditional insurance products and are subject to the risk factors.

ii) The premium paid in Linked Insurance policies are subject to investment risks associated with capital markets and the NAVs of the units may go up or down based on the performance of fund and factors influencing the capital market and the insured is responsible for his/her decisions.

iii) _____is only the name of the Insurance Company and_____ is only the name of the linked insurance contract and does not in any way indicate the quality of the contract, its future prospects or returns.

iv) Please know the associated risks and the applicable charges, from your Insurance agent or the Intermediary or policy document issued by the insurance company.

v) The various funds offered under this contract are the names of the funds and do not in any way indicate the quality of these plans, their future prospects and returns.

vi) In view of the paucity of time and space, on the advertisements in the hoardings and posters and in audio visual media, wherever the linked insurance contract has been advertised, point nos. (ii) & (iii) shall have a place invariably.

e. The advertisements shall not compare funds offered by one insurer with funds offered by another insurer, implicitly or explicitly.

f. Any advertisement reproducing or purporting to reproduce any information contained in as policy document shall reproduce such information in full and disclose all relevant facts and not be restricted to select extracts relating to that item which could be misleading.

g. Every advertisement shall comply with IRDA (Insurance Advertisements and Disclosure) Regulations, 2000.

Chapter: XVI

Furnishing of Information

62. Furnishing of Information to IRDA:

a. All the life insurers shall furnish data in respect of the following information relating to their linked policies to the Authority in a prescribed format every half year (Sept and March), to enable the Authority to monitor the functioning of various options offered under linked policies with respect to each product

i) Switching options exercised by the policy holder.

ii) Premium redirections exercised by the policy holders.

iii) Partial withdrawals allowed.

iv) Top-up premiums received.

v) Insurance cover multiple granted for each product— separately for Single Premium and non-Single Premium contracts.

vi) Expense ratios and fund performance for each fund.

b. Every insurer shall send a statement of account, on a half yearly basis, within fifteen days, in respect of policies in force including discontinued policies where the proceeds are yet to be paid to the policyholder or her nominee as the case may be, his last known address, which shall contain the following details :-

i) The total premium paid by the policyholder

ii) Next due date of the premium

iii) Pattern of the investment chosen

iv) Pattern of investment

v) Status of the policy

vi) Total fund value/policy account value

vii) Total units

viii) Detail of charges recovered.

c. Further, the above details shall also be submitted separately , in respect of discontinued policies where the proceeds are yet to be paid to the policyholder or her nominee as the case may be, his last known address.

d. A detailed analysis on the functioning and the performance of discontinued policy fund / discontinued policy account value and the movements in the fund shall be explained as a separate chapter in the Appointed Actuary Annual Report.

e. The Authority may prescribe additional forms from time to time.

Chapter –XVII

Rating of Unit Linked Funds

63. Rating of Unit Linked Funds: The Insurers may move towards the evaluation of their respective unit linked funds done by an independent rating agency with an objective of providing qualitative information to the policyholder as to the assessment of performance of the various unit linked funds to enable the insuring public to choose the product in an informed manner. **This information shall provide the prospects a level of comfort on operational practices,**

fund management quality, organizational strength of life insurers. This may be initiated by the life insurers and life insurance council on a voluntary basis.

Chapter –XVIII

Procedure for Implementation and Other provisions

64. The insurers shall follow the following procedure for implementation of this regulation:

a. All existing products must be examined and ensured that they are in conformity with these Regulations.

b. The Chief Executive Officer and the Appointed Actuary will certify such compliance with regard to each product and submit such certificates to the Authority in a consolidated form on or before 30th June, 2013 or 30th September, 2013 as applicable for Group and Individual products.

c. In case of products which are non-compliant with the provisions of this regulation:

i) the modifications required to confirm to the provisions of this Regulations does not include any change in the benefits offered, premium bases, charges levied or any discounts offered in the products, than the insurer shall carry out such modifications and file the modified File and Use for those products along with the certification of the CEO and the AA that all the entire File and Use after the modification is in conformity with the provision of this Regulations and submit to the Authority before 30th June, 2013. The Authority shall accept the file as final and allot the unique identification number. However, later if such filings are found to be non-complaint with the provisions of this Regulation, the Authority may initiate such action against the said insurer, as deemed appropriate, under the provisions of the Act, the Insurance Regulatory and Development Authority Act, 1999 and the relevant regulations framed there under.

ii) For group products, the modifications required to confirm to the provisions of this Regulations include any change in the benefits offered, premium bases, charges levied or any discounts offered in the products, than the insurer shall carry out such modifications and file the modified File and Use for those products along with the certification of the CEO and the AA that all the entire File and Use after the modification is in conformity with the provision of this Regulations and submit to the Authority before 30th September, 2013 for approval. The products submitted under File and Use for approval shall clearly state the current provisions and the proposed provisions in line with this regulation in a tabular form and also indicate the implications on the pricing, reserving, profit margin etc, if any. The Insurer shall file the products in a phased manner and avoid filing of all the products at one time.

iii) For individual products, the modifications required to confirm to the provisions of this Regulations include any change in the benefits offered, premium bases, charges levied or any discounts offered in the products, than the insurer shall carry out such modifications and file the modified File and Use for those products along with the certification of the CEO and the AA that all the entire File and Use after the modification is in conformity with the provision of this Regulations and submit to the Authority before 30th September, 2013 for approval. The products submitted under File and Use for approval shall clearly state the current provisions and the proposed provisions in line with this regulation in a tabular form and also indicate the implications on the pricing, reserving, profit margin etc, if any. The Insurer shall file the products in a phased manner and avoid filing of all the products at one time.

d. In case of products which are already filed with the Authority, but not approved, the files shall be returned for filing afresh in conformity with this regulation.

e. All the existing group policies and all the existing individual products not in conformity with the provisions of this regulation shall be withdrawn from 1st July, 2013 and 1st October, 2013 respectively. No new members shall be

enrolled into the existing group policies once the product is withdrawn. However, all group policies at the time of renewal of such policy shall be given an option to switch over to the modified version of the group product, if any, once introduced. Those group policies which do not switch over to the modified version:

i) may continue to be renewed under the old policy;

ii) closed to new members and

iii) specific written consent is obtained by the group policyholder to continue in the old policy.

f. Subject, to (e), this regulation shall not invalidate the linked individual policies entered prior to this regulations coming into force.

g. All the insurers shall inform the prospective policyholders about the possible changes in the products being sold during the transition period and give an option to the existing policyholders including prospective policyholders to switch over to the modified version if any, once introduced.

65. Action in case of Default:

a. The Authority may, at any time, by an order in writing, direct any officer of the Authority to inspect the affairs of any insurer and submit a report on the reasonableness or otherwise of the compliance with the any of these regulations

b. Upon receipt of the report, the Authority shall, after giving an opportunity to the insurer to make a representation in connection with the findings in the report, direct the insurer appropriately.

c. Without prejudice to the above, the Authority may also initiate such action against the said insurer, as deemed appropriate, under the provisions of the Act, the Insurance Regulatory and Development Authority Act, 1999 and the relevant regulations framed there under.

d. All the insurers shall inform the prospective policyholders about the possible changes in the products being sold during the transition period and give an option to the existing policyholders including prospective policyholders to switch over to the modified version if any, once introduced.

e. Where any product or feature of a product is cleared under File and Use by the IRDA, such clearances for the same kind of product or feature shall not be denied to any other insurer. However, the Authority reserves the right to require insurers to withdraw a product or a feature of the product if such is found not to be consistent with policyholder interests. In all such cases, the Authority shall give three months notice for such withdrawal.

66. Power of the Authority to issue clarifications:

a. In order to remove any difficulties in respect of the application or interpretation of any of the provisions of these regulations, the Authority may issue appropriate clarifications or guidelines, as and when required

67. Repeal and Savings:

a. The IRDA (Treatment of discontinued policies) Regulation, 2010, all the guidelines/ clarifications/circulars/letters issued in respect of the unit linked insurance products, Pension and Variable insurance products and Regulation 19 of the IRDA (INSURANCE BROKERS) REGULATIONS, 2002 shall be repealed from the date this regulation comes into force.

b. Unless otherwise provided by these regulations, nothing in these regulations shall deem to invalidate the Unit linked insurance, Pension and Variable insurance contracts entered prior to these regulations coming into force.

68. Review of the guidelines: The Authority has power to make a detailed review of the guidelines on an ongoing basis for such modifications as may be deemed necessary towards protection of the interests of the policyholders

J. Hari Narayan
Chairman
(ADVT.III/4/161/13/EXTY)

d) IRDA (Non-Linked Insurance Product) Regulations 2013

THE GAZETTE OF INDIA
EXTRAORDINARY
PART III SECTION IV
PUBLISHED BY AUTHORITY
INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY
NOTIFICATION
HYDERABAD, the 11th FEBRUARY, 2013

Insurance Regulatory and Development Authority (Non-Linked Insurance Products) Regulations, 2013

F. No. IRDA/Reg/13/71/2013 :- In exercise of the powers conferred under Section 114A of the Insurance Act, 1938(4 of 1938) read with Sections 14 and 26 of the Insurance Regulatory and Development Authority, Act 1999, the Authority in consultation with the Insurance Advisory Committee, hereby makes the following regulations, namely:-

CHAPTER I

1. Short title and commencement.

a. These regulations may be called Insurance Regulatory and Development Authority (Non Linked Insurance Products) Regulations, 2013

b. They shall come into force on the date of their publication in the Official Gazette.

c. Unless otherwise provided by these regulations, nothing in these regulations shall deem to invalidate the non-linked insurance policies entered prior to these regulations coming into force.

d. These regulations shall be applicable to all the products offered by the life insurance companies under the non-linked platform.

2. Definitions: In these Regulations, unless the context otherwise requires,—

a. "**Act"** means the Insurance Act, 1938 (4 of 1938).

b. "**Authority"** means the Insurance Regulatory and Development Authority established under sub-section (1) of section 3 of the Insurance Regulatory and Development Authority Act, 1999 (41 of 1999)

c. "**Date of payment of premium"** means the date on which premium payment is received by the insurer in accordance with the provisions of Section 64 VB (2) of the Act.

d. **"Death benefit"** means the benefit, agreed at the inception of the contract, which is payable on death as specified in the policy document.

e. "Free-look" period shall be as stipulated in sub-regulation 2 of Regulation 6 of Insurance Regulatory and Development Authority (Protection of Policyholders' Interests) Regulations, 2002.

f. **"Employer-Employee group"** means groups where an employer-employee relationship exists between the master policyholder and the member in accordance with the relevant laws.

g. "**Grace Period"** means the time granted by the insurer from the due date for the payment of premium, without any penalty/late fee, during which time the policy is considered to be in-force with the risk cover without any interruption as per the terms of the policy.

h. **"Limited premium payment products"** means the non linked insurance products where the premium payment period is limited compared to the policy term and are paid at regular intervals like yearly, half-yearly etc.

i. **"Maturity benefit"** means the benefit, which is payable on maturity i.e. at the end of the term, as specified in the policy document and is stated at the inception of the contract.

j. **"Non Employer-Employee Groups" means** groups other than employer-employee where a clearly evident relationship between the member and the group policyholder for services other than insurance exist.

k. **"Regular Premium Products"** means non linked insurance products where the premium payment is throughout the term of the product and are paid in regular intervals like yearly, half-yearly etc.

l. "**Rider benefits**" means an amount of benefit payable on a specified event offered under the rider, and is allowed as add-on benefit to main benefit.

m. "**Revival of a policy"** means restoration of the policy, which was discontinued due to the non-payment of premium, by the insurer with all the benefits mentioned in the policy document, with or without rider benefits if any, upon the receipt of all the premiums due and other charges/late fee if any, as per the terms and conditions of the policy, upon being satisfied as to the continued insurability of the insured/ policyholder on the basis of the information, documents and reports furnished by the policyholder, in accordance with their Board approved Underwriting guidelines.

n. "**Revival Period**" means the period of two consecutive years from the date of discontinuance of the policy, during which period the policyholder is entitled to revive the policy which was discontinued due to the non-payment of premium.

o. **"Sales illustrations"** means a document furnished in accordance with life insurance council circular number LC/SP/Ver 1.0 dated 3rd February, 2004.

p. **"Settlement options"** means a facility made available to the policyholder to receive the maturity proceeds in installments in accordance with the terms and conditions are specified in advance at the inception of the contract.

q. **"Single premium products"** means non linked insurance products, where the premium payment is made by a single payment at the inception of the policy.

r. **"Sum Assured on death"** means an absolute amount of benefit which is guaranteed to become payable on death of the life assured in accordance with the terms and conditions of the policy.

s. **"Sum Assured on maturity"** means an absolute amount of benefit which is guaranteed to become payable on maturity of the policy in accordance with the terms and conditions of the policy.

t. **"Surrender"** means complete withdrawal/ termination of the entire policy

u. **"Surrender Value"** means an amount, if any, that becomes payable in case of surrender in accordance with the terms and conditions of the policy

v. **"Non-linked Whole Life products"** means non linked insurance products which do not have a definite policy term and the policy terminates on death of the life assured. This can be issued with item (h) or (k) or (q) stated above.

w. All words or expressions not defined in these regulations but defined in the Insurance Act 1938 or Insurance Regulatory and Development Authority Act 1999 shall have the same meanings respectively assigned to them in those Acts.

Chapter-II

Product structures

3. Product structures: The product structure shall be classified as participating products (herein after referred as "par products") and non-participating products (herein after referred as "non-par products").

4. Par products: Par products shall be as defined in IRDA (Actuarial Report and Abstract) Regulations, 2000 and can be offered only under non-linked platform. Under the par products, the bonus accruals during the term shall be as follows:

a. Regular bonus shall declared only on an annual basis;

b. Interim bonus shall be declared at the annual valuation period which shall become payable during the inter-valuation period.

c. Terminal bonus, if any, declared shall become payable on the specified events agreed in the policy or at the end of the term of the policy.

5. Non-par products: Non-par products may be offered either under a linked platform or a non-linked platform, and are those products which contain the following features:

a. Non-Linked platform: Individual and Group Savings Variable Insurance Products:

i) Benefits assured to be payable on the occurrence of a specified event which are explicitly stated at the outset and not linked to any index or benchmark;

ii) Additional benefits, if any, accrued at regular intervals during the policy term, which are explicitly stated at the outset and not linked to any index or benchmark;

iii) Subject to Regulation 12 herein, for additional benefits accrued during the term under non-par products:

(1) benefit accrual shall only be either at the beginning of every quarter or half-year or year as may be stated at the outset, where year shall mean the financial year;

(2) such benefits to be accrued at the specified frequencies and shall not be linked to any index or benchmark and shall be explicitly stated at the outset.

iv) Where the benefits under the products depend on regular interest rate credits, all such products shall fall under variable insurance products.

b. Non-Linked platform: Fund based Groups:

i) The benefits or interest rates, in respect of fund based Group insurance products:

(1) shall not be linked to any index or benchmark; and

(2) are explicitly stated in advance at the inception of the policy; and

ii) Additional benefits or additional interest credits, if any, may be accrued either at the beginning of every quarter or half-year or year as may be explicitly defined or stated at the outset with no discretion to the insurer, where year shall mean the financial year.

iii) Where the benefits under the fund based group products depend on regular interest rate credits, all such products shall fall under variable insurance products.

c. Linked platform:

i) Unit Linked insurance products which comply with the definition of "Linked business" in accordance with IRDA (Registration of Indian Insurance companies) Regulations, 2000 and IRDA (Asset Liability Solvency Margin) Regulations 2000, Schedule II-A, Section 1(b).

ii) Variable Linked insurance products which comply with the definition of "Linked business" in accordance with IRDA (Registration of Indian Insurance companies) Regulations, 2000.

Chapter: III

Minimum Death Benefit

6. Minimum Death Benefit: Except for variable insurance products, for all the non-linked individual life insurance products as stipulated in Regulations 4 and 5 (a) herein, the minimum death benefit during the entire term of the policy shall not be less than the sum of Sum Assured on death and Additional Benefits, if any:

a. For the purpose of this provision the minimum Sum Assured on death shall be as per Table 1:

i) For the purpose of this provision, the annualized premium shall be the premium payable in a year chosen by the policyholder, excluding the underwriting extra premiums and loadings for modal premiums, if any.

b. In addition to the minimum sum assured on death as stipulated in 6 (a) herein, the bonus/ additional benefits as specified in the policy and accrued till the date of death shall become payable on death, if not paid earlier.

Table: 1

S.No.	Type of product	Age of the life assured less than 45 years	45 years and above
1	Single premium products	Highest of 125% of the single premium or minimum guaranteed sum assured on maturity or any absolute amount assured to be paid on death.	Highest of 110% of the single premium or minimum guaranteed sum assured on maturity or any absolute amount assured to be paid on death.
2	Other than single premium products	Highest of, 10 times the annualised premium or 105% of all the premiums paid as on date of death or minimum guaranteed sum assured on maturity or any absolute amount assured to be paid on death	Highest of, 7 times the annualised premium or 105% of all the premiums paid as on date of death or minimum guaranteed sum assured on maturity or any absolute amount assured to be paid on death

c. The insurer may pay such death benefit in installments over a definite period of time at a defined rate of interest, as approved under the file and use, on the declining balance if such option is provided at the inception of a policy.

d. In case of death due to suicide, within 12 months from the date of inception of the policy, the nominee of the policyholder shall be entitled to at least 80% of the premiums paid or from the date of revival of the policy, the nominee of the policyholder shall be entitled to a minimum of the surrender value / policy account value, as available on the date of death.

e. In case fraud or misrepresentation, the policy shall be cancelled immediately by paying the surrender value, subject to the fraud or misrepresentation being established by the insurer in accordance with Section 45 of the Insurance Act, 1938.

f. For policies issued on minor life, the date of commencement of policy and date of commencement of risk shall be same.

g. This provision shall not be applicable to reduced paid-up policies, pension products, all types of immediate annuity products, and decreasing cover term insurance products.

Chapter: IV

Non-Linked Variable Insurance Products

7. Variable Non-Linked Insurance Products: Variable insurance products shall be offered in any of the following manner:

a. Individual Non-par;

b. Group Savings Non-Par;

c. Fund based Group Non-par;

d. Individual Par;

e. Group Saving Par;

f. Fund based Group Par.

8. Except for Fund based group products, all Non-Linked Variable Insurance products may only offer the following death benefits:

a. (i) The sum assured as agreed in the policy plus the balance in the policy account **or**

(ii) Higher of the sum assured as agreed in the policy or the balance in the policy account

In either case, the sum assured shall be at a minimum consistent with the provision stipulated in accordance with Regulation 5 of IRDA (Linked Insurance Products) Regulations, 2013

b. A minimum maturity benefit which shall be at least equal to the balance in the policy account together with a terminal bonus, if any, as applicable.

9. Benefit payable on death/ Benefits offered under the Health Cover: For variable insurance products, the benefit payable on death/ benefits offered under the Health Cover shall be in accordance with the Regulation 5 of the IRDA (Linked Insurance Products), Regulations, 2013.

10. Non-Par Variable insurance product:

a. The Variable insurance products shall have a:

i) Guaranteed non-negative interest rate, referred as minimum floor rate and

ii) Non-negative additional interest rate, if any, as stipulated in Regulation 5 herein**,** which is over and above the minimum floor rate, to be accrued at various points in time as approved in the File and Use clearance accorded by the Authority.

iii) Non- negative residual additions, if any, shall be credited to the policy account in order to meet the maximum reduction in yield as stipulated in Regulation 37 of IRDA (Linked Insurance Products) Regulations, 2013 at the end of each year starting from policy year 5. Such non-negative residual additions shall be determined as:

(1) Gross Investment Yield earned in the shadow account at the end of each policy year less

(2) Actual yield earned in the policy account value, at the end of each policy year less

(3) Yield referred in the reduction in yield at that duration as stipulated in Regulation 37 of IRDA (Linked Insurance Products) Regulations, 2013.

(4) For the purpose of this regulation, the yield earned on each of the policy account shall be calculated using the money weighted rate of return method at end of each policy year.

b. This minimum floor rate, as approved in the File and Use clearance accorded by the Authority, shall be:

i) Guaranteed for the entire term of the policy accumulating on the balance of the policy account;

ii) Such accumulation shall be at a frequency of not less than quarterly on the balance of the policy account at the beginning of each such quarter.

c. At each interval, after the minimum floor rate is credited, the non-negative additional interest rate shall be credited to the balance of the policy account value.

d. At the end of each policy year , in order to comply with maximum reduction in yield as stipulated in regulation 37 of IRDA (Linked Insurance Products) Regulations, 2013, after minimum floor rate and non-negative additional interest rate are credited, non-negative residual additions, if any shall be credited to the policy account value.

11. Participating Variable Insurance Products:

a. The Variable insurance products shall have a:

i) Guaranteed non-negative interest rate, referred as minimum floor rate and

ii) Non-negative bonus rate, as an additional interest rate over and above the minimum floor rate to be accrued at various points in time as approved in the File and Use clearance accorded by the Authority.

iii) Non- negative residual additions, if any, shall be credited to the policy account in order to comply with the maximum reduction in yield as stipulated in Regulation 37 of IRDA (Linked Insurance Products) Regulations, 2013 at the end of each year starting from policy year 5. Such non-negative residual additions shall be determined as:

(1) Gross Investment Yield earned in the shadow account at the end of each policy year less

(2) Actual yield earned in the policy account value, at the end of each policy year less

(3) Yield referred in the reduction in yield at that duration as per Regulation 37 of IRDA (Linked Insurance Products) Regulations, 2013

(4) For the purpose of this regulation, the yield earned in the policy account shall be calculated using the money weighted rate of return method at end of each policy year.

b. This minimum floor rate, as approved in the File and Use clearance accorded by the Authority, shall be:

i) Guaranteed for the entire term of the policy accumulating on the balance of the policy account;

ii) Such accumulation shall be at a frequency of not less than quarterly on the balance of the policy account at the beginning of each such quarter.

c. At the end of every financial year, the insurer shall also declare regular bonus rates and also terminal bonus rates, if any, in accordance with section 49 of the Insurance Act, 1938 and other regulations and directives of IRDA as applicable to participating products. Once declared, such bonus shall be guaranteed for the remaining term and shall be calculated on the balance of the policy account.

d. At each interval, after the minimum floor rate is credited, the non-negative bonus rate shall be credited to the balance of the policy account value.

e. At the end of each policy year, in order to comply with the maximum reduction in yield stipulated in regulation 37 of IRDA (Linked Insurance Products) Regulations, 2013, after minimum floor rate and non-negative bonus rate are credited, non-negative residual additions, if any, shall be credited to the policy account value.

12. Frequency of accrual of interest rates/ bonus:

a. For all modes of premium payment (viz., single premium, annual, half-yearly, quarterly and monthly) the non-negative additional interest rate to be credited shall not be less than quarterly frequency.

b. For all modes of premium payment (viz., single premium, annual, half-yearly, quarterly and monthly) the bonus with respect to the par products shall be declared once a year immediately after the annual actuarial valuation i.e., as on March 31st of each year, with respect to the par products.

c. The minimum floor rate, for par and non-par products, shall be credited to the policy account at a frequency not less than quarterly.

13. Policy Account Value:

a. Every variable non-linked insurance policy shall have a corresponding policy account whose balance shall depict the accrual to the policyholder. The policy account shall be credited with premium net of charges as stipulated in Regulation 35 of IRDA (Linked Insurance Products), Regulations, 2013, as applicable to variable insurance products. The guaranteed rate and variable interest rate shall be applicable to the balance of the policy account.

b. Shadow policy account value shall be maintained on a daily basis. Such shadow policy account shall be computed based on the actual accruals of all income elements like premiums, top-up premiums, income from investments as and when received and all actual debits i.e. partial withdrawals to the policy account value as and when debited, to arrive at the actual gross investment return and reduction in yield to the policy account value, at the end of each year starting from policy year 5.

c. The policy account value shall comply with the maximum reduction in yield requirements as stipulated in Regulation 37 of IRDA (Linked Insurance Products), Regulations, 2013.

14. Charges, Reduction in yield, Discontinuance Terms, Surrender Value, Partial withdrawals and Top-ups: All the provisions applicable to variable linked insurance products in accordance with the IRDA (Linked Insurance Products), Regulations, 2013 shall be applicable to the non-linked variable insurance products for charges, reduction in yield, discontinuance terms, surrender value, partial withdrawals, top-ups etc.

15. Separation of assets:

a. The insurer shall keep a separate account of all receipts and payments in respect of this product. The valuation of assets and liabilities

shall be in accordance with the IRDA (Assets, Liabilities and Solvency Margin) Regulations, 2000 and all other relevant regulations.

b. The insurer shall earmark assets for each product separately and the policy account value of each of the product shall be disclosed on a daily basis in the website through a specifically assigned identification number called "SAIN" where the SAIN shall start with the unique identification number assigned to the product followed by a three digit running number to be assigned to such products.

c. The insurer shall prepare the financial statements separately in addition to the businesses mentioned in Part V of the Schedule-A of the Insurance Regulatory and Development Authority (Preparation of Financial Statements and Auditor's Report of Insurance Companies) Regulations, 2002.

16. Furnishing Statements of Accounts:

a. The statement of policy account shall be sent to the policyholder at least once a year.

b. Policy account statement shall be issued at the end of each financial year to the policyholder giving the breakup of the opening balance, premium received, deductions towards charges, minimum floor interest earned, additional interest earned or bonus accrued, as applicable, non-negative residual interest rate credited and closing balance in the manner prescribed in the **Annexure-I.**

17. Valuation of Liabilities and Solvency Margin Requirements: Valuation of liabilities and the solvency margin requirements shall be in accordance with the provisions of IRDA (Actuarial Report and Abstract) Regulations, 2000 and IRDA (Assets, Liabilities and Solvency Margin) Regulations, 2000.

Chapter: V

Administration of Insurance Products

18. Administration of additional benefits and various features of insurance products:

a. The insurers shall not launch any product, unless all the processes are lay down and suitable infrastructure requirements on an ongoing basis for the products to be launched are established and enable the insurer to perform all the day-to-day operations including all policyholder servicing/ payments at day of launch and determination of the reserves and solvency margin as required under the legislation, regulation from time to time etc.

b. Where policies may be credited with additional benefits during the term of the contract or where the benefits are complexly designed and deviates from the simple insurance product structured, the insurer shall demonstrate to the Authority that it has established all the systems required to manage the day to day operations of the portfolio and shall enable the Appointed Actuary to determine the reserves and solvency margin calculations as required.

c. The Board or its delegated risk committee shall certify that "all the processes and suitable infrastructure/system requirements on an ongoing basis for the product……..(product name) to be launched are established and the systems enable the insurer from day of launch of the product, to perform all the day-to-day operations including all policyholder servicing/ payments from day of launch and determination of the reserves and solvency margin as required under the legislation, regulation from time to time etc. The certificate shall be submitted before the launch of the product.

Chapter: VI

Policy Term, Premium Paying Term & Commission

19. Minimum Policy Term: The minimum policy term:

a. For individual products, shall be at least five years and

b. For fund based group products, shall be on annually renewable basis.

20. Premium Payment Term:

a. "Premium Payment Term of Policies: Irrespective of the policy term, all individual

non-linked products, shall have the minimum features as stated below:

i) Except for single premium payment products, no product shall have a minimum premium payment term (PPT) of 5 years.

ii) Insurers may design products which offer a range of premium paying terms and policy terms within a product.

iii) Insurers may extend an option to a policyholder to alter the premium payment term or policy terms provided that such alteration is in accordance with their Board approved underwriting policy"

21. Commissions or remuneration in any form:

a. Commission or remuneration in any form for the procurement of all individual policies, group term insurance, group credit insurance and group saving variable insurance policies in respect of all the Distribution Channels except the Direct Marketing shall not exceed the following:

i) Other than Pension Products:

(1) In case of single premium, 2% of the single premium;

(2) In case of other than single premium, the Table 21 (a) shall apply.

Table 21 (a)

Premium paying terms	Maximum Commission or remuneration in any form as % of premium		
	1st year	2 & 3 year	Subsequent years
5	15	7.5/5(*)	5
6	18	7.5/5(*)	5
7	21	7.5/5(*)	5
8	24	7.5/5(*)	5
9	27	7.5/5(*)	5
10	30	7.5/5(*)	5
11	33/30(*)	7.5/5(*)	5
12 years or more	35/30(*)	7.5/5(*)	5

Note – (*) The maximum commission or remuneration:

(a) For brokers shall be

(i) 30% in the first year for policies with premium paying term of 10 and above; and

(ii) 5% in the subsequent years for all premium paying terms.

(b) During the first ten years of a life insurer's business for all intermediaries, except for brokers, shall be 40% in first year for policies with premium paying term of 12 and above.

ii) Pension Products:

(1) In case of single premium, 2 per cent of single premium.

(2) In case of other than single premium:

(a) 7½ per cent of the first year's premium, and.

(b) 2% per cent of each renewal premium.

b. For all distribution channels, except direct marketing, the maximum commission or remuneration in any form with respect to fund based group products as stipulated in regulation 31 (a) herein, with respect to all premium payment modes, shall be:

i) 2 per cent of the premiums paid during the year with a ceiling of rupees one lakhs per scheme for the entire year.

ii) At subsequent renewal 2 per cent of the premiums paid during the year with a ceiling of rupees one lakh per schemes for the entire year.

c. For single premium group term insurance and single premium Group Credit insurance with long term, the maximum commission or remuneration in any form shall be 2 per cent of premium with a ceiling of Rs.50000/ per scheme.

d. For one year renewable group term insurance and One year Group Health Insurance, the maximum commission or remuneration in any form shall be 2 per cent of premiums paid during the first year and 2 per cent of premium

paid during the subsequent renewals with a ceiling of Rs.50000/- per scheme in any year.

e. For the purpose of (b), (c) and (d), insurer and intermediaries shall ensure that the policies shall not be split to breach the ceiling prescribed for the commission.

f. If the commission or remuneration in any form offered in a product is substantially different between the distribution channels, the AA shall justify

i) The reasons for the difference;

ii) How the difference is allowed in the pricing along with the volumes projected for each distribution channel;

iii) The premium for each such distribution channels arrived independently and altogether combined.

g. Provided where the policies are procured by Direct marketing, no commission shall be payable.

Chapter VII

Pension Products

22. General Provisions with respect to Pension and annuity products :

a. Pension products may be offered on any of the following platforms:

i) Individual Non-linked pension products;

ii) Group Non-linked pension products;

b. Regulations 26 to 33 of IRDA (Linked Insurance Products) Regulation, 2013 shall be applicable in case of pension products offered under the Non-Linked variable insurance products. And the provisions of this chapter shall be applicable to all non-linked products other than non-linked variable insurance products.

c. Defined Assured Benefits:

i) All individual pension products shall have explicitly defined assured benefit that is payable on:

(1) Death and;

(2) Vesting.

ii) The defined assured benefit shall be disclosed at the time of sale.

iii) The assured benefit shall be utilized on the vesting date OR on date of death as stipulated in the regulation 24 and 25 herein, as applicable.

d. Pension products offered by the insurers may have an insurance cover throughout the deferment period or may offer riders. The sum of all the rider premiums attached to the pension product shall not exceed 15% of the premium paid for the pension policy. Such rider premiums shall be separately accounted for and shall not be included in arriving at the assured benefit as stipulated in (c) above.

23. Surrender Value and Options on Surrender:

a. For other than non-linked variable insurance products, the surrender value shall be as stipulated in Regulation 35 herein and the extant Income Tax Rules shall be complied with at the time of closure of the contract at the end of the lock-in-period.

b. On the date of surrender, the policyholder shall exercise one of the following options:

i) To commute to the extent allowed under Income Tax Act and to utilize the balance amount to purchase immediate annuity from the same insurer, which shall be guaranteed for life, at the then prevailing annuity/pension rate, or

ii) To utilize the entire proceeds to purchase the single premium deferred pension product from the same insurer.

24. Options on Vesting: On the date of vesting, the policyholder shall exercise one of the following options:

a. To commute to the extent allowed under Income Tax Act and to utilize the balance amount to purchase immediate annuity with the same insurer, which shall be guaranteed for life, at the then prevailing annuity/pension rate, or

b. To utilize the entire proceeds to purchase the single premium deferred pension product with the same insurer; or

c. To extend the accumulation period / deferment period within the same policy with the same terms and conditions as the original policy provided the policyholder is below an age of 55 years, subject to underwriting if it there is a sum at risk on death.

25. Options to the Nominee on death of the policyholder: If the policyholder dies during the deferment period, the nominee shall exercise one of the following options:

a. To utilize the entire proceeds of the policy or part thereof for purchasing an annuity at the then prevailing rate from the same insurer; or

b. Withdraw the entire proceeds of the policy;

26. Financial Planning: For the purpose of financial planning, any pension product offered by the insurer shall comply with the sales literature guidelines issued by the life insurance Council circular number LC/SP/Ver. 1.0 dated 3rd February, 2004 and shall also necessarily disclose:

a. An illustrative target purchase price for each policyholder considering the premium payment capacity, age, vesting age and the future expected conditions.

b. Possible risks involved, if any, including the targeted pension rate in meeting the targeted purchase price.

c. Possible risks involved, if any, in purchasing the targeted pension rate/annuity rate.

d. An illustrative target annuity/pension rates for the illustrative target purchase price.

e. For the purpose of providing benefit illustration, in addition to the benefit illustration requirement stipulated in Regulation 43 herein, additional benefit illustration shall be disclosed to the prospective policyholder as in **Annexure II.**

27. A yearly disclosure shall be sent to each policyholder in **Annexure-III,** on 1st April indicating:

a. The current accumulated/available amount;

b. The expected accumulated/available amount on the date of vesting on the basis of the then prevailing and the likely assumed economic & demographic environment, as relevant with the caveat, that the projected rates shall not reflect any guarantee;

c. Likely annuity amounts based on the then prevailing annuity rates and on assumed interest rates of 4% p.a. and 8% p.a. with the caveat, that the projected rates shall not reflect any guarantee;

28. Fund Based Groups Non-Linked Pension Products:

a. For all fund based group non-linked pension products with the defined benefits subscribed to by an employer, where the scheme does not maintain individual member accounts and only maintains a superannuation fund:

i) There shall be an assured benefit that shall be applicable on the entire superannuation fund available with the insurer.

ii) For exits on account of death, retirement or any other exit allowed in accordance with the scheme rules as agreed at the inception of the contract with group policyholder, the insurer shall make payments from the superannuation funds, subject to availability of such funds, as per the terms of the scheme rules applicable to the member who is exiting.

iii) Except for exits as per the scheme rules, no other withdrawals shall be allowed.

b. For all fund based group non-linked pension products with the defined contributions subscribed to by an employer, where the scheme maintain individual member accounts:

i) There shall be an assured benefit that shall be applicable on each of such individual accounts.

ii) For exits on account of death, retirement or any other exit allowed in accordance with the scheme rules as agreed at the inception of the contract with group policyholder, the insurer shall make payments from the superannuation

funds, subject to availability of such funds, as per the terms of the scheme rules applicable to the member who is exiting.

iii) Except for exits as per the scheme rules, no other withdrawals shall be allowed.

c. Provisions stipulated in Regulations 23, 24 and 25 herein shall not be applicable to group non-linked pension products; however the benefits on exits shall be subject to the scheme rules.

d. Provisions stipulated in Regulation 31 (e) herein shall apply in case of complete surrender of the policy.

e. Where the group policyholder maintains superannuation funds with more than one insurer, the group policyholder shall have the option to choose the insurer to purchase the immediate annuity.

29. For the purpose of this Regulation:

a. Target purchase price shall mean an absolute amount guaranteed at the outset of the contract or the accumulated value of the premiums/contributions accumulating at an illustrative rate of 4% p.a. and 8% p.a., which is expected to meet the policyholder's pension needs after allowing for commutation.

b. Targeted pension rate shall mean the pension that a policyholder expects to receive at the date of vesting at an illustrative assumed rate of interest of 4% p.a. and 8% p.a. allowed in pricing the annuity

c. "Guaranteed for life" shall mean:

i) an amount of annuity is guaranteed, in absolute terms, at the time of vesting or at the time of surrender or at the time of sale and

ii) Such guaranteed amount shall become payable as long as the policyholder survives.

d. An assured benefit means at least one of the guarantees from the following options of providing either:

(1) non-zero positive rate of return on the premiums paid, excluding service tax, from the date of payment to date of vesting or

(2) an absolute amount to be paid on death or maturity (which shall result in non-zero positive return).

ii) In both the cases, the amount of such guarantee shall be disclosed at the time of purchase of contract.

iii) The non-zero positive return on death may be more than the non-zero positive return on maturity/vesting.

iv) A guaranteed maturity benefit (in absolute amounts) which shall be utilized at the vesting date or guaranteed death benefit (in absolute amounts) payable on death shall be disclosed at the time of purchase of contract.

e. The prevailing annuity rate shall mean the annuity rates that are approved by the authority as per the file and use procedure and are attached to the pension products.

f. Commutation shall mean the giving up of a part or all of the annuity payable from vesting/ surrender for an immediate lump sum.

Chapter: VIII

Group Products

30. Group Non-Linked Products:

a. Employer-Employee Group Products: Under the group business, only the following group products shall be permitted for employer-employee groups:

i) Fund based Group Insurance products.

ii) Group Credit Life Insurance products, provided the premiums are aligned with that of Pure Term products with similar term and entry age, and suitably adjusted to the decreasing cover.

iii) Single premium Group Term insurance Products.

iv) Group Savings Variable Insurance Products offered.

v) One year renewable group term life insurance products.

vi) One year renewable group health insurance products.

vii) Group immediate annuity products.

b. Non-Employer-Employee Group Products: Under the group business, only the following group products shall be permitted for Non-employer- employee groups:

i) Group term insurance products with minimum term of 5 years shall be allowed only under the micro-insurance products provided the premiums are aligned with that of Pure Term products with similar term and entry age. The maximum premium shall not exceed Rs.750/- per annum per member under these products.

ii) Group Credit Life Insurance products, provided the premiums are aligned with that of Pure Term products with similar term and entry age, and suitably adjusted to the decreasing cover.

iii) Single premium Group Term insurance Products offered to only non-employer-employee homogenous groups.

iv) Group Savings Variable Insurance Products offered to only non-employer-employee homogenous groups.

v) One year renewable group term life insurance products.

vi) One year renewable group health insurance products.

vii) Government (Central or State) sponsored Group Insurance Products/Schemes.

For the purpose of this regulation, non-employer-employee homogenous groups shall mean:

(1) Any Associations, where the members represent a particular profession/trade/ domestic workers/Anganwadi workers;

(2) Government agencies;

(3) Any Co-operative Societies;

(4) Parents of school/college students as members;

(5) Any other groups as may be approved by the Authority;

31. Fund based Group Non-Linked Products

a. Fund based group non-linked products are those which are offered to Employer-Employee groups and consists of:

i) Group Non-Linked Superannuation Product;

ii) Group Non-Linked Gratuity Product;

iii) Group Leave Encashment Product;

b. Provisions stipulated in Regulations 6 herein shall not be applicable to fund based group non-linked products. However, the fund based group non-linked policies stipulated in Regulations 31 (a) (ii) & 31 (a) (iii) herein shall have minimum life cover as approved under File and use Procedure, with an explicit mortality charge levied.

c. The premium with respect to group products shall be made in accordance with the Actuary's certificate submitted by the employer in accordance with the AS15 (Revised). Where the fund is overfunded/in surplus as per such certificate, the insurer may allow "nil contributions/premiums" under the policy and in all such cases, the policy shall not be treated as discontinued.

d. The fund based group non-linked products shall not allow any top-ups, unless required as per the actuary's certificate in accordance with the AS 15 (Revised), to address the underfunding of the scheme.

e. The fund based group non-linked products may levy a surrender charge not exceeding 0.05 per cent of the total policy account value, with a maximum of Rs. 500, 000/-, if the policy is surrendered within third renewal of the policy.

f. Provisions stipulated in Regulations 34, 35, 36 and Regulation 37 of IRDA (Linked Insurance Products) Regulations, 2013 shall be applicable to fund based group non-linked variable insurance products:

i) At each individual account level, if individual accounts are maintained;

ii) At each policyholder fund level, if individual accounts are not maintained and only one fund is maintained.

For the purpose of this Regulation, "number of years elapsed since inception" stipulated in Regulation 37 shall be read as "number of years elapsed since renewal of the policy".

g. Fund based group non-linked pension products may offer life insurance cover with an explicit mortality charge levied.

32. Fund Based Group products stipulated in regulation 30 (a) (ii) & (iii) and 30 (b) (i), (ii) & (iii) herein shall acquire surrender value as stipulated in regulation 35 herein, if the premium payment term is either single premium or limited premium paying term.

33. Group Savings Variable Insurance Products:

a. Group saving variable insurance products shall be simple and easy to understand. The following features shall be the minimum mandatory requirements under these products:

i) The minimum size of the group shall be at least 20 and the maximum size of the group shall not exceed 5000. If the group size is more than 5000, the policy shall be split appropriately to ensure that the maximum size does not exceed 5000 in any group.

ii) The term of the product shall be at least 5 years.

iii) All the provisions applicable to individual variable insurance products shall be applicable to group savings variable insurance products.

iv) Discounts in premium allocation charges shall be offered for group sizes, premium sizes etc and shall be explicitly stated at the outset.

v) The front page of the Prospectus shall state clearly in bold font the following:

(1) Minimum premium payment term and Maximum premium payment term;

(2) Mode of premium payments allowed;

(3) Minimum premium amount and Maximum premium amount;

(4) Minimum policy term and Maximum policy term;

vi) The prospectus shall be given to each member of the group before the sale is concluded and specific consent in writing from each member shall be taken for the premium amount, premium paying term, mode of premium payment and the policy term as agreed by the policyholder, except for micro-insurance products. In case of micro-insurance products, the onus lies on the group policyholder to disseminate the information to its members and obtaining written consent.

vii) Provisions stipulated in Regulations 34, 35, 36 and 37 of IRDA (Linked Insurance Products) Regulations, 2013 shall be applicable to group non-linked variable insurance products.

viii) The insurer shall monitor the experience regularly and submit an analysis of all the products in terms of expected and actual experience as an annexure to the Appointed Actuary Annual Report.

ix) In case of surrender of the group policy, the insurer shall give an option to the individual members of the group, on such surrender, to continue the policy as an individual policy and the insurer/intermediary if any, shall continue to be responsible to serve such members till their coverage is terminated.

34. Group Insurance Products Administration:

a. The premium charged and benefits admissible to each member of the group shall be clearly specified in the group policy and the group policyholder shall not have the liberty to vary the premium or benefits with regard to the individual members.

b. Group discounts on premium shall be given for the benefit of the insured members of the group and shall not be appropriated as additional remuneration by the agent or corporate agent or broker or group policyholder. Such discounts shall be based on valid underwriting considerations such as the group size and shall be passed on to the members.

c. Where a part or whole of the premium is paid by the group policyholder, for example, the employer in respect of insurance of his

employees, the discounts may be shared by those who paid the premium in proportion to the premium paid by them.

d. There shall be no other payment whether as management expenses or documentation expenses or profit commission or bulk discount or payment of any other description, to the agent or corporate agent or group policyholder. The group policyholder shall be specifically prohibited from collecting by way of premium from the members of a group, any amount higher than the amount charged by or paid to the insurer for such insurance.

e. In non-employer-employee cases, the individual group member would be treated as the insured beneficiary and the group policyholder will be only the holder of the group policy. In such cases every care shall be taken by the insurer in the matter of issue of certificate of insurance to the members of the group, who are insured. It is necessary that such certificate contains information on the schedule of benefits, the premium and charges, if any, levied and important terms and conditions of the insurance contract. The certificate shall also state the procedure to be followed to register a claim with the insurer including the full address of the office of the insurer where the claim shall be registered. While the group policyholder may play a role in facilitating the registering and settlement of a claim, the insurer is totally responsible to ensure that the claim payment is made in the name of the insured member or his/her nominee even if the cheque is sent to the group policyholder for administrative convenience or through any other electronic mode of payment to the specific bank account of the insured.

f. In respect of non-employer-employee groups the insurer may provide the facility to the group policyholder to issue certificates of insurance to persons insured under the group, provided the underwriting guidelines for acceptance or rejection of such a risk do not require use of subjective judgment and can be easily programmed into a computer that will review acceptance and print the certificate of insurance. In such cases, the certificate forms shall be supplied by the insurer with in-built security features and in pre-numbered lots to the group organizer or manager. Utilisation and full accounting of the certificate forms should be independently checked by the staff of the insurer every time before furnishing a fresh lot of forms, either by personal verification or based on a certificate by the auditor of the agent.

g. The insurer, under an agreement with the group policyholder, may leverage on the existing infrastructure, if any, for better administration of the scheme with respect to the following services:

i) Data management – Documenting the list of the persons insured under the group policy from time to time and supporting the insurer with quality data on all members of the scheme and Know Your Customer requirements. The data management shall enable seamless transfer of data to insurer at regular intervals of each month or at short intervals as decided between the insurer and the group policyholder, to ensure efficient claims handling and establishing accurate reserving and pricing.

ii) Collection of Premium — Group policyholder may support the insurer through prompt premium collections under contributory schemes and its remittance to the insurer on a timely manner for better cash flow management.

iii) Issuance of Certificate of Insurance –The insurer shall be responsible to issue certificate of insurance to each group member of the policy where individual accounts are maintained under fund based group policies. However, the insurer may provide the facility to the group policyholder to issue certificates of insurance to persons insured under the group, provided the underwriting guidelines for acceptance or rejection of such a risk do not require use of subjective judgment and can be easily programmed into a computer that will review acceptance and print the certificate of insurance. The procedure to be followed include:

(1) The certificate shall contain information on the schedule of benefits, the premium to be paid and important terms and conditions of the insurance contract.

(2) The certificate shall also state the procedure to be followed to register a claim with the insurer including the full address of the office of the insurer where the claim should be registered.

(3) The certificate forms shall be supplied by the insurer with in-built security features and in pre-numbered lots to the group. Before furnishing a fresh lot of forms, insurer shall personally verify the previous issue of certificate of insurers.

(4) Under any circumstances the insurer shall be responsible for the certificate of insurance issued by a group policyholder, in certificate forms provided by the insurer.

(5 he insurer shall conduct a surprise inspection of the books and records of the non employee –employer group policyholder at least once a year to ensure total compliance with this Regulation or require a certificate of such compliance from the auditors of the group policyholder, at least once a year.

(6) The insurer shall be held responsible to the group members insured, in respect of the group policy in case of failure of the group policyholder to account for the business to the insurer, if the group member insured can prove that he had paid the premium and secured a proper receipt leading him to believe that he was duly insured.

iv) Claims settlement – The insurer may take the services of the group policyholder in facilitating the registering and settlement of a claim, however, the insurer is totally responsible to ensure that the claim payment is made in the name of the insured member or his/her nominee even if the cheque is sent to the group policyholder for administrative convenience or through any other electronic mode of payment to the specific bank account of the insured. This payment shall be made only when the service is rendered.

h. The insurer may make payments directly to the group policyholder for the services rendered as stipulated in (g) herein under an agreement. The Authority may prescribe such remuneration to be paid to the Group Policyholder from time to time for each of the services rendered as stipulated in (g) herein and the current limits shall not be more than:

i) For data management: Rs.15/- per member per annum;

ii) Premium collection: Rs.10/- per member per annum;

iii) Issuance and delivery of certificate of Insurance: Rs.10/- per member subject to a minimum of Rs. 500/-. Issue of duplicate certificate of insurance shall not be done by the group policyholder;

iv) Claims settlement: Rs.10/- per claim;

If the business is procured through an intermediary, the remuneration with respect to the functions stipulated in (g) (i), (ii) and (iv) above shall not be paid to the group policyholder, as these functions are part of obligations of an intermediary. However, with respect to the services stipulated in g (iii) above, the services of a group policyholder may be utilized and payment may be made as stipulated in h (iii) above.

i. If the business is procured directly, the insurer:

i) may utilize the services of the group policyholder with respect to the functions stipulated in (g) above and may make payments as stipulated in (h) above.

ii) may pass on the savings, if any, in the commission or remuneration through discount in premium allocation charges.

j. If the business is procured through an intermediary, the remuneration with respect to the functions referred in (g) (i), (ii) and (iv) shall not be paid to the group policyholder, as these functions are part of obligations of an intermediary. However, with respect to the services referred in g (iii), the services of a group policyholder may be utilized and payment may be made as stipulated in h (iii).

k. If the business is procured directly, the remuneration with respect to the functions referred in (g) (i), (ii) and (iv) may be paid to the group policyholder, only if the group policyholder has provided all the services in accordance with the agreement. The payments to the group policyholder:

i) all put together shall not in any case exceed 20% of the commission payable as stipulated in Regulation 21 herein in case of both Single premium products and other than single premium products.

ii) shall ensure that for each of the services individually, the payments shall not exceed the rated proportion to the overall limit of 20% of the commission payable as stipulated in Regulation 21 herein in case of both Single premium products and other than single premium products.

Chapter: IX

Surrender Value

35. Acquisition of Surrender Value under other than variable insurance products: All individual savings and protection oriented products such as non-linked life insurance products, and non-linked pension products, other than pure protection products such as term insurance, health insurance and immediate annuities, shall acquire a guaranteed surrender value and special surrender value, if higher. The guaranteed surrender value shall acquire in the following manner:

a. Products with a Premium Paying Term (PPT) of 10 years or more: If all premiums have been paid for at least three consecutive years, the policy shall acquire a guaranteed surrender value, to which shall be added the surrender value of any subsisting bonus or guaranteed additions, as applicable, already accrued to the policy.

b. Products with a Premium Paying Term of less than 10 years: If all premiums have been paid for at least two consecutive years, the policy shall acquire a guaranteed surrender value, to which shall be added the surrender value of any subsisting bonus or guaranteed additions, as applicable, already accrued to the policy.

c. Other than single premium products: The minimum guaranteed surrender value shall be the sum of guaranteed surrender value and the surrender value of the any subsisting bonus or guaranteed additions, as applicable, already accrued to the policy. The guaranteed surrender value shall be at least:

i) 30% of the total premiums paid less any survival benefits already paid, if surrendered between the second year and third year of the policy, both inclusive.

ii) Subject to (iii), 50% of the total premiums paid less any survival benefits already paid, if surrendered between the fourth year and seventh year of the policy, both inclusive.

iii) 90% of the total premiums paid less any survival benefits already paid, if surrendered during the last two years of the policy, if the term of the policy is less than 7 years.

iv) The surrender value beyond the seventh year shall be filed by the insurer under the File and Use for clearance. Such surrender value shall consider the premiums already paid and the possible asset shares on such products.

d. Single premium products: The guaranteed surrender value shall be the sum of guaranteed surrender value and the surrender value of the any subsisting bonus already attached to the policy. The guaranteed surrender value shall be at least:

i) 70% of the total premiums paid less any survival benefits already paid, if surrendered any time within third policy year.

ii) Subject to (iii), 90% of the total premiums paid less any survival benefits already paid, if surrendered in the fourth policy year.

iii) 90% of the total premiums paid less any survival benefits already paid, if surrendered during the last two years of the policy, if the term of the policy is less than 7 years.

iv) The surrender value beyond the fourth year shall be filed by the insurer under the File and

Use for clearance. While determining such surrender value the insurer shall consider the premiums already paid and the possible asset shares on such products.

v) Surrender value of any subsisting bonus already attached to the policy shall be filed and approved under the File and Use explicitly.

e. Every such policy shall show the guaranteed surrender value of the policy at the close of each year after the second year/third year, as applicable of its currency or at the close of each period of three years throughout the currency of the policy in the policy document.

f. A policy which has acquired a surrender value shall not lapse by reason of the non-payment of further premiums but shall be kept alive to the extent of the paid-up sum insured, and the paid-up sum insured shall include in full all subsisting reversionary bonuses that have already attached to the policy.

g. The minimum paid-up value shall be in accordance with the Section 113 of the Insurance Act, 1938.

h. The surrender value shall be the higher of the guaranteed surrender value and the special surrender value.

i. The special surrender value shall represent the asset share in case of the par policies, where the asset share shall be determined in accordance with the guidance or practice standards issued by the Institute of Actuaries of India. For non-par policies the special surrender value shall reflect the experience of the insurer and shall be determined as per the proxy asset share in accordance with the guidance or practice standards issued by the Institute of Actuaries of India.

j. The special surrender value shall be filed with the Authority under File and Use.

k. The fund based group non-linked products may levy a surrender charge not exceeding 0.05 per cent of the fund, with a maximum of Rs. 500, 000/-, if the policy is surrendered within the third renewal of the policy.

l. In case of surrender of the group policy, other than fund based group policies, the insurer shall give an option to the individual members of the group, on such surrender, to continue the policy as an individual policy and the insurer/intermediary if any, shall continue to be responsible to serve such members till their coverage is terminated.

m. The Authority reserves the right to instruct the insurer to withdraw any product any time, if the persistency of the product appears to be low.

Chapter: X

Miscellaneous Provisions

36. Advance Premium: Collection of advance premium under non-linked individual products shall not be allowed except in the following cases:

a. The premium due may be accepted 30 days before the date of due of payment of premium. However, the commission shall only be paid on the premium due date.

b. For monthly premium payment mode, the insurer may accept three months' premiums in advance only on the date of commencement of policy, if it is a prerequisite to allow monthly mode of premium payment and is allowed under File and Use.

37. Level Premiums:

a. Except for fund based group products, the premium chosen at the outset shall become payable throughout the premium paying term of the policy and shall not be altered during the term of the policy. Such premium shall be level / uniform and shall not vary over the term of the policy.

b. The insurer shall not accept any amounts less than the due stipulated regular premium payable as stated in the policy.

c. Any additional payments made on ad hoc basis shall be considered as top-up premium and treated as single premium for the purpose of providing insurance cover under variable insurance products.

d. Service tax, if any, shall not be included in the contractual premium and shall be collected from the policyholder separately as over and above such premium.

38. Splitting of Policies:

a. Splitting of policies shall not result into any increase, directly or indirectly to the policyholder by way of fees or charges in whatsoever name at any time during the term of the policies and not just at the inception.

b. A policy will be deemed to be split, if multiple policies of the same nature are sold to a prospect at the same time which results into a situation defined in (a) above.

39. Misleading names: The misleading and misrepresenting the benefits through the name of the products shall not be allowed.

40. Benefits offered on Maturity:

a. The product literature shall clearly indicate whether the product is protection oriented or savings oriented or a combination of the two.

b. Where the products offer the maturity benefit as return of premiums paid or a percentage of return of premiums paid or a meager amount in excess of return of premiums paid, these products shall not be termed as savings products.

c. The maturity benefits shall closely reflect the asset share in case of par products.

41. Approval of Innovative products:

a. Innovative products can be defined as the products which are uncommon in the market. Any product design, which is not approved so far by the Authority, shall be treated as innovative product.

b. The innovativeness in product design shall result in meeting customer needs, better customer understanding and satisfaction and shall not result in complexity of understanding the product, additional strain on the company's infrastructure, which may result in increased cost to the customer.

c. The insurer shall discuss with the Authority, the product design concept of the proposed innovative product along with:

i) Market research inputs which identify the specific needs of customer or meeting the existing needs in innovative manner through the proposed product design.

ii) A separate note on how such new product will enhance the satisfaction of customer and of any other stakeholder.

iii) Details on systems support that is being envisaged for execution of the proposed product.

iv) Details on underwriting, claims settlement, investment strategies for such new products.

v) Treatment for arriving at the reserves, solvency margin required for such products.

vi) Market conduct requirements for such products.

d. Whether any such products are available elsewhere in other markets. If available, the general structure of such products, the valuation requirements, market conducts and specific regulations on such products.

42. Financial Viability of the Products:

a. All the products once approved shall be reviewed by the Appointed Actuary at least once a year on the financial viability of the product. If the product is found to be financial unviable, the Appointed Actuary shall revise the product under File and Use procedure. After 5 years of File and Use approval, the Appointed Actuary shall re-file the product along with the past five years experience in terms of mortality, lapse, interest rates, inflation, expenses etc. and seek fresh approval with suitable justifications for the assumptions made.

b. If the pricing assumption for mortality is less than 50% of the prescribed table, the Appointed Actuary shall justify such assumptions with the actual claims experience for similar products for the past 3 year.

c. The insurer shall monitor the experience regularly and submit an analysis of all micro-insurance products in terms of expected and actual experience as an annexure to the Appointed Actuary Annual Report.

Chapter: XI

Benefit Disclosure

43. Benefit Disclosure:

a. All insurance products shall provide the prospective policyholder a customized benefit illustration, illustrating the guaranteed and non-guaranteed benefits at gross investment returns of 4% and 8% respectively and as specified by IRDA or Life Insurance Council from time to time.

b. Such benefit illustration shall be signed by both the prospective policyholder & the intermediary and shall form part of the policy document.

c. The benefit illustration as approved under the File and Use Procedure shall be part of the sales literature and shall be furnished to the prospective policyholder along with the sales literature before concluding the sale.

d. In case of non-linked variable insurance products:

i) The benefit illustrations shall be shown as per the gross investment returns of 4% and 8% respectively and subsequently at the rates as prescribed by the Life Insurance Council from time to time and the corresponding net yield shall be demonstrated only with respect to gross investment return of 8% p.a.

ii) The net yield and hence reduction in net yield as calculated, shall be disclosed in the benefit illustration indicating the corresponding gross yield figures.

Chapter: XII

With Profit Fund Management

44. With Profit Fund Management : The Appointed Actuary shall clearly demonstrate in the Actuarial Report and Abstract:

a. That the reinsurance arrangements are appropriate and in the best interests of the with profit policyholders in terms of maximizing the value to with profit funds and minimizing the risks.

b. The appropriateness and prudence in debiting of expenses to with profits funds vis-à-vis other funds; reducing the cross-subsidy between various groups of with profit policyholders; overall financial management of with profits funds and governance of with profits funds.

45. Asset Share:

a. The insurer shall maintain the asset shares, at policy level, and to ensure that only the portion of expenses representing this business shall be allocated to and interest rate credits to these asset shares shall represents the underlying assets of these funds.

b. The Appointed Actuary shall be responsible to determine the asset share for each product in accordance with the guidance or practice standards etc issued by the Institute of Actuaries of India.

c. The detailed working of the asset share, the expenses allowed for, the investment income earned on the fund etc which are represented in the asset share shall be approved by a with profits committee.

d. With Profits Committee: The With Profits Committee shall be constituted with one independent director of the Board, the CEO, the Appointed Actuary and an independent actuary.

e. The report of with profits committee shall be appended to the Actuarial Report and Abstract.

f. The Authority may prescribe the method of allocation of expenses to various funds in consultation with the institutions such as Institute of Actuaries of India, Institute of Chartered Accountants of India etc

Chapter: XIII

Market Value adjustment

46. Market Value adjustment:

a. Market value adjustment shall not be allowed under:

i) Non-linked Individual products and Group savings variable insurance products.

ii) Par and non-par fund based group products where the exits are in accordance with the scheme rules filed with the insurer at the outset, except as specified in (b) below.

b. Market value adjustment may be allowed for par and non-par fund based group products, for bulk exits and complete surrender, where the bulk exits are clearly defined in the contract and provided there is an investment guarantee assured throughout the policy.

c. Market value adjustment shall be defined explicitly & objectively and approved under File and Use. There shall not any discretion left to the insurer in arriving at the market value adjustment.

d. Market value adjustment shall not be applicable for the amounts below the amount which represents the bulk exits and shall be applied only to the amount which is over and above the amount representing bulk exit.

e. Market value adjustment shall be applied only if:

i) The assets are earmarked separately for the product;

ii) The revaluation of assets at the time of market value adjustment is carried out on the entire portfolio of assets.

f. For the purpose of this regulation:

i) if the amount to be paid on total exits in any event exceeds 25% of the total fund of the scheme at the beginning of the year, such transactions shall be treated as bulk exits, where exit shall be as per the scheme rules and

ii) exit shall mean exit of the member from the group.

Chapter: XIV

Procedure for Implementation and Other provisions

47. The insurers shall follow the following procedure for implementation of this regulation:

a. All existing products must be examined and ensured that they are in conformity with these Regulations.

b. The Chief Executive Officer and the Appointed Actuary will certify such compliance with regard to each product and submit such certificates to the Authority in a consolidated form on or before 30.06.2013 or 30.09.2013 as applicable for Group and Individual products respectively.

c. In case of products which are non-compliant with the provisions of this regulation:

i) the modifications required to confirm to the provisions of this Regulations does not include any change in the benefits offered, premium bases, charges levied or any discounts offered in the products, than the insurer shall carry out such modifications and file the modified File and Use for those products along with the certification of the CEO and the AA that all the entire File and Use after the modification is in conformity with the provision of this Regulations and submit to the Authority before 30th June, 2013. The Authority shall accept the file as final and allot the unique identification number. However, later if such filings are found to be non-complaint with the provisions of this Regulation, the Authority may initiate such action against the said insurer, as deemed appropriate, under the provisions of the Act, the Insurance Regulatory and Development Authority Act, 1999 and the relevant regulations framed there under.

ii) For group products, the modifications required to confirm to the provisions of this Regulations include any change in the benefits offered, premium bases, charges levied or any

discounts offered in the products, than the insurer shall carry out such modifications and file the modified File and Use for those products along with the certification of the CEO and the AA that all the entire File and Use after the modification is in conformity with the provision of this Regulations and submit to the Authority before 30th June, 2013 for approval. The products submitted under File and Use for approval shall clearly state the current provisions and the proposed provisions in line with this regulation in a tabular form and also indicate the implications on the pricing, reserving, profit margin etc, if any. The Insurer shall file the products in a phased manner and avoid filing of all the products at one time.

iii) For individual products, the modifications required to confirm to the provisions of this Regulations include any change in the benefits offered, premium bases, charges levied or any discounts offered in the products, than the insurer shall carry out such modifications and file the modified File and Use for those products along with the certification of the CEO and the AA that all the entire File and Use after the modification is in conformity with the provision of this Regulations and submit to the Authority before 30th September, 2013 for approval. The products submitted under File and Use for approval shall clearly state the current provisions and the proposed provisions in line with this regulation in a tabular form and also indicate the implications on the pricing, reserving, profit margin etc, if any. The Insurer shall file the products in a phased manner and avoid filing of all the products at one time.

d. In case of products which are already filed with the Authority, but not approved, the files shall be returned for filing afresh in conformity with this regulation.

e. All the existing group policies and all the existing individual products not in conformity with the provisions of this regulation shall be withdrawn from 1st July, 2013 and 1st October, 2013 respectively. No new members shall be enrolled into the existing group policies once the product is withdrawn. However, all group policies at the time of renewal of such policy shall be given an option to switch over to the modified version of the group product, if any, once introduced. Those group policies which do not switch over to the modified version:

i) may continue to be renewed under the old policy;

ii) closed to new members and

iii) specific written consent is obtained by the group policyholder to continue in the old policy.

f. In exceptional cases, where the insurer has received a written request from a prospective policyholder opting for a withdrawn individual product, the same may be allowed after obtaining specific approval from the Authority on a case to case basis. However, such provision would be extended for a further period of 6 months only from the dates stipulated in e above.

g. Subject, to (e) above, this regulation shall not invalidate the non-linked individual policies entered prior to this regulations coming into force.

h. All the insurers shall inform the prospective policyholders about the possible changes in the products being sold during the transition period and give an option to the existing policyholders including prospective policyholders to switch over to the modified version if any, once introduced.

i. Where any product or feature of a product is cleared under File and Use by the IRDA, such clearances for the same kind of product or feature shall not be denied to any other insurer. However, the Authority reserves the right to require insurers to withdraw a product or a feature of the product if such is found not to be consistent with policyholder interests. In all such cases, the Authority shall give three months notice for such withdrawal.

48. Action in case of Default:

a. The Authority may, at any time, by an order in writing, direct any officer of the Authority to inspect the affairs of any insurer and submit a report on the reasonableness or otherwise of

the compliance with the any of these regulations

b. Upon receipt of the report, the Authority shall, after giving an opportunity to the insurer to make a representation in connection with the findings in the report, direct the insurer appropriately.

c. Without prejudice to the above, the Authority may also initiate such action against the said insurer, as deemed appropriate, under the provisions of the Act, the Insurance Regulatory and Development Authority Act, 1999 and the relevant regulations framed thereunder.

49. Power of the Authority to issue clarifications:

a. In order to remove any difficulties in respect of the application or interpretation of any of the provisions of these regulations, the Authority may issue appropriate clarifications or guidelines, as and when required.

50. Repeal and Savings:

a. All the guidelines/clarifications/circulars/letters issued in respect of the non-linked insurance , Pension and Variable insurance products and Regulation 19 of the IRDA (INSURANCE BROKERS) REGULATIONS, 2002 shall be repealed from the date this regulation comes into force

b. Unless otherwise provided by these regulations, nothing in these regulations shall deem to invalidate the non-linked insurance contracts entered prior to these regulations coming into force.

51. Review of the guidelines: The Authority has power to make a detailed review of the guidelines on an ongoing basis for such modifications as may be deemed necessary towards protection of the interests of the policyholders.

J. Hari Narayan
Chairman
(ADVT.III/4/161/13/EXTY)

e) Premium rates for Motor Third Party Liability Insurance Covers for 2015-16

ORDER Of Insurance Regulatory and Development Authority of India On Premium Rates for Motor Third Party liability Insurance Covers for the Year 2015-16

IRDA/NL/NTFN/MOTP/054/03/2015

31st March 2015

The Authority hereby refers to its notification no. IRDA/ NL/NTFN/MOTP/066/04/2011 dated 15th April 2011 whereby the Authority decided to review the premium rates for motor third party liability insurance covers annually using t he specified formula:

P (t) =Cl (t)* Cll (t-1) + C2 (t)

Where,

P (t) is the motor TP premium applicable to the financial year 't',

Cll (t-1) is the Cost Inflation Index for the year 't-1' as notified by CBDT, and Cl (t) and C2 (t) are the parameters applicable to the financial year 't' whose values shall be determined and notified by the Authority in each financial year based on the experience measured in terms of average claim amounts, frequency and expenses involved in servicing the motor TP business. The values of the parameters Cl (t) and C2 (t) may vary according to the class of vehicle.

It is observed that the cost inflation index (Cll) has increased by 9.05 % over the previous year, i.e. from 939 in FY 2013-14 to 1024 in FY 2014-15.

Accordingly, the Authority issued an Exposure Draft no. IRDA/NL/MTP/2015-16/EXDRF dated 09th March 2015 on revision of premium rates for motor third party insurance covers for the year 2015-16 inviting comments on the proposed rates from all the stakeholders concerned. The exposure draft published data provided by the IIB which included no. of policies, no. of claims paid, amount of claims outstanding as on 31st March 2014 for each underwriting year and for each class of vehicle. The methodology used in estimating premium rates was also briefly explained in the exposure draft.

The Authority received the comments from many stakeholders which were examined. Overall, the consumers conveyed their dissent against proposal to increase the rates. The general insurers conveyed that the current premium rates are inadequate and revision in rates matching levels of ultimate loss ratios of the companies is required. The insurers also drew attention to the Authority's direction to provide Ultimate Loss Ratio (U LR) in respect of Declined Risk Pool at 175 % for the year 2013-14.

It is observed that there is a wide variation in premium changes amongst the various subclasses of a given class of vehicle. Based on the above methodology, it is observed that the estimated premium rate increase over the previous year in some of the vehicle classes is much higher. At the same time, some vehicle classes are showing negative change. Looking into the sudden and adverse impact on the policyholders of such an increase in rates and taking into consideration the comments received on the exposure draft, the Authority decided to moderate the rate increases in the following classes:

a. Private Cars

b. Two Wheelers - Exceeding 150 cc but not exceeding 350 cc

c. Goods Carrying Vehicles Public Carriers (Other than 3 wheelers) - Exceeding 20000 kgs but not exceeding 40000 kgs and Exceeding 40000 kgs

d. Goods Carrying Vehicles Private Carriers (Other than 3 wheelers) - Exceeding 40000 kgs

e. Four wheeled vehicles used for carrying passangers for hire or reward with carrying capacity not exceeding 6 passangers - Not exceeding 1000 cc and Exceeding 1500 cc

f. Three wheeled vehicles used for carrying passengers for hire or reward with carrying capacity not exceeding 6 passengers

g. Motorized three wheeled passenger vehicles used for carrying passengers for hire or reward

with carrying capacity exceeding 6 passengers but not exceeding 17 passengers

h. Special Types of Vehicles

In case of two wheelers - exceeding 350 cc, Goods Carrying Vehicles Public Carriers (other than 3 wheelers) - GVW not exceeding 7500 kgs, and Exceeding 7500 kgs but not exceeding 12000 kgs, Goods Carrying Vehicles Private Carriers (other than 3 wheelers) - except exceeding 40000 kgs subcategory, Motorized Two Wheelers used for ca rrying passengers for hire or reward, Motor Trade (Road Transit Risks), and Motor Trade (Road Risks), the Authority decided to moderate the rate reductions

In accordance with the above, and in exercise of t he powers vested in the Authority under Section 14 (2) (i) of the IRDA Act, 1999, the Authority hereby notifies the premium rates applicable to Motor Third Party Liability Insurance covers with effect from 01t April 2015 as given in the Annexure "A".

Insurers are advised to be mindful of the concerns expressed by vehicle owners about both the rates and availability of insurance. Considering the mandatory nature of motor third party insurance, insurers are advised to ensure that motor third party insurance is made available at their underwriting offices and that requests for insurance are processed expeditiously and policies are issued promptly. The Authority will t reat any complaint of non-availability of insurance or use of methods to deny/delay the client seeking insurance cover, seriously.

Insurers are not permitted to cancel the current insurance policies and issue fresh policies to effect new premium rates. This notification as well as en closed schedule of premium rates shall be prominently displayed on the Notice Board of every underwriting office of the insurers where it can be viewed by the public. This notification is issued in supersession of the Authority's earlier Notification Ref: IRDA/NL/NTFN/MOTP/098/03/2014 dated 27th March 2014

TS Vijayan
Chairman, IRDA

Regulatory Framework for Grievance Redressal in the Insurance Sector

INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY

NOTITICATION, the 16th October 2002

Insurance Regulatory and Development Authority (Protection of Policyholders' Interests) Regulations, 2002 (As amended up to 16.10.2002)

In exercise of the powers conferred by clause (zc) of sub-section (2) of section 114A of the Insurance Act, 1938 (4 of 1938) read with sections 14 and 26 of the Insurance Regulatory and Development Authority Act, 1999 (41 of 1999), the Authority, in consultation with the Insurance Advisory Committee, hereby makes the following regulations, namely:

Short title and commencement

(1) These regulations may be called the Insurance Regulatory and Development Authority (Protection of Policyholders' Interests) Regulations, 2002

(2) They shall come into force on the date of their publication in the Official Gazette and shall apply to all contracts of insurance effected thereafter, except regulation 4(1) which shall come into force on 1st October, 2002.

(3) These Regulations are in addition to any other regulations made by the Authority, which may, inter alia, provide for protection of the interest of policyholders.

(4) These Regulations apply to all insurers, insurance agents, insurance intermediaries and policyholders.

Definitions

2. (1) In these regulations, unless the context otherwise requires:

a) "Act" means the Insurance Act, 1938 (4 of 1938);

b) "Authority" means the Insurance Regulatory and Development Authority established under the provisions of section 3 of the Insurance Regulatory and Development Authority Act, 1999 (41 of 1999);

c) "Cover" means an insurance contract whether in the form of a policy or a cover note or a Certificate of Insurance or any other form prevalent in the industry to evidence the existence of an insurance contract;

d) "Proposal form" means a form to be filled in by the proposer for insurance, for furnishing all material information required by the insurer in respect of a risk, in order to enable the insurer to decide whether to accept or decline, to undertake the risk, and in the event of acceptance of the risk, to determine the rates, terms and conditions of a cover to be granted.

Explanation:"Material" for the purpose of these regulations shall mean and include all important, essential and relevant information in the context of underwriting the risk to be covered by the insurer.

e) "Prospectus" mean a document issued by the insurer or in its behalf to the prospective buyers of insurance, and should contain such particulars as are mentioned in Rule 11 of Insurance Rules, 1939 and includes a brochure or leaflet serving the purpose. Such a document should also specify the type and character of riders on the main product indicating the nature of benefits flowing thereupon;

f) Words and expressions used and not defined in these regulations, but defined in the Act, or the Life Insurance Corporation Act, 1956, (31 of 1956) or the General Insurance Business (Nationalisation) Act 1972 (57 of 1972), or the Insurance Regulatory and Development Authority Act, 1999 (41 of 1999) or the Insurance Rules, 1939 shall have the meanings respectively assigned to them in those Acts or the Rules.

3. Point of Sale

(1) Notwithstanding anything mentioned in regulation 2(e) above, 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 and, in case of life insurance, whether the product is participating (with-profits) or non-participating (without-profits). The allowable rider or riders on the product shall be clearly spelt out with regard to their scope of benefits, and in no case, the premium relatable to health related or critical illness riders in case of term or group products shall exceed 100% of premium under the basic product. All other riders put together shall be subject to a ceiling of 30% of the premium of the basic product. Any benefit arising under each of the riders shall not exceed the sum assured under the basic product.

Provided that the benefit amount under riders shall be subject to section 2(11) of the Insurance Act, 1938.

Explanation: The rider or riders attached to a life policy shall bear the nature and character of the main policy, viz. participating or non-participating and accordingly the life insurer shall make provisions, etc., in its books."

(2) An insurer or its agent or other intermediary shall provide all material information in respect of a proposed cover to the prospect to enable the prospect to decide on the best cover that would be in his or her interest.

(3) Where the prospect depends upon the advice of the insurer or his agent or an insurance intermediary, such a person must advise the prospect dispassionately.

(4) Where, for any reason, the proposal and other connected papers are not filled by the prospect, a certificate may be incorporated at the end of proposal form from the prospect that the contents of the form and documents have been fully explained to him and that he has fully understood the significance of the proposed contract.

(5) In the process of sale, the insurer or its agent or any intermediary shall act according to the code of conduct prescribed by:

(a) the Authority

(b) the Councils that have been established under section 64C of the Act and

(c) the recognized professional body or association of which the agent or intermediary or insurance intermediary is a member.

4. Proposal for insurance

i. Except in cases of a marine insurance cover, where current market practices do not insist on a written proposal form, in all cases, a proposal for grant of a cover, either for life business or for general business, 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.

ii. Forms and documents used in the grant of cover may, depending upon the circumstances of each case, be made available in languages recognised under the Constitution of India.

iii. In filling the form of proposal, the prospect is to be guided by the provisions of Section 45 of the Act. Any proposal form seeking information for grant of life cover may prominently state therein the requirements of Section 45 of the Act.

iv. 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.

v. Wherever the benefit of nomination is available to the proposer, in terms of the Act or the conditions of policy, the insurer shall draw the attention of the proposer to it and encourage the prospect to avail the facility.

vi. Proposals shall be processed by the insurer with speed and efficiency and all decisions

thereof shall be communicated by it in writing within a reasonable period not exceeding 15 days from receipt of proposals by the insurer.

5. Grievance redressal procedure

Every insurer shall have in place proper procedures and effective mechanism to address complaints and grievances of policyholders efficiently and with speed and the same along-with the information in respect of Insurance Ombudsman shall be communicated to the policyholder along-with the policy document and as maybe found necessary.

6. Matters to be stated in Life Insurance policy

(1) A life insurance policy shall clearly state:

(a) the name of the plan governing the policy, its terms and conditions;

(b) whether it is participating in profits or not;

(c) the basis of participation in profits such as cash bonus, deferred bonus, simple or compound reversionary bonus;

(d) the benefits payable and the contingencies upon which these are payable and the other terms and conditions of the insurance contract;

(e) the details of the riders attaching to the main policy;

(f) the date of commencement of risk and the date of maturity or date(s) on which the benefits are payable;

(g) the premiums payable, periodicity of payment, grace period allowed for payment of the premium, the date the last instalment of premium, the implication of discontinuing the payment of an instalment(s) of premium and also the provisions of a guaranteed surrender value.

(h) the age at entry and whether the same has been admitted;

(i) the policy requirements for (a) conversion of the policy into paid up policy, (b) surrender (c) non-forfeiture and (d) revival of lapsed policies;

(j) contingencies excluded from the scope of the cover, both in respect of the main policy and the riders;

(k) the provisions for nomination, assignment, and loans on security of the policy and a statement that the rate of interest payable on such loan amount shall be as prescribed by the insurer at the time of taking the loan;

(l) any special clauses or conditions, such as, first pregnancy clause, suicide clause etc.; and

(m) the address of the insurer to which all communications in respect of the policy shall be sent.

(n) the documents that are normally required to be submitted by a claimant in support of a claim under the policy.

(2) While acting under regulation 6(1) in forwarding the policy to the insured, the insurer shall inform by the letter forwarding the policy that he has a period of 15 days from the date of receipt of the policy document to review the terms and conditions of the policy and where the insured disagrees to any of those terms or conditions, he has the option to return the policy stating the reasons for his objection, when he shall be entitled to a refund of the premium paid, subject only to a deduction of a proportionate risk premium for the period on cover and the expenses incurred by the insurer on medical examination of the proposer and stamp duty charges.

(3) In respect of a unit linked policy, in addition to the deductions under sub-regulation (2) of this regulation, the insurer shall also be entitled to repurchase the unit at the price of the units on the date of cancellation.

(4) In respect of a cover, where premium charged is dependent on age, the insurer shall ensure that the age is admitted as far as possible before issuance of the policy document. In case where age has not been admitted by the time the policy is issued, the insurer shall make efforts to obtain proof of age and admit the same as soon as possible.

7. Matters to be stated in General Insurance policy

(1) A general insurance policy shall clearly state:

(a) 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;

(b) full description of the property or interest insured;

(c) the location or locations of the property or interest insured under the policy and, where appropriate, with respective insured values;

(d) period of Insurance;

(e) sums insured;

(f) perils covered and not covered;

(g) any franchise or deductible applicable;

(h) premium payable and where the premium is provisional subject to adjustment, the basis of adjustment of premium be stated;

(i) policy terms, conditions and warranties;

(j) action to be taken by the insured upon occurrence of a contingency likely to give rise to a claim under the policy;

(k) 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;

(l) any special conditions attaching to the policy;

(m) provision for cancellation of the policy on grounds of mis-representation, fraud, non-disclosure of material facts or non-cooperation of the insured;

(n) the address of the insurer to which all communications in respect of the insurance contract should be sent;

(o) the details of the riders attaching to the main policy;

(p) proforma of any communication the insurer may seek from the policyholders to service the policy.

(2) Every insurer shall inform and keep informed periodically the insured on the requirements to be fulfilled by the insured regarding lodging of a claim arising in terms of the policy and the procedures to be followed by him to enable the insurer to settle a claim early.

8. Claims procedure in respect of a Life Insurance policy

(1) A life insurance policy shall -state the primary documents, which are normally required to be submitted by a claimant in support of a claim.

(2) A life insurance company, upon receiving a claim, shall process the claim without delay. Any queries or requirement of additional documents, to the extent possible, shall be raised all at once and not in a piece-meal manner, within a period of 15 days of the receipt of the claim.

(3) A claim under a life policy shall be paid or be disputed giving all the relevant reasons, within 30 days from the date of receipt of all relevant papers and clarifications required. However, where the circumstances of a claim warrant an investigation in the opinion of the insurance company, it shall initiate and complete such investigation at the earliest. Where in the opinion of the insurance company the circumstances of a claim warrant an investigation, it shall initiate and complete such investigation at the earliest, in any case not later than 6 months from the time of lodging the claim.

(4) Subject to the provisions of section 47 of the Act, where a claim is ready for payment but the payment cannot be made due to any reasons of a proper identification of the payee, the life insurer shall hold the amount for the benefit of the payee and such an amount shall earn interest at the rate applicable to a savings bank account with a scheduled bank (effective from 30 days following the submission of all papers and information).

(5) Where there is a delay on the part of the insurer in processing a claim for a reason other than the one covered by sub-regulation (4), the life insurance company shall pay interest on the

claim amount at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by it.

9. Claim procedure in respect of a General Insurance policy

(1) An insured or the claimant shall give notice to the insurer of any loss arising under contract of insurance at the earliest or within such extended time as may be allowed by the insurer. On receipt of such a communication, a general insurer shall respond immediately and give clear indication to the insured on the procedures that he should follow. In cases where a surveyor has to be appointed for assessing a loss/ claim, it shall be so done within 72 hours of the receipt of intimation from the insured.

(2) Where the insured is unable to furnish all the particulars required by the surveyor or where the surveyor does not receive the full cooperation of the insured, the insurer or the surveyor as the case may be, shall inform in writing the insured about the delay that may result in the assessment of the claim. The surveyor shall be subjected to the code of conduct laid down by the Authority while assessing the loss, and shall communicate his findings to the insurer within 30 days of his appointment with a copy of the report being furnished to the insured, if he so desires. Where, in special circumstances of the case, either due to its special and complicated nature, the surveyor shall under intimation to the insured, seek an extension from the insurer for submission of his report. In no case shall a surveyor take more than six months from the date of his appointment to furnish his report.

(3) If an insurer, on the receipt of a survey report, finds that it is incomplete in any respect, he shall require the surveyor under intimation to the insured, to furnish an additional report on certain specific issues as may be required by the insurer. Such a request may be made by the insurer within 15 days of the receipt of the original survey report.

Provided that the facility of calling for an additional report by the insurer shall not be resorted to more than once in the case of a claim.

(4) The surveyor on receipt of this communication shall furnish an additional report within three weeks of the date of receipt of communication from the insurer.

(5) On receipt of the survey report or the additional survey report, as the case may be, an insurer shall within a period of 30 days offer a settlement of the claim to the insured. If the insurer, for any reasons to be recorded in writing and communicated to the insured, decides to reject a claim under the policy, it shall do so within a period of 30 days from the receipt of the survey report or the additional survey report, as the case may be.

(6) Upon acceptance of an offer of settlement as stated in sub-regulation (5) by the insured, the payment of the amount due shall be made within 7 days from the date of acceptance of the offer by the insured. In the cases of delay in the payment, the insurer shall be liable to pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by it.

10. Policyholders' Servicing

(1) An insurer carrying on life or general business, as the case may be, shall at all times, respond within 10 days of the receipt of any communication from its policyholders in all matters, such as:

a) recording change of address;

b) noting a new nomination or change of nomination under a policy;

c) noting an assignment on the policy;

d) providing information on the current status of a policy indicating matters, such as, accrued bonus, surrender value and entitlement to a loan;

e) processing papers and disbursal of a loan on security of policy;

f) issuance of duplicate policy;

g) issuance of an endorsement under the policy; noting a change of interest or sum assured or perils insured, financial interest of a bank and other interests; and

h) guidance on the procedure for registering a claim and early settlement thereof.

11. General

1) The requirements of disclosure of "material information" regarding a proposal or policy apply, under these regulations, both to the insurer and the insured.

2) The policyholder shall assist the insurer, if the latter so requires, in the prosecution of a proceeding or in the matter of recovery of claims which the insurer has against third parties.

3) The policyholder shall furnish all information that is sought from him by the insurer and also any other information which the insurer considers as having a bearing on the risk to enable the latter to assess properly the risk sought to be covered by a policy.

4) Any breaches of the obligations cast on an insurer or insurance agent or insurance intermediary in terms of these regulations may enable the Authority to initiate action against each or all of them, jointly or severally, under the Act and/or the Insurance Regulatory and Development Authority Act, 1999.

N.Rangachary
Chairman

Redressal of Public Grievances Rules, 1998
-Insurance Ombudsman

MINISTRY OF FINANCE
(Department of Economic Affairs)
(Insurance Division)

NOTIFICATION
New Delhi, the 11th November, 1998

G. S. R. 670(E). - In exercise of the powers conferred by sub-section (1) of Section 114 of the Insurance Act, 1938 (4 of 1938) the Central Government hereby frames the following Rules, namely:-

1. Short title. - These Rules may be called the Redressal of Public Grievances Rules, 1998.

2. Application. - These Rules shall apply to all the insurance companies operating in general insurance business and in life insurance business.

Provided that the Central Government may exempt an insurance company from the provisions of these Rules, if it is satisfied that an insurance company has already a grievance redressal machinery which fulfills the requirements of these Rules.

3. The objects of these Rules are to resolve all complaints relating to settlement of claim on the part of insurance companies in cost effective, efficientand impartial manner.

4. Definition. - In these rules unless the context otherwise requires:-

(a) "Act" means Insurance Act, 1938.

(b) "committee" means an advisory committee referred to in Rule 19.

(c) "financial year" means period of twelve months commencing from the 1st day of April of any year and ending on 31st day of March of the succeeding year.

(d) "General Insurance Corporation of India" means a government company formed under subsection (1) of section 9 of the General Insurance Business (Nationalisation) Act, 1972 and shall include a subsidiary company of such company.

(e) "governing body" means governing body of the Insurance Council constituted under sub-rule (1) of ruleS.

(f) "Insurance Council" means the Life Insurance Council and the General Insurance Council referred to in section 64C of the Act.

(g) "Insurance Regulatory Authority" means a body established by Government of India vide Resolution No. 17(2)/941ns. Vdated 23-01-1996to monitor the orderly growth of insurance industry.

(h) "Insurance Company" means the Life Insurance Corporation of India, the General Insurance Corporation of India and any other company which has been given a license to carry on business of life insurance or of the general insurance, as the case maybe.

(i) "insured person" means an individual by whom or on whose behalf an insurance policy has been taken on personal lines.

(j) "Life Insurance Corporation of India" means the Life Insurance Corporation of India established under the Life Insurance Corporation Act, 1956.

(k) "Personal lines' means an insurance policy taken or given in an individual capacity.

5. Governing body of Insurance Council -

(1) There shall be a Governing Body of the Insurance Council which shall consist of o representative from each of the insurance companies.

(2) The representatives of an insurance company shall ordinarily be Chairman or Managing Director or any one of the Directors of such company.

(3) The Governing body shall formulate its own procedure for conducting its business including the election of the Chairman.

Provided that the Chairman of the Life Insurance Corporation of India shall act as the first Chairman of the governing body.

6. Ombudsman-

(1) The governing body shall appoint one or more persons as ombudsman forthe purpose of these rules.

(2) The Ombudsman selected may be drawn from *a* wider circle including those who have experience or have been exposed to the industry, civil service, administrative service, etc. in addition to those drawn from judicial service.

(3) An Ombudsman shall be appointed by the Governing Body from a panel prepared by the Committee consisting of-

(a) Chairman of Insurance Regulatory Authority -Chairman.

(b) Two representatives of Insurance Council including one each from the Life Insurance Business and from General Insurance Business respectively- Member.

(c) One representative of the Central Government -Member.

7. Term of Office - An Ombudsman shall be appointed for a term of three years and shall be eligible for re-appointment. Provided that no person shall hold office as such Ombudsman after he has attained the age of 65 years. (According to the amendment dt. 21.6.99, provision of reappointment has been cancelled).

8. Removal from Office. -

(1) An Ombudsman may be removed from service for gross misconduct committed by him during his term of office.

(2) The Governing Body may appoint such person as it thinks fit to conduct enquiry in relation to misconduct of the Ombudsman.

(3) All enquiries on misconduct will be sent to Insurance Regulatory Authority which may take a decision as to the proposed action to be taken against the Ombudsman.

(4) On recommendations of the Insurance Regulatory Authority if the Governing Body is of opinion that the Ombudsman is guilty of misconduct, it may terminate his services.

9. Remuneration etc. of Ombudsman -

(1) There shall be paid to Ombudsman a salary which is equal to the salary of the Judge of a High Court. (This has been changed as per amendment dt. 21.6.99)

(2) The other allowances and perquisites of the Ombudsman shall be such as may *be* specified by the Central Government.

10. Territorial Jurisdiction of Ombudsman

(1) The office of the Ombudsman shall be located at such place as may be specified by the Insurance Council from time to time.

(2) The Governing Body shall specify the territorial jurisdiction of each Ombudsman.

(3) The Ombudsman may hold sitting at various places within his area of jurisdiction in order to expedite disposal of complaints.

11. Staff -

(1) The Ombudsman shall have such secretarial staff as may be provided to him by the insurance Council after having consultation with the Ombudsman.

(2) The ombudsman may engage the services of professional expert with a view to assist him in discharging his functions.

(3) The salary, allowances and perquisites payable to Ombudsman, the salary, allowances and other benefits payable to the staff of the secretariat and all expenses incurred for the purposes of these rules shall be borne by the Insurance council.

(4) The Ombudsman shall prepare the budget indicating the requirement of funds before the beginning of every financial year.

(5) The budget of the office of Ombudsman will be sent to the Governing Body.

(6) The Governing Body will finalise the budget in consultation with the Ombudsman and shall allocate the funds to the office of Ombudsman.

(7) The total expenses on Ombudsman and his staff shall be incurred by the insurance companies who are members of the insurance council in such proportion as may be decided by the Governing Body from time to time. Provided that till a decision is taken by the Governing Body, the entire expenditure shall be shared equally between the insurance companies in the life insurance business and general insurance business in equal proportion.

(8) The share of expenditure which is to be incurred by each insurance company shall be in the ratio of premium income for the previous year of such company.

Explanation:- For the purpose of this sub-rule "premium income" means the gross direct premium income of the insurer without taking into account from time to time income on reinsurance accepted by the insurance company.

12. Power of Ombudsman :-

(1) The Ombudsman may receive and consider :-

(a) Complaints under rule 13;

(b) any partial or total repudiation of claims by an insurer;

(c) any dispute in regard to premium paid or payable in terms of the policy;

(d) any dispute on the legal construction of the policies in so far as such disputes relate to claims;

(e) delay in settlement of claims;

(f) non-issue of any insurance document to customers after receipt of premium.

(2) The Ombudsman shall act as counsellor and mediator in matters which are within his terms of reference and, if requested to do so in writing by mutual agreement by the insured person and insurance company.

(3) The Ombudsman's decision whether the complaint is fit and proper for being considered by it or not shall be final.

13. Manner in which complaint is to be made:-

(1) Any person who has a grievance against an insurer, may himself or through his legal heirs make a complaint in writing to the Ombudsman within whose jurisdiction the branch or office of the insurer complaint against is located.

(2) The complaint shall be in writing duly signed by the complainant or through his legal heirs and shall state clearly the name and address of the complainant, the name of the branch or office of the insurer against which the complaint is made, the fact giving rise to complaint supported by documents, if any, relied on by the complainant, the nature and extent of the loss caused to the complainant and the relief sought from the Ombudsman.

(3) No complaint to the Ombudsman shall lie unless:-

(a) the complainants had before making a complaint to the Ombudsman made a written

representation to the insurer named in the complaint and either insurer had rejected the complaint or the complainant had not received any reply within a period of one month after the insurer concerned received his representation or the complainant is not satisfied with the reply given to him by the insurer.

(b) the complaint is made not later than one year after the insurer had rejected the representation or sent his final reply on the representation of the complainant; and

(c) the complaint is not on the same subject matter, for which any proceedings before any court, or Consumer Forum, or arbitrator is pending or were so earlier.

14. Ombudsman to act fairly and equitably.:

(1) The Ombudsman may, if he deems fit, adopt a procedure otherthan mentioned in sub-rule (1) and (2) of Rule 13 for dealing with a claim: Provided that the Ombudsman may ask the parties for necessary papers in support of their respective claims and where he considers necessary, he may collect factual information available with the insurance company.

(2) The Ombudsman shall dispose of a complaint fairly and equitably.

15. Recommendations made by the Ombudsman:

(1) When a complaint is settled, through mediation of the Ombudsman, undertaken by him in pursuance of request made in writing by complainant and insurer through mutual agreement, the Ombudsman shall make a recommendation which he thinks fair in the circumstances of the case. The copies of the recommendation shall be sent to the complainant and the insurance company concerned. Such recommendation shall be made not later than one month from the date of the receipt of the complaint.

(2) If a complainant accepts the recommendation of the Ombudsman, he will sent a communication in writing within 15 days of the date of receipt of the recommendation. He will confirm his acceptance to Ombudsman and state clearly that the settlement reached is acceptable to him, in totally, in terms of recommendations made by the Ombudsman in full and final settlement of complaint.

(3) The Ombudsman shall sent to the insurance company a copy of the recommendation along with the acceptance letter received from the complainant. The insurer shall thereupon comply with the terms of the recommendations immediately not later than 15 days of the receipt of such recommendation and the insurer shall inform the Ombudsman of its compliance.

16. Award:

(1) Where the complaint is not settled by agreement under Rule 15, the Ombudsman shall pass an award which he thinks fair in the facts and circumstances of a claim.

(2) An award shall be in writing and shall state the amount awarded to the complainant: Provided that Ombudsman shall not award any compensation in excess of which is necessary to cover the loss suffered by the complainant as a direct consequence of the insured peril, or for an amount not exceeding rupees twenty lakhs (including ex-gratia and other expenses), whichever is lower.

(3) The Ombudsman shall pass an award within a period of three months from the receipt of the complaint.

(4) A copy of the award shall be sent to the complainant and the insurer named in the complaint.

(5) The complainant shall furnish to the insurer within a period of one month from the date of receipt of the award, a letter of acceptance that the award is in full and final settlement of his claim.

(6) The insurer shall comply with the award within 15 days of the receipt of the acceptance letter under sub-rule (5) and it shall intimate the compliance to the Ombudsman.

17. Consequences of non-acceptance of award: If the complainant does not intimate the acceptance under sub-rule (5) of rule 16, the award may not be implemented by the insurance company.

18. Power to make Ex-gratia payment.: If the Ombudsman deems fit, he may award an Ex-gratia payment.

MISCELLANEOUS PROVISIONS:

19. Advisory Committee: An Advisory Committee consisting of not exceeding five eminent persons shall be notified by the Government to assist the Insurance Regulatory Authority to review the performance of the Ombudsman from time to time. The Insurance Regulatory Authority shall decide the time, venue and quorum of such meeting. The authority, after discussing the matter with the Governing Body, may recommend to Government appropriate proposals for effecting improvements in the functioning of Ombudsman. In the light of recommendations made by the Insurance regulatory Authority, the Government may carry out such amendments to these rules as they may deem fit.

20. The Ombudsman shall furnish a report every year containing a general review of the activities of the office of the Ombudsman during preceding financial year to the Central Government and such other information as may be considered necessary by it. In the Annual Report, the Ombudsman will make an annual review of the quality of services rendered by the insurer and make recommendations to improve these services.

21. Recommendation of the Insurance Council: The Insurance Council may suggest to the Ombudsman such recommendation as it deems fit and which in its opinion will enhance the utility of the annual report and also so that the objectives of the rules are clearly analysed in terms of the activities in the year under review. Suggestions for long term improvement of insurance sector will be incorporated by the Ombudsman in his report.

[F.No. 56/32/97 - Ins.I]
D.C, SRIVASTAVA, Director

The Gazette of India
EXTRAORDINARY

PART II-Section 3-Sub-section (I)
PUBLISHED BY AUTHORITY
NEW DELHI, FRIDAY, DECEMBER 18, 1998/
AGRAHAYANA 27, 1920.
MINISTRY OF FINANCE
(Department of Economic Affairs)
(Insurance Division)

Ref: 3/CA/GRV/GrvRedrGuidelines/YPB/10-II dated 27th July, 2010

ALL LIFE AND GENERAL INSURANCE COMPANIES
Re: GUIDELINES FOR GRIEVANCE REDRESSAL BY INSURANCE COMPANIES

Further to Regulation 5 of IRDA Regulations for Protection of Policyholders Interests, 2002 which provides for insurers to have in place speedy and effective grievance redressal systems, and in terms of the Authority's powers and functions as enunciated in Section 14 of IRDA Act, 1999, the IRDA hereby issues the following guidelines pertaining to minimum time-frames and uniform definitions and classifications with respect to grievance redressal by insurance companies.

These guidelines are applicable for disposal of "grievances/complaints" as defined herein. All insurers shall ensure that the guidelines of the Authority are followed strictly.

1. Definition of "Grievance/Complaint":

There shall be a uniform definition of "Grievance or Complaint". Grievances shall be clearly distinguished from Inquiries and Requests, which do not fall within the scope of these guidelines.

The following definition of grievance shall be adopted:

Grievance/Complaint: A "Grievance/Complaint" is defined as any communication that expresses dissatisfaction about an action or lack of action, about the standard of service/deficiency of service of an insurance company and/or any intermediary or asks for remedial action.

On the other hand, an Inquiry and Request would mean the following:

Inquiry: An "Inquiry" is defined as any communication from a customer for the primary purpose of requesting information about *a* company and/or its services.

Request: A "Request" is defined as any communication from a customer soliciting a service such as a change or modification in the policy.

2. Grievance Redress Policy:

Every insurer shall have a Board approved Grievance Redressal Policy which shall be filed with IRDA.

3. Grievance Officer/s:

Every insurer shall have a designated Grievance Officer of a senior management level. Senior Management would mean either the CEO or the Compliance Officer of the company. Every office other than the Head/Corporate/Principal officer of an insurer shall also have an officer nominated as the Grievance Officer for that office.

4. Grievance Redressal System/Procedure:

Every insurer shall have a system and a procedure for receiving, registering and disposing of grievances in each of its offices. This and all other relevant details along with details of Turnaround Times (TATs) shall be clearly laid down in the policy. While insurers may lay down their own TATs, they shall ensure that the following minimum time-frames are adopted:

(a). An insurer shall send a written acknowledgment to a complainant within 3 working days of the receipt of the grievance.

(b). The acknowledgment shall contain the name and designation of the officer who will deal with the grievance.

(c). It shall also contain the details of the insurer's grievance redressal procedure and the time taken for resolution of disputes.

(d). Where the insurer resolves the complaint within 3 days, it may communicate the resolution along with the acknowledgment.

(e). Where the grievance is not resolved within 3 working days, an insurer shall resolve the grievance within 2 weeks of its receipt and send a final letter of resolution.

(f). Where, within 2 weeks, the company sends the complainant a written response which offers redress or rejects the complaint and gives reasonsfordoing so,

(i). The insurer shall inform the complainant about how he/she may pursue the complaint, if dissatisfied.

(ii). the insurer shall inform that it will regard the complaint as closed if it does not receive a reply within 8 weeks from the date of receipt of response by the insured/policyholder.

Any failure on the part of insurers to follow the above-mentioned procedures and time-frames would attract penalties by the Insurance Regulatory and Development Authority.

It may be noted that it is necessary for each and every office of the insurer to adopt a system of grievance registration and disposal.

5. Turnaround Times:

There are two types of turnaround times involved.

(i). The service level turnaround times, which are mapped to each classification of complaint (which is itself based on the service aspect involved).

(ii). The turnaround time involved for the grievance redressal.

As to (i), the TATs are as mapped to the classification and prescribed by the Authority to insurers. These TATs reflect the time-frames as already laid down in the IRDA Regulations for Protection of Policyholders Interests and more, as, wherever considered necessary(for certain service aspects not getting specifically reflected in the Regulations), specific TATs are indicated in the classification and mapping provided by the Authority.

As regards (ii) above, the minimum TATs required to be followed shall be as prescribed in guideline 4 (a) to (g) as prescribed above.

6. Closure of grievance:

A complaint shall be considered as disposed of and closed when

(a). The company has sent a final response to the satisfaction of the complainant.

(b). Where the complainant has indicated in writing, acceptance of this response.

(c). Where the complainant has not responded to the insurer within 8 weeks of the company's written response.

7. Categorisation of complaints:

a). Categorisation of complaints as prescribed by the Authority from time to time shall be adopted by insurers and incorporated in their systems.

b). The present classification prescribed by the Authority is placed at Annexure A. All insurers shall provide for these classification categories in their respective systems.

8. Minimum software requirements:

It is necessary for insurers to have automated systems that will enable online registration, tracking of status of grievances by complainants and periodical reports as prescribed by IRDA. The system should also be one which can integrate seamlessly with the Authority's system in the manner prescribed by the Authority. The Authority shall define these requirements from time to time and insurers shall ensure that they provide for such software/system modifications as may be required. The objective is to create the required industry level database and systems that would enable speedy and effective redressal of complaints.

9. Calls relating to grievances:

Insurers shall also have in place a system to receive and deal with all kinds of calls including voice/e-mail, relating to grievances, from prospects and policyholders. The system should enable and facilitate the required interfacing with IRDA's system of handling calls/e-mails.

10. Publicizing Grievance Redressal Procedure:

Every insurer shall publicize its grievance redressal procedure and ensure that it is specifically made available on its website.

11. Policyholder Protection Committee:

Every insurer that ensure that the Policyholder Protection Committee, as stipulated in the guidelines for Corporate Governance issued by the Authority, is in place and is receiving and analyzing the required reports from the management and is carrying out all other requisite monitoring activities.

(A. Giridhar)
Executive Director

CORPORATE GOVERNANCE GUIDELINES

Policyholder Protection Committee of the Board

The Authority places significant emphasis on the protection of policyholder's interests and on the adoption of sound and healthy market conduct practices by insurers. Towards meeting these objectives, IRDA has notified the (i) Protection of Policyholders' Interests Regulations, 2002 and (ii) Insurance Advertisements and Disclosure Regulations, 2002. The Authority has also put in place the Guidelines on Advertisements, Promotion & Publicity of Insurance Companies and Insurance Intermediaries in January 2006. Insurers are also required to report on the number and nature of complaints to the IRDA at monthly intervals to enable IRDA to assess the governance and market conduct issues with respect to each insurer. With a view to addressing the various compliance issues relating to protection of the interests of policyholders, as also relating to keeping the policyholders well informed of and educated about insurance products and complaint-handling procedures, each insurer shall set up a Policyholder Protection Committee which shall directly report to the Board.

The Committee should put in place systems to ensure that policyholders have access to redressal mechanisms and shall establish policies and procedures, for the creation of a dedicated unit to deal with customer complaints and resolve disputes expeditiously.

Thus, the responsibilities of the Policyholder Protection Committee shall include:

- Putting in place proper procedures and effective mechanism to address complaints and grievances of policyholders including misselling by intermediaries.
- Ensure compliance with the statutory requirements as laid down in the regulatory framework. Review of the mechanism at periodic intervals.
- Review of the mechanism at periodic intervals.
- Ensure adequacy of disclosure of "material information" to the policyholders. These disclosures shall, for the present, comply with the requirements laid down by the Authority both at the point of sale and at periodic intervals.
- Review the status of complaints at periodic intervals to the policyholders.
- Provide the details of grievances at periodic intervals in such formats as may be prescribed by the Authority.
- Provide details of insuranceombudsmentothepolicyholders

CIRCULAR

Ref: IRDA/CAD/CPR/245/11/2012,
Dated :20-11-2012

Re: Guidelines on Periodic Disclosures to the Public

CEOs of all Insurance Companies

Reference is invited to the following circulars issued on the subject by the Authority:

1. Public Disclosures by Insurers (Ref: IRDA/F&I/CIR/F&A/012/01/2012,dt: 28-01-20 10)
2. Guidelines on Periodic Disclosures(Dt: 09-04-2010)
3. Public Disclosures by Insurers(Ref: IRDA/F&I/CIR/PBDIS/105/05/2011, dt: 27-05-2011)

Forms L41 and NL 41 prescribed vide circular ref: IRDA/F&I/CIR/F&A/012/01/2012, dt: 28/1/2010 relate to disclosure of grievance disposal by insurance companies on a quarterly basis in respect of Life insurance and Nonlife insurance respectively. The forms basically reflect absolute numbers relating to certain broad categories of complaints.

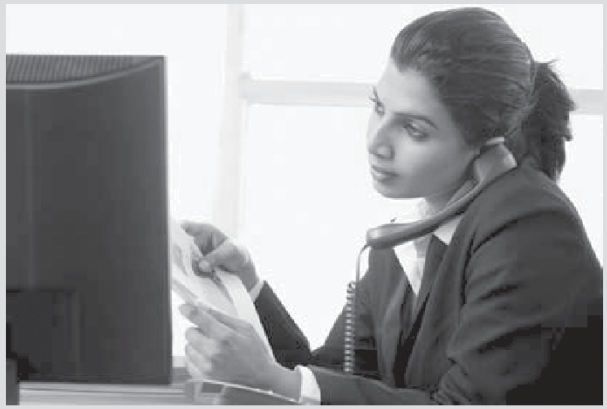
You are indeed aware that the Integrated Grievance Management System has been fully functional with effect from 1s` April, 2011 and the categorization of complaints is now more detailed. Next, analysis of data relating to grievances becomes more meaningful when the grievances are correlated to policy servicing parameters or claims related parameters as may be the case. Data presented in this manner also provides for a fair comparison of the performance of different insurance companies. Absolute data is itself is quite meaningless and does not lend itself to proper comparison and analysis as the numbers involved are contingent upon several factors such as the age of the insurer, the size of the insurer, the number of policyholders, the number of claims registered etc. Keeping this aspect in view the Authority has revised forms L4I and NL41 respectively. Insurance companies are required to put up the revised forms for Public Disclosure on a quarterly basis with effect from the quarter ending 31st Dec, 2012.

Insurers are also required to submit the data in the new format for the first two quarters of the current financial year in order to ensure uniformity in data collection and collation for the financial year 2012-13. The data for the first two quarters in the new format need only to be submitted to the Authority(Consumer Affairs Department) and are not required to be put up for Public Disclosure. The data for the first two quarters in the revised formats may please be Submitted to IRDA - on or before 15th Dec, 2012.

J. Hari Narayan
Chairman

Hand book on Insurance Sector's Grievance Redressal System

Is your insurance company listening to you?



If your complaints have not been addressed by your insurance company, please contact

IRDA Grievance Call Centre

Toll Free No.: 155255

to register your complaints and track their status or you may log on to www.igms.irda.gov.in

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बीमा विनियामक और विकास प्राधिकरण

INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY

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INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY

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Contents:

1. About IRDA

Insurance Regulatory and Development Authority (IRDA) was set up as an autonomous body under the IRDA Act, 1999 to protect the interests of policyholders and to regulate, promote and ensure orderly growth of the insurance industry. Redressal of grievances is one of the key components of IRDA's efforts in protection of interests of proposers and policyholders.

2. Does IRDA stipulate any turnaround time for services by insurance companies?

Yes. IRDA's regulations stipulate the Turnaround Times (TAT) for various services that an insurance company has to render to the consumer. These are part of the IRDA Protection of Policyholders' Interests Regulations 2002. Insurance companies are also required to have an effective Grievance Redressal Mechanism and IRDA has issued guidelines for that too. Here are the TATs for an insurance company to deal with various types of service requests including complaints:

Life Insurance Companies	
Service	**Maximum Turn Around Time**
General	
Processing of Proposal and Communication of decisions including requirements/issue of Policy/Cancellations	15 days
Obtaining copy of the proposal	30 days
Post Policy issue service requests concerning mistakes/ refund of proposal deposit and also Non-Claim related service requests	10 days
Life Insurance	
Surrender value/annuity/pension processing	10 days
Maturity claim/Survival benefit/penal interest not paid	15 days
Raising claim requirements after lodging the Claim	15 days
Death claim settlement without Investigation requirement	30 days
Death claim settlement/repudiation with Investigation requirement	6 months
Grievances	
Acknowledging a grievance	3 days
Resolving a grievance	15 days

General Insurance Companies	
Service	**Maximum Turn Around Time**
General	
Processing of Proposal and Communication of decisions including requirements/issue of Policy /Cancellations	15 days
Obtaining copy of the proposal	30 days
Post Policy issue service requests concerning mistakes/refund of proposal deposit and also Non-Claim related service requests	10 days
General Insurance	
Survey report submission	30 days
Insurer seeking addendum report	15 days
offer of Settlement/rejection of Claim after receiving first/addendum survey report	30 days
Grievances	
Acknowledging a grievance	3 days
Resolving a grievance	15 days

3. Proposer or Policyholder Grievances

Grievance / Complaint has been specifically defined in Para 1 of the Guidelines for Grievance Redressal by Insurance Companies dated 27 July 2010 issued by IRDA which reads as follows:

"A 'Grievance or Complaint' is defined as any communication that expresses dissatisfaction about an action or lack of action about the standard of service / deficiency of service of an insurance company and/or any intermediary or asks for remedial action."

An insurance company is required to resolve a grievance within two weeks of its receipt.

If a customer is unhappy with an insurance company or an intermediary associated with the company, he should approach the Grievance Redressal Officer of the company first and give the complaint. It is preferable to give a complaint in writing along with the necessary support documents.

4. What is the course of action in case the complaint is not resolved within the prescribed time frame or there is no response from the insurance company?

In case the complaint is not resolved within two weeks of its receipt or it is unattended, the complainant can approach the Consumer Affairs Department of IRDA for registering his complaint.

IRDA plays a facilitating role by taking up the complaint with the insurance companies for their resolution and responding to the complaint. A complaint can be registered with IRDA through any of the following modes

- Calling Toll Free Number 155255/1800 425 4732 (i.e. IRDA Grievance Call Centre) or
- Sending an e-mail to complaints@irda.gov.in
- Registering a complaint on Integrated Grievance Management System at www.igms.irda.gov.in
- Sending the complaint through letter / courier to IRDA at Consumer Affairs Department, Insurance Regulatory and Development Authority, 3-5-817/818, United India Towers, 9th Floor, Hyderguda, Basheerbagh, Hyderabad - 500 029
- Sending the complaint by Fax to 040-66789768

5. What is IRDA Grievance Call Centre?

IRDA Grievance Call Centre was launched on July 20, 2010 as a true alternative channel for prospects and policy holders with comprehensive telefunctionalities. The call centre serves as a toll free, 12 hours X 6 days service platform, from 8 AM to 8 PM, Monday to Saturday. The services are offered not only in Hindi and English but also in other major Indian languages. The toll free number

of the call centre is 155255/1800 425 4732 and is serving as an inexpensive, expeditious and simple method of registering complaints, ascertaining their status and escalating them to IRDA.

6. What is Integrated Grievance Management System?

IRDA launched the Integrated Grievance Management System (IGMS) in April 2011. IGMS is a comprehensive solution which not only has the ability to provide a centralized and online access to the proposer or policyholder but also provides for complete access and control to IRDA for monitoring market conduct issues of which proposer or policyholder's grievances are the main indicators. IGMS has the ability to classify different complaint types based on pre-defined rules. The system has the ability to assign, store and track unique complaint IDs. It also sends intimations to various stakeholders as required, within the workflow. The system has defined target Turnaround Times (TATs) and measures the actual TATs on all complaints. IGMS sets up alerts for pending tasks nearing the laid down Turnaround Time. The system automatically triggers activities at the appropriate time through rule based workflows.

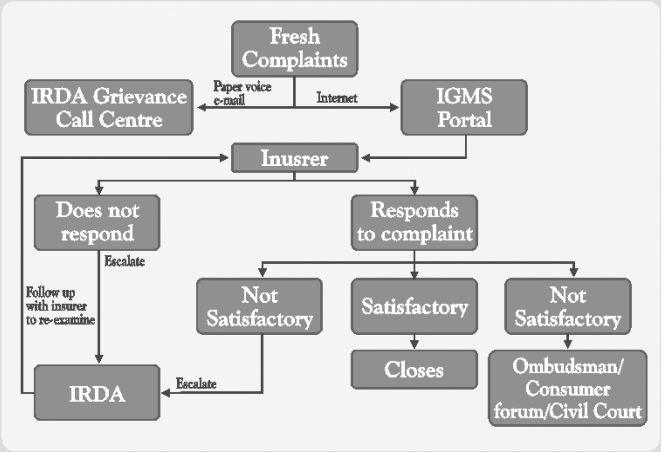
Proposers or Policyholders who have grievances should register their complaints with the Grievance Redress Channel of the Insurance Company first. If they are not able to access the insurance company directly for any reason, IGMS provides a gateway to register complaints with insurance companies and track their status. A complaint registered through IGMS will flow to the insurance company's system as well as the IRDA repository. Thus, IGMS provides a standard platform to all insurance companies to resolve proposer or policyholder's grievances and provides IRDA with a tool to monitor the effectiveness of the grievance redress system of insurance companies. Updating of status will be mirrored in the IRDA system. Therefore, apart from creating a central repository of industry-wide insurance grievance data, IGMS is a grievance redress monitoring tool for IRDA.

7. How are grievances handled at IRDA?

The complaint is registered with a unique token number. An acknowledgement of complaint with the complaint token number is sent to the complainant by email or if no email id is registered, by letter to his postal address. A brief description of the grievance is given on the IGMS. The documents relating to the complaint are captured and forwarded to the insurance company for

resolution. The insurance company is required to examine the complaint and attend to it within two weeks by responding to the complainant. The action taken on the complaint has to be updated by the insurance company in the IGMS. The status of the complaint and the description of action taken can be checked by the complainant from the IGMS or by calling up the IRDA Grievance Call Centre by using the token number assigned to the complaint. In case the complainant does not come back within 8 weeks of the insurance company attending to the complaint and recording the action taken, the complaint will be closed by the insurance company. In case the company does not respond even after 15 days or if the complainant is not satisfied with the action taken, he can again escalate the complaint to IRDA. IRDA will then take up the complaint with the company for its resolution and responding to the complainant. In case the complainant is not satisfied with the resolution of the insurance company, he may approach the Insurance Ombudsman or the appropriate legal authority

8. What is the work flow relating to grievances handled by IRDA?



9. Is there a Scheme of Ombudsman for Insurance Sector?

Yes. With an objective of providing a forum for resolving disputes and complaints from the aggrieved insured public or their legal heirs against insurance companies, the Government of India, in exercise of powers conferred on it under Section 114(1) of Insurance Act, 1938, framed "**Redressal of Public Grievances Rules, 1998**", which came into force with effect from 11 November 1998. These Rules aim at resolving complaints relating to settlement of disputes of proposers or policyholders with insurance companies on personal lines of

insurance, in a cost effective, efficient and impartial manner. These Rules apply to all the insurance companies operating in general Insurance business and life insurance business, in public and private sectors. To implement the above Rules, the Institution of Insurance Ombudsman has been established which has been functioning since 1999.

10. Who is an Insurance Ombudsman?

An Insurance Ombudsman is a person appointed by Government of India under the Redressal of Public Grievance Rules, 1998. There are 12 Insurance Ombudsman in different locations in India.

11. What are the grounds under which a complaint can be made to the Insurance Ombudsman?

- Any partial or total repudiation of claims by an insurance company
- Any dispute about premium paid or payable in terms of the policy
- Any dispute on the legal construction of the policies as far as it relates to claims
- Delay in settlement of claims
- Non-issue of any insurance document to after payment of premium

12. What are the requirements of lodging a complaint before the Insurance Ombudsman?

- A complaint in writing should have been made to the Insurance Company and the same should have been rejected or not satisfactorily replied to or not responded to within 30 days of its receipt.
- The complaint should be lodged within 1 year of rejection or receipt of reply or non-response after 30 days of making complaint.
- The complaint should be by an individual on 'Personal Lines' of insurance
- The complaint should be in writing duly signed by the complainant or through legal heirs and should state clearly the name and address of the complainant, the name of the branch or office of the insurance company against which the complaint is made, the fact giving rise to complaint supported by documents, if any, relied on by the complainant, the nature and extent of the loss caused to the complainant and the relief sought from the Ombudsman
- The complaint should be made to the Ombudsman having jurisdiction over the location of office or branch of the insurance company against which the complaint is made.
- The complaint should be on one of the grounds of complaint that can be handled by the Insurance Ombudsman.

- The subject matter of the complaint is not currently before a Court/Consumer Forum/Arbitrator or disposed of earlier by a Court/Consumer Forum/Arbitrator.
- The total relief sought is not exceeding Rs.20 lakhs.

13. How does the Insurance Ombudsman deal with a complaint?

The Ombudsman takes up a complaint for settlement through mediation if both the complaint and insurance company, by mutual agreement, request for the same in writing. In such a case, the Ombudsman, within one month of receipt of complaint, will make a recommendation which he thinks fair based on the circumstances of the case. The recommendation is sent to complainant and insurance company. If the complainant accepts the recommendation in full and final settlement of his grievance within 15 days, the same is communicated to the insurance company. The insurance company should comply with the recommendation immediately or within 15 days and inform compliance to the Ombudsman.

If a settlement by recommendation does not work, the Ombudsman will dispose the complaint by passing a speaking Award within 3 months from

receipt of complaint. The award, with reasons indicating the amount awarded and ex gratia, if any, will be communicated to complainant and insurance company. The complainant must convey his acceptance of the Award in full and final settlement of his grievance to the insurance company within one month. In case he does not do so, the insurance company may not implement the Award. If the award is accepted by the complainant, the insurance company should comply with the same within 15 days of receipt of letter of acceptance and submit compliance to the Ombudsman.

14. What are the important regulations relevant to proposers and policy holders?

- IRDA (Protection of Policyholders' Interest) Regulations, 2002
- Redress of Public Grievances Rules, 1998
- Guidelines for Grievance Redressal by Insurance Companies (Ref. 3/CA/GRV/ GrvRedrGuidelines/YPB/10-11 dated 27 July 2010)

15. For further information please visit

IRDA's Consumer Education Website - www.policyholder.gov.in

IRDA Site - www.irda.gov.in

Disclaimer:

The Handbook is intended to provide you general information only and is not exhaustive. It is an education initiative and does not seek to give you any legal advice.

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