IC - 38

WEB AGGREGATORS COMPOSITE

ACKNOWLEDGEMENT

This course is based on revised syllabus prescribed by Insurance Regulatory and Development Authority of India (IRDAI) and prepared by Insurance Institute of India, Mumbai.

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Year of Edition: 2023

The contents are based on prevailing best practices and not intended to give interpretations or solutions in case of disputes, legal or otherwise.

This is only an indicative study material. Please note that the questions in the examination shall not be confined to this study material only.

Published by: Secretary General, Insurance Institute of India, G- Block, Plot C-46, Bandra Kurla Complex, Bandra (E) Mumbai – 400 051 and Printed at

Any communication regarding this study material may be addressed to ctd@iii.org.in mentioning the subject title and unique publication number mentioned on the cover page

PREFACE

Insurance Institute of India, (the Institute) has developed this course material for Corporate Agents based on the syllabus prescribed by Insurance Regulatory and Development Authority of India (IRDAI). Industry experts were involved in preparing the course material.

The course provides basic knowledge of Life, General and Health insurance to enable agents in the respective line of business to understand and appreciate their professional career in the right perspective.

The course is structured as four sections. (1) Overview - a Common section that covers Insurance Principles, Legal Principles and Regulatory matters that Insurance agents need to know. Separate sections are provided for those aspiring to become (2) Life Insurance Agents, (3) General Insurance Agents and (4) Health Insurance Agents.

A set of model questions are included in the course to give students an idea of the examination format and the types of objective questions that may be asked. The model questions will also help them in revising what they have learnt.

Insurance operates in a dynamic environment. Agents need to be up to date about changes in the market. They should actively pursue knowledge through personal study and participation in the in-house training programmes arranged by the respective insurers.

The Institute thanks IRDAI for entrusting this work to the Institute. The Institute wishes all interested in studying the material a successful career in insurance marketing.

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SECTION

AN OVERVIEW

CHAPTER C-01
INTRODUCTION TO INSURANCE

Chapter Introduction

This chapter aims to introduce the basics of insurance, trace its evolution and how it works. It intends to teach how insurance provides protection against economic losses arising as a result of unforeseen events and serves as an instrument of risk transfer.

Learning Outcomes

A. Insurance – History and evolution

B. The Principle of Risk Pooling

C. Risk management techniques

D. Insurance as a tool for managing risk

E. Considerations before opting for Insurance

F. Insurance Market Players

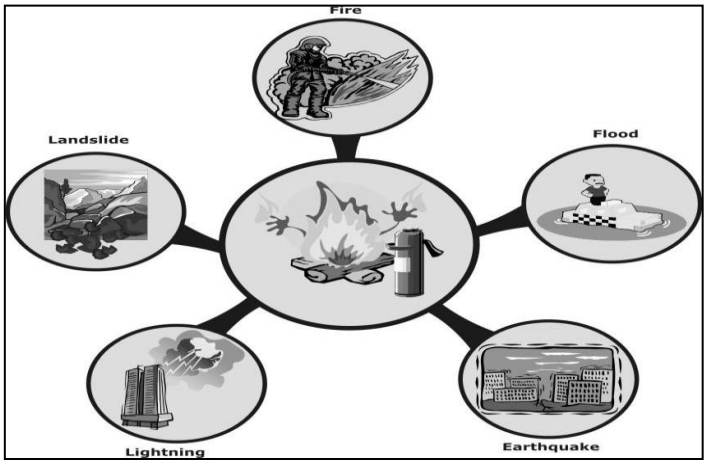
G. Role of Insurance in the Society

A. Insurance – History and Evolution

We live in a world of uncertainty. We hear about:

- ✓ Trains colliding
- ✓ Floods destroying entire communities
- ✓ Earthquakes destroying buildings
- ✓ Young people dying unexpectedly

Diagram 1: Events happening around us



Why do these events make people anxious and afraid?

The reason is simple.

i. Firstly these **events are unpredictable.** If one can anticipate and predict an event, one can prepare for it.

ii. Secondly, such unpredictable and untoward events are often a **cause of economic loss and grief**.

The people around can come to the aid of individuals who are affected by such events, by having a system of sharing and mutual support. The idea of insurance is thousands of years old. Yet, the present form of insurance, is only two or three centuries old.

1. History of insurance

Insurance has existed in some form or other since 3000 BC. Many civilisations, have practiced the concept of pooling and sharing among themselves, all the losses suffered by some members of the community. Let us take a look at some of the ways in which this concept was applied.

2. Insurance through the ages – Some instances

Bottomry Loans	**Traders of Babylon** paid extra money to their lenders to write off their loans if shipment was lost or stolen. **Traders of Bharuch and Surat** also had similar practices.
Benevolent Societies/ Friendly Societies	Greeks of 7th Cy. AD, used to pay in advance to take care of the family of members who died and also the funeral expenses of the member. Similar practices were followed in England as well.
Rhodes	Traders of Rhodes who were sending goods by sea, were sharing losses if any of them lost their goods due to jettison[1].
Chinese Traders	**Chinese traders** in ancient days used to send their goods in different ships, so that even if some boats sank, their loss would be partial.

3. Modern concepts of insurance

In India the principle of life insurance was reflected in the joint-family system. Losses arising from the demise of a member were shared by various family members so that each member of the family continued to feel secure.

The break-up of the joint family system and emergence of the nuclear family in the modern era, coupled with the stress of daily life has made it necessary to evolve alternative systems for security. This highlights the importance of life insurance to an individual.

i. **Lloyds**: The origins of modern commercial insurance started at Lloyd's Coffee House in London, where traders agreed to share losses they suffered due to various perils at sea.

ii. **Amicable Society for a Perpetual Assurance** founded in 1706 in London is considered to be the first life insurance company in the world.

4. History of insurance in India

a) **India**: Modern insurance in India began in early 1800 or thereabouts, with agencies of foreign insurers starting marine insurance business.

The Oriental Life Insurance Co. Ltd	The first life insurance company to be set up in India was an English company
Triton Insurance Co. Ltd.	The first non-life insurer to be established in India

[1] Jettison/ Jettisoning' refers to throwing away some of the cargo to reduce the weight of the ship while at sea.

Bombay Mutual Assurance Society Ltd.	The first Indian insurance company. It was formed in 1870 in Mumbai
National Insurance Company Ltd.	The oldest insurance company in India. It was founded in 1906

Many other Indian companies were set up subsequently as a result of the Swadeshi movement at the turn of the century.

Important

a) The **Insurance Act 1938** was the first legislation to regulate the conduct of insurance companies in India. This Act, as amended from time to time continues to be in force.

b) Life insurance business was nationalised on 1st September 1956 and the **Life Insurance Corporation of India (LIC)** was formed. From 1956 to 1999, the LIC held exclusive rights to do life insurance business in India.

c) In 1972, the non-life insurance business was also nationalised and the **General Insurance Corporation of India (GIC) and its four subsidiaries** were set up.

d) **The Malhotra Committee, in its report submitted in 1994, recommended** opening of the market for competition

e) The Insurance market was liberalised in 2000, with the passing of the Insurance Regulatory & Development Act, 1999 (IRDAI), which also established the Insurance Regulatory and Development Authority of India (IRDAI) in April 2000 as a statutory regulatory body for the insurance industry.

f) An amendment of the Insurance Act in 2021, has allowed Foreign investors, to hold up to 74% of the paid up equity capital in an Indian Insurance company. Foreign insurers can now establish branches in India to do reinsurance.

a. Insurance industry today (As on 30th September 2021)

a) There are 24 Life insurance companies operating in India. Of these, Life Insurance Corporation (LIC) of India is a public sector company (PSU) and the remaining 23 life insurance companies are in the private sector.

b) There are 34 General Insurance companies of which 4 - National Insurance Co. Ltd, The New India Assurance Co. Ltd., The Oriental Insurance Co. Ltd and United India Insurance Co. Ltd. are PSU Companies dealing with all lines of general insurance. 26 Private Companies also deal with all lines of general insurance. 6General Insurers deal only in Health insurance. 2 are specialised insurers - Agricultural Insurance Company [AIC] and Export Credit and Guarantees Corporation [ECGC], both set up as Public sector entities.

c) There is one Reinsurance Company – The General Insurance Corporation of India [GIC Re] and 11 foreign Reinsurers that operate through branch offices.

d) The Department of Posts (called as India Post) of the Government of India, also transacts life insurance known as Postal Life Insurance. India post is exempt from the purview of the Insurance Regulator.

Test Yourself 1

Which among the following is the regulatory body for the insurance industry in India?

I. Insurance Authority of India
II. Insurance Regulatory and Development Authority of India
III. Life Insurance Corporation of India
IV. General Insurance Corporation of India

How insurance works

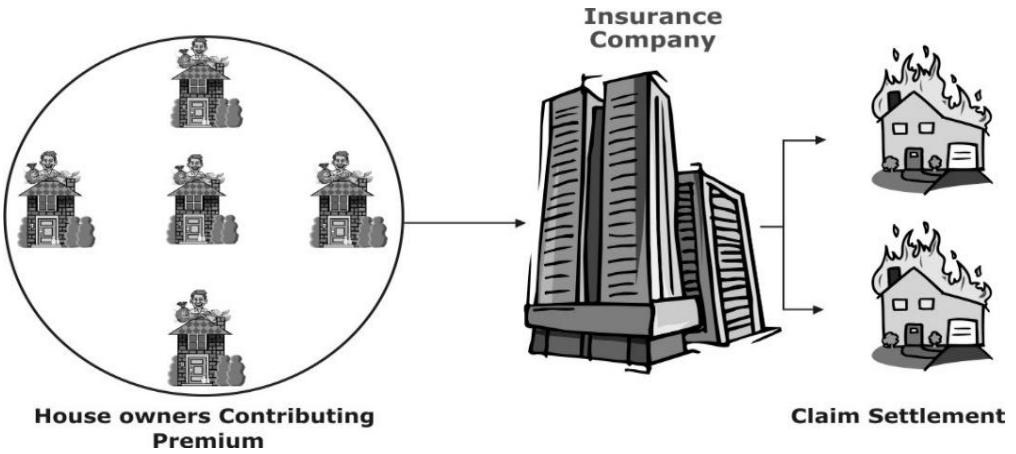
Modern commerce was founded on the principle of ownership of property. When an asset loses value (by loss or destruction), the owner of the asset suffers an economic loss. This loss can be compensated from a common fund made up of small contributions from many similar asset owners. This process of transferring the chance and consequence of a loss making event is insurance.

This mechanism of pooling risks works differently in the case of death and disability as there is no loss/ destruction of a commercial asset.

Definition

Insurance may thus be considered as a process by which the losses of a few are shared amongst many of those exposed to similar uncertain events/ situations.

Diagram 2: How insurance works



There are however some questions that need to be answered.

i. Would people agree to part with their hard earned money, to create such a common fund?

ii. How could they trust that their contributions are actually being used for the desired purpose?

iii. How would they know if they are paying too much or too little?

iv. Who would take the responsibility of managing these funds and paying those who suffer the loss?

The need for an Insurer comes as an answer to all these questions. The Insurer assesses the risk, decides and collects the individual contributions (called premium), pools the risks and premiums, and arranges to pay to those who suffer the loss. The insurer must also win the trust of the individuals and the community.

1. Insurance is about value

a) Firstly, there must be an asset which has an economic value. The **Asset** may be:

   i. P**hysical** (like a car or a building) or

   ii. N**on-physical** (like reputation, goodwill, liability to pay to someone) or

   iii. P**ersonal** (like one's eyes, limbs, body and physical capabilities).

b) The asset may lose its value if a certain event happens. This chance of loss is called as **risk**. The cause of the risk event is known as **peril**.

c) There is a principle known as **pooling**. This consists of collecting numerous individual contributions (known as premiums) from various persons. These persons have similar assets which are exposed to similar risks. Their assets are also referred to as 'risks' in many contexts.

d) This pool of funds is used to compensate the few who might suffer the losses caused by a **peril**.

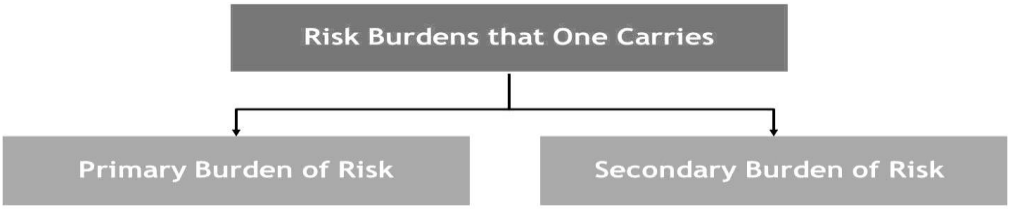
e) This process of pooling funds and compensating the unfortunate few is carried out through an institution known as the **insurer** (Insurance Company).

f) The insurer enters into an insurance **contract** with each person who seeks to participate in this mechanism of pooling. The persons who participate are known as **insured.**

2. Insurance reduces Risk Burden

The burden of risk refers to the costs, losses and disabilities one has to bear as a result of being exposed to a given loss situation/ event.

Diagram 3: Risk burdens that one carries



There are two types of risk burdens that one carries – **primary and secondary**.

a) Primary burden of risk

The **primary burden of risk** consists of losses that are actually suffered by households (and business units), as a result of pure risk events. These losses are often direct and measurable; and can be easily compensated for by insurance.

Example

When a factory gets destroyed by fire, the actual value of goods damaged or destroyed can be estimated and the compensation can be paid to the owner of the factory who has suffered the loss.

Similarly, if an individual undergoes a heart surgery, the medical cost of the same is known and compensated. In addition there may be some indirect losses.

Example

A fire may interrupt business operations and lead to loss of profits which also can be estimated and the compensation can be paid to the one who suffers such a loss.

Someone whose scooter hits a pedestrian is liable to pay the victim the compensation that the Court decides.

b) Secondary burden of risk

Even when no such event occurs and there is no loss, the people who are exposed to the peril carry some burden. That is, apart from the primary burden, one also carries a secondary burden of risk.

The **secondary burden of risk** consists of costs and strains that one has to bear, even if the said event does not occur, from the mere fact that one is exposed to a loss situation.

Let us understand some of these burdens:

i. Firstly there is **physical and mental strain caused by fear and anxiety**. This can cause stress and affect a person's wellbeing.

ii. Secondly when one is **uncertain about whether a loss would occur or not**, it would be prudent to keep a reserve fund to meet such an eventuality. Such funds may be held in liquid form and yield low returns.

By transferring the risk to an insurer, it becomes possible to enjoy peace of mind and also invest one's funds more effectively. It is precisely for these reasons that insurance is needed.

In India, one must purchase third party insurance if he/ she owns a vehicle because it is mandatory if one wants to drive on a public road. At the same time it would be prudent to cover the possibility of loss of own damage to the car though it is not mandatory. It is also compulsory to have a Personal Accident cover for the Owner-Driver.

Test Yourself 2

Which among the following is a secondary burden of risk?

I. Business interruption cost
II. Goods damaged cost
III. Setting aside reserves as a provision for meeting potential losses in the future
IV. Hospitalisation costs as a result of heart attack

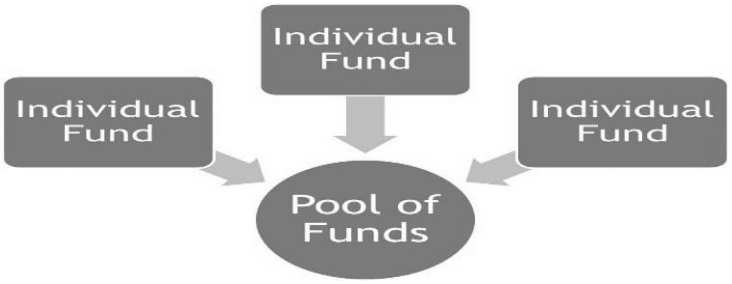
B. The Principle of Risk Pooling

Insurance companies enter into contracts with different entities – policyholders, who can be individuals or corporates. The benefits they pay to policyholders are contractual obligations. Insurance contracts are meaningful only if the Insurers are financially capable of taking over the risks and compensating for the losses, if and when they occur. The structure arises from application of the mutuality or the pooling principle.

Mutuality and Diversification are two important ways to reduce risk in financial markets. They are fundamentally different.

Diversification	Mutuality
Here the funds are spread out among various assets (eggs are placed in different baskets).	Under mutuality or pooling, the funds of various individuals are combined (all eggs are placed in one basket).
Funds flow from one source to many destinations.	Funds flow from many sources to one.

Diagram 4: Mutuality - Mutuality (Funds flow from many sources to one)



The Principle of Mutuality is what gives insurance contracts their power and uniqueness. By paying a small contribution (the premium), an insured immediately creates a large quantity of funds (corpus)that is available to him/ her in the event of a loss arising due to the insured risk. This potential corpus of money is what makes insurance unique and without any substitutes among all financial products.

C. Risk Management Techniques

One may also ask whether insurance is the right solution to all kinds of risk situations. The answer is 'No'.

Insurance is only one of the methods by which individuals may seek to manage their risks. Here they transfer the risks they face to an insurance company. However there are other methods of dealing with risks, which are explained below:

1. Risk avoidance

Reducing risk by avoiding a loss situation is known as risk avoidance. Thus one may try to avoid activities or situations, or avoid dealing with property or persons due to which there can be an exposure.

Example

i. One may avoid certain manufacturing risks by contracting out the manufacturing to someone else.

ii. One may not venture outside the house for fear of meeting with an accident or may not travel at all for fear of falling ill when abroad.

Risk avoidance is considered a negative way to handle risk. Individuals and societies need to take some risks for doing activities for their progress. Avoiding such risk taking activities would lead to losing the benefits from such activity.

2. Risk retention

One tries to manage the impact of risk and decides to bear the risk and its effects by oneself. This is known as self-insurance.

Example

A business house may decide, based on experience about its capacity to bear small losses upto a certain limit, to retain the risk with itself.

3. Risk reduction and control

This is a more practical and relevant approach than risk avoidance. It means taking steps to lower the chance of occurrence of a loss and/ or to reduce severity of its impact if such loss should occur.

Important

Measures to reduce the chance of occurrence of loss causing events are known as **'Loss Prevention'**. The measures to reduce the degree of loss, in case a loss happens, are called **'Loss Reduction'**/ Loss Minimisation.

Risk reduction involves reducing the frequency and/ or sizes of losses through:

a) **Education and training of various types of employees in proper risk practices – e.g.** (i) participating in 'fire drills'; (ii)wearing of seatbelts helmets on cars.

b) **Making Environmental changes –** like improving physical conditions - e.g. (i) installing fire alarms; (ii) spraying chemicals to kill mosquitoes to reduce spread of Malaria.

c) **Changes made in dangerous or hazardous operations,** while using machinery and equipment or in the performance of other task - e.g. (i) wearing helmets inside construction sites; (ii) wearing gloves and face shields while handling chemicals.

d) **Leading a healthy lifestyle**- helps in reduce the incidence of falling ill - e.g. (i) undergoing regular medical check-ups; (ii) practicing yoga regularly.

e) **Separation**, or spreading out various items of property into varied locations rather than concentrating them, to reduce impact of mishap in any one location - e.g. (i) storing large quantities of flammable substances at separate locations; (ii) fixing fire proof doors in hazardous areas of factories.

4. Risk financing

This refers to the provision of funds to meet losses that may occur.

a) **Risk retention through self-financing** involves bearing losses oneself as they occur. The firm assumes and finances its own risk, either through its own or borrowed funds, this is known as **self-insurance**.

b) **Risk retention within a bigger group:** If the risk is part of a bigger group, like a parent company, the risk can be retained within the larger group which would finance the losses. This can be a group formed by mutual consent as well.

c) **Risk transfer** is an alternative to risk retention. It involves transferring the responsibility for losses to another party.

Insurance is one of the major forms of risk transfer. Instead of facing the uncertainty of many of the other forms, people prefer Insurance as it provides certainty and peace of mind.

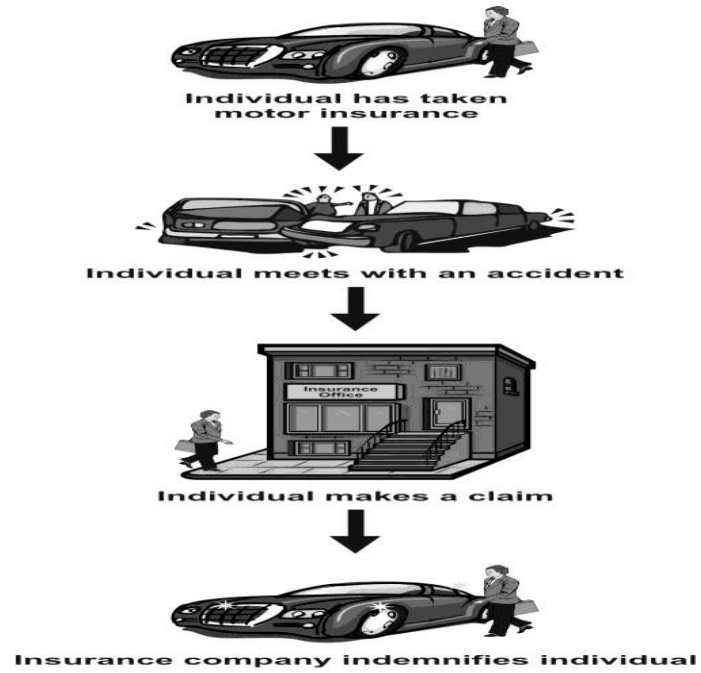
5. Insurance vs Assurance

Insurance is used for most General insurance contracts which provide protection against an event that may or may not happen, and where the loss amount can be assessed only after the event.

Assurance refers to financial coverage for extended periods or until death. In the case of life, the happening of death (the loss making event), is certain. Only the timing is uncertain. Further, it is not possible to estimate the amount of economic loss suffered when a person dies. The loss amount that is to be paid, must be fixed in advance. This is why people use the term 'Assurance' in case of Life insurance.

Though there are such subtle technical differences, the terms 'Insurance' and 'Assurance' are used interchangeably in most markets, including India. *[One of the biggest general insurers in India carries the name – New India **Assurance** Company Ltd. and no life company in India is using the word **'Assurance'** in its name!]*

Diagram 5: How insurance indemnifies the insured



Test Yourself 3

Which among the following is a method of risk transfer?

I. Bank Fixed Deposit
II. Insurance
III. Equity shares
IV. Real Estate

D. Insurance as a tool for managing risk

The term 'Risk' refers not to a loss that has actually been suffered but a loss that is likely to occur. It is thus an expected loss. The cost of this expected loss is the product of two factors:

i. The **probability** that the peril being insured against may happen, leading to the loss

ii. The **severity (impact)** or the amount of loss that may be suffered as a result.

The cost of risk would increase in direct proportion with both the **probability** and the **severity** (amount of loss). This works in different ways – (a) If the amount of loss is very high, and the probability of its occurrence is small, the cost of the risk would be low as such instances may be very few. (b) Even if the amount of

loss is small, if the probability of its occurrence is very high, the cost of the risk would be high, as there would be many such occurrences. Insurance can be seen as a powerful tool for managing one's risk. It protects one from the financial impact of losing one's assets/ wealth due to an insured loss.

Diagram 6: Considerations before opting for insurance

E. Considerations before opting for Insurance

When deciding whether to insure or not, one needs to evaluate the cost of transferring the risk [the insurance premium] against the cost of bearing it oneself. Insurance would be most required where the loss impact could be very high, but the probability (and hence the premium), is very low. E.g. (i) the chance of an earthquake; (ii) the chance of a ship sinking.

a) **Do not risk a lot for a little**: A reasonable relationship must be there between the cost of transferring the risk and the value derived.

Would it make sense to insure an ordinary ball pen?

b) **Do not risk more than one can afford to lose:** If the loss that can arise as a result of an event is large enough to cause bankruptcy, retention of the risk would not be appropriate.

If a large oil refinery gets destroyed, the owners cannot afford to bear the loss.

c) **Consider the likely outcomes of the risk carefully:** It is best to insure those assets for which the probability of occurrence (frequency) of a loss is low but the possible impact (severity), is high.

The loss of a space satellite can be so costly that it has to be insured.

Test Yourself 4

Which among the following scenarios needs insurance?

I. The sole bread winner of a family might die untimely
II. A person may lose his wallet
III. Stock prices may fall drastically

IV. A house may lose value due to natural wear and tear

F. Insurance Market Players

The Insurance Companies (Insurers) are the major players in the insurance industry. In addition to insurers, there are multiple parties who are part of the Insurance value chain. There is the Insurance Regulator, which regulates the entire market.

Intermediaries like Agents, Brokers, Banks (through Bancassurance) Insurance Marketing Firms and Point of Sales Persons are in the field of interacting with the prospects/ insured finding out their needs, giving them information about the policies available for covering their needs.

Surveyors and Loss Assessors/ Adjusters go into assessing claims and ancillary work. Third Party Administrators deal with Health and Travel Insurance Claims. Regulations provides that all intermediaries have a responsibility towards the customer.

Agents, being intermediaries between the insurance company and the insured have the responsibility to ensure all material information about the risk is provided by the insured to insurer.

Important

Duty of an Insurance Agent/ Intermediary towards the Prospect (Customer)

IRDAI regulations provides that intermediaries have certain responsibilities towards the prospect. The intermediary has a responsibility towards the insurer as well.

The regulation states that where the prospect depends upon the advice of the insurer or his agent or an insurance intermediary, such a person must advise the prospect in a fair manner. It also says that "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".

If the proposal and other connected papers are not filled by the customer, a certificate may be incorporated at the end of proposal form from the customer that the contents of the form and documents have been fully explained to him and that he has fully understood the importance of the proposed contract.

When the customer pays the insurer towards premium, the insurer is bound to issue a receipt. That is, even if the premium is paid in advance.

G. Role of Insurance in the Society

Insurance companies play an important role in a country's economic development. They ensure that the wealth of the country is protected and preserved. Some of their contributions are given below.

a) Insurance is founded on the principle of Mutuality, in which the collective power of the community is brought together to support its unfortunate few members who suffer an economic loss. There are no substitutes for insurance.

b) Insurance companies collect small amounts of premium and pool them together as huge funds. These funds are held and invested for the interests of policyholders and the benefit of the community. They are not unduly invested in speculative ventures.

c) Insurance provides the benefit of protection to numerous insured - both individuals and enterprises –against losses caused by accidents or fortuitous events. It preserves capital and releases it for development of business and industry, which helps the country's growth.

d) Insurance enables investment of capital leading to commercial and industrial development. It also helps in removing the fear, worry and anxiety associated with entrepreneurship.

e) Many Banks and Financial institutions do not advance loans on property unless it is insured against loss or damage. Many of them insist on assigning the policy as collateral security.

f) Before accepting large complicated risks, general insurers arrange for inspection of the property by qualified engineers/ other experts. They assess the risk and suggest risk management measures to reduce the risk and help in rating.

g) Insurance earns foreign exchange for the country like trade, shipping and banking services.

h) Insurers are associated with institutions engaged in fire loss prevention, cargo loss prevention, industrial safety and road safety.

i) Entrepreneurs get the confidence to invest in new or relatively unknown fields with the protection offered by Insurance.

Information

Insurance and Social Security

a) Social security is an obligation of the State. Social security schemes of the State involve the use of compulsory or voluntary insurance, as a tool of

social security. The Employees State Insurance Act, 1948 provides for **Employees State Insurance Corporation** to pay for the expenses of sickness, disablement, maternity and death for industrial employees and their families, who are covered.

b) Insurers play an important role in social security schemes sponsored by the Government such as

1. PMJJBY –Pradhan Mantri Jeevan Jyoti Bima Yojana
2. PMSBY – Pradhan Mantri Suraksha Bima Yojana
3. PMFBY- Pradhan Mantri Fasal Bima Yojana
4. PMJAY – Pradhan Mantri Jan Arogya Yojana (Ayushmaan Bharat)
5. PMVVY - Pradhan Mantri Vaya Vandana Yojana – a Pension plan
6. APY - Atal Pension Yojana

These, and other Government schemes have been benefiting the Indian society/ community.

c) In addition to supporting Government schemes, the insurance industry offers insurance covers on a commercial basis which have the ultimate objective of providing social security. The **rural insurance schemes**, operated on a commercial basis, are designed to provide social security to the rural families.

Test Yourself 5

Which of the following insurance schemes are sponsored by the Government of India?

I. PM Jan Arogya Yojana - Ayushmaan Bharat
II. PM Fasal Bima Yojana
III. PM Suraksha Bima Yojana
IV. All of the above

Summary

- Insurance is risk transfer through risk pooling.
- Commercial insurance business as practiced today started at the Lloyd's Coffee House in London.
- An insurance arrangement involves the following:
  - ✓ Asset,
  - ✓ Risk,
  - ✓ Peril,
  - ✓ Contract,
  - ✓ Insurer and
  - ✓ Insured

- When persons having similar assets, exposed to similar risks, contribute into a common pool of funds it is known as pooling.
- Apart from insurance, other risk management techniques include:
  - ✓ Risk avoidance,
  - ✓ Risk control,
  - ✓ Risk retention,
  - ✓ Risk financing and
  - ✓ Risk transfer
- The thumb rules of insurance are:
  - ✓ Do not risk more than one can afford to lose,
  - ✓ Consider the likely outcomes of the risk carefully and
  - ✓ Do not risk a lot for a little

Key Terms

1. Risk
2. Pooling
3. Asset
4. Burden of risk
5. Risk avoidance
6. Risk control
7. Risk retention
8. Risk financing
9. Risk transfer

Answers to Test Yourself

Answer 1 - The correct option is II.
Answer 2 - The correct option is III.
Answer 3 - The correct option is II.
Answer 4 - The correct option is I.
Answer 5 - The correct option is IV.

CHAPTER C-02

CORE ELEMENTS OF INSURANCE

Chapter Introduction

In this chapter, we shall learn about the various key elements and principles of insurance that govern the working of insurance.

Learning Outcomes

A. Elements of Insurance

Assets and Risk

Hazard and Peril

Risk Pooling

After studying this chapter, one should be able to:

1. Understand Assets are
2. Understand Risk, Hazards and Perils
3. Appreciate Risk Management
4. Understand Risk Pooling in insurance

A. Elements of insurance

We have seen that the process of insurance has four elements

- ✓ Asset
- ✓ Risk
- ✓ Risk pooling

Let us now look at the various elements of the insurance process in some detail.

1. Asset

Definition

An asset may be defined as 'anything that confers some benefits and has an economic value to its owner'.

An asset must have the following features:

- **Economic value:** An asset must have economic value. Value can arise in two ways.

a) Income generation: Asset may be productive and generate income.

Example

A machine used to manufacture biscuits, or a cow that yields milk, both generate income for their owner. A healthy worker is an asset to an organization.

b) Serving needs: An asset could also add value by satisfying one or a group of needs.

Example

A refrigerator cools and preserves food while a car provides comfort and convenience in transportation, similarly a body free of illness adds value to oneself and family also.

- **Scarcity and Ownership**

What about air and sunlight? Are they not assets? - **The answer is 'No'.**

Few things are as valuable as air and sunlight. We cannot live without them. Yet they are not considered as assets in the economic sense of the term.

There are two reasons for this:

- ✓ Their supply is abundant and not scarce.
- ✓ They are not owned by any one individual but are freely available to all.

This implies that an asset must satisfy two more conditions to qualify as such - its scarcity and its ownership or possession by someone.

- **Insurance of assets**

Insurance provides protection only against financial losses arising from unexpected events and not natural wear and tear, of assets due to usage over time.

We must note that **insurance cannot protect an asset from loss or damage**. An earthquake will destroy a house whether it is insured or not. The insurer can only pay a sum of money, which would reduce the economic impact of the loss.

Losses can arise in the event of breach of an agreement.

Example

An exporter would lose a great deal if the importer on the other side refused to accept the goods or defaulted on payments.

- **Life insurance**

What about our lives? There is indeed nothing as valuable to us as our own lives and those of our loved ones. Our lives can be seriously affected when subjected to an accident or an illness.

This can impact in two ways:

- ✓ Firstly there are costs of treatment of a particular disease.
- ✓ Secondly there may be loss of economic earnings, both due to death or disability.

These kinds of losses are covered by insurances of the person or personal lines of insurance. Insurance is possible for anyone who has assets that have value [i.e. which generate income or meet some needs]; the loss of which [due to fortuitous or accidental events] cause financial loss that can be [measured in terms of money].

Thus these assets are commonly referred to as subject matter of insurance in insurance parlance.

2. Risk

The second element in the process of insurance is the concept of risk. Risk can be defined as the **chance of a loss**. Risk thus refers to the likely loss or damage that can arise on account of happening of an event. [Risk is sometimes used to refer the subject matter of insurance, as well.] One do not usually expect one's house to burn or one's car to have an accident. Yet it can happen.

Examples of risks are the possibility of economic loss arising from the burning of a house or a burglary or an accident which results in the loss of a limb.

This has two implications.

i. **Firstly,** it means that that the loss may or may not happen.

ii. **Secondly,** the event, the occurrence of which actually leads to the loss, is known as a **peril**. It is the cause of the loss.

Example

Examples of perils are fire, earthquakes, floods, lightning, burglary, heart attack etc.

Natural wear and tear

It is true that nothing lasts forever. Every asset has a finite lifetime during which it is functional and yields benefits. This is a natural process and one discards or changes one's mobiles, washing machines and clothes when they are worn out. Therefore losses arising out of normal wear and tear are not covered in insurance.

Exposure to risk: Occurrence of a peril need not necessarily lead to a loss. A person staying in Mumbai does not suffer any loss due to a flood in coastal Andhra. For loss to happen the asset must be exposed to the peril. Exposure to risk alone is not enough ground for insurance compensation.

Example

A fire may break out in factory premises without causing actual damage. Insurance comes into play only if there is an actual economic (financial) loss as a result of a peril.

Degree of Risk Exposure:

Two assets may be exposed to the same peril but the likelihood of loss or the amount of loss may vary greatly. A vehicle carrying explosives can yield far greater loss from fire than tanker carrying water.

3. Risk Management

- **Extent of damage likely to be suffered**

  This is given by the degree of loss and its impact on an individual or business. On this basis one may identify three types of risk events or situations:

- **Critical**

  Where losses are of such a magnitude; that may result in total loss or bankruptcy. Losses can be critical when the accident results in significant and

severe impact, disability, damage to equipment and the environment, which may be reversible to some extent. Critical losses would include those resulting in serious financial losses, compelling a firm to borrow to continue operations.

Example: Critical

- ✓ A fire in the plant of a large multinational company at Gurgaon destroys inventory worth Rs 1 crore. The loss is heavy but not so high as to lead to bankruptcy.
- ✓ A torpedo from a pirate ship sinks an entire passenger ship but most passengers are saved.
- ✓ A major accident resulting in a kidney damage necessitating a kidney transplant operation entailing prohibitive costs

- **Catastrophic**

Catastrophic losses signify death or total disability for a large number of people, widespread loss of assets, having significant environmental impact which are practically irreversible. Catastrophic losses usually signify disasters that are sudden, widespread and unstoppable.

Example: Catastrophic

- ✓ An earthquake or flood that completely destroys a few villages
- ✓ A major fire that completely destroys a multi crore installation over a large territory
- ✓ The terrorist attack of 9/ 11 on World Trade Centre which caused injuries to a large number of people
- ✓ A pandemic like Covid – 19 causing disease to people across the globe

- **Marginal/ Insignificant**

Where the possible losses are insignificant and can be easily met from an individual or a firm's existing assets or current income without imposing any undue financial strain.

Example

- ✓ A minor car accident results in the side being slightly grazed due to which some of the paint is damaged and a fender is slightly bent.
- ✓ An individual suffering from common cold and cough.

4. Hazards and Perils

The condition or conditions which increase the probability of a loss or its severity, and thus impact(s) the risk is known as hazard. When insurers make an assessment

of the risk, it is generally with reference to the hazards to which the asset is subject.

The term hazard in insurance language refers to those conditions or features or characteristics which create or increase the chance of loss arising from a given peril. A thorough knowledge of various hazards to which a risk is exposed to is most essential for underwriting. Examples of the link between assets, peril and hazards are given below.

Asset	Peril	Hazard
Life	Cancer	Excessive Smoking
Factory	Fire	Explosive material left Unattended
Car	Car Accident	Careless driving by driver
Cargo	Storm	Water seeping in cargo and spoiling; Cargo not packaged in waterproof containers

Important

- **Types of hazards**

a) Physical hazard is a physical condition that increases the chance of loss.

Example

i. Defective wiring in a building
ii. Indulging in water sports
iii. Leading a sedentary lifestyle

b) Moral hazard refers to dishonesty or character defects in an individual that influence the frequency or severity of the loss. A dishonest individual may attempt to commit fraud and make money by misusing the facility of insurance.

Example

If one deliberately sets a fire to one's property and collects claims against losses under the policy, such claims are clearly fraudulent and could be justifiably rejected

A classic instance of moral hazard is purchasing insurance for a factory and then burning it down to collect the insurance amount or buying health insurance after onset of a major ailment.

c) **Legal hazard** is more prevalent in cases involving a liability to pay for damages. It arises when certain features of the legal system or regulatory environment can increase the incidence or severity of losses.

Example

The enactment of law governing workmen's compensation in the case of accidents can raise the amount of liability payable considerably.

A major concern in insurance is the relationship between risks and associated hazards. Assets are classified into various risk categories on this basis and the price [premiums] charged for insurance coverage would increase if the susceptibility to loss, arising as a result of the presence of associated hazards, is high.

5. Mathematical Principle of Insurance (Risk pooling)

The third element in insurance is a mathematical principle that makes insurance possible. It is known as the principle of risk pooling.

Example

Suppose there are 100000 RCC houses exposed to the risk of fire that can cause an average loss of Rs. 50000. If the chance of a house catching fire is 2 in 1000 [or 2/ 1000 = 0.002] it would mean that the total amount of loss suffered would be Rs 10000000 [= 50000x 0.002 x 100000].

If an insurer were to get the owners of each of the 100000 houses to contribute Rs 100 and if these contributions (100000 x 100 = Rs.10000000) were to be pooled into a single fund, it would be enough to pay for the loss of the unfortunate few who suffered from the fire.

To ensure that there is equity [fairness] among all those being insured, it is necessary that the houses should all be similarly exposed to the risk. In the above example risk exposure to mud houses will be different.

a) How exactly does the principle work in insurance?

It is by pooling number of risks of all the insured similarly placed and exposed to possibility of loss due to a peril that the insurer is able to assume that risk and its financial impact.

Large number of people	Paying Premium	Premium	Paying Claims to a few who suffered loss
Many people pay	Small amounts of money as Premiums	These small amounts are pooled together as a Common Pool, big enough to pay a statistically estimated number of claims	Big amounts are paid to those who suffer a loss

b) Risk pooling and the law of large numbers

The probability of damage [derived as 2 out of 1000 or 0.002 in the example above] forms the basis on which the premium is determined. The insurer would face no risk of loss if the actual experience was as expected. In such a situation the premiums of the numerous insured would be sufficient to completely compensate for the losses of those who have been affected by the peril. The insurer would however face a risk if the actual experience was more adverse than expected and the premiums collected were not sufficient to pay the claims.

How can the insurer be sure about its predictions? This becomes possible because of a principle known as the "Law of large numbers". It states that the larger the size of the pool of risks, the actual average of losses would be closer to the estimated or expected average loss.

c) Insurance Companies to remain Solvent:

If the pools of risks and the premium pools created are not sufficient to meet the liabilities towards paying claims (in case they occur), the system of risk pooling and insurance may fail. Insurers need to have sufficient money with them to honour their promises to all the members of the pool. If they have the sufficient money, they are considered solvent and if they do not have money to meet their obligations, they become insolvent.

In other words, Insurers need to keep with them some surplus money (or solvency margin) to meet unforeseen deviations between expected and actual claims situations. Solvency Ratio assesses the extent to which assets are available to cover the insurers' commitments towards future payments. Different countries use different measures to assess Solvency Ratio. In India, IRDAI has mandated that insurers are required to maintain a minimum solvency ratio of 1.5.

Example

To give a simple illustration, the probability of getting heads on a toss of the coin is 1 out of 2. But one cannot be sure to actually get 2 heads if a coin is tossed four times.

Only when the number of tosses gets very large and closer to infinity, the chance of getting heads once for every two tosses will become closer to one.

It follows that insurers can be sure of their ground only when they have been able to insure a large number of insured. An insurer who has insured only a few hundred houses, likely would be worse affected than one who has insured several thousand houses.

Important

Conditions for insuring a risk

When does it make sense to insure a risk from the insurer's point of view?

Six broad requirements for a risk to be considered insurable are given below.

i. **A sufficiently large number of homogenously [similar] exposed units** to make the losses reasonably predictable. This follows from the **law of large numbers**. Without this it would be difficult to make predictions.

ii. **Loss produced by the risk must be definite and measurable**. It is difficult to decide the compensation if one cannot say for sure that a loss has occurred and how much it is.

iii. **Loss must be fortuitous or accidental**. It must be the result of an event that may or may not happen. The event must be beyond the control of insured. No insurer would cover a loss that is intentionally caused by the insured.

iv. **Sharing of losses of the few by many** can work only if a small percentage of the insured group suffers loss at any given period of time.

v. **Economic feasibility:** The cost of insurance must not be high in relation to the possible loss; otherwise the insurance would be economically unviable.

vi. **Public policy:** Finally the contract should not be contrary to public policy and morality.

Test Yourself 1

Which one of the following does not represent an insurable risk?

I. Fire
II. Stolen goods
III. Burglary

IV. Loss of goods due to ship capsizing

Summary

a) The process of insurance has four elements (asset, risk, risk pooling and an insurance contract).

b) An asset may be anything that confers some benefit and is of economic value to its owner.

c) A chance of loss represents risk.

d) Condition or conditions that increase the probability or severity of the loss are referred to as hazards.

e) The mathematical principle, that makes insurance possible is known as principle of risk pooling.

Key terms

a) Asset
b) Risk
c) Hazard
d) Risk pooling
e) Offer and acceptance
f) Lawful consideration

Answers to Test Yourself

Answer 1 - The correct option is II.

CHAPTER C-03
PRINCIPLES OF INSURANCE

Chapter Introduction

In this chapter, we discuss the principles, based on which the mechanism of insurance works.

a) Utmost Good Faith or "Uberrima fides" is defined as involving “a positive duty to voluntarily disclose, accurately and fully, all facts material to the risk being proposed, whether requested or not". All insurance contracts are based on the principle of Uberrima Fides

b) The existence of ‘Insurable Interest’ is an essential ingredient of every insurance contract and is considered as the legal pre-requisite for insurance.

c) Indemnity ensures that the insured is compensated to the extent of his loss on the occurrence of the contingent event.

d) Subrogation means the transfer of all rights and remedies, with respect to the subject matter of insurance, from the insured to the insurer.

e) The principle of contribution implies that if the same property is insured with more than one insurance company, the compensation paid by all the insurers together cannot exceed the actual loss suffered.

f) Proximate cause is a key principle of insurance and is concerned with how the loss or damage actually occurred and whether it is indeed as a result of an insured peril.

Learning Outcomes

A. Uberrima fides

B. Insurable Interest

C. Proximate Cause

D. Indemnity

E. Subrogation

F. Contribution

A. Uberrima Fides

Insurance contracts have various special features that are discussed below:

1. Utmost Good Faith or *'Uberrima Fides'*

Utmost Good Faith or "Uberrima fides", one of the fundamental principles of an insurance contract, is defined as "a positive duty to voluntarily disclose, accurately and fully, all facts material to the risk being proposed, whether requested or not".

All commercial contracts are based on Good Faith in so much as there shall be no fraud or deceit when giving information or doing the transaction. The rule observed here is that of **"Caveat Emptor"** which means **Buyer Beware**. The parties to the contract are expected to examine the subject matter of the contract and so long as one party does not mislead the other and the answers are given truthfully, there is no question of the other party avoiding the contract.

Insurance contracts stand on a different footing as the subject matter of the contract is intangible and cannot be easily known to the insurer. Again, there are many facts, which may be known only to the proposer. The insurer has to rely entirely on the proposer for information. Hence the proposer has a legal duty to disclose all material information about the subject matter of insurance to the insurers. That is, the insured should not make any misrepresentation regarding any fact that is material for the insurance contract. This higher obligation of full representation and full disclosure in respect of Insurance contracts makes them contracts of Utmost Good Faith.

If Utmost Good Faith is not observed by either party, the contract may be avoided by the other. This follows from the logic that no one should be allowed to take advantage of his own wrong especially while entering into a contract of insurance.

a) Material fact has been defined as a fact that would affect the judgment of an insurance underwriter in deciding whether to accept the risk and if so, the rate of premium and the terms and conditions. The insured has an obligation to fully and accurately disclose all facts that are material to an insurance contract.

Whether an undisclosed fact was material or not would depend on the circumstances of the individual case and could be decided ultimately only in a court of law. The insured **has to disclose** facts that affect the risk.

Material facts denote the information which enables the insurers to decide:

- ✓ Whether they will accept the risk?

- ✓ If so, at what rate of premium and subject to what terms and conditions?

This legal duty of utmost good faith arises under common law. The duty applies not only to material facts which the proposer knows, but also extends to material facts which he ought to know. There is a corresponding duty of the insurer not to withhold any information about the policy to the insured.

Example

The following are some examples of material information that the proposer should disclose while making a proposal:

i. **Life Insurance:** One's own medical history, family history of hereditary illnesses, habits like smoking and drinking, absence from work, age, hobbies, financial information like income details of proposer, pre-existing life insurance policies, occupation etc.

ii. **Fire Insurance:** Construction, location/ situation of risk and usage of building, age of the building, nature of goods in premises etc.

iii. **Marine Insurance:** Description of goods, method of packing and mode of transit etc.

iv. **Motor Insurance:** Description of vehicle, date of purchase and Regional Registration authority etc.

v. **Health Insurance:** Pre-existing disease, age etc.

b) **When a Fact becomes 'Material': Some types of material facts that one** needs to disclose are those indicating that the particular risk represents a greater exposure than can be normally expected.

Example

Hazardous nature of cargo being sent by a ship, past history of illness, past history burglary of a house.

i. Existence of policies taken from all insurers and their present status

ii. All questions in the proposal form or application for insurance are considered to be material, as these relate to various aspects of the subject matter of insurance and its exposure to risk. They need to be answered truthfully and be full in all respects.

The following are some scenarios wherein material facts need not be disclosed.

Information

a. **Material Facts that need not be disclosed:** Unless there is a specific enquiry by underwriters, the proposer has no obligation to disclose facts like:

i. **Measures implemented to reduce the risk. E.g.:** The presence of a fire extinguisher

ii. **Facts which the insured does not know or is unaware of. E.g.:** An individual, who had high blood pressure but was not aware about the same at the time of taking the policy, cannot be charged with non-disclosure of this fact.

iii. **Which could be discovered, by reasonable diligence.** It is not necessary to disclose every minute material fact. The underwriters must be conscious enough to ask for the same if they require further information. E.g.: When insuring a textile shop one does not need to specifically say that some of the synthetic clothes in the shop are highly combustible.

iv. **Matters of law**: Everybody is supposed to know the law of the land. **E.g.:** Municipal laws about storing of explosives

v. **About which insurer appears to be indifferent (or has waived the need for further information)**

In such cases, the insurer cannot later disclaim responsibility on grounds that the answers were incomplete.

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b. **Duty to Disclose:** In the case of insurance contracts, the duty to disclose is present throughout the entire period of negotiation until the proposal is accepted and a Life Insurance policy is issued.

Once the Life Insurance policy is accepted, there is no further need to disclose any material facts that may come up during the term of the policy.

Example

Mr. Rajan has taken a Life insurance policy for a term of fifteen years. Six years after taking the policy, Mr. Rajan has some heart problems and has to undergo some surgery. Mr. Rajan does not need to disclose this fact to the insurer.

[However, if the policy is in a lapsed condition because of failure to pay the premiums when due and the policy holder seeks to revive the policy contract and bring it back in force, he may, at the time of such revival, have the duty to disclose all facts that are material and relevant, as though it is a new policy.]

In the case he has Health Insurance, at the time of renewing the policy, Mr. Rajan has to inform the insurer about this health issue.

Similarly, in the case of General Insurance, at the time of renewing the Fire policy for an enterprise/ factory, the insured has to inform the insurer if a change was made in the occupancy of the building.

At the time of renewing the Hull policy for a ship, the insured has to inform the insurer if the ship was modified to carry a different type cargo; say, hazardous chemicals instead of pulses.

c. **Situations of Non-Disclosure** may arise when the insured is silent about material facts because the insurer has not raised any specific enquiry. Such situations may also arise through evasive answers to queries raised by the insurer.

   Often non-disclosure may be inadvertent (meaning that it may be made without one's knowledge or intention) or because the proposer thought that a fact was not material. In such a case it is innocent.

   When a fact is intentionally suppressed it is treated as concealment. Here, there is the intent to deceive.

d. **Misrepresentation:** Any statement made during negotiation of a contract of insurance is called representation. A representation may be a definite statement of fact or a statement of belief, intention or expectation. It is expected that the statement must be substantially correct. Representations that concern matters of belief or expectation must be made in good faith. Misrepresentation is of two kinds:-

   i. **Innocent Misrepresentation** relates to inaccurate statements, which are made without any fraudulent intention.

   ii. **Fraudulent Misrepresentation** on the other hand refers to false statements that are made with deliberate intent to deceive the insurer or are made recklessly without due regard for truth.

   An insurance contract generally becomes void when there is a clear case of concealment with intent to deceive, or when there is fraudulent misrepresentation.

   Amendments (March, 2015) to Insurance Act, 1938 have provided certain guidelines about the conditions under which a policy can be called into question for fraud. The new provisions are as follows

e. **Fraud:** The term "Fraud" has been specified under **Section 45 (2) of the Insurance Act (amended in 2015).** Accordingly, a Life Insurance policy can be called in question on the ground of Fraud by the insurer only within a time period and not later. However, Insurers can do so only within three years from (a) the date of issuance of the policy (b) the date of commencement of risk, (c) the date of revival of the policy or (d) the date of the rider to the policy, whichever is later.

The insurer needs to communicate the reasons on which the policy is questioned in writing to the insured or his/ her legal representatives, nominees or assignees.

The expression "fraud" means any act committed by the insured, with the intent to deceive the insurer or to induce the insurer to issue an insurance policy. It is also provided that in case the policyholder is not alive, the onus of disproving fraud, lies upon the beneficiaries.

B. Insurable interest

The existence of 'insurable interest' is an essential ingredient of every insurance contract and is considered as the legal pre-requisite for insurance.

Three essential elements of insurable interest:

i. There must be property, right, interest, life or potential liability capable of being insured.

ii. Such property, right, interest, life or potential liability must be the subject matter of insurance.

iii. The insured must bear a legal relationship to the subject matter such that he stands to benefit by the safety of the property, right, interest, life or freedom of liability. By the same token, he must stand to lose financially by any loss, damage, injury or creation of liability.

Let us see how insurance differs from a gambling or wager agreement.

a) Gambling and insurance: Unlike a card game, where one could win or lose, a fire can have only one consequence – loss to the owner of the house.

The owner takes insurance to ensure that the loss suffered is compensated for in some way.

In other words, Insurable Interest is the interest the insured has in the subject matter of insurance. Insurable interest makes an insurance contract valid and enforceable under the law.

Example

If Mr. Patel has brought a house with a mortgage loan of Rs 15 lakhs from a bank and he has repaid 12 lakhs of this amount, the bank's interest would be only to the tune of the balance three lakhs which is outstanding.

Thus the bank also has an insurable interest financially in the house for the balance amount of loan that is unpaid and would ensure that it is made a co insured in the policy

Mr. Patel owns a house for which he has taken a mortgage loan of Rs. 15 lakhs from a bank. Ponder over the questions below:

- ✓ Does he have an insurable interest in the house?
- ✓ Does the bank have an insurable interest in the house?
- ✓ What about his neighbour?

Mr. Dass has a family consisting of spouse, two kids and old parents. Ponder over the below questions:

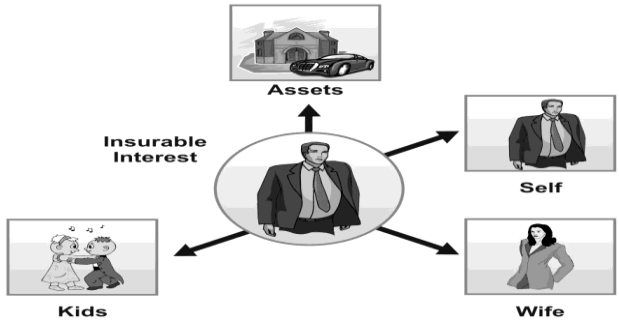
- ✓ Does he have an insurable interest in their well-being?
- ✓ Does he stand to financially lose if any of them are hospitalised?
- ✓ What about his neighbour's kids? Would he have an insurable interest in them?

It would be relevant here to make a distinction between the subject matter of insurance and the subject matter of an insurance contract.

The subject matter of insurance relates to property being insured against, which has an intrinsic value of its own.

The subject matter of an insurance contract on the other hand is the insured's financial interest in that property. It is only when the insured has such an interest in the property that he/ she has the legal right to insure. The insurance policy in the strictest sense covers not the property per se, but the insured's financial interest in the property.

Diagram 1: Insurable interest according to common law



b) Time when insurable interest should be present: In life insurance, insurable interest should be present at the time of taking the policy. In general insurance, insurable interest should be present both at the time of taking the policy and at the time of claim with some exceptions like marine policies in which case it must exist at the time of claim.

In case of fire and accident insurance, insurable interest should be present both at the time of taking the policy and at the time of loss.

In case of health and personal accident insurance apart from self, family can also be insured by the proposer since he/ she stands to incur financial losses if the family meets with an accident or undergoes hospitalisation. However, in marine cargo insurance, insurable interest is required only at the time of loss as the ownership of the goods would change hands when the cost is paid, which can happen during the period of transit.

C. Proximate Cause

Proximate cause is a key principle of insurance and is concerned with how the loss or damage actually occurred and whether it is as a result of an insured peril. If the loss has been caused by the insured peril, the insurer is liable. If the immediate cause is an insured peril, the insurer is bound to make good the loss, otherwise he is not. This application of principle is practically more in respect of non-life insurance claims.

When a loss occurs, there can often be a series of events leading up to the incident and so it is sometimes difficult to determine the nearest or proximate cause. Under this rule, the insurer looks for the predominant cause which sets into motion the chain of events producing the loss. This may not necessarily be the last event that immediately preceded the loss i.e. it is not necessarily an event which is closest to, or immediately responsible for causing the loss. For example, a fire might cause a water pipe to burst. Despite the resultant loss being water damage, the fire would still be considered the proximate cause of the incident. Other causes may be classified as remote causes, which are separate from proximate causes. Remote causes may be present but are not effectual in causing an event.

Definition

Proximate cause is defined as the active and efficient cause that sets in motion a chain of events which brings about a result, without the intervention of any force started and working actively from a new and independent source.

How does the principle of proximate cause apply to insurance contracts? Since insurance provides for payment of a death benefit, regardless of the cause of death, the principle of proximate cause would not usually apply. However many insurance contracts may also have an accident benefit add-on wherein an additional sum assured is payable in the event of accidental death. In such a situation, it becomes necessary to ascertain the cause - whether the death occurred as a result of an accident. The principle of proximate cause would become applicable in such instances.

To understand the principle of proximate cause, consider the following situation:

Example

Scenario 1: Mr. Ajay had parked his car in the garage and gone on a long vacation. Six months later, when he came back and started the car, he noticed that the air-conditioning of the car was not working. Mr. Ajay filed a claim with the insurance company for the cost of repairing the air-conditioning and the insurance company rejected the claim. The reason given by the insurance company was that the damage was due to the 'normal wear and tear' of the car and the air-conditioning system, which was an excluded peril in the insurance policy. Mr Ajay approached the Court and after examining the survey report which said that the car was 12 years old and neither the car nor the air-conditioning had been serviced/ repaired during the previous 6 years, the damage was due to the 'normal wear and tear' and the insurance company was not liable to pay the claim.

Scenario 2: Mr. Pinto, while riding a horse, fell on the ground and had his leg broken, he was lying on the wet ground for a long time before he was taken to hospital. Because of lying on the wet ground, he had fever that developed into pneumonia, finally dying of this cause. Though pneumonia might seem to be the immediate cause, in fact it was the accidental fall that emerged as the proximate cause and the claim was paid under personal accident insurance.

There are certain losses which are suffered by the insured as a result of fire but which cannot be said to be proximately caused by fire. In practice, some of these losses are customarily paid by business under fire insurance policies.

Example of such losses can be –

- ✓ Damage to property caused by water used to extinguish fire
- ✓ Damage to property caused by fire brigade in execution of their duty
- ✓ Damage to property during its removal from a burning building to a safe place

Test Yourself 1

Mr. Pinto contracted pneumonia as a result of lying on wet ground after a horse riding accident. The pneumonia resulted in death of Mr. Pinto. What is the proximate cause of the death?

I. Pneumonia
II. Horse
III. Horse riding accident
IV. Bad luck

D. Indemnity

The Principle of Indemnity is applicable to Non-life insurance policies. **It means that the policyholder, who suffers a loss, is compensated so as to put him or her in the same financial position as he or she was before the occurrence of the loss event**. The insurance contract guarantees that the insured would be indemnified or compensated up to the amount of loss and no more.

The philosophy is that one should not make a profit through insuring one's assets and recovering more than the loss. The insurer would assess the economic value of the loss suffered and compensate accordingly.

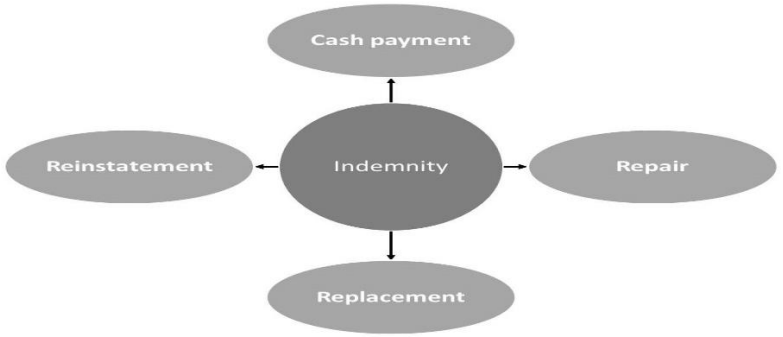
Example

Ram has insured his house, worth Rs. 10 lakhs, for the full amount. He suffers loss on account of fire estimated at Rs. 70,000. The insurance company would pay him an amount of Rs. 70,000. The insured can claim no further amount.

The indemnity to be paid would depend on the type of insurance one takes.Indemnity might take one or more of the following modes of settlement:

- ✓ Cash payment
- ✓ Repair of a damaged item
- ✓ Replacement of the lost or damaged item
- ✓ Reinstatement (Restoration). E.g. Rebuilding a house destroyed by fire

Diagram 2: Indemnity



a) **Agreed Value:** However, there is some subject matter whose value cannot be easily estimated or ascertained at the time of loss. For instance, it may be difficult to put a price in the case of family heirlooms or rare artefacts. Similarly in marine insurance policies it may be difficult to estimate the extent of loss suffered in a ship accident half way around the world.

   In such instances, a principle known as the 'Agreed Value' is adopted. The insurer and insured agree on the value of the property to be insured, at the

beginning of the insurance contract. In the event of total loss, the insurer agrees to pay the agreed amount of the policy. This type of policy is known as **"Agreed Value Policy"**.

b) Underinsurance: Consider a situation now where the property has not been insured for its full value. One would then be entitled to indemnity for loss only in the same proportion as one's insurance.

Suppose the house, worth Rs. 10 lakhs has only been insured for a sum of Rs. 5 lakhs. If the loss on account of fire is Rs. 60,000, one cannot claim this entire amount. It is deemed that the house owner has insured only to the tune of half its value and he is thus entitled to claim just 50% [Rs. 30,000] of the amount of loss. This is known as underinsurance.

In most types of non-life insurance policies, which deal with insurance of property and liability, the insured is compensated to the extent of actual amount of loss i.e. the amount of money needed to replace lost or damaged property at current market prices less depreciation.

E. Subrogation

Subrogation means the transfer of all rights and remedies with respect to the subject matter of insurance, from the insured to the insurer. Subrogation follows from the principle of Indemnity. Hence, it is often called a 'corollary' of Indemnity.

In other words, if an insured suffers a loss and the loss has been indemnified by the insurer, the insured's right to get compensated by any third party for that loss, would get shifted to the insurer. Note that the amount of damage that can be collected by the insurance company is only to the extent of the amount paid by the insurance company.

Important

Subrogation: It is the process an insurance company uses to recover claim amounts paid to a policy holder from a negligent third party.

Subrogation can also be defined as surrender of rights by the insured to an insurance company that has paid a claim against the third party.

Example

Mr. Kishore's household goods were being carried in Sylvain Transport service. They got damaged due to driver's negligence, to the extent of Rs. 45,000 and the insurer paid an amount of Rs. 30,000 to Mr. Kishore. The insurer stands subrogated to the extent of only Rs. 30,000 and collect that amount from Sylvain Transports.

In case the matter went into litigation and the Court directed Sylvain Transports to pay Rs.35,000 as compensation to Mr. Kishore, he is liable to pay the insurer the claim amount of Rs 30,000 under the subrogation clause, and to keep the balance amount of Rs 5,000 with himself.

The Subrogation Clause prevents the insured from collecting more than the loss - from the insurance company and from any third party. Subrogation arises only in case of contracts of indemnity and not against benefit policies like Life Insurance Policy or Personal Accident Policy.

Example

Mr. Suresh dies in an air crash. His family is entitled to collect the full Sum Assured of Rs 50 lakhs from the insurer who has issued a Personal Accident Policy plus the compensation paid by the airline, say, Rs 15 lakhs.

F. Contribution:

Like Subrogation, 'Contribution' also follows from the Principle of Indemnity. Hence, it is also called a 'corollary' of Indemnity. Contribution is a principle that arises in general insurance contracts. It tells us how the liability is to be met when the insured has taken insurance from more than one insurer. Contribution implies that if the same property is insured with more than one insurance company, the compensation paid by all the insurers together cannot exceed the actual loss suffered. The policy holder can claim from each of the insurers only a portion of the loss in proportion to the amount insured with each.

Example: If Mr Srinivas has taken a fire policy on his house with two insurance companies, with both of whom, he insured for the full value of Rs.12 lakhs. Suppose a fire breaks out and he suffers a loss of Rs 3 lakhs as a result, he can claim an amount of Rs 1.5 lakhs from each of the insurers.

The Principle of Contribution applies only to indemnity policies. It does not arise in the case of Life Insurance, because there is no upper limit that can be placed on the losses suffered when there is a loss of life.

Test Yourself 2

Which among the following is an example of coercion?

I. Ramesh signs a contract without having knowledge of the fine print
II. Ramesh threatens to kill Mahesh if he does not sign the contract
III. Ramesh uses his professional standing to get Mahesh to sign a contract
IV. Ramesh provides false information to get Mahesh to sign a contract

Test Yourself 3

Which among the following options cannot be insured by Ramesh?

I. Ramesh's house
II. Ramesh's spouse
III. Ramesh's friend
IV. Ramesh's parents

Test Yourself 4

What is the significance of the principle of contribution?

I. It ensures that the insured also contributes a certain portion of the claim along with the insurer
II. It ensures that all the insured who are a part of the pool, contribute to the claim made by a participant of the pool, in the proportion of the premium paid by them
III. It ensures that multiple insurers covering the same subject matter; come together and contribute the claim amount in proportion to their exposure to the subject matter
IV. It ensures that the premium is contributed by the insured in equal instalments over the year.

Summary

- The special features of insurance policies include:
    i. Uberrima fides,
    ii. Insurable interest,
    iii. Proximate cause,
    iv. Indemnity
    v. Subrogation
    vi. Contribution

Key Terms

1. Non-Disclosure
2. Misrepresentation
3. Material facts
4. Agreed Value
5. Under Insurance

Answers to Test Yourself

Answer 1 - The correct option is III
Answer 2 - The correct option is II
Answer 3 - The correct option is III
Answer 4 - The correct option is III

CHAPTER C-04

FEATURES OF INSURANCE CONTRACTS

Chapter Introduction

In this chapter, we discuss the elements that govern the working and special features of an insurance contract.

Learning Outcomes

A. Legal Aspects of Insurance Contracts

B. Elements of a valid contract

C. Premium payment in advance

D. Solicitation

E. Enabling Provisions like Grace Period and Free-look

A. Insurance contracts – Legal aspects and special features.

The chapter also deals with the legal aspects and special features of an insurance contract.

1. The Insurance Contract

Insurance involves a contractual agreement in which the insurer agrees to provide financial protection against certain specified risks for a price or consideration known as the premium. The contractual agreement takes the form of an insurance policy.

2. Legal aspects of an insurance contract

This section looks at some features of an insurance contract and considers the legal principles that govern insurance contracts in general.

Important

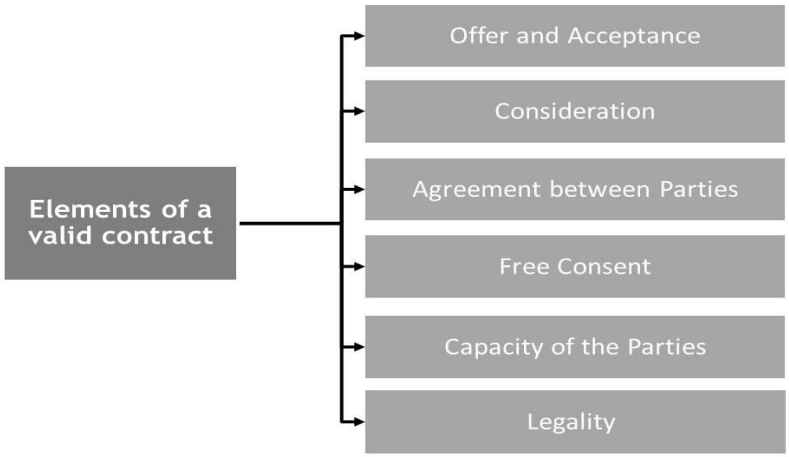
A contract is an agreement between parties, enforceable at law. The provisions of the Indian Contract Act, 1872 govern all contracts in India, including insurance contracts.

An insurance policy is a contract entered into between two parties, viz., the company, called the **insurer**, and the policy holder, called the **insured** and fulfils the requirements enshrined in the Indian Contract Act, 1872.

Diagram 1: Insurance contract

B. Elements of a valid contract

Diagram 2: Elements of a valid contract



The elements of a valid contract are:

1. Offer and acceptance

When one person signifies to another his willingness to do or to abstain from doing anything with a view to obtaining the assent of the other to such act, he is said to make an offer or proposal. Usually, the offer is made by the proposer, and acceptance made by the insurer.

When a person to whom the offer is made signifies his assent thereto, this is deemed to be an acceptance. Hence, when a proposal is accepted, it becomes a promise. The acceptance needs to be communicated to the proposer which results in the formation of a contract.

When a proposer accepts the terms of the insurance plan and signifies his/ her assent by paying the deposit amount, which, on acceptance of the proposal, gets converted to the first premium, the proposal becomes a policy. If any condition is put, it becomes a counter offer. The policy bond becomes the evidence of the contract.

2. Consideration

This means that the contract must contain some mutual benefit for the parties. The premium is the consideration from the insured, and the promise to indemnify, is the consideration from the insurers.

3. Agreement between the parties (Consensus Ad-Idem)

Both the parties, the insurer and the policyholder, should agree to the same thing in the same sense. In other words, there should be "**consensus ad-idem**" between both parties.

4. Free consent

There should be free consent while entering into a contract. Consent is said to be free when it is not caused by

- ✓ Coercion/ By Force
- ✓ Undue influence
- ✓ Fraud
- ✓ Misrepresentation
- ✓ Mistake

When consent to an agreement is caused by coercion, fraud or misrepresentation, the agreement is voidable.

5. Capacity of the parties

Both the parties to the contract must be legally competent to enter into the contract. The policyholder must be legally an adult at the time of signing the proposal and should be of sound mind and not disqualified under law. For example, minors cannot enter into insurance contracts.

6. Legality

The object of the contract must be legal, for example, no insurance can be had for illegal acts. Every agreement of which the object or consideration is unlawful is void. The object of an insurance contract is a lawful object.

Also one's entering into an insurance contract should be done out of one's free will, without any kind of force, fear or mistake.

C. Paying Premium in Advance

As per Indian laws, Insurers are not allowed to assume risk unless they receive the premium in advance. In other words, insurance protection cannot be sold on credit basis in India.

Section 64 VB of the Insurance Act 1938 states, "No risk to be assumed unless premium is received in advance". No insurer shall assume any risk unless and until the premium is received in advance or is guaranteed to be paid or a deposit is made in advance in the prescribed manner. This is an important feature of the insurance industry in India.

The Insurance Rules, 1939, provide certain exceptions to this condition of advance payment of premium, in respect of particular categories of insurances. Section 59 of the Insurance Rules allows accepting premiums in instalments in respect of Sickness Insurance, Group Personal Accident Insurance Medical Benefits Insurance and Hospitalisation Insurance Schemes, subject to certain conditions. Section 59 of the Insurance Rules allows relaxations for policies issued to Government and semi-Government bodies, Fidelity Guarantee Insurance policies covering Government and semi-Government employees, Workmen's Compensation policies, Cash in Transit policies, and some other categories of insurances subject to certain conditions.

Solicitation

Insurance has always been regarded as something to be purchased after a proper understanding the product and not just bought/ sold. Hence, insurance is to be 'solicited' or asked for by the customer. Traditionally, insurers declare that "Insurance is the subject matter of solicitation". To elucidate, insurance is not a ready-made product like a packet of biscuits or a bar of chocolate to be bought/ sold outright. Customers have to discuss their insurance needs with a person qualified for the same and based on professional advice, the right insurance product is to be purchased. The Insurance product has to be understood and the offering most suited to the specific needs and requirements of the customer in terms of the policy coverage, exclusions, terms and conditions, is to be considered.

'Solicitation' is usually initiated when an insurer or an authorised intermediary approaches a prospect with a view to understand his/ her insurance needs and provides professional advice in selecting appropriate insurance products. The prospect solicits the proper solution and provides all requisite details to the advisor. As per regulations of IRDAI, **Insurance Agents** are appointed by an insurer for the purpose of engaging in the solicitation process and procuring insurance business, including business relating to the continuance, renewal or revival of policies of insurance. Only authorised employees of insurance companies, and specified persons of licensed intermediaries, who are trained and authorised for the purpose can be part of the process of solicitation and sales of insurance.

D. Enabling Provisions

1. Grace Period

Grace period is the specified period of time immediately following the premium due date during which a payment can be made to renew or continue

a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received. The days of grace are computed from the next day after the due date fixed for payment of the premium.

For **Life insurance**, if there is no grace period, a single delay in payment can lead to a policy lapse. This would be detrimental for the policyholder, the insurer and the insurance industry in general. IRDAI Regulations allow a grace period of 15 days is applicable in case of Monthly mode of Premium collection and 30 days in other modes.

In respect of **Health insurance** also, certain number of days as grace period is allowed for renewal of individual health policies. This period depends on the policy of the company and the product offered. All continuity benefits are maintained if the policy is renewed within the grace period. However Claims, if any, during the break period will not be considered. As per IRDAI Regulations, the grace period is 15 days in case of Monthly mode of Premium collection and 30 days in other modes.

Motor Policies are usually valid for a period of one year and have to be renewed before the due date. Grace period for paying the premium do not apply. In case a comprehensive policy lapses for more than 90 days, the accrued No Claim Bonus (NCB) benefit would also be lost.

In the interest of smooth operation of affairs during the Covid-19 pandemic, IRDAI permitted the following relaxations:

i. In case of Life insurance policies, Insurers were asked to enhance the grace period by additional 30 days if desired by the policyholders.

ii. In case of Health insurance policies, Insurers were told to condone delays in renewal up to 30 days without deeming such condonation as a break in policy. Insurers were requested to contact the policyholders well in advance to avoid discontinuance in coverage.

iii. As regards Motor Vehicle Third Party Insurance policies that fell due for renewal and premiums could not be paid due to the Covid-19 situation, IRDAI allowed a grace period till 15th May, 2020.

2. Free-Look Period introduced by "IRDAI"

Insurance contracts are drafted by the insurer, and the other party has to adhere to it if he/ she wants the insurance. Such contracts where someone has to accept the contract as it is and cannot make any change to it are legally called Contracts of Adhesion. Because of this one-sided situation, the Courts always make insurers

liable for any ambiguity or confusion that may arise in interpreting these terms and conditions.

To reduce this one-sidedness and make insurance transactions more customer friendly, IRDAI has built into its regulations a consumer-friendly provision called 'Free-Look Period' whereby, if the customer is not satisfied with any term and conditions of the policy, he/ she can return it and get a refund. This provision whereby policyholders are given the option of cancelling the policy within 15 days (30 days, in case of electronic policies and policies sourced through distance mode) after receiving the policy document, in case they are not satisfied with the policy, has been introduced for Life Insurance and Health Insurance policies (having a tenure of at least one year). The company has to be intimated in writing and the premium is refunded less, proportionate risk premium for the period of cover, expenses and charges.

Cancellation of Policies: When policies are cancelled by the insurer, the proportion of the premium corresponding to the expired period of insurance is charged/ retained by the insurer and the proportion corresponding to the unexpired period of insurance is returned to the insured, provided no claim has been paid under the policy. Such proportionate calculation of premium is called Pro-rata premium.

When annual policies are cancelled by the insured, insurers usually charge/ retain premiums at a higher rate and refund premiums at higher rates, instead of calculating pro-rata premiums. This would prevent anti-selection against the insurers and take care of the initial expenses of the insurer. Such rates are disclosed as part of the terms and conditions of the insurance contract and referred to as Short period scales.

Important

i. **Coercion** - Involves pressure applied through criminal means.

ii. **Undue influence** – using one's position to dominate the will of another person, to obtain an undue advantage over that person.

iii. **Fraud** – inducing another to act on a false belief that is caused by a representation one does not believe to be true. It can arise either from deliberate concealment of facts or through misrepresenting them.

iv. **Mistake** - Error in one's knowledge or belief or interpretation of a thing or event. This can lead to an error in understanding and agreement about the subject matter of the contract.

Test Yourself 1

Which among the following cannot be an element in a valid insurance contract?

I. Offer and Acceptance
II. Coercion
III. Consideration
IV. Legality

Summary

i. Insurance involves a contractual agreement in which the insurer agrees to provide financial protection against specified risks for a price or consideration known as the premium.
ii. A contract is an agreement between parties, enforceable at law.
iii. The elements of a valid contract include:
    - Offer and acceptance
    - Consideration,
    - Consensus ad-idem,
    - Free consent
    - Capacity of the parties and
    - Legality of the object

Key Terms

1. Offer and Acceptance
2. Lawful consideration
3. Consensus ad idem

Test Yourself 2

During the Free-look period, if the policyholder, who has bought a policy through an Agent, disagrees to any of its terms and conditions, he/ she can return it and get a refund subject to the following conditions:

I. He/ she can exercise this option within 15 days of receiving the policy document
II. He/ she has to communicate to the company in writing
III. The premium refund will be adjusted for proportionate risk premium for the period on cover, expenses incurred by the insurer on medical examination and stamp duty charges
IV. All the above

Test Yourself 3

If the policyholder has bought a policy and does not want it, he/ she can return it during the _____ period, and get a refund.

I. Free evaluation
II. Free-look
III. Cancellation
IV. Free trial

Answers to Test Yourself

Answer 1 - The correct option is II.
Answer 2 - The correct option is IV.
Answer 3 - The correct option is II.

CHAPTER C-05

UNDERWRITING AND RATING

Chapter Introduction

In this chapter you will learn the basics of underwriting and rating. You will learn about the different methods of dealing with hazards in the process of rating of risks. You will be able to appreciate the common aspects of underwriting, product approval and rating.

Learning Outcomes

A. Basics of Underwriting

B. Product Filing with IRDAI

C. Basics of Ratemaking

D. Rating factors

After studying this chapter, you should be able to:

1. Define the basics of underwriting
2. Understand the basics of product approvals in India
3. Appreciate rating factors and the importance of ratemaking

A. Basics of Underwriting

In the previous chapters, we have seen that the concept of insurance involves managing risk through pooling. Insurers create a pool consisting of premiums that are made by several individuals/ commercial/ industrial firms/ organizations.

This process of understanding risks, classifying risks, identifying which category they fall into, **deciding whether to accept the risk or not** and if so, how much premium the insurer would require to accept the risk and whether any extra conditions are to be imposed on the risk - all these are part of **underwriting**.

It is also important to know what rate is to be charged and how the rates are made.

Definition

Underwriting is the process of determining whether a risk offered for insurance is acceptable, and if so, at what rates, terms and conditions.

Underwriting comprises the following steps:

i. Assessment and evaluation of hazard and risk in terms of frequency and severity of loss

ii. Formulation of policy coverage and terms and conditions

iii. Fixing of rates of premium

The underwriter decides on whether or not to accept the risk

The next step would be to decide the **rates, terms and conditions** under which the risk is to be accepted.

Underwriting skills are acquired through a continuous learning process involving adequate training, field exposure and deep insights. To be a fire insurance underwriter one needs to have a good knowledge of the likely causes of fire, impact of fire on various physical goods and property, the process involved in an industry, geography, climatic conditions etc.

Similarly a marine insurance underwriter must be aware about port/ road conditions, problems encountered by cargo/ goods in transit or storage, ships and their seaworthiness and so on.

A health underwriter needs to understand the risk profile of the insured, age, medical aspects, fitness levels and family history and measure the effect of each factor affecting the risk.

Sources of information for underwriting

The first stage in any numerical (or statistical) analysis is the collection of data. When pricing a risk, an underwriter should gather as much information as possible to aid accurate assessment.

Sources of information are:

i. **Proposal form or underwriting presentation**

ii. **Risk surveys**

iii. **Historic claims experience data:** For some classes of business, such as personal and motor lines, underwriters often utilise historic claims experience data to provide an indication of the likely future claims experience, and to arrive at a suitable premium**.**

Underwriting, equity and business sustainability

The need for careful underwriting and risk classification in insurance arises from the simple fact that **all risks are not equal**. Each risk thus needs to be appropriately assessed and priced in accordance with the likelihood of loss occurrence and severity.

Since all risks are not equal, it would not be proper to ask all those who are to be insured, to pay equal premium. **The purpose of underwriting is to classify risks so that, depending on their characteristics and degree of risk posed, an appropriate rate of premium may be charged.** It is important for the underwriter to ensure that the risk evaluation is done properly and the premium charged is neither too low to cover the risk nor too high to make it non-competitive.

The main features of underwriting are as follows

i. To **identify risk** based upon the characteristics

ii. To **determine the level** of risk presented by the proposer

The objectives of underwriting are achieved, in short, by deciding the level of acceptability, adequacy of premium and other terms.

B. Product Filing with IRDAI

Every Insurance product needs to be filed with IRDAI for approval before it is offered for sale. IRDAI allots a Unique Identification number (UIN) for every insurance product. Once products are introduced in the market, there are guidelines to be followed for withdrawing the product as well.

1. The Regulator asks for a clear commitment by the Board of the insurer that it is willing to accept the risks in the policy and agrees to pay the claims. It also

asks the insurer to commit that the policy wordings are fair to the customer and that the prices are decided on a scientific basis.

2. The insurer should plan for the possibility of withdrawal of the products in the future and the options that would be available to the policyholder on such withdrawal of the product.

3. The withdrawn product shall not be offered to the prospective customers.

C. Basics of Ratemaking

Insurance is based on transfer of risk to the insurer. By purchasing an insurance policy, the insured is able to reduce the impact of financial losses arising from the peril against which the property is insured. The Insurer needs to adopt a process of calculating a price to cover the future cost of insurance claims and expenses, including a margin for profit. This is known as **ratemaking.**

A rate is the price of a given unit of insurance. For example, a rate may be expressed as Rs.1.00 per mile (per thousand) sum assured for earthquake coverage. Each rate is established after looking at past trends and changes in the current environment that may affect potential losses in the future.

Note that rates are not the same as premiums.

Premium = (Sum Insured) x (rate)

Example

Taking an example of health insurance, numerical or percentage assessments are made on each component of the risk. Factors like age, race, occupation, habits etc. are examined and scored numerically based on predetermined criteria.

The amount of premium to be paid by each depends on a rate, which is determined by two factors;

- ✓ The probability of loss due to a loss event (caused by an insured peril) and
- ✓ The estimated amount of loss that may arise due to the loss event

Example

Assume the average amount of a house being destroyed by fire is Rs 1,00,000.

The probability of the loss of a house being destroyed by fire 1 out of 100 [or 0.01]. That is, the experience is that out of a 100 insured houses, one house gets destroyed by fire.

The expected average loss would be Rs.1,00,000 x 0.01 = Rs. 1000.

So, Insurers would need to charge a minimum of Rs.1000 to insure a house of Rs.1,00,000 value.

How can the insurer ensure that the pool is sufficient to compensate for the losses that are actually incurred?

As seen earlier, the whole mechanism of insurance involves pooling of many similar risks so that the probability of the number of losses (frequency) as well as the extent of loss (severity) becomes predictable. This principle, referred to as 'the law of large numbers' states that as the sample size grows, the results come closer to the expected value. Insurance companies need to sell more policies to more and more people to make their expectations/ predictions work.

An example is that if a coin is tossed, the chances of getting 'heads' or 'tails' is 50:50. However, if the coin is tossed only once, the result can be 100% heads and 0% 'tails' or 0% 'heads' and or 100% tails. However, if one tosses a coin many times, the chance of the average count of 'heads' and 'tails' being 100% and 0% reduces and will get closer to 50:50.

Example

In the field of property insurance, the chances of a wooden structure catching fire are more than stone structures; hence, a higher premium is required to insure the wooden structure.

The same concept applies to Life and Health Insurance also. An individual suffering from high blood pressure or diabetes has higher chances of suffering a heart attack.

Test Yourself 1

Identify the two factors that affect insurance ratemaking.

I. Probability and severity of risk
II. Source and nature of risk
III. Source and timing of risk
IV. Nature and impact of risk

1. Determining the rate of premium

The pure rate of premium is arrived at on the basis of past loss experience. Therefore, statistical data regarding past losses is most essential for purposes of calculating rates. To fix the rates, it is necessary to give a 'mathematical value' to the risks.

Example

If loss experience of a large number of motor cycles is collected for a period of say 10 years, we will get the sum total of the losses resulting from damage to the vehicles. By expressing this amount of loss as percentage of the total value of

motor cycles we can fix the 'mathematical value' of the risk. This may be expressed in the formula given below:

M = $\frac{\text{L X 100}}{\text{V}}$	L refers to the sum total of the losses and V to the total values of all the motor cycles and M to average loss percentage.

Let us suppose that:

- ✓ The Value of a motor cycle: Rs. 50,000/ -
- ✓ Loss experience: Out of 1000 motor cycles, 50 motor cycles get stolen over 10 years
- ✓ On an average, 5 motor cycles become total losses due to theft every year

Applying the formula, the result will be:

Losses per year (Rs. 50,000 X 5) = Rs. 2,50,000

Total Values of 1000 motor vehicles (Rs. 50,000 X 1000) **= Rs. 5,00,00,000**

This means that average loss percentage per vehicle (L/ V) x 100= [2,50,000/ 5,00,00,000] x 100 = 0.5%

Therefore the rate of premium that a motor cycle owner pays is half a percent of Rs. 50,000/ - i.e. Rs. 250/ - per year. This is called the **'Pure' premium,** also known as 'Burning Cost'.

At the rate of Rs. 250 per motor cycle, Rs. 2.5 lakhs is collected which is paid out in claims on total losses of 5 vehicles.

If the pure premium, which is arrived above, is collected it would constitute a fund which will be sufficient only to pay for losses.

In the example above we can see that there is no surplus. But insurance operations also involve costs of administration (expenses of management) and costs of procurement of business (agency commission). It is also necessary to provide a margin for unexpected heavy losses.

Finally, since insurance is transacted on a commercial basis, like any other business, it is necessary to provide for a margin of profit which is a return on the capital invested in the business.

Therefore, the 'pure premium' is suitably loaded or increased by adding percentages to provide for expenses, reserves and profits.

The final rate of premium will consist of the following components:

- ✓ Loss payments
- ✓ Loss expenses (e.g. survey fees)
- ✓ Agency commission
- ✓ Expenses of management

- ✓ Margin for reserves for unexpected heavy losses e.g. 7 total losses against 5 expected
- ✓ Margin for profits

By taking all the relevant rating factors into consideration, one can ensure the rates are adequate, excessive or unfairly discriminatory as between risks of similar type and quality.

Test Yourself 2

What is pure premium?

I. Premium sufficiently big enough to pay for losses only
II. Premium applicable to marginal members of the society
III. Premium after loading for administrative costs
IV. Premium derived from the most recent loss experience period

2. Deductible

'Deductible' or 'excess' is a cost-sharing provision between an insurer and insured. Deductibles provide that only the claims in excess of a particular threshold are payable by the insurer. In other words, the insurer will not be liable for claims below a specified level. The level or the threshold would be set as a fixed amount, or a percentage or even as a specified period of time (when it is called time-excess.) In case of health policies, there could be a condition that claims would be payable only if the hospitalization is beyond a specified number of days/ hours. Deductibles are not used in life policies.

In products such as property, motor and home insurances, deductibles are predetermined amounts that the insured must bear towards an indemnity claim. Deductibles can be compulsory for some policies or voluntary. Insurers generally charge lower premiums when the insured voluntarily opt for higher deductibles. An agent must examine how specific deductibles work and inform the insured whether the deductible is applicable on a 'per year' or 'per event' basis.

There are various reasons for having deductibles. Corporate customers covering factories, multiple cargo consignments, large groups of employee, public liability exposures etc. and having huge amounts of Sum Insured, may prefer to bear small claims themselves and avoid the documentation to prove claims. For example, a large factory owner paying lakhs or rupees as premium may not be bothered about a minor repair cost of a machine amounting to around Rs.2,000.

Some type of policies may need the insured also to bear some part of the loss to ensure that he/ she takes due care. For instance, health insurers may insist on a deductible so that insured would not overspend on costly hospital rooms just because insurance is there. Some Insurers also may not prefer spending time on

processing small claims. Also, in certain situations, insurers may not want to get exposed to the financial stress caused by accumulation of a large number of small losses at one location. For example, a small flood in an industrial estate area can cause many low value claims from all the warehouses in the area.

Franchise: Franchise refers to a threshold set, usually as a percentage of the sum insured, below which no claim is admissible, as in the case of deductibles. However, when the claim amount is beyond the franchise limit, the entire claim is admissible by the insurer. In other words, franchise determines the minimum threshold of the insurance companies' financial responsibility. Franchise will apply to the policy in the same way and for the same reasons as a deductible in case of claims below the threshold, but in the event of a claim exceeding the franchise, the full amount of the loss will be paid.

D. Rating factors

The relevant elements that are used to add up the rates and make the rating plan are referred to as **rating factors**. Insurers use 'rating factors' to determine the risk and to decide the price they will charge.

- ✓ The Insurer uses his assessments to establish a base rate.
- ✓ The Insurer then adjusts this rate with discounts applied for positive features such as superior fire protection on property risk and loadings applied for adverse features such as presence of inflammable materials in the premises.
- ✓ In Life Insurance the usual practice is to apply loading for adverse health, habits, heredity or occupational factors.

Key Terms

- Deductibles
- Franchise

Answers to Test Yourself

Answer 1 - The correct option is I.

Answer 2 - The correct option is I.

CHAPTER C-06
CLAIMS PROCESSING

Chapter Introduction

The insured get to taste the benefit of insurance only when they are affected by losses. The entire insurance industry is sensitive to the losses faced by insured and try to settle the claims that arise as amicably as possible and as fast as possible.

Learning Outcomes

A. Loss Assessment and Claim settlement

B. Categories of claim

C. Arbitration

D. Other dispute resolution mechanisms

After studying this chapter, you should be able to understand:

1. Claims settlement
2. Importance of claim procedures

A. Loss Assessment and Claim settlement

Claims Assessment (Loss Assessment) is the process of determining whether the loss suffered by the insured is covered by the insurance policy, i.e. the loss does not fall under any exclusion and there is no breach of warranty.

Settlement of claims has to be based on considerations of fairness. For an Insurance company, expeditious settlement of claim is the benchmark of efficiency for its services. Each company has internal guidelines about time taken in claims processing, which its employees follow.

This is generally known by the term "Turnaround time" (TAT). Some insurers have also put in place, facility for the insured to check claim status online from time to time. Some insurance companies have also set up claims hub for speedy processing of claims.

Important aspects in an insurance claim

Although most companies are bound by their TAT it is important for an agent to know the aspects that are looked into for settling a claim. Six of the most important aspects for Non-life claims are given below.

i. Whether the loss causing event is within the scope of the policy

ii. Whether the insured has complied with his part of the policy conditions

iii. Compliance with warranties. The survey report would indicate whether or not warranties have been complied with.

iv. Observance of utmost good faith by the proposer, during the currency of the policy.

v. On the occurrence of a loss, the insured is expected to act as if he is uninsured. In other words, he has a duty to take measures to minimise the loss.

vi. Determination of the amount payable. The amount of loss payable is subject to the sum insured. However, the amount payable will also depend upon the following:

- ✓ The extent of the insured's insurable interest in the property affected
- ✓ The value of salvage
- ✓ Application of underinsurance
- ✓ Application of contribution and subrogation conditions

In the matter of claims relating to life insurance, the insurer checks whether

1) Conditions of policy have not been breached
2) Utmost good faith has been followed and

3) No material facts have been concealed fraudulently.

B. Categories of claim

Insurance Claims fall into the following categories:

i. Standard claims

These are claims which are clearly within the terms and conditions of the policy. The assessment of claim is done keeping in view scope and the sum insured opted for and other methods of indemnity laid down for various classes of insurance.

ii. Condition of average or average clause

This is a condition in some policies which penalises the insured for insuring his property at a sum insured less than its actual value known as underinsurance. In the event of a claim the insured gets an amount that is proportionately reduced from his actual loss in accordance to the amount underinsured. Such situations occur more in the case of non-life insurance.

iii. Act of God perils - Catastrophic losses

Natural perils like storm, cyclone, flood, inundation, and earthquake are termed as “Act of God” perils. These perils may result in losses to many policies of insurer in the affected region. Surveyors are appointed for assessment of certain categories of non-life insurance claims.

In such major and catastrophic losses, the surveyor is asked to proceed to the loss site immediately for an early assessment and loss minimisation efforts. Simultaneously, insurers’ officials also visit the scene of loss particularly when the amount involved is large. The purpose of the visit is to obtain an immediate, on the spot idea of the nature and extent of loss.

Preliminary reports are also submitted if the surveyors face some problems in regards to the assessment and may desire guidance and instructions from insurers who are thus given an opportunity to discuss the issues with the insured, if necessary.

iv. On account payment

In Non-life insurance claims, apart from preliminary reports, interim reports may be submitted from time to time where repairs and/ or replacements are made over a long period. Interim reports also give the insurer an idea of the development of assessment of loss. It also helps in recommendation of "On account payment" of the claim if desired by the insured. This usually happens if the loss is large and the completion of assessment may take some time.

If the claim is found to be in order, payment is made to the claimant and entries made in the company records. Appropriate recoveries are made from the co-

insurers and reinsurers, if any. In some cases, the insured may not be the person to whom the money is to be paid.

v. Discharge vouchers

Settlement of the claim is made only after obtaining a discharge under the policy. A sample of discharge receipt for claims (under personal accident insurance) for injuries is worded along the following lines: (may vary from company to company)

Name of the Insured
Claim No. Policy No.
Received from the Company Ltd.
The sum of Rs. _____ in full and final settlement of compensation due to me/ us on account of injuries sustained by me/ us due to accident which occurred on or about the_____ I/ we give this discharge receipt to the Company in full and final settlement of all my/ our claim present or future arising directly or indirectly in respect of the said claim.
Date (Signature)

vi. **Post settlement action**

The action taken after settlement of the non-life claim in relation to underwriting varies from one class of business to another.

Example

Sum insured under a fire policy stands reduced to the extent of the amount of claim paid. However, it can be reinstated on payment of pro-rata premium, which is deducted from the amount of claim paid.

On payment of the capital sum insured under a personal accident policy, the policy stands cancelled.

Similarly, payment of a claim under individual fidelity guarantee policy automatically terminates the policy.

vii. Salvage

Salvage generally refers to damaged property. On payment of loss, the salvage belongs to insurers.

Example

When motor claims are settled on total loss basis, the damaged vehicle is taken over by insurers. Salvage can also arise in other non-life insurances like fire claims, marine cargo claims etc.

Salvage is disposed of according to the procedure laid down by the companies for the purpose. Surveyors, who have assessed the loss, will also recommend methods of disposal.

viii. Recoveries

After settlement of claims, the insurers under subrogation rights applicable to insurance contracts, are entitled to the rights and remedies of the insured and to recover the loss paid from a third party who may be responsible for the loss under respective laws applicable. Thus, insurers can recover the loss from shipping companies, railways, road carriers, airlines, port trust authorities etc.

Example

In the case of non-delivery of consignment, the carriers are responsible for the loss. Similarly, the port trust is liable for goods which are safely landed but subsequently missing. For this purpose, a letter of subrogation duly stamped is obtained from the insured before the settlement of the claim.

ix. Disputes related to claims

Despite best efforts, there could be delay in payment, non-payment (repudiation) of the claim, or the claim being admitted for a lesser amount, which might lead to dissatisfaction and dispute between Insurer and the insured.

Apart from these, the most common reasons, to name a few are:

- ✓ Non-disclosure of material facts
- ✓ Lack of coverage
- ✓ Loss caused by excluded perils
- ✓ Lack of adequate sum insured
- ✓ Breach of warranty
- ✓ Issues regarding quantum due to underinsurance, depreciation, etc.

All this could cause considerable grief to the insured at a time when he is already suffering from financial constraints arising due to losses. In order to reduce his sufferings, grievance redressal and dispute handling procedures are well laid out in the policy itself. Policies of fire or property have the condition of "Arbitration" in the policy itself.

C. Arbitration

Arbitration is a method of settling disputes arising out of contracts. Arbitration is done in accordance with the provisions of the Arbitration and Conciliation Act, 1996. The normal method of enforcing a contract or settling a dispute there under would be to go to a court of law. Such litigation, however, involves considerable delay and expense. The Arbitration Act allows the parties to submit disputes

under a contract to the more informal, less costly and private process of arbitration.

Arbitration may be done by a single arbitrator or by more than one, chosen by the parties to the dispute themselves. In the event of a single arbitrator, the parties have to agree about that person. Many commercial insurance policies contain an **arbitration clause** stating that disputes will be subject to arbitration. Fire and most miscellaneous policies also contain an arbitration clause which provides that if the liability under the policy is admitted by the company, and there is a difference concerning the quantum to be paid, such a difference must be referred to arbitration. Normally the arbitrator's decision is considered final and binding on both the parties.

The wording of the condition varies from policy to policy. Generally, it provides as follows:

i. The dispute is submitted to the decision of a single arbitrator to be appointed by the parties, or in the event of any disagreement between them upon appointment of a single arbitrator, to the decision of two arbitrators each appointed by the parties.

ii. These two arbitrators shall appoint an Umpire, who presides at the meetings. The procedure during these meetings resembles that of a court of law. Each party states his case, if necessary, with the help of a counsel and witnesses are examined.

iii. If the two arbitrators do not agree on a decision, the matter is submitted before the Umpire, who makes his award.

iv. Costs are awarded at the discretion of the arbitrator/ arbitrators or Umpire making the award.

Disputes relating to question of liability are to be settled through litigation.

Example

If the insurers contend that the loss is not payable because it is not covered under the policy, the matter has to be decided by a Court of Law. Again, if the insurers refuse to pay the claim on the ground that the policy is void because it was obtained through fraudulent non-disclosure of material facts (breach of the legal duty of 'utmost good faith'), the issue has to be resolved through litigation.

D. Other dispute resolution mechanisms

As per IRDAI regulations, all policies have to mention about the grievance redressal mechanism available to the insured in the event the insured is dissatisfied with the service of the insurer for any reason.

In case of claims under personal lines of business, a dissatisfied insured can approach Insurance Ombudsman. The procedure is discussed in detail in Chapter 9. The Office details of Insurance Ombudsman are given in the policy. Decision of Ombudsman is binding on Insurer but not on insured.

Matters like the financial authority and the limitations of Ombudsmen are also discussed in detail in Chapter 9.

Test Yourself 1

Which of the following activities would not be categorised under professional settlement of claims?

I. Seeking information relating to the cause of the loss
II. Approaching the claim with a prejudice
III. Ascertaining whether the loss was a result of an insured peril
IV. Quantifying the amount payable under the claim

Answers to Test Yourself

Answer 1 - The correct option is II.

Key Terms

Turn Around Time
Salvage
Recoveries
Claims Assessment

CHAPTER C-07
DOCUMENTATION

Chapter Introduction

In the insurance industry we deal with a large number of forms and documents. These are required for the purpose of bringing clarity in the relationship between the insured and the insurer. In this chapter, we shall deal with the various documents that are involved at the proposal stage and their significance.

Learning Outcomes

Understand the Importance of:
A. Prospectus
B. Proposal form
C. Know Your Customer (KYC) documents

After learning this Chapter you will be able to:

- Understand proposal stage documentation and its importance
- Familiarize with the purposes of the Prospectus
- Understand the importance of the Proposal form
- Appreciate Anti-Money Laundering (AML), Know Your Customer (KYC) norms and the important documents, commonly applicable for practically all policies
- Importance of Age Proof and acceptable documents.

A. Prospectus

Prospectus is a proposal stage document. The prospectus is a formal legal document used by insurance companies that provides details about the product. It can mean a document issued by the insurer in physical, electronic or any other format to sell or promote insurance products. For this purpose, Insurance products would also include the add-on covers/ riders offered, if any. The prospectus is like an introductory document which helps the prospective policyholder to get familiar with the company's products.

As per IRDAI's (Protection of Policyholders' Interests) Regulations, 2017 the prospectus should contain all facts that are necessary for a prospective policyholder to make an informed decision regarding purchase of a policy. It should contain the following for each plan of insurance:

- The Unique Identification Number (UIN) allotted by the Authority for the concerned insurance product
- The extent of insurance cover
- The Scope of benefits/ entitlements – guaranteed and non-guaranteed
- Warranties, exclusions/ exceptions of the insurance cover with explanations
- The terms and conditions of the insurance cover
- Description of the contingency or contingencies to be covered by insurance
- The class or classes of lives or property eligible for insurance under the terms of such prospectus
- Whether the plan is participative or non-participative

The allowable Add-on covers (also called Riders in Life insurance) on the product and their benefits are also stated.

Other important information which a Prospectus includes:

1. Any differences in covers and premium. E.g. for different age groups or for different entry ages
2. Renewal terms of the policy
3. Terms of cancellation of policy under certain circumstances
4. The details of any discounts or loading applicable under different circumstances
5. The possibility of any revision or modification of the terms of the policy including the premium

6. Any incentives to reward policyholders for early entry, continued renewals, favourable claims experience etc. with the same insurer.
7. Prospectus shall necessarily contain the product UIN allotted by IRDAI
8. IRDAI Regulations mandate that Prospectus shall contain a copy of Section 41. This section prohibits any direct or indirect inducement to any person for buying a new insurance, continuing or renewing any kind of insurance relating to lives or property in India, including any rebate of the whole or part of the commission payable on the policy.

In particular the prospectus informs the proposer about the availability of facility for nomination.

Test Yourself 1

Which of the following it not usually part of the insurance prospectus?

I. Name of Ombudsman
II. Date of Scope of benefits
III. The Entitlements
IV. The Exceptions

B. Proposal Form

The insurance policy is a legal contract between the insurer and the policyholder. As required for any contract, it has a proposal and its acceptance.

The "Proposal form" is the application document that is used for making a proposal. It is a form to be filled in by the proposer in written or electronic or any other format approved by the Authority. It contains all information required by the insurer to decide whether to accept or reject to cover the risk. In case the risk is accepted, the insurer can on the basis of this information, decide the rates, terms and conditions of the cover to be granted.

The Principle of Utmost Good Faith and the Duty of Disclosure of material information begin with the Proposal Form for insurance. The proposer must provide all information correctly and completely as this document becomes the basis of granting insurance and any wrong or concealed information could result in denial of claim.

This duty to disclose continues beyond the proposal stage even after finalizing the insurance contract. That is, any material change that happens anytime during the period of insurance needs to be disclosed in non-life policies.

Information collected from the Proposal Form during the course of solicitation of an insurance policy or issuance of an insurance policy are confidential and should

not be shared with any third party. Where a proposal deposit is refundable to a prospect for any reason, the same shall be refunded within 15 days from the date of underwriting decision on the proposal.

As per IRDAI guidelines, it is the duty of the insurer to furnish to the insured, free of charge, within 30 days of the acceptance of a proposal, a copy of the proposal submitted by the Insured. The agent is expected to keep track of these timelines, follow up internally and communicate with the prospect/ insured as and when required by way of customer service.

a) Proposal Form - Details

The proposal form is first stage of documentation through which the insured informs the insurer:

- ✓ Who he/ she is
- ✓ What kind of insurance he/ she needs
- ✓ Details of what he/ she wants to insure and
- ✓ For what period of time
- ✓ Details of the risk (E.g., for Life and Health insurances – details of health or any ailments suffered are to be given)
- ✓ Details would include the monetary value proposed on the subject matter of insurance and all **material facts** connected with the proposed insurance.

In other words, the Proposal form collects details on the proposer's identity such as name, father's name, address and other identifying inputs. To determine the true identity of their customers, documents like address proof, PAN card, photographs etc. are collected with the proposal.

In respect of Life and Health insurances, details of the proposers' family members (including parents) indicating their longevity, status of health and ailments suffered by any of them are collected. Depending on the product, the medical details of the life proposed for insurance, personal characteristics and his/ her personal history of disease may also be asked for.

Details of the monetary value proposed on the subject matter of insurance and the material facts connected with the proposed insurance would be collected for many lines of insurance.

The insurance advisor's recommendations including the reasons for such recommendation may also be part of the proposal form. There would be a declaration that the recommended policy's details have been fully explained to the proposer and the latter has acknowledged the same.

A Proposal form may have the following Sections starting with details of the Insurer, the Agent, the details of the product, the Sum Assured, the mode of payment of premiums etc. The form would also contain the signature of the proposer, as proof of the fact that he/ she has filled up the form and has submitted the proposal.

Other details asked for are the Proposer's name, date of birth, contact details, marital status, nationality, names of parents and spouse, educational qualifications, habits and ID Proof, family particulars, employment details, bank details, name of nominee/ appointee; details of existing insurance and reasons for opting for the policy.

Depending on the Product, medical details of the life proposed for insurance, personal characteristics and his/ her personal history of disease may be asked for.

Aspects related to the personal financial planning of the life being proposed including his/ her work span, projected income and expenses, as well as needs for savings and investment, health, retirement and insurance may also be enquired about.

The Agents recommendations including the reasons for such recommendation may also be part of the proposal form. In compliance to the IRDAI regulations mentioned above, the Agent would make a declaration that the recommended policy's details have been fully explained to the proposer and the latter has acknowledged the same.

Proposal forms are printed by insurers usually with the insurance company's name, logo, address and the class/ type of insurance/ product that it is used for. It is customary for insurance companies to add a printed note in the proposal form, though there is no standard format or practice in this regard.

b) Declaration in the Proposal Form

Insurance companies usually add a declaration at the end of the proposal form to be signed by the proposer. This ensures that the insured takes the pain to fill up the form accurately and has understood the facts given therein, so that at the time of a claim there is no scope for disagreements on account of misrepresentation of facts. Such declaration converts the common law principle of utmost good faith to a contractual duty of utmost good faith.

Example

Examples of such declarations are:

'I/ We hereby declare and warrant that the above statements are true and complete in all respects and that there is no other information which is relevant to the application for insurance that has not been disclosed to you.'

'I/ We agree that this proposal and the declarations shall be the basis of the contract between me/ us and (insurer's name).'

Test Yourself 2

Which of the following is not relevant in respect of a Proposal form?

I. Utmost Good-faith
II. Amount expected to be claimed
III. Duty to Disclose material facts
IV. Confidentiality of details given

Some examples of such notes are:

'Non-disclosure of facts material to the assessment of the risk, providing misleading information, fraud or non-co-operation by the insured will nullify the cover under the policy issued'.

'The company will not be on risk until the proposal has been accepted by the Company and full premium paid'.

C. Know Your Customer (KYC) Norms

Anti-Money Laundering and KYC Norms

Money Laundering is the process by which criminals transfer funds to conceal the true origin and ownership of the proceeds of criminal activities. Money laundering processes are used by criminals to make funds obtained through illegal activities appear legal money. In the process, they try to cover up the criminal origin of the money and make it appear valid.

Criminals attempt to use financial services, including banks and insurance, to launder their money. They make transactions using false identities, for example, by purchasing some form of insurance and then managing to withdraw that money and then disappearing once their purpose is served. Governments across the world, including India constantly try to prevent such money laundering attempts.

Definition

Money laundering is the process of bringing illegal money into an economy by hiding its illegal origin so that it appears to be legally acquired. The Government of India launched the PMLA, 2002 to rein in money-laundering activities.

The Prevention of Money Laundering Act (PMLA), 2002 came into effect from 2005 to control money laundering activities and to provide for confiscation of property derived from money-laundering.

The Anti-Money Laundering guidelines issued by IRDAI soon after have indicated suitable measures to determine the true identity of customers requesting for insurance services, reporting of suspicious transactions and proper record keeping of cases involving or suspected of involving money laundering. It is necessary to be vigilant and ensure, right at the beginning of the contract that it is not intended to be a tool for money laundering of any sort.

The Prevention of Money Laundering Act, 2002 (PMLA) was been brought into force by the Government of India with effect from 1st July 2005. As per the Act, every banking company, financial institution (which includes Insurance companies) and intermediary shall have to maintain a record of all the transactions prescribed under the PMLA. Accordingly, IRDAI issued the Guidelines on Anti-Money laundering/ Counter Financing of Terrorism (AML/ CFT) 31st March 2006.

Know your customer is the process used by a business to verify the identity of their clients. Banks and insurers are increasingly demanding their customers provide detailed information to prevent identity theft, financial fraud and money laundering. The objective of KYC guidelines is to prevent financial institutions from being used by criminal elements for money laundering activities.

Insurers, hence, need to determine the true identity of their customers. Agents should ensure that proposers submit the proposal form along with the following as part of the KYC procedure:

i. Proof of identity – driving license, passport, voter ID card, PAN card, Photographs etc.

ii. Proof of address – driving license, passport, telephone bill, electricity bill, bank passbook etc. Different documentation are prescribed for individuals, corporates, partnership firms, trusts and foundations

iii. Income proof documents and financial status, esp. in case of high-value transactions

iv. Purpose of insurance contract

a) Age Proof – for Personal Lines

While dealing with person related insurances like Life, Health, Personal Accident, etc. Insurance companies use age as an important factor to determine the risk profile of the insured. In life business, as age assumes great importance, life insurers used to follow more detailed norms of age related documentation. [However, the Government, the Reserve Bank of India and the IRDAI are becoming stricter on following KYC norms.]An important part of the underwriting process is admission of age, after verifying the proof of age.

i. Standard Age Proofs

There are two types of age proofs that insurers come across as evidence of age. Valid age proofs may be standard or non-standard.

- ✓ Standard **age proofs** are normally issued by a public authority, like birth certificate issued by a municipality or other government body, school leaving certificate, passport etc.
- ✓ Non-standard, when a standard age proof is not available (not to be accepted readily)

Some documents considered as standard age proofs are:

i. School or college certificate
ii. Birth certificate extracted from municipal records
iii. Passport
iv. PAN card
v. Service register
vi. Identity card in case of defence personnel
vii. Marriage certificate issued by appropriate authority

ii. Non-standard age proofs

When standard age proofs like the above are not available, the life insurer may allow submission of a non-standard age proof. Some documents considered as non-standard age proofs are:

i. Horoscope
ii. Ration card
iii. An affidavit by way of self-declaration
iv. Certificate from village panchayat

Test Yourself 3

Which of the following is not acceptable as valid Age Proof?

I. Birth certificate extracted from municipal records

II. Birth Certificate issued by Member of Legislative Assembly

III. Passport

IV. PAN Card

Answers to Test Yourself

Answer 1 -The correct option is I.
Answer 2 - The correct option is II.
Answer 3 – The correct option is II.

Summary

- Prospectus is a formal legal document used by insurance companies that provides details about the product.
- The application document used for making the proposal is commonly known as the 'proposal form'.
- Some documents considered as standard age proofs include school or college certificate, birth certificate extracted from municipal records etc.
- Insurers need to determine the true identity of their customers. KYC documents like address proof, PAN card and photographs etc. need to be collected as a part of the KYC procedure.

Key Terms

1. Prospectus
2. Proposal form
3. Moral hazard
4. Know your Customer (KYC)
5. Age Proof
6. Standard and non-standard age proofs
7. Free-look period

CHAPTER C-08
CUSTOMER SERVICE

Chapter Introduction

In this chapter you will learn the importance of customer service. You will learn the role of agents in providing service to customers. You will also learn how to communicate and relate with customers.

Learning Outcomes

A. Customer service – General concepts

B. Insurance Agent's role in providing customer service

C. Communication skills in customer service

D. Non-verbal communication

E. Ethical behavior

After studying this chapter, you should be able to:

Understand the importance of customer service

1. Describe quality of service
2. Examine the importance of service in the insurance industry
3. Discuss the role of an insurance agent in providing good service
4. Explain the process of communication
5. Demonstrate the importance of non-verbal communication
6. Recommend ethical behaviour

A. Customer Service – General concepts

1. Why Customer Service?

Customers are the most important part of any industry and no enterprise can afford to treat them indifferently. The role of customer service and relationships is important in the service sector and more so for insurance.

Every enterprise has a goal to delight its customers. This can be explained by examining how buying insurance differs from buying a car.

A car can be seen, touched, test driven and experienced, whereas the Insurance of the car is just a promise to pay if there is loss or damage to the car due to an accident. This promise is intangible – it cannot be seen, touched or experienced.

While the customer of the car will be able to understand and experience the car easily, the customer of insurance can evaluate and experience the insurance protection that he buys only when a loss happens and the insurance company settles the claim. All customers do not get the chance to experience this. In insurance, when such a situation arises, if the service exceeds expectations, the customer would be delighted.

2. Quality of service

It is necessary for insurance companies and their personnel, which includes their agents, to render high quality service and delight the customer.

But what is high quality service? What are its attributes?

The well-known SERVQUAL approach to service quality of Zeithaml, Parasuraman and Berry highlights 5 major indicators of service quality:

a) **Reliability**: The ability to perform the promised service dependably and accurately is considered the most important indicator of good service. It is the foundation on which trust is built.

b) **Responsiveness**: Refers to the willingness and ability of service personnel to help customers and provide prompt response to the customer's needs. It may be measured by indicators like speed, accuracy, and attitude while giving the service.

c) **Assurance**: Refers to the knowledge, competence and courtesy displayed by an employee or agent in understanding and meeting the needs of a customer, thus conveying trust and confidence.

d) **Empathy**: Empathy is described as the human touch. It is reflected in the caring attitude and individualised attention provided to customers.

e) **Tangibles**: Represent physical environmental factors like location, layout and cleanliness as also the sense of professionalism that a customer feels when contacting a service provider. First impressions last long.

3. Customer service and insurance

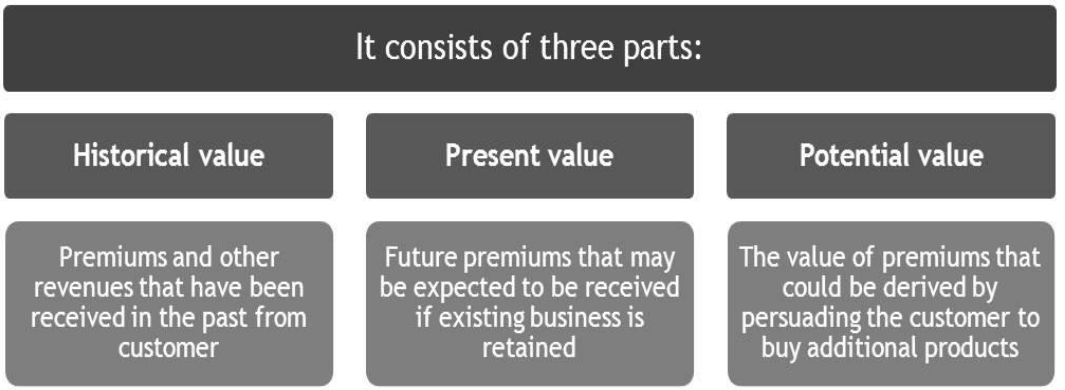
Leading sales producers in the insurance industry state that the secret of reaching the top and staying there is in getting the patronage and support of a large number of existing clients with whose help the business gets built. These clients are a source of commissions from renewal of existing contracts. These can be a valuable source for acquiring new customers.

One great mantra of success in insurance selling is to be able to convert one's customers into one's clients. Customers are those who buy a product. Clients, on the other hand are people with whom an agent relates for life, who continue to buy from him/ her as also help and possibly, support him/ her in reaching out to and selling to other customers.

Clients are built by working with deep commitment to serving one's customers. To understand how keeping a customer happy benefits the agent and the company, one should understand the concept of Customer's Lifetime Value.

Customer Lifetime Value may be defined as the sum of economic benefits that can be derived from building a sound relationship with a customer over a long period of time.

Diagram 1: Customer Lifetime Value



An agent who renders service and builds close relationships with her customers, builds goodwill and brand value, which helps in expanding the business.

Test Yourself 1

What is meant by customer lifetime value?

I. Sum of costs incurred while servicing the customer over his lifetime

II. Rank given to customer based on business generated
III. Sum of economic benefits that can be achieved by building a long term relationship with the customer
IV. Maximum insurance that can be attributed to the customer

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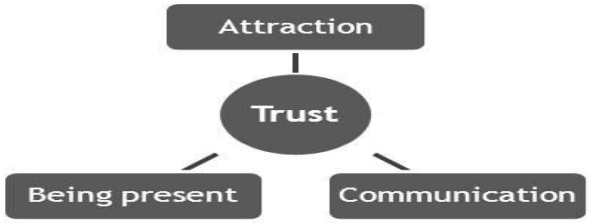
4. Customer Relationships and Service

While customer service is a key element in creating satisfied and loyal customers, it is also necessary to build a strong relationship with them. A Customer's views about an insurer depends on the service and relationships experience the insurer offers.

What goes to make a healthy relationship? At its heart, of course, there is trust. At the same time, there are other elements, which reinforce and promote that trust. Let us illustrate some of the elements.

Diagram 2: Elements for Trust



i. Every relationship begins with **attraction**: Attraction means being liked and being able to build a rapport with the customer, starting with creating a great first impression. Attraction is regarded the key to unlocking every heart. Without it a relationship is hardly possible. A sales person cannot make much headway if he/ she is not liked by the customer.

ii. The second element of a relationship is one's presence, being there when needed

iii. **Communication:** Even if one is not fully present and unable to do full justice to all the expectations of one's customers, one can still **maintain a strong relationship by communicating in a manner that is assuring, full of empathy and conveying a sense of responsibility.**

The above dimensions of communication call for discipline and skills. They ultimately reflect how one thinks and sees.

Companies emphasise on customer relationship management, as the cost of retaining a customer is far lower than acquiring a new customer. A customer

relation opportunity arises at various touch points e.g. while understanding customers insurance needs, explaining coverage's, handing over forms etc.

B. Insurance agent's role in providing customer service.

Let us now consider how an agent can render great service to the customer. It is important to realise that from the moment a customer gets contacted by a sales person to the final point of settlement of a claim, the customer goes on a journey of experience that we shall call the '**Customer Journey'**. The agent needs to partner with the customer through the entire duration of the contract, hand holding him/ her in each step of the journey to create memorable experiences at every step.

Let us look at some milestones in the journey and the role played at each step.

1. The Sale

It is said that selling is both an art and a science. It is a science because it calls for a set process which, if consistently and properly followed, is likely to lead to success. It is also an art in the sense that each sales person brings his or her distinctive beliefs, style and personality into the process and the results depend on what each person puts into the process.

- **Prospecting:** The Sales Process begins with **Prospecting**, which literally means 'searching' for a prospective customer. Searching is important as '***One cannot find till one searches'*, it is the most important step in the process. An agent typically begins with his or her natural market, made up of known and easily approachable people. The challenge lies in getting across to more networks of people who are outside one's immediate circle – getting to know them and be known by them.

  All the people one knows and approaches may not be proper candidates for insurance or they may not be interested in buying. It is thus necessary to **qualify** them so that one targets only those who are likely to buy insurance. The prospecting process becomes successful only when an agent is able to build strong relationships with the prospect. The first task of any sales person is thus to **sell trust and build confidence.**

- ***Invite for an Interview:*** While personal relationships are the foundation on which insurance business is built, it is necessary to convert the goodwill one earns into a sale. This begins when the sales person sets up a formal appointment for a detailed sales interview. This step is critical for establishing one's professional credentials and also to separate business from casual discussions.

- ***Determining the needs and recommending the Solution:*** The heart of the Sales Interview is the steps wherein the sales agent determines and makes the prospective customer aware about the exact needs for which insurance is a solution. A master sales person is distinguished by his/ her skill in guiding a prospect, through asking gentle questions, to understand the gaps in protection that give rise to the needs for insurance.

The Agent has the responsibility to provide *Best Advice* to the Prospect about the right kind of insurance solutions to meet his/ her needs. Firstly one must determine and make the prospective customer aware about the exact needs for which insurance is a solution. This also includes giving proper advice on the amount of insurance to be purchased. For example the amount of life insurance to be purchased by an individual needs to be linked to his/ her income and paying capacity.

It is also important to keep a basic percept in mind, especially when buying non-life insurance: Do not recommend insuring where the risk can be managed otherwise.

Whether insurance is needed or not, depends on the circumstances. If the premium payments are high compared to the loss involved, it may be advisable to just bear the risk. On the other hand, if the loss consequences of a risk are likely to be severe, it is wise to insure against it.

Example

To a homeowner living in a flood prone area, purchasing an add-on cover against floods would prove to be helpful. On the other hand, if the home owner owns a home at a place where the risk of floods is negligible it may not be necessary to obtain such cover.

Many customers may not be much concerned about getting maximum insurance per rupee spent, but would be interested in **reducing the cost of handling risk**. The concern would be thus on identifying those risks which a customer cannot retain and hence must be insured.

The agent becomes successful when he/ she renders best advice. The agent needs to constantly ask himself/ herself about his/ her role vis-à-vis the customer. He/ she should go to the customer not just to get a sale but to relate to the customer as a coach and partner who can help him/ her to manage his/ her risks more effectively?

- ***Handling Objections and Closing the Sale:*** It may not be enough to give best advice and recommendations to a customer about the right products to buy. One also needs to persuade him/ her to take the decision to buy. Quite often

the customer may have a number of questions and may raise objections that need to be addressed before he/ she decides to commit to the purchase. Whilst handling these objections, it is vitally important to understand that the objections being voiced may reflect underlying concerns that need to be identified and resolved.

In sum, the role of an insurance agent is more than that of a mere sales person. He/ she also **needs to be a risk assessor, underwriter, risk management counsellor, designer of customised solutions and a relationship builder** (who thrives on building trust and long-term relationships), all rolled into one.

2. The Proposal stage

The agent has to support the customer in filling out the proposal for insurance. The insured is required to take responsibility for the statements made therein. The salient aspects of a proposal form have been discussed in a later chapter.

The agent should explain and clarify to the proposer the details to be filled as answers to each of the questions in the proposal form. A failure to give proper and complete information can jeopardise the customer's claim.

Sometimes, if additional information is required to complete the policy, the company may inform the customer directly or through the agent/ advisor. The agent should help the customer in completing such formalities, explaining why they are necessary.

IRDAI (Issuance of e-Insurance Policies) Regulations, 2016, provide for e – Proposal forms that are similar to the physical proposal form and having a provision to the Prospect to give his consent to the proposal, which can be validated by one time password (mobile phone OTP).

3. Acceptance stage

a) Cover notes/ Certificates of Insurance

After underwriting is completed it may take some time before the policy is issued. Pending the preparation of the policy or when the negotiations for insurance are in progress and it is necessary to provide cover on a provisional basis or when the premises are being inspected for determining the actual rate applicable, a cover note is issued to confirm protection under the policy.

As Cover notes and Certificates of Insurance are used predominantly in marine and motor classes of business, cover note is discussed in detail under the General Insurance Section.

It is the agent's responsibility to ensure that the cover note is issued by the company, where applicable, to the insured. Promptness in this regard

communicates to the client that his/ her interests are safe in the hands of the agent and the company.

b) Policy Document

The policy is a formal document which provides an evidence of the contract of insurance. This document has to be stamped in accordance with the provisions of the Indian Stamp Act, 1899. The insurer is duty bound to give the policy document to the insured.

4. Premium Payment

Premium is the consideration or amount paid by the insured to the insurer for insuring the subject matter of insurance, under a contract of insurance.

A good agent takes active interest in ensuring that the insured pays the premium for taking or continuing or renewing his policy and the customer is made aware of various options available for payment of premium.

5. Method of payment of premium

The premium to be paid by any person proposing to take an insurance policy or by the policyholder to an insurer may be made in any one or more of the following methods:

a) Cash

b) Any recognised banking negotiable instrument such as cheques, demand drafts, pay order, banker's cheques drawn on any schedule bank in India;

c) Postal money order;

d) Credit or debit cards;

e) Bank guarantee or cash deposit;

f) Internet;

g) E-transfer

h) Direct credits via standing instruction of proposer or the policyholder or the life insured through bank transfers;

i) Any other method or payment as may be approved by the Authority from time to time;

As per IRDA Regulations, in case the proposer/ policyholder opts for premium payment through net banking or credit/ debit card, the payment must be made only through net banking account or credit/ debit card issued on the name of such proposer/ policyholder.

6. Service after issuance of Policy Document and Receipt for Premium

Once the premium is paid by the customer, the insurer is bound to issue a receipt. A receipt is also to be issued even in case the premium is paid in advance.

The agent may approach the insured and enquire whether the Policy Document has been received from the insurance company. It presents a great opportunity for the agent to connect with the customer. The agent will be able to clear any doubts and also explain the various policy provisions and policy holders' rights and privileges. This demonstrates commitment to the customer and provides an opportunity to pledge continued support and service. One should also inform the customer about the free-look period provision, during which period, the policy can be returned and refund of premium obtained.

If the policy being purchased is an Electronic insurance policy, the agent can help the Customer to open an e-Insurance Account (e-I-A), through the Registered Insurance Repository.

This also paves the way for the next step which is to ask the customer for the names and particulars of other individuals he/ she knows, who can possibly benefit from the agent's services. It would be even better if the client itself contacted these people and introduced the agent to them.

7. Policy Renewal

Most general Insurance policies have to be renewed each year. For general insurance policies, at the time of each renewal, the customer has a choice to continue insuring with the same company or switch to another company. In case of Life Insurance, a policy would continue to be in force when the customer pays the premium at regular intervals based on premium payment term. This does not apply to one-time payments.

General Insurers usually send a Renewal Notice, well in advance of the date of expiry of the premium paying period, inviting renewal of the policy.

The customer's choice to renew or continue with the policy may often depend on the trust and goodwill created by the agent and company and the agent needs to be in touch to remind the customer about the renewal or continuity of policy well before the due date.

High producer agents constantly keep in touch with their clients, and win their trust and loyalty through various acts of service and relationships – like

greeting their clients on various occasions like festivals or family events and being with them to share their joys and sorrows.

8. The claim stage

The crucial test comes at the time of claim settlement. The agent must ensure that the incident giving rise to the claim is immediately informed to the insurer and that the customer carefully follows all the formalities. The agent may also assist in all the investigations that may need to be done to assess the loss. A good agent assists the customers or his representatives in fulfilling the claim lodgement formalities quickly, correctly and completely.

Test Yourself 2

Identify the scenario where a debate on the need for insurance is not required.

I. Property insurance
II. Business liability insurance
III. Motor insurance for third party liability
IV. Fire insurance

C. Communication skills in customer service

An agent needs to possess soft skills for effective performance in the work place.

Soft skills relate to one's ability to interact effectively with others, both at work and outside. Communication skills are the most important of these soft skills.

1. Process of communication

What is communication?

All communications require a sender, who sends a message, and a person who received that message. The process is complete once the receiver has understood the message of the sender.

Diagram 3: Forms of communication

Communication may be face to face, over the phone, or by mail or internet. It may be formal or informal. Whatever the content or form of the message or the media used, the effectiveness of communication depends on whether or not the recipient has understood what was sought to be communicated.

Since an insurance policy is essentially a promise, it is important that what is promised by the insurer is clearly understood by the insured. The agent as an intermediary has to not only provide complete, accurate and unambiguous account of the terms of the insurance to the customer, but also seek and clarify doubts or queries that a customer may have.

2. Barriers to effective communication

Different kinds of barriers to effective communication can arise at each step in the above process, due to which communication can get distorted. The challenge is to visualize, understand and remove the barriers.

Test Yourself 3

What does not go on to make a healthy relationship?

I. Attraction
II. Trust
III. Communication
IV. Dislike

D. Non-verbal Communication

Let us now look at some concepts that the agent needs to understand.

Important

1. Making a great first impression

The prospect judges an agent based on his appearance, body language, mannerisms, dress and speech. As attraction is the first pillar of a relationship and first impressions last long, some tips for making a good first impression are given below:

i. **Be on time always**. Plan to arrive a few minutes early, allowing flexibility for all kinds of possible delays.

ii. **Present yourself appropriately**.

- ✓ The appearance should to create the right first impression
- ✓ The dress must be appropriate for the meeting or occasion
- ✓ The look must be clean and tidy – with good haircut and shave, clean and tidy clothes, neat and tidy make up

iii. **A warm, confident and winning smile** puts a person and his/ her audience immediately at ease with one another.

iv. **Being open, confident and positive**

- ✓ body language must project confidence and self-assurance
- ✓ stand tall, smile, make eye contact, greet with a firm handshake
- ✓ remain positive even in the face of some criticism or when the meeting is not going as well as expected

v. **Interest in the other person** - The most important thing is about being genuinely interested in the other person.

- ✓ Take some time to find out about the customer as a person
- ✓ Be caring and attentive to what he or she says
- ✓ Be totally present and available to your customer
- ✓ Not engaging in one's mobile phone during the interview?

2. Body language

Body language refers to movements, gestures, facial expressions. The way we talk, walk, sit and stand, all says something about us, and what is happening inside us.

It is often said that people listen to only a small percentage of what is actually said. What we don't say may speak a lot more about us in a louder way. Obviously, one needs to be very careful about one's body language.

a) Confidence

Here are a few tips about how to appear confident and self-assured, giving the impression of someone to be seriously listened to:

- ✓ Posture – standing tall with shoulders held back.
- ✓ Solid eye contact - with a "smiling" face
- ✓ Purposeful and deliberate gestures

b) Trust

- ✓ Quite often, a sales person's words fall on deaf ears because the audience does not trust him/ her – his/ her body language does not give the assurance that he/ she is sincere about what he/ she says

3. Listening skills

The third set of communication skills that one needs to be aware about and cultivate are listening skills. These follow from a well-known principle of personal effectiveness – 'first try to understand before being understood'.

Active listening calls for:

- ✓ Allowing the speaker to finish each point before asking questions
- ✓ Not interrupting the speaker with any counter arguments
- ✓ This may require that we reflect on the message and ask questions to clarify what was said
- ✓ Another way to provide feedback is to summarize the speaker's words and repeat it back to him or her periodically or at the end of the conversation.

Let us look at the skills required for active listening:

a) Demonstrating that one is listening:

- ✓ For instance one may:
- ✓ Give an occasional nod and smile
- ✓ Adopt a posture that is open and draws out the other to speak freely
- ✓ Have small verbal comments like "I understand", "I see", "yes" and "uh".

b) Paying attention

One needs to give the speaker one's undivided attention, and acknowledge him. Some aspects of paying attention are as follows:

Look at the speaker directly

- ✓ Put aside distracting thoughts
- ✓ Don't mentally prepare a rebuttal
- ✓ Avoid all external distractions [for instance, keep your mobile on silent mode]
- ✓ "Listen" to the speaker's body language

c) Removing filters:

A lot of what we hear may get distorted by one's personal filters, like the assumptions, judgments, and beliefs one carries.

Not being judgemental: If the listener is judgemental, even if he hears what the speaker is saying, he will understand only according to his biased interpretation.

d) Empathetic listening:

Empathy implies hearing and listening patiently, and with full attention, to what the other person has to say, even when one does not agree with it. It is important to show the speaker acceptance, not necessarily agreement.

e) Responding appropriately:

Active listening implies much more than just hearing what a speaker says. The communication can be completed only when the listener responds in some way, through word or action. Certain rules need to be followed for ensuring that the speaker is not put down but treated with respect.

These include:

- ✓ Being candid, open, and honest in your response
- ✓ Asserting one's opinions respectfully
- ✓ Treating another person in a way, one would like oneself to be treated

Example

Asking for clarity – "I realize that we have not been able to clear about the benefits of some of our health plans. Could you help us by asking us your doubts?"

Paraphrasing the speaker's exact words – "So, you are saying that 'our health plans are not attractive enough' – Have I understood you correctly?"

Test Yourself 4

Which among the following is not an element of active listening?

I. Paying good attention
II. Being extremely judgemental
III. Empathetic listening
IV. Responding appropriately

E. Ethical Behavior

In recent years, there are many reports of improper conduct, and serious concerns have been raised about ethical behaviour in business causing betrayal of trust.

This has led to discussions about concepts like accountability, corporate governance, and treating customers fairly in insurance, which form part of "Ethics" in business.

It is not wrong to look after one's interests. But it is wrong to do so at the cost of the interests of others. Unethical behaviour arises when there is no concern for others and there is high concern for oneself.

Insurance is a business of trust. Breach of trust amounts to cheating. When wrong information is given to prospects tempting them to buy insurance, or if the insurance given does not cater to the specific needs of the prospect, things go wrong.

The Code of Ethics spelt out by the IRDAI in various regulations are directed towards ethical behaviour. It is not enough just to know the code. What is more important for the insurers and their representatives is to always keep the interests of the prospect/ policy holder as primary.

Characteristics: Some characteristics of ethical behaviour are:

a) Placing the best interests of the client above one's own direct or indirect benefits

b) Holding in strictest confidence and considering as privileged, all business and personal information pertaining to client's affairs

c) Making full and adequate disclosure of all facts to enable clients make informed decisions

There could be a likelihood of ethics being compromised in the following situations:

a) Having to choose between two plans, one giving much less premium or commission than the other

b) Temptation to recommend discontinuance of an existing policy and taking out a new one

c) Being aware of circumstances that, if known to the insurer, could adversely affect the interests of the client or the beneficiaries of the claim.

Test Yourself 5

Which among the following is not a characteristic of ethical behaviour?

I. Making adequate disclosures to enable the clients to make an informed decision
II. Maintaining confidentiality of client's business and personal information
III. Placing self-interest ahead of client's interests
IV. Placing client's interest ahead of self interest

Summary

a) The role of customer service and relationships is far more critical in the case of insurance than in other products.

b) Five major indicators of service quality include reliability, responsiveness, assurance, empathy and tangibles.

c) Customer lifetime value may be defined as the sum of economic benefits that can be derived from building a sound relationship with a customer over a long period of time.

d) The role of an insurance agent in the area of customer service is absolutely critical.

e) Active listening involves paying attention, providing feedback and responding appropriately.

f) Ethical behaviour involves placing the customer's interest before one's own.

Key terms

a) Quality of service

b) Empathy

c) Body language

d) Active listening

e) Ethical behavior

Answers to Test Yourself

Answer 1 -The correct option is III.
Answer 2 - The correct option is III.
Answer 3 - The correct option is IV.
Answer 4 - The correct option is II.
Answer 5 - The correct option is III.

CHAPTER C-09
GRIEVANCE REDRESSAL MECHANISM

Chapter Introduction

Insurance industry is essentially a service industry where customer expectations are constantly rising. There is dissatisfaction with the standard of services. Despite continuous product innovation and significant improvement in the level of customer service, aided by use of modern technology, the industry suffers badly in terms of customer dissatisfaction and poor image. The Government and the regulator have taken a number of initiatives to improve the situation.

IRDAI Regulations on Protection of Policyholders' Interests 2017 mandate that every Insurer shall have their own board approved policy for protection of policyholders' interests which shall include

i. Service parameters including turnaround times for various services rendered.
ii. Procedure for speedy resolution of complaints.

Learning Outcomes

A. Grievance Redressal Mechanism

B. Integrated Grievance Management System (IGMS)

C. Consumer Courts

D. Consumer disputes redressal agencies

E. The Insurance Ombudsman

F. Right to Information

A. Grievance Redressal

The time for high priority action is when the customer has a complaint. Remember that in the case of a complaint, the customer is angry due to a failure of service. This is only a part of the story.

Many times, Customers get upset because they understand the situation wrongly. All service failures causes two types of feelings:

1. A feeling that the insurer was unfair (a feeling of being cheated)
2. A feeling of hurt ego (being made to look and feel small)

The customers want to feel valued and human touch is critical in this situation. As a professional insurance advisor first of all, the agent would not allow such a complaint situation to happen. He would take up the matter with the appropriate officer of the company.

A complaint is a crucial "**moment of truth**" in the customer relationship. If the agent/ company can use the situation to clarify the position, the situation can actually improve customer loyalty.

Remember, no one else in the company has ownership of the client's problems as much as an agent does.

Complaints/ grievances give us the chance to show how much we care for the customer's interests. They are in fact the pillars on which an insurance agent builds goodwill and business. **Word of mouth publicity (Good/ Bad) plays a significant role in selling and servicing**.

The procedure for grievance redressal is detailed at the end of every policy document. This should be bought to the notice of customers. As per the regulations, any grievance of a policy holder should be first referred to the Insurer's Grievance Cell. If it is not satisfactorily resolved, the complainant may approach the Regulator through the Integrated Grievance Management System.

B. Integrated Grievance Management System (IGMS)

Each Insurer has its own grievance redressal mechanism. All operating/ controlling/ corporate offices of Insurance companies have Grievance Redressal Officers. A policyholder can approach them directly for any grievance.

IRDAI has launched an Integrated Grievance Management System (IGMS) which acts as an online consumer complaints registration system. Insurers have to register all grievances that they receive in the system which is integrated with IGMS of IRDAI. IGMS helps IRDAI in monitoring grievance redress in the industry and also acts as a central repository of insurance grievance data.

Policyholders can approach the respective insurer first for any grievance. If he does not receive any response from the insurer or if the response/ resolution received is not to his satisfaction, he can approach the Regulator under the IGMS. The complaint registration process involves two steps – (i) Registering oneself by entering one's policy details and (ii) Registering one's complaints and viewing the status of the complaints. Complaints are then forwarded to the respective insurance companies and IRDAI facilitates disposal of Grievances.

IGMS tracks complaints and the time taken for their redressal. The complaints can be registered at the following URL: http://www.policyholder.gov.in/Integrated_ Grievance_Management.aspx

C. Consumer Protection

The Consumer Protection Act, 2019: This original Act of 1986 was passed *"to provide for better protection of the interest of consumers and to make provision for the establishment of consumer councils and other authorities for the settlement of consumer's disputes"*. The Act was amended by the Consumer Protection (Amendment) Act, 2002 and later on 2019.Some definitions provided in the Act are as follows:

"**Service**" means service of any description which is made available to potential users and includes the provision of facilities in connection with banking, financing, **insurance**, transport, processing, supply of electrical or other energy, board or lodging or both, housing construction, entertainment, etc. **Insurance is included as a service.** However, "Service" does not include the rendering of any service free of charge or under a contract of personal service.

"**Consumer**" means any person who

- ✓ Buys goods for a consideration. It includes any user of such goods. (It does not include a person who obtains such goods for resale or for any commercial purpose) or
- ✓ Hires or avails of any services for a consideration. It includes the beneficiary of such services. (It does not include any person who avails of such service for any commercial purpose.)

"**Defect**" means any fault, imperfection, shortcoming, inadequacy in the quality, nature and manner of performance which is required to be maintained by or under any law or has been undertaken to be performed by a person in pursuance of a contract or otherwise in relation to any service.

"Complaint" means any allegation in writing made by a complainant that:

- ✓ an unfair trade practice or restrictive trade practice has been adopted
- ✓ the goods bought by him suffer from one or more defects
- ✓ the services hired or availed of by him suffer from deficiency in any respect
- ✓ price charged is in excess of that fixed by law or displayed on package
- ✓ goods which will be hazardous to life and safety when used are being offered for sale to the public in contravention of the provisions of any law requiring

trader to display information in regard to the contents, manner and effect of use of such goods.

"Consumer dispute" means a dispute where the person against whom a complaint has been made, denies and disputes the allegations contained in the complaint.

D. Consumer disputes redressal agencies

Consumer disputes redressal agencies are established at district, state and national levels.

i. District Consumer Disputes Redressal Commission

- ✓ The District Consumer Disputes Redressal Commission (District Commission), has jurisdiction to entertain complaints, where value of the goods or services does not exceed Rs. 1 crore. The District Commission has the powers of a civil court.

ii. State Consumer Disputes Redressal Commission

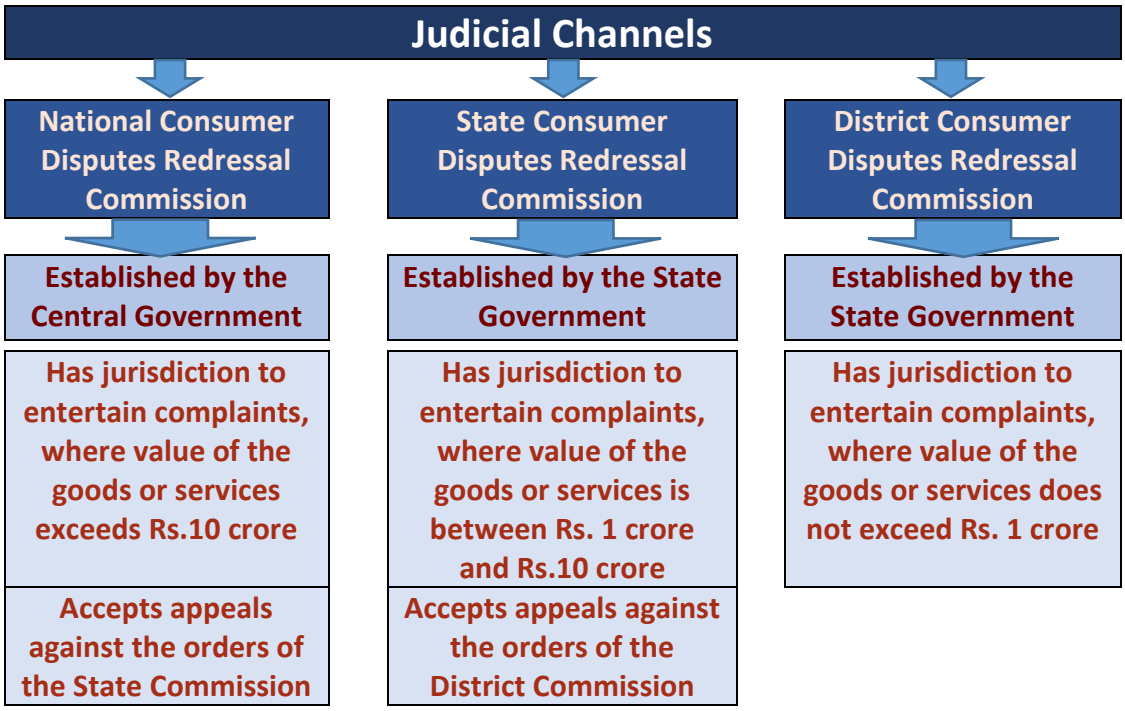
- ✓ The State Consumer Disputes Redressal Commission (State Commission) has original jurisdiction to entertain complaints where the value of goods/ service and compensation, if any claimed exceeds Rs. 1 crore but does not exceed Rs.10 crores.
- ✓ It also has appellate and supervisory jurisdiction to entertain appeals from the District Commission.
- ✓ Other powers and authority are similar to those of the District Commission.

iii. National Consumer Disputes Redressal Commission

- ✓ The National Consumer Disputes Redressal Commission (National Commission) is the final authority established under the Act.
- ✓ It has original jurisdiction to entertain disputes, where goods/ services and the compensation claimed exceeds Rs.10 crores.
- ✓ It has appellate as well as supervisory jurisdiction to hear the appeals from the orders passed by the State Commission.

Every order made by a District Commission, State Commission or the National Commission shall be enforced by it in the same manner as if it were a decree made by a Court in a suit before it. Appeals against the orders of the National Commission have to be made only at the Supreme Court.

Channels for Consumer Disputes Redressal



a) Procedure for filing a complaint

The procedure for filing a complaint is very simple in all the above three agencies. There is no fee for filing a complaint or filing an appeal whether before the State Commission or National Commission. The complaint can be filed by the complainant himself or by his authorised agent. It can be filed personally or can even be sent by post. It may be noted that no advocate is necessary for the purpose of filing a complaint.

b) Consumer Commission Orders

If the Commission is satisfied (a) that the goods in question have the defects specified in the complaint or (b) that the allegations about the services are proven; the Commission can issue orders directing the opposite party to do any of the following:

i. To **return** to the complainant the **price** (or premium in case of insurance) and/ or charges paid by the complainant
ii. To award such amount as **compensation** to the consumers for any loss or injury suffered by the consumer due to negligence of the opposite party
iii. To remove the defects or **deficiencies** in the services in question.
iv. To **discontinue the unfair trade practice** or the restrictive trade practice or not to repeat them
v. To provide for **adequate costs** to the complainants.

c) Nature of complaints

The **majority of consumer disputes** with the three Commissions relating to insurance business fall in the following main categories:

i. Delay in settlement of claims
ii. Non-settlement of claims
iii. Repudiation of claims
iv. Amount or Quantum of loss
v. Policy terms, conditions etc.

E. The Insurance Ombudsman

The Central Government under the powers of the Insurance Regulatory & Development Authority Act, 1999 made **Insurance Ombudsman Rules 2017** by a notification published in the official gazette on 25th April 2017.

Rules regarding Insurance Ombudsmen apply to all insurers and their agents and intermediaries in respect of complaints on all personal lines of insurance, group insurance policies, policies issued to sole proprietorship and micro enterprises. ['Personal lines' here means insurances taken in an individual capacity, in contrast to insurances sold to corporate entities.] Complaints relating to (a) delay in settlement of claims beyond the time specified by IRDAI, (b) partial or total repudiation of claims by the insurer, (c) disputes about premium paid or payable in terms of insurance policy, (d) misrepresentation of policy terms and conditions at any time in the policy document or policy contract, (e) legal construction of insurance policies that affect the claim; and (f) policy servicing and related grievances against insurers and their agents and intermediaries.

a) Issuance of life insurance policy, general insurance policy including health insurance policy which is not in conformity with the proposal form submitted by the proposer.
b) Non issuance of insurance policy after receipt of premium in life insurance and general insurance including health insurance and
c) Any other matter resulting from the violation of provisions of the Insurance Act, 1938 or the regulations, circulars, guidelines or instructions issued by the IRDAI from time to time or the terms and conditions of the policy contract, in so far as they relate to issues mentioned at clauses (a) to (f)

The objective of these rules is to resolve all types of complaints mentioned above, in a cost effective, and impartial manner.

The Ombudsman, by mutual agreement of the insured and the insurer can act as a mediator and counsellor within the terms of reference.

The decision of the Ombudsman, whether to accept or reject the complaint, is final.

a) Complaint to the Ombudsman

Any complaint made to the Ombudsman should be in writing, and must be signed by the insured or his legal heirs, nominee or assignee, and addressed

to an Ombudsman within whose jurisdiction, the insurer has a branch/ office. It should contain the facts giving rise to the complaint, supported by documents, the nature and extent of the loss caused to the complainant and the relief sought.

Complaints can be made to the Ombudsman if:

i. The complainant had made a previous written representation to the insurance company and:
   - ✓ the insurance company had rejected the complaint or
   - ✓ the complainant had not received any reply within one month after receipt of the complaint by the insurer.

ii. The complainant is not satisfied with the reply given by the insurer
iii. The complaint is made within one year from the date of rejection by the insurance company
iv. The complaint is not pending in any court or consumer Commission or in arbitration
v. The value of the claim including expenses claimed is not above Rs 30 lakhs.

b) Recommendations by the Ombudsman

The Ombudsman will send copies of complaints to both the complainant and the insurance company. The Ombudsman will make his recommendations within one month of the receipt of the complaint.

c) Award

The dispute can be settled by intermediation. If this is not possible, the Ombudsman will pass an award to the insured which he thinks is fair within a period of 3 months from the date of receipt of all requirements from the complainant and sending a copy of the award to the complainant and the insurer.

The insurer shall comply with the award within 30 days of the receipt of the award and intimate compliance of the same to the Ombudsman. The award of the Ombudsman shall be binding on the insurer.

F. Right to Information

In addition to the rules and regulations that are specific for grievance redressal in insurance, there are certain general laws common to everyone in the country. The Right to Information (RTI) Act, 2005 enacted by the Govt. of India is an important law that gives citizens of India access to the information available with public authorities which promotes transparency and accountability in these organisations. The Act provides for appointment of a Chief Public Information Officer (CPIO) to deal with requests for information. IRDAI is obliged to provide information to members of public in accordance with the provisions of the said Act. Agents should be aware that as per the RTI Act, IRDAI and Insurance Companies may have to reveal certain information to customers and others; as also allow them to inspect the work, document, records, extracts or certified

copies of documents/ records and also information stored in electronic form. However, there are certain categories of information that are exempt from disclosure.

Test Yourself 1

The _____ has jurisdiction to entertain complaints, where value of the goods or services and the compensation claimed is up to Rs.20 lakhs.

I. District Commission
II. State Commission
III. Zilla Parishad
IV. National Commission

Summary

- IRDAI has launched an Integrated Grievance Management System (IGMS) which acts as a central repository of insurance grievance data and as a tool for monitoring grievance redress in the industry.
- Consumer disputes redressal agencies are established in each district and state and at national level.
- As far as insurance business is concerned, the majority of consumer disputes fall in categories such as delay in settlement of claims, non-settlement of claims, repudiation of claims, quantum of loss and policy terms, conditions etc.
- The Ombudsman, by mutual agreement of the insured and the insurer can act as a mediator and counsellor within the terms of reference.
- If the dispute is not settled by intermediation, the Ombudsman will pass award to the insured which he thinks is fair, and is not more than what is necessary to cover the loss of the insured.

Key Terms

1. Integrated Grievance Management System (IGMS)
2. The Consumer Protection Act, 2019
3. District Commission
4. State Commission
5. National Commission
6. Insurance Ombudsman

Answers to Test Yourself

Answer 1 -The correct answer is I.

CHAPTER C-10

REGULATORY ASPECTS FOR WEB AGGREGATORS

Chapter Introduction

In this chapter, we discuss Regulatory aspects of Web Aggregators.

Learning Outcomes

A. Regulations of Web Aggregators.

A. **Web Aggregators**

The Web Aggregator regulations came into effect from 3rd December 2013.

The following definitions are relevant.

1. Definitions:

a. "Act" means the Insurance Act, 1938 (4 of 1938), as amended from time to time.

b. "Agreement" for the purpose of these regulations means an agreement entered into between a web aggregator and an Insurer;

c. "Authorised Verifier" for the purpose of these Regulations is a person employed by the Insurance Web Aggregator or a Tele-marketer for insurance solicitation and procurement through Telemarketing and Distance Marketing mode and who has undergone training and passed the examination as specified by the Authority;

d. "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);

e. "Distance Marketing" for the purpose of these regulations refers to the process of solicitation or sale of insurance products or services where the consumer is physically not present at the point of solicitation or sale or the conclusion of the sale, and the process is accomplished through telephone or Short Messaging Service (SMS) or e-mail or Internet or web services;

f. "Key Management Personnel" for the purposes of these regulations means Chief Executive Officer, Chief Operating Officer, Chief Marketing Officer, Chief Financial Officer, Head - Technical, Head – IT.

g. "Lead" for the purpose of these regulations means information pertaining to a person who has accessed the website of a web aggregator and has submitted contact information of any kind, for obtaining information on prices or features/benefits of insurance products;

h. "Lead Generation" for the purpose of these Regulations, is the process of collecting the details of the prospects to ascertain their intention to purchase insurance, before proceeding with solicitation of insurance products;

i. "Lead Management System" (LMS) for the purpose of these Regulations refers to the Software implemented by the Web Aggregator for recording, filtering, validating, grading, distribution, follow up and closure of leads from the enquiries received on the website of the Web Aggregator;

j. "Outsourcing": for the purpose of these Regulations means activities which can be carried out by the Web Aggregators to the extent as specified by the Authority.

k. "Person" means

1. **A company formed under the Companies Act, 2013 (18 of 2013);** or

1. A limited liability partnership formed under the Limited Liability Partnership Act, 2008 (6 of 2009) with no partner being a non-resident entity/person resident outside India as defined in clause (w) of section 2 of the Foreign Exchange Management Act, 1999 (42 of 1999) FEMA, and not being a foreign limited liability partnership registered there under; or
2. Any other person recognized by the Authority to act as a Web Aggregator;

l. "Principal Officer" means
1. A director / partner, who is responsible for the activities of the Web Aggregator in the case of a body corporate; or
2. The chief executive officer appointed exclusively to carry out the functions of a Web Aggregator;

m. "Solicitation" for the purpose of these Regulations is defined as the approach of a Prospect by an insurer or an intermediary with a view to convince the Prospect to purchase an insurance policy;

n. "Telemarketer" for the purpose of these Regulations, is an entity registered with Telecom Regulatory Authority of India under Chapter III of The Telecom Commercial Communications Customer Preference Regulations, 2010 (as amended from time to time);

o. "Web Aggregator" for the purpose of these regulations is a person licensed by the Authority under these Regulations;

p. "Website" is a set of related web pages served from a single web domain. A website is hosted on at least one web server, accessible via a network such as the Internet or a private local area network through an Internet address known as a Uniform resource locator. The word "website" includes a web portal and/or a mobile site for the purpose of these regulations;

q. "Designated Website" for the purpose of these regulations is a website(s) with domain name(s) registered, owned by and used exclusively for the functions of the Web Aggregator;

r. Words and expressions used and not defined in these Regulations but defined in the Insurance Act, 1938 (4 of 1938), the Insurance Regulatory and Development Authority Act, 1999 or in any of the Regulations made there under shall have the meanings respectively assigned to them in those Acts or Regulations.

2. Eligibility criteria for License of the Web Aggregator:

a. For the grant of License / Renewal of license of the web aggregator, the applicant shall ensure the fulfilment of the conditions including but not limited to the following:
   i. The applicant is a person as defined under regulation 1 (i).
   ii. The Memorandum of Association of the company or such other documents of applicants shall have the business of web aggregation of Insurance Products only as its main object.

iii. The applicant is not engaged in any other business other than the main object (Web Aggregation of Insurance Products) of the applicant;

iv. The applicant shall not be licensed / registered as an insurance agent, corporate agent, micro-insurance agent, TPA, surveyor, Loss assessor or any other Insurance Intermediary under the relevant Regulations framed by the Authority.

v. The applicant shall not have a referral arrangement with an Insurer.

vi. The applicant shall not be a related party of an insurer, insurance broker, corporate agent, micro-insurance agent, TPA, Surveyor or a loss assessor or other insurance intermediary at any time.

b. The Principal Officer shall possess the required qualification as specified by the regulator

c. The Principal Officer of the Web Aggregator should have undergone 50 hours of training initially and 25 hours of renewal training at the end of every three years thereafter.

d. The Principal Officer / Directors / Promoter(s) / Shareholders / Partners / Key Management Personnel should fulfil the conditions in the FIT and PROPER criteria notified by the authority from time to time.

e. The Authorised Verifier has undergone the prescribed training and passed the examination as specified by the Authority.

f. The web aggregator should not have violated the obligations and the code of conduct as specified by the regulator.

g. The Authority is of the opinion that the grant of license will be in the interest of policyholders.

3. Application seeking Grant of License.

a. An applicant, seeking grant of License as Web Aggregator shall make an application to the Authority in **the application Form A (Application for grant of certificate of registration to an Insurance Web Aggregator) of Schedule I of these Regulations.**

b. The application shall be accompanied by a non-refundable fee of rupees ten thousand plus applicable taxes paid by way of a demand draft drawn in favour of 'Insurance Regulatory and Development Authority of India' payable at Hyderabad or by recognised electronic funds transfer to Insurance Regulatory and Development Authority of India.

No application shall be processed without the application fee.

Applicants seeking permission for Outsourcing and Telemarketing functions/facility shall mention the same specifically in the application Form.

The documents to be submitted along with the application for grant of certificate of registration as Insurance Web Aggregator are mentioned in Form B (Forms to be attached with the Application Form A) of Schedule I of these Regulations.

c. The applicant seeking grant of certificate of registration as Insurance Web Aggregator shall fulfil all the requirements for consideration of application as specified under Regulation 7 and fulfil the conditions mentioned in these Regulations

d. The application for grant of license as Web Aggregator shall be dealt by the authority as per the applicable provisions and under these Regulations.

e. On the applicant fulfilling all the eligibility criteria and requirements mentioned in these Regulations; the authority shall grant License to the applicant to function as a Web aggregator

f. A license once issued shall be valid for a period of three years from the date of its issue, unless the same is suspended or cancelled pursuant to these Regulations.

g. An application, which is not complete in all respects, shall be liable to be rejected.

4. Application seeking Renewal of License:

a. Web Aggregators interested in continuing in the business shall apply with the Authority for renewal of the License at least THIRTY DAYS before expiry of the previous License. The application for renewal of license should be accompanied by a fee of rupees ten thousand Applicants seeking permission for Outsourcing and Telemarketing functions / facility shall mention the same specifically in the application Form.

b. No Web Aggregator shall be allowed to carry out the functions of the Web Aggregator, after expiry of the license.

Note: A Web Aggregator is permitted to submit the renewal application within ninety days before expiry of the license.

c. The application for renewal of license as Web Aggregator shall be dealt with by the authority as per the applicable provisions and under these Regulations.

d. A Web Aggregator, before seeking a renewal of license, shall ensure that their Principal Officer has received at least twenty-five hours of theoretical and practical training from an institution recognized by the Authority from time to time.

e. The Authority, on being satisfied that the applicant fulfils all the conditions specified for renewal of a license, shall renew the license for a period of three years and send intimation to that effect to the applicant.

f. Wherever it is found that the Web Aggregator is not doing any amount of business during the entire/part of the previous licensed period, the Authority may refuse to renew the license.

5. Employees of the Web Aggregator:

a. The employees of the Web Aggregator involved in insurance solicitation and verification should have completed the fifty hours of theoretical and practical training on insurance from an institution recognized by the Authority from time to time and passed an examination, at the end of the period of training mentioned above, conducted by the National Insurance Academy, Pune or any other examining body recognized by the Authority.

b. Tele-callers deployed by Web Aggregators to solicit business should be employees on the rolls of the Web aggregator and should have undergone training as prescribed by Authority.

c. Web Aggregators shall be responsible for all acts of commission and omission of the employees deployed on their behalf.

6. Annual Fees:

a. Every Web Aggregator shall pay annual license fees of Rs. 5,000/-.

b. The annual license fee shall be paid within 15 days of the finalization of annual audited accounts of the Web Aggregator or 30th of September, whichever is earlier.

c. The fees shall be payable by an Account Payee draft in favour of "The Insurance Regulatory and Development Authority" payable at Hyderabad.

7. Requirements of Capital and Net worth

[a] Capital Requirements

i. An applicant seeking to become an Insurance Web Aggregator under these regulations shall have a minimum paid up capital/ contribution of rupees twenty five lakhs.

ii. The capital of the Insurance Web Aggregator shall be issued and subscribed in the form of Equity Shares where the Insurance Web Aggregator is a company registered under Companies Act, 2013.

iii. The contribution of partners in case of LLP shall be only in cash

iv. The applicant shall also comply with the Rule, Regulation, Circular, Guidelines, etc. issued in respect of Indian owned and controlled.

v. The shares of the Insurance Web Aggregator held as capital shall not be pledged in any form or manner to secure credit or any other facility and shall at all times be unencumbered.

[b] Manner of calculation of equity capital held by foreign investors

The aggregate holdings of equity shares or contribution of the Insurance Web Aggregator by foreign investors, including portfolio investors, shall not exceed forty-nine per cent of paid-up equity capital of Insurance Web

Aggregator at any time or such foreign investment limit as prescribed by the Central Government.

[c] Net-worth requirements

i. The net-worth of an Insurance Web Aggregator shall at no time during the period of certificate of registration period fall below 100% of the minimum capital requirements or contribution specified under sub-regulation (a)(i) above.

[Explanation: For the purposes of these regulations, "net worth" shall have the meaning assigned to it in Companies Act 2013 and as amended from to time.]

ii. Every Insurance Web Aggregator shall review the status of the net-worth specified in sub-regulation (i) above, every half year as at 30th September, and 31stMarch every year and report non-compliance, if any, to the Authority within 15 days thereon and shall restore the requirements within 30 days thereafter and confirm compliance to the Authority.

iii. In case the Insurance Web Aggregator is not able to maintain the minimum net-worth even after 30 days, then he shall immediately stop doing insurance related business/ activity.

iv. The Insurance Web Aggregator shall submit to the Authority a net worth certificate duly certified by a Chartered Accountant every year after finalization of books of accounts.

[d] Transfer of shares

i. The beneficial ownership and control of the shares or contribution shall totally and completely rest with the entity/individual approved by the Authority.

ii. The process of transfer of shares of Web Aggregator shall be as given in Form AB (Transfer of shares) of Schedule XII of these regulations.

8. Grant of registration certificate by IRDA

i. When the application is filed after fulfilling all the required conditions and after submitting all the required documents, the IRDA will accept the application and grant the registration certificate to the applicant

ii. The certificate of registration issued holds validity for a period of three years from the date of its issue unless the same is suspended or cancelled by the IRDA.

iii. An incomplete application is liable for rejection. However, before rejection, an opportunity will be given to complete the formalities within 30 days. If no intimation is received within 30 days, the application will be rejected,

9. Policy of Board

Every Insurance Web Aggregator shall have a policy on "manner of soliciting insurance products" approved by the Board, which shall be reviewed at least once in three years.

10. Professional indemnity insurance

Every Web Aggregator shall take out and maintain and continue to maintain a professional indemnity insurance cover throughout the validity of the period of the license granted to them by the Authority. The Professional Indemnity Policy shall be obtained from the Insurer licensed by the Authority.

Provided that the Authority shall in suitable cases allow a newly licensed Web Aggregator to produce such a guarantee within six months from the date of issue of original license.

11. Change in name of an Insurance Web Aggregator: An Insurance Web Aggregator shall take the prior approval of the Authority for change of its name.

12. Arrangements with insurers for distribution of products

No arrangements shall be made by the Insurance Web Aggregators with the insurers which are against the interests of policyholders;

13. Conflict of interest –

While soliciting and procuring the insurance business, the Insurance Web Aggregator shall comply with the following:

(a) The Insurance Web Aggregator having tie-ups with more than one insurer in a particular line of business, shall display to the prospective customer the list of insurers, with whom they have arrangements to distribute the products and provide them with the details such as scope of coverage, term of policy, premium payable, premium terms and any other information which the customer seeks on all products available with them;

(b) The product to be sold shall be based on the need analysis of the prospect.

(c) No Insurance Web Aggregator shall promote or push a particular product of a particular company either through its web-site or through distance marketing approaches

14. **Role and responsibilities of the Authorised Verifier.**

a) Insurance Web Aggregator shall be responsible for all acts of commission and omission of the authorised verifier deployed on their behalf.

b) The Authorised Verifier shall:

i. be on the rolls of either the Insurance Web Aggregator or the Tele-marketer.
ii. solicit insurance business only through tele-marketing mode.
iii. receive inbound telephone calls from prospects/ policyholders seeking assistance or clarifications on the insurance products they want to buy.
iv. sell an insurance product based on the need analysis of the prospect.
v. explain the main features of the similar insurance product of other companies to help customer make a choice.
vi. not make any unsolicited outbound telephone calls for solicitation of insurance products
vii. not make false promise or lure the prospects by exaggerating the benefits under the insurance product

c) An Insurance Web Aggregator shall tag every insurance policy sold by the Authorised Verifier to his identity for tracking sales and complaints if any which shall be given access to the Authority on remote basis.

d) An Authorised Verifier may shift from one insurance Web Aggregator/ Tele-marketer to another after obtaining a No Objection Certificate from his previous employer or 30 days of requesting for the same whichever is earlier.

15. Duties and Functions of web Aggregators.

a) The Web Aggregator shall

i. Display Information pertaining to the Insurers who have signed agreement with the Web Aggregators.
ii. Carryout the activities for the purpose of Lead Generation for insurers.
iii. Ensure that the information systems, (both hardware and software) including the aggregation website(s) / portals, Lead Management System and the Data Centers hosting the website(s) / Portal(s) / Lead Management System are in compliance with the generally accepted information security standards and procedures in force in India from time to time.

iv. Ensure that the leads and other data is transmitted to the insurers and others using secured layer data encryption technologies like 128 bit encryption.

v. Use only RBI licensed payment gateways for collection and transfer of premium to insurers when the web aggregator is authorized by the insurer to collect the premium on behalf of the insurer.

vi. Ensure to get the information systems (both hardware and software) including the aggregation website(s) / portals, Lead Management System and the Data Centers hosting the website(s) / Portal(s) / Lead Management System Audited by CERT-In empanelled Information Security Auditing organisations once in a financial year and submit a copy of the Audit Certificate/Report to IRDA and the insurers with whom the web aggregator has entered into an agreement, within 15 days from the date of receipt of the same.

b) The Web Aggregators shall not:

i. Display any information pertaining to products or services of other financial institutions / FMCG or any product or service on the website

ii. Display advertising of any sort, either pertaining to any product or service including insurance product or service, other financial products or service / or any other product or service in the Web Aggregators Website.

iii. Operate multiple websites or tie up with other approved/unapproved/unlicensed entities/websites for lead generation / comparison of product etc. subject to few exceptions.

iv. Operate the websites of other Financial / Commercial / marketing or sales or service entities or use other Social Media sites etc. for comparison of products etc.

v. Operate in any other manner for the purpose of transmitting leads to any entity engaged in insurance business except these following regulations.

c) Nomenclature of Web Aggregators

i) All Web Aggregators shall have the word `Insurance Web Aggregator' or 'Insurance Web Aggregators` in the name of the Insurance Broking Company to reflect its line of activity and to enable the public to differentiate IRDA licensed insurance Web Aggregator from other non-licensed insurance related entities. The application of the new applicant companies making an application to seek the license to act as web aggregator shall not be considered in the absence of the compliance of the nomenclature requirement.

ii) Every licensed insurance Web Aggregator shall display in all its correspondences with all stakeholders its name registered with the

Authority, address of the Registered and Corporate Office, IRDA license number and validity period of the license.

iii) Insurance web aggregators are not permitted to use any other name in their correspondence/literature/letter heads without the prior approval of the Authority.

16. Agreement of Insurer with a Web Aggregator:

a. An Insurer desirous of obtaining leads from web aggregator shall enter into an "agreement" with the web aggregator approved by the Authority which shall necessarily include details relating to, though not limited to, the following:
   i) Time-frame and mode of transmission of leads to be shared
   ii) Onus of complying with regulatory and other legal requirements on both the parties to the agreement
   iii) Identifying the different data elements to be shared (viz., name of prospect / client (visitor of the web site), contact details etc)
   iv) The timeframe for providing the premium and feature tables of the agreed products to the Web Aggregator after concluding the agreement and keeping them up to date.

b. The agreement between an insurer and web aggregator shall be valid for a period of three years from its date, subject to the validity of license of web aggregator.

c. The web aggregator shall file the agreement with the Authority within fifteen days from the date of entering the agreement.

17. Display of product comparisons on the web site:

a. Web aggregators shall disclose prominently on the home page, a notice that:
   i. The Prospect's / visitor's particulars could be shared with insurers.
   ii. "Insurance is the subject matter of solicitation"
   iii. "the information displayed on this website is of the insurers with whom our company has an agreement"

b. Product information displayed by web aggregators shall be authentic and be based solely on information received from insurers.

c. Web aggregators shall not display ratings, rankings, endorsements or bestsellers of insurance products on their website. The content of the websites of the web aggregators shall be unbiased and factual in nature; they shall desist from commenting on insurers or their products in their editorials or at any other location in their websites.

18. Remuneration.

Remuneration in any form shall be payable to web aggregators by insurers in compliance with the following provisions:

a. Web aggregator will put in place a robust LMS and transmit leads to the insurers as outlined in Regulation 14 above. No charges should be paid for such leads by the Insurer.

b. A flat fee of not exceeding Fifty thousand per year towards each product displayed by the web aggregator in the comparison charts of its web site.

c. Web Aggregator can undertake Outsourcing functions to provide 'Insurance Services' in respect of policies procured through them. In such instances; the insurer may pay the web aggregators, reasonable service charges at rates fixed in the service agreements with the web aggregators.

d. Web Aggregator can use the Telemarketing / Distance Marketing modes, as per the instructions outlined by the Authority, for solicitation of Insurance based on the leads generated from its aggregation website. The Remuneration paid by the Insurer towards a policy procured through such services of the Web Aggregator, including the remuneration paid towards procuring such a policy to any other insurance intermediary deployed by the insurer, shall not exceed the limits prescribed by the Authority from time to time in terms of the Sec. 42-E of the Insurance Act, 1938.

19. Cancellation or suspension of license with notice —

a. The license of a Web Aggregator may be cancelled or suspended after due notice and after giving him a reasonable opportunity of being heard if he —

i) Violates the provisions of the Insurance Act,1938 (4 of 1938), Insurance Regulatory And Development Authority Act, 1999 (41 of 1999) or rules or regulations, made there under;

ii) Fails to act in accordance with the Obligations of the Web Aggregators and in conducting telemarketing and distance marketing activities;

iii) Fails to adhere to the Code of Conduct specified above.

iv) Furnishes wrong or false information for obtaining a license; or conceals or fails to disclose material facts in the application submitted for obtaining a license;

v) Fails to furnish any information relating to his activities as an insurance Web Aggregator as required by the Authority or furnishes wrong or false information or conceals or fails to disclose material facts to the Authority during the validity of license;

vi) Does not submit periodical returns as required by the Authority;

vii) Does not co-operate with any inspection or enquiry conducted by the Authority;

viii) Fails to resolve the complaints of the policy holders or fails to give a satisfactory reply to the Authority in this behalf;

ix) Indulges in rebates or inducements in cash or kind to a Prospect or any of the Prospect's directors or other employees or any person acting as an introducer;

x) Fails to pay the fees required as specified by Authority.

xi) Fails to maintain the capital requirements in accordance with the provisions specified by Authority.

xii) If the principal officer does fulfil the conditions mentioned in the regulation

xiii) If the Web Aggregator indulges in sourcing of business by themselves or through call centers by way of misleading calls or spurious calls;

b. In the circumstances where the Authority feels that the establishment of a Web Aggregator is only to divert funds within a group of companies or their associates, it can after due enquiries made by it cancel the license granted to the Web Aggregator.

c. A Web Aggregator whose license is suspended after due notice and after giving him a reasonable opportunity of being heard, shall not solicit any new business or carry out any other functions of web aggregator for which the License was granted, from the date of receipt of such Suspension Order till such time the suspension is revoked.

20. Maintenance of books of account, records, etc.

a. Every Web Aggregator shall prepare for every accounting year —

i) A balance sheet or a statement of affairs as at the end of each accounting period;

ii) A profit and loss account for that period;

iii) A statement of cash/fund flow;

iv) Additional statements on Web Aggregators business as may be required by the Authority.

Note: For purposes of these Regulations, the accounting year shall be a period of 12 months (or less where a business is started after 1st April) commencing on the first day of the April of an year and ending on the 31st day of March of the year following, and the accounts shall be maintained on accrual basis.

b. Every Web Aggregator shall submit to the Authority, a copy of the audited financial statements along with the auditor's report thereon within ninety days from the close of the accounting year along with the remarks or observations of the auditors, if any, on the conduct of the business, state of accounts, etc., and a suitable explanation on such observations shall be appended to such accounts filed with the Authority.

c. Every Web Aggregator shall, within ninety days from the date of the Auditor's report take steps to rectify any deficiencies, made out in the auditor's report and inform the Authority accordingly.

d. All the books of account, statements, document, etc., shall be maintained at the head office of the Web Aggregator or such other branch office as may be designated by them and notified to the Authority, and shall be available on all working days to such officers of the Authority, authorised in this behalf by it for an inspection.

e. All the Electronic Records, books and documents, statements, contract notes etc., referred to in these Regulations and maintained by the Web Aggregator shall be retained for a period of at least ten years from the end of the year to which they relate. However the Digital Records / documents pertaining to the cases of legal disputes reported and the disposal of the same is pending for a decision from courts the Records are required to be maintained till the disposal of the cases by the court.

f. Every Web Aggregator shall maintain the Insurer wise records of :

i) Leads generated and transmitted

ii) Leads converted into policies

iii) Complaints received and disposed
iv) Products Displayed on the website for comparison
v) Remuneration received for Products displayed
vi) Remuneration received for leads converted to policies
vii) Remuneration received from outsourcing activities
viii) Any other Remuneration received from Insurers (mention details)

21. Action against a person acting as a Web Aggregator without a valid license—

i) From the date of commencement of these Regulations no person can function as a Web Aggregator unless a license has been granted to him by the Authority under these Regulations.
ii) Notwithstanding and without prejudice to initiation of any criminal proceedings against any person, who acts as a Web Aggregator without holding a valid license issued under these Regulations, the Authority may invoke against such a person penal action under the Act.

22. Certification of Compliance

The Principal Officer of each Web Aggregator shall submit to the Authority, at the end of each financial year, a certificate confirming that the Web Aggregator has complied with all the provisions of these Regulations during the financial year.

SECTION

LIFE INSURANCE

CHAPTER L-01

WHAT LIFE INSURANCE INVOLVES

Chapter Introduction

We have seen some aspects related to Insurance in the common chapters. However, when it comes to Life insurance, we need to look at them more deeply.

- ✓ An asset
- ✓ The risk insured against
- ✓ The principle of pooling
- ✓ The contract

Let us now examine the features of life insurance. This chapter will take a brief look at the various components of life insurance mentioned above.

Learning Outcomes

A. Life insurance business –Components, human life value, mutuality
B. Risks and Life Insurance

A. Life insurance business – Components, human life value, mutuality

a) The Asset – Human Life Value (HLV)

We have already seen that an asset is a kind of property that yields value or a return. For most kinds of property both the value and loss of value amounts can be measured in precise monetary terms.

Example

If the estimated damage of a car meeting an accident is Rs 50000, the insurer will compensate the owner for this loss.

How do we estimate the amount of loss when a person dies?

Is he worth Rs. 50,000 or Rs. 5,00,000?

An Agent must be able to answer the above question when meeting a customer. Based on this the agent can determine how much insurance to recommend to the customer. It is in fact the first lesson a life insurance agent must learn.

Luckily we have a measure, developed almost seventy years ago by Prof. Hubener. It is known as **Human Life Value (HLV)** and is used worldwide.

The HLV concept considers human life as a kind of property or asset that earns an income. It thus measures the value of human life based on an individual's expected net future earnings. Net earnings means the income a person expects to earn each year in the future, less the amount he would spend on himself. It thus indicates the economic loss a family would suffer if the wage earner were to die prematurely. These earnings are capitalised, using an appropriate interest rate to discount them.

Although there are multiple parameters used to calculate HLV including taking into account inflation, wage rise, future earning capacity etc., a simple thumb rule to calculate HLV is to determine the amount that would generate the annual income the family would be needing by way of interest. In other words HLV is the annual contribution for the family by the breadwinner divided by the prevailing rate of interest.

Example

Mr. Rajan earns Rs. 1,20,000 a year and spends Rs. 24,000 on himself. The net earnings his family would lose, were he to die prematurely, would be Rs. 96,000 per year. Suppose the rate of interest is 8% (expressed as 0.08).

Human-Life-Value (HLV) = Annual Contribution for Dependents ÷ Rate of Interest

HLV = 96000/ 0.08 = Rs. 12,00,000

HLV helps to determine how much insurance one should have for full protection. It also tells us the upper limit beyond which providing life insurance may not be reasonable.

In general, the amount of insurance should be around 10 to 15 times one's annual income. Thus one should grow suspicious if Mr. Rajan was to ask insurance of Rs. 2 crores, while earning only Rs. 1.2 lakhs a year. The actual amount of insurance purchased would depend on factors like how much insurance one can afford and would like to buy.

B. Risk and Life Insurance

As we have seen above, life insurance provides protection against those risk events that can destroy or reduce the value of human life as an asset. There are three kinds of situations where such loss can occur. They are typical concerns which ordinary people face.

Diagram 1: Typical concerns faced by ordinary people

General insurance on the other hand typically deals with risks that affect property – like fire, loss of cargo while at sea, theft and burglary and motor accidents. They also cover events leading to loss of name and goodwill. These are covered by liability insurance.

Finally there are risks that can affect the person. Termed as personal risks, these may also be covered by general insurance.

Example

Accident insurance which protects against losses suffered due to an accident.

a) How exactly does life insurance differ from general insurance?

General Insurance	Life Insurance
• Indemnity: General insurance policies, with the exception of Personal Accident Insurance, are usually contracts of indemnity i.e. after an event like fire, the insurer assesses the exact amount of loss that has occurred and compensates only that amount of loss – no more, no less.	• **Assurance:** Life insurance policies are contracts of assurance. • The amount of benefit to be paid in the event of death is fixed at the beginning of the contract.

	• An assured sum is paid to the nominees or beneficiaries of the insured when he dies.
• Duration: The contract is generally short period or for one year renewable basis	• The contract is generally long term though some one year renewable contracts are also prevalent
• Uncertainty: In general insurance contracts, the concerned risk event is uncertain. No one can be certain about whether a house would catch fire or a car meet an accident.	• There is no such question Death is certain once a person is born. What is uncertain is the time of death. Life insurance offers protection against the risk of premature death.
• Increase in probability: In case of General insurance perils like fire or earthquake, the probability of happening of the event does not increase with time.	• In life insurance the probability of death increases with age.

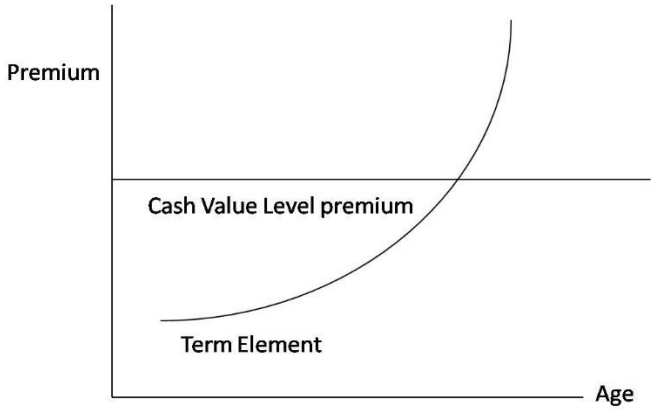
b) Nature of life insurance risk

Since probability of death increases with age, lower premiums are charged for those who are young and higher premiums for older people. One result was that old individuals who were in good health, tended to withdraw while unhealthy members remained in the scheme. Insurance companies faced serious problems as a result. Their attempts to develop life insurance policies that people could afford led to the development of level premiums.

c) Level premiums

The level premium is fixed such that it does not increase with age but remains constant throughout the contract period. This means premiums collected in early years is more than the amount needed to cover death claims of those dying when young, while premiums collected in later years are less than what is needed to meet claims of those dying at higher ages. The level premium is an average of both. The excess premiums of earlier ages compensate for the deficit of premiums in later ages. The level premium feature is illustrated below.

Diagram 2: Level Premium



Level premiums are required because life insurance contracts are long term insurance contracts that run for 10, 20 or many more years. The concept of level premiums, do not arise for general insurance policies, which are typically short term and expire annually.

Example

The level premium rate is arrived at by the insurers based on the mortality (probability of death) during the term of the policy as the age of the insured would increase every year. The rate once decided shall be constant for the entire term of the policy.

d) The Principle of Risk Pooling and Life Insurance

We have already discussed the Principle of Pooling and Mutuality earlier. The pooling principle plays two specific roles in life insurance.

i. It **provides protection against the economic loss arising as a result of one's untimely death**. This is done by creating a fund that pools the contributions of many who have purchased a life insurance contract.

e) The Life Insurance Contract

The Policy document is the **evidence of the insurance contract** which a details all the terms and conditions of the **insurance**.

The contract states the sum assured of the life insurance policy. Life insurance is regarded a **financial security** as the sum Insured is guaranteed by the contract. The guarantee implies that life insurance is managed efficiently and conservatively; strongly regulated and strictly supervised.

Since Life insurance contracts involve both risk cover and savings, they are often compared with financial products. They are also seen as a way of holding wealth than as protection. Indeed, many life insurance products have a large cash value or savings component which can form a significant part of an individual's savings.

Some do argue that it may be better to buy only Term Insurance from an insurance company and invest the balance premiums in instruments that yield higher returns.

Let us consider the arguments for and against traditional cash value insurance contracts.

a) Advantages

i. Insurance has historically been proven as a **safe and secure investment offering** a minimum guaranteed rate of return, which may increase with contract duration.

ii. Regularity of premium payments requires compulsory planning of one's savings and results in savings **discipline**.

iii. The Insurer takes care of professional investment management and **frees** the **individual** of this responsibility

iv. Insurance **provides liquidity**. The insured can take a loan on or surrender the policy and convert it into cash.

v. Both cash value type life insurance and annuities may enjoy some **income tax advantages.**

vi. Insurance may be **safe from creditors' claims**, generally in the event of the insured's bankruptcy or death.

b) Disadvantages

i. As insurance gives relatively fixed and stable returns, it can be seriously affected by inflation.

ii. High marketing and other initial costs reduces the amount of cash value accumulated in earlier years of life insurance policies.

iii. The guaranteed yield may be below that of other financial instruments

Test Yourself 1

How does diversification reduce risks in financial markets?

I. Collecting funds from multiple sources and investing them in one place

II. Investing funds across various asset classes

III. Maintaining time difference between investments

IV. Investing in safe assets

Summary

a) Asset is a kind of property that yields value or a return.

b) The HLV concept considers human life as a kind of property or asset that earns an income. It thus measures the value of human life based on an individual's expected net future earnings.

c) The level premium is a premium fixed such that it does not increase with age but remains constant throughout the contract period.

d) Mutuality is one of the important ways to reduce risk in financial markets, the other being diversification.

e) The element of guarantee in a life insurance contract implies that life insurance is subject to stringent regulation and strict supervision.

Key Terms

1. Asset
2. Human Life Value
3. Level premium
4. Mutuality
5. Diversification

Answers to Test Yourself

Answer 1 - The correct answer is II.

CHAPTER L-02
FINANCIAL PLANNING

Chapter Introduction

In previous chapters we discussed life insurance and its role in providing financial protection. Security is only one of the concerns of individuals who seek to allocate their income and wealth to meet various needs of the present and the future. Life insurance must be understood in the wider context of "Personal Financial Planning". The purpose of this chapter is to introduce the subject of financial planning.

Learning Outcomes

A. Financial planning and the individual life cycle

B. Role of financial planning

C. Financial planning - Types

A. Financial planning and the individual life cycle

1. What is financial planning?

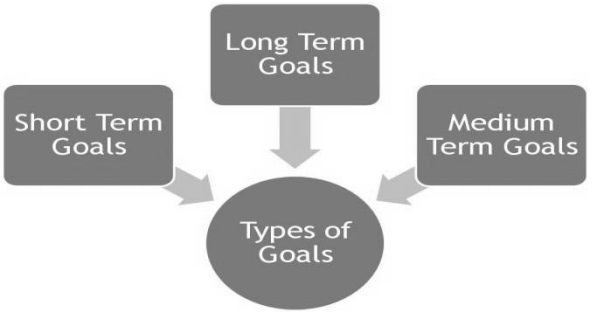
Most of us spend a major part of our lives working to make money. Financial planning is a smart way to make money work for us.

Definition

Financial planning is a process of identifying one's life's goals, translating these goals into financial goals and managing one's finances to achieve those goals.

Financial planning involves preparing a roadmap to meet both current and future needs, which may be unforeseen. It plays a crucial role in building a life with less worry. Careful planning can help to set one's priorities and work to achieve your various goals.

Diagram 1: Types of Goals



i. Goals may be **short term**: Buying an LCD TV set or a family vacation

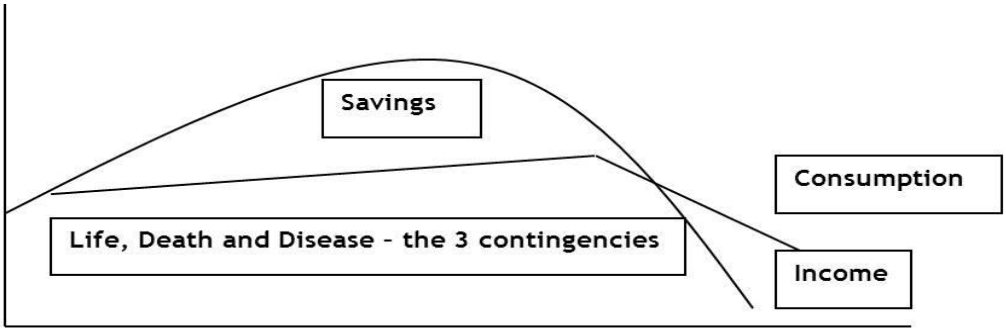
ii. They could be **medium term**: Buying a house or a vacation abroad

iii. The **long term** goals may include: Education or marriage of one's child or post retirement provision

2. Individual's life cycle

From the day a person is born till the day of his/ her death, he/ she goes through various stages in life, during which he/ she is expected to play a series of roles These stages are illustrated in the diagram given below.

Diagram 2: The Economic Life Cycle



Life Stages and Priorities

a) **Learner (till say age 20 -25)**:The stage when one is preparing for his future byimproving his or her knowledge and skills. Funds are required for financing one's education. For instance, meeting the high cost of fees for Medical or Management Education.

b) **Earner (from 25 onwards)**:When one has found employment and perhaps earns enough to meet his or her needs and has some surplus to spare.There are family responsibilities and one may also save and invest in order to have money to meet the needs that may arise in the immediate future.For instance, a young man takes a housing loan and invests in a house.

c) **Partner(on getting marriage at say 28 - 30)**: The stage when one is married and has a family of one's own.This creates new needs like having a house of one's own, perhaps a car, consumer durables, planning for children's future etc.

d) **Parent(say 28 to 35)**: The years when one becomes the parent of one or more children.One now has to worry about their health and education - getting them into good schools etc.

e) **Provider(say age 35 to 55)**: The stage when children have grown into teenagers, and includes their high school and college years. One is concerned about the high cost of education to make the child qualified to face the challenges of life.For instance, consider the amount that needs to be set up to finance a medical course that runs for five years.In many Indian homes, making provision for marriage and settlement of girl children is a critical area of concern.Indeed, marriage and education of children is a prime motive for savings for most Indian families today.

f) **Empty Nester(age 55 to 65):**The term 'empty nester' implies that the offspring have flown away leaving the nest [the household] empty.This is the period when children have married and sometimes have migrated to other places for work, leaving the parents.Hopefully by this stage, one has liquidated one'sliabilities [like housing loan and other mortgages] and has built up a fund for

reirement.It is also the period when ailments like BP and Diabetes begin to manifest and plague one's life.Health care,financial independence and security of income become very important at this stage.

g) **Retirement – the twilight years (age 60 and beyond):**The age when one has retired from active work and spends one's savings to meet the needs of life.The living needs of the husband and wife as long as both are alive is the focus.One is concerned abouthealth issues,adequateincome and loneliness.This is also the period when one would seek to enhance the quality of life and enjoy many of the things that one had dreamt of but could not achieve – like pursuing a hobby or going on a vacation or a pilgrimage.Whether one ages gracefully or in poverty would depend on how much one has provided for these years.

As we can see above, the economic life cycle has three phases: a student or Pre – job phase; the working phase that begins between ages 18 to 25 and lasts for 35 to 40 years; and the retirement years that begin after one has stopped working.

3. Why does one need to save and purchase various financial assets?

The reason is that during each stage in an individual's life, when one performs a particular role, a number of needs come up for which funds have to be provided.

Example

When a person gets married and starts a family of his own, he may need to have his own house. As children grow older, funds are needed for their higher education. As an individual goes well past middle age, the concern is for having money to meet health costs and post retirement savings so that one does not need to depend on one's children and become a burden. Living with independence and dignity becomes important.

The Savings – Investment process may be considered as being made of two decisions.

i. **Postponement of consumption:** an allocation of resources between present and future consumption.

ii. **Parting with liquidity** (or ready purchasing power) in exchange for less liquid assets. For instance, purchase of a life insurance policy would mean exchanging money for a contract which is less liquid.

Financial planning includes both kinds of decisions. One needs to plan in order to save for the future and also must invest wisely in appropriate assets to meet the various needs that will arise in future.

4. Individual needs

If we look at the stages of the life cycle that has been discussed above, we would see that three types of needs can arise. These give rise to three types of financial products.

a) **Enabling future transactions**

The first set of needs arise from funds for meeting a range of anticipated expenditures that are expected to arise at different stages of the life cycle. There are two types of such needs:

i. **Specific transaction needs**: that are linked to specific life events which require a commitment of resources. For instance making a provision for higher education/ marriage of dependents; or purchase of a house or consumer durables

ii. **General transaction needs:** Amounts set aside from current consumption without being earmarked for any specific purposes – these are popularly termed as 'future provisions'

b) Meeting contingencies

Contingencies are unforeseen life events that may call for large funds. These cannot met from current income and need to be pre-funded. Some of these events, like death and disability or unemployment, lead to a loss of income. Others, like a fire, may result in a loss of wealth.

Such needs may be addressed through insurance, if the probability of their occurrence is low but cost impact is high. One may alternatively meet them by setting aside a large amount of liquid assets as a reserve.

c) Wealth accumulation

The accumulation motive refers to an individual's desire to invest for accumulating wealth, taking advantage of favourable market opportunities. Some individuals may take a cautious approach while investing, while some may be willing to take more risks, with a view to earn a higher return. Higher return is desired because it helps to increase one's wealth or net worth more rapidly. Wealth is linked with independence, enterprise, power and influence.

5. Financial products

Corresponding to the above sets of needs there are three types of products in the financial market:

Transactional products	Bank deposits and other savings instruments that enable one to have adequate purchasing power (liquidity) at the right time and quantum.
Contingency products like insurance	These provide protection against large losses that may be suffered in the event of sudden unforeseen events.
Wealth accumulation products	Shares and high yielding bonds or real estate are examples of such products. Here the investment is made with a view to committing money for making more money.

An individual would typically have a mix of all of the above needs and thus may need to have all three types of products. In a nutshell one may say there is:

i. A need to save – For cash requirements

ii. A need to insure – Against uncertainties

iii. A need to invest – For wealth creation

6. Risk profile and investments

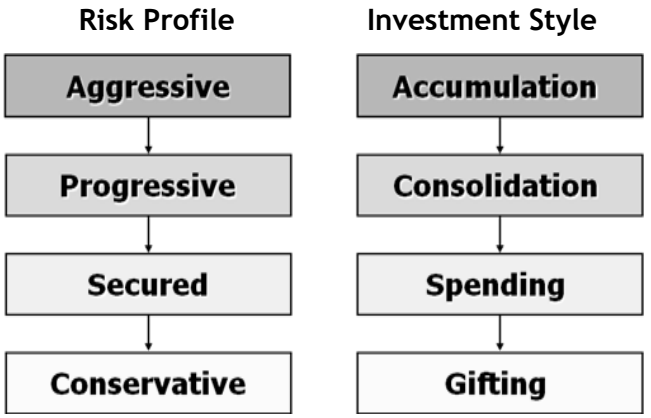
As an individual moves through various stages in the life cycle, from young earner towards middle ages and then towards the final years of one's work life, the risk profile, or approach towards taking risks also changes.

When one is young, one may be quite aggressive and willing to take risks in order to accumulate as much wealth as possible. As the years pass however, one may become more prudent and careful about investing. One is now concerned to secure and consolidate one's investments.

Finally, as one nears retirement one may be more conservative. The focus is now to have a corpus from which one can spend in the post retirement years. One may also think about making donations for one's children, for gifting to charity etc.

One's investment style also changes to keep pace with the risk profile. This is indicated below:

Diagram 3: Risk Profile and Investment Style



Test Yourself 1

Which among the following gives specific protection against unforeseen events?

I. Insurance

II. Transactional products like bank Fixed Deposits

III. Shares

IV. Debentures

B. Role of financial planning

1. Financial planning

Financial planning is the process of carefully evaluating a client's current and future needs along with his or her risk profile and income, to chart out a road map for meeting various anticipated/ unforeseen needs through recommending appropriate financial products.

Elements of financial planning include:

- ✓ Investing - allocating assets based on one's risk taking appetite,
- ✓ Risk management,
- ✓ Retirement planning,
- ✓ Tax and estate planning, and
- ✓ Financing one's needs

To put it in a nutshell financial planning involves 360 degrees planning.

Diagram 4: Elements of Financial Planning

2. Role of Financial planning

Financial planning is not a new discipline. It was practiced in simple form by our fore fathers. There were limited investment options then. A few decades ago many considered equity investment as akin to gambling. Savings were largely channelled in bank deposits, postal savings schemes and other fixed income instruments. The challenges facing our society and our customers are far different today. Some of them are:

i. Disintegration of the joint family

The joint family has given way to the nuclear family, consisting of father, mother and children. The typical head and earning member of this family has to bear the responsibility for taking care of oneself and one's immediate family. This may call for a lot of proper planning and advice from a professional financial planner.

ii. Multiple investment choices

A large number of investment instruments are available today for wealth creation, each offering varying degrees of risk and return. To achieve financial goals, one has to choose wisely and make the right investment decisions based on one's risk taking appetite. Financial planning can help with one's asset allocation.

iii. Changing lifestyles

Instant pleasure seems to be the order of the day. Individuals want to have the latest mobile phones, cars, large homes, memberships of prestigious clubs, etc. To satisfy these desires, people often borrow heavily and spend a good part of their income to pay off loans, leaving little scope to save. Financial planning helps to plan and one's expenditure so that one can cut down unnecessary expenses so as to maintain one's present standard of living while upgrading it over time.

iv. Inflation

Inflation is a rise in the general level of prices of goods and services in an economy over a period of time. This leads to a fall in the value of money. As a result, the purchasing power of money gets reduced. Inflation can play havoc post retirement. Financial planning can help to ensure that one is equipped to deal with inflation, especially in later years.

v. Other contingencies and needs

Financial planning also enables individuals to meet a number of other needs and challenges like medical emergencies and tax liabilities. Individuals also need to ensure that their estate consisting of their wealth and properties, smoothly pass on to their loved ones after their death. There are other needs like the need to do charity or meet certain social and religious obligations during one's lifetime and even thereafter. Financial planning is the means to achieve all this.

3. **When is the right time to start financial planning?**

Financial planning is not meant only for the wealthy. Indeed, Planning should ideally start one earns one's first salary. There is no trigger point to tell when one should begin to plan.

There is however an important principle that should guide us – the longer the time period of our investments, the more they will multiply.

Hence one should start early. One's investments would then get the maximum benefit of time. Again, planning is not only for wealthy individuals. It is for everyone. To achieve one's financial goals, one must follow a disciplined approach. An unplanned, impulsive approach to financial planning is one of the prime causes of financial distress of individuals.

Test Yourself 2

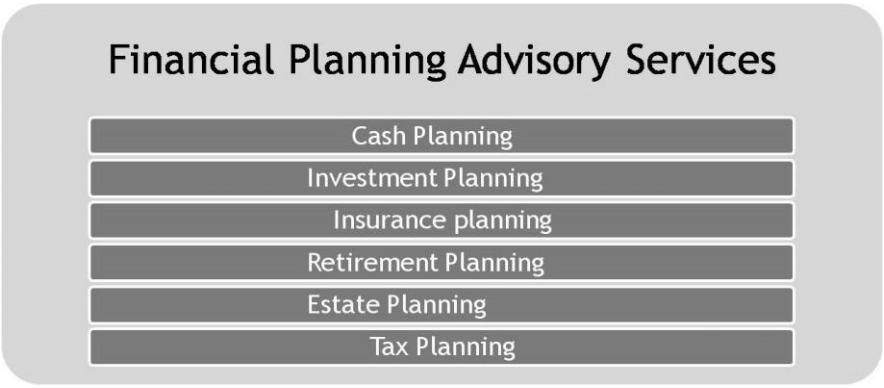
When is the best time to start financial planning?

I. Post retirement
II. As soon as one gets his first salary
III. After marriage
IV. Only after one gets rich

C. Financial planning - Types

Let us now look at the various types of financial planning exercises that an individual may need to do.

Diagram 5: Financial Planning Advisory Services



Consider the various advisory services that may be provided. There are six such areas that are taken up

- ✓ Cash planning
- ✓ Investment planning
- ✓ Insurance planning
- ✓ Retirement planning
- ✓ Estate planning
- ✓ Tax planning

1. Cash planning

Managing cash flows has two purposes.

i. To manage income and expenditures flow including establishing and maintaining a reserve of liquid assets to meet unanticipated needs.

ii. To systematically create and maintain a surplus of cash for capital investment.

Cash Planning involves a number of steps. One must prepare a budget and analyse one's income and expenditure flows to check on what regular and lump sum costs

have been incurred. While fixed expenses cannot be controlled easily, one can reduce, postpone and manage expenses that are variable. The next step is to **predict future monthly income and expenses over the whole year and** design a plan for managing these cash flows.

Another part of the cash planning process is to design strategies for maximizing discretionary income.

Example

One can restructure one's outstanding debts.

One can meet outstanding credit card debts through consolidating them and paying them off through a bank loan with lower interest.

One may reallocate one's investments to make them earn more income.

2. Insurance planning

There are certain risks to which individuals are exposed that can keep them from attaining their personal financial goals. Insurance planning involves constructing a plan of action to provide adequate insurance against such risks.

The task here is to estimate how much insurance is needed and determining what type of policy is best suited.

i. **Life insurance** may be decided by estimating the income and expense requirements of the dependents in the event of premature death of the bread winner.

ii. **Health insurance** requirements may be assessed in terms of the hospitalisation expenses that are likely to be incurred in any family medical emergency.

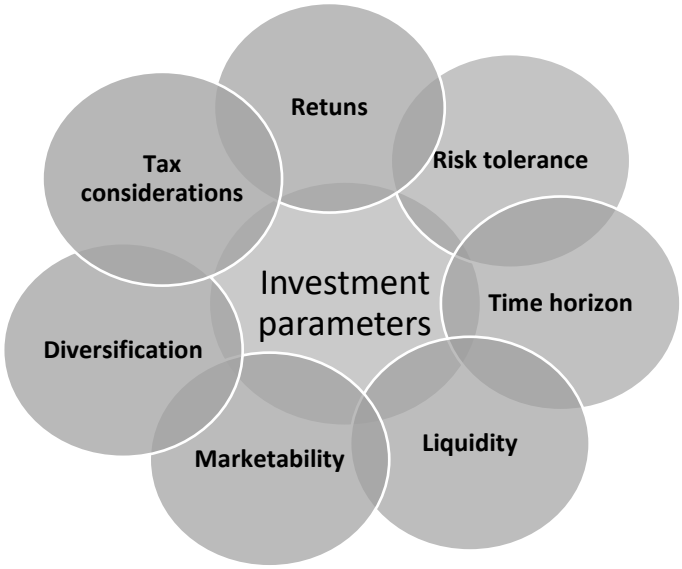
    a. Finally **insurance for one's assets** may be considered in terms of the type and quantum of cover required to protect one's home/ vehicle/ factory etc. from the risk of loss.

3. Investment planning

There is no one right way to invest. What is appropriate would vary from individual to individual. Investment planning is a process of determining the most suitable investment and asset allocation strategies based on an individual's risk taking appetite, financial goals and the time horizon to meet those goals.

a) Investment parameters

Diagram 6: Investment Parameters



The first step here is to define certain investment parameters. These include:

i. **Returns**: Returns on Investment is often the most important parameter that people look for when they invest their money. The rate of return determines how fast one's wealth from investments would grow over time. The role of returns can be appreciated when one considers the 'Power of compounding'. For instance, if an amount of Rs 1000 is invested today at 8% rate of interest, at the end of five years, it would accumulate to Rs 1469 and at the end of 10 years it would more than double to reach Rs 2159. This expectation of returns which helps to accumulate wealth is one of the prime motives of investment. At the same time, one must note that higher rates of return may be typically accompanied with higher levels of risk. One has to make a trade-off between return and risk. This depends on an individual's risk tolerance.

ii. **Risk tolerance**: A measure of how much risk someone is willing to take in purchasing an investment.

iii. **Time horizon**: This is the amount of time available to attain a financial objective. The longer the time horizon, the less concern is there about short term liability. One can invest in longer term, in less liquid assets that earn a higher return.

iv. **Liquidity**: Individuals with limited investment capacity, or uncertain income and expenditure flows, or who are investing for meeting a particular personal or business expenditure, would be concerned with liquidity [This refers to the ability to convert investment into cash without loss of value.]

v. **Marketability**: The ease with which an asset can be bought or sold.

vi. **Diversification**: The extent to which one seeks to diversify or spread the investments to reduce the risks.

vii. **Taxes**: Many investments confer certain income tax benefits and one may like to consider the post-tax returns of various investments.

b) Selection of appropriate investment vehicles

The next step is selection of appropriate investment vehicles based on the above parameters. The actual selection would depend on the individual's expectations about return and risk.

In India there are a variety of products that may be considered for the purpose of investments. These include:

- ✓ Fixed deposits of banks/ corporates,
- ✓ Small savings schemes of post office,
- ✓ Public issues of shares,
- ✓ Debentures or other securities,
- ✓ Mutual funds
- ✓ Unit linked policies that are issued by life insurance companies etc.

4. Retirement planning

It is the process of determining the amount of money that an individual needs to meet his needs post retirement and deciding on various retirement options for meeting these needs. Retirement planning involves three phases

a) Accumulation: Accumulation of funds is done through various kinds of strategies to set aside money for investment with this purpose.

b) Conservation: Conservation refers to the efforts made to ensure that one's investments are put to hard work and that the principal gets maximised during the individual's working years.

c) Distribution: Distribution refers to the optimal method of converting the corpus or principal into withdrawals/ annuity payments for meeting income needs after retirement.

5. Estate planning

It is a plan for the devolution and transfer of one's estate after one's demise. There are various processes like nomination and assignment or preparation of a will. The basic idea is to ensure that one's property and assets are smoothly distributed and or utilised according to one's wishes after one is no more.

6. Tax planning

Tax planning is done to determine how to gain maximum tax benefit from existing tax laws and also for planning of income, expenses and investments taking full advantage of the tax breaks. As per the tax laws in India, life insurance premium

paid by an individual on a life insurance policy on his/ her own life, on the life of his/ her spouse and children is eligible for deduction under Section 80C of the Income Tax Act for calculating the taxable income. Currently, this deduction is allowed up to Rs.1,50,000 subject to conditions. The maturity proceeds (sum assured plus bonus) of such policies are also exempted under Section 10 (10D). Similarly, Death Claim amounts are exempt from Income Tax at the hands of the recipient. One must note that the purpose here is to minimise and not evade taxes.

Life insurance agents may be often required by their clients and prospective customers to advise them not only about meeting their insurance needs but also for support in meeting their other financial needs as well. A sound knowledge of financial planning would be of great value to any insurance agent.

Test Yourself 3

Which among the following is not an objective of tax planning?

I. Maximum tax benefit

II. Reduced tax burden as a result of prudent investments

III. Tax evasion

IV. Full advantage of tax breaks

Summary

- Financial planning is a process of:
  - ✓ Identifying one's life's goals,
  - ✓ Translating these identified goals into financial goals and
  - ✓ Managing one's finances in ways that will help one to achieve those goals
- Based on the individual life cycle three types of financial products are needed. These help in:
  - ✓ Enabling future transactions,
  - ✓ Meeting contingencies and
  - ✓ Wealth accumulation
- The need for financial planning is further increased by the changing societal dynamics like disintegration of the joint family, multiple investment choices that are available today and changing lifestyles etc.
- The best time to start financial planning is right after one receives the first salary.
- Financial planning advisory services include:
  - ✓ Cash planning,
  - ✓ Investment planning,
  - ✓ Insurance planning,

- ✓ Retirement planning,
- ✓ Estate planning and
- ✓ Tax planning

Key Terms

1. Financial planning
2. Life stages
3. Risk profile
4. Cash planning
5. Investment planning
6. Insurance planning
7. Retirement planning
8. Estate planning
9. Suitability information
10. Tax planning

Answers to Test Yourself

Answer 1 - The correct option is I.
Answer 2 - The correct option is II.
Answer 3 - The correct option is III.

CHAPTER L-03

LIFE INSURANCE PRODUCTS: TRADITIONAL

Chapter Introduction

The chapter introduces you to the world of life insurance products. It begins by talking about products in general and then proceeds to discussing the need for life insurance products and the role they play in achieving various life goals. Finally we look at some traditional life insurance products.

Learning Outcomes

A. Overview of life insurance products

B. Traditional life insurance products

A. Overview of life insurance products

1. What is a product?

To begin with, let us understand what is meant by a 'product'. In popular terms a product is normally just considered as a commodity or good that is brought and sold in the market.

It is necessary to understand that every Product is a bundle of features or attributes that confer certain benefits.

All Companies try to differentiate their products by making them more attractive to customers and offering different kinds of features and benefits. A life insurance agent's role is to understand and pitch on these features and benefits to make the products of their companies unique and attractive compared to others.

Example

Colgate, Close up and Promise are all different brands of toothpastes. But the features of each brand is different from the other.

Products may be:

i. **Tangible**: refers to physical objects that can be directly seen or felt by touch (for instance a car or a television set)

ii. **Intangible:** refers to products that can only be perceived indirectly.

Life insurance is a product that is intangible.

2. Purpose of Life Insurance products.

Human beings possess **an immensely valuable asset - human capital – which is the source of our productive earning capacity.** However, there is an uncertainty about life and human well-being. Events like death and disease can destroy our Earning capabilities and life savings. Insurance provides protection for such situations.

Life insurance products offer protection against the loss of economic value of an individual's productive abilities, as a result of death or disability. The moment an individual takes a life insurance policy and pays the first premium, **an immediate estate is created** in his/ her name and its proceeds are available to his/ her dependents or loved ones.

Life insurance provides peace of mind and protection to the near and dear ones of an individual, in case of one' unfortunate death. Beyond providing such protection, life insurance fulfils other needs of the market, such as savings, wealth accumulation, safety and security of investment and certain rates of return, which are not discussed in this course.

Life insurance industry has seen enormous innovations in product offerings over the last two centuries. The journey began with death benefit products but over

the period, multiple living benefits like endowment, disability benefits, dreaded disease covers and so on were added.

One of the major innovations of recent years was the creation of market linked policies where the insured was invited to participate in choosing and managing his investment assets. Another major innovation was the evolution of flexible unbundled products, in which different benefits as well as cost components could be varied by the policy holder as per changing needs, affordability and life-stages.

3. Suitability Information

In order to make insurance intermediaries including agents and brokers more accountable and reduce instances of mis-selling, IRDAI has created a concept of 'product suitability'. 'Suitability information' is the information of a prospect on age, income, family status, life stage, financial and family goals, investment objectives, insurance portfolio already held, etc. That is, before selling an insurance policy to a client, an Agents should be able to justify the suitability of the product for the client's needs.

In other words, the Agent takes into account the particular prospect's risk profile - age, income, family status, life stage, financial and family goals, investment objectives, insurance portfolio already held, insurance needs etc. and decides whether the product is suitable for that prospect. The nature of product, the amount of premium, the mode of premium payment and tenure of the policy as well as the manner of premium payment are also part of the parameters of 'Suitability'.

IRDAI mandates that the suitability information collected should be signed by the prospect and the agent; and preserved by the Insurer as part of the policy records and made available for inspection by the Authority.

4. Riders in Life Insurance Products

A rider is a provision typically added through an endorsement, which becomes part of the contract. Riders are commonly used to provide supplementary benefits like increasing the amount of death benefit provided by a policy, say, because of accidents. Life insurance companies offer a number of riders through which the value of their offerings get enhanced Riders help to customise different requirements of a person into a single plan.

Riders provide a means to provide benefits like Disability cover, accident cover and Critical Illness cover as additional benefits in a standard life insurance contract. Policy holders can avail of them by paying an extra premium.

Test Yourself 1

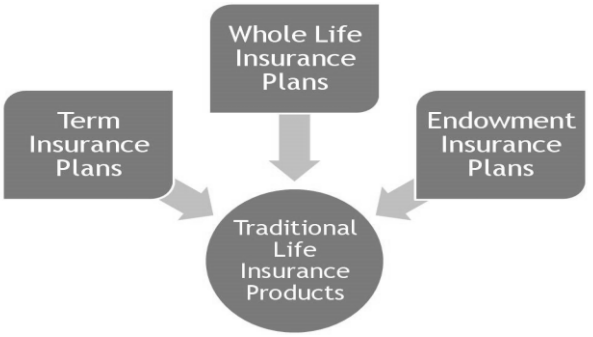
Which among the following is an intangible product?

I. Car
II. House
III. Life insurance
IV. Soap

B. Traditional life insurance products

We shall now learn about some of the traditional types of life insurance products.

Diagram 1: Traditional Life Insurance Products



1. Term insurance plans

Term insurance is a contract that is valid only during a certain time period. This may range from the short time required to complete an airplane trip to multiple years. Protection may extend up to age 65 or 70. One-year term policies are quite similar to property and casualty insurance contracts. There is no savings or cash value element in this policy.

In October 2020, IRDAI has introduced a Standard Individual Term Life Insurance Product called, "Saral Jeevan Bima" (the Insurer's name shall be prefixed to the product name), a non-linked non-participating individual pure risk premium life insurance plan, which provides for payment of Sum Assured in lump sum to the nominee in case of the Life Assured's unfortunate death during the policy term.

Apart from certain benefits and riders specified by the Regulator, no other riders/ benefits/ options/ variants are allowed to be offered. Also, there shall be no exclusions under the product other than the suicide exclusion. Saral Jeevan Bima is to be offered to individuals without restrictions on gender, place of residence, travel, occupation or educational qualifications.

a) Purpose

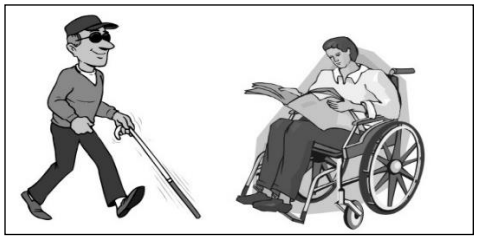
A Term Life insurance plan fulfils the main and basic idea behind life insurance, which is to provide an assured sum of money to the dependents of the insured on his/ her death.

The policy works as an income replacement plan also. Here the payment of a lump-sum amount is replaced by a series of monthly, quarterly or similar periodical payments to the dependent beneficiaries.

b) Disability

Normally a Term insurance policy covers only death. However, it is possible to buy a Disability Protection Rider on the main policy. In such a case, if the insured suffers from a specified disability during the term of the contract, a disability benefit would be paid to the beneficiaries/ insured person. The benefits will continue till the death of the insured person.

Diagram 2: Disability



c) Term insurance as a rider

Protection under Term Life is usually provided as a stand-alone policy but it could also be provided through a rider in a policy.

Example

A rider to a pension plan provides for a death benefit to be payable if one dies before the date when pension is to start.

d) Convertibility

Convertible term insurance policies allow a policyholder to change or convert a term insurance policy into a permanent plan like "Whole Life" without providing fresh evidence of insurability. This privilege helps those who wish to have permanent cash value insurance but are unable to afford its high premiums. When the term policy is converted into permanent insurance the new premium rate would be higher.

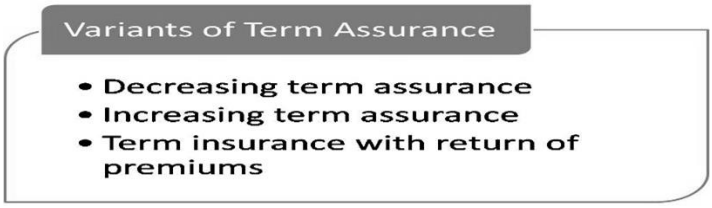
e) Unique Selling Proposition (USP)

The unique selling proposition (USP) of term assurance is its low price, enabling one to buy relatively large amounts of life insurance on a limited budget.

f) Variants

A number of variants of term assurance are possible.

Diagram 3: Variants of Term Assurance



i. Decreasing Term Assurance

These plans typically consist of decreasing term insurance which provides an amount of death benefit that is equal to the balance that is due on a loan, if the borrower dies before the loan is paid. These are often marketed as Mortgage Redemption (discussed in Chapter 15) or Credit Life Insurance. The plans are usually sold to lending institutions as group insurance to cover the lives of their borrowers. Purchase of mortgage redemption insurance is often a condition of the mortgage loan. Such plans may also be available for automobile or other personal loans.

ii. Increasing term assurance

As the name suggests, the plan provides a death benefit, which increases along with the term of the policy. Premium generally increases as the amount of coverage increases.

iii. Term insurance with return of premiums

Another type of policy (quite popular in India) is term assurance with return of premiums. Though the premium paid would be much higher than for a similar term insurance plan without return of premiums, some customers may need such policies.

g) Relevant scenarios

Term insurance may have relevance in the following situations:

i. Where the need for insurance protection is purely temporary, as in case of mortgage redemption
ii. As an additional supplement to a savings plan.
iii. As part of a "buy term and invest the rest" philosophy, where one seeks only cheap term insurance protection from the insurance company and wants to invest the difference of premiums in other attractive investments.

Important

Limitations of term plans: Term Insurance plans are available only for specific periods and one may not be able to continue the coverage beyond a certain age, say 65 or 70.

2. Whole life insurance

Whole life insurance is an example of a permanent life insurance policy. Here, the life insurer offers to pay the agreed death benefit when the insured dies, no matter when the death might occur. The premiums can be paid throughout one's life or for a limited time as specified.

Whole life premiums are much higher than term premiums as whole life policies are designed to remain in force until the death of the insured, and pay the death benefit anytime. The Plan also provides for a cash value in the policy holder's account. He/ she can withdraw cash in the form of a policy loan from this cash value or even redeem it by surrendering the policy for its cash value.

In case of outstanding loans, the amount of loan and interest get deducted from the pay-out to the beneficiaries upon death.

A whole life policy is a good plan for the main earner of the family who wishes to protect his/ her loved ones in the event of premature death and preserve his/ her capital against erosion from various events like terminal illness. One can also use the cash value of the whole life insurance policy for retirement needs, if required. Whole life insurance thus plays an important role in household saving and creating wealth to be passed on to the next generation.

3. Endowment Assurance

It is a contract in which the sum assured is payable to the nominees of the insured in case of the death of the insured during the term of the policy. If the insured survives the term the sum assured is paid to the insured.

The product has both death and survival benefit components. Endowment Assurance links one's insurance and savings programmes by offering a safe and compulsory method of savings accumulation.

People buy endowment plans as a sure method of providing against old age or for meeting specific purposes like having a fund for (a) educational purposes, (b) meeting children's marriage expenses or(c) paying a mortgage (housing) loan.

Government usually offers tax benefits on the premiums paid, which make it attractive. Many endowment policies mature at ages 55 to 65, when the insured is planning for his/ her retirement. In such cases such policies can supplement retirement savings.

Variants: Endowment assurance has certain variants - discussed below.

4. Money Back Policy

The Money Back policy is a popular endowment plan in India. It has a provision for returning some part of the sum assured in instalments during the term and the balance sum assured at the end of the term.

Example

A Money Back policy for 20 years may provide for paying survival benefits of 20% of the sum assured each at the end of the 5^{th}, 10^{th} and 15^{th} years and the balance 40% at the end of the full term of 20 years. If the life assured dies at the end of, say 18 years, the full sum assured and bonuses (explained in the next section) accrued are paid as death benefit, even though the insured would have been paid a benefit of 60% of the face value already, as money back.

Money Back plans have been popular because of their liquidity (cash back) element, which make them attractive for meeting short and medium term needs. Such plans provide full death protection also, if the individual dies at any point during the term of the policy.

5. Participating (Par) and Non-Participating (Non-Par)Plans

The Life Insurance products can also be classified as Participating (Par) and Non-participating (Non-Par) products. The term "Par" implies policies which are participating in the profits of the life insurer. "Non–Par", on the other hand, represents policies which do not participate in the profits. Both kinds are present in traditional life insurance. Under all traditional plans, the pooled life funds, which are derived from policyholders' premiums, are invested as per regulatory norms. Policy holders who opt for 'par products' are eligible to receive, in addition to a guaranteed sum assured, a share in the surpluses(bonuses) that are generated by the insurer. These are known as 'With Profit' plans.

6. Non-participating products

The Policy holders who buy non-linked without profit [non par] plans are paid a benefit that is fixed and guaranteed at the beginning of the contract and nothing more. Non-participating products may be offered either under a 'linked platform' or a 'non-linked platform'. These are known as 'Without Profits' plans.

Example

One may have an endowment policy of twenty years providing a guaranteed addition of 2% of sum assured for each year of term, so that the maturity benefit is sum assured plus a total addition of 40% of the sum assured.

Under the IRDAI's guidelines on traditional non-par policies, the benefits to be paid on the happening of a specified event, have to be explicitly stated at the outset and not linked to an index or benchmark. The same applies to additional benefits that are accrued at regular intervals. This means that the return on these policies must be disclosed at the time of taking the policy.

Important

Death benefits are subject to regulations of IRDAI issued from time to time. At present, as per the new Regulation 9 of IRDAI (Non-linked) Products Regulation, 2019 pertaining to traditional products, the minimum death cover is as follows:

For all non-linked individual life insurance products, the minimum Sum Assured on death during the entire term of the policy shall not be less than 7 times the annualized premium, for limited or regular premium products, and 1.25 times the single premium for single premium products.

For participating products, in addition to the sum assured on death, the bonus and additional benefits as stated in the policy and accrued till the date of death shall become payable on death as part of the death benefit, if not paid earlier. In essence, there are **two variants**, participating and non-participating plans.

i. For **participating polices** the bonus is linked to the investment performance of the fund and is not declared or guaranteed before. The **bonus, once it is announced, becomes a guarantee**. It is usually paid in

case of death of the policyholder or maturity benefit. This bonus is also called **reversionary bonus**.

ii. In case of **non-participating policies**, the return on the policy is disclosed in the beginning of the policy itself.

7. Pension Plans and Annuities

A pension plan is typically a fund into which money is paid during a person's employment years and from which money is drawn to support the person after his retirement from work in the form of periodic payments.

Pension plans are designed on group (usually employer driven) or individual basis. A group pension may be a "defined benefit plan", where a fixed sum is paid regularly to a person, or a "defined contribution plan", under which a fixed sum is invested which becomes available at retirement age. Pensions are essentially guaranteed life annuities, thus insuring against the risk of longevity. A pension created by an employer for the benefit of an employee is commonly referred to as an occupational or employer pension.

On retirement, the money in the member's account is used to provide retirement benefits, typically by purchasing an annuity which then provides a regular income. An annuity is a long-term investment issued by an insurance company designed to help protect one from the risk of outliving one's income. Through annuitization, one's contributions are converted into periodic payments that can last for life.

Individuals can avail of pension benefits by purchasing pension plans from insurance companies. Pension plans can be **on accumulation or deferred basis** which allows a person to contribute in two ways, (i) in lump sum, or (ii) over a period of time; so that he/ she can get a pension from the desired age/ date (called as the 'vesting' date). One can opt to receive pensions/ annuities on monthly, quarterly, half-yearly or annual modes. Pension plans are available on an **immediate basis** also, from the very next month of purchase, on payment of a lump sum amount, called as immediate annuity.

The Indian insurance industry has several deferred and immediate annuity products marketed by Life Insurers. Each product has its own features, terms, conditions and annuity options.

Saral Pension: To provide uniformity across Insurers, to reduce confusion in the market about annuity schemes, and to make available a product that will broadly meet the needs of an average customer, in January 2021, IRDAI mandated all Life Insurers to introduce a standard, immediate annuity product, with simple features and standard terms and conditions on an individual (not group) basis. Such a standard product will make it easier for the customers to make an informed choice, enhance the trust between the Insurers and the insured, and reduce mis-selling as well as potential disputes.

The standard individual immediate annuity product is called, "Saral Pension", prefixed by the Insurer's name. The product offer two (and only two) annuity options as follows:

a) Life annuity with 100% Return of Purchase Price; and

b) Joint Life annuity with a provision of 100% annuity to the secondary annuitant on death of the primary annuitant and return of 100% Purchase Price on death of last survivor.

Mode of Annuity payment would be Monthly, Quarterly, Half-Yearly and Yearly. Details are available on IRDAI's website at the following link - https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo4353&flag=1

Test Yourself 2

The premium paid for whole life insurance is _____ than the premium paid for term assurance.

I. Higher
II. Lower
III. Equal
IV. Substantially higher

Summary

- Life insurance products offer protection against the loss of economic value of an individual's productive abilities, which is available to his/ her dependents or to the self.
- A life insurance policy, at its core, provides peace of mind and protection to the near and dear ones of the individual in case something unfortunate happens to him or her.
- Term insurance provides valid cover only during a certain time period that has been specified in the contract.
- The unique selling proposition (USP) of term assurance is its low price, enabling one to buy relatively large amounts of life insurance on a limited budget.
- While term assurance policies are examples of temporary assurance, where protection is available for a temporary period of time, whole life insurance is an example of a permanent life insurance policy.

Key Terms

1. Term insurance
2. Whole life insurance
3. Endowment assurance
4. Money back policy
5. Par and non-par schemes
6. Reversionary bonus

Answers to Test Yourself

Answer 1 -The correct option is III.
Answer 2 - The correct option is I.

CHAPTER L-04

LIFE INSURANCE PRODUCTS: NON-TRADITIONAL

Chapter Introduction

The chapter introduces you to the world of non-traditional life insurance products. We start by examining the limitations of traditional life insurance products and then have a look at the appeal of non-traditional life insurance products. Finally we look at some of the different types of non-traditional life insurance products available in the market.

Learning Outcomes

A. Overview of non-traditional life insurance products

B. Non-traditional life insurance products

A. Overview of non-traditional life insurance products

1. Non-traditional life insurance products – Purpose and need

In the previous chapters we have considered some of the traditional life insurance products which have insurance as well as a savings element in them.

People have been questioning the ability of traditional life insurance policies to provide a rate of return comparable to other assets in the financial market. Issues have also been raised about the way they are structured into a single package of benefits and premiums.

2. Limitations of traditional products

A critical examination would reveal the following areas of concern:
Cash value component: The savings or cash value component in traditional policies is not well defined. This makes it less transparent about mortality, interest rates, expenses and other parameters that are made.

Rate of return: It is not easy to ascertain the rate of return on traditional policies because the value of the benefits under "With Profit policies" can be known only when the contract ends. This makes it difficult to compare these policies with other financial instruments.

Surrender value: The method of arriving at the cash and surrender values (at any point of time), are set by the life insurer and not transparent.

Yield: The yield on these policies are much lower than those from other investments.

3. **Features of Non-Traditional Policies:** Life insurance companies started designing policies with certain innovative features, some of which are given below:

    a) **Direct linkage with investment gains:** Policies with direct linkage with the capital market were designed in an attempt to make investment gains.
    b) **Policies that can beat inflation:** Policies were designed to give returns closer to the inflation rates. The change was that insurers started thinking that life policies need to match if not beat inflation.
    c) **Policies with Flexibility:** Policies which allowed customers to decide (within certain limits) the amount of premium they wanted to pay; and the amount of death benefits and cash values they wanted, got designed.
    d) **Surrender value:** Policies that gave better surrender values available under traditional policies were also designed by insurers.

These policies became very popular and even began to replace traditional products in many countries, including India.

Test Yourself 1

Which among the following is a non-traditional life insurance product?

I. Term assurance
II. Universal life insurance
III. Endowment insurance
IV. Whole life insurance

B. Non-traditional life insurance products

Some non-traditional products

We shall discuss some of the non-traditional products which have emerged in the Indian market and elsewhere.

1. Universal Life and Variable Life

Universal Life policy was introduced in the United States in 1979 and quickly became very popular. Its features are **flexible premiums, flexible face amount and death benefit amounts.** Unlike traditional policies, where fixed premiums have to be paid periodically to keep the contract in force, universal life policies allow the policyholder (within limits) to decide the amount of premiums he or she wants to pay for the coverage.

Variable Life was introduced in the United States in 1977.It is a typeof "Whole Life" policy where the death benefit and cash value of the policy fluctuates according to the investment performance of a special investment account into which premiums are credited.

The design and sale of the above two kinds of products, both of which were called Variable Insurance Products, have been discontinued and are not allowed in India since2019,further to the issue of IRDAI (ULIP) Regulations, 2019.

2. Unit linked insurance

Unit Linked Plans, also known as ULIPs were first introduced in UK during the 1960s.They have today emerged as one of the most popular and significant products, displacing traditional plans in many markets.

Unit linked policies help to overcome the limitations of traditional products.
The premium paid by the policyholder gets divided into two major portions

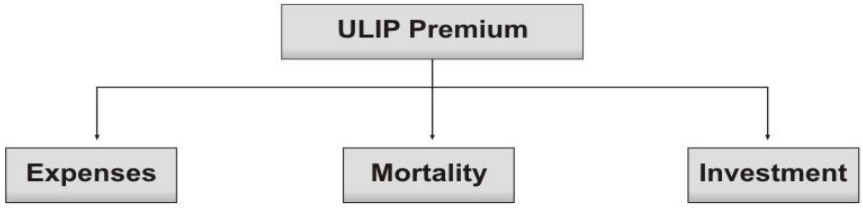
- the first portion which is utilised for providing insurance cover, and
- the second portion that gets invested into the fund opted by the insured.

The benefits under such contracts are wholly or partially determined by the value of units credited to the policyholder's account at the date when payment is due.

In many markets these policies were positioned and sold as investment vehicles with an attached insurance component.

Unlike traditional savings policies that are bundled, Unit linked contracts are unbundled. Their structure is transparent with the charges to pay for the insurance and expenses component being clearly specified.

Diagram 1: Premium break-up



After deducting the charges from the premium, the balance of the account and income are invested in **units**.

The Value of Units

The value of units is defined by a rule or formula, which is outlined in advance. Typically the value of the units is given by the Net Asset Value (NAV), which reflects the market value of the assets in which the fund is invested. Different persons could arrive at the same benefits payable by following the formula.

The Formula is as follows:

Net Asset Value [NAV] = Market Value of Assets of the fund/ Number of units of the funds

Thus, Policyholder benefits do not depend on the assumptions of the life insurance company.

Unit linked policies allow policy holders to choose between different kinds of funds. Each fund would have a different portfolio mix. The investor gets to choose between a broad option of debt, balanced and equity funds, defined below. Even within these broad categories there may be other types of options.

Equity Fund	Debt Fund	Balanced Fund	Money Market Fund
This fund invests the major portion of the money in equity	This fund invests major portion of the money in Govt.	This fund invests in a mix of equity and	This fund invests money mainly in instruments such as

and equity related instruments.	Bonds, Corporate Bonds, Fixed Deposits etc.	debt instruments	Treasury Bills, Certificates of Deposit, Commercial Paper etc.

There is also provision to switch from one kind of fund to another if performance of one or more funds is not found to be up to the mark.

Some of the specific features of ULIP Policies are given below:

i. Unitising

Benefits under ULIP policies are determined by the value of units credited to the policyholder's account at the date when the claim payment is due to be made. A unit is created by dividing an investment fund into a number of equal parts.

ii. Transparent structure

The charges for insurance cover and expenses in ULIPs are clearly specified. Once these charges are deducted from the premium, the balance of the account and income from it are invested in units.

iii. Pricing

Under ULIPs, the insured decides the amount of premium that he/ she can contribute at regular intervals.

In all Life Insurance policies, the initial costs are very high. Under traditional policies, the premium charges for meeting these costs are spread throughout the policy term.

In the case of ULIPs, they are deducted from the initial premiums itself. This significantly reduces the amount allocated for investment. This is why the value of the benefits, vis-à-vis the premiums paid, would be very low and even less than the premiums paid in the early years of the contract.

iv. Death Benefit

Unlike in traditional policies, the amount of death benefit in ULIP policies is a multiple of the premiums paid. In case of death during the term of the policy, the beneficiary would be paid the higher of the Sum Assured [which is a multiple of the premium] or the Fund Value (unit price multiplied by the number of units) standing to his or her account.

v. The bearing of investment risk

The value of the units depends on the value of the life insurer's investments, which are not guaranteed.

The life insurer, though expected to manage the portfolio efficiently, does not give any guarantee about unit values. Hence, the investment risk is borne by the policyholder/ unit holder.

Test Yourself 2

Which of the following statements is/ are incorrect?

I. Variable life insurance is a temporary life insurance policy
II. Variable life insurance is a permanent life insurance policy
III. The policy has a cash value account
IV. The policy provides a minimum death benefit guarantee

Summary

- A critical concern with respect to life insurance policies was giving a competitive rate of return comparable to other assets in the financial marketplace.
- Some of the trends that led to the increase in non-traditional life products include unbundling, investment linkage and transparency.
- Universal life insurance is a form of permanent life insurance characterised by its flexible premiums, flexible face amount and death benefit amounts, and the unbundling of its pricing factors.
- ULIPs became one of the most popular and significant products, replacing traditional plans in many markets.
- ULIPs provide the means for directly and immediately cashing on the benefits of a Life Insurer's investment performance.

Key Terms

1. Universal life insurance
2. Variable life insurance
3. Unit linked insurance
4. Net asset value

Answers to Test Yourself

Answer 1 -The correct option is II.

Answer 2 - The correct option is I.

CHAPTER L-05

APPLICATIONS OF LIFE INSURANCE

Chapter Introduction

Life insurance does not merely seek to protect individuals from premature death. It has other applications as well. It can be applied to the creation of trusts with resultant insurance benefits; it can be applied for creating a policy covering key personnel of industries and also for redeeming mortgages. We shall briefly describe these various applications of life insurance.

Learning Outcomes

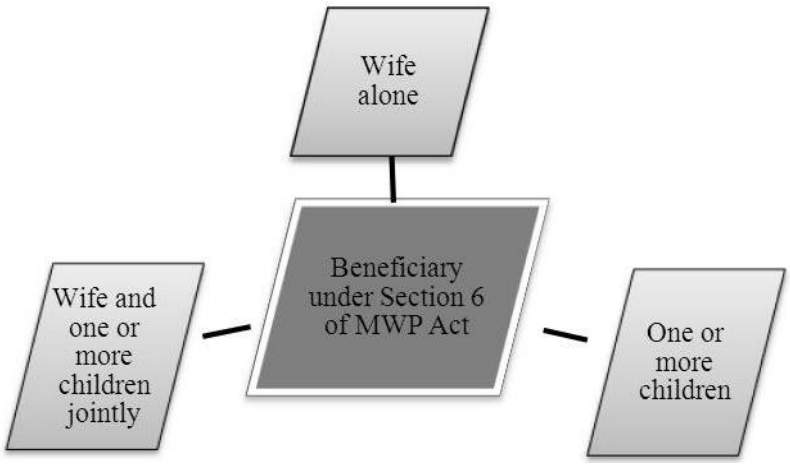
A. Married Women's Property Act, 1874
B. Keyman Insurance
C. Mortgage Redemption Insurance

A. Applications of Life insurance

1. Married Women's Property Act

Section 6 of the Married Women's Property Act, 1874 tries to ensure that the benefits under a life insurance policy will pass on in a secure manner to the wife and children through creation of a trust for the purpose.

Diagram 1: Beneficiaries under MWP Act



The section provides that when a married man takes a policy on his own life and clearly expresses on the face of such policy that it is for the benefit of his wife or his wife and children, and to be held in a trust for their benefit only, the proceeds of such a policy shall not, so long as the objects of the trust remains, be subject to the control of the husband or to his creditors or form part of his estate.

Features of a policy under the MWP Act

i. Each policy will remain a separate Trust. Either the wife or child (over 18 years of age) can be a trustee.

ii. The policy shall be beyond the control of court attachments, creditors and even the life assured.

iii. The claim money shall be paid to the trustees.

iv. The policy cannot be surrendered and neither nomination nor assignment is allowed.

v. If the policyholder does not appoint a special trustee to receive and administer the benefits under the policy, the sum secured under the policy

becomes payable to the Official Trustee of the State in which the office at which the insurance was effected is situated.

Benefits

The Trust is set up under a deed that cannot be revoked or amended. It can contain one or more insurance policies. It is important to appoint a trustee who would be responsible for administering the trust property, including investing the insurance proceeds, on behalf of the beneficiaries. These benefits are secured from passing to future creditors

2. Key-man Insurance

Keyman insurance is an important form of business insurance.

Definition

Key-man Insurance can be described as an insurance policy taken out by a business to compensate that business for financial losses that would arise from the death or extended incapacity of an important member of the business.

Many businesses have key persons responsible for a major part of its profits or has knowledge and skills that are vital to the organisation and difficult to replace. Key man insurance is taken by employers on the life of such key persons to facilitate business continuity and offset the costs and losses which are likely to be suffered in the event of the loss of a key person. Keyman insurance does not indemnify the actual losses incurred but compensates with a fixed monetary sum as specified on the insurance policy.

Keyman insurance is allowed as a term insurance policy where the sum assured is linked to the profitability of the company rather than the key person's own income. The premium is paid by the company. In case the key person dies, the benefit is paid to the company. The proceeds of Keyman insurance is taxable at the hands of the company.

a) Who can be a key-man?

A key person can be anyone directly associated with the business whose loss can cause financial strain to the business. For example, the person could be a director of the company, a partner, a key sales person, key project manager, or someone with specific skills or knowledge which is especially valuable to the company.

b) Insurable losses

The following are the losses for which key person insurance can provide compensation:

i. Losses related to the extended period when a key person is unable to work, to provide temporary personnel and, if necessary to finance the recruitment and training of a replacement

ii. Insurance to protect profits. For example, offsetting lost income from lost sales, losses resulting from the delay or cancellation of any business project that the key person was involved in, loss of opportunity to expand, loss of specialised skills or knowledge

3. Mortgage Redemption Insurance (MRI)

A person taking a loan to buy a property, may be required to pay for mortgage redemption insurance by the bank, as part of the loan arrangement. "Mortgage Redemption Insurance" is popularly referred to "Credit Life Insurance policy".

a) What is MRI?

It is an insurance policy that provides financial protection for home loan borrowers. It is basically a decreasing term life insurance policy taken by mortgagor to repay the balance on a mortgage loan if he/ she dies before its full repayment. It can be called a loan protector policy. This plan is suitable for people whose dependents may need assistance in clearing their debts in case of the unexpected demise of the policyholder.

b) Features

The insurance cover under this policy decreases each year unlike a term insurance policy where insurance cover is constant during the policy period.

Test Yourself 1

What is the objective behind Mortgage Redemption Insurance?

I. Facilitate cheaper mortgage rates
II. Provide financial protection for home loan borrowers
III. Protect value of the mortgaged property
IV. Evade eviction in case of default

Summary

- Section 6 of the Married Women's Property Act, 1874 provides for security of benefits under a life insurance policy to the wife and children.

- The policy effected under MWP Act shall be beyond the control of court attachments, creditors and even the life assured.

- Keyman insurance is an important form of business insurance. It can be described as an insurance policy taken out by a business to compensate at for financial losses that would arise from the death or extended capacity of an important member of the business.

- Mortgage redemption insurance is basically a decreasing term life insurance policy taken by a mortgagor to repay the balance on a mortgage loan if he/ she dies before its full repayment.

Key Terms

1. Married Women's Property Act
2. Keyman insurance
3. Mortgage Redemption Insurance

Answers to Test Yourself

Answer 1 - The correct option is II.

CHAPTER L-06

PRICING AND VALUATION IN LIFE INSURANCE

Chapter Introduction

The objective of this chapter is to introduce to the learner the basic elements that are involved in the pricing and benefits of life insurance contracts. We shall first discuss the elements that constitute the premium and then discuss the concept of surplus and bonus.

Learning Outcomes

A. Insurance pricing – basic elements

B. Surplus and bonus

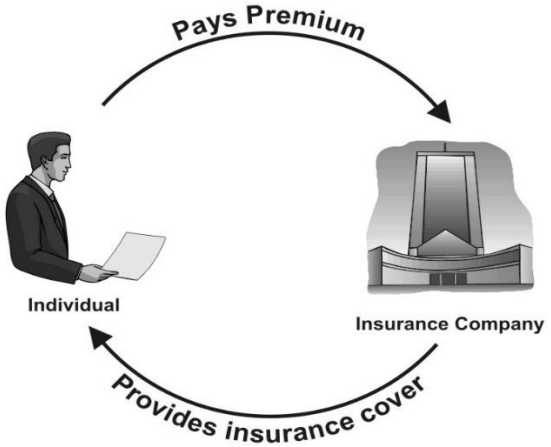
A. Insurance pricing – Basic elements

1. Premium

In ordinary language, the term premium denotes the price that is paid by an insured for purchasing an insurance policy. It is normally expressed as a rate of premium per thousand rupees of sum assured. The premium rates depend on the age of the prospect and the plan.

These premium rates are available in the form of tables of rates that are available with insurance companies.

Diagram 1: Premium



The rates printed in these tables are known as "Office Premiums". They are in most cases the same throughout the term and are expressed as an annual rate.

Example

If the premium for a twenty year endowment policy for a given age is Rs. 4,800, it means that Rs. 4,800 has to be paid each year for twenty years.

However it is possible to have some policies in which the premiums are payable only in the first few years. Companies also have single premium contracts in which only one premium is payable at the beginning of the contract. These policies are usually investment oriented.

2. Rebates

Life insurance companies may also offer certain types of rebates on the premium that is payable. Two such rebates are:

- ✓ For sum assured

- ✓ For mode of premum

Rebate for sum assured

The rebate **for sum assured** is offered to those who buy policies with higher amounts of sum assured. It is offered as a way of passing on to the customer, the gains that the insurer may make when servicing higher value policies. The logic is that the effort and cost required to process a policy of Rs 50,000 or 5,00,000 remains the same. But higher sum assured policies yield more premium and so more profits.

Rebate for mode of premium

Similarly a rebate may be offered **for the mode of premium**. Life insurance companies may allow premiums to be paid on annual, half yearly, quarterly or monthly basis. More frequent the mode, more the administrative costs for collecting and accounting the premium. Again, in the yearly mode, the insurer can utilise this amount during the entire year and earn interest on it. Insurers would hence encourage payment via yearly and half yearly modes by allowing a rebate on these. They may also charge a little extra for monthly mode of payments, to cover additional administrative expenses involved.

3. Extra charges

The tabular premium is charged for those individuals who are not subject to any significant factors that would pose an extra risk. They are known as **standard lives** and the rates charged are known as ordinary rates.

If a person proposing for insurance suffers from certain health problems like heart ailments or diabetes that can pose a hazard to his life, he or she is considered to be sub-standard. The insurer may decide to impose an extra premium by way of a health extra. Similarly an occupational extra may be imposed on those engaged in a hazardous occupation, like a circus acrobat. These extras would result in the premium being more than the tabular premium.

Again, an insurer may offer certain extra benefits under a policy, which are available on payment of an extra premium.

Example

A life insurer may offer a Double Accident Benefit or DAB (where double the sum assured is payable as a claim if death is a result of accident). For this it may charge an extra premium of one rupee per thousand sum assured.

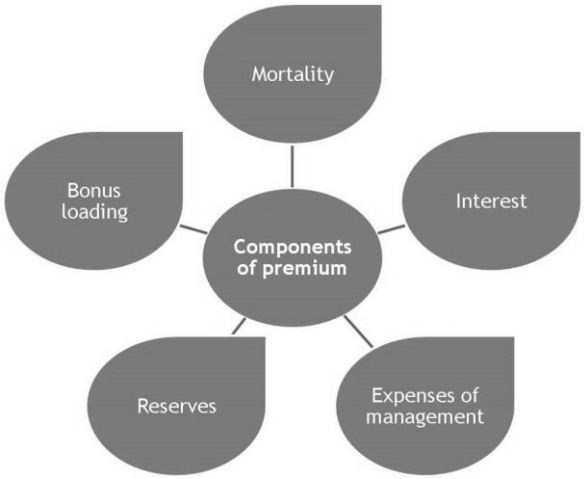
Similarly a benefit known as Permanent Disability Benefit (PDB) may be availed by paying an extra per thousand sum assured.

4. Determining the premium

Let us now examine how life insurers arrive at the rates that are presented in the premium tables. This task is performed by an actuary. The process of setting the premium in case of traditional life insurance policies like term insurance, whole life and endowment considers following elements:

- ✓ Mortality
- ✓ Interest
- ✓ Expenses of management
- ✓ Reserves
- ✓ Bonus loading

Diagram 2: Components of Premium



The first two elements give us the Net premium. By adding [also called 'loading'] the other elements to the net premium we get the gross or office premium

a) Mortality and Interest

Mortality is the first element in premiums. It is the chance or likelihood that a person of a certain age would die during a given year. To find out the expected Mortality of a person, "Mortality Tables" are used.

Example

If the mortality rate for age 35 is 0.0035 it implies that out of every 1000 people who are alive as on age 35, 3.5 (or 35 out of 10,000) are expected to die between age 35 and 36.

The table may be used to calculate mortality cost for different ages. For example the rate of 0.0035 for age 35 implies a cost of insurance of 0.0035 x 1000 (sum assured) = Rs. 3.50 per thousand sum assured.

The above cost may be also called the "Risk Premium". For higher ages the risk premium would be higher.

Example

If we need to have Rs. 5 per thousand to meet the cost of insurance after five years and if we assume a rate of interest of 6%, the present value of Rs. 5 payable after five years would be $5 \times 1/ (1.06)^5 = 3.74$.

If instead of 6% we were to assume 10%, the present value would be only 3.10. In other words the higher the rate of interest assumed, the lower the present value.

From our study of mortality and interest there are two major conclusions we can derive

- ✓ Higher the mortality rate in the mortality table, higher the premiums would be
- ✓ Higher the interest rate assumed, lower the premium

Net premium
The estimates of mortality and interest give the "Net Premium"

Gross premium
Gross premium is the net premium plus an amount called loading. There are three considerations or guiding principles that needs to be borne in mind when determining the amount of loading:

b) Expenses and reserves

Life insurers have to incur various types of operating expenses including:

- ✓ Agents training and recruitment,
- ✓ Commissions of agents,
- ✓ Staff salaries,
- ✓ Office accommodation,
- ✓ Office stationery,
- ✓ Electricity charges,
- ✓ Other miscellaneous etc.

All these have to be paid from premiums that are collected by insurers. These expenses are suitably loaded to the net premium.

c) Lapses and contingencies

In addition to expenses, there are other factors that can make the calculations of life insurers go wrong.

One source of risk is that of lapses and withdrawals. A lapse means that the policyholder discontinues payment of premiums. In case of withdrawals, the policyholder surrenders the policy and receives an amount from the policy's acquired cash value.

Lapses usually happen within the first three years, especially in the first year of the contract.

d) With Profit (participating) policies and Bonus loading

The concept of 'With Profit' policies originated when Life insurers started the practice of charging a high loading in advance to create a buffer to keep them solvent even in adverse situations. If subsequent experience proved to be more favourable, the life insurer would share some of the profits it made as a result with policy holders by way of bonus.

In sum we can say that:

Gross premium = Net premium + Loading for expenses + Loading for contingencies + Bonus loading

Test Yourself 1

What does a policy lapse mean?

I. Policyholder completes premium payment for a policy
II. Policyholder discontinues premium payment for a policy
III. Policy attains maturity
IV. Policy is withdrawn from the market

B. Surplus and bonus

1. Determination of surplus and bonus

Every life insurance company is expected to undertake a periodic valuation of its assets and liabilities. Such a valuation has two purposes:

i. To assess the financial state of the life insurer and determine if it is solvent or insolvent
ii. To determine the surplus available for distribution among policyholders/ share holders

Definition

Surplus is the excess of value of assets over value of liabilities. If it is negative, it is known as a strain.

Let us now see how the concept of surplus in life insurance is different from that of profit of a firm.

Firms in general look at profits in two ways. Firstly, profit is the **excess of income over outgo** for a given accounting period, as it appears in the profit and loss account. Profit also forms part of the balance sheet of a firm - it may be defined as the **excess of assets over liabilities**. In both instances, profits are determined at the end of the accounting period.

Surplus = Assets - Liabilities

Let us understand what liabilities mean in life insurance. For a given block of life insurance policies, the life insurer has to make provision for meeting future claims, expenses and other expected pay-outs that may arise. The insurer also expects to receive premiums in future for these policies.

Liabilities are thus the present value of all payments that have to be made less the present value of premiums expected to be received on these policies. The present value is arrived at by applying a suitable rate of discount [the interest rate]
Surplus arises as a result of the life insurer's actual experience being better than what it had assumed. Life insurers are obliged to share the benefits arising as a result with holders of it's with profit policies.

Example

The profits of XYZ firm as on 31stMarch 2013, is given as its income less expenses or its assets less liabilities as on that date.

In both instances, the profit is clearly defined and is known.

2. Bonus

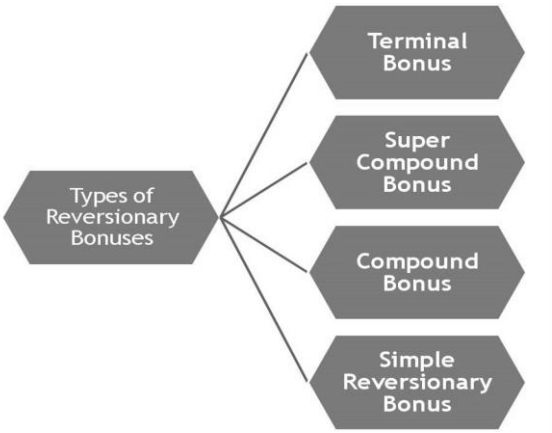
Insurers have to declare and distribute its divisible surplus among the policy holders and shareholders of the company [if any] in the form of a bonus. In India, the United Kingdom and many other countries, distribution of surplus is popular.

Bonus is paid as an addition to the basic benefit payable under a contract. Typically it may appear as an addition to basic sum assured or basic pension per annum. It is expressed, for example, as Rs. 60 per thousand sum assured

The most common form of bonus is the **reversionary bonus**. Once declared these bonus additions, made each year, get attached to the policy and cannot be taken away. They are called 'Reversionary' bonuses because they are received only at the time of a claim by death or maturity. Bonuses may also be payable on surrender provided the contract is eligible through having run for a minimum term [say 5 years]

Types of reversionary bonuses

Diagram 3: Types of Reversionary Bonuses



i. Simple Reversionary Bonus

This is a bonus expressed as a percentage of the basic cash benefit under the contract. In India for example, it is declared as amount per thousand sum assured.

ii. Compound Bonus

Here the company expresses a bonus as a percentage of basic benefit and already attached bonuses. It is thus a bonus on a bonus. A way to express it may be as @ 8% of basic sum assured plus attached bonus.

iii. Terminal Bonus

As the name suggests, this bonus attaches to the contract only at the time of its termination [by death or maturity]. It is applicable only for the claims arising in the ensuing year. Thus terminal bonus declared for 2013 would only apply to claims that have arisen during 2013-14 and not for subsequent years. Terminal bonuses depend on the time duration of the contract and increase with it. A contract that has run for 25 years would have higher terminal bonus than one which has run for 15 years.

3. The Contribution Method

Another method of distribution of surplus adopted in North America is the "Contribution" method. Here, the surplus, i.e. the difference between what was expected to happen and what actually happened over the year with respect to mortality, interest and expenses is declared and distributed as dividends.

The dividends can be paid in cash, by way of adjustments/ reductions in future premiums, by allowing purchase of non-forfeitable paid up additions to the policy or as accumulations to the credit of the policy.

4. Unit Linked Policies

The Principles of Pricing and other features of ULIP Policies have already been covered in an earlier chapter.

Summary

- In ordinary language, the term premium denotes the price that is paid by an insured for purchasing an insurance policy.
- The process of setting the premium for life insurance policies involves consideration of mortality, interests, expense management and reserves.
- Gross premium is the net premium plus an amount called loading.
- A lapse means that the policyholder discontinues payment of premiums. In case of withdrawals, the policyholder surrenders the policy and receives an amount from the policy's acquired cash value.
- Surplus arises as a result of the life insurer's actual experience being better than what it had assumed.
- Surplus allocation could be towards maintaining solvency requirements, increasing free assets etc.
- The most common form of bonus is the reversionary bonus.

Key Terms

1. Premium
2. Rebate
3. Bonus
4. Surplus
5. Reserve
6. Loading
7. Reversionary bonus

Answers to Test Yourself

Answer 1 - The correct option is II.

CHAPTER L-07

LIFE INSURANCE DOCUMENTATION

Chapter Introduction

We have seen that the insurance industry deals with a large number of forms and documents in Chapter 7. There are some documents specific to life insurance, which are discussed in this chapter. Here, we are also discussing the main provisions incorporated in a policy document. Provisions related to grace period, policy lapse and non-forfeiture and certain other privileges are also discussed.

Learning Outcomes

A. Proposal stage documentation

B. Policy stage documentation

C. Policy conditions and privileges

A. Proposal stage documentation

Further to the common points discussed about the Prospectus and the Proposal Form in Chapter 7, there are some additional points that Life Insurers need to understand.

Prospectus: In insurance, 'Prospectus' means a document in physical, electronic or any other format issued by the insurer to sell or promote the insurance product. The prospectus of an insurance product shall clearly state

(a) the Unique Identification Number (UIN) allotted by the Authority for the concerned insurance product:
(b) the scope of benefits;
(c) the extent of insurance cover;
(d) the warranties, exclusions/exceptions and conditions of the insurance cover along with explanations.

The prospectus should also provide:

(a) a description of the contingency or contingencies to be covered by insurance;
(b) the class or classes of lives or property eligible for insurance under the terms of such prospectus.

In Life insurance, the prospectus should also mention about the Riders (also called Add-on covers in Health and General Insurance) allowable on the product and their benefits.

Proposal Form: In respect of Life insurance, the details of the proposers' family members (including parents) indicating their longevity, status of health and ailments suffered by any of them, are collected through the Proposal form. Depending on the product, the medical details of the life proposed for insurance, his/ her personal history of disease and personal characteristics may also be asked for. The Proposal Form is the document by which insurers get all the information that they need from the prospect.

Section 45 of the Insurance Act, provides that the Policy shall not be called in question on the ground of mis-statement after three years. Agents have an important role in guiding the prospect to give answers to all the questions in the Proposal Form/ Medical Forms etc. truthfully and advising them of the implications of not doing so in terms of Section 45.

Proposal Forms for Life Insurance should state the requirements of Section 45 of the Act. While answering the questions in the Proposal Form for obtaining life insurance cover, the prospect is to be guided by the provisions of Section 45 of the Act.

Similarly, Section 39 of the Act is about the provision of nomination. Wherever the facility of Nomination is available to the proposer, the Agent shall inform him/ her of the provisions of Section 39 of the Act and encourage the proposer to avail the facility.

Aspects related to the personal financial planning of the life proposed including his/ her work span, projected income and expenses, as well as needs for savings and investment, health, retirement and insurance may also be asked in the Life Insurance Proposal Form.

Age Proof: Age being an important factor for assessing the risk profile of the life to be insured, Life insurers collect documentary evidence to verify correct age. Valid age proofs may be standard or non-standard, as discussed in Chapter 7.

Life insurers look into the following documents as well.

a) Agent's Confidential Report

The agent is the primary underwriter. All material facts and particulars about the policyholder, relevant to risk assessment, need to be revealed by the agent in his/ her report. This means that matters of health, habits, occupation, income and family details need to be mentioned in the report.

b) Medical Examiner's report

In many cases, the life to be insured has to be medically examined by a doctor who is empanelled by the insurance company. Details of physical features like height, weight, blood pressure, cardiac status etc. are recorded and mentioned by the doctor in his report called the medical examiner's report. The underwriter of the insurance company thereby gets an account of the current health position of the life to be insured.

Many proposals are underwritten and accepted for insurance without calling for a medical examination. They are known as non–medical cases. The medical examiner's report is required typically when the proposal cannot be considered under non-medical underwriting because the sum proposed or the age of the proposed life is high or there are certain characteristics which are revealed in the proposal, which call for examination and report by a medical examiner.

c) Moral Hazard report

Moral Hazard is the likelihood that a client's behaviour might change as a result of purchasing a life insurance policy and such a change would increase the chance of a loss. This is one factor that Life insurance underwriters take into account seriously when assessing the risk.

Life insurance companies seek to guard against the possibility of individuals seeking to make a profit from the purchase of life insurance through actions like ending one's own life or the life of another. Life insurance underwriters would thus look for any factors which might suggest such hazard. For this purpose, the company may require that a Moral Hazard Report has to be submitted by an official of the insurance company.

Example

Vikas recently purchased a life insurance policy. He then decided to go on a skiing expedition at a site which was touted to be one of the most dangerous skiing places on earth. In the past he had refused to undertake such expeditions.

B. Policy Stage Documentation

1. First Premium Receipt

An insurance contract commences when the life insurance company issues a first premium receipt (FPR).
The FPR is the evidence that the policy contract has begun. The first premium receipt contains the following information:

i. Name and address of the life assured
ii. Policy number
iii. Premium amount paid
iv. Method and frequency of premium payment
v. Next due date of premium payment
vi. Date of commencement of the risk
vii. Date of final maturity of the policy
viii. Date of payment of the last premium
ix. Sum assured

After the issue of the FPR, the insurance company will issue subsequent premium receipts when it receives further premiums from the proposer. These receipts are known as renewal premium receipts (RPR). The RPRs act as proof of payment in the event of any disputes related to premium payment.

2. Policy Document

The policy document is the most important document associated with insurance. **It is evidence of the contract between the assured and the insurance company.** It is not the contract itself. If the policy document is lost by the policy holder, it does not affect the insurance contract. The insurance company will issue a duplicate policy without making any changes to the contract. The policy document has to be signed by a competent authority and should be stamped according to the Indian Stamp Act. Life insurers are very careful while designing the policy document because they bear onus of responsibility for any ambiguity or confusion that may arise in the interpretation of its wordings.

The standard policy document typically has three parts:

a) Policy Schedule

The policy schedule forms the first part. It is usually found on the face page of the policy. The schedules of life insurance contracts would be generally similar. They would normally contain the following information:

Diagram 1: Policy document components

i. Name of the insurance company

ii. Some common details of a policy are:

- ✓ Policy owner's name and address
- ✓ Date of birth and age last birthday
- ✓ Plan and term of policy contract
- ✓ Sum assured
- ✓ Amount of premium
- ✓ Premium paying term
- ✓ Date of commencement, date of maturity and due date of last premium
- ✓ Whether policy is with or without profits
- ✓ Name of nominee
- ✓ Mode of premium payment – yearly; half yearly; quarterly; monthly; via deduction from salary
- ✓ The policy number – which is the unique identity number of the policy contract

iii. The insurer's promise to pay. The events on the happening of which and the amounts that are promised to be paid. This forms the heart of the insurance contract

iv. The signature of the authorised signatory and policy stamp

v. The address of the local Insurance Ombudsman.

b) Standard Provisions

The second component of the policy document is made up of standard policy provisions, such as relating to proof of age, premium payment grace period etc. which are normally present in all life insurance contracts. Some of these provisions may not be applicable in the case of certain kinds of contracts, like term, single premium or non-participating (with profits) policies. These standard provisions define the rights and privileges and other conditions, which are applicable under the contract.

c) Specific Policy Provisions

The third part of the policy document consists of specific policy provisions that are specific to the individual policy contract. These may be printed on the face of the document or inserted separately in the form of an attachment.

While standard policy provisions, like days of grace or non-forfeiture in case of lapse, are often statutorily provided under the contract, specific provisions are generally linked to the particular contract between the insurer and the insured.

Example

A clause precluding death due to pregnancy for a lady who is expecting at the time of writing the contract.

Test Yourself 1

What does a first premium receipt (FPR) signify? Choose the most appropriate option.

I. Free-look period has ended
II. It is evidence that the policy contract has begun
III. Policy cannot be cancelled now
IV. Policy has acquired a certain cash value.

C. Policy conditions and privileges

Grace Period

As mentioned in Chapter 4, the Grace Period provision enables a policy that would otherwise have lapsed for non-payment of premium, to continue in force during the grace period. Every life insurance contract undertakes to pay the death benefit on the condition that the premiums have been paid up to date and the policy is in force. The "Grace Period" clause grants the policyholder an additional period of time to pay the premium after it has become due.

The premium however remains due and if the policyholder dies during this period, the insurer deducts the premium from the death benefit. If premiums remain unpaid even after the grace period is over, the policy would then be considered lapsed and the company is not under obligation to pay the death benefit. The only amount payable would be whatever is applicable under the non-forfeiture provisions.

Important

Lapse and Reinstatement/ Revival

We have already seen that a policy may be said to be in lapse condition if premium has not been paid even during the days of grace. The good news is that most lapsed life insurance policies can be reinstated [revived]. As per IRDAI Product Regulations, a Non-Linked Policy can be revived within 5 years from the date of unpaid premium, whereas a Linked Policy can be revived within 3 years.

Definition

Reinstatement is the process by which a life insurance company puts back into force a policy that has either been terminated because of non-payment of premiums or has been continued under one of the non-forfeiture provisions.

A revival of the policy cannot however be an unconditional right of the insured. It can be accomplished only under certain conditions:

i. **Revival application within specific time period:** The policy owner must complete the revival application within the time frame stated in the provision for such reinstatement, say five years from the date of lapsation.

ii. **Satisfactory evidence of continued insurability:** The insured must present to the insurance company satisfactory evidence of continued insurability of the insured. Not only must her health be satisfactory but other factors such as financial income and morals must not have deteriorated substantially.

iii. **Payment of overdue premiums with interest:** The policy owner is required to make payment of all overdue premiums with interest from due date of each premium.

iv. After having evaluated the evidence of continued insurability the insurer may decide to revive the policy as per existing terms and premium or even offer revival with increase in premium or reduced risk cover or both.

Perhaps the most significant of the above conditions is that which requires evidence of insurability at revival. The type of evidence called for would depend on the circumstances of each individual policy. If the policy has been in a lapsed state for a very short period of time, the insurer may reinstate the policy without any evidence of insurability or may only require a simple statement from the insured certifying that he is in good health.

The company may however require a medical examination or other evidence of insurability under certain circumstances:

i. If the grace period has expired since long and the policy is in a lapsed condition for say, nearly a year.

ii. If the insurer has reason to suspect that a health or other problem may be present. Fresh medical examination may also be required if the sum assured or face amount of the policy is large.

Important

Revival of lapsed policies is an important service function that life insurers seek to actively encourage since policies in lapsed state may do little good to either insurer or policyholder.

Non-forfeiture provisions

The Insurance Act, 1938 (Section 113) protects policies (which have acquired surrender value), from lapsation, by keeping them alive to the extent of paid-up sum assured even without payment of further premiums. This is because the policyholder has a claim to the cash value accumulated under the policy.

a) Surrender values

Surrender value is the amount you stand to get when you decide to make a premature exit from the plan, i.e. when you have decided to completely withdraw or terminate the policy before its maturity.

Life insurers normally have a chart that lists the surrender values at various times and also the method that will be used for calculating the surrender values. The formula takes into account the type and plan of insurance, age of the policy and the length of the policy premium-paying period.

The actual amount of cash one gets in hand on surrender may be different from the surrender value amount prescribed in the policy. The actual amount may differ on account of any accrued bonuses, recoveries etc.

Guaranteed Surrender Value [GSV]: The law in India as per IRDAI Guidelines (revised in 2019) provides for a Guaranteed Surrender Value [GSV] to be payable if all premiums have been paid for at least two consecutive years. This Value arrived as a percentage (say 30%) of premiums paid is called Guaranteed Surrender Value. The value depends on the duration of premium paid. The GSV is required to be mentioned in the policy document.

b) Policy loans

Life insurance policies that accumulate a cash value also have a provision to grant the policyholder the right to borrow money from the insurer by using the cash value of the policy as a security for the loan. The policy loan is usually limited to a percentage of the policy's surrender value (say 90%). Note that the policyholder borrows from his own account. He or she would have been eligible to get the amount if the policy had been surrendered. In that case the insurance would have been terminated.

Insurers charge interest on policy loans, which are payable semi-annually or annually. Although loan and interest are repayable periodically, If the loan has not been repaid, the insurer deducts the amount of outstanding (unpaid) loan and interest from the policy benefit that is payable. A loan provides relief to policyholder in case of financial emergencies while keeping the insurance alive.

Since the loan is granted on the policy being kept as security, the policy has to be assigned (explained in later para) in favour of the insurer. Where the policyholder has nominated (explained in later para) someone to receive the money in the event of death of the insured, this nomination shall not be cancelled but the nominee's right will be affected to the extent of the insurer's interest in the policy.

Example

Arjun bought a life insurance policy wherein the total death claim payable under the policy was Rs. 2.5 lakhs. Arjun's total outstanding loan and interest under the policy amounts to Rs. 1.5 lakhs. Hence in the event of Arjun's death, the nominee will be eligible to get the balance of Rs. 1 lakh.

Special policy provisions and endorsements

a) Nomination

i. Under Section 39 of the Insurance Act 1938, the holder of a policy on his/ her own life may nominate the person or persons to whom the money secured by the policy shall be paid in the event of his/her death.
ii. The life assured can **nominate one or more than one person** as nominees.
iii. Nominees are entitled for **valid discharge** and have to **hold the money as a trustee** on behalf of those entitled to it.
iv. Nomination can be done either **at the time the policy is bought or later** at any time before the maturity of the Policy.
v. Nomination may be incorporated in the text of the Policy itself or by an endorsement on the Policy. Nominations need be communicated to the insurer and registered by the insurer in the records relating to the Policy.
vi. Nomination can be cancelled or changed at any time before Policy matures, by an endorsement or a further endorsement or a will as the case may be.

Important

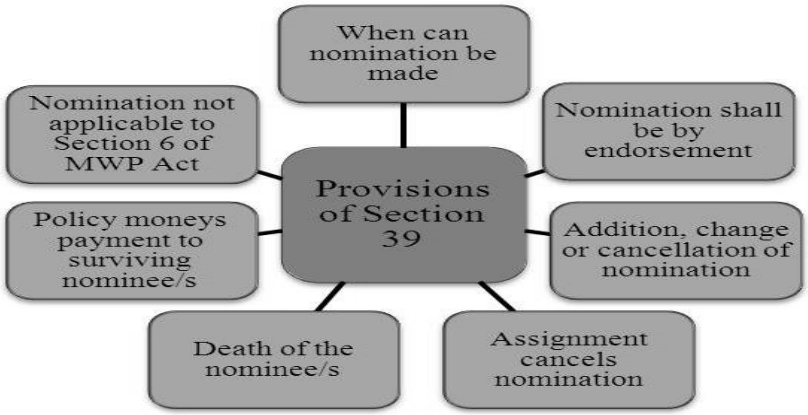
Nomination only gives the nominee the right to receive the policy monies from the insurer in the event of the death of the life assured. However, the money would be belonging to the legal heir only. **A nominee does not have any right to the whole (or part) of the claim.** However vide Section 39(7) of Insurance Act,1938, in respect of all policies maturing for payment after 26th December, 2014, nomination in favour of parents, spouse, children or spouse and children by the owner of the policy on his/ own life makes the nominees beneficially entitled to the amount payable by the insurance company.

Where the nominee is a minor, the policy holder needs to appoint an appointee. The appointee needs to sign the policy document to show his or her consent to acting as an appointee. The appointees lose their status when the nominee reaches majority age. The policy holder can change the appointee at any time. If no appointee is given, and the nominee is a minor, then on the death of the life assured, the death claim is paid to the legal heirs of the policyholder.

Where more than one nominee is appointed, the death claim will be payable to them jointly, or to the survivor or survivors. Nominations made after the commencement of the policy have to be intimated to the insurers to be effective.

Section 39(11) of the Insurance Act says that where a policyholder dies after the maturity of the policy but the proceeds and benefit of his policy has not been made to him because of his death, his nominee shall be entitled to the proceeds and benefit of his policy.

Diagram 2: Provisions related to nomination



b) Assignment

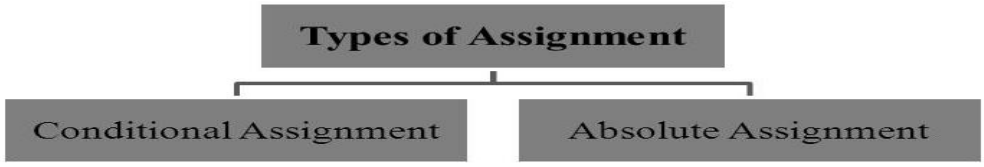
Since life insurance policy carries a promise or a debt that the insurance company owes the insured, it is considered a security for money or property. We have seen that loan is advanced against by the insurers against the surrender value of the policy. Similarly, many financial institutions including banks advance loan against the security of the insurance policy by having it assigned it in their favour.

The term assignment ordinarily refers to transfer of property by writing in favour of another person.

The assignment of a life insurance policy implies the act of transferring the rights, title and interest in the policy (as property) from one person to another. The person who transfers the rights is called **assignor** and the person to whom property is transferred is called **assignee**. On assignment, the ownership of the policy changes and hence nomination is cancelled, except when assignment is made to the insurance company for a policy loan.

There are two types of assignments.

Diagram 3: Types of Assignment



Conditional Assignment	Absolute Assignment

Conditional assignment provides that the policy shall revert back to the life assured on his or her surviving the date of maturity or on death of the assignee.	• Absolute assignment provides that all rights, title and interest which the assignor has in the policy are transferred to the assignee without reversion to the former or his/ her estate in any event. • The policy thus vests absolutely with the assignee. The latter can deal with the policy in whatever manner he or she likes without the consent of the assignor.

Absolute assignment is more commonly seen in many commercial situations where the policy is typically mortgaged against a debt assumed by the policyholder, like a housing loan.

Conditions for valid assignment

Let us now look at the conditions that are necessary for a valid assignment.

i. The assignor must have **absolute right and title or assignable interest** to the policy being assigned.

ii. The assignment should **not be opposed to any law in force**.

iii. Assignee can do another assignment, but cannot do nomination because assignee is not the life assured.

Important:

- A life insurance policy can be assigned wholly or partially
- The assignment must be signed by the transferor or assignor or duly authorized agent and attested by at least one witness.
- The transfer of title has to be specifically set forth in the form of an endorsement on the policy or a separate instrument.
- The policyholder must give notice of the assignment to the insurer, without which the assignment will not be valid.
- Section 38(2) specifies that an insurer may accept the assignment, or decline the same, if it has sufficient reason to believe that such assignment is not bona fide or is not in the interest of the policyholder or in public interest or is for the purpose of trading of insurance policy.
- However, the insurer shall, before refusing to act upon the endorsement, record in writing the reasons for such refusal and communicate the same to the policyholder not later than thirty days from the date of the policyholder giving notice of such transfer or assignment.

Diagram 4: Provisions related to assignment of insurance policies

Commonly extended privileges to policyholders

a) **Duplicate Policy:**

A life insurance policy document is only an evidence of a promise. Loss or destruction of the policy document does not in any way absolve the company of its liability under the contract. Life insurance companies generally have standard procedures to be followed in case of loss of the policy document.

Normally the office would examine the case to see if there is any reason to doubt the alleged loss. Satisfactory proof may need to be produced that the policy has been lost and not dealt with in any manner. Generally the claim may be settled on the claimant furnishing an indemnity bond with or without surety.

If payment is shortly due and the amount to be paid is high, the office may also insist that an advertisement be placed in a national paper with wide circulation, reporting the loss. A duplicate policy may be issued on being sure that there is no objection from anyone else.

b) **Alteration**

Policyholders may seek to effect alterations in policy terms and conditions. There is provision to make such changes subject to consent of both the insurer and assured. Normally alterations may not be permitted during the first year of the policy, except for change in the mode of premium or alterations which are of a compulsory nature – like

- ✓ change in name or/ address;
- ✓ readmission of age in case it is proved higher or lower;
- ✓ request for grant of double accident benefit or permanent disability benefit etc.

Alterations may be permitted in subsequent years. Some of these alterations may be affected by placing a suitable endorsement on the policy or on a separate paper. Other alterations, which require a material change in policy

conditions, may require the cancellation of existing policies and issue of new policies.

Some of the main types of alterations that are permitted are

i. Change in certain classes of insurance or term [where risk is not increased]
ii. Reduction in the sum assured
iii. Change in the mode of payment of premium
iv. Change in the date of commencement of the policy
v. Splitting up of the policy into two or more policies
vi. Removal of an extra premium or restrictive clause
vii. Change from without profits to with profits plan
viii. Correction in name
ix. Settlement option for payment of claim and grant of double accident benefit

These alterations generally do not involve an increase in the risk. There are other alterations in policies that are not allowed. These may be alterations that have the effect of lowering the premium. Examples are extension of the premium paying term; change from with profit to without profit plans; change from one class of insurance to another, where it increases the risk: and increase in the sum assured.

Test Yourself 2

Under what circumstances would the policyholder need to appoint an appointee?

I. Insured is minor
II. Nominee is a minor
III. Policyholder is not of sound mind
IV. Policyholder is not married

Summary

- Matters of health, habits and occupation, income and family details need to be mentioned by the agent in the agent's report.
- Details pertaining to physical features like height, weight, blood pressure, cardiac status etc. are recorded and mentioned by the doctor in his/ her report called the medical examiner's report.
- Moral hazard is the likelihood that a client's behaviour might change as a result of purchasing a life insurance policy and such a change would increase the chance of a loss.
- An insurance contract commences when the life insurance company issues a first premium receipt (FPR). The FPR is the evidence that the policy contract has begun.
- The policy document is the most important document associated with insurance. It is the evidence of the contract between the assured and the insurance company.
- The standard policy document typically has three parts which are the policy schedule, standard provisions and the policy's specific provisions.

- The grace period clause grants the policyholder an additional period of time to pay the premium after it has become due.
- Reinstatement is the process by which a life insurance company puts back into force a policy that has either been terminated because of non-payment of premiums or has been continued under one of the non-forfeiture provisions.
- A policy loan is different from an ordinary commercial loan in two respects, firstly the policy owner is not legally obligated to repay the loan and the insurer need not perform a credit check on the insured.
- Nomination is where the life assured proposes the name of the person(s) to which the sum assured should be paid by the insurance company after their death.
- The assignment of a life insurance policy implies the act of transferring the rights right, title and interest in the policy (as property) from one person to another. The person who transfers the rights is called assignor and the person to whom property is transferred is called assignee.
- Alteration is subject to consent of both the insurer and assured. Normally alterations may not be permitted during the first year of the policy, except for some simple ones.

Key Terms

1. Agents Confidential Report
2. Medical Examiner's Report
3. Moral Hazard Report
4. First Premium Receipt (FPR)
5. Policy document
6. Policy schedule
7. Standard provisions
8. Special Provisions
9. Grace period
10. Policy lapse
11. Policy revival
12. Surrender value
13. Nomination
14. Assignment

Answers to Test Yourself

Answer 1 - The correct option is II.

Answer 2 - The correct option is II.

CHAPTER L-08

LIFE INSURANCE UNDERWRITING

Chapter Introduction

A life insurance agent's work does not stop once a proposal is secured from a prospective customer. The proposal must also be accepted by the insurance company and result in a policy.

Every life insurance proposal has to pass through a gateway where the life insurer decides whether to accept the proposal and if so, on what terms. In this chapter we shall know more about the process of underwriting and the elements involved in the process.

Learning Outcomes

A. Underwriting – Basic concepts

B. Non-medical underwriting

C. Medical underwriting

A. Underwriting – Basic concepts

1. Underwriting purpose

Underwriting has two purposes

i. To assess the risk, classify the risk and decide the terms of acceptance or to decline the risk.
ii. To prevent anti-selection against the insurer

Definition

The term **underwriting** refers to the process of evaluating each proposal for life insurance in terms of the degree of risk it represents and then deciding whether or not to grant insurance and on what terms.

Anti-selection is the tendency of people, who suspect or know that their chance of experiencing a loss is high, to seek out insurance with a view to gain in the process.

Example

If life insurers were to be not selective about whom they offered insurance, there is a chance that people with serious ailments like heart problems or cancer, who did not expect to live long, would seek to buy insurance.

In other words, if an insurer did not exercise underwriting discretion, it would be selected against and may suffer losses in the process.

2. Equity among risks

The term "Equity" means that applicants who are exposed to similar degrees of risk must be placed in the same premium class. The Mortality table, used to determine premiums, represents the mortality experience of standard lives or average risks. They include the vast majority of individuals who propose to take life insurance.

a) Risk classification

To usher equity, the underwriter engages in a process known as **risk classification** i.e. individual lives are categorised and assigned to different risk classes depending on the degree of risks they pose. There are four such risk classes.

Diagram 1: Risk classification

i. Standard lives

These consist of those whose anticipated mortality corresponds to the standard lives represented by the mortality table.

ii. Preferred risks

These are the ones whose anticipated mortality is significantly lower than standard lives and hence could be charged a lower premium.

iii. Substandard lives

These are the ones whose anticipated mortality is higher than the average or standard lives, but are still considered to be insurable. They may be accepted for insurance with higher (or extra) premiums or subjected to certain restrictions.

iv. Declined lives

These are the ones whose impairments and anticipated extra mortality are so great that they could not be provided insurance coverage at an affordable cost. Sometimes an individual's proposal may also be temporarily declined if he or she has been exposed to a recent medical event, like an operation.

3. Underwriting process

Underwriting process takes place at two levels:

- ✓ At Field level
- ✓ At Underwriting department level

a) Field or Primary level

Field level underwriting is also known as **primary underwriting**. It includes information gathering by an agent or company representative to decide whether an applicant is suitable for granting insurance coverage. The agent plays a critical role as primary underwriter. He is in the best position to know the life to be insured.

Many insurance companies may require that agents complete a statement or a confidential report, asking for specific information, opinion and

recommendations to be provided by the agent with respect to the proposed life.

Fraud monitoring and role of agent as primary underwriter

Much of the decision with regard to acceptance of a risk depends on the facts that have been disclosed by the proposer in the proposal form. It may be difficult for an underwriter who is sitting in the underwriting department to know whether these facts are untrue and have been fraudulently misrepresented with deliberate intent to deceive.

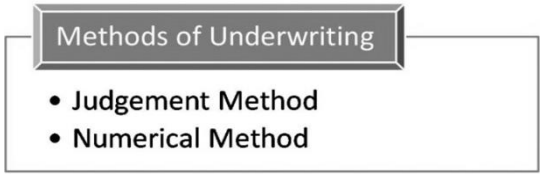
The agent plays a significant role here. He or she is in the best position to ensure that the facts that have been represented are true, due to his/ her direct and personal contact with the proposed life.

b) Underwriting at the Department level

The main level of Underwriting is at the Department or Office level. It involves specialists and persons who consider all the relevant data on the case to decide whether to accept a proposal for Life insurance and on what terms.

4. Methods of underwriting

Diagram 2: Methods of Underwriting



Underwriters may use two types of methods for the purpose:

Judgment Method	Numerical Method
Under this method subjective judgment is used, especially when deciding on a case that is complex.	Under this method underwriters assign positive rating points for all negative or adverse factors (negative points for any positive or favourable factors).
Example: Deciding whether life insurance can be given to a person staying in a disturbed country/ area.	**Example:** A person with history of cardiac ailments and/ or early deaths in the family may be assigned positive points. The total number of points so assigned will help an underwriter in deciding the extent of risk involved.
In such situations, the department may get the expert opinion of a medical doctor who is also called a medical referee.	The sum total of these positive/negative points, and/or is referred to as Extra Mortality Rating (EMR). Higher EMR indicates that the life is substandard. If the EMR is very high, underwriters may decline insurance.

Underwriting Decisions

Let us now consider the various kinds of decisions that underwriters may take with regard to a life proposed for underwriting.

a) **Acceptance at ordinary rates (OR)** is the most common decision. This rating indicates that the risk is accepted at the same rate of premium as would apply to an ordinary or standard life.

Diagram 3: Underwriting decisions

b) **Acceptance with an extra:** This is the most common way of dealing with the large majority of sub-standard risks. It involves charging an extra over the tabular rate of premium.

c) **Acceptance with a lien on the sum assured:** A lien is a kind of hold which the life insurance company can exercise (in part or whole) on the amount of benefit it has to pay in the event of a claim.

Example: Consider the case of an insured who has suffered and recovered from a certain disease like TB. Imposition of Lien would imply that if this person were to die from a relapse of the TB, within a given period, only a decreased amount of death benefit may be payable.

d) **Acceptance with a restrictive clause:** For certain kinds of hazards a restrictive clause may be applied which limits death benefit in the event of death under certain circumstances.

Example is a pregnancy clause imposed on pregnant ladies that limits insurance payable in the event of pregnancy related deaths occurring within say three months of delivery.

e) **Decline or postpone:** Finally, a life insurance underwriter may decide to decline or reject a proposal for insurance. This would happen when there are certain health/ other features which are so adverse that they considerably increase the risk.

Example: An individual who suffers from cancer and has little chance of remission, would be a candidate for rejection,

Similarly in some cases it may be prudent to postpone acceptance of the risk until such time as the situation has improved and become more favourable.

Example

A lady who has just had a hysterectomy operation may be asked to wait for a few months before insurance on her life is allowed, to allow any post operation complications that may have arisen to disappear.

Test Yourself 1

Which of the following cases is likely to be declined or postponed by a life insurer?

I. A healthy 18 year old
II. A sports person
III. A person suffering from AIDS
IV. A housewife with no income of her own

B. Non-medical underwriting

1. Non-medical underwriting

A large number of life insurance proposals may typically get selected for insurance without conducting a medical examination to check the insurability of a life to be insured. Such cases are termed as **non-medical proposals**.

In view of multiple reasons including the costs involved, in some types of policies, Life insurers grant insurance without insisting on a medical examination

2. Conditions for non-medical underwriting

However non-medical underwriting calls for conditions like applicability to certain class of lives, certain plans of insurance, certain upper limits of sum insured, entry age limits, maximum term of insurance etc.to be followed.

3. Rating factors in underwriting

Rating factors refer to various aspects related to financial situation, life style, habits, family history, personal history of health and other personal circumstances in the prospective insured's life that may pose a hazard and increase the risk. Underwriting involves identifying these hazards and their likely impact and classifying the risk accordingly.

Rating factors may be broadly divided into two – those which contribute to moral hazard and those which contribute to physical [medical] hazards. Life insurance companies often divide their underwriting into categories accordingly. Factors

like income, occupation, lifestyle and habits, which contribute to moral hazard, are assessed as part of **financial underwriting**, while medical aspects of health fall under **medical underwriting**.

a) Female insurance

Women generally have greater longevity than men. However they may face some problems with respect to moral hazard. This is because many women in Indian society are victims of male domination and social exploitation. Evils like dowry deaths exist even today. Longevity of women can also be affected from problems connected with pregnancy.

Insurability of women is governed by need for insurance and capacity to pay premiums. Insurance companies may thus decide to grant full insurance only to those who have earned income of their own and may impose limits on other categories of women. Similarly some conditions may be levied on pregnant women.

b) Minors

Minors have no contracting power of their own. Hence a proposal on the life of a minor has to be submitted by another person who is related to the minor in the capacity of a parent or legal guardian. It would also be necessary to ascertain the need for insurance, since minors usually have no earned income of their own. Three conditions would generally be sought when considering insurance for minors:

i. **Whether they have a properly developed physique**

   Poor physique can be a result of malnutrition or other health problems posing grave risks.

ii. **Proper family history and personal history**

   If there are adverse indicators here, it may pose risks.

iii. **Whether the family is adequately insured**

   It is necessary to check if the family has a culture of insurance. One must be on guard if no other member of the minor's family has been insured. Amount of insurance is generally linked to that of parents.

c) Large sums assured

An underwriter needs to be wary when the amount of insurance is very large relative to annual income of the proposed insured. Generally sum assured may be assumed to be around ten to twelve times one's annual income. If the ratio is much higher than this, it raises the possibility of selection against the insurer.

Example

If an individual has an annual income of Rs. 5 lakhs and proposes for a life insurance cover of Rs. 3 crores, it raises a cause for concern.

Typically concerns can arise in such instances because of the possibility that such a large amount of insurance is being proposed in anticipation of suicide

or as a result of expected deterioration in health. A third reason for such large sums could be excessive misselling by the sales person.

Large sums assured would also mean premiums increasing in proportion and raise the question of whether the payment of such premiums would be continued. In general, the premium payable should be within one third of an individual's annual income

d) Age

Mortality risk is closely related to age. The underwriter needs to be careful when considering insurance for people of advanced ages.

Example

If the insurance is being proposed for the first time after age 50, there is a need to suspect moral hazard and enquire about why such insurance was not taken earlier.

We must also note that chances of occurrence of degenerative diseases like diseases of the heart and kidney failure increase with age and become higher at older ages. Life insurers may also seek for some special reports when proposals are submitted for high sums assured/ advanced ages or a combination of both.

Example

Examples of such reports are ECG; EEG; X-Ray of the chest and Blood Sugar test. These tests may reveal deeper insights about the health of the proposed life than the answers given in the proposal or an ordinary medical examination can provide.

Examples

When a proposal is submitted at a branch located far away from the place of residence of the proposed insured

A medical examination is done elsewhere even when a qualified medical examiner is available near one's place of residence.

A third case is when a proposal is made on the life of another without having clear insurable interest, or when the nominee is not the near dependent of the life proposed.

In each such case an enquiry may be made. Finally, when the agent is related to the life assured a moral hazard report may be called from a branch official like the agency manager/ development officer.

e) Occupation

Occupational hazards can arise from three sources:

- ✓ Accident
- ✓ Health hazard
- ✓ Moral hazard

Diagram 4: Sources of Occupational Hazards

i. **Accidental hazards** arise because certain kinds of jobs expose one to the risk of accident. There is any number of jobs in this category – like circus artistes, scaffolding workers, demolition experts and film stunt artistes.

ii. **Health hazards** arise when the nature of the job is such as to give rise to possibility of medical impairment. There are various kinds of health hazards.

- ✓ Some jobs like that of **rickshaw pullers** involve a lot of physical strain and impact the respiratory system.
- ✓ Situations where one may be exposed to **toxic substances** like mining dust or carcinogenic substances (that cause cancer) like chemicals and nuclear radiation.
- ✓ Working in **high pressure environments** like underground tunnels or deep sea, can cause acute decompression sickness.
- ✓ Finally, **overexposure** to certain job situations (like sitting cramped before a computer or working in a high noise setting) can impair functioning of certain body parts in the longer run.

iii. **Moral hazard** can arise when a job involves proximity or can cause predisposition towards criminal elements or to drugs and alcohol. An example is that of a dancer in a nightclub or an enforcer in a liquor bar or the 'bodyguard' of a businessman with suspected criminal links. Again the job profiles of certain individuals like superstar entertainers may lead them to intoxicating lifestyles, which sometimes come to tragic ends.

When an occupation falls under any such hazardous category, the applicant for insurance may need to complete an occupational questionnaire that asks for specific details of the job, duties involved and risks exposed to. A rating may also be imposed for occupation in the form of a flat extra (for example Rupees two per thousand sums assured.) Such extra may be reduced or removed when the insured's occupation changes.

f) Lifestyle and habits

Lifestyle and habits are terms, covering a wide range of individual lifestyle characteristics, which may be brought out in the agent's confidential reports

and moral hazard reports, suggesting an exposure to risk. In particular three features are important:

Smoking and tobacco use: Use of tobacco is not only a risk in itself but also contributes to increasing other medical risks. Companies charge differential rates today for smokers and non-smokers and users of other forms of tobacco usage like *gutkha* and *paan masala*.

Alcohol: Drinking alcohol occasionally or in modest quantities is not considered a hazard. However, long term heavy drinking can impair liver functioning, affect the digestive system and lead to mental disorders. Alcoholism is also linked with accidents, violence, family abuse, depression and suicides.

Substance abuse: Substance abuse refers to the use of various kinds of substances like drugs or narcotics, sedatives and other similar stimulants. Some of these are even illegal and their use indicates criminal disposition and moral hazard.

Test Yourself 2

Which of the following is an example of moral hazard?

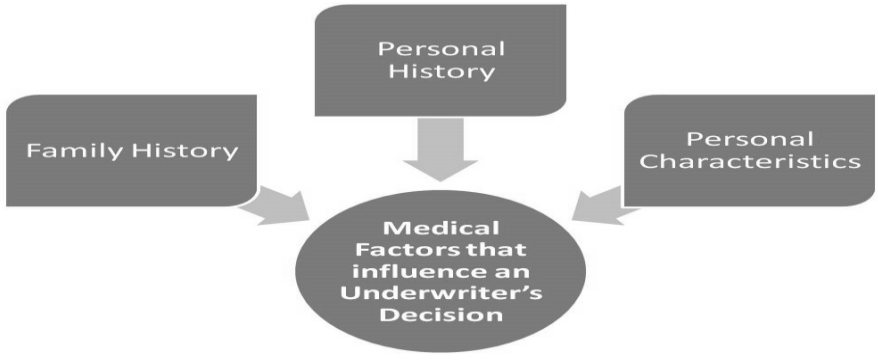
I. Stunt artist dies while performing a stunt
II. A person drinking copious amounts of alcohol because he is insured
III. Insured defaulting on premium payments
IV. Proposer misplacing policy document

C. Medical underwriting

1. Medical underwriting

Let us now consider some of the medical factors that would influence an underwriter's decision. These are generally assessed through medical underwriting. They may often call for a medical examiner's report. Let us look at some of the factors that are checked.

Diagram 5: Medical Factors that influence an Underwriter's Decision



a) Family history

The impact of family history on mortality risk has been studied from three angles.

i. **Heredity**: Certain diseases can be transmitted from one generation to another, say from parents to children.

ii. **Average longevity of the family**: When the parents have died early on account of certain diseases like heart trouble or cancer, it may be a pointer that the offspring may also not live long.

iii. **Family environment**: Thirdly, the environment in which the family lives can cause exposure to infection and other risks.

Life insurers have thus to be careful when entertaining cases of individuals with adverse family history. They may call for other reports and may impose an extra mortality rating in such cases.

b) Personal history

Personal history refers to past impairments of various systems of the human body which the life to be insured has suffered from. The proposal form for life insurance typically contains a set of questions which enquire whether the life to be insured has been under treatment for any of these.

The major kinds of ailments that are considered by the underwriters include Cardiovascular diseases, diseases of the respiratory system, malignant tumours/ cancer, ailments of the renal system, impairments of the endocrine system, diseases of the digestive system like gastric ulcers and cirrhosis of the liver and diseases of the nervous system.

c) Personal characteristics

These can also be significant indicators of the tendency to disease.

i. Build

A person's build consists of his height, weight, chest and girth of the abdomen. For given age and height, there is a standard weight that has been defined and if the weight is too high or low in relation to this standard weight, we can say that the person is overweight or underweight.

Similarly, it is expected that the chest should be expanded at least by four centimetres in a normal person and that the abdominal girth should not be more than one's expanded chest.

ii. Blood pressure

Another indicator is a person's blood pressure. There are two measures of this

- ✓ Systolic
- ✓ Diastolic

When the actual readings are much higher than the normal values, we say that the person has high blood pressure or hypertension. When it is too low, it is termed as hypotension. The former can have serious consequences.

iii. Urine – Specific gravity

Finally, a reading of the specific gravity of one's urine can indicate the balance among various salts in the urinary system. It can indicate any malfunctioning of the system.

d) Backdating:

Backdating means changing the start date of the policy to an earlier one. For example, you bought a Life insurance policy on 1st June, 2013 but later you think that the policy would have generated better returns if you had bought it in April 2013. You and your insurance company agree to change the policy to officially start it from April, 2013. In this case, you have backdated the policy. Usually, no interest is charged if the policy is backdated by less than a month.

Backdating is done for the following purposes:

(i) **Getting a lower premium based on age:** While issuing the policy, insurers consider the nearest age of the policyholder. It means if you are 32 years and 7 months old, the insurer will consider your age as 33 years. This nearest age may put you in a higher premium slab. However, if you backdate the policy by 2 months, the insurer will consider your age as 32 years and 5 months only. Now you will be paying lower premiums based on a plan for a 32-year old.

(ii) **Set the timing of payment:** There are specific professions where the income flow is not steady. In such a scenario if an individual accidently buys a life insurance policy in its off-season then the policy can be backdated to the period of maximum earnings. For instance, a farmer may have a seasonal income. He would prefer to make insurance payments only after he has received his crop proceedings. In this case, a farmer could backdate the policy to start it in the harvest season.

(iii) **To coincide with special dates:** You can backdate the policy to coincide with your important dates, such as birthday and anniversary. It keeps easy for you to remember your premium due date.

(iv) **Early maturity claims**: Backdating reduces the tenure of a policy and facilitates early maturity. For instance, if a 30-year life insurance cover bought on March 2000 is backdated to April 1999, the policy would mature on April, 2029 instead of March 2030. In case of endowment policies, this could be beneficial as maturity benefits accrue earlier.

Test Yourself 3

Why is heredity history of importance in medical underwriting?

I. Rich parents have healthy kids
II. Certain diseases can be passed on from parents to children
III. Poor parents have malnourished kids
IV. Family environment is a critical factor

Summary

- To bring equity, the underwriter engages in risk classification where individual lives are categorised and assigned to different risk classes depending on the degree of risks they pose.
- Underwriting process may be said to take place at two levels:
  - ✓ At field level and
  - ✓ At underwriting department level
- Underwriting decisions made by underwriters include acceptance of standard risk at standard rates or charging extra for sub-standard risks. Sometimes there is acceptance with lien on sum assured or acceptance is based on restrictive clauses. Where the risk is large the proposal is declined or postponed.
- A large number of life insurance proposals may typically get selected for insurance without conducting a medical examination. Such cases are termed as non-medical proposals.
- Some of the rating factors for non-medical underwriting include
  - ✓ Age
  - ✓ Large sum assured
  - ✓ Moral hazard etc.
- Some of the factors considered in medical underwriting include
  - ✓ Family history,
  - ✓ Heredity and personal history etc.

Key Terms

1. Underwriting
2. Standard life
3. Non-medical underwriting
4. Rating factor

5. Medical underwriting
6. Anti-selection

Answers to Test Yourself

Answer 1 - The correct option is III.

Answer 2 - The correct option is II.

Answer 3 - The correct option is II.

CHAPTER L-09
LIFE INSURANCE CLAIMS

Chapter Introduction

This chapter explains the concept of claim and how claims are ascertained. The chapter then explains the types of claims. In the end you will learn about the forms to be submitted for a death claim and the safeguards in place to protect a beneficiary from claim rejection by the insurer, provided no material information has been suppressed by the insured.

Learning Outcomes

A. Types of claims and claims procedure
B. Ascertaining whether a claim situation has occurred
C. Claims Procedure for Life Insurance Policies

A. Types of claims and claims procedure

Concept of claims

The real test of an insurance company and an insurance policy comes when a policy results into a claim. The true value of life insurance is judged by the way a claim is settled and benefits are paid.

IRDAI's Protection of Policyholders' Interests Regulations, 2017 prescribes that life insurers, shall process death claims without delay and call for all requirements together, within 15 days of the receipt of the death intimation.

A death claim shall be paid, rejected or repudiated giving all the relevant reasons, within 30 days from the date of receipt of all relevant papers/ clarifications.

If, in the opinion of the insurer, the claim warrants investigation, it shall complete the same expeditiously, within 90 days from the date of intimation and settle the claim within 30 days thereafter.

IRDAI specifies that in respect of Maturity clams, Survival Benefit claims and Annuities, the Life Insurer shall initiate the claim process by sending advance intimation, by sending post-dated cheque or by giving direct credit to the bank account of the claimant through any electronic mode approved by RBI, so as to pay the claim on or before the due date.

Definition

A claim is a demand that the insurer should make good the promise specified in the contract.

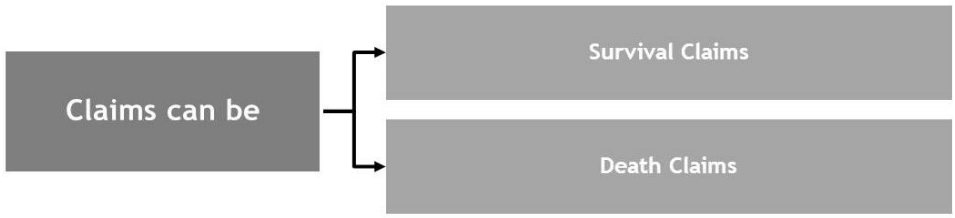
A claim under a life insurance contract is triggered by the happening of one or more of the events covered under the insurance contract. While in some claims, the contract continues, in others, the contract is terminated.

Claims can be of two types:

i. survival claims payable when the life assured is alive and

ii. death claim

Diagram 1: Types of claims



While a **death claim** arises only upon the death of the life assured, **survival claims** are payable on happening of events specified in the policy.

Important

In all claims situations, the insurer has to ensure that the identity of the claimant is proven and well documented as per KYC norms.

Example

Such specified events where the claims are paid to the insured.

i. The insured reaching the maturity period of the policy;
ii. The insured reaching the pre-decided duration(s) under a money-back policy, when instalment(s) become payable; or under annuity plans.
iii. Occurrences of Critical illnesses covered under the policy (as a rider benefit or otherwise);
iv. Surrender of the policy either by the policyholder or assignee;

B. Ascertaining whether a claim situation has occurred

i. **Survival claim** is payable to the insured on reaching the period of maturity or fulfilling conditions stipulated in the policy.

ii. **Maturity claims and money-back instalment claims** are easily established as they are based on dates which are determined at the beginning of the contract itself. For instance, the date of maturity and the dates when the instalments of survival benefits may be paid under a money back policy are clearly laid out at the time of preparing the contract.

iii. **Surrender value payments** are different from other claim payments. Here, unlike other claims, the event is triggered by the decision of the policy holder or assignee to cancel the contract and withdraw what is due to him or her under the contract. There is typically a penalty for premature withdrawal. The amount paid would be less than what would be due under a full claim and hence would be less than what would have been due if the full claim were to be paid.

iv. **Critical illness** claims are ascertained based on the medical and other records provided by the policyholder in support of his claim.

v. **Annuities:** In case of annuity payments (pension plans), insured need to provide life certificates periodically.

The purpose of a critical illness benefit is to enable a policy holder to defray his/ her expenses in the event of a critical illness. If this policy were to be assigned, all the benefits would be payable to the assignee and it would not meet the intended purpose of the critical illness benefit. To avoid this situation, policy holders need to be educated about the extent of benefits they may assign by way of a conditional assignment.

A **maturity or death claim** or a surrender leads to termination of the insurance cover under the contract and no further insurance cover is available.

Types of claims: The following payments may occur during the policy term:

a) Survival Benefit Payments

Periodical payments are made by the insurer to the insured at specified times during the term of the policy.

I. Surrender of Policy

Surrender value reflects the value of investments and depends on various factors such as sum assured, bonuses, policy term and premiums paid. Premature closing of a life insurance policy is a voluntary termination of the policy contract. A policy can be surrendered only if it has acquired paid-up value. The amount payable to the insured is the **surrender value** which is usually a percentage of the premiums paid. The actual surrender value paid to the insured is more than the Guaranteed Surrender Value (GSV).

II. Rider Benefit

A payment under a rider is made by an insurance company on the occurrence of a specified event according to the terms and conditions.

Under a **critical illness rider**, in the event of diagnosis of a critical illness, a specified amount is paid as per terms. The illness should have been covered in the list of critical illnesses specified by the insurance company.

Under **hospital care rider**, the insurer pays the treatment costs in the event of hospitalisation of the insured, subject to terms and conditions.

The policy contract continues even after the rider payments are made.

The following claim payments are made at the end of the policy term specified in the insurance contract.

III. Maturity Claim

In such claims, the insurer promises to pay the insured a specified amount at the end of the term, if the insured survives the plan's entire term. This is known as a **maturity claim.**

i. **Participating Plan:** The maturity claim amount payable under a participating plan is the sum assured plus accumulated bonuses less dues such as outstanding premium and policy loans and interests thereon.

ii. **Return of Premium (ROP) Plan:** In some cases premiums paid over the term period are returned when the policy matures.

iii. **Unit Linked Insurance Plan (ULIP):** In case of ULIPs, the insurer pays the fund value as the maturity claim.

iv. **Money-back Plan:** In case of money-back policy, the insurer pays the maturity claim minus the survival benefits already paid during the term of the policy.

The insurance contact terminates after the claim is paid.

b) Death Claim

If the insured expires during the term of his/ her policy, accidentally or otherwise, the insurer pays the sum assured plus accumulated bonuses, if participating, less dues to be recovered by the insurer [like outstanding policy loan and interest or premiums plus interest]. This is the **death claim**, which is paid to the nominee or assignee or legal heir whatever the situation may be. A death claim generally marks the end of the contract as a result of death.

A death claim may be:

- ✓ Early (less than three years policy duration) or
- ✓ Non-early (more than three years)

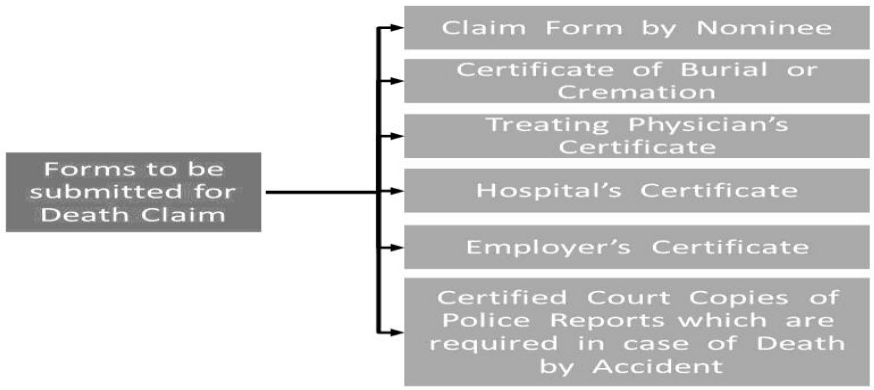
The nominee or assignee or legal heir has to intimate the insurer of the cause, date and place of death.

i. Forms to be submitted for death claim

Usually, the following forms are to be submitted by the beneficiary to the insurer to facilitate processing of the claim:

- ✓ Claim form by nominee
- ✓ Certificate of burial or cremation
- ✓ Treating physician's certificate
- ✓ Hospital's certificate
- ✓ Employer's certificate
- ✓ Death certificate issued by municipal authorities etc., as proof of death
- ✓ Certified court copies of police reports like First Information Report (FIR), Inquest Report, Post-Mortem Report, and Final Report - these reports are required in case of death by accident.

Diagram 2: Forms to be submitted for Death Claim



ii. Repudiation of death claim

The death claim may be paid or repudiated. If, while processing the claim, the insurer detects that the proposer had made any incorrect statements or had suppressed material facts relevant to the policy, the contract would be declared as void. All benefits under the policy are forfeited.

iii. Section 45: Indisputability Clause

However this penalty is subject to **Section 45** of the Insurance Act, 1938.

Important

Section 45 states:

"No policy of life insurance shall be called in question on any ground whatsoever after the expiry of three years from the date of the policy, i.e. from the date of issuance of the policy or the date of commencement of risk or the date of revival of the policy or the date of the rider to the policy, whichever is later".

C. Claim Procedure for Life Insurance Policy

Although there is no laid down standard claims procedure for all insurers, the IRDAI has laid down guidelines for insurers in the matter of claim settlement.

Regulation 8: Claims procedure in respect of a life insurance policy

i. A life insurance policy shall state the **primary documents** which are normally required to be submitted by a claimant in support of a claim.

ii. 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.

iii. As per the IRDAI (Protection of Policyholders' Interests) Regulations, 2017, a death claim under a life insurance policy shall be paid, rejected or repudiated giving all the relevant reasons, within 30 days from the date of receipt of all relevant papers and required clarifications. However, if the insurer needs the claim to be investigated, it shall initiate and complete the investigation at the earliest, in any case not later than 90 days from the date of receipt of claim intimation. The claim should be settled within 30 days of completing the investigation.

iv. Where a claim is ready for payment but the payment cannot be made due to any reasons of proper identification of the payee, the life insurer shall hold the amount for the benefit of the payee and it 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).

v. 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 (iv), 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.

Role of an agent

An agent shall render all possible service to the nominee/ legal heir or the beneficiary in filling up of claim forms accurately and assisting in submission of these at the insurer's office.

Apart from discharging obligations, goodwill is generated from such a situation whereby there exists ample opportunity for the agent to procure business or referrals in future from the family of the deceased.

Test Yourself 1

Which of the below statement best describes the concept of claim? Choose the most appropriate option.

I. A claim is a request that the insurer should make good the promise specified in the contract
II. A claim is a demand that the insurer should make good the promise specified in the contract
III. A claim is a demand that the insured should make good the commitment specified in the agreement
IV. A claim is a request that the insured should make good the promise specified in the agreement

Summary

- A claim is a demand that the insurer should make good the promise specified in the contract.
- A claim can be survival claim or death claim. While a death claim arises only upon the death of the life assured, survival claims can be caused by one or more events
- For payment of a survival claim, the insurer has to ascertain that the event has occurred as per the conditions stipulated in the policy.
- The following payments may occur during the policy term:
  - ✓ Survival Benefit Payments
  - ✓ Surrender of Policy
  - ✓ Rider Benefit
  - ✓ Maturity Claim
  - ✓ Death Claim

- Section 45 (Indisputability Clause) of the Insurance Act offers protection against rejection of claim by the insurer on flimsy grounds provided and sets a time limit of 3 years for the Insurer for calling a policy into question.
- Under the IRDAI (Protection of Policyholders Interests) Regulations, 2017, the IRDAI has laid down regulations to safeguard/ protect the insured or beneficiary in case of claims.

Answers to Test Yourself

Answer 1 The correct option is II.

SECTION

HEALTH SECTION

CHAPTER H-01

INTRODUCTION TO HEALTH INSURANCE

Chapter Introduction

This chapter will tell you about how insurance evolved over time. It will also explain what healthcare is, levels of healthcare and types of healthcare. You will also learn about the healthcare system in India and factors affecting it. Finally, it will explain how health insurance evolved in India and also the various players in the health insurance market in India.

Learning Outcomes

A. Understanding Healthcare

B. Levels of Healthcare

C. Types of Healthcare

D. Evolution of Health Insurance in India

E. Health Insurance Market

After studying this chapter, you should be able to:

a) Understand how insurance evolved.
b) Explain the concept of healthcare and the types and levels of healthcare.
c) Appreciate the factors affecting healthcare in India and the progress made since independence.
d) Discuss the evolution of health insurance in India.
e) Know the health insurance market in India.

A. Understanding Healthcare

The word 'Health' was derived from the word 'hoelth', which means 'soundness of the body'.

In olden days, health was considered to be a 'Divine Gift' and illness was believed to have been caused due to the sins committed by the concerned person. It was Hippocrates (460 to 370 BC) who came up with the reasons behind illness. According to him, illness is caused due to various factors relating to environment, sanitation, personal hygiene and diets. Vedic texts of ancient India speak about *'Arogyame Mahabhagyam'* meaning 'Health is great luck' or in other words, 'Health is Wealth'. Many treatises of ancient India like *Atharva Veda, Charaka Samhita, Sushruta Samhita, Ashtangahrdayam, Ashtangasamgraha, Bhela Samhita*, and *Kashyapa Samhita* discuss healing traditions practiced in India in olden times.

Definition

A widely accepted definition of health was given by World Health Organization (WHO) –*'Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.'*

Determinants of health

It is generally believed that the following factors determine the health of any individual:

a) Lifestyle factors

Lifestyle factors are those which are mostly in the control of the individual concerned e.g. exercising and eating within limits, avoiding worry and the like leading to good health; leading to diseases such as cancer, aids, hypertension and diabetes, to name a few.

b) Environmental factors

Communicable diseases like Influenza and Chickenpox etc. are spread due to bad hygiene, diseases like Malaria and Dengue are spread due to bad environmental sanitation, while certain diseases are also caused due to environmental factors.

c) Genetic factors

Diseases may be passed on from parents to children through genes. Such genetic factors result in differing health trends amongst the population spread across the globe based on race, geographical location and even communities.

It is quite obvious that a country's social and economic progress depends on the health of its people. This poses a question as to whether different types of healthcare are required for different situations.

Test Yourself 1

Which of the following diseases is not attributed to Lifestyle factors (i.e. not in the control of the individual)?

I. Cancer
II. Aids
III. Malaria
IV. Hypertension

B. Levels of Healthcare

Healthcare is nothing but a set of services provided by various agencies and providers including the government, to promote, maintain, monitor or restore health of people. Health care to be effective must be:

- Appropriate to the needs of the people
- Comprehensive
- Adequate
- Easily available
- Affordable

The health care facilities should be based upon the probability of the incidence of disease for the population. For example, a person may get fever, cold, cough, skin allergies etc. many times a year, but the probability of him/ her suffering from Hepatitis B is less as compared to cold and cough.

Hence, the need to set up the healthcare facilities in any area whether a village or a district or a state will be based upon the various healthcare factors called indicators of that area such as:

- ✓ Size of population
- ✓ Death rate
- ✓ Sickness rate
- ✓ Disability rate
- ✓ Social and mental health of the people
- ✓ General nutritional status of the people
- ✓ Environmental factors such as if it is a mining area or an industrial area
- ✓ The possible health care provider system e.g. heart doctors may not be readily available in a village but may be in a district town
- ✓ How much of the health care system is likely to be used
- ✓ Socio-economic factors such as affordability

Based on the above factors, the government decides upon setting up of centres for primary, secondary and tertiary health care and takes other measures to make appropriate healthcare affordable and accessible to the population.

C. Types of Healthcare

Healthcare is broadly categorized as follows:

1. Primary healthcare

Primary health care refers to the services offered by the doctors, nurses and other small clinics which are contacted first by the patient for any sickness, that is to say that primary healthcare provider is the first point of contact for all patients within a health system.

For example, if a person visits a doctor for fever and the first diagnosis is indicative of Dengue fever, the primary health care provider will prescribe some medicines but also direct the patient to get admitted in a hospital for specialized treatment.

At a country level, Primary Health care centres are set up both by Government and private players. Government primary health care centres are established depending upon the population size and are present right up to the village level in some form or the other.

2. Secondary healthcare

Secondary health care refers to the healthcare services provided by medical specialists and other health professionals who generally do not have first contact with patient. It includes acute care requiring treatment for a short period for a serious illness, often (but not necessarily) as an in-patient, including Intensive Care services, ambulance facilities, pathology, diagnostic and other relevant medical services.

3. Tertiary healthcare

Tertiary Health care is specialized consultative healthcare, usually for inpatients and on referral from primary/ secondary care providers.

Examples of Tertiary Health care providers are those who have advanced medical facilities and medical professionals, beyond the scope of secondary health care providers e.g. Oncology (cancer treatment), Organ Transplant facilities, High risk pregnancy specialists etc.

It is to be noted that as the level of care increases, the expenses associated with the care also increase. The infrastructure for different levels of care also varies from country to country, rural-urban areas, while socio-economic factors also influence the same.

Test Yourself 2

Which of the following are part of primary healthcare?

I. Fever
II. Cancer
III. Organ Transplant
IV. High risk pregnancy

D. Evolution of Health Insurance in India

While the government had been busy with its policy decisions on healthcare, it also put in place health insurance schemes. Insurance companies came with their health insurance policies only later. Here is how health insurance developed in India:

1. Employees' State Insurance Scheme

Health Insurance in India formally began with the beginning of the Employees' State Insurance Scheme, introduced vide the ESI Act, 1948, shortly after the country's independence in 1947. This scheme was introduced for blue-collar workers employed in the formal private sector and provides comprehensive health services through a network of its own dispensaries and hospitals.

ESIC (Employees State Insurance Corporation) is the implementing agency which runs its own hospitals and dispensaries and also contracts public/ private providers wherever its own facilities are inadequate.

2. Central Government Health Scheme

The ESIS was soon followed by the Central Government Health Scheme (CGHS), which was introduced in 1954 for the central government employees including pensioners and their family members working in civilian jobs. It aims to provide comprehensive medical care to employees and their families and is partly funded by the employees and largely by the employer (central government).

3. Commercial Health insurance

Commercial health insurance was offered by some of the non-life insurers before as well as after nationalisation of insurance industry.
In 1986, the first standardised health insurance product for individuals and their families was launched in the Indian market by all the four nationalized non-life insurance companies (these were then the subsidiaries of the General Insurance Corporation of India). This product, **Mediclaim** was introduced to provide coverage for the hospitalisation expenses up to a certain annual limit of indemnity with certain exclusions such as maternity, pre-existing diseases etc.
The hospitalization indemnity-based annual contract continues to be the most popular form of private health insurance in India today. With private players coming into the insurance sector in 2001, health insurance has grown tremendously. However, there is a large untapped market even today.

The Government has encouraged individuals to purchase Health Insurance policies. Premiums paid by the individuals towards Health Insurance of self, spouse and family members are allowed to be deducted from taxable income under Section 80 D of the Income Tax Act. The Section allows higher limits for paying premiums of parents/ parents in law above 60 years of age.

Considerable variations in covers, exclusions and newer add-on covers have been introduced which will be discussed in later chapters.

Test Yourself 3

The first standardised health insurance product for individuals and their families was launched in the Indian market by all the four nationalized non-life insurance companies in the year _____.

I. 1948
II. 1954
III. 1986
IV. 2001

E. Health Insurance Market

The health insurance market today consists of a number of players some providing the health care facilities called providers, others the insurance services and also various intermediaries. Some form the basic infrastructure while others provide support facilities. Some are in the government sector while others are in the private sector.

1. Private sector Health Care providers

India has a very large private health sector providing all three types of healthcare services - primary, secondary as well as tertiary. These range from voluntary, not-for-profit organisations and individuals to for-profit corporate, trusts, solo practitioners, stand-alone specialist services, diagnostic laboratories, pharmacy shops, and also the unqualified providers (quacks).

India also has the largest number of qualified practitioners in other systems of Medicine (Ayurveda/ Siddha/ Unani/ Homeopathy) which is over 7 lakh practitioners. These are located in the public as well as the private sector. Apart from the for-profit private providers of health care, the NGOs and the voluntary sector have also been engaged in providing health care services to the community.

Insurance Companies in the general insurance sector provide the bulk of the health insurance services. Stand Alone Health Insurance (SAHI) Companies are allowed to transact all types of Health Insurances, while Life Insurance Companies are also permitted to transact certain types of Health Insurances.

2. Intermediaries:

A number of people and organizations providing services as part of the insurance industry also form part of the health insurance market. Insurance Intermediaries are defined under Section 2 of the IRDA Act, 1999. These include insurance

brokers, reinsurance brokers, insurance consultants, surveyors and loss assessors as well as Third Party Administrators.

A Third Party Administrator (TPA) is a company registered with IRDAI and engaged by an insurer, for a fee, for providing health services. A TPA may render the following services to an insurer under an agreement in connection with health insurance business:

a. Servicing of claims under health insurance policies by way of pre authorization of cashless treatment or settlement of claims other than cashless claims or both, as per the underlying terms and conditions of the respective policy and within the framework of the guidelines issued by the insurers for settlement of claims.
b. Servicing of claims for Hospitalization cover, if any, under Personal Accident Policy and domestic travel policy.
c. Facilitating carrying out of pre-insurance medical examinations in connection with underwriting of the health insurance policies.

Summary

a) Insurance in some form or other existed many centuries ago but its modern form is only a few centuries old. Insurance in India has passed through many stages with government regulation.

b) Health of its citizens being very important, governments play a major role in creating a suitable healthcare system.

c) Level of healthcare provided depends on many factors relating to a country's population.

d) The three type of healthcare are primary, secondary and tertiary depending on the level of medical attention required. Cost of healthcare rises with each level with tertiary care being the costliest.

e) India has its own peculiar challenges such as population growth and urbanization which require proper healthcare.

f) The public sector insurance companies were the first to come up with schemes for health insurance followed later by commercial insurance by private insurance companies.

g) The health insurance market is made up of many players some providing the infrastructure, with others providing insurance services, intermediaries such as brokers, agents and third party administrators servicing health insurance business and also other regulatory, educational as well as legal entities playing their role.

Answers to Test Yourself

Answer 1 The correct option is III.
Answer 2 The correct option is I.
Answer 3 The correct option is III.

Key terms

a) Healthcare
b) Commercial insurance
c) Nationalization
d) Primary, Secondary and Tertiary Healthcare
e) Third Party Administrator

CHAPTER H-02

HEALTH INSURANCE DOCUMENTATION

Chapter Introduction

In the insurance industry, we deal with a large number of forms, documents etc. This chapter takes us through the documents and their importance in a health insurance contract.

Learning Outcomes

A. Proposal forms

B. Acceptance of the proposal (underwriting)

C. Prospectus

D. Policy Document

E. Conditions and Warranties

After studying this chapter, you should be able to:

a) Explain the contents of proposal form.
b) Describe the importance of Prospectus
c) Explain terms and wordings in insurance policy document.
d) Discuss policy conditions and warranties.
e) Appreciate why endorsements are issued.
f) Understand the premium receipt.
g) Appreciate why renewal notices are issued.

A. Proposal forms

1. Health Insurance Proposal forms

As discussed in the common chapters, the Proposal Form contains information which is useful for the insurance company to accept the risk offered for insurance. Given below are some of the details of the proposal form for a health insurance policy:

1. The proposal form incorporates a prospectus which gives details of the cover, such as coverage, exclusions, provisions etc. The prospectus forms part of the proposal form and the proposer has to sign it as having noted its contents.
2. The proposal form collects information relating to the name, address, occupation, date of birth, sex, and relationship of each insured person with the proposer, average monthly income and income tax PAN No., name and address of the Medical Practitioner, his qualifications and registration number. Bank details of the insured are also now a days collected to make payment of claim money directly through bank transfer.
3. In addition, there are questions relating to the medical condition of the insured person. These detailed questions in the form are based on past claims experience and are to achieve proper underwriting of the risk.
4. The insured person is required to state full details if he has suffered from any of the specified diseases in the form.
5. Further, the details of any other illness or disease suffered or accident sustained are called for as follows:
   a. Nature of illness/ injury and treatment
   b. Date of first treatment
   c. Name and address of attending Doctor
   d. Whether fully recovered
6. The proposer as to state any additional facts which should be disclosed to insurers and if he has any knowledge of any positive existence or presence of any illness or injury which may require medical attention.
7. The form also includes questions relating to past insurance and claims history and additional present insurance with any other insurer.
8. The special features of the declaration to be signed by the proposer must be noted.
9. The insured person agrees and authorises the insurer to seek medical information from any hospital/ medical practitioner who has at any time attended or may attend concerning any illness which affects his physical or mental health.
10. The insured person confirms that he has read the prospectus forming part of the form and is willing to accept the terms and conditions.
11. The declaration includes the usual warranty regarding the truth of the statements and the proposal form as the basis of the contract.

2. Medical Questionnaire

In case of adverse medical history in the proposal form, the insured person has to complete a detailed questionnaire relating to diseases such as Diabetes, Hypertension, Chest pain or Coronary Insufficiency or Myocardial Infarction.

These have to be supported by a form completed by a consulting physician. This form is scrutinised by company's panel doctor, based on whose opinion, acceptance, exclusion, etc. are decided.

Standard form of Declaration

The IRDAI has specified the format of the standard declaration in the health insurance proposal as under:

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 any time 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.

3. Nature of questions in a proposal form

The number and nature of questions in a proposal form vary according to the type of insurance concerned. Sum insured indicates the limit of liability of the insurer under the policy and has to be indicated in all proposal forms.

In **personal lines** like health, personal accident and travel insurance, proposal forms are designed to get information about the proposer's health, way of life and habits, pre-existing health conditions, medical history, hereditary traits, past health-insurance experience etc. along with the proposer's profession, occupation or business which important as they could have a material bearing on the risk.

Example 1

- ✓ A delivery man of a fast-food restaurant, who has to frequently travel on motor bikes at a high speed to deliver food to his customers, may be more exposed to accidents than the accountant of the same restaurant.
- ✓ A person working in a coal mine or a cement plant may be exposed to dust particles leading to lung ailments.

Example 2

- ✓ For the purpose of overseas travel insurance, the proposer is required to state (who is travelling, when, to which country, for what purpose) or

  For the purpose of health insurance, the proposer is asked about his/ her health (with person's name, address and identification) etc. depending on the case.

Example 3

- ✓ In case of health insurance, it could be the cost of hospital treatment, while for personal accident insurance this could be a fixed amount for loss of life, loss of a limb, or loss of sight due to an accident.

a) Previous and Present insurance

The proposer is required to inform the details about his previous insurances to the insurer. This is to understand his insurance history. In some markets there are systems by which insurers confidentially share data about the insured.

The proposer is also required to state whether any insurer had declined his proposal, imposed special conditions, required an increased premium at renewal or refused to renew or cancelled the policy. Details of current insurance with any other insurer including the names of the insurers are also required to be disclosed. Further, in personal accident insurance an insurer would like to restrict the amount of coverage (sum insured) depending on the sum insured under other PA policies taken by the same insured.

b) Claim Experience

The proposer is asked to declare full details of all losses suffered by him/ her, whether or not they were insured. This will give the insurer information about the subject matter of insurance and how the insured has managed the risk in the past. It means the insurance company has a duty to record all the information received even orally, which the agent has to keep in mind by way of follow up.

B. Acceptance of the proposal (underwriting)

A completed proposal form broadly gives the following information:

- ✓ Details of the insured
- ✓ Details of the subject matter
- ✓ Type of cover required

- ✓ Details of the physical features both positive and negative
- ✓ Previous history of insurance and claim experience

In the case of a health insurance proposal, the insurer may also refer the prospective customer e.g. above 45 years of age to a doctor and/ or for medical check-up. Based on the information available in the proposal and, where medical check-up has been advised, based on the medical report and the recommendation of the doctor, the insurer takes the decision. Sometimes, where the medical history is not satisfactory, an additional questionnaire to get more information is also required to be obtained from the prospective client. The insurer then decides about the rate to be applied to the risk factor and calculates the premium based on various factors, which is then conveyed to the insured.

C. Prospectus

A Prospectus is a document issued by the insurer or on its behalf to the prospective buyers of insurance. It is usually in the form of a brochure or leaflet or it can be in electronic form also and serves the purpose of introducing a product to such prospective buyers. Issue of prospectus is governed by the Insurance Act, 1938 as well as by Protection of Policyholders' Interest Regulations 2017 and the Health Insurance Regulations 2016 of the IRDAI. Insurers of Health policies usually publish Prospectuses about their Health insurance products. The proposal form in such cases would contain a declaration that the customer has read the Prospectus and agrees to it.

As discussed in Chapter 4, Section 64 VB of the Insurance Act 1938 stipulates that Premiums have to be collected in advance. However, considering the need for easing the payment of health insurance premiums in view of conditions owing to COVID-19 outbreak, IRDAI allowed insurers to collect premiums of individual health insurance products in instalments. It was also mandated that Insurance companies would announce the availability of the facility of payment of premiums in instalments, and the conditions thereof, on their websites. This facility would be offered to all policyholders without any discrimination.

D. Policy Document

IRDAI Regulations for protecting policy holder's interest act 2017 specified that a Health Insurance Policy document should contain:

a) The name(s) and address(es) of the insured and any other person having insurable interest in the subject matter
b) Full description of the persons or interest insured
c) The sum insured under the policy person and/ or peril wise
d) UIN of the product, name, code number, contact details of the person involved in sales process;
e) Date of birth of the insured and corresponding age in completed years;
f) The period of insurance and the date from which the policyholder has been continuously obtaining health insurance cover in India from any of the insurers without break

g) The sub-limits, Proportionate Deductions and the existence of Package rates if any, with cross reference to the concerned policy section;
h) Co-pay limits if any;
i) The pre-existing disease (PED) waiting period, if applicable;
j) Specific waiting periods as applicable;
k) Deductible as applicable – general and specific, if any Perils covered and exclusions
l) Premium payable and where the premium is provisional subject to adjustment, the basis of adjustment of premium along with periodicity of instalments if any
m) Policy terms, conditions and warranties
n) Action to be taken by the insured upon occurrence of a contingency likely to give rise to a claim under the policy
o) 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
p) Any special conditions
q) Provision for cancellation of the policy on grounds of misrepresentation, fraud, non-disclosure of material facts or non-cooperation of the insured
r) The details of the Add-on covers, if any
s) Details of Grievance Redressal mechanism and address of Ombudsman
t) Details of Grievance Redressal mechanism of Insurer;
u) Free-look period facility and portability conditions;
v) Policy migration facility and conditions where applicable.

E. Conditions and Warranties

Here, it is important to explain two important terms used in policy wordings. These are called Conditions and Warranties.

1. **Conditions:** A condition is a provision in an insurance contract which forms the basis of the agreement.

EXAMPLES:

a. One of the standard conditions in most insurance policies states:

If the claim be in any respect fraudulent, or if any false declaration be made or used in support thereof or if any fraudulent means or devices are used by the Insured or any one acting on his behalf to obtain any benefit under the policy or if the loss or damage be occasioned by the wilful act, or with the connivance of the Insured, all benefits under this policy shall be forfeited.

b. The Claim Intimation condition in a Health policy may state:

Claim must be filed within certain days from date of discharge from the Hospital. However, waiver of this Condition may be considered in extreme cases of hardship.

A breach of condition makes the policy voidable at the option of the insurer.

2. **Warranties:** A warranty is an agreement between insurer and insured that must be carried out fully. It forms a part of the policy document. For example, the Insurer may be covering the risk of a particular disease on the condition that the insured shall do a quarterly consultations with a specialist. In the above example, failure of the insured to fulfil his part of the agreement shall either negate or reduce the liability in respect of that particular section/ warranty.

Warranties must be observed and complied with strictly and literally, whether it is material to the risk or not.

Test Yourself 1

Which of the below statement is correct with regards to a warranty?

I. A warranty is a condition which is implied without being stated in the policy
II. A warranty forms part of a policy document
III. A warranty is always communicated to the insured separately and cannot be part of the policy document
IV. Claims will be payable even if a warranty is breached.

Endorsements in Health Insurance

It is the practice of insurers to issue policies in a standard form; covering certain perils and excluding certain others.

Definition

If certain terms and conditions of the policy need to be changed at the time of issuance, it is done by setting out the amendments/ changes through a document called endorsement.

It is attached to the policy and forms part of it. The policy and the endorsement together make up the contract. Endorsements may also be issued during the currency of the policy to record changes/ amendments.

Whenever material information changes, the insured has to advice the insurance company who will take note of this and incorporate the same as part of the insurance contract through the endorsement.

Endorsements normally required under a policy relate to:

a) Variations/ changes in sum insured
b) Addition and deletion of insured family members
c) Change of insurable interest by way of taking of a loan and mortgaging the policy to a bank.
d) Extension of insurance to cover additional perils/ extension of policy period
e) Change in risk, e.g. change of destinations in the case of an overseas travel policy
f) Cancellation of insurance
g) Change in name or address etc.

Test Yourself 2

If certain terms and conditions of the policy need to be modified at the time of issuance, it is done by setting out the amendments through _____.

I. Warranty
II. Endorsement
III. Alteration
IV. Modifications are not possible

Answers to Test Yourself

Answer 1 -The correct option is II.

Answer 2 - The correct option is II.

CHAPTER H-03

HEALTH INSURANCE PRODUCTS

Chapter Introduction

This chapter will give you an overall insight into the various health insurance products offered by insurance companies in India. From just one product – Mediclaim to hundreds of products of different kinds, the customer has a wide range to choose appropriate cover. The chapter explains the features of various health products that can cover individuals, family and group.

Learning Outcomes

A. Classification of health insurance products
B. IRDA Guidelines on Standardization in health insurance
C. Hospitalization indemnity product
D. Top-up covers or high deductible insurance plans
E. Senior citizen policy
F. Fixed benefit covers – Hospital cash, critical illness
G. Combo-products
H. Micro insurance and health insurance for poorer sections
I. Rashtriya Swasthya Bima Yojana
J. Pradhan Mantri Jan Arogya Yojna
K. Pradhan Mantri Suraksha Bima Yojana
L. Personal accident and disability cover
M. Overseas travel insurance
N. Group health cover
O. Special products
P. Key terms in health policies

After studying this chapter, you should be able to:

a) Explain the various classes of health insurance
b) Describe the IRDAI guidelines on standardization in health insurance
c) Discuss the various types of health products available in the Indian market today
d) Explain Personal Accident insurance
e) Discuss overseas travel insurance
f) Understand key terms and clauses in health policies

A. Classification of health insurance products

1. Introduction to health insurance products

Definition

"Health insurance business" is defined under Section 2(6C) of the Insurance Act, 1938 as *"the effecting of contracts which provide for sickness benefits or medical, surgical or hospital expense benefits, whether in-patient or out-patient travel cover and personal accident cover."* IRDAI follows this definition of Health insurance business.

Health insurance products available in the Indian market are mostly in the nature of **hospitalization products.** These products cover the expenses incurred by an individual during hospitalization.

Therefore, health insurance is important mainly for two reasons:

- ✓ **Providing financial assistance to pay for medical facilities** in case of any illness.
- ✓ **Preserving the savings of an individual** which may otherwise be wiped out due to illness.

Today, the health insurance segment has developed to a large extent, with hundreds of products offered by almost all general Insurance companies, standalone health insurers and life insurers. However, the basic benefit structure of the Mediclaim policy i.e. cover against hospitalization expenses still remains the most popular form of insurance.

2. Broad classification of health insurance products

Whatever be the product design, health insurance products can be broadly classified into two categories:

a) Indemnity covers

These products constitute the bulk of the health insurance market and pay for actual medical expenses incurred due to hospitalization.

b) Fixed benefit covers

Also called as 'hospital cash', these products pay for a fixed sum per day for the period of hospitalization. Some products also provide for a pre-decided amount for different surgeries.

3. Classification based on customer segment

Products can also be classified on the basis of the target customer segment. Products classified based on customer segments are:

a) **Individual cover** offered to retail customers and their family members

b) **Group cover** offered to corporate clients, covering employees and groups, covering their members

c) **Mass policies** for government schemes like/ Pradhan Mantri Jan Arogya Yojana/ various State health insurance schemes covering very poor sections of the population.

The benefit structures, pricing, underwriting and marketing for each segment are quite distinct.

Regulations for Health Insurance: Some important changes have been brought in Health Regulations, 2016 regarding Health Products, some of which have been given below:

1. Life Insurance Companies can 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.
2. Non-Life and Standalone Health insurance companies can offer individual health products with a minimum tenure of one year and a maximum tenure of three years, provided that the premium will remain unchanged for the tenure.
3. Insurance companies may offer innovative 'Pilot-Products'. General-Insurers and Health-Insurers, can offer these products for policy tenure of 1 Year, but not exceeding 5 Years. Group Health Policies can be offered by any insurer for a term of one year except credit linked products where the term can be extended up to the loan period not exceeding five years.
4. No Group Health Insurance Policy shall be issued where a Group is formed with the main purpose of availing itself of insurance. The Group shall have a size as determined by the Insurer which shall be applicable for all its group policies, subject to a minimum of 7.
5. General Insurers and Health Insurers may also offer Credit Linked Group Personal Accident policies for a term extended up to the loan period not exceeding five years.
6. Multiple policies –In case insured has taken health policies from more than one insurance company which provide fixed benefits, each insurer shall make the claim payment, on occurrence of an insured event, independent of payments received from other similar policies in accordance with the terms and conditions of the policies.

   If two or more policies are taken by an insured during a period from one or more insurers to indemnify treatment costs, the policyholder shall have the right to ask for a settlement of his/ her claim in terms of any of his/ her policies. The insurer on whom the claim is made shall make the claim payment and balance claim or claims disallowed under the earlier chosen policy/ policies may be made from the other policy/ policies even if the sum insured is not exhausted in the earlier chosen policy/ policies.

B. IRDA Guidelines on Standardization in health insurance

With so many insurers providing numerous varied products and with different definitions of various terms and exclusions, confusion arose in the market. It became difficult for the customer to compare products and take a considered decision. Moreover, in critical illness policies, there is no clear understanding as to what is meant by critical illness and what is not.

To remove the confusion among insurers, service providers, TPAs and hospitals and the grievances of the insuring public, the regulator tried to provide some kind of standardization in health insurance. Based on a common understanding, IRDA issued Guidelines on standardization in health insurance in 2016 which was further amended in 2020. These are applicable to all General and Health Insurers offering indemnity based Health insurance (excluding PA and Domestic/ Overseas Travel) products (both Individual and Group)

The guidelines now provide for standardization of:

1. definitions of commonly used insurance terms
2. definitions of critical illnesses
3. list of optional items of expenses in hospitalization indemnity policies
4. claim forms and pre-authorization forms
5. billing formats
6. discharge summary of hospitals
7. standard contracts between TPAs, insurers and hospitals
8. standard File and Use format for getting IRDAI for new policies
9. Standardisation of exclusions
10. Exclusions not allowed

C. Hospitalization indemnity product

Hospitalization indemnity products protect individuals from the expenditure they may need to incur in the event of hospitalisation. In most of the cases, they also cover a specific number of days before and after hospitalisation, but exclude any expenses not involving hospitalisation.

Hospitalization indemnity policy popularly called Mediclaim operates on an **'indemnity' basis. It indemnifies the policyholder by covering the expenses** during hospitalisation. **Some expenses that are not covered are specified in the policy document.**

Example

Raghu has a small family consisting of his wife and a 14 year old son. He has taken a Mediclaim policy, covering each member of his family, from a health insurance company, for an individual cover of Rs. 1 lakh each. Each of them could get recovery of medical expenses up to Rs. 1 lakh in case of hospitalization.

Raghu was hospitalized due to heart attack and required surgery. The medical bill raised was Rs. 1.25 lakhs. The insurance company paid Rs 1 lakh according to

the plan coverage and Raghu had to pay the remaining amount of Rs. 25,000 from his own pocket

The main features of the indemnity based Mediclaim policy are detailed below, **though variations in limits of cover, additional exclusions or benefits or some add-ons may apply to products marketed by each insurer**.

1. Inpatient hospitalization expenses

The policy pays the insured the cost of hospitalization expenses incurred on account of illness/ accident. The policy has a minimum prescribed period of hospitalization (generally 24 hours) after which the policy provisions come into force. However once this period is reached then the expenses for the entire period become payable.

Most of the expenses related with the treatment are paid, yet certain expenses that includes items of personal comfort, cosmetic surgeries are not. It is therefore important for the customer to be made aware of the excluded items of expenses that are not covered under the policy.

i. Room, boarding and nursing expenses as provided by the hospital/ nursing home. This includes nursing care, RMO charges, IV fluids/ blood transfusion/ injection administration charges and similar expenses

ii. Intensive Care Unit (ICU) expenses

iii. Surgeon, anaesthetist, medical practitioner, consultants, specialists fees

iv. Anaesthetic, blood, oxygen, operation theatre charges, surgical appliances,

v. Medicines and drugs,

vi. Dialysis, chemotherapy, radiotherapy

vii. Cost of prosthetic devices implanted during surgical procedure like pacemaker, orthopaedic implants, infra cardiac valve replacements, vascular stents

viii. Relevant laboratory/ diagnostic tests and other medical expenses related to the treatment

ix. Hospitalization expenses (excluding cost of organ) incurred on donor in respect of organ transplant to the insured.

2. Day Care Procedures

There are many surgeries that do not require can be conducted at specialized hospitals. Treatments such as eye surgeries, chemotherapy; dialysis etc. can be classified under day-care surgeries and the list is ever growing. These are also covered under the policy.

3. OPD cover

Coverage of outpatient expenses is still very limited in India, with few such products offering OPD covers. However there are some plans that provide cover

treatment as outpatient and also related health care expenses associated with doctor visits, regular medical tests, dental and pharmacy costs.

4. Pre and post hospitalization expenses

i. Pre hospitalization expenses

Hospitalization could be either emergency hospitalization or planned. If a patient goes in for a planned surgery, there would be expenses incurred by him prior to the hospitalization. Such expenses are known as Pre hospitalisation expenses

Definition

It means medical expenses incurred during a predefined number of days preceding the hospitalization of the Insured Person, provided that these expenses are incurred immediately before the insured person is hospitalized and

a) Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
b) The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
   Pre hospitalization expenses could be in the form of tests, medicines, doctors' fees etc. Such expenses relevant and pertaining to the hospitalization are covered under the health policies.

ii. Post hospitalization expenses

After stay in the hospital, in most cases there would be expenses related to recovery and follow-up immediately after the insured is discharged from hospital.

Both these two types of expenses are admissible if
a) They are incurred for the same condition for which the Insured Person's Hospitalization was required, and
b) The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

Post hospitalization expenses would be relevant medical expenses incurred during period up to the defined number of days after hospitalization and will be considered as part of claim.
Post hospitalization expenses could be in the form of medicines, drugs, review by doctors etc. after discharge from hospital. Such expenses have to be related to the treatment taken in hospital and are covered under the health policies.

Though the duration of cover for pre and post hospitalization expenses would vary from insurer to insurer and is defined in the policy, the most common cover is for **thirty days pre and sixty days post hospitalization**.

Pre and post-hospitalization expenses form part of the overall sum insured for which cover is granted under the policy.

iii. Domiciliary Hospitalization

iv. There is also a benefit available for patients whose illness otherwise needs hospitalisation but avail treatment at home either for accommodation in hospitals or in a position that they cannot be moved to a hospital.

To prevent misuse of the provision, this cover usually carries an **excess clause of three to five days** meaning that treatment costs for the first three to five days have to be borne by the insured. The cover excludes domiciliary treatments for certain chronic or common ailments such as Asthma, Bronchitis, Diabetes Mellitus, Hypertension, Influenza Cough, Cold, and fevers etc.

Example

Mira had taken a health insurance policy for coverage of expenses in the event of hospitalisation. The policy had a clause for initial waiting period of 30 days. Unfortunately, 20 days after she took the policy, Mira contracted malaria and was hospitalised for 5 days. She had to pay heavy hospital bills.

When she asked for reimbursement from the insurance company, they denied payment of the claim because the event of hospitalization occurred within the waiting period of 30 days from taking the policy.

a) COVERAGE OPTIONS AVAILABLE

i. Individual coverage: An individual insured can cover himself along with family members such as spouse, dependent children, dependent parents, dependent parents in law, dependent siblings etc. Some insurers do not have a restriction on the dependents who can be covered. It is possible to cover each of such dependent insured's under a single policy with a separate sum insured chosen for each insured person. In such covers, each person insured under the policy can claim up to the maximum amount of his sum insured during the currency of the policy. Premium will be charged for each individual insured according to his age and sum insured chosen and any other rating factor.

ii. Family floater: In the variant known as a family floater policy, the family consisting of spouse, dependent children and dependent parents are offered a single sum insured which floats over the entire family.

Example

If a floater policy of Rs. 5 lacs is taken for a family of four, it means that during the policy period, it will pay for claims related to more than one family member or multiple claims of a single member of the family. All these together cannot exceed the total coverage of Rs. 5 lacs. Premium will normally be charged based on the age of the oldest member of the family proposed for insurance

The covers and exclusions under both these policies would be the same. Family floater policies are getting popular in the market as the entire family gets coverage for an overall sum insured which can be chosen at a higher level at a reasonable premium.

Pre-Existing diseases
Insurance is designed to cover accidents/ diseases etc. that happen unexpectedly. Covering the costs of treating existing medical conditions is not part of insurance, as it is unfair to healthy people who would have to pay for the existing illnesses of some others. It goes against the principle of creating risk pools covering similarly placed risks. So, it is very important to collect details of the existing ailments/ injuries of each insured person before issuing a health policy. This will enable the insurer to decide on accepting the proposal for insurance, charging proper premiums and/ or providing additional conditions for those who are more likely to make claims.

What is a pre-existing disease?
Diseases suffered by an insured person within 48 months prior to commencement of the policy are regarded as pre-existing diseases. Based on the same logic, insurers are not allowed to exclude pre-existing diseases after a person is covered for insurance continuously for 48 months.

Renewability: Although Healthcare policies have a contract life of one year, and a fresh policy is to be issued every year, Lifelong renewability has been made compulsory by IRDAI for all policies.

SPECIAL FEATURES

In order to provide new features in the product as also to maintain the pricing, insurance companies have come out innovative modifications in the products. For example, the Mediclaim Policy, which was the most popular policy before 2000, has undergone many changes and new special features have been added to the coverage. Some features have been added to the basic indemnity cover. These features may vary from insurer to insurer and product to product and may not be available uniformly for all products.

i. Sub limits and Disease specific capping

Some of the products have disease specific capping e.g. cataract. A few also have sub limits on room rent linked to sum insured e.g. per day room rent restricted to 1% of sum insured and ICU charges to 2% of sum insured. As expenses under other heads such as ICU charges, OT charges and even surgeon's fees are linked to the type of room opted for, room rent capping helps in restricting expenses under other heads also and hence the overall hospitalization expenses.

ii. Co-payment (popularly called Co-pay)

Co-payment is defined by IRDAI as a cost sharing requirement under a health insurance policy that provides that the policyholder/ insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.
Co-payment is the concept of the insured bearing a portion of each and every claim under a health policy. These could be compulsory or voluntary depending on the product. Co-payment brings in a certain discipline among the insured to avoid unnecessary hospitalizations. This ensures that the insured exercises caution in selecting his healthcare options and avoids luxurious ones.
When an insured event occurs, many health policies require the insured to share a part of the insured loss. E.g. If the insured loss is INR 20000 and the co-pay amount is 10% in the policy, then insured pays INR 2000.

iii. Deductible/ Excess

As explained in Chapter 5, 'Deductible', also called 'Excess' is a cost-sharing provision. Under a health insurance policy, it provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/ hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. In Health policies, it is the fixed amount of money the insured is required to pay initially before the claim is paid by insurer, for e.g. if the deductible in a policy is Rs. 10,000, the insured pays first Rs. 10,000 in each insured loss claimed for. To illustrate, if the claim is for Rs. 80,000, the insured bears the first Rs. 10,000 and the insurer pays Rs. 70,000. A deductible does not reduce the Sum Insured.

Deductible may also be a specified number of days/ hours in case of hospital cash policies which will apply before any benefits are payable by the insurer.

An agent must examine and inform the insured whether the deductible is applicable per year, per life or per event and the specific deductible to be applied.

iv. Waiting Period

A waiting period of 30 days from inception of policy is normally applicable in most policies for making any claim. This however will not be applied for hospitalization due to an accident.

v. Waiting periods for specific diseases

This is applicable for diseases for which treatment can be delayed and planned. Depending on the product waiting periods of one/ two/ four years are imposed by the insurance companies and claims are paid for these ailments only after expiry of this period. Some of the diseases are Cataract, Benign Prostatic Hypertrophy, Hysterectomy for Menorrhagia or Fibromyoma, Hernia, Hydrocele, Congenital internal disease, Fistula in anus, piles, Sinusitis and related disorders etc.

vi. Coverage for Day care procedure

Advancement of medical science has seen inclusion of large number of procedures under day care category as already discussed earlier

vii. Cost of pre policy check up

Cost of medical examination was earlier borne by prospective clients. Now insurer reimburses the cost, provided the proposal is accepted for underwriting, the reimbursement varying from 50% to 100%.Now this has also been mandated by IRDAI that insurer would bear at least 50% of health check-up expenses.

viii. Add on covers

Various new additional covers called Add-on covers have been introduced by some of the insurers. Some of them are:

- ✓ **Maternity cover:** Maternity was not offered earlier under retail policies but is now offered by most insurers, with varying waiting periods.
- ✓ **Critical illness cover:** Available as an option under the high end version products for certain ailments which are life threatening and entail expensive treatment.
- ✓ **Reinstatement of sum insured:** After payment of claim, the sum insured (which gets reduced on payment of a claim) can be restored to the original limit by paying extra premium.
- ✓ **Coverage for AYUSH – Ayurveda – Yoga – Unani – Siddha – Homeopath: A f**ew policies cover expenses towards AYUSH treatment up to a certain percentage of the hospitalization expenses.

ix. Value added covers

Few indemnity products include value added covers as listed below. The benefits are payable up to the limit of sum insured specified against each cover in the schedule of the policy, not exceeding the overall sum insured.

- ✓ **Outpatient cover:** Health insurance products in India mostly cover only in-patient hospitalization expenses. Few companies now offer limited cover for out-patient expenses under some of the high-end plans.

- ✓ **Hospital cash:** This provides for fixed lump sum payment for each day of hospitalization for a specified period. Normally the period is granted for 7 days excluding the policies deductible of 2/ 3 days. Thus, the benefit would trigger only if hospitalization period is beyond the deductible period. This is in addition to the hospitalization claim but within the overall sum insured of the policy or may be with a separate sub-limit.

- ✓ **Recovery benefit:** Lump sum benefit is paid if the total period of stay in hospital due to sickness and/ or accident is not less than 10 days.

- ✓ **Donor's expenses:** The policy provides for reimbursement of expenses towards donor in case of major organ transplant as per the terms and condition defined in the policy.

- ✓ **Reimbursement of ambulance:** Expenses incurred towards ambulance by Insured/ insured person are reimbursed up to a certain limit specified in the schedule of the policy.

- ✓ **Expenses for accompanying person:** This is intended to cover the expenses incurred by accompanying person towards food, transportation whilst attending to insured patient during the period of hospitalization. Lump sum payment or reimbursement payment as per the policy terms is paid, up to the limit specified in the schedule of the policy.

- ✓ **Family definition:** Definition of family has undergone changes in few health products. Earlier, primary insured, spouse, dependent children were granted cover. Now there are policies where parents and in-laws can also be granted cover under the same policy.

x. Failure to seek or follow medical advice or failure to follow treatment

Initially the health insurance cover was denied to persons suffering from pre-existing diseases. Such cases are now being offered cover by excluding such diseases.

Standard Health Product – Arogya Sanjeevani: In the background of the Covid-19 pandemic, IRDAI asked all Insurance Companies to come out with a standard health product called Arogya Sanjeevani with no variations in terms and conditions to make it easy to understand. The premium may however vary according to the pricing policy of each company. This is to ensure better penetration of Health Insurance in market. All Insurers are required to offer this product called Arogya Sanjeevani. [The context for this move was that there were different Health Insurances available in the market and customers were not able to compare them, causing confusion.]

The following two types of plans are available under Arogya Sanjeevani Insurance Policy:

- **Individual Plan**: A single policyholder will be the beneficiary of Arogya Sanjeevani policy.
- **Family Floater Plan**: Multiple family members of the policyholder can become the beneficiaries of Arogya Sanjeevani plan.

This product comes with a capping on room rent and ICU charges but it also covers modern day treatment and stem cell therapy with 50% capping.

D. Top-up covers or high deductible insurance plans

A top-up cover is also known as a high deductible policy. Top-Up policies by insurers, provide cover for high sums insured over and above a specified amount (called threshold).This policy works along with a basic health cover having a low sum insured and comes at a comparatively reasonable premium. For example, Individuals covered by their employers can also opt for a top-up cover for additional protection (keeping the sum insured of the first policy as the threshold).

To be eligible to receive a claim under the top-up policy, the medical costs must be greater than the deductible (or threshold) level chosen under the plan and the reimbursement under the high deductible plan would be the amount of expense incurred i.e. greater than the deductible.

Example

An individual is covered for a sum insured of Rs. 3 lacs by his employer. He could opt for a top-up policy of Rs. 10 lacs in excess of Rs. Three lacs. If the cost of a single hospitalization is Rs. 5 lacs, the basic policy would cover up to Rs. Three lacs only. With the top-up cover, the balance sum of Rs. Two lacs would be paid out by the top-up policy.

Top-up policies come cheap and the cost of a single Rs. 10 lacs policy would be far higher than the top-up policy of Rs. 10 lacs in excess of Rs. Three lacs.

These covers are available on individual basis and family basis the top-up plan requires the deductible amount to be crossed at every single event of hospitalization. However some top-up plans that allow the deductible to be crossed post a series of hospitalizations during the policy period are known as Aggregate based high deductible plans or Super top-up cover as known in the Indian market. A super top-up plan covers the total of all hospitalisation bills (up to the super top-up plan limit) above the deductible amount, that is, the deductible is applied to the total claims in one year. Hence, once the deductible is paid, the plan becomes active for subsequent claims.

E. Senior Citizen Policy

These plans are designed to offer cover to elderly people who often were denied coverage after certain age (e.g. people over 60 years of age). The structure of the coverage and exclusions are much like a hospitalization policy.

Special attention is paid to diseases of the elderly in setting coverage and waiting period. Entry age is mostly after 60 years and renewable lifelong. Sum insured range from Rs. 50,000 to Rs. 5,00,000. There is variation of waiting period applicable to certain ailments.

Example: Cataract may have 1 year waiting for one insurer and 2 year waiting period for some other insurer.

Example: Sinusitis does not fall in waiting period clause of some insurers but few others include it in their waiting period clause.

Some policies have waiting periods or capping in respect of Pre-existing diseases. Pre-post hospital expenses are either paid as a percentage of hospital claims or a sub limit whichever is higher. In some policies they follow the typical indemnity plans such as expenses falling within specified period of 30/ 60 days or 60/ 90 days.

IRDAI has mandated that all health insurers and TPAs shall establish a separate channel to address the health insurance related claims and grievances of senior citizens.

F. Fixed benefit covers – Hospital Cash, Critical Illness

Under this cover, the insured gets a fixed sum as claim amount irrespective of the amount spent by him for the named treatment. In this product, commonly occurring treatments are listed under segments such as ENT, Ophthalmology, Obstetrics and Gynaecology, etc. and the maximum pay out for each of these is spelt out in the policy.

These policies are simple as only proof of hospitalization and coverage of ailment under the policy are sufficient to process the claim. Some products package a daily cash benefit along with the fixed benefit cover.

A provision is made to pay a fixed sum for surgeries/ treatment which do not find a place in the list named in the policy. Multiple claims for different treatments are possible during the policy period. However the claims are finally limited by the sum insured chosen under the policy.

Some of the fixed benefit insurance plans are:

- ✓ Hospital daily cash insurance plans
- ✓ Critical illness insurance plans

1. HOSPITAL DAILY CASH POLICY

a) Per day amount limit

Hospital cash coverage provides a fixed sum to the insured person for each day of hospitalization. Per day cash coverage could vary from (for example) Rs. 1,500 per day to Rs. 5,000 or even more per day. An upper limit is provided on the daily cash pay-out per illness as well as for the duration of the policy, which is usually an annual policy.

b) Number of payment days

In some of the variants of this policy, the number of days of daily cash allowed is linked to the disease for which treatment is being taken. A detailed list of treatments and duration of stay for each is stipulated which limits the daily cash benefit allowed for each type of procedure/ illness.

c) Standalone cover or add-on cover

The hospital daily cash policy is available as a standalone policy as offered by some insurers while, in other cases, it is an add-on cover to a regular indemnity policy. These policies help the insured to cover incidental expenses as the pay-out is a fixed sum and not related to the actual cost of treatment. This also allows the pay out under the policy to be provided in addition to any cover received under an indemnity based health insurance plan.

d) Supplementary cover

These policies could supplement a regular hospital expenses policy as it is cost effective and provides compensation for incidental expenses and also expenses not payable under the indemnity policy such as exclusions, co-pay etc.

e) Other advantages of the cover

From the insurer's point of view, this plan has several advantages as it is easy to explain to a customer and hence can be sold more easily. It beats medical inflation as a fixed sum per day is paid for the duration of hospitalization whatever may be the actual expense. Also, acceptance of such insurance covers and claims settlements are really simplified.

2. CRITICAL ILLNESS POLICY

With advancement in medical science, people are surviving some of the major diseases like cancer, strokes and heart attack etc., which in earlier times would have resulted in death. However surviving a major illness entails huge expense for treatment as well as for living expenses post treatment. Onset of critical illness threatens the financial security of a person. A basic health insurance policy may not be sufficient to cover all medical costs in such cases.

Critical illness policy has a provision to pay a lump sum amount on diagnosis of certain named critical illness. The sum insured is high to take care of large expenses.

In India, Critical Illness (CI) benefits are most commonly sold by life insurers as riders to life policies and two forms of cover are offered by them – accelerated CI benefit plan and standalone CI benefit plan. To avoid confusion, the definitions of 22 most common critical illnesses have been standardized under IRDA Health Insurance Standardization guidelines.

The critical illnesses covered vary across insurers and products. Generally 100% of the sum insured is paid on diagnosis of a critical illness. In some cases compensation could vary from 25% to 100% of sum insured depending on the policy terms and conditions and severity of illness.

There is a waiting period of 90 days from inception of policy for any benefit to become payable under the policy and the survival clause of 30 days after diagnosis of the illness. Rigorous medical examinations are to be undergone for persons especially over 45 years of age.

The policy terminates, once compensation is paid under the policy in respect of any of the insured person. This policy is also offered to groups especially corporates who take policies for their employees.

Disease Specific Products- Corona Kavach

In June 2020, when the country was facing many cases of Corona Virus infection (Covid-19), the market saw the introduction of many benefit based products providing lump sum payment on the diagnosis of Covid-19 positive. Later some companies introduced indemnity based products too. However, there were many consumables like PPE kits, Oximeter etc. and quarantine expenses that were not taken care of in these products.

IRDAI came up with two standard Health Insurance Policies called *Corona Kavach* and *Corona Rakshak (discussed separately under Life insurance section)*. While it is mandatory for general and health insurers to provide *Corona Kavach* as an indemnity-based standard COVID-19 product, *Corona Rakshak*, offering the benefit-based product, is optional for all insurers. Both products have a waiting period of 15 days.

Corona Rakshak is a standard benefit based health insurance designed for providing lump sum benefit to insured individuals affected by COVID-19 and require hospitalisation for a minimum continuous period of 72 hours. The plan offers coverage on individual basis for people between the age of 18 years and 65 years, with different policy terms of 3.5months, 6.5 months and 9.5 months as a one-time benefit policy and terminates upon the payment of benefit. *Corona Rakshak* offers sum insured options ranging from Rs. 50,000 to Rs. 2.5 lakh, in multiples of 50,000.The policy provides (i) complete sum insured benefit, (ii) economical premium, (iii) lump-sum amount of claim, (iv) a short waiting period of 15 days and (v) tax benefits.

Corona Kavach offers the following coverage vide Guidelines issued by IRDAI in June 2020:

1. Hospitalization Expenses incurred for the treatment of Covid-19 on Positive diagnosis of Covid-19 in a government authorized diagnostic centre covering

the following: (Expenses on Hospitalization for a minimum period of 24 hours are admissible.)

a. Room, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home.
b. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees
c. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances, ventilator charges, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities, PPE Kit, gloves, mask and such other similar expenses
d. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses.
e. Expenses incurred on road Ambulance subject to a maximum of Rs.2000/- per hospitalization.

2. Home Care Treatment Expenses for availing treatment at home up to maximum 14 days per incident subject to the conditions (not exhaustive) mentioned below:
   a. The Medical practitioner advices the Insured person to undergo treatment at home.
   b. There is a continuous monitoring of the health status by a medical practitioner for each day, including records of treatment administered.

3. Other Expenses covered if prescribed by the treating medical practitioner and related to treatment of COVID,
   a. Diagnostic tests undergone at home or at diagnostics centre
   b. Medicines prescribed in writing
   c. Consultation charges of the medical practitioner
   d. Nursing charges related to medical staff
   e. Medical procedures limited to parenteral administration of medicines
   f. Cost of Pulse oximeter, Oxygen cylinder and Nebulizer

Additional Cover - Hospital Daily Cash: The Insurer will pay 0.5% of sum insured per day for each 24 hours of continuous hospitalization for treatment of Covid following an admissible hospitalization claim under this policy.

Standard Vector Borne Disease Health Policy:

IRDAI vide its Guidelines dated 3 February 2021 decided that Standard Products for vector borne diseases shall offer the following coverage:

1. **Hospitalization Benefit:** Lump sum benefit equal to 100% of the Sum Insured shall be payable on positive diagnosis of any of the following vector borne disease (s) requiring hospitalization for a minimum continuous period of 72 hours.
   a) Dengue fever
   b) Malaria
   c) Filaria (Lymphatic Filariasis)
   d) Kala-azar

e) Chikungunya
f) Japanese Encephalitis
g) Zika Virus

2. **Diagnosis Cover:** 2% of the sum insured shall be payable on positive diagnosis (through laboratory examination and confirmed by the medical practitioner) of every covered vector borne disease on the first diagnosis during the Cover Period, subject to policy terms and conditions. The Policyholder is entitled for payments under "diagnosis cover" payment for each disease only once in the policy year.

G. Combo-products

Health plus Life Combo Products offer the combination of a life insurance cover of a Life Insurance Company and a health insurance cover offered by Non-Life and/ or Standalone Health Insurance Company.

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.

Package policies

Package or umbrella covers give, under a single document, a combination of covers.

Examples of package policy in health insurance include combining Critical illness cover benefits with indemnity policies and even life insurance policies and hospital daily cash benefits with indemnity policies.

Travel Insurance:

Travel insurance policy is also offered as a package policy covering not only health insurance but also accidental death/ disability benefits along with Medical expenses due to illness/ accident and the coverages like Loss of or delay in arrival of checked in baggage, Loss of passport and documents, Third party liability for property/ personal damages, Cancellation of trips and even Hijack cover traditionally provided under travel policies. (Details of Travel Insurance are provided later.)

H. Micro insurance and health insurance for poorer sections

Micro-insurance products are specifically designed to aim for the protection of low income people from rural and informal sectors. It is a low value product, with an affordable premium and benefit package. Micro insurance is governed by the IRDA Micro Insurance Regulations, 2005.

Such covers are mostly taken on a group basis by various community organizations or non-governmental organizations (NGOs) for their members.

Two policies particularly created by PSUs to cater to the poorer sections of society are Jan Arogya Bima Policy and Universal Health Scheme. The private sector insurance companies have also come out with many innovative micro insurance health products to cater to this target segment like Bima Kavach Yojana, Grameena Jeevan Raksha Plan, Bhaghya Laxmi - the entire list can be found on IRDAI website.

I. Rashtriya Swasthya Bima Yojana

The government has also launched various health schemes, some of them applicable to particular states. It had implemented the Rashtriya Swasthya Bima Yojana (RSBY) in association with insurance companies to provide health insurance coverage for the below poverty line (BPL) families. However RSBY provided a Sum Insured of only Rs 30,000 which was not considered enough to cover major surgeries/ hospitalisation expenses.

J. Pradhan Mantri Jan Arogya Yojana

To address the shortcomings of RSBY, as recommended by the National Health Policy 2017, the Government of India launched 'Ayushman Bharat Scheme' in 2017, a flagship scheme of to achieve the vision of Universal Health Coverage (UHC). Also known as Pradhan Mantri Jan Arogya Yojana (PMJAY) Ayushman Bharat came with a Sum Insured of Rs. 5,00,000.

It subsumed the then existing Rashtriya Swasthya Bima Yojana (RSBY). PM-JAY is fully funded by the Government and cost of implementation is shared between the Central and State Governments.

K. Pradhan Mantri Suraksha Bima Yojana

Features of the recently announced PMSBY covering personal accident death and disability cover are as follows:

Scope of coverage: All savings bank account holders in the age 18 to 70 years in participating banks are entitled to join through one savings bank account only and if he enrols in more than one bank, he gets no extra benefit and the extra premium paid will stand forfeited. Aadhaar would be the primary KYC for the bank account.

Enrolment Modality/ Period: The cover shall be for the one year period from 1st June to 31st May for which option to join/ pay by auto-debit from the designated savings bank account on the prescribed forms will be required to be given by 31st May of every year,

Joining subsequently on payment of full annual premium may be possible on specified terms. Individuals who exit the scheme at any point may re-join the scheme in future years through the above modality.

Benefits under the insurance are as follows:

Table of Benefits	Sum Insured
Death	Rs. 2 Lakh
Total and irrecoverable loss of both eyes or loss of use of both hands or feet or loss of sight of one eye and loss of use of hand or foot	Rs. 2 Lakh
Total and irrecoverable loss of sight of one eye or loss of use of one hand or foot	Rs. 1 Lakh

Joining and Nomination facility is available by SMS, email or personal visit.

Premium: Rs.12/- per annum per member. The premium will be deducted from the account holder's savings bank account through 'auto debit' facility

Termination of cover: The accident cover for the member shall terminate:

1. On member attaining the age of 70 years (age nearest birth day) or
2. Closure of account with the Bank or insufficiency of balance to keep the insurance in force or

If the insurance cover is ceased due to any technical reasons such as insufficient balance on due date or due to any administrative issues, the same can be reinstated on receipt of full annual premium, subject to conditions that may be laid down.

L. Personal Accident and Disability cover

A **Personal Accident (PA) Cover** provides compensation due to death and disability in the event of unforeseen accident.

In a PA policy,

a) The death benefit is payment of 100% of the sum insured,

b) In the event of disability, compensation varies from a fixed percentage of the sum insured in the case of permanent disability

c) Weekly compensation for temporary disablement.

Weekly compensation means payment of a fixed sum per week of disablement subject to a maximum limit in terms of number of weeks for which the compensation would be payable.

1. Types of disability covered

Types of disability which are normally covered under the policy are:

i. **Permanent total disability (PTD):** means becoming totally disabled for lifetime viz. paralysis of all four limbs, comatose condition, loss of both eyes/ both hands/ both limbs or one hand and one eye or one eye and one leg or one hand and one leg,

ii. **Permanent partial disability (PPD):** means becoming partially disabled for lifetime viz. loss of fingers, toes, phalanges etc.

iii. **Temporary total disability (TTD):** means becoming totally disabled for a temporary period of time. This section of cover is intended to cover the loss of income during the disability period.

The client has choice to select only death cover or death plus permanent disablement of Or Death plus permanent disablement and also temporary total disablement.

2. Sum insured

Sums insured for PA policies are usually decided on the basis of gross monthly income. Typically, it is 60 times of the gross monthly income. However, some insurers also offer on fixed plan basis without considering the income level. In such policies sum insured for each section of cover varies as per the plan opted.

3. Personal Accident Insurance – a Benefit plan

Being a benefit plan, PA policies are not subject to the principle of 'contribution' at the time of claim. Thus, if a person has more than one policy with different insurers, claims would be paid under all the policies.

4. Scope of cover

These policies are often extended to cover medical expenses, i.e. reimbursement of hospitalization/ medical costs incurred following the accident.

5. Value added benefits

Along with personal accident, many insurers also offer value added benefits like hospital cash on account of hospitalization due to accident, cost of transportation of mortal remains, education benefit for a fixed sum and ambulance charges on the basis of actual or fixed limit whichever is lower.

6. Exclusions:

Common exclusions under Personal Accident insurance are accidents arising out of disability existing prior to the inception of policy, death or disability due to mental disorders or any sickness, injury due to war, invasion, culpable homicide or murder, intentional self-injury, suicide, intake of drugs/ alcohol, injury while engaging in defined extra hazardous activity like aviation or ballooning . This is an indicative list and can vary from company to company.

PA policies are offered to individuals, family and also to groups.

Group Personal Accident Policies

Group Personal Accident Policies are usually annual policies with renewals being allowed on the anniversary. However, non-life and standalone health insurers may offer group personal accident products with term less than one year also to provide coverage to specific events.

Broken bone policy and compensation for loss of daily activities

This is a specialised PA policy. This policy is designed to provide cover against listed fractures. Fixed benefit or percentage of sum insured mentioned against each fracture is paid at the time of claim. Quantum of benefit depends on the type of bone covered and nature of fracture sustained.

M. Overseas Travel insurance

Need for the policy: To cover expenses of accidental injury or hospitalisation whilst travelling outside India for business, holidays or studies. , The cost of

medical care, especially in countries such as USA and Canada, is very high and could cause major financial problems.

Scope of coverage

Such policies are primarily meant for accident and sickness benefits, but most products available in the market package a range of covers within one product.

The usual covers offered are:

a) Medical and sickness section:
   i. Accidental death/ disability
   ii. Medical expenses due to illness/ accident

b) Repatriation and evacuation

c) Personal accident cover

d) Personal liability

e) Other non-medical covers:
   i. Trip Cancellation
   ii. Trip Delay
   iii. Trip interruption
   iv. Missed Connection
   v. Delay of Checked Baggage
   vi. Loss of Checked Baggage
   vii. Loss of Passport
   viii. Emergency Cash Advance
   ix. Hijack Allowance
   x. Bail Bond insurance
   xi. Hijack cover
   xii. Sponsor Protection
   xiii. Compassionate Visit
   xiv. Study Interruption
   xv. Home burglary

1. Types of plans

The popular policies are the Business and Holiday Plans, the Study Plans and the Employment Plans.

2. Who can take the policy

An Indian citizen travelling abroad on business, holiday or for studies can avail this policy. Employees of Indian employers sent on contracts abroad can also be covered.

3. Sum insured and premiums

The cover is granted in US Dollars and generally varies from USD 100,000 to USD 500,000 for the section covering medical expenses, evacuation and repatriation. For other sections the Sum Insured is lower, except for the liability cover. Premiums can be paid in Indian rupees except in the case of the employment plan where premium has to be paid in dollars. The plans are usually of two types:

- ✓ World-wide excluding USA/ Canada
- ✓ World-wide including USA/ Canada

Some products provide cover for a group of countries. Examples are travel to Asian countries only, European countries only or travel to a particular country only.

Corporate Frequent Flyer plans

This is an annual policy whereby a corporate/ employer takes individual policies for its executives who frequently make trips outside India. This cover can also be taken by individuals who fly overseas many times during a year. An advance premium is paid based on the estimated man days of travel in a year by a company's employees. The above policies are granted only for business and holiday travels. Pre-existing diseases are usually excluded for Overseas Medical/ Travel Insurances.

N. Group Health cover

1. GROUP POLICIES

As explained earlier in the chapter a group policy is taken by a group owner who could be an employer, an association, a bank's credit card division, where a single policy covers the entire group of individuals. These policies are usually, one year renewable contracts.

Features of group policies - Hospitalisation benefit covers.

1. **Scope of coverage**

   The most common form of group health insurance is the policy taken by employers covering employees and their families including dependent spouse, children and parents/ parents in law.

2. **Tailor-made cover**

   Group policies are often tailor-made covers to suit the requirements of the group. Thus, in group policies, one will find several standard exclusions of the individual policy being covered under the group policy.

3. **Maternity cover**

   One of the most common extensions in a group policy is the maternity cover. Maternity cover would provide for the expenses incurred in hospitalization for delivery of child and includes C- section delivery. This cover is generally restricted to a certain amount within the overall sum insured of the family.

4. **Child cover**

   Coverage is given to babies from day one, sometimes restricted to the maternity cover limit and sometimes extended to include the full sum insured of the family.

5. **Pre-existing diseases covered, waiting period waived off**

   Several of the usual exclusions, such as the pre-existing disease exclusion, thirty days waiting period, two years waiting period, congenital diseases may be waived off, in tailor-made group policies.

6. Premium calculation

The premium charged for a group policy is based on the age profile of the group members, the size of the group and most importantly the claims experience of the group.

7. Non-employer employee groups

In India, regulatory provisions strictly prohibit formation of groups primarily for the purpose of taking out a group insurance cover. When group policies are given to other than employers, it is important to determine the relation of the group owner to its members.

Example

A bank taking a policy for its saving bank account holders or credit card holders constitutes a homogenous group, whereby a large group is able to benefit by a tailor-made policy designed to suit their requirements.

8. Pricing

In group policies, there is provision for discount on premium based on size of the group as also the claims experience of the group

2. CORPORATE BUFFER OR FLOATER COVER

In most group policies, each family is covered for a defined sum insured, varying from Rs. One lac to five lacs and sometimes more. There arise situations where the sum insured of the family is exhausted, especially in the case of major illness of a family member. In such situations, if the buffer cover is opted for it brings relief, whereby the excess expenses over and above the family sum insured are met from this buffer amount.

Amounts are drawn from the buffer, once a family's sum insured is exhausted. However this utilization is usually restricted to major illness/ critical illness expenses where a single hospitalization exhausts the sum insured.

O. Special Products

1. Disease covers

In recent years, disease specific covers for cancer, diabetes, Covid-19 have been introduced in the Indian market. The cover is either short term or long term – 5 years to 20 years and a wellness benefit is also included – a regular health check-up paid for by the insurer. There is incentive for better control of factors like blood glucose, blood pressure etc. in the form of reduced premiums from second year of policy onwards. On the other hand, a higher premium would be chargeable for poor control.

2. Product designed to cover diabetic persons

This policy can be taken by persons between 26 and 65 years and is renewable up to 70 years. Sum Insured ranges from Rs. 50,000 to Rs. 5,00,000. Capping on Room rent is applicable. Product is aimed to cover hospitalization complications of diabetes like diabetic retinopathy (eye), kidney, diabetic foot, kidney transplant including donor expenses.

Test Yourself 1

Though the duration of cover for pre-hospitalization expenses would vary from insurer to insurer and is defined in the policy, the most common cover is for _____ pre-hospitalization.

I. Fifteen days

II. Thirty days

III. Forty Five days

IV. Sixty days

Key terms in health policies **(All the terms are as defined in IRDAI Master Circular on Standardization of Health Insurance Products dated 22.07.2020)**

1. Network Provider

Network provider refers to a hospital/ nursing home/ day care centre which is under tie-up with an insurer/ TPA for providing cashless treatment to insured patients. Patients are free to go to out-of-network providers but there they are generally charged much higher fees.

2. Preferred provider network (PPN)

An insurer has the option to create a preferred network of hospitals to ensure quality treatment and at best rates. When this group is limited to only a select few by the insurer based on experience, utilization and cost of providing care, preferred provider networks get formed.

3. Cashless service

A cashless service enables the insured to avail of the treatment up to the limit of cover without any payment to the hospitals. All that the insured has to do is approach a network hospital and present his medical card as proof of insurance. The insurer facilitates a cashless access to the health service and directly makes payment to the network provider for the admissible amount. However, the insured has to make payment for amounts beyond the policy limits and for expenses not payable as per policy conditions.

4. Third Party Administrator (TPA)

A major development in the field of health insurance is the introduction of the third party administrator or TPA. Several insurers across the world utilize the services of independent organizations for managing health insurance claims. These agencies are known as the TPAs. In India, a TPA is engaged by an insurer for provision of health services which includes among other things:

i. Providing an identity card to the policyholder which is proof of his insurance policy and can be used for admission into a hospital

ii. Providing a cashless service at network hospitals

iii. Processing of claims

TPAs service health policyholders starting from issuance of unique identity cards for hospital admissions up to settlement of claims either on cashless basis or reimbursement basis. Third party administrators enter into an MOU with hospitals

or health service providers and ensure that any person who undergoes treatment in the network hospitals is given a cashless service. They are the intermediaries between the insurer(s) and the insured(s), who co-ordinate with the hospitals and finalize health claims.

5. Hospital

A hospital means any institution established for in-patient care and day care treatment of sickness and/ or injuries and which has been registered as a hospital with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:

a) Has at least 10 inpatient beds in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places;

b) Has qualified nursing staff under its employment round the clock;

c) Has qualified medical practitioner(s) in charge round the clock;

d) Has a fully equipped operation theatre of its own where surgical procedures are carried out;

e) Maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.

6. Medical practitioner

A Medical practitioner is a person who holds a valid registration from the medical council of any state of India or for homeopathy and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license. However, insurance companies are free to make a restriction that the registered practitioner should not be the insured or any close family member. This is to ensure fraudulent claims are not lodged by taking treatment from relatives or by self or by hospitals owned by either.

Qualified nurse: Qualified nurse means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

7. Reasonable and necessary expenses

A health insurance policy always contains this clause as the policy provides for compensation of expenses that would be deemed to be reasonable for treatment of a particular ailment and in a particular geographical area.

8. Notice of claim

Every insurance policy provides for immediate intimation of claim and specified time limits for document submission. In health insurance policies, wherever cashless facility is desired by the customer, intimations are given well before the hospitalization. However in cases of reimbursement claims the time limit for submission of claim documents is normally fixed at 15 days from the date of discharge.

9. Free health check

In individual health policies, a provision is generally available to give some form of incentive to a claim free policyholder. Many policies provide for reimbursement of the cost of health check-up at the end of four continuous, claim free policy periods.

10. Cumulative bonus

A cumulative bonus is given on the sum insured for every claim free year. This means that the sum insured gets increased on renewal by a fixed percentage say 5% annually and is allowed up to a maximum of 50% for ten claim-free renewals. Moreover, if a claim is made in any particular year, the cumulative bonus accrued can only be reduced at the same rate at which it is accrued.

Example

A person takes a policy for Rs. 3 lacs at a premium of Rs. 5,000. In the second year, in case of no claims in the first year, he gets a sum insured of Rs. 3.15 lacs (5% more than the previous year) at the same premium of Rs. 5,000. This could go up to Rs. 4.5 lacs over a ten year claim free renewal.

11. Malus/ Bonus

Just as there is an incentive to keep the health policy free of claims, the opposite is called a malus. Here, if the claims under a policy are very high, a malus or loading of premium is collected at renewal. However, in case of group policies, the malus is charged by way of loading the overall premium suitably to keep the claim ratio within reasonable limits.

12. No claim discount

Some products provide for a discount on premium for every claim free year instead of a bonus on sum insured.

13. Room rent restrictions

Some health plans place a restriction on the category of room that an insured chooses by linking it to the sum insured. Hence a person with a sum insured of one lac would be entitled to a room of Rs 1,000 per day if the policy has a room rent restriction of 1% of sum insured per day.

14. Renewability clause

The IRDAI guidelines on renewability of health insurance policies makes lifetime guaranteed renewal of the health policies compulsory, except on grounds of fraud and misrepresentation. In accordance to the provisions of IRDAI Health Insurance Regulation 2016, once a proposal is accepted in respect of a health insurance policy (except Personal Accident and Travel Policies) and a policy is issued which is thereafter renewed periodically without any break, further renewal shall not be denied on the grounds of age of the Insured. Thus, health insurance policies are renewable lifelong.

15. Cancellation clause

An insurance company may at any time cancel the policy only on grounds of misrepresentation, fraud, and non-disclosure of material fact or non-cooperation by the insured.

When policies are cancelled by the insurer, a proportion of the premium corresponding to the unexpired period of insurance, is returned to the insured provided no claim has been paid under the policy. This is usually on pro-rata basis.

When annual policies are cancelled by the insured, insurers usually charge premiums at Short period scales, instead of pro-rata premiums. This would prevent anti-selection against the insurers and take care of the initial expenses of the insurer.

16. Grace period for renewal

As mentioned in Chapter 4, the Grace Period provision enables a policy that would otherwise have lapsed for non-payment of premium, to continue in force during the grace period.

Most of above key clauses, definitions, exclusions relating to grace period have been standardized under Health Regulations and Health Insurance Standardization Guidelines issued by IRDAI and updated from time to time.

Test Yourself 2

As per IRDA guidelines, a _____ grace period is allowed for renewal of individual health policies.

I. Fifteen days

II. Thirty days

III. Forty Five days

IV. Sixty days

Answers to Test Yourself

Answer 1 - The correct option is II.

Answer 2 - The correct option is II.

CHAPTER H-04

HEALTH INSURANCE UNDERWRITING

Chapter Introduction

This chapter aims to provide you detailed knowledge about underwriting in health insurance. Underwriting is a very important aspect of any type of insurance and plays a vital role in issuance of an insurance policy. In this chapter, you will get an understanding about basic principles, tools, methods and process of underwriting. It will also provide you the knowledge about group health insurance underwriting.

Learning Outcomes

A. What is underwriting?

B. Underwriting – Basic concepts

C. Other health insurance regulations of IRDAI

D. Portability of Health Insurance

E. Basic principles and tools for underwriting

F. Underwriting process

G. Health Insurance at Group Level

H. Underwriting of Overseas Travel Insurance

I. Underwriting of Personal Accident Insurance

After studying this chapter, you should be able to:

a) Explain what is meant by underwriting
b) Describe the basic concepts of underwriting
c) Explain the principles and the various tools followed by underwriters
d) Appreciate the complete process of underwriting individual health policies
e) Discuss how group health policies are underwritten

Look at this Scenario

Manish aged 48 years, working as a software engineer, decided to take a health insurance policy for himself. He went to an insurance company, where they gave him a proposal form in which he was required to answer a number of questions related to his physical build and health, mental health, pre-existing illnesses, his family health history, habits and so on.

On receipt of his proposal form, he was also required to submit many documents such as identity and age proof, proof of address and previous medical records. Then they told him to undergo a health check-up and some medical tests which frustrated him.

Manish, who considered himself a healthy person and with a good income level, started wondering why such a lengthy process was being followed by the insurance company in his case. Even after going through all this, the insurance company told him that high cholesterol and high BP had been diagnosed in his medical tests, which increased the chances of heart diseases later. Though they offered him a policy, the premium was much higher than what his friend had paid and so he refused to take the policy.

Here, the insurance company was following all these steps as part of their underwriting process. While providing risk coverage, an insurer needs to evaluate risks properly and also to make reasonable profit. If the risk is not assessed properly and there is a claim, it will result in a loss. Moreover, insurers collect premiums on behalf of all insuring persons and have to handle these moneys like a trust.

A. What is underwriting?

1. Underwriting

Insurance companies try to insure people who are expected to pay adequate premium in proportion to the risk they bring to the insurance pool. This process of collecting and analysing information from a proposer is known as underwriting. On the basis of information collected through this process, they decide whether they want to insure a proposer. If they decide to do so, then at what premium, terms and conditions so as to make a reasonable profit from taking such risk.

Definition

Underwriting is the process of assessing the risk appropriately and deciding the terms on which the insurance cover is to be granted. Thus, it is a process of risk assessment and risk pricing.

2. Need for Underwriting

Underwriting is the backbone of an insurance company as acceptance of the risk carelessly or for insufficient premiums will lead to insurer's insolvency. On the other hand, being too selective or careful will prevent the insurance company from creating a big pool so as to spread the risk uniformly. It is therefore critical to strike the correct balance between risk and business, thereby being competitive and yet profitable for the organization.

This process of balancing is done by the underwriter, in accordance with the philosophy, policies and risk hunger of the insurance company concerned. Although age affects the chance of sickness as well as death, it must be remembered that sickness usually comes much before death and could be frequent. Hence, it is quite logical that the underwriting norms and guidelines are much tighter for health coverage than death coverage.

3. Underwriting – Risk Assessment

In health insurance, there is a higher focus on medical or health findings than financial or income based underwriting. However, the latter cannot be ignored as there has to be an insurable interest and financial underwriting is important to rule out any adverse selection and ensure continuity in health insurance.

Example

An individual who is diabetic has a far higher chance of developing a cardiac or kidney complication requiring hospitalization than of death, and also health episodes can happen multiple times during the course of insurance coverage. A life insurance underwriting guideline might rate this individual as an average risk. However, for medical underwriting, he would be rated as a higher risk.

4. Factors which affect chance of illness

The factors which affect morbidity (risk of falling ill) should be considered carefully while assessing risk are as follows:

a) **Age:** Premiums are charged corresponding with age and the degree of risk. For e.g. the premiums for infants and children are higher than young adults due to increased risk of infections and accidents. Similarly, for adults beyond the age of 45 years, the premiums are higher, as the probability of an individual suffering from a chronic ailment like diabetes, a sudden heart ailment or other such morbidity is much higher.
b) **Gender:** Women are exposed to additional risk of illness during child bearing period. However, men are more likely to get affected by heart attacks than women or suffer job related accidents than women as they may be more involved in hazardous employment.

c) **Habits:** Consumption of tobacco, alcohol or narcotics in any form has a direct bearing on the morbidity risk.
d) **Occupation:** Extra risk to accidents is possible in certain occupations, e.g. driver, blaster, aviator etc. Likewise, certain occupations may have higher health risks, like an X-Ray machine operator, asbestos industry workers, miners etc.
e) **Family history:** This has greater relevance, as genetic factors influence diseases like asthma, diabetes and certain cancers. This does impact the morbidity and should be taken into consideration while accepting risk.
f) **Build:** Stout, thin or average build may also be linked to morbidity in certain groups.
g) **Past illness or surgery:** It has to be ascertained whether the past illness has any possibility of causing increased physical weakness or even recur and accordingly the policy terms should be decided. For e.g. kidney stones are known to recur and similarly, cataract in one eye increases possibility of cataract in the other eye.
h) **Current health status and other factors or complaints:** This is important to ascertain the degree of risk and insurability and can be established by proper disclosure and medical examination.
i) **Environment and residence:** These also have a bearing on morbidity rates.

Understanding Moral Hazard in Health Insurance

While factors like age, gender, habits etc. refer to the physical hazard of a health risk, there is something else that needs to be closely watched. This is the moral hazard of the client which can prove very costly to the insurance company.

An extreme example of bad moral hazard is that of an insured taking health insurance knowing that he will undergo a surgical operation within a short time but not disclosing this to the insurer. There is thus a deliberate intention of taking insurance just to collect a claim.

Test Yourself 1

Underwriting is the process of _____.
I. Marketing insurance products
II. Collecting premiums from customers
III. Risk assessment and risk pricing
IV. Selling various insurance products

B. Underwriting – Basic concepts

1. Purposes of Underwriting

There are two main purposes for Underwriting.
i. To prevent anti-selection, that is selection against the insurer
ii. To classify risks and ensure equity among risks

Definition

The term **assessment of risks** refers to the process of evaluating each proposal for health insurance in terms of the degree of risk it represents and then deciding whether or not to grant insurance and on what terms.

Anti-selection (or **adverse selection**) is the tendency of people, who suspect or know that their chance of experiencing a loss is high, to seek out insurance eagerly and to gain in the process.

Example

If insurers were not selective about whom and how they offered insurance, there is a chance that people with serious ailments like diabetes, high BP, heart problems or cancer, who knew that they would soon require hospitalization, would seek to buy health insurance, create losses for the insurer. In other words, if an insurer does not assess risk properly, it would be selected against and suffer losses in the process.

2. Equity among risks

Let us now consider equity among risks. "Equity" means that applicants who are exposed to similar types and degrees of risk be placed in the same premium class. Insurers would like to have some type of standardization to determine the premiums to be charged. The proposals that come to the underwriter are classified into following risk types:

i. Standard risks

These are the people whose expected morbidity (chance of falling ill) is average.

ii. Preferred risks

In some cases, the expected morbidity is significantly lower than average and hence are preferred risks. These could be charged a lower premium.

iii. Substandard risks

In some other cases, the expected morbidity may be higher than the average. Though these risks also may be insurable, insurers may charge higher premiums and/or accept them subject to certain conditions and restrictions.

iv. Declined risks

There are some persons who have certain medical or other conditions, which make them highly prone to sicknesses and making claims. It is highly probable that such persons fall sick and cause a disproportionate degree of liability on the common pool. In other words, while others in the pool have a more or less average chance of falling sick, these persons have a very high chance of falling sick making it difficult to insure them even at higher rates of premium.

[Sometimes, such persons may be posing a Moral Hazard when they do not reveal their high probability of falling sick and try to get insured like other normal people.] Most insurers decline such risks and create a database of such people for future use.

Being a 'Declined Risk' means only that a particular insurer does not wish to insure a person for that type of insurance product, at that particular point in time. However, it is possible that another insurer might insure him/ her at a different premium and/or with different conditions. The same insurer might also consider him/ her for another type of policy or even for the same policy at a later date, when the conditions change.

3. Underwriting process

The underwriting process takes place at two levels:

- ✓ At the primary or field level or
- ✓ At the underwriting department level

a) Primary Underwriting

Primary underwriting (or Field level underwriting) includes information gathering by an agent or company representative to decide whether an applicant is suitable for granting insurance coverage. The agent plays this critical role of **primary underwriting**. He is in the best position to know whether prospective client is insurable.

Some insurance companies require the agents to provide a statement or a confidential report, with specific information, opinion and recommendations with respect to the proposer.

A similar kind of report, which has been called as **Moral Hazard report**, may also be sought from an official of the insurance company. These reports typically cover the occupation, income and financial standing and reputation of the person proposed for health insurance.

4. Fraud monitoring role of Agent

Decisions regarding selecting a risk for insurance depends on the facts disclosed by the proposer in the Proposal Form. It would be difficult for an underwriter sitting in the office to know whether these facts are true or have been fraudulently misrepresented with an intention to cheat the insurer.

The agent, **as primary underwriter** plays a significant role here. Since the agent has direct personal contact with the proposer, he or she is in the best position to find out whether the information submitted is true and whether any wilful non-disclosure or misrepresentation has been made.

a) Role of the Underwriting department

The Underwriting department in the insurer's office does the major part of the underwriting. Here, specialists who are proficient in such work, consider and analyse all the relevant data on the particular risk and even some demographical data. They finally decide whether to accept the proposal for insurance, decide the terms, and charge the appropriate premiums.

C. Other Health Insurance regulations of IRDAI

The regulator has also brought in some changes for benefit of the Insured as given below.

a. The insured is to 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.
b. 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 has prescribed standard forms to be filled up by the insured which forms part of the policy document.
c. Insurers have come out with various mechanisms 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.

D. Portability of Health Insurance

Portability is defined by IRDAI as **the right** accorded to individual health insurance policyholders (including all members under 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.

Portability is the provision by which an Insured can move from one insurer to another carrying with him/ her all the benefits earned over a period of time. Students may please read IRDAI's Consolidated Guidelines on Product filing in Health Insurance Business dated 22 July 2020 lays down norms for standardising many of the practices including Portability.

IRDAI mandates that Portability shall be allowed under all individual indemnity health insurance policies issued by General Insurers and Health Insurers including family floater policies.

However, porting can be done only at the time of renewal. Apart from the waiting period credit, other terms of the new policy including the premium would be decided by the new insurance company. Procedurally, the request for porting should be made by the insured to the old insurer at least 45 days before the renewal, specifying the company to which the policy has to be ported. The policy has to be renewed without a break (there is a 30 day grace period if porting is

under process). IRDA has created a web-based facility that maintains data about all health insurance policies issued by insurance companies to individuals, to enable the new insurer to access and obtain data on the porting policyholder's health insurance history in a smooth manner.

E. Migration of Health Insurance

Migration is defined by IRDAI as the right accorded to health insurance policyholders (including all members under family cover and members of group health insurance policy), **to transfer** the credit gained for pre-existing conditions and time bound exclusions, **with the same insurer**.

IRDAI's Consolidated Guidelines on Product filing in Health Insurance Business dated 22 July 2020 revised the guidelines on Migration of health insurance policies. It provides that every individual policyholder (including members under family floater policy) covered under an indemnity based individual health insurance policy shall be provided an option of migration at the explicit option exercised by the policyholder. Migration from group policies to individual policy will be subject to underwriting.

A policyholder desirous of migrating his/ her policy shall be allowed to apply to the insurance company to migrate the policy along with all members of the family, if any, at least 30 days before the premium renewal date of his/her existing policy. However, if the insurer is willing to consider even less than 30 days period, then the insurer may do so. Insurers shall not levy any charges exclusively for migration.

F. Basic principles of insurance and tools for underwriting

1. Basic principles relevant to underwriting

In any form of insurance, whether it is life insurance or general insurance, there are certain legal principles which operate along with acceptance of risks. Health insurance is equally governed by these principles and any violation of the principles may result in the insurer deciding to avoid the liability. (These principles have been discussed in the common chapters.)

2. Tools for underwriting

These are the sources of information for the underwriter and the basis on which the risk classification is done and premiums finally decided. The following are the key tools for underwriting:

a) Proposal form

This document is the base of the contract where all the critical information pertaining to the health and personal details of the proposer (i.e. age,

occupation, build, habits, health status, income, premium payment details etc.) are collected. Any breach or concealment of information by the insured shall render the policy void. (This has been discussed in the common chapters.)

b) Age proof

Premiums are determined on the basis of the age of the insured. Hence it is imperative that the age disclosed at the time of enrolment is verified through submission of an age proof.

Example

In India, there are many documents which can be considered as age proof but all of them are not legally acceptable. Mostly valid documents are divided into two broad categories. They are as follows:

a) Standard age proof: Some of these include school certificate, passport, domicile certificate, PAN card etc.
b) Non-standard age proof: Some of these include ration card, voter ID, elder's declaration, gram panchayat certificate etc.

Financial documents

Knowing the financial status of the proposer is particularly relevant for benefit products and to reduce the moral hazard. However, normally the financial documents are only asked for in cases of:

a) Personal accident covers or
b) High sum assured coverage or
c) When the stated income and occupation as compared to the coverage sought, show a mismatch.

c) Medical reports

Requirement of medical reports is based on the norms of the insurer, and usually depends upon the age of the insured and sometimes on the amount of cover opted. Some replies in the proposal form may also contain some information that leads to medical reports being asked for.

d) Reports of sales personnel

Sales personnel can also be seen as grassroots level underwriters for the company and the information given by them in their report could form an important consideration. However, as the sales personnel have an incentive to generate more business, there is a conflict of interest which has to be watched out for.

Test Yourself 2

The principle of utmost good faith in underwriting is required to be followed by _____.

I. The insurer
II. The insured
III. Both the insurer and the insured
IV. The medical examiners

Test Yourself 3

Insurable interest refers to _____.

I. Financial interest of the person in the asset to be insured
II. The asset which is already insured
III. Each insurer's share of loss when more than one company covers the same loss
IV. The amount of the loss that can be recovered from the insurer

G. Underwriting process

Once the required information is received, the underwriter decides the terms of the policy. The common forms used for underwriting health insurance business are as below:

1. Medical underwriting

Medical underwriting is a process in which medical reports are called for from the proposer to determine the health status of an individual applying for health insurance policy. The health information collected is then evaluated by the insurers to determine whether to offer coverage, up to what limit and on what conditions and exclusions. Thus medical underwriting can determine the acceptance or declining of a risk and also the terms of cover.

Example

Medical conditions like hypertension, overweight/ obesity and raised sugar levels have a high probability of future hospitalization for diseases of the heart, kidney and the nervous system. So, these conditions should be carefully considered while assessing the risk for medical underwriting.

Medical underwriting guidelines may also require a signed declaration of the proposer's health status by his/ her family physician.

Persons above the age of 45-50 years, enrolling for the first time are normally required to undergo specified pathological investigations to assess health risk

profile and to obtain information on their current health status. Such investigations also provide an indication of prevalence of any pre-existing medical conditions or diseases.

2. Non-medical underwriting

Most of the proposers which apply for health insurance do not need medical examination.

Even, if the proposer were to disclose all material facts completely and truthfully and the same were checked by agent carefully, then also the need for medical examination could be much less.

Example

If an individual has to take health insurance coverage quickly without going through a long process of medical examinations, waiting periods and processing delays, then he can opt for a non-medical underwriting policy. In a non-medical underwriting policy, premium rates and sum assured are usually decided on the basis of answers to a few health questions mostly based on age, gender, smoking class, build etc. The process is speedy but the premiums may be relatively higher.

3. Numerical rating method

This is a process adopted in underwriting, wherein numerical or percentage assessments are made on each component of the risk.
Factors like age, sex, race, occupation, residence, environment, build, habits, family and personal history are examined and scored numerically based on pre-determined criteria.

4. Underwriting decisions

The underwriting process is completed when the received information is carefully assessed and classified into appropriate risk categories. Based on the above tools and his judgment, the underwriter classifies the risk into the following categories:

a) Accept risk at standard rates
b) Accept risk at an extra premium (loading), though it may not be practiced in all companies
c) Postpone the cover for a stipulated period/ term
d) Decline the cover
e) Counter offer (either restrict or deny part of the cover)
f) Impose a higher deductible or Co-pay
g) Levy permanent exclusion(s)under the policy

If any illness is permanently excluded, it is endorsed on the policy certificate. This becomes an additional exclusion apart from the standard policy exclusion and shall form the part of the contract.

5. Use of general or standard exclusions

The majority of policies impose exclusions that apply to all their members. These are known as standard exclusions or sometimes referred to as general exclusions. Insurers limit their exposure by the implementation of standard exclusions. These have been discussed in an earlier chapter.

6. Zone wise premium

Normally, the premium would depend on the age of the insured person and the sum insured selected. Premium differential has been introduced in certain zones with higher claims cost e.g. Delhi and Mumbai form part of highest premium zone for certain products by some insurers. For e.g. Individual Policy for age group of 55-65 years would be rated higher in Metros and 'A Class' cities than a similar policy for the same age bracket in a city like Indore or Jammu.

Test Yourself 4

Which of the following statements about medical underwriting is incorrect?

I. It involves high cost in collecting and assessing medical reports.
II. Current health status and age are the key factors in medical underwriting for health insurance.
III. Proposers have to undergo medical and pathological investigations to assess their health risk profile.
IV. Percentage assessment is made on each component of the risk.

H. Health Insurance at Group Level

While accepting a group for health insurance, the insurers take into consideration the possibility of existence of a few members in the group who may have severe and frequent health problems.

1. Group Health Insurance

Underwriting of group health insurance requires analysing the characteristics of the group to evaluate whether it falls within the insurance company's underwriting guidelines as well as the guidelines laid down for group insurance by the insurance regulators.

Standard underwriting process for group health insurance requires evaluating the proposed group on the following factors:

a) Type of group
b) Group size
c) Type of industry
d) Eligible persons for coverage
e) Whether entire group is being covered or there is an option for members to opt out

f) Level of coverage – whether uniform for all or differently
g) Composition of the group in terms of sex, age, single or multiple locations, income levels of group members, employee turnover rate, whether premium paid entirely by the group holder or members are required to participate in premium payment
h) Difference in healthcare costs across regions in case of multiple locations spread in different geographical locations
i) Preference of the group holder for administration of the group insurance by a third party administrator (of his choice or one selected by the insurer) or by the insurer itself
j) Past claims experience of the proposed group

Example

A group of members working in mines or factories is at higher health risk than a group of members working in air-conditioned offices. Also the nature of diseases (thereby claims) are also likely to be quite different for both groups. Therefore, the insurer will price the group health insurance policy accordingly in both the cases.

Similarly to avoid adverse selection in case of groups with high turnover such as IT companies, insurers can introduce precautionary criteria requiring employees to serve their probationary period before becoming eligible for insurance.

2. Underwriting other than employer- employee groups

Employer-employee groups are traditionally the most common groups offered group health insurance, the character of the group composition is one of the important consideration while underwriting the group.

Health insurance can also be offered to Non Employer employee groups. The IRDAI has issued group insurance guidelines with a view to regulate the approach to be adopted by insurers in dealing with various groups. Such non-employer groups include:

a) Employer welfare associations
b) Holders of credit cards issued by a specific company
c) Customers of a particular business where insurance is offered as an add-on benefit
d) Borrowers of a bank and professional associations or societies

I. Underwriting of Overseas Travel Insurance

Since the main cover under Overseas Travel Insurance policies is the health cover, the underwriting would follow the pattern for health insurance in general.

The premium rating and acceptance would as per individual company guidelines but a few important considerations are given below:

1. Premium rate would depend on the age of the proposer and the duration of foreign travel.
2. As medical treatment is costly overseas, the premium rates are normally much higher compared to domestic health insurance policies.
3. Even among the foreign countries, USA and Canada premium is the highest.
4. Care should be taken to rule out the possibility of a Proposer using the policy to take medical treatment abroad and hence the existence of any pre-existing disease must be carefully considered at the proposal stage.

J. Underwriting of Personal Accident Insurance

The underwriting considerations for Personal Accident Policies are discussed below:

Rating

In personal accident insurance, the main factor considered is the occupation of the insured. The risks associated with profession or occupation varies in accordance with the nature of work performed. For example, an office manager is less exposed to risk at work than a civil engineer working at a site where a building is being constructed. To fix a rate, occupations are classified into groups, each group reflecting, more or less, similar risk exposure.

Classification of Risk

On the basis of occupation, the risks associated with the insured person may be classified into three groups:

- **Risk group I**
  Accountants, Doctors, Lawyers, Architects and persons engaged in administration functions, persons primarily engaged in occupations of similar hazards.
- **Risk group II**
  Builders, Contractors and Engineers engaged in superintending functions and persons engaged in occupation of similar hazards. All persons engaged in manual labour (except those falling under Group III),
- **Risk group III**
  Persons working in underground mines or engaged in activities like racing on wheels and persons engaged in occupations/ activities of similar hazard.
  Risk groups are also known in the form of 'Normal', 'Medium' and 'High' respectively.

Age Limits

General age limits for the working population (employer employee) is 18-70.However for students Minimum age could be 5 years too.
The minimum and maximum age for being covered and renewed varies from company to company.

Family Package Cover

The Personal accident policy also has a family package cover wherein Children and Non-earning spouse are covered for to death and permanent disablement (total or partial) only.

Premium Discount in Group Policies

A group discount is allowed off the premium, if the number of insured person exceeds a certain number say 100. Group policy however may be issued when number is smaller, say 25 but without any discount.

Group discount criteria

Group policies should be issued only in respect of the named groups. For the purpose of availing of group discount and other benefits, the proposed "Group" should fall clearly under one of the following categories, given below:

- Employer – employee relationship including dependents of the employee
- Members of a registered co-operative society
- Members of registered service clubs
- Holders of credit card of banks/ Diners/ Master/ Visa

In case of proposals relating to any further category different from the above categories, they may be deliberated and decided upon by the technical department of the respective insurers.

Premium

Varying rates of premium are applicable to named employees as per the classification of risks and the benefits selected.

On-duty cover

PA policies may have a cover for both on-duty and off-duty period or for either separately. The premium is dependent on the Sum Assured, the number of hours of duty etc. Some employers may like to restrict themselves to cover the duty period only.

Exclusion of death cover

It is possible to issue group P.A. policies excluding the death benefit, subject to individual company guidelines.

Group discount and Bonus/ Malus

Rating under renewal of group policies is determined with reference to the claims experience.

- Favourable experience is rewarded with a discount in the renewal premium (bonus)

- Adverse experience is penalised by loading of renewal premium (malus), according to a scale
- Normal rates will apply for renewal if the claims experience is, say, 70 percent

Test Yourself 5

1) In a group health insurance, any of the individual constituting the group could anti-select against the insurer.
2) Group health insurance provides coverage only to employer-employee groups.

I. Statement 1 is true and statement 2 is false
II. Statement 2 is true and statement 1 is false
III. Statement 1 and statement 2 are true
IV. Statement 1 and statement 2 are false

Answers to Test Yourself

Answer 1 - The correct option is III.
Answer 2 - The correct option is III.
Answer 3 - The correct option is I.
Answer 4 - The correct option is IV.
Answer 5 - The correct option is IV.

CHAPTER H-05

HEALTH INSURANCE CLAIMS

Chapter Introduction

In this chapter we will discuss about claim management process in Health Insurance, claims related procedures and documentation. Apart from this, we will also look into claims management under Personal Accident Insurance and understand the role of TPAs.

Learning Outcomes

A. Claims Management in insurance

B. Management of Health Insurance claims

C. Documentation in Health Insurance claims

D. Role of Third Party Administrators (TPA)

E. Claims Management – Personal Accident

F. Claims Management- Overseas Travel Insurance

After studying this chapter, you should be able to:

a) Explain the various stakeholders in insurance claims
b) Describe how health insurance claims are managed
c) Discuss the various documents required for settlement of health insurance claims
d) Explain how reserves for claims are provided for by insurers.
e) Discuss personal accident claims
f) Understand the concept and role of TPAs

A. Claims Management in Insurance

It is very well understood that insurance is a '**promise**' and the policy is a '**witness**' to that promise. The occurrence of an insured event leading to a claim under the policy is the true test of that promise. How well an insurer performs is evaluated by how well it keeps its claims promises. One of the key rating factors in insurance is the claims paying ability of the insurance company.

1. Stakeholders in claim process

One needs to understand the parties interested in the claims process before looking at how claims are managed.

Diagram 1: Stakeholders in claim process

Customer	The person who buys insurance is the first stakeholder and 'receiver of the claim'.
Owners	Owners of the insurance company have a big stake as the 'payers of the claims'. Even if the claims are met from the policy holders' funds, in most cases, it is they who are liable to keep the promise.
Underwriters	Underwriters within an insurance company and across all insurers have the responsibility to understand the claims and design the products, decide policy terms, conditions and pricing etc.

Regulator	The regulator (Insurance Regulatory and Development Authority of India) is a key stakeholder in its objective to: ✓ Maintain order in the insurance environment ✓ Protect policy holders' interest ✓ Ensure long term financial health of insurers.
Third Party Administrators	Service intermediaries known as Third Party Administrators, who process health insurance claims.
Insurance agents/ brokers	Insurance agents/ brokers not only sell policies but are also expected to service the customers in the event of a claim.
Providers/ Hospitals	They ensure that the customer gets a smooth claim experience, especially when the hospital is on the panel of the TPA the Insurer to provide cashless hospitalization.

Thus managing claims well means managing the objectives of the each of these stakeholders related to the claims. Of course, it may happen that some of these objectives can conflict with each other.

Reserving: In many cases, insurance companies may not be able to settle claims instantly and may have to wait for information or the results of disputes, litigation etc. So, they have to hold the claim amounts in reserve till the payments are due. Reserves are usually are actuarial estimates of the amounts that will be paid on outstanding claims.

Reserving refers to the amount of provision made for all claims in the books of the insurer based on the status of the claims.

Test Yourself 1

Who among the following is not a stakeholder in Health insurance claim process?

I. Customers
II. Police Department
III. Regulator
IV. TPA

B. Management of Health Insurance Claims

1. Claim process in health insurance

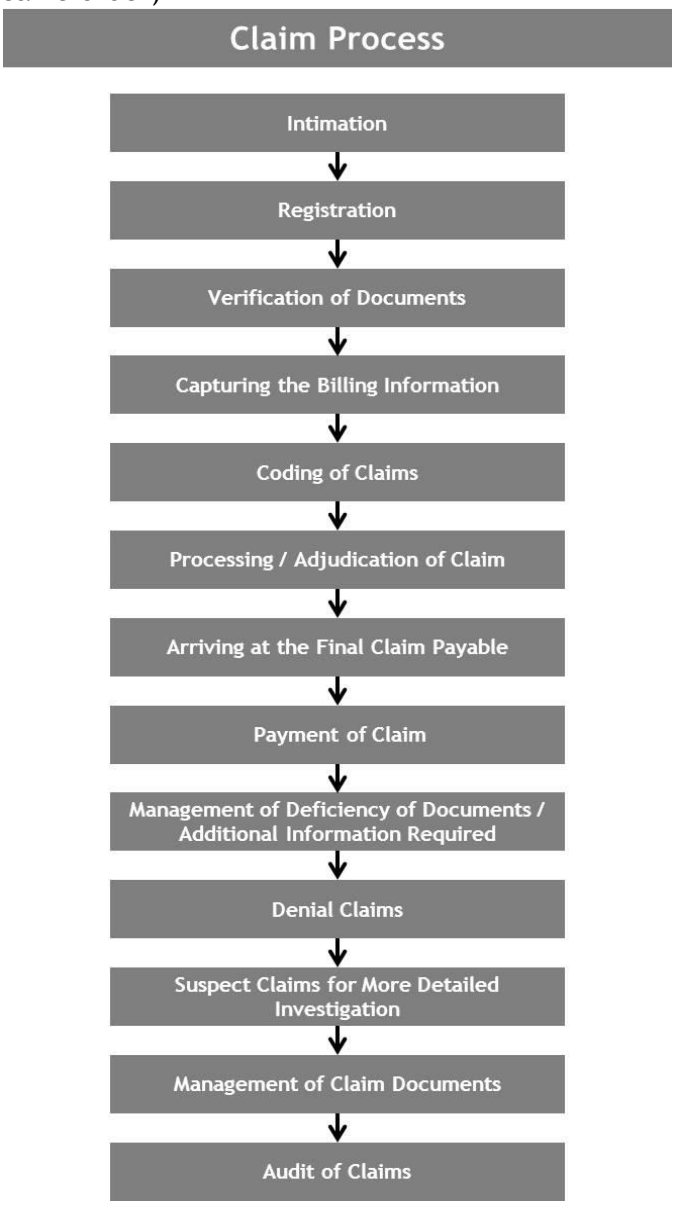
A claim may be serviced either by the insurance company itself or through the services of a Third Party Administrator (TPA) authorized by the insurance company.

From the time a claim is made known to the insurer/ TPA to the time the payment is made as per the policy terms, the health claim passes through a set of well-defined steps, each having its own relevance.

The processes detailed below are in specific reference to health insurance (hospitalization) indemnity products which form the major part of health insurance business.
The general process and supporting documents for a claim under fixed benefit product or critical illness or daily cash product etc. would be quite similar, except for the fact that such products may not come with cashless facility.

In both cases of indemnity as well as reimbursement type of claim, the basic steps remain the same.

Diagram 2: Claim process broadly comprises following steps (may not be in the same order)



a) Intimation

Claim intimation is the first instance of contact between the customer and the claims team. The customer could inform the company that he is planning to avail a hospitalization or the intimation would be made after the hospitalization has taken place, especially in case of emergency admission to a hospital.

Till recently, the act of intimation of a claim event was a formality. However, recently insurers have started insisting on the intimation of claim as soon as practicable. Typically it is required before hospitalization in case of planned admission, and within 24 hours of hospitalization in case of an emergency. Intimation is now possible through Mobile Apps/ call centres run by insurers/ TPAs open 24 hours as well as through the internet and e-mail.

b) Registration

Once the intimation is received by the company directly or through the TPA, the details thereof are matched for accuracy and a reference number or claim control number generated and intimated to the claimant. The documents are then scrutinized for prima facie coverage and pre-authorisation of likely expenditure is given to the Hospital in case the intimation is of a planned surgery under the Cash-less scheme (detailed in subsequent section).

The claims that come for the final settlement on the reimbursement basis are scrutinized in detail about admissibility, sum assured, deductibles, sub-limits etc. In case of deficiency in documents the same has to be communicated together, not in piecemeal. It is worth knowing that the claim processing involves not only ensuring that the terms of the contract have to be fulfilled, but also in ensuring that the Hospitals do not indulge in overcharging, double-charging etc.

Example

Hospitalization is typically associated with Allopathic method of treatment. However, the patient could undergo other modes of treatment such as:

- ✓ Unani
- ✓ Siddha
- ✓ Homeopathy
- ✓ Ayurveda
- ✓ Naturopathy etc.

Most policies now include these treatments, however there could be sub-limits.

Telemedicine: IRDAI has asked insurers to allow telemedicine wherever regular medical consultation is allowed, in the terms and conditions of medical insurance policies.

This will help policy holders who may prefer to consult medical practitioners online or telephonically to avoid going out of their homes or if they are in quarantine themselves due to the coronavirus infection.

Arriving at the final claim payable: The factors that decide the claim amount payable are:

a) Sum insured available for the member under the policy

b) Balance sum insured available under the policy for the member after taking into account any claim made already:

c) Sub-Limits

d) Check for any limits specific to illness

e) Check whether entitled or not to cumulative bonus

f) Other expenses covered with limitation:

What are finally paid are the Reasonable and Customary Charges meaning the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness/ injury involved.

Earlier every TPA/ insurer had its own list of non-payable items, now the same has been standardized under IRDAI Health Insurance Standardization Guidelines.

c) Payment of claim

Once the payable claim amount is arrived at, payment is done to the customer or the hospital as the case may be. The payment may be made either by cheque or by transferring the claim money to the customer's bank account.

d) Denial of claims

The experience in health claims show that 10% to 15% of the claims submitted do not fall within the terms of the policy. This could be because of a variety of reasons some of which are:

i. Date of admission is not within the period of insurance.
ii. The Member for whom the claim is made is not covered.
iii. Due to Pre-existing illness (where the policy excludes such condition).
iv. Undue delay in submission without valid reason.
v. No active treatment; admission is only for investigation purpose.
vi. Illness treated is excluded under the policy.
vii. The cause of illness is abuse of alcohol or drugs
viii. Hospitalization is less than 24 hours.

Denial or repudiation of a claim (due to whatever reason) has to be informed to the customer in writing by the insurance company. Usually, such denial

letter clearly states the reason for denial, narrating the policy term/ condition on which the claim was denied.

Apart from the representation to the insurer, the customer has the option to approach the following in case of denial of claim:

- ✓ Insurance Ombudsman or
- ✓ The Consumer Commissions or
- ✓ IRDAI or
- ✓ Law courts.

e) Suspect claims require more detailed investigation by the companies/ TPAs

Wherever the insurance company suspects foul-play it can get claims investigated. A few examples of frauds committed in health insurance are:

i. Impersonation, the person insured is different from person treated.
ii. Fabrication of documents to make a claim where there is no hospitalization.
iii. Inflation of expenses, either with the help of the hospital or by addition of external bills fraudulently created.
iv. Outpatient treatment converted to in-patient/ hospitalization to cover cost of diagnosis, which could be high in some conditions.

It is to be noted that in respect of claims that need to be investigated, investigations shall be initiated and completed at the earliest, in any case not later than 90 days from the date of receipt of claim intimation. The claim should be settled within 30 days of completing the investigation. (Pl refer to IRDAI (Protection of policyholder's), 2017 Regulations and updated accordingly)

f) Cashless settlement process by TPA

How does the cashless facility work? At the heart of this is an agreement that the TPA insurer enters into, with the hospital. There are agreements possible with other medical service providers as well. The process used for providing cashless facility are discussed in this section:

Table 3.1

Step 1	• A customer covered under health insurance suffers from an illness or sustains an injury and so is advised admission into a hospital. He/ she (or someone on his/ her behalf) approaches the hospital's insurance desk with the insurance details such as: i. TPA name, ii. Customer's membership number, iii. Insurer's name, etc.

Step 2	• The hospital compiles the necessary information such as: i. Diagnosis of illness ii. Treatment, iii. Name of treating doctor, iv. Number of days of proposed hospitalization and v. The estimated cost • This is presented in a format, called the cashless authorization form.
Step 3	• The TPA studies the information provided in the *cashless authorization form* and takes a decision on whether the cashless authorization could be provided and if so, for how much amount it should be authorized and it is communicated to the hospital without delay.
Step 4	• The patient is treated by the hospital, keeping the amount authorized by the TPA as credit in the patient's account. The member may be called on to make a deposit payment to cover the non-treatment expenses and any co-pay required under the policy.
Step 5	• When the patient is ready for discharge, the hospital checks the amount of credit in the account of the patient approved by the TPA against the actual treatment charges covered by insurance. • If the credit is less, the hospital requests for additional approval of credit for the cashless treatment. • TPA analyses the same and approves the additional amount.
Step 6	• Patient pays the non-admissible charges and gets discharged. He will be asked to sign the claim form and the bill, to complete the documentation.
Step 7	• Hospital consolidates all the documents and presents to the TPA the documents for processing of the bill
Step 8	• TPA will process the claim and recommend for payment to the hospital after verifying details.

g) Customer must make sure that he/ she has his/ her insurance details with him/ her.

This includes his TPA card, Policy copy, Terms and conditions of cover etc.

When these are not available, he can contact the TPA (through a 24 hour helpline) and seek the details.

i. Customer must check if the hospital suggested by his/ her consulting doctor is in the network of the TPA. If not, he needs to check with the TPA the options available where cashless facility for such treatment is available.

ii. He/ she needs to make sure that the correct details are entered into the pre-authorization form. This form has been standardized by IRDAI as per Guidelines on Standardization in Health Insurance issued in 2013. If the case is not clear, the TPA could deny the cashless facility or raise query.

iii. He/ she needs to ensure that the hospital charges are consistent with the limits such as room rent or caps on specified treatments such as cataract.

iv. The customer must inform the TPA in advance of the discharge and request the hospital to send to the TPA any additional approval that may

be required before discharge. This will ensure the patient does not wait unnecessarily at the hospital.

It is also possible that the customer requests and takes an approval for cashless treatment at a hospital but decides to admit the patient elsewhere. In such cases, the customer must inform and ask the hospital to communicate to the TPA that the cashless approval is not being used.

If this is not done, the amount approved could get blocked in the customer's policy and could prejudice the approval of the subsequent request.

C. Documentation in Health Insurance Claims

This section explains the need for and content of each of the documents required to be submitted by the customers:

1. Discharge summary

Discharge summary can be termed as the most important document that is required to process a health insurance claim. It details the complete information about the condition of the patient and the line of treatment and helps the claim processing person immensely to understand the illness/ injury and the line of treatment. Where the patient unfortunately does not survive, the discharge summary is termed **Death Summary** in many hospitals. The discharge summary is always sought in original.

2. Investigation reports

Investigation reports assist in comparing the diagnosis and the treatment, thereby providing the necessary information to understand the exact condition that prompted the treatment and the progress made during the hospitalization for e.g. Blood test reports, X-ray reports and Biopsy reports. The insurer may return the X-ray and other films to the customer on specific request.

3. Consolidated and detailed bills:

This is the document that decides what needs to be paid under the insurance policy. While the consolidated bill presents the overall picture, the detailed bill will provide the break up, with reference codes. The bills have to be received in original.

4. Receipt for payment

The reimbursement of a health insurance claim will also require the formal receipt from the hospital of the amount paid which must correspond to the total of the bill.

The receipt should be numbered and or stamped and be presented in original.

5. Claim form

Claim form is the formal and legal request for processing the claim and is submitted in original signed by the customer. The claim form has now been standardized by IRDAI.

Besides information on disease, treatment etc., the declaration the insured person makes in the claim form is the most important document in the legal sense.

6. Identity proof

With the increasing use of identity proof across various activities in our life, the general Proof of identity helps in verifying whether the person covered and the person treated are one and the same. Usually identification document which is sought could be voters' identity card, driving license, PAN card, Aadhaar card etc.

7. Documents contingent to specific claims

There are certain types of claims that require additional documents apart from what has been stated above. These are:

a) Accident claims, where FIR or Medico-legal certificate issued by the hospital to the registered police station, may be required.

b) Case indoor papers in case of complicated or high value claims.

c) Dialysis/ Chemotherapy/ Physiotherapy charts where applicable.

d) Hospital registration certificate, where the compliance with the definition of hospital needs to be checked

Test Yourself 2

Which of the following document is maintained at the hospital detailing all treatment done to an in-patient?

I. Investigation report

II. Discharge summary

III. Case paper

IV. Hospital registration certificate

Test Yourself 3

The amount of provision made for all claims in the books of the insurer based on the status of the claims is known as _____.

I. Pooling
II. Accounting
III. Reserving
IV. Investing

D. Role of Third Party Administrators (TPA)

The Role of TPA has been discussed in earlier chapters too. It is important to know the services offered by TPA so that the customer can be provided suitable services by the salesperson.

The scope of TPA services starts after the sale and issue of the insurance policy. In case of insurers not using TPAs, the services are performed by in-house team.

1. Post sale service of health insurance

a) Once the proposal (and the premium) is accepted, the coverage commences.
b) If a TPA is to be used for servicing the policy, the insurer passes on the information about the customer and the policy to the TPA.
c) The TPA enrols the members (while the proposer is the person taking the policy, members are those covered under the policy) and may issue a membership identification in the form of a card, either physical or electronic.
d) The membership with the TPA is used for availing cashless facility as well as processing of claims when the member requires the support of the policy for a hospitalization or treatment that is covered.
e) TPA processes the claim or cashless request and provides the services within the time agreed with the insurer.
f) The insured persons must carry an Identity Card that relates them to the policy and the TPA.
g) TPA issues a pre-authorization or a Letter of Guarantee to the hospital based on the information provided for requesting the cashless facility.
h) Where the information is not clear or not available, the TPA may reject the cashless request. In such cases the claim could be examined on reimbursement basis.

2. Customer relationship and contact management

Since TPAs are involved in claims servicing, they usually have a grievance redressal mechanism themselves.

E. Claims Management – Personal Accident

On receipt of the notification of the claim the following aspects should be looked into:

a) Person in respect of whom the claim is made is covered under the policy
b) Policy is valid as on date of accident and premium has been received
c) Loss is within the policy period
d) Loss has arisen out of "Accident" and not sickness
e) Check for any fraud triggers and assign investigation if need be
f) Register the claim and create reserve for the same
g) Maintain the turnaround time (claim servicing time) and keep the customer informed of the development of the claim.

1. Claims Investigation

Claims Investigation is about determining the validity of the claim and finding out the real cause and extent of the loss. On receipt of the claim documents, if a claim appears suspicious, the claim may be assigned to an internal/ professional investigator for verification.

Example

Example of case guideline:

Road traffic accident

i. When did the incident take place – exact time and date place? Date and time
ii. Was the insured a pedestrian, traveling as passenger/ pillion rider or driving the vehicle involved in accident?

Some examples of possible fraud and leakage in personal accident claims:

i. Exaggeration in TTD period.
ii. Illness presented as accident e.g. backache due to pathological reasons converted into a PA claim after reported 'fall/ slip' at home

Discharge voucher is an important document for settlement of personal accident claim, especially those involving death claims. It is also important to obtain nominee details at the time of proposal and the same should form part of policy document.

2. Claim documentation- Each company gives a list

a) Duly completed Personal Accident claim form signed by the claimant's nominee/ family member
b) Original or Attested copy of First Information Report.
c) Original or Attested copy of Death certificate.
d) Attested copy of Post Mortem Report if conducted.
e) Attested copy of AML documents (Anti-money laundering) - for name verification (passport/ PAN card/ Voter's ID/ Driving license) for address verification (Telephone bill/ Bank account statement, Electricity bill/ Ration card).
f) Legal heir certificate containing affidavit and indemnity bond both duly signed by all legal heirs and notarized
g) Permanent disability certificate from a civil surgeon or any equivalent competent doctors certifying the disability of the insured.
h) Medical certificate from treating doctor mentioning the type of disability and disability period. Leave certificate from employer giving details of exact leave period, duly signed and sealed by the employer.

The above list is only indicative, further documents (including photographs of scar marks, site of accident etc.) may be required depending on particular facts of the case, especially the cases with suspected fraud angle to be investigated.

Test Yourself 4

Which of the following documents are not required to be submitted for Permanent Total Disability claim?

I. Duly completed Personal Accident claim form signed by the claimant.
II. Copy of Insurance Policy.
III. Permanent disability certificate from a civil surgeon or any equivalent competent doctors certifying the disability of the insured.
IV. Fitness certificate from the treating doctor certifying that the insured is fit to perform his normal duties.

F. Claims Management- Overseas Travel Insurance

The coverage under this policy has already been discussed under the product chapter. This section tries to explain how the claims arising during overseas travel are handled.

Claims services essentially include:

a) Taking down the claim notification 24*7 basis;
b) Sending the claim form and procedure;
c) Guiding customer on what to do immediately after loss;
d) Extending cashless services for medical and sickness claims;
e) Arranging for repatriation and evacuation, emergency cash advance.

Assistance companies – Role in overseas claims

Assistance companies have their own offices and tie up arrangements with other similar service providers world over. These companies offer assistance to the customers of insurance companies in case of contingencies covered under the policy.

These companies operate a 24*7 call centre including international toll free numbers for claim registration and information. They also offer the following services and charges for the services vary depending on agreement with the particular insurance company, benefits covered etc.

a) Medical assistance services:
    i. Medical service provider referrals
    ii. Arrangement of hospital admission
    iii. Arrangement of Emergency Medical Evacuation
    iv. Arrangement of Emergency Medical Repatriation
    v. Mortal remains repatriation
    vi. Compassionate visit arrangements
    vii. Minor children assistance/ escort
b) Monitoring of Medical Condition during and after hospitalisation
c) Delivery of Essential Medicines
d) Guarantee of Medical Expenses Incurred during hospitalization subject to terms and condition of the policy and approval of insurance company.
e) Pre-trip information services and other services:
    i. Visas and inoculation requirements
    ii. Embassy referral services
    iii. Lost passport and lost luggage assistance services
    iv. Emergency message transmission services
    v. Bail bond arrangement
    vi. Financial Emergency Assistance
f) Interpreter Referral
g) Legal Referral

h) Appointment with lawyer

a) Hospitalization Procedures

i. Most hospitals accept Guarantee of Payments from all international insurance companies once the insured provides them with a valid health or overseas travel insurance policy.

ii. Hospitals start the treatment immediately. If there is insurance cover the insurance policy pays or the patient person has to pay. The hospitals tend to inflate charges since payments are delayed.

iii. Information regarding network hospitals and the procedures is available to the insured on the toll free numbers provided by the assistance companies.

iv. In event of the necessity of a hospitalization the insured needs to intimate the same at the call centre and proceed to a specified hospital with the valid travel insurance policy.

v. Hospitals usually contact the assistance companies/ insurers on the call centre numbers to check the validity of the policy and verify coverages.

vi. Once the policy is accepted by the hospital the insured would undergo treatment in the hospital on a cashless basis.

vii. Some basic information required by the insurer/ assistance provider to determine admissibility are:

1. Details of ailment

2. In case of any previous history ,details of hospital, local medical officer in India:

- ✓ Past history, current treatment and further planned course in hospital and request for immediate sending of
- ✓ Claim form along with attending physicians statement
- ✓ Passport copy
- ✓ Release of medical information form

b) Reimbursement of medical expenses and other non-medical claims:

Reimbursement claims are normally filed by insured after they return to India. Upon receipt of the claim papers, claim is processed as per usual process. Payments for all admissible claims are made in Indian Rupee (INR), unlike in cashless claims where payment is made in foreign currency.

While processing the reimbursement claims, currency conversion rate is applied as on date of loss to arrive at quantum of liability in INR. Then the payment is made though cheque or electronic transfer.

c) Claim documentation for Medical Accident and Sickness Expenses

i. Claim form

ii. Doctor’s report

iii. Original Admission/ discharge card

iv. Original Bills/ Receipts/ Prescription

v. Original X-ray reports/ Pathological/ Investigative reports

vi. Copy of passport/ Visa with Entry and exit stamp

The above list is only indicative. Additional information/ documents may be required depending on specific case details or depending upon claim settlement policy/ procedure followed by particular insurer.

Test Yourself 5

Most hospitals accept Guarantee of Payments from all international insurance companies once the insured provides them with a valid _____ Insurance policy.

I. Legal Liability
II. Corona Rakshak
III. Overseas Travel
IV. Endowment

Answers to Test Yourself

Answer 1 - The correct option is II.
Answer 2 - The correct option is II.
Answer 3 - The correct option is III.
Answer 4 - The correct option is IV.
Answer 5 - The correct option is III.

Summary

a) Insurance is a 'promise' and the policy is a 'witness' to that promise. The occurrence of insured event leading to a claim under the policy is the true test of that promise.

b) One of the key rating parameter in insurance is the claims paying ability of the insurance company.

c) Customers, who buys insurance is the primary stakeholder as well as the receiver of the claim.

d) In Cashless claim a network hospital provides the medical services based on a pre-approval from the insurer/ TPA and later submits the documents for settlement of the claim.

e) In reimbursement claim, the customer pays the hospital from his own resources and then files claim with Insurer/ TPA for payment.

f) Claim intimation is the first instance of contact between the customer and the claims team.

g) If a fraud is suspected by insurance company in case of insurance claim, it is sent for investigation. Investigation of a claim could be done in-house by an insurer/ TPA or be entrusted to a professional investigation agency.

h) Reserving refers to the amount of provision made for all claims in the books of the insurer based on the status of the claims.

i) In case of a denial, the customer has the option, apart from the representation to the insurer, to approach the Insurance Ombudsman or the consumer Commissions or even the legal authorities.

j) Frauds occur mostly in hospitalization indemnity policies but Personal accident policies also are used to make fraud claims.

k) The TPA provides many important services to the insurer and gets remunerated in the form of fees.

SECTION

GENERAL INSURANCE

CHAPTER G-01
GENERAL INSURANCE DOCUMENTATION

Chapter Introduction

As discussed in Chapter 7, the Proposal form contains information which are useful for the insurance company to accept the risk offered for insurance.

We have seen that in different branches of insurance, the documentation needs are different based on the subject matter insured, type of insurance coverage and the types of claims that can arise.

Learning Outcomes

A. Proposal forms

B. Acceptance of a proposal (underwriting)

C. Premium Receipt

D. Cover Notes/ Certificate of Insurance/ Policy Document

E. Warranties

F. Endorsements

G. Interpretation of Policies

H. Renewal Notice

After studying this chapter, you should be able to:

a) Explain the contents of a Proposal form.
b) Describe the importance of Prospectus
c) Understand the premium receipt.
d) Explain terms and wordings in insurance policy document.
e) Discuss policy conditions and warranties.
f) Appreciate why endorsements are issued.
g) Appreciate why renewal notices are issued.

A. Proposal forms

The Proposal form contains information which are useful for the insurance company to accept the risk offered for insurance. The principle of utmost good faith and the duty of disclosure of material information begin with the proposal form for insurance.

Example

If the insured was required to maintain an alarm or had stated that he has an automatic alarm system in his gold jewellery showroom, then not only is he required to disclose it, he has to ensure the same remains in a working condition throughout the policy period. The existence of the alarm is a material fact for the insurer who will be accepting the proposal based on these facts and pricing the risk accordingly.

1. Nature of questions in a proposal form

The number and nature of questions in a proposal form vary according to the class of insurance concerned.

i. **Fire insurance** proposal forms are usually used for relatively simple/ standard risks like houses, shops etc. For large industrial risks, inspection of the risk is arranged by insurer before acceptance of the risk. Special questionnaire are sometimes used in addition to the proposal form to gather specific information.

   Fire insurance proposal form seeks, among other things, the description of the property which would include the following information:

   - ✓ Construction of external walls and roof, number of story
   - ✓ Occupation of each portion of the building
   - ✓ Presence of hazardous goods
   - ✓ Process of manufacture including raw material and finished goods
   - ✓ The sums proposed for insurance
   - ✓ The period of insurance, etc.

ii. **For motor insurance,** questions are asked about the vehicle, its operations, make and carrying capacity, how it is managed by the owner and related insurance history.

iii. **In personal lines** like health, personal accident and travel insurance, proposal forms are designed to get information about the proposer's health, way of life and habits, pre-existing health conditions, medical history, hereditary traits, past insurance experience etc.

iv. **In other miscellaneous insurances,** proposal forms are compulsory and they incorporate a declaration which extends the common law duty of good faith.

2. Elements of a proposal

i. Proposer's name in full

The proposer should be able to identify himself/ herself unambiguously. It is important for the insurer to know with whom the contract has been entered, so that the benefits under the policy would be received only by the insured.

ii. Proposer's address and contact details

The reasons stated above are applicable for collecting the proposer's address and contact details as well.

iii. Proposer's profession, occupation or business

In some cases like health and personal accident insurance, the proposer's profession, occupation or business are of importance as they could have a material bearing on the risk.

iv. Details and identity of the subject matter of insurance

The proposer is required to clearly state the subject matter that is proposed for insurance.

Example

The proposer is required to state if it is:

i. A private car [with its identification like engine number, chassis number, registration number] or

ii. A residential house [with its full address and identification numbers] or

iii. An overseas travel [by whom, when, to which country, for what purpose] or

iv. A person's health [with person's name, address and identification] etc. depending on the case

v. **Sum insured** indicates limit of liability of the insurer under the policy and has to be indicated in all proposal forms.

vi. **Previous and present insurance**: As seen in the common chapters, the proposer is required to inform the details about his previous insurances to the insurer.

In property insurance, there is a chance that insured may take policies from different insurers and when a loss happens, claim from more than one insurer. This information is required to ensure that the principle of

contribution is applied so that the insured is indemnified and does not gain/ profit due to multiple insurance policies for the same risk.

Further, in personal accident insurance an insurer would like to restrict the amount of coverage (sum insured) depending on the sum insured under other PA policies taken by the same insured.

vii. Loss experience

The proposer is asked to declare full details of all losses suffered by him/ her, whether or not they were insured. This will give the insurer information about the subject matter of insurance and how the insured has managed the risk in the past. Underwriters can understand the risk better from such answers and decide on conducting risk inspections or collecting further details.

viii. Declaration by insured

As the purpose of the proposal form is to provide all material information to the insurers, the form **includes a declaration by the insured that the answers are true and accurate and he agrees that the form shall be the basis of the insurance contract.** Any wrong answer will give the right to insurers to avoid the contract. Other sections common to all proposal forms relate to **signature, date and in some cases agent's recommendation.**

B. Acceptance of the Proposal (underwriting)

As seen earlier, a completed proposal form broadly gives the following information:

- ✓ Details of the insured
- ✓ Details of the subject matter
- ✓ Type of cover required
- ✓ Details of the physical features both positive and negative - including type and quality of construction, age, presence of fire-fighting equipment, the type of security etc.,
- ✓ Previous history of insurance and loss

In the case of property, motor or cargo insurance, the insurer may also arrange for pre-inspection survey of the risk before acceptance, depending on the nature and value of the risk. Insurers take their decision based on the information available in the proposal, the risk inspection report, answers to the additional questionnaire and other documents (as may be called for by the insurer). The insurer then decides about the rate to be applied to the risk factor and calculates the premium based on various parameters, which is then conveyed to the insured. Proposals are processed by the insurer with speed and efficiency and all decisions thereof are communicated by it in writing within a reasonable period.

Definition

Underwriting: As per Protection of Policyholders' Interests) Regulations, 2017, the company has to process the proposal within 15 days' time. The agent is expected to keep track of these timelines, follow up internally and communicate with the prospect/ insured as and when required by way of customer service. This entire process of scrutinizing the proposal and deciding about acceptance is known as underwriting.

Test Yourself 1

As per Protection of Policyholders' Interests) Regulations, 2017, an insurance company has to process an insurance proposal within _____.

I. 7 days

II. 15 days

III. 30 days

IV. 45 days

C. Premium Receipt

Premium is the consideration or amount paid by the insured to the insurer for insuring the subject matter of insurance, under a contract of insurance. As discussed in Chapter 4, the Agent should be always mindful that the **premium is to be paid in advance, before the inception date of the insurance contract** as per Section 64 VB of the Insurance Act**.**

Important

a) Section 64 VB of the Insurance Act-1938 provides that no insurer shall assume any risk unless and until the premium is received in advance or is guaranteed to be paid or a deposit is made in advance in the prescribed manner. Insurance Rules 58 and 59 provide certain exceptions to this condition of advance payment of premium in some situations.

b) Where an insurance agent collects a premium on a policy of insurance on behalf of an insurer, he shall deposit with or dispatch by post to the insurer the premium so collected in full without deduction of his commission within twenty-four hours of the collection excluding bank and postal holidays.

c) It is also provided that the risk may be assumed only from the date on which the premium has been paid in cash or by cheque.

d) Where the premium is tendered by postal or money order or cheque sent by post, the risk may be assumed on the date on which the money order is booked or the cheque is posted as the case may be.

e) Any refund of premium which may become due to an insured on account of the cancellation of policy or alteration in its terms and conditions or otherwise, shall be paid by the insurer directly to the insured by a crossed or order cheque or by postal/ money order or by Electronic Mode and a proper

receipt shall be obtained by the insurer from the insured, and such refund shall in no case be credited to the account of the agent.

D. Cover Notes/ Certificate of Insurance/ Policy Document

After underwriting is completed it may take some time before the policy is issued. **Pending the preparation of the policy or when the negotiations for insurance are in progress and it is necessary to provide cover on a provisional basis or when the premises are being inspected for determining the actual rate applicable,** a cover note is issued to confirm protection under the policy. It gives description of cover. Sometimes, insurers issue a letter confirming the provisional insurance cover instead of a cover note.

Although the cover note is not stamped, the wording of the cover note makes it clear that it is subject to the usual terms and conditions of the insurers' policy for the class of insurance concerned. If the risk is governed by any warranties, then the cover note would state that the insurance is subject to such warranties. The cover note is also made subject to special clauses, if applicable e.g. Agreed Bank Clause, Declaration Clause etc.

A cover note would incorporate the following:

a) Name and address of insured
b) Sum insured
c) Period of insurance
d) Risk covered
e) Rate and premium: if rate is not known, the provisional premium
f) **Description of the risk covered**: for example a fire cover note would indicate identification particulars of the building, its construction and occupancy.
g) Serial number of the cover note
h) Date of issue
i) **Validity of cover note** is usually for a period of a fortnight and rarely up to 60 days

Cover notes are used predominantly in marine and motor classes of business.

1. Marine Cover Notes

These are normally issued when details required for the issue of policy such as name of the steamer, number of packages, or exact value etc. are not known. Even in respect of exports, a cover note may be issued e.g. a certain quantity of cargo meant for shipment is sent by the exporter to the docks. It may happen that, owing to difficulty of securing adequate shipping space, shipment of the cargo by the intended vessel does not take place. The quantity therefore, that may be sent by a particular vessel cannot be known. In the circumstances, a cover note may be required which is to be followed subsequently by the issue of regular policy when full details are available and made known to the insurance company.

Marine cover note may be worded along the following lines:

i. Marine Cover Note Number

ii. Date of issue

iii. Name of the insured

iv. Valid up to

"As requested, you are hereby held covered subject to usual conditions of the company's policy to the extent of Rs. _____."

a) Clauses: Institute Cargo Clauses A, B or C including War SRCC risks as per Institute Clauses, but subject to 7 days' notice of cancellation.

b) Conditions: Details of shipment to be supplied on receipt of shipping documents for issue of policy. In the event of loss or damage prior to declaration and/ or shipment on board the steamer, it is hereby agreed that the basis of valuation shall be prime cost of the goods plus charges actually incurred and for which the assured is liable.

With regard to inland transit normally all relevant data required for issue of policy are available and therefore a cover note is rarely required. There may however, be some occasions when cover notes are issued and substituted later on by policies containing full description of the cargo, transit etc.

2. Motor Cover Notes

These are to be issued in the form prescribed by the respective companies the operative clause of a motor cover note may read as follows:

"The insured described in the form, referred to below, having proposed for insurance in respect of the Motor Vehicle(s) described therein and having paid the sum of Rs….as premium the risk is hereby held covered under the terms of the company's usual form of……Policy applicable thereto (subject to any Special Conditions mentioned below) unless the cover be terminated by the Company by notice in writing in which case the insurance will thereupon cease and a proportionate part of the premium otherwise payable for such insurance will be charged for the time the company had been on risk."

The Motor Cover Note generally contains the following particulars:

a) Registration mark and number, or description of the vehicles insured/ cubic capacity/ carrying capacity/ make/ year of manufacture, engine number, chassis number
b) Name and address of the insured
c) Effective date and time of commencement of insurance for the purpose of the Act. Time……, Date……
d) Date of expiry of insurance
e) Persons or classes of persons entitled to drive
f) Limitations as to use
g) Additional risks, if any

The Motor Cover Note incorporates a certificate to the effect that it is issued in accordance with the provisions of Chapters X and XI of the Motor Vehicles Act, 1988.

Important

The validity of the Cover Note may be extended for a further period of 15 days at a time, but in, but in no case the total period of validity of a Cover Note shall exceed sixty days.

Note: The wordings of the cover note may vary from insurer to insurer

Use of cover notes is being discouraged by most companies. Present day technology facilitates issuance of policy document immediately.

3. Certificate of Insurance – Motor Insurance

A certificate of insurance provides existence of insurance in cases where proof may be required. For instance in motor insurance, in addition to the policy, a certificate of insurance is issued as required by the Motor Vehicles Act. **This certificate provides evidence of insurance to the Police and Registration Authorities.** A specimen certificate for private cars is reproduced below, showing salient features.

MOTOR VEHICLES ACT, 1988

CERTIFICATE OF INSURANCE

Certificate No. Policy No.

1. Registration mark and Number, Place of registration, Engine No./Chassis No./ Make/ Year of manufacture.
2. Type of Body/ C.C/ Seating capacity/ Net Premium/ Name of Registration Authority,
3. Geographical area – India. `
4. Insured declared value (IDV)
5. Name and address of the Insured, Business or profession.
6. Effective date of commencement of Insurance for the purpose of the Act. From……. 'O' clock on ……
7. Date of expiry of insurance: midnight on ……
8. Persons or classes of persons entitled to drive.

Any of the following:

(a) The insured:

(b) Any other person who is driving on the insured's order or with his permission

Provided that the person driving holds an effective driving license at the time of the accident and is not disqualified from holding or obtaining such a license. Provided also that the person holding an effective learner's license may also drive the vehicle and such a person satisfies the requirement of Rule 3 of Central Motor Vehicles Rules 1989.

LIMITATIONS AS TO USE

The policy covers use for any purpose other than:

(a) Hire or reward;

(b) Carriage of goods (other than personal luggage)

(c) Organised racing,

(d) Race making,

(e) Speed testing

(f) Reliability Trials

(g) Any purpose in connection with Motor Trade.

I/ we hereby certify that the Policy to which this Certificate relates as well as this Certificate of Insurance are issued in accordance with the provisions of Chapter X and Chapter XI of the Motor Vehicles Act, 1988.

Examined .....

(Authorized Insurer)

Motor certificate of Insurance is required to be carried in the vehicle at all times for the scrutiny of the relevant authorities.

4. Policy Document

The policy is a formal document which provides an evidence of the contract of insurance. This document has to be stamped in accordance with the provisions of the Indian Stamp Act, 1899.

A general insurance policy usually contains:

a) The name(s) and address(es) of the insured and any other person having insurable interest in the subject matter;
b) Full description of the property or interest insured;
c) The location/ s 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 exclusions ;
g) Any excess/ deductible applicable;
h) Premium payable and where the premium is provisional subject to adjustment, the basis of adjustment of premium ;
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 ;
m) Provision for cancellation of the policy on grounds of misrepresentation, 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 policy should be sent;
o) The details of Add–on covers and/ or Endorsements if any;
p) Details of Grievance Redressal mechanism and address of Ombudsman

Test Yourself 2

Which of the following statements is true with regards to cover notes?

I. Cover notes are predominantly used in life insurance
II. Cover notes are predominantly used in all classes of general insurance
III. Cover notes are predominantly used in health insurance
IV. Cover notes are predominantly used in marine and motor classes of general insurance

E. Warranties

A warranty is a condition expressly stated in the policy which has to be literally complied with for validity of the contract. Warranty is not a separate document. It is part of both cover notes and policy document. It is a condition precedent to the contract. It must be observed and complied with strictly and literally, irrespective of the fact whether it is material to the risk or not. If a warranty is breached, the policy becomes voidable at the option of the insurers even when it is clearly established that the breach has not caused or contributed to a particular loss. However, in practice, if the breach of warranty is of a purely technical nature and does not, in any way, contribute to or aggravate the loss, insurers at their discretion may process the claims according to norms and guidelines as per company policy.

1. Fire Insurances warranties (some examples) are as given below

Warranted, that no hazards goods shall be stored in the insured premises during the currency of policy.

Silent Risk: Warranted that no manufacturing activity is carried out in the insured premises for consecutive period of 30 days or more.

Cigarette Filter Manufacturing: Warranted that no solvents having flash point below 30^0C are used/ stored in the premises

2. In **Marine Insurance, a warranty** is defined as follows: "a promissory warranty, that is to say, a warranty by which the assured undertake that some particular thing shall or shall not be done, or that some condition will be fulfilled, or whereby he affirms or negates the existence of a particular state of facts"

In **Marine Cargo Insurance, a warranty** is inserted to the effect that goods (e.g. tea) are packed in tin-lined cases. In **Marine Hull insurance by inserting a warranty** that the insured vessel will not navigate in a certain area, gives an idea to the insurer about the extent of risk he has agreed to provide cover for. If the warranty is breached, the risk agreed to initially is altered and the insurer is allowed to discharge himself from further liability from the date of breach

3. In **Burglary Insurance**, it is warranted that the property is guarded by a watchman for twenty four hours. The rates, terms and conditions of the policy

continue to be the same only if the warranties attached to the policy are complied with.

Test Yourself 3

Which of the following statements is correct with regards to a warranty?

I. A warranty is a condition which is never stated in the policy
II. A warranty forms part of a policy document
III. A warranty is always communicated to the insured separately and cannot be part of the policy document
IV. Claims will be payable even if a warranty is breached.

F. Endorsements

It is the practice of insurers to issue policies in a standard form; covering certain perils and excluding certain others.

Definition

If certain terms and conditions of the policy need to be modified at the time of issuance, or during the policy tenure, it is done by setting out the amendments/ changes through a document called endorsement.

It is attached to the policy and forms part of it. The policy and the endorsement together constitute the evidence of the contract. Endorsements may also be issued during the currency of the policy to record changes/ amendments.

Whenever material information changes, the insured has to advice the insurance company who will take note of this and incorporate the same as part of the insurance contract through the endorsement.

Endorsements normally required under a policy related to:

a) Variations/ changes in sum insured
b) Change of insurable interest by way of sale, mortgage, etc.
c) Extension of insurance to cover additional perils/ extension of policy period
d) Change in risk, e.g. change of construction, or occupancy of the building in fire insurance
e) Transfer of property to another location
f) Cancellation of insurance
g) Change in name or address etc.

Specimen

For the purpose of illustration, specimen wordings of some endorsements are reproduced below:

Cancellation

At the request of the insured the insurance by this Policy is hereby declared to be cancelled as from ……. The insurance having been in force for a period over …….. Months, no refund is due to the Insured.

Increase in Stock Value Cover:

"The Insured having advised that the stock covered by this policy has been increased it is hereby agreed that the sum insured is accordingly altered to Rs..... discussed as follows:

On (Describe) Rs.
On (Describe) Rs.

In consideration whereof an additional premium is hereby charged.
Further annual premium Rs…….

The total insurance now stands at Rs …….

Subject otherwise to the terms, provisions and conditions of this policy.

Extension of cover to include extraneous peril in a Marine Policy

At the request of the insured, it is hereby agreed to include the risks of breakage under the above policy.

In consideration, thereof an additional premium as under is charged to the insured on Rs.

Test Yourself 4

If certain terms and conditions of the policy need to be modified at the time of issuance, or during the policy tenure it is done by setting out the amendments through _____.

I. Warranty
II. Endorsement
III. Alteration
IV. Modifications are not possible

G. Interpretation of policies

Contracts of insurance are expressed in writing and the insurance policy wordings are drafted by insurers. These policies have to be interpreted according to certain well-defined rules of construction or interpretation which have been established by various courts. **The most important rule of construction is that the intention**

of the parties must prevail and this intention is to be looked for in the policy itself. If the policy is issued in an ambiguous manner, it will be interpreted by the courts in favour of the insured and against the insurer on the general principle that the policy was drafted by the latter.

Policy wordings are understood and interpreted as per the following rules:

a) An express condition overrides an implied condition except where there is inconsistency in doing so.
b) In the event of a contradiction in terms between the standard printed policy form and the typed or handwritten parts, the typed or handwritten part is deemed to express the intention of the parties in the particular contract, and their meaning will overrule those of the original printed words.
c) If an endorsement contradicts other parts of the contract the meaning of the endorsement will prevail as it is the later document.
d) Clauses in italics over-ride the ordinary printed wording where they are inconsistent.
e) Clauses printed or typed in the margin of the policy are to be given more importance than the wording within the body of the policy.
f) Clauses attached or pasted to the policy override both marginal clauses and the clauses in the body of the policy.
g) Printed wording is over-ridden by typewritten wording or wording impressed by an inked rubber stamp.
h) Handwriting takes precedence over typed or impressed wording.
i) Finally, the ordinary rules of grammar and punctuation are applied if there is any ambiguity or lack of clarity.

Important

1. Construction of policies

An insurance policy is evidence of a commercial contract and the general rules of construction and interpretation adopted by courts apply to insurance contracts as in the case of other contracts.

The principal rule of construction is that the intention of the parties of the contract must prevail, that intention must be gathered from the policy document itself and the proposal form, clauses, endorsements, warranties etc. attached to it and forming a part of the contract.

2. Meaning of wordings

The words used are to be construed in their ordinary and popular sense. **The meaning to be used for words is the meaning that the ordinary man in the street would construe. Thus, "fire" means flame or actual burning.**

On the other hand, **words which have a common business or trade meaning will be construed with that meaning unless the context of the sentence indicates otherwise**. Where words are defined by statute, the meaning of that definition will be used, such as "theft" as in the Indian Penal Code.

Many words used in insurance policies have been the subject of previous legal decisions and those decisions of a higher court will be binding on a lower court decision. Technical terms must always be given their technical meaning, unless there is an indication to the contrary.

H. Renewal Notice

Most of the non-life insurance policies are insured on annual basis.

Although there is no legal obligation on the part of insurers to advise the insured that his policy is due to expire on a particular date, yet as a matter of courtesy and healthy business practice, insurers issue a renewal notice in advance of the date of expiry, inviting renewal of the policy. The notice incorporates all the relevant particulars of the policy such as sum insured, the annual premium, etc. It is also the practice to include a note advising the insured that he should intimate any material alterations in the risk.

In motor renewal notice, for example, the insured's attention is to be drawn to revise the sum insured (i.e. the Insured's Declared Value of the vehicle) in the light of current requirements.

The insured's attention is also to be invited to the statutory provision that no risk can be assumed unless the premium is paid in advance.

Test Yourself 5

Which of the following statements is correct with regards to renewal notice?

I. As per regulations there is a legal obligation on insurers to send a renewal notice to insured, 30 days before the expiry of the policy
II. As per regulations there is a legal obligation on insurers to send a renewal notice to insured, 15 days before the expiry of the policy
III. As per regulations there is a legal obligation on insurers to send a renewal notice to insured, 7 days before the expiry of the policy
IV. As per regulations there is no legal obligation on insurers to send a renewal notice to insured before the expiry of the policy

Summary

a) The first stage of documentation is essentially the proposal forms through which the insured informs about himself/ herself
b) The duty of disclosure of material information arises prior to the inception of the policy, and continues even after the conclusion of the contract
c) Insurance companies usually add a declaration at the end of the Proposal form to be signed by the insurer
d) Elements of a proposal form include:
    i. Proposer's name in full
    ii. Proposer's address and contact details
    iii. Proposer's profession, occupation or business
    iv. Details and identity of the subject matter of insurance
    v. Sum insured
    vi. Previous and present insurance
    vii. Loss experience
    viii. Declaration by the insured
e) An agent, who acts as the intermediary, has the responsibility to ensure all material information about the risk is provided by the insured to insurer.
f) The process of scrutinising the proposal and deciding about acceptance is known as underwriting.
g) Premium is the consideration or amount paid by the insured to the insurer for insuring the subject matter of insurance, under a contract of insurance.
h) Payment of premium can be made by cash, any recognised banking negotiable instrument, postal money order, credit or debit card, internet, e-transfer, direct credit or any other method approved by IRDAI from time to time.
i) A cover note is issued when preparation of policy is pending or when negotiations for insurance are in progress and it is necessary to provide insurance cover on provisional basis.
j) Cover notes are used predominantly in marine and motor classes of business.
k) A certificate of insurance provides existence of insurance in cases where proof may be required
l) The policy is a formal document which provides an evidence of the contract of insurance.
m) A warranty is a condition expressly stated in the policy which has to be literally complied with for validity of the contract.
n) If certain terms and conditions of the policy need to be modified at the time of issuance or during the policy tenure, it is done by setting out the amendments/ changes through a document called endorsement.
o) The most important rule of construction is that the intention of the parties must prevail and this intention is to be looked for in the policy itself.

Key Terms

a) Policy form
b) Advance payment of premium
c) Cover note
d) Certificate of Insurance
e) Renewal notice
f) Warranty

Answers to Test Yourself

Answer 1 - The correct option is II.
Answer 2 - The correct option is IV.
Answer 3 - The correct option is II.
Answer 4 - The correct option is II.
Answer 5 - The correct option is IV.

CHAPTER G-02
UNDERWRITING AND RATE MAKING

Chapter Introduction

We have learnt various concepts and principles related to general insurance. Underwriting is the process by which the Insurer decides whether to accept a risk or not. For this, the underwriters analyse the risk. They understand how risky the risk is. Also, how much of money should be collected as premium. Again, sometimes the risks can be accepted only subject to conditions to improve the risk. All these angles are discussed in this chapter.

Learning Outcomes

A. Physical Hazards

B. Physical Hazards –Importance of Risk Management, Clauses and Rating

C. Deciding on Excess/ Deductibles and Restricting the Cover

D. Moral Hazard

E. Fixing the Sum Insured

After studying this chapter, you should be able to:

1. Understand Physical hazards
2. Appreciate Underwriting as a function
3. Methods used by underwriters to reduce the risk
4. Understand how the Sum Insured is fixed.

A. Physical Hazards

A thorough knowledge of various hazards to which property and persons are exposed is most essential for underwriting.

Physical hazard can be ascertained from the information given in a proposal form. It can be better ascertained by a survey or inspection of the risk. The following are some examples of physical hazard in various classes of insurance.

a) Fire

i. **Construction:** Construction refers to the building materials used in walls and roof. A concrete building is superior to a timber building.

ii. **The height:** Greater the number of storey's, the greater the hazard because of difficulties of extinguishing fire. Besides, a greater number of floors involve risk of collapse of the upper floors causing heavy impact damage.

iii. **Nature of flooring:** Wooden floors add fuel to fire. Besides, wooden floors collapse easily in the event of fire, causing damage to property on lower floors through falling machinery or goods from upper floors.

iv. **Occupancy:** The occupancy of a building, and the purpose for which it is used. Various types of hazards arise from occupancy.

v. **Ignition hazard:** Buildings in which chemicals are produced or used in large quantity involve a considerable **ignition hazard**. A timber yard presents a **high combustibility hazard** because once a fire starts, timber burns quickly. The contents may be highly susceptible to damage in the event of fire.

   For example, paper, clothing etc. are susceptible not only to fire damage but also to damage by water, heat etc.

vi. **The process of manufacture:** If work is carried during the night, the hazard is increased due to the use of artificial lights, continuous use of machinery leading to friction and the likely carelessness of workers due to fatigue.

vii. **Situation/ location of risk:** Location in a congested area, exposure to hazardous adjacent premises and distance from the fire brigade is an example of physical hazard.

b) Marine

i. **The age and condition of vessel: Older vessels are inferior risks.**

ii. **The voyage to be undertaken: The route of the voyage, loading and unloading conditions and warehousing facilities at the ports are factors.**

iii. **The nature of the stocks: Articles of high value are exposed to theft; machinery is liable to breakage in transit.**

iv. **The method of packing: Cargo packed in bales is considered to be better than cargo in bags. Again, double bags are safer than single bags. Liquid cargo in second-hand drums constitute bad physical hazard.**

c) Motor

i. **The age and condition of the vehicle:** Older vehicles are more prone to accidents.

ii. **The type of vehicle:** Sports cars involve greater physical hazard etc.

d) Burglary

i. **The nature of the stocks:** Articles of high value in small bulk (e.g. Jewellery) and easily disposable are considered to be bad risks.

ii. **Situation:** Ground floor risks are inferior to upper floor risks: private dwellings situated in isolated areas are hazardous.

iii. **Constructional hazard**: Too many doors and windows constitute bad physical hazard.

e) Personal accident

i. **The age of the person:** Very old persons are accident prone; besides they will take longer to recover in the event of an accident.

ii. **Nature of occupation:** Jockeys, mining engineers, manual workers are examples of bad physical hazard.

iii. **Health and physical condition:** A person suffering from Diabetes may not respond to surgical treatment in the event of accidental bodily injury.

B. Physical Hazards – Importance of Risk Management, Clauses and Rating

Underwriters use the following methods to deal with physical hazards:

- ✓ Loading of premium
- ✓ Applying warranties on the policy
- ✓ Applying certain clauses
- ✓ Imposition of excess/ deductibles
- ✓ Restricting the cover granted
- ✓ Declinature of cover

a) Loading of premium

There may be some adverse features in a risk exposure for which the underwriters may decide to charge an extra premium before acceptance of the same. By loading the premium the higher probability of claims or occurrence of large claims is taken into consideration.

Example

Normal rate of premium is charged for cargo shipped by liners or other vessels, which comply with the prescribed standards. However, if an over-aged or under-tonnage vessel ships the cargo then extra premium is charged.

In personal accident insurance if the insured is engaged in hazardous pursuits like mountaineering, racing on wheels, big game hunting etc. extra premium is charged.

Sometimes loading of premium is also done for adverse claims ratio, as in case of motor insurance or health insurance policies.

b) Imposition of warranties

Insurers incorporate appropriate warranties to reduce the physical hazard. Some examples are provided below.

Example

i. **Marine cargo:** A warranty is inserted to the effect that goods (e.g. Tea) are packed in tin lined cases.

ii. **Burglary:** It is warranted that the property is guarded by a watchman for twenty four hours.

iii. **Fire:** In fire insurance, it is warranted the premises would not be used beyond normal working hours.

iv. **Motor:** It is warranted that the vehicle will not be used for speed testing or racing.

Example

Marine cargo: Small damage to parts may cause costly machinery to be a constructive total loss. Such machinery are subject to the Replacement Clause, which limits underwriter's liability only to the cost of replacing, forwarding and refitting any broken part.

Cast pipes, hard board sometimes get damaged only at the edges. Marine policies on cast pipes, hardboard etc., are subject to the cutting clause warranting that the damaged portion should be cut off and the balance utilised.

c) Deciding on Excess/ Deductibles and Restricting the Cover

When the loss amount exceeds the deductible/ excess mentioned the balance is paid under 'excess' clause. Loss below the limit is not payable.

The object of these clauses is to eliminate small claims. As the insured is made to pay part of a loss, he is encouraged to exercise more care and to practice loss prevention.

Example

i. **Motor**: A proposal for an old motor vehicle will not be accepted on comprehensive terms but insurers will offer a restricted cover i.e. against third party risks only.

ii. **Personal accident**: A personal accident proposer who has crossed the maximum acceptance age limit may be covered for death risk only instead of on comprehensive terms i.e. including disablement benefits.

d) Discounts

Lower rates are charged or a discount is given in the normal premium if the risk is favourable. The following features are considered to contribute to improvement of risk in fire insurance.

i. Installation of sprinkler system within the premises

ii. Installation of hydrant system in the compound

iii. Installation of hand appliances consisting of buckets, portable extinguishers and manual fire pumps

iv. Installation of automatic fire alarm

Example

Under **motor insurance** a discount in the premium is provided if the motor cycle is always used with a side-car attached, as this feature contributes to improved risk because of the greater stability of the vehicle.

In **marine insurance**, the insurer may consider giving discounts on premium for "Full Load" container as this reduces the incidence of theft and shortage.

Under a **group personal accident** cover, discounts would be given for coverage of a large group, which reduces the administrative work and expenses of the insurer.

e) No claim bonus (NCB)

A certain percentage is given as bonus for every claim free renewal year with a limit to the maximum bonus that can be availed. It is allowed by way of deduction on the total premium at renewal only, depending upon the incurred claim ratio for the entire group or to Motor vehicle Own damage policy holders for claim free years.

No claim bonus is a powerful strategy to improve underwriting experience and forms an integral part of rating systems. This bonus recognises the factor of moral hazard in the insured. It rewards the insured for not lodging claims either by adopting better driving skills as in motor insurance or taking better care of his health in Health policies.

f) Declinature

If the physical hazard involved is considerably bad, the risk becomes uninsurable and is declined. Based on their past loss experience, knowledge of hazards and overall underwriting policy, insurers have formulated a list of risks to be declined in each class of insurance.

C. Moral hazard

Moral hazard could arise in the following ways:

a) Dishonesty

An extreme example of bad moral hazard is that an insured taking insurance with deliberate intention of creating or making a loss to collect a claim. Even, an honest insured may be tempted to stage a loss, if he happens to be in financial difficulties.

b) Carelessness

Indifference towards loss is an example of carelessness. Because of the existence of insurance, the insured may tend to adopt a careless attitude towards the insured property.

If the insured does not take the same care of the property as a prudent and reasonable man would if he were uninsured the moral hazard is unsatisfactory.

c) Industrial relations

Employer-employee relationship may involve an element of bad moral hazard.

d) Wrong claims

This kind of moral hazard arises when claims occur. An insured may not deliberately bring about a loss but once a loss occurs, he would attempt to demand unreasonably high amount of compensation, in total disregard of the principle of indemnity.

Information

Sub-limits: The insurer may impose a limit on the total pay-out separately each for room expenses, surgical procedures or doctor fees to check the inflated bills.

Where the moral hazard of the insured is suspected, the agent should not entertain or bring such proposals to the insurance company. S/ he should also bring such issues before the insurance company officials.

1. Short period scales

Normally, premium rates are quoted for a period of twelve months. If a policy is taken for a shorter period, the premium is charged according to a special scale, known as short period scale. The premium chargeable for short period insurance is not on proportionate basis.

Need for short period scales

a) These rates are applied because the expenses involved in the issue of the policy whether for a 12 months period or a shorter period, are almost the same.

b) Further, an annual policy requires renewal procedure only once during a year whereas short period insurances involve more frequent renewals. If a proportionate premium is allowed, there would be a tendency on the part of the insured to go on taking short period policies and thereby, in effect, pay premiums in instalments.

c) Besides, some insurance are seasonal in character and the risk is greater during that season. Insurances are sometimes taken during such period when the risk is greatest and thereby selection takes place against the insurers. Short period scales are evolved to prevent such selection against the insurers. They are also applicable when annual insurance is cancelled by the insured. In that case refund is made keeping the premium on short period scale for the period Insurer was in risk.

Minimum premium

It is the practice to charge minimum premium under each policy so that administrative expenses of issuing the policy are covered.

Test Yourself 1

What is expected of an agent when she detects a moral hazard?

I. Continue with the insurance as before

II. Report the same to the insurer

III. Ask for a share in the claims

IV. Turn a blind eye

D. Fixing the Sum Insured

It's the maximum amount that an insurance company will indemnify as per policy condition. An insured has to be very careful in choosing the limit of indemnity, because that is the maximum amount that would be reimbursed at the time of claim.

The sum insured is always fixed by the insured. It is an amount on which rate is applied to arrive at the premium under the policy.

It should be representative of the actual value of the property. If there is over insurance, no benefit accrues to the insured and in case of under insurance, the claim gets proportionately reduced.

Deciding the sum insured

Under each class of business the insured should be advised of the following points which have to be borne in mind while deciding the sum insured:

a) Personal accident insurance: The sum insured offered by a company can be a fixed amount or it can also be based on the insured's income. Some insurance companies may give a benefit equal to 60 times or 100 times of the insured's monthly income for a particular disability. There could be an upper limit or 'cap' on the maximum amount. Compensations can vary from company to

company. In group personal accident policies the sum insured may be fixed separately for each insured person or may be linked to emoluments payable to the insured person.

b) Motor insurance: In case of motor insurance the sum insured is the insured's declared value [IDV]. It is the value of the vehicle, which is arrived at by adjusting the current manufacture's listed selling price of the vehicle with depreciation percentage as prescribed in the erstwhile India Motor Tariff. Manufacturer's listed selling price will include local duties/ taxes excluding registration and insurance.

IDV = (Manufacturer's listed selling price – depreciation) + (Accessories that are not included in listed selling price-depreciation) and excludes registration and insurance costs.

The IDV of vehicles that are obsolete or aged over 5 years is calculated by mutual agreement between insurer and the insured. Instead of depreciation, IDV of old cars is arrived at by assessment of vehicle's condition done by surveyors, car dealers etc.

IDV is the amount of compensation given in case a vehicle is stolen or suffers total loss. It is highly recommended to get IDV which is near the market value of the car. Insurers provide a range of 5% to 10% to decrease IDV to the insured. Less IDV would mean lesser premium.

c) Fire insurance: In fire insurance the sum insured may be fixed on the basis of indemnity or reinstatement value for buildings/ plant and machinery and fixtures. Contents are covered on the basis of their market value which is cost of the item less depreciation. (Reinstatement value is explained in detail in Chapter 28 - Commercial Insurance)

d) Stocks insurance: In case of stocks, sum insured is their market value. The insured will be reimbursed at the cost at which these stocks can be purchased in the market to replace the damaged raw material, after the loss.

e) Marine cargo insurance: It is an agreed valued policy and the sum insured is as per the agreement between insurer and insured at the time of contract. Normally it would consist of the sum of cost of the commodity plus Insurance + freight i.e. CIF value.

f) Marine hull insurance: In marine hull insurance, the sum insured is the value, agreed between the insured and the insurer at the beginning of the contract. This value would be arrived at by a certified valuer after an inspection of the hull/ ship.

g) Liability insurance: In case of liability policies, the sum insured is the liability exposure of the industrial units based on the degree of exposure, geographical spread. Additional legal costs and expenses may also form part of claim compensation. The sum insured is decided by the insured based on the above parameters.

Test Yourself 2

Suggest an insurance scheme for a doctor to protect himself from any claims of negligence against him.

I. Personal accident insurance

II. Professional Liability insurance

III. Marine hull insurance

IV. Health insurance

Summary

a) Process of classifying risks and deciding into which category they fall is important for rate making.

b) Underwriting is the process of determining whether a risk offered for insurance is acceptable, and if so, at what rate, terms and conditions the insurance cover will be accepted.

c) A rate is the price of a given unit of insurance.

d) The basic objective of rate making is to ensure that price of insurance should be adequate and reasonable.

e) 'Pure premium' is suitably loaded or increased by adding percentages to provide for expenses, reserves and profits.

f) The term hazard in insurance language refers to those conditions or features or characteristics which create or increase the chance of loss arising from a given peril.

g) The objective of imposing deductible/ excess clauses is to eliminate small claims.

h) No claim bonus is a powerful strategy to improve underwriting experience and forms an integral part of rating systems.

i) Sum insured is the maximum amount that an insurance company will indemnify as per policy condition.

Key terms

a) Underwriting

b) Rate making

c) Physical hazards

d) Moral hazards

e) Indemnity

f) Loading of premium

g) Warranties

h) Deductibles

i) Excess

Answers to Test Yourself

Answer 1 - The correct option is II.

Answer 2 - The correct option is II.

CHAPTER G-03
PERSONAL AND RETAIL INSURANCE

Chapter Introduction

In the previous chapters we have learnt various concepts and principles related to general insurance. General insurance products are classified differently in different markets. Some classify them as property, casualty and liability. Elsewhere, they are grouped as fire, marine, motor and miscellaneous. In this chapter, common products such as personal accident, travel, home and shop keepers and motor insurance that are bought by such retail customers are discussed.

Learning Outcomes

A. Retail Insurance Products

B. 'All Risks' and 'Named Perils' Insurance Policy

C. Package policies

D. Shopkeeper's Insurance

E. Householder's Insurance

F. Sum Insured and Premium

G. Motor Insurance

After studying this chapter, you should be able to:

1. Explain householder's insurance
2. Prepare shop insurance cover
3. Discuss motor insurance

A. Retail Insurance Products

There are some insurance products that are purchased for individuals for covering certain interests. Though small commercial or business interests could be there for such insurances, these are generally sold to individuals. In some markets these are called ‘small ticket’ policies or ‘retail policies’ or ‘retail products’. Insurances of the home, motor cars, two-wheelers, small businesses like shops etc. fall under this category. These products are usually sold by the same agents/ distribution channels that deal with personal lines of insurance as the buyers also are essentially from the same consumer segment.

B. 'All Risks' and ‘Named Perils’ Insurance Policy

Non-life insurance policies can be broadly classified into two categories:

- ✓ Named peril policies
- ✓ All risk policies

i. "All risks" typically means that any risk that the insurance contract does not specifically exclude is covered, subject to terms and conditions.

ii. All-risks insurance is the most comprehensive type of coverage available. It is therefore priced proportionately higher than other types of policies, and the cost of this type of insurance is measured against the probability of a claim.

iii. Named peril policies are those where the perils covered are specifically listed and defined.

C. Package policies

i. Package covers give, under a single document, a combination of covers.
ii. For instance there are covers such as Householder’s Policy, Shopkeeper’s Policy, Office Package Policy etc. that, under one policy, seek to cover various physical assets including buildings, contents etc.
iii. Such policies may also include certain personal lines or liability covers.
iv. Package covers could have common terms and conditions for all sections as also specific terms for specific sections of the policy.

D. Shopkeeper’s Insurance

A shop owner is not a corporate house that has large reserves of money to restart business. A single mishap may lead to closure of her/ his shop and could probably ruin her/ his family. There may be bank loans also to repay. There is always the possibility that a member of the public suffers a personal injury or damage to her/ his property, caused by the shop owner’s operations and a court holds the shop owner liable to pay the damages. Such situations can also ruin a shopkeeper. Therefore, it's very essential to secure this means of livelihood.

Shopkeeper's Insurance policies are devised to cover many of such aspects of commercial shop/ retail business. There are policies that are customised to cover specific interests of many types of shops such as antique shop, barbershop, beauty parlour, bookstore, department store, dry cleaners, gift shop, pharmacy, stationery shop, toy shop, apparel store etc.

1. What does shopkeeper's insurance cover?

The policy can be tailored to provide cover to protect the specific areas of retail business. It usually covers damage to the shop structure and contents due to fire, earthquake, flooding or malicious damage; and burglary. Shop insurance can also include business interruption protection. This will cover any loss of income or additional expenditure in the event of operation of unexpected peril causing interruption of business operation. The coverage can be selected by the insured depending on her/ his range of activities.

The additional covers the insured can opt may vary from insurer to insurer and can be verified from the respective websites of the non-life insurance companies. These could be:

i. **Burglary and Housebreaking:** Cover for housebreaking, theft, and larceny of office content
ii. **Machinery Breakdown:** Cover for breakdown of electrical/ mechanical appliances
iii. **Electronic Equipment and Appliances:**
   - ✓ Provides all-risk cover for electronic appliances
   - ✓ Cover for loss of electronic installations
iv. **Money Insurance**: Provides coverage against loss of money due to an accident while it is in:
   - ✓ Transit from the business premises to bank and vice versa
   - ✓ A safe at the business premises
   - ✓ A till (box/ drawer/ counter) at the business premises
v. **Baggage**: Compensates for loss of baggage while on travel for official purposes
vi. **Fixed Plate Glass and Sanitary Fittings covers accidental loss of damage to:**
   - ✓ Fixed plate glass
   - ✓ Sanitary fittings
   - ✓ Neon Sign/ Glow Sign/ Hoarding
vii. **Personal Accident**
viii. **Infidelity/ Dishonesty of employees**: Covers loss or damage caused by dishonest acts of employees
ix. **Legal Liability:**
   - ✓ Compensation for accidents arising out of and in the course of employment
   - ✓ Provides cover for legal liability to third parties

Fire/ Burglary/ Baggage/ Plate Glass/ Fidelity Guarantee/ Workmen Compensation and Public Liability Polices (dealt with next chapter) can be taken separately also.
Terrorism cover may also be extended. The exclusions are generally the same as in householder's insurance.

E. Householder's Insurance

The coverages under a Householder's Insurance Policy can be quite wide. It is usually a package of all the needs of a Householder.

Losses normally covered include fire, lightning, explosion and aircraft fall/ impact damage (commonly known as FLEXA); storm, tempest, flood and inundation (commonly known as STFI); and burglary. Coverage differs from company to company and from policy to policy.

Apart from the structure, it covers the contents of the house against burglary, housebreaking, larceny and theft. Jewellery whilst being worn or kept in locked safe can also be insured under Householder's Insurance. Cover is also given for electrical and mechanical failure of domestic and electronic appliances.

Similarly, Householder's insurance Package also provides coverage for loss of personal baggage, lost during travel, or liabilities to neighbours/ visitors may also be part of Householders' insurance package. Some insurers also provide coverage for pedal cycle, personal accident and workmen's compensation.

IRDAI has introduced a standard product with effect from 1st April, 2021 – Bharat Griha Raksha policy with a tenure of upto 10 years, which shall be mandatorily offered by all general insurers carrying on Fire and allied perils insurance business.

Bharat Griha Raksha (meant for Home Building and Home Contents) policy offers cover against a wide range of perils, namely Fire, Natural Catastrophe, Forest, Jungle and Bush fires, Impact Damage of any kind, Riot, Strike, Malicious Damages, Acts of terrorism, Bursting and overflowing of water tanks, apparatus and pipes, Leakage from automatic sprinkler installations and Theft within 7 days from the occurrence of any of the aforesaid events. This policy can be for a period of 1 to 10 years.

In addition to the Home Building, the policy covers General Home Contents automatically (without any need for declaration of details) for 20% of the Sum Insured of the Building subject to a maximum of Rs.10 lakhs. One can also opt for a higher Sum Insured for general contents by declaring the details.

The policy offers two optional covers, namely (i) Insurance for Valuable Contents like jewellery and curios; and (ii) Personal Accident of the insured and spouse due to an insured peril under the policy.

The policy gives complete waiver of underinsurance. That is, if the Sum Insured declared by a policyholder is less than what ought to have been declared for the property in question, the policyholder's claim will not be settled proportionately but upto the Sum Insured that is declared.

F. Sum Insured and Premium

Industrial units or offices will maintain books of accounts showing therein value of assets, therefore, it may not be difficult to arrive at the sum insured. In the case of shop and house this may not be always possible.

As already stated under householder's insurance, generally, there are two methods of fixing the sum insured, viz. market value and reinstatement/ replacement value.

For additional coverage like money, baggage, personal accident the premium would depend on the sum insured and the covers opted for.

How does one fix the Sum Insured?

i. Generally, for fire insurance, there are two methods of fixing the Sum Insured. One is Market Value (MV) and the other is Reinstatement Value (RIV). In the case of M.V., in the event of a loss, depreciation is levied on the asset depending on its age. Under this method, the insured is not paid amount sufficient to replace the property.

ii. In the RIV method, the insurance company will pay the cost of replacement subject to ceiling of sum insured. Under this method, no depreciation is levied. One condition is that the damaged asset should be repaired/ replaced in order to get the claim. It may be noted that RIV method is allowed only for fixed assets and not for other assets like stocks and stocks in process.

Most policies insure the structure of the home for its reconstruction, which is called 'reinstatement value' (and not on 'market value'). Reinstatement value is the cost incurred to reconstruct the home if it is damaged. On the other hand, market value depends on factors like age of the property, depreciation, etc.

Sum insured is generally calculated by multiplying the built up area of insured's home with the construction rate per square foot. The contents of the home - furniture, durables, clothes, utensils, etc. - are valued on market value basis i.e. the current market value of similar items after depreciation.

Premium would depend on the value insured and the coverage taken.

Test Yourself 1

Which of the below statements is correct with regards to a package policy?

I. Package Policy provide a combination of covers under a single document
II. Package Policy can cover only physical assets like buildings
III. A named peril policy or package policy comes at the same price.
IV. Only named peril policies can be bought and package policies are not available.

Definition

Some important definitions

a) Burglary means the unforeseen and unauthorised entry to or exit from the insured premises by aggressive and detectable means with the intent to steal contents there from.

b) Housebreaking is said to have taken place when a house trespass has been committed by entering it for the purpose of committing an offence.

c) Robbery means the theft of contents at the insured's premises using aggressive and violent means against the Insured and/ or insured's employees.

d) Safe means a strong cabinet within the insured's premises designed for the safe and secure storage of valuable items, and access to which is restricted.

e) Theft is a generic term for all crimes in which a person intentionally and fraudulently takes the property of another without permission or consent and with the intent to convert it to the taker's use or potential sale. Theft is synonymous with 'larceny'.

Test Yourself 2

Under the shopkeeper package policy, the insured may opt for an additional 'Fixed plate glass and sanitary fittings' cover. This will cover accidental loss of damage to which of the following?

I. Fixed plate glass
II. Sanitary fittings
III. Neon signs
IV. All of the above

G. Motor Insurance

Think of this situation: Revathi has bought a new car using all her savings and taken it for a drive. Out of nowhere, a dog comes in the way and to avoid hitting

it, Revathi swerves sharply, breaks and goes over the divider, hits another car and injures a person walking on the road. The outcome of a single incident has resulted in damage to Revathi's own car, public property, another car and also caused injury to another person.

In this scenario, if Revathi does not have a car insurance, she may end up paying far more than what it cost her to purchase the car.

- ✓ Will Revathi or similar people have that much money to pay?
- ✓ Should the other party's insurance pay for Revathi's actions?
- ✓ What if they don't have insurance?

That is why the laws of the land make it mandatory to have third-party liability insurance. While motor insurance does not prevent these things from happening, it provides a financial security blanket for the owner.

Apart from an accident, the car can also be stolen, damaged by an accident or destroyed by fire and the owner would suffer financially.

Motor insurance must be taken by a vehicle owner (i.e. the person in whose name the vehicle is registered with the Regional Transport Authority in India.)

Important

Mandatory Third Party Insurance

As per the Motor Vehicles Act, 1988, it is mandatory for every owner of a vehicle plying on public roads, to take an insurance policy, to cover the amount, which the owner becomes legally liable to pay as damages to third parties as a result of accidental death, bodily injury or damage to property. A Certificate of Insurance must be carried in the vehicle as a proof of such insurance.

1. Motor insurance coverage

The country has a large vehicle population. A number of new vehicles keep coming on to the road every day. Many of them are very costly as well. People say that in India, vehicles do not get junked, but only keep changing hands. This means that old vehicles continue to be on the road and new vehicles get added. The area of the roads (the space for driving) is not growing correspondingly with the number of vehicles. The number of people walking on the road is also increasing. Police and hospital statistics say that the number of road accidents in the country is increasing. The amount of compensations awarded to accident victims by Courts of Law are increasing. Even vehicle repair costs are going up. **All these show the importance of motor insurance in the country.**

Motor insurance covers the loss of vehicles and the damages to them due to accidents and some other reasons. Motor insurance also covers the legal liability

of vehicle owners to compensate the victims of the accidents caused by their vehicles.

Despite, the government mandate, all the vehicles in the country are not insured.

Motor Insurance covers all types of vehicles plying on public roads such as:

- ✓ Two wheelers
- ✓ Private cars
- ✓ All types of commercial vehicles: Goods carrying and passenger carrying
- ✓ Miscellaneous type of vehicles e.g. cranes,
- ✓ Motor Trade (Vehicles in Showrooms and Garages)

'Third-Party Insurance'

An insurance policy purchased for protection against the legal actions of another party. Third-party insurance is purchased by the insured (first party) from an insurance company (second party) for protection against another party's claims (third party) for liability arising out of the action of the insured

Third party insurance is called 'Liability Insurance' as well.

Two important types of covers that are popular in the market are discussed below:

Act [Liability] Only Policy: As per Motor Vehicles Act it is mandatory for any vehicle plying in public place to insure liabilities towards third parties.

The policy only covers the vehicle owner's legal liability to pay compensation for:

- ✓ Third party bodily injury or death
- ✓ Third party property damage

Liability is covered for an unlimited amount in respect of death or injury and damage.
The claims for compensation to third party victims in case of death or injury caused by a motor accident are to be filed by the complainant in Motor Accident Claim Tribunal (MACT).

'Compulsory Personal Accident (CPA) Insurance'

IRDAI permitted the issuance of a stand-alone Compulsory Personal Accident cover for Owner-Driver effective 1st January, 2019. The Cover is provided to the Owner-Driver whilst driving the vehicle including mounting into/ dismounting from or traveling in the insured vehicle as a co-driver. However, the policyholder can choose to opt for the CPA cover as part of the Liability Only policy or the Package policy. In the event the policyholder chooses to take a stand-alone CPA policy, the CPA cover offered as part of Liability only or Package policy shall be deleted.

Package/ Comprehensive Policy: (Own Damage + Third Party Liability)

In addition to the above, the loss or damage to the vehicle insured by specified perils (known as own damage to motor vehicles) is also covered subject to the value declared (called IDV – discussed above) other terms and conditions in the policy. Some of these perils are fire, theft, riot and strike, earthquake, flood, accident etc.

Some insurers may also pay for towing charges from the place of accident to the workshop. A restricted cover is also available covering the risk of fire and/ or theft only, in addition to the compulsory cover granted under Act (Liability) Only Policy.

The policy can also cover loss or damage to accessories fitted in the vehicle, personal accident cover under private car policies for passengers, paid driver; legal liability to employees and non-fare paying passengers in commercial vehicles. Insurers also provide free emergency services or use of alternative car in case of breakdown.

2. Exclusions

Some of the important exclusions under the policies are wear and tear, breakdowns, consequential loss, and loss due to driving with invalid driving license or under the influence of alcohol. Use of vehicle not in accordance with `limitations as to use ' (e.g. private car being used as a taxi) is not covered.

3. Sum Insured and Premium

The sum insured of a vehicle in a Motor Policy is referred to as Insured's Declared Value (IDV).

In case of theft of vehicle or total damage beyond repairs in an accident, the claim amount will be determined on the basis of the IDV.

Rating/ premium calculation depends on factors like the Insured's Declared Value, cubic capacity, geographical zone, age of the vehicle etc.

Test Yourself 3

Motor insurance should be taken in whose name?

I. In the name of the vehicle owner whose name is registered with Regional Transport Authority
II. If the person who will be driving the vehicle is different from the owner, then in the name of the person who will be driving the vehicle, subject to approval from Regional Transport Authority
III. In the name of any family member of the vehicle owner, including the vehicle owner, subject to approval from the Regional Transport Authority
IV. If the vehicle will be driven by anyone other than the owner, then primary policy should be in the name of the vehicle owner and additional policies

should be purchased in the names of all the people who will be driving the vehicle.

Summary

a) A householder's insurance policy only provides coverage on losses incurred to an insured property from hazards or events named in the policy. The perils covered will be clearly spelt out.
b) Householder's insurance covers the structure and its contents against fire, riots, bursting of pipes, earthquakes etc. Apart from the structure, it covers the contents against burglary, housebreaking, larceny and theft.
c) Package covers give, under a single document, a combination of covers.
d) For a householder's insurance policy generally there are two methods of fixing the sum insured: Market Value (MV) and Reinstatement Value (RIV).
e) Shopkeeper's insurance usually covers damage to the shop structure and contents due to fire, earthquake, flooding or malicious damage; and burglary. Shop insurance can also include business interruption protection.
f) Motor insurance covers the loss of vehicles and the damages to them due to accidents and some other reasons. Motor insurance also covers the legal liability of vehicle owners to compensate the victims of the accidents caused by their vehicles. Compulsory Personal Accident cover for Owner-Driver is provided to whilst driving the vehicle including mounting into/ dismounting from or traveling in the insured vehicle as a co-driver.

Key terms

a) Householder's insurance
b) Shopkeeper's insurance
c) Motor insurance

Answers to Test Yourself

Answer 1 - The correct option is I.
Answer 2 - The correct option is IV.
Answer 3 - The correct option is I.

CHAPTER G-04
COMMERCIAL INSURANCE

Chapter Introduction

In the previous chapter we considered various kinds of insurance products that cover the risks faced by individuals and households. There is another set of customers who have other needs for protection. These are the commercial or business enterprises or firms, who are engaged in or deal with of various kinds of goods and services. In this chapter we shall consider the insurance products available to cover the risks faced by this segment.

Learning Outcomes

Understand the basics of the following lines of insurance:

A. Property/ Fire Insurance

B. Business Interruption Insurance

C. Burglary Insurance

D. Money Insurance

E. Fidelity Guarantee Insurance

F. Bankers Indemnity Insurance

G. Jewelers' Block Policy

H. Engineering Insurance

I. Industrial All Risks Insurance

J. Marine Insurance

K. Liability Insurance policies

After studying this chapter, you should be able to understand the importance and basic purposes of the 11 types of insurances discussed.

A. Property/ Fire Insurance

Commercial enterprises are broadly divided into two types:

- ✓ Small and Medium Enterprises [SMEs]
  - Bharat Sookshma Policy
  - Bharat Laghu Policy
- ✓ Large Business Enterprises

  -Standard fire and Special Perils Policy (SFSP), IAR etc.

Historically, general insurance sector has largely developed by catering to the needs of these customers.

Selling general insurance products to commercial enterprises calls for a careful matching of insurance products with their needs. Agents must have a proper understanding of the products available. Let us briefly consider some of these general insurance products.

1. Standard Fire and Special Perils Policy (SFSP)

Fire insurance policy is suitable for commercial establishments as well as for the owner of property, one who holds property in trust or in commission and for, individuals/ financial institutions who have financial interest in the property.

All immovable and movable property located at a particular premises such as buildings, plant and machinery, furniture, fixtures, fittings and other contents, stocks and stock in process, including stocks at suppliers/ customer's premises,

Stocks held in trust, if specifically declared, machinery temporarily removed from the premises for repairs can be insured. Monetary relief is essential to rebuild and renew the property damaged to bring back the business to its normal course. It is here that fire insurance plays its role.

2.1. What does the Standard Fire policy cover?

Some of the perils traditionally covered by the Fire policy (as per the erstwhile All India Fire Tariff) are discussed below.

The fire policy for commercial risks covers the perils of:

- ✓ Fire
- ✓ Lightning
- ✓ Explosion/ implosion
- ✓ Riot strike and malicious damage
- ✓ Impact damage
- ✓ Aircraft damage
- ✓ Storm, tempest, cyclone, typhoon, hurricane, tornado, flood and inundation
- ✓ Subsidence and landslide including rock slide
- ✓ Bursting and overflowing of water tanks, apparatus and pipes
- ✓ Missile testing operations
- ✓ Leakages from automatic sprinkler installation

- ✓ Bush fire

There are two important features which differentiate commercial insurance from individual and retail lines.

a) The insurance needs of firms or business enterprises are much larger than that of individuals. The reason is that the value of the assets of a commercial enterprise is much larger than that of an individual's assets. Their loss or damage could adversely impact the very survival and future of the company.

b) The demand for insurance of commercial enterprise is often mandated or made necessary by legal or other requirements. For instance, when plants and assets are set up through a bank loan, their insurance may be a condition of the loan. Many corporate enterprises in India are professionally run companies and a number of them are multinationals.

   They are required to maintain global quality standards, including the adoption of appropriate risk management strategies and insurance for protecting their assets.

Any loss arising out of the above perils is covered by the policy subject to some exclusion.

2.2. Revised Standard Fire and Special Perils (SFSP) Policies:

IRDAI has issued guidelines with effect from 1st April, 2021 whereby the Standard Fire and Special Perils (SFSP) Policy will be replaced by the following two standard products **for the risks** given **below** that shall be mandatorily offered by all general insurers carrying on Fire and allied perils insurance business.

i. **Bharat Sookshma Udyam Suraksha (meant for enterprises where the total value at risk is upto Rs. 5 Crore)**- designed for financial protection of MSMEs

This policy provides cover for the Building/ Structures, Plant and Machinery, Stock and other assets of enterprises where the total value at risk across all insurable asset classes at one location is up to Rs. 5 Crore. This policy also offers cover against a wide range of perils, quite similar to the policy meant for Dwellings.

The policy has many in-built covers in addition to the basic coverage — Cover for alterations, additions or extensions, Cover for stocks on a floater basis, Cover for temporary removal of stocks, Cover for Specific Contents, Cover for start-up expenses (following a loss), Cover for payment of professional fees for Architects, Surveyors and Consulting Engineers, Cost for removal of debris and Costs compelled by Municipal Regulations.

The policy can be taken by micro level enterprises such as offices, hotels, industries, storage risks and so on. The policy underinsurance to the extent of

15% is waived. Bharat Sookshma Udyam Policies allow increase in Sum Insurer during the policy tenure by endorsement.

ii. **Bharat Laghu Udyam Suraksha(meant for enterprises where the total value at risk is more than Rs. 5 Crore and upto Rs. 50 crore)** designed for financial protection of MSMEs

This policy provides cover for the Buildings/ Structures, Plant and Machinery, Stock and other assets of enterprises where the total value of risk across all insurable asset classes at one location exceeds Rs.5 Crore but does not exceed Rs. 50 Crore at the policy commencement date. This policy also has all the in-built covers offered by the policy for micro level enterprises mentioned above. The perils against which insurance is offered are also similar to the policy meant for micro level enterprises.

The policy, again, can be taken for all types of risks such as offices, hotels, industries, storage risks and so on. Bharat Laghu Udyam Policies allow increase in Sum Insurer during the policy tenure by endorsement.

iii. Exclusions under Fire Policies

Insurers traditionally exclude the following from the scope of Fire policies.

Losses due to excepted perils like

i. War and war like activities.
ii. Nuclear perils
iii. Ionisation and radiation
iv. Pollution and contamination losses

Perils that are covered by other policies in General Insurance

i. Machinery Breakdown,
ii. Business Interruption

iv. **Add-on Covers**

However some perils can be covered by payment of additional premium like earth quake, fire and shock; deterioration of stock in the cold storages following power failure as a result of insured peril, additional expenditure involved in removal of debris, architect, consulting engineers' fee over and above the amount covered by the policy, forest fire, spontaneous combustion and impact damage due to own vehicles; terrorism.

v. **Variants of Fire policy**

Fire policies are generally issued for a period of 12 months. Only for dwellings, insurance companies offer long term policies, i.e. for a period over 12 months. In some cases short period policies are also issued, to which the short period scales are applicable.

a. **Market Value and Reinstatement Value Policies:** In the event of a loss, the insurer would normally pay the market value [which is the depreciated value]. Under Reinstatement Value Policy, however, the insurers would pay cost of replacement of the damaged property, by new property of the same kind.

   Reinstatement value policies are issued for covering buildings, plant, machinery and furniture, fixture, fittings. Reinstatement value policies are not issued to cover stocks, which are usually covered on market value basis.

b. **Declaration Policy:** To take care of frequent fluctuations in stocks values in warehouse, Declaration Policy is granted subject to certain conditions. The sum insured should be the highest value that is expected to be stored in the godown during the period of policy. On this value a provisional premium is charged. The insured has to declare the value of his stocks at agreed intervals, during the currency of policy. This is adjustable along with the premium at the end of the policy period.

c. **Floater Policies:** Floater policies may be issued for stocks of goods which are stored at various specified locations under one sum insured. Unspecified locations are not covered. The premium rate is the highest rate applicable to insured's stocks at any one location with a loading of 10%. These are also called fire floater policies as the sum insured 'floats' over multiple locations.

vi. Premium rating depends on:

a) The type of occupancy, whether industrial or otherwise.
b) All property located in an industrial complex will be charged one rate depending on the product(s) made.
c) Facilities outside industrial complexes will be rated depending on the nature of occupancy at individual location.
d) Storage areas will be rated based on the hazardous nature of goods held.
e) Additional premium is charged to include "Add on" covers.
f) Discount in premium is given based on past claims history & fire protection facilities provided at the premises.
g) One can also opt out of riot, strike, malicious damage covers and flood group perils for reduction in premium.

The rating pattern may again vary from insurer to insurer.

Test Yourself 1

A fire policy for commercial risks covers the peril of _____

I. Vehicle burning on highway
II. Fire on ship
III. Explosion in factory
IV. Hospitalization due to fire

B. Business Interruption Insurance

Business Interruption insurance is also known as Consequential Loss Insurance or Loss of Profit Insurance.

Fire insurance provides indemnity against material or property damage or loss suffered to building, plant, machinery fixtures, fittings, merchandise goods, etc. by insured perils. **This may result in total or partial interruption of the insured's business**, resulting in various economic losses, during the period of interruption.

Coverage under Business Interruption Policy

Consequential Loss (CL) Policy [Business Interruption (BI)] provides indemnity for loss of what is termed as gross profit – which includes Net Profit plus Standing Charges along with the increased cost of working incurred by the insured to get the business back to normalcy, as soon as possible to reduce the final loss. The perils covered and conditions are the same as those covered under the fire policy.

Example

If a Fire results in damage to the car manufacturer's plant, the production loss will result in loss of income to the manufacturer. This loss of income along with extra expenses incurred can be insured provided it has resulted from a peril insured.

This policy can be taken only in conjunction with standard fire and special perils policy as claims under this policy are admissible only if there is a claim under standard fire and special perils policy.

Test Yourself 2

A business interruption insurance policy can be taken only in conjunction with _____.

I. Standard fire and special perils insurance policy
II. Standard marine insurance policy
III. Standard motor insurance policy
IV. Standard health insurance policy

C. Burglary Insurance

The policy is meant for business premises like factories, shops, offices, warehouses and godowns which may contain stocks, goods, furniture fixtures and cash in a locked safe which can be stolen. The scope of cover is clearly expressed in the policy.

Risks covered under burglary insurance

a) Loss of property following actual forcible and violent entry into the premises or loss followed by actual, forcible and violent exit from the premises or hold up.

b) Damage to insured property or premises by burglars. Property insured is covered only when it is lost from the insured premises and not from any other premises.

Cash cover: An important part of burglary cover is cash cover. It operates only when the cash is secured in a safe, which is burglar proof and is of an approved make and design. The common conditions applicable for granting cash cover are given below:

a) Cash lost from the safe following the use of the original key to open, it is covered only where such key has been obtained by violence or threats of violence or through means of force. This is generally known as "key clause".

b) A complete list of the amounts of cash in safe is kept secure in some place other than the safe. The liability of the insurer is limited to the amount actually shown by such records.

1. First Loss Insurance

In the cases, which are of low value in high bulk, (such as cotton in bales, grain, sugar etc.) the risk of losing the entire stock on a single occasion is considered remote. The value that can be burgled is ascertained as probable maximum loss (PML) and the full premium is charged for this maximum probable loss and certain percentage of full premium is charged on rest amount of stock as PML floats over the entire stock. It is assumed that a second burglary may not follow immediately or the insured may take additional security measures from its recurrence.

2. Declaration cover and floater cover is also possible in respect of stocks, similar to fire insurance.

3. Exclusions

The policy does not cover theft by employees, family members or other persons who are lawfully on the premises, nor does it cover larceny or ordinary theft. It also excludes losses that are covered by a fire or plate glass policy.

4. Extensions

The policy can be extended to cover riot, strikes and terrorism risks at extra premium.

5. Premium

Rates of premium for burglary policy depend upon the nature of insured property, the moral hazard of the insured himself, construction and location of premises, safety measures (*e.g. watchmen, burglar alarm)*, previous claims experience etc.

In addition to details given in the proposal form, a pre-acceptance inspection is done by insurers where high values are involved.

Test Yourself 3

The premium for burglary policy depends on _____.

I. Nature of insured property

II. Moral hazard of the insured himself
III. Construction and location of the premises
IV. All of the above

D. Money Insurance

Handling of cash is an integral part of any business. The Money Insurance policy is intended to protect banks and industrial business establishments against loss of money. Money is at risk in the premises as well as outside. It can be unlawfully taken away while withdrawing, depositing, making payments or collections.

1. Coverage of Money Insurance

Money insurance policy is designed to cover the losses that may occur while cash, cheques/ postal orders/ postal stamps are being handled. The policy normally provides cover under two sections

a) Transit section: It covers loss of money as a result of robbery or theft or other fortuitous cause whilst it is carried outside by the insured or her authorised employees.

The transit section specifies two amounts:

i. Limit per carrying: This is the maximum amount that insurers may be required to pay in respect of each loss.

ii. Estimated amount in transit during the policy period: It represents the amount to which the rate of premium is to be applied to arrive at the amount of premium.

Policies can be issued on **"declaration basis"**, similar to the practice in fire insurance. Insurers thus charge a provisional premium on the estimated amount in transit and adjust this premium at the time of expiry of the policy, based on actual amount in transit during the policy period, as declared by the insured.

b) Premises section: This section covers loss of cash from one's premises/ locked safe due to burglary, housebreaking, hold up etc. Other features of the policy are normally the same as of burglary insurance (of business premises) that this was discussed under Learning Outcome C above.

2. Important exclusions

These include:

a) Shortage due to error or omission,

b) Loss of money that has been entrusted to other than authorized person and

c) Riot, strike and terrorism

3. Extensions

On payment of additional premium the policy may be extended to cover:

a) Dishonesty of persons carrying cash,

b) Riot, strike and terrorism risks

c) Disbursement risk, which is the loss suffered during payment of wages to employees

4. Premium

Premium rate is fixed depending on the insured, cash carrying liability of the company at any one time, the mode of conveyance, distance involved, safety measures taken etc. Premium is adjustable according to actual cash carried throughout the year based on declaration made within 30 days of expiry of the policy.

Test Yourself 4

Which of the below is covered under a money insurance policy?

I. Shortage due to error or omission
II. Loss of cash from one's premises due to burglary
III. Loss of money that has been entrusted to other than authorized person
IV. Riot, strike and terrorism

E. Fidelity Guarantee Insurance

Companies suffer financial loss due to what are termed as white collar crimes like fraud or dishonesty of their employees. Fidelity guarantee insurance indemnifies employers against the financial loss suffered by them due to fraud or dishonesty of their employees by forgery, embezzlement, larceny, misappropriation and default.

1. Coverage under Fidelity Guarantee Insurance

Cover is granted against a direct pecuniary loss and does not include consequential losses.

a) The loss should be in respect of moneys, securities or goods
b) The act should be committed in the course of the duties specified;
c) The loss has be discovered within 12 months of expiry of the policy or death retirement resignation or dismissal of the employee, whichever is earlier
d) No cover is provided in respect of a dishonest employee who has been re-employed

2. Types of Fidelity Guarantee Policy

There are various types of fidelity guarantee policies, as discussed below:

a) Individual policy: This type of policy is used where only one individual is to be guaranteed. Name, designation of the employee and amount of guarantee has to be specified.

b) Collective policy: This policy comprises a schedule listing out the names of those employees to whom the guarantee applies, along with a note on the duties of each employee and separate individual sums insured.

c) Floating policy or floater: In this policy, the names and duties of the individuals to be covered are inserted in a schedule, but instead of individual amounts of guarantee, a specified amount of guarantee is

"floated" over the whole group. A claim in respect of any one employee will, therefore, reduce the floated guarantee, unless the original sum is reinstated by payment of an extra premium.

d) Positions policy: This is similar to a collective policy with the difference that only the schedule lists out "positions' (say, Cashier, Account Officer Etc.) that are to be guaranteed for a specified amount and the name are not mentioned.

e) Blanket policy: This policy covers the entire staff without showing names or positions. No enquiries about the employees are made by the insurers. Such policies are only suitable for an employer with a large staff and the organization makes adequate enquiries into the antecedents of employees. The references that the employer obtains must be available to the insurers in the event of a claim. The policy is granted only to large firms of repute.

3. Premium

The rate of premium depends upon the type of business occupation, status of the employee, the system of check and supervision.

Test Yourself 5

Fidelity Guarantee Insurance indemnifies _____.

I. Employers against the financial loss suffered by them due to fraud or dishonesty of their employees
II. Employees against the financial loss suffered by them due to fraud or dishonesty of their employer
III. Third parties against the financial loss suffered by them due to fraud or dishonesty of the corporate
IV. Shareholders against the financial loss suffered by them due to fraud or dishonesty of the company management

F. Bankers Indemnity Insurance

This comprehensive cover was drafted for the banks, NBFC's and other institutions who deal with operations involving money, considering the special risks faced by them regarding money and securities.

1. Coverage under Bankers Indemnity Insurance

There are different variations to this policy based on the requirement of banker.

a) Money securities lost or damaged whilst within the premises due to fire, burglary, riot and strike.

b) Loss suffered due to any cause whatsoever including negligence of the employees, when the property is carried outside the premises in the hands of authorized employees.

c) Forgery or alteration of cheques, drafts, fixed deposit receipts etc.

d) Dishonesty of employees with reference to money/ securities or in respect of goods pledged.

e) Dispatches by registered post parcels.

f) Dishonesty of appraisers.

g) Money lost while in the hands of agents of the bank like 'Janata Agents', 'Chhoti Bachat Yojana Agents'.

The cover is issued on discovery basis, this means the policy will respond to a period during which a loss is discovered and not necessarily the period when it occurred. But a cover should have been in existence when the loss actually occurred.

Conventionally losses within a period of 2 years prior to date of discovery only are payable, subject to the cover having been continuous, from a date earlier than that when the loss has occurred.

2. Important exclusions

Major exclusions are Trading losses, Negligence, Software crimes and dishonesty of the partners/ directors

3. Scope

The policy comprises of 7 sections viz.:

1. On Premises
2. In Transit
3. Forgery or Alteration
4. Dishonesty
5. Hypothecated Goods
6. Registered Postal Service
7. Appraisers
8. Janata Agents

4. Sum insured

The bank has to fix the **sum insured** which would usually float over the first 5 sections. This is termed as 'basic sum insured'. Additional sum insured can be purchased for section (1) and (2) if the basic sum insured is not sufficient. The policy also allows one compulsory and automatic reinstatement of sum insured by payment of an extra premium

5. Rating

The premium calculation is based on:

a) Basic sum insured
b) Additional sum insured

c) Number of staff
d) Number of branches.

Test Yourself 6

Which of the below can be covered under a bankers indemnity insurance policy?

I. Money securities lost or damaged whilst within the premises due to fire
II. Forgery or alteration of cheques
III. Dishonesty of employees with reference to money
IV. All of the above

G. Jewelers' Block Policy

In recent years India has emerged as a leading centre in world trade for jewellery, especially diamonds. Imported raw diamonds are cut, polished and exported. It takes care of all risks of a jeweller whose business involves sale of articles of high value in small bulk like jewellery gold &silver articles, diamonds and precious stones, wrist watches etc. The trade involves stocking these expensive items in large quantity and moving them between different premises.

1. Coverage of Jeweller's Block Policy

Jewellers block policy is a package policy, traditionally divided into 4 sections. Coverage under Section 1 is usually made compulsory while the insured are allowed to avail of other sections at their option. It is also the market practice to include some more sections to cover other assets like Electronic equipment, Plate glass, Signage etc. and liabilities like Employees Compensation, Infidelity of employees.

Fidelity guarantee cover should also be taken by the insured for full protection if there is no separate section for this cover.

Risks are rated on merits of each case. Different premium rates are applied for each section with discounts for exclusive round the clock watchman, close circuit TV/ alarm system, exclusive strong room and for any other safety expedient etc.

Test Yourself 7

In case of a Jeweller's Block Policy, there are traditionally multiple sections, of which one is usually compulsory while the remaining sections are _____.

I. Mandatory
II. Retrospective
III. Optional
IV. Compensatory

H. Engineering Insurance

Engineering insurance is a branch of general insurance that developed parallel with the growth of fire insurance. Its origins can be traced to the development of industrialization, which highlighted the need for a separate cover for plant and machinery. Concept of **All Risks** cover was also developed with regard to engineering projects - covering damage due to any cause except those specifically excluded. The products covered various stages – from construction to testing till the plant became operational. The customers for this insurance are both large and small industrial units. This also includes units having electronic equipment and contractors doing big projects. There are two types of engineering insurance policies:

1) Annual Policies-Generally of one year duration-
    a. Machinery Breakdown Policy
    b. Boiler Pressure Plant policy
    c. Electronic Equipment Policy
    d. Contractor's Plant & Machinery Policy
    e. Deterioration of Stock Policy
    f. Civil Engineering Completed Risk
2) Project Policies with variable duration based on project period-
    a) Contractors All Risk Policy
    b) Erection All Risk Policy

There are two "Consequential Loss" policies associated with Engineering Policies:

a) Machinery Breakdown Loss of Profit Policy (MBLOP) taken with Machinery Breakdown Policy or with Boiler and Pressure Plant policy and

b) Advance loss of Profit (ALOP) or Delay in Startup (DSU) Policy taken with project policy.

Let us briefly consider the policies:

A. <u>Annual Policies</u>

1. **Machinery Breakdown Policy (MB):** This policy is suitable for every industry which operates on machines and for whom breakdown of plant and machinery is of serious consequence. This policy covers machines like generators, transformer and other electrical, mechanical and lifting equipment.

The policy covers unforeseen and sudden physical damage by mechanical or electrical breakdown by any cause (subject to excepted risks) to the insured property:

a) While it is at work or at rest.
b) While being dismantled for cleaning or overhauling
c) During cleaning or overhauling operations and during reassembly thereafter.
d) When being shifted within the premise.

Premium is charged on the reinstatement/ replacement value of individual machinery. The machine as a whole should be insured. Rates depend on the type of machine; the industry in which it is used and its value. Discounts are offered based on factors such as stand-by facilities, spares available and claims experience.

2. **Boiler and Pressure Plant Policy:** This covers boilers and pressure vessels, against:

    a) Damage, other than by fire, to the boilers and/ or other pressure plant and to surrounding property of the insured; and
    b) Legal liability of the insured on account of bodily injury to the person, or damage to the property, of third parties, caused by explosion or collapse due to internal pressures of such boiler and/ or pressure plant.

Since fire policy and boiler insurance policy are mutually exclusive, for adequate
cover, both the policies need to be taken. Sum insured under all Engineering Policies should be the current replacement value.

3. **Electronic Equipment Policy:** This covers various kinds of electronic equipment, which includes the entire computer system consisting of CPU, keyboards, monitors, printers, UPS, system software etc. Auxiliary equipment such as air-conditioning, heating and power conversion, etc. are also covered.

This policy is a combination of fire policy, machinery insurance policy and burglary policy. The policy covers the contingencies such as defective design (not covered under a warranty), effects of natural phenomena; defective functioning due to voltage fluctuations, impact shock etc., burglary, housebreaking & theft are also covered.

The policy is available to the owner, lessor or hirer, depending upon the responsibility or liability in each case. It has usually three sections that cover various types of losses:

    a) Section 1: Loss and damage to equipment
    b) Section 2: Loss and damage to external data media like computer external hard disks
    c) Section 3: Increased cost of working - to ensure continued data processing on substitute equipment up to 12, 26, 40 or 52 weeks.

4. **Contractors Plant & Machinery (CPM) Policy:** Suitable for contractors involved in construction business for covering all kinds of machinery like cranes, excavators from unforeseen and sudden physical loss or damage from any cause including:

    a) Burglary, Theft, Riot, Storm, Malicious Damage, Tempest

b) Fire and lightning, external explosion, earthquake and other Acts of God perils
c) Accidental damage while at work due to faulty manhandling, dropping or falling, collapse, collision and impact; can be extended for third party damage.

The Premium to be charged depends on the type of equipment and the location at which it operates.

The cover is operative whilst the equipment is at work or at rest or being dismantled for cleaning or overhauling or re-assembling thereafter. The cover also applies while the same are lying at contractors own premises. However floater policy covering the equipment "Anywhere in India basis" is also available by charging 10% extra premium and with certain conditions.

5. **Deterioration of Stock Policy:** This policy is suitable for the owner of the cold storage (individual or a cooperative society) or those who take the cold storage on lease or hire for storage of perishable commodities. The cover is against the risk of deterioration and contamination following breakdown of the refrigeration plant and machinery and also due to rise in temperature and sudden and unforeseen escape of refrigerants into the cold storage rooms.

6. **Civil Engineering Completed Risk:** It is generally taken by contractors who has to maintain the civil projects after completion. The civil projects like – Bridges, Dry docks, Harbours, Jetties Railway lines, Rock Filled dams, Concrete dams, Earthen dams, Canals , Irrigation system are considered under this policy. Risks covered are –
   1. Fire
   2. Lightning
   3. Explosion/ Implosion
   4. Riot, Strike, Malicious Damage
   5. Impact by any Rail/ Road or water borne vehicle or animal
   6. Storm Cyclone, Typhoon, Tempest, Hurricane, Tornado, Flood and Inundation, Wave action of water
   7. Subsidence and Landslide (Including Rockslide) damage
   8. Earthquake Fire and Shock (Including flood due to earthquake), Tsunami
   9. Frost, avalanche, ice.

B. <u>Project Policies</u>

These policies are typically issued for the period of the project and may not be on an annual basis.

1. **Contractors All Risks (C.A.R.) Policy:** This is designed to protect the interests of contractors and principals engaged in civil engineering projects from small buildings to massive dams, buildings, bridges, tunnels, etc. The policy provides an "All Risk" cover – thus providing indemnity against any sudden and

unforeseen loss or damage that occurs to property insured at the construction site. This can be extended to cover third party liability and other exposures. Premium chargeable depends on the nature of the project, the project cost, the project period, geographic location and the period of testing.

2. **Erection All Risks (EAR) Policy:** This policy is also known as Storage-cum-Erection (SCE) policy. It is suitable for the principal or contractors of a project whereas plant and machinery is being erected as it is exposed to various external risks. This is a comprehensive insurance policy that covers any sort of contingency right from the moment the materials are unloaded at the project site and continues during the entire project period until the project is tested, commissioned and handed over.

   Premium chargeable depends on the nature of the project, the cost, the project period, geographic location, and the period of testing.

   If required a marine cover can be issued along with the erection policy for providing coverage to the equipment and materials during the transit phase till delivered at the project site.

C. Consequential Loss Policies

These type of policies are issued to cover losses consequential to other losses. These are also called 'Business Interruption' policies or 'Loss of Profits' policies.

3. Machinery Loss of Profits (MLOP) Policy

This policy is suitable for industries where interruptions or delays as a result of machinery breakdown or boiler explosion result in huge consequential losses.

Where the time lag between the breakdown or loss and the restoration is large, this policy compensates for the loss of profits during the intervening period due to reduction in turnover and increase in cost of working. The terms and conditions and coverage of business interruption policy is the same as the business interruption policy following a fire policy loss, which has been discussed earlier in this chapter.

4. Advance Loss of Profit Cover (ALOP) or Delay in Start-up Policy (D.S.U.)

This covers financial consequences of a project being delayed because of accidental damages during the project. It is suitable for the insured who is deprived of the anticipated earning and for the financial institutions to the extent of their interest in the project. It is issued as an extension to the MCE/ EAR/ CAR Policy before the actual commencement of project.

The policy also covers financial losses in the form of continuing expenses such as interest on term loan, debentures, wages and salaries etc. and on the anticipated

net profit which the business could have earned if it had commenced on the scheduled date.

Premium rating depends on various critical factors and on re-insurance support available. The anticipated gross profit or turnover and the indemnity period are also critical factors in deciding the premium payable.

Test Yourself 8

Delay in start-up policy is also known as _____.

I. Machinery Loss of Profits cover
II. Advance Loss of Profits cover
III. Contractors All Risk cover
IV. Contractors Plant & Machinery cover

I. Industrial All Risks Insurance

The Industrial All Risks Policy was designed to cover, industrial properties – both manufacturing and storage facilities, anywhere in India under one policy. It provides indemnification against material damage and business interruption. Usually, the policy provides cover for the following:

i. Fire and specified perils as per fire insurance practice,
ii. Burglary (except larceny)
iii. Machinery breakdown/ boiler explosion/ electronic equipment
iv. Business interruption following operation of perils mentioned above

(Note: Business interruption following perils under (iii) above is usually not included in the package cover but available as optional cover)

- ✓ The policy offers widest range of cover compared to that provided by individual operational policies.
- ✓ Premium rates for the policy depend on the cover opted, claims experience, and deductibles opted, risk assessment report for MLOP etc.

Test Yourself 9

Which of the following is not covered under Industrial All Risks insurance?

I. Fire and special perils as per fire insurance practice
II. Larceny
III. Machinery breakdown
IV. Electronic equipment

J. Marine Insurance

Marine insurance is classified into two types: marine cargo and marine hull

1. Marine Cargo Insurance

Though the term 'marine' may indicate only losses due to sea (marine) misadventures, **marine cargo insurance** covers much more. It provides indemnity in respect of loss of or damage to goods during transit by rail, road, sea, air or registered post, within the country as well as abroad. Type of goods may range from diamonds to household goods, bulk items like cement, grains, over dimensional cargoes for projects etc.

Cargo insurance plays an important role in domestic trade as well as in international trade. Most contracts of sale require that the goods must be covered, either by the seller or the buyer, against loss or damage.

Who effects the insurance: The seller or the buyer of the goods [consignment] may insure the cargo depending upon the contract of sale.

Marine insurance contract needs to have provisions that apply internationally. This is because it covers goods that are in transit beyond any country's borders. The covers are accordingly governed by international conventions and certain clauses attached to the policy.

While the basic policy document contains general conditions, the scope of cover and exceptions and special exclusions are attached by separate clauses known as Institute cargo Clauses (ICC). These are drafted by the Institute of London Underwriters.

a) Coverage under Marine Cargo Insurance

Cargo policies are essentially voyage policies, i.e. they cover the subject matter whilst in transit from one place to another. However, the insured is required to always act with reasonable care in all circumstances within his control. The main feature of this policy is that it's an Agreed Value Policy. The valuation is agreed between the insurer and insured and is not subject to revaluation later unless fraud is suspected. The convention for the Sum Insured is CIF + 10% (Cost Insurance & Freight + 10%). Another unique feature is that the policy is freely assignable.

The cover normally commences from the time the goods leave the warehouse at the place named in the policy and terminates at the destination named in the policy, depending on the terms of the contract of sale.

The terms and conditions applicable are governed by either;

i. Inland Transit Clause (ITC) A, B or C for inland transit

ii. Institute Cargo Clause (ICC) A, B, or C for voyage by sea
iii. Institute Cargo (Air) Clause – A for transport by air

Institute Cargo Clause C grants the minimum cover, which is loss or damage due to accident to the vehicle or vessel carrying the cargo due to:

i. Fire or explosion
ii. Derailment or overturning of the vehicle
iii. Stranding, grounding or sinking of the vessel (in case of ship)
iv. Collision with an external object
v. Discharge of cargo at a port of distress
vi. General average sacrifice
vii. Jettison.

Institute Cargo Clause B is wider than C. Apart from the perils covered in C it also covers loss or damage due to:

i. Act of God (AOG) perils like earthquake, volcanic eruption and lightning
ii. Collapse of bridges in Inland transit
iii. Washing overboard and sling loss in case of ocean transit
iv. Entry of water into the vessel.

Institute Cargo Clause A is the widest cover as it covers all perils of B and C and loss or damage due to any other risk except some exclusion specified such as:

i. Loss or damage due to wilful conduct of the insured
ii. Ordinary leakage, breakage, wear and tear or ordinary loss in weight/ volume
iii. Insufficiency in packing
iv. Inherent vice
v. Delays
vi. Loss due to insolvency of owners
vii. Nuclear perils

These exclusions are common to all clauses of inland, air and sea. There are separate clauses also for trading of specific commodities like coal, bulk oil and tea etc. Marine cover can be extended by paying additional premium to cover War, Strikes, Riots, Civil Commotion and Terrorism. Marine and Aviation policies are the only branches of insurance that offer cover against War perils.

Important

Risks covered under a marine policy, under the standard policy form and under the various clauses attached to the policy broadly fall into three categories:

i. Marine perils,
ii. Extraneous perils and
iii. War, strike riot, civil commotion and terrorism risks.

b) Different types of marine policies

i. Specific Policy

This policy covers a single shipment. It is valid for the particular voyage or transit. Merchants who are engaged in regular import and export trade or who are sending consignments regularly by inland transit would find it convenient to arrange insurances under special arrangements like the open policy.

ii. Open Policy

The carriage of goods within the country can be covered under an open policy. The policy is valid for one year and all consignments during this period have to be declared by the insured to the insurer as agreed between them on a fortnightly, monthly or quarterly basis.

iii. Open Cover

The open cover is a contract for a year giving the Insured continuous protection to cover a large number of shipments/ despatches. The premium on the consignments would be adjusted from the respective cash deposit account maintained by the Insured. Open covers are issued to large exporters and importers who have continuous trade

Open covers set out the terms of cover and rates of premium for transactions of marine dispatches for one-year. The open cover is not a policy and it is not stamped. A certificate of insurance is issued for each declaration duly stamped for appropriate value.

iv. Duty and increased value insurance

These policies provide extra insurance if the value of the cargo is increased due to payment of customs duty or increase in the market value of the goods at the destination on the date of the landing.

2. Marine Hull insurance

The term 'Hull' refers to the body of a ship or other water transport vessel.

Marine hull insurance is done as per international clauses applicable across different countries. Marine hull covers are essentially of two types:

a) Covering a particular Voyage: The set of clauses used here are called Institute Voyage Clauses

b) Covering a period of time: Usually one year. The set of clauses used here are called Institute (Time) Clauses

c) War risks are governed by special regulations and the premiums collected will be credited to the Central Government.

Information

Hull insurance also includes the following insurances:

i. Inland vessels such as barges, launches, passenger vessels etc.
ii. Dredgers (Mechanized or non-mechanized)
iii. Fishing Vessels (Mechanized or non-mechanized)
iv. Sailing Vessels (Mechanized or non-mechanized)

v. Jetties and Wharves
vi. Vessels in the course of construction

The ship owner has insurable interest not only in the ship, but also in the freight to be earned during the period of insurance. In addition to freight the ship owner has insurable interest in the amount spent by him in fitting out the vessel, including provisions and stores. **These expenses are termed disbursements and are insured concurrently with the hull policy for a period of time.**

Important

Aviation insurance: A comprehensive policy is also available for aircraft which covers loss or damage to the aircraft as also the legal liability to third parties and to passengers arising out of the operation of the aircraft.

Test Yourself 10

Which branch of insurance offers cover against war perils?

I. Marine policies
II. Aviation policies
III. Both of the above
IV. None of the above

K. Liability Policies

Accidents cannot be avoided altogether, however careful a person is. This could result in injury to oneself and damage to one's property and also may simultaneously cause injury to third parties and damage to their property. The persons thus affected would claim compensation for such loss.

A liability could also arise from a defect in a product manufactured and sold, say chocolates or medicines, causing harm to the consumer. Similarly, liability could arise from wrong diagnosis/ treatment of a patient or from a case improperly handled by a lawyer for his client.

In all such cases, where a third party, consumer or the patient would demand compensation for the alleged wrong doing, it would raise a need for payment of compensation or meeting expenses involved in defending the suits filed by the claimants. In other words there is a financial loss arising from a liability to pay. The existence of such a liability and the amount of compensation to be paid would be decided by a civil court which would go into the aspect of alleged negligence/ fraud. Liability insurance policies provide coverage of such liabilities. Let us look at some of the liability policies.

Statutory liability

There are certain laws or statutes which provide for the payment of compensation. The laws are:

- ✓ Public Liability Insurance Act, 1991 and
- ✓ Employees Compensation Act 1923 amended in 2010

Insurance policies are available for protection in respect of such liabilities. Let us look at some of them.

1. **Compulsory Public Liability Policy**

The Public Liability Insurance Act, 1991 imposes liability on no fault basis on those who handle hazardous substances if a third party is injured or his property is damaged during the course of such handling. The names of hazardous substances and the quantity of each, is listed in the 'Act'. The amount of compensation payable per person is fixed as shown below.

Compensation payable

Fatal Accident	Rs. 25,000
Permanent Total Disability	Rs. 25,000
Permanent Partial Disability	% of Rs. 25,000 based on % of disability
Temporary Partial Disablement	Rs. 1000 per month, maximum 3 months
Actual Medical Expenses	Up to a maximum of Rs. 12,500
Actual damage to property up to	Rs. 6,000

The premium is based on the AOA (Any One Accident) limit and the turnover of the client. A special feature of this policy is that the insured has to pay compulsorily an amount equal to the premium as contribution to Environment Relief Fund. If large numbers of third parties are affected and the total amount of relief payable exceeds A.O.A. limit, the balance amount will be paid by the fund.

2. Public Liability Policy (Industrial/ Non-industrial Risks)

This type of policy covers liability arising out of fault/ negligence of the insured causing third party personal injury or property destruction [TPPI OR TPPD].

There are separate policies covering industrial risks as well as non-industrial risks like those affecting hotels, cinema halls, auditoriums, residential premises, offices, stadiums, godowns and shops. It covers the legal liability to pay compensation including claimant's costs, fees and expense according to Indian Law, in respect of TPPI/ TPPD.

The policy does not cover:

a) Products liability
b) Pollution liability
c) Transportation and
d) Injuries to workmen/ employees

3. Products Liability Policy

The demand for products liability insurance has arisen because of the wide variety of products (e.g. canned food stuff, aerated waters, medicines and injections, electrical appliances, mechanical equipment, chemicals etc.) that are today manufactured and sold to the public. If a defect in the product causes death,

bodily injury or illness or even damage to the property of third parties, it could cause a claim to arise. Product liability policies cover this liability of the insured.

Cover is available for exports as well as domestic sales.

4. **Lift (Third Party) Liability Insurance**

The policy provides indemnity to owners of buildings in respect of liabilities arising out of the use and operation of lifts. It covers legal liabilities for:

a) Death/ bodily injury of any person (excluding employees of the insured)

b) Damage to property (excluding insured's own or employee's property)

The premium rates depend upon the limit of indemnity, any one person, any one accident and any one year.

5. **Professional Liability**

Professional indemnities are designed to provide insurance protection to professional people against their legal liability to pay damages arising out of negligence in the performance of their professional duties. Such covers are available for doctors hospitals; engineers, architects; chartered accountants, financial consultants, lawyers, insurance brokers.

6. **Directors' and Officers' Liability Policy**

Directors and Officers of a company hold positions of trust and responsibility. They may become liable to pay damages to shareholders, employees, creditors and other stakeholders of the company, for wrongful acts committed by them in the supervision and management of the affairs of the company. A policy has been devised to cover such liability and is issued to the company covering all their directors.

7. **Employee's Compensation Insurance**

This policy provides indemnity to the insured in respect of his legal liability to pay compensation to his employees who sustain personal injury by accident or disease arising out of and in the course of his employment. This is also called **Workman's Compensation Insurance.**

Two forms of insurance are prevalent in the market:

a) Table A: Indemnity against legal liability for accidents to employees under the Employees Compensation Act, 1923, (Workman's Compensation Act, 1923), Fatal Accident Act, 1855 & Common Law.

b) Table B: Indemnity against legal liability under Fatal Accidents Act, 1855 and Common law.

The premium rate is applied on the estimated wages of employees as declared in the proposal form.

The policy may be extended to cover:

i. Medical and hospital expenses incurred by the insured for treatment of employee injuries, up to specific amounts

ii. Liability for occupational diseases listed in the Act

iii. Liability towards employees of contractors

Test Yourself 11

Under the Public Liability Insurance Act, 1991, how much is the compensation payable for actual medical expenses for non-fatal accidents?

I. Rs. 6,250
II. Rs, 12,500
III. Rs. 25,000
IV. Rs. 50,000

Answers to Test Yourself

Answer 1 - The correct option is III.
Answer 2 - The correct option is I.
Answer 3 - The correct option is IV.
Answer 4 - The correct option is II.
Answer 5 - The correct option is I.
Answer 6 - The correct option is IV.
Answer 7 - The correct option is III.
Answer 8 - The correct option is II.
Answer 9 - The correct option is II.
Answer 10 - The correct option is III.
Answer 11 - The correct option is II.

CHAPTER G-05
GENERAL INSURANCE CLAIMS

Chapter Introduction

At the core of any insurance contract is the promise made at the beginning i.e. to indemnify the insured in the event of a loss. This chapter talks about the procedures and documents involved, from the time loss takes place, making it easier to comprehend the entire process of claims settlement. It also explains the method of dealing with disputed claims either by insured or insurer.

Learning Outcomes

A. Claims Settlement Process

B. Role of Surveyors and Loss Assessors

After studying this chapter, you should be able to:

1. Argue the importance of claim settlement functions
2. Describe the procedures for intimation of loss
3. Appraise claim investigation and assessment
4. Explain the importance of surveyors and loss assessors
5. Illustrate the contents of claim forms
6. Define claims adjustment and settlement

A. Claims settlement process

1. Importance of settling claims

The most important function of an insurance company is to settle claims of policyholders on the happening of a loss event. Insurer fulfils this promise by providing prompt, fair and equitable service in either paying the policyholder or paying claims made against the insured by a third party.

One of the non-life insurance companies had the inscription "Pay if you can; repudiate if you must" in its board room. That is the spirit of the noble business of insurance.

Settling claims professionally is regarded the biggest advertisement for an insurance company.

a) **Promptness**

Prompt settlement of claims, whether the insured is a corporate client or an individual or whether the size of the loss is big or small is very important. It must be understood that the insured needs insurance compensation as soon as the possible after the loss.

If he gets the money promptly, it is of maximum use to him. It is insurance company's duty to pay the claim amount when insured needs it most – as early as possible after the loss.

b) **Professionalism**

The insurance officials consider each and every claim on its merits and do not apply prejudicial or pre-conceived notions to reject the claim without examining all the documents that would answer the following questions.

i. Did the loss really happen?
ii. If so, did the loss making event really cause the damage?
iii. The extent of damage out of this event.
iv. What was the reason for the loss?
v. Was the loss covered under the policy?
vi. Is the claim payable as per the contract/ policy conditions?
vii. If so, how much is payable?

The answers to all these questions need to be found out by the insurance company.

Processing claims is an important activity. All claims forms, procedures and processes have been carefully designed by the company to ensure that all claims 'payable' under the policy are promptly paid and those that are not payable are not paid.

The agent, being the representative of the company known to the insured, has to ensure that all the relevant forms are properly filled up with correct information, all documents evidencing the loss are attached and all prescribed procedures are followed in a timely manner and duly submitted to the company. The role of the agent at the time of loss has already been discussed earlier.

2. **Intimation or Notice of Loss**

Policy conditions provide that the loss be intimated to the insurer immediately. The purpose of an immediate notice is to allow the insurer to investigate a loss at its early stages. Delays may result in loss of valuable information relating to the loss. It would also enable the insurer to suggest measures to minimise the loss and to take steps to protect salvage. The notice of loss is to be given as soon as reasonably possible.

After this initial check/ scrutiny, the claim is allotted a number and entered in the claims register, with details like policy number, name of insured, estimate of amount of loss, date of loss, the claim is now ready to be processed.

Under certain types of policies (e.g. Burglary) notice is also to be given to police authorities. Under cargo rail transit policies, notice has to be served on the Railways.

3. **Investigation and assessment**

a) Overview

On receipt of the claim form, from the insured, the insurers decide about investigation and assessment of the loss. If the claim amount is small, the investigation to determine the cause and extent of loss is done, by an officer of the insurers.

The investigation of other claims is entrusted to independent licensed professional surveyors who are specialists in loss assessment. The assessment of loss by independent surveyors is based on the principle that since both the insurers and insured are interested parties, the unbiased opinion of an independent professional person should be acceptable to both the parties as well as to a court of law in the event of any dispute.

b) Claims assessment

In case of fire, claim is assessed on the basis of survey report along with supporting documents. Where necessary Police report/ fire Brigade report, Investigator's report are also obtained. For personal accident claims, the insured is required to submit a report from the attending doctor specifying the cause of accident or the nature of illness as the case may be, and the duration of disablement.

Under policy conditions, the insurers reserve the right to arrange an independent medical examination. Medical evidence is also required in support of "Workmen's Compensation" claims. Livestock and cattle claims are assessed on the basis of the report of a veterinary doctor.

Information

On receipt of intimation of loss or damage insurers check whether:

1. The insurance policy is in force on the date of occurrence of the loss or damage
2. The loss or damage is caused by an insured peril
3. The property (subject matter of insurance) affected by the loss is the same as insured under the policy
4. Notice of loss has been received without delay.

Motor third party claims involving death and personal injuries are assessed on the basis of doctor's report. These claims are dealt by Motor Accident Claims Tribunal and the amount to be paid is decided by factors like the age and income of the claimant.

Claims involving third party property damage are assessed on the basis of a survey report.

- ✓ Motor own damage claim is assessed on the basis of surveyors report.
- ✓ It may require police report if third party damage is involved.

Information

Investigation is different from the assessment of loss. Investigation is done to ensure that a valid claim has been made and verify the important details and doubts like absence of insurable interest, suppression or misrepresentation of material facts, deliberately creating the loss, etc. are ruled out.

Insurance surveyors undertake the work of investigation also. It helps if a surveyor gets on to the job as early as possible. Therefore, the practice is to appoint the surveyor, as soon as possible after the intimation of the claim is received.

B. Role of Surveyors and Loss Assessors

a) Surveyors

Surveyors are professionals licensed by IRDAI. They are experts in inspecting and evaluating losses in specific areas. Surveyors are generally paid fees by the insurance company, engaging them. Surveyors and loss assessors are hired by general insurance companies normally, at the time of a claim. They inspect the property in question, examine and verify the causes and circumstances of the loss. They also estimate the quantum of the loss and submit reports to the insurance company.

They also advise insurers, regarding appropriate measures to prevent further losses. Surveyors are governed by provisions of the Insurance Act, 1938, Insurance Rules 1939 and specific regulations issued by IRDAI.

Claims made outside the country in case of 'Travel Policy' or 'Marine Open Cover' for exports, are assessed by the claims settling agents abroad named in the policy. These agents may assess the loss and make payment, which is reimbursed by the insurers along with their settling fees. Alternatively, all the claims papers are collected by the insurance claim settling agents and submitted to the insurers, along with their assessment.

Important

Section 64 UM of Insurance Act

For the claim more than Rupees fifty thousand for Motor Own Damage and Rupees One lakh for other property damage, Insurers need to appoint surveyors for assessment of such claims. For other claims Insurers may employ other persons (not being a person disqualified for the time being for being employed as a surveyor or loss assessor) for assessment.

5. Claim forms

The contents of the claim form vary with each class of insurance. In general the claim form is designed to get full information regarding the circumstances of the loss, such as date of loss, time, cause of loss, extent of loss, etc. The other questions vary from one class of insurance to another.

Example

An example of information sought in a fire claim form is given here under:

i. Name of the insured, policy number and address

ii. Date, time, cause and circumstances of the fire

iii. Details of damaged property

iv. Sound value of the property at the time of fire. Where the insurance consists of several items under which the claim is made. [The claim must be based on actual value of property at the place and time of occurrence after allowance for depreciation, wear and tear (unless the policy in respect of building, plant and machinery is on "reinstatement value" basis). It shall not include profit]

v. Amount claimed after deduction of salvage value

vi. Situation and occupancy of the premises in which the fire occurred

vii. Capacity in which the insured claims, whether as owner, mortgage or the like

viii. If any other person is interested in the property damaged

ix. If any other insurance is in force upon such property if so, details thereof

This is followed by the declaration as to the truth and accuracy of the statement of in the form and signature of the insured and the date.

The issuance of claim form by the insurance company does not imply or mean that liability for the claim is admitted by insurers. Claim forms are issued with the remark 'without prejudice'.

Supporting documents

In addition to the claim form, certain documents are required to be submitted by the claimant or secured by the insurers to substantiate the claim.

i. For fire claims, a report from the Fire Brigade would be necessary.

ii. For cyclone damage, a report from the Meteorological office may be called for

iii. In burglary claims, a report from the Police may be necessary.

iv. For fatal accident claims, reports may be necessary from the Coroner and the Police.

v. For motor claims, the insurer may like to examine driving license, registration book, police report etc.

vi. In marine cargo claims, the nature of documents varies according to the type of loss i.e. total loss, particular average, inland or overseas transit claims etc.

Test Yourself 1

Which of the following activities is not considered as professional in settlement of claims?

I. Seeking information relating to the cause of the loss

II. Approaching the claim with a prejudice

III. Ascertaining whether the loss was a result of an insured peril

IV. Quantifying the amount payable under the claim

Test Yourself 2

Raj is involved in a car accident. His car is insured under a motor insurance comprehensive policy. Which among the following is most appropriate for Raj to do?

I. Notify the insurer of the loss as soon as reasonably possible

II. Notify the insurer at the time of insurance renewal

III. Damage the car further so as to receive a bigger compensation

IV. Ignore the damage

Test Yourself 3

Which of the following statements about claims investigation and claims assessment is correct?

I. Claims Investigation and Claims Assessment are the same

II. Claims Investigation is to determine the validity of the claim whereas assessment is whether the loss was caused by an insured peril and whether there was any breach of warranty

III. Claims Assessment tries to determine the validity of the claim whereas investigation is more concerned with the cause and extent of the loss

IV. Claims Investigation is done before the claim is paid and Claims Assessment is done after the claim is paid

Test Yourself 4

Who is the licensing authority for surveyors?

I. Surveyor Association of India

II. Surveyor Regulatory and Development Authority

III. Insurance Regulatory and Development Authority of India

IV. Government of India

Test Yourself 5

Which among the following documents is most likely to be requested while examining a cyclone damage claim?

I. Coroner's report

II. Report from Fire Brigade

III. Police report

IV. Report from Meteorological Department

Test Yourself 6

Under which principle can the insurer assume the rights of the insured in order to recover from a third party the loss paid under a policy?

I. Contribution

II. Discharge

III. Subrogation

IV. Indemnity

Test Yourself 7

If the insurer decides that a certain loss is not payable because it is not covered under the policy then who decides on such matters?

I. Insurer's decision is final

II. Umpire

III. Arbitrator

IV. Court of Law

Summary

a) Settling claims professionally is regarded as the biggest advertisement for an insurance company.

b) Policy conditions provide that the loss be intimated to the insurer immediately.

c) If the claim amount is small, the investigation to determine the cause and extent of loss is done by an officer of the insurer. But for other claims it is entrusted to independent licensed professional surveyors who are specialists in loss assessment.

d) In general the claim form is designed to get full information regarding the circumstances of the loss, such as date of loss, time, cause of loss, extent of loss, etc.

e) Claims assessment is the process of determining whether the cause of the loss suffered by the insured was caused by an insured peril and whether there was any breach of warranty. The quantum of loss suffered by the insured and the insurer's liability under the policy are assessed. This is done before payment of the claim.

f) Settlement of the claim is made only after obtaining a discharge under the policy.

Key terms

a) Intimation of loss

b) Investigation and Assessment

c) Surveyors and Loss Assessors

d) Claim forms

e) Adjustment and Settlement

Answers to Test Yourself	
Answer 1	- The correct option is II.
Answer 2	- The correct option is I.
Answer 3	- The correct option is II.
Answer 4	- The correct option is III.
Answer 5	- The correct option is IV.
Answer 6	- The correct option is III.
Answer 7	- The correct option is IV.

SECTION

ANNEXURES

CHAPTER A-01
ANNEXURES

These annexures are provided so that the students get a better idea of proposal forms used in general insurance.

Annexure- A

MOTOR INSURANCE PROPOSAL FORM
PRIVATECAR /TWOWHEELER- PACKAGE POLICY

Proposer's Name			
Address for Correspondence	Identification of Insured		
Telephone & Fax Number		Mobile No:	
E-mail Address			
Bank Account No.		PAN No:	
tion			
Type of Policy Required	**Package policy**		
Period of Insurance	From Time..... Date :	To	

DetailsofVehicle

Regn.No.	Eng.No. & Chas. No.	Year of Make	Make& Model / Type of Body	Cubic Capacity	Seating Capacity	Colour	Fuel Used

Correct Identification of the vehicle insured

Registering Authority - Name and location:

Value of the Vehicle:

Invoice Value	Electric / Electronic Accessories	Non-Electrical Accessories	Side Car/Trailer	LPG/CN G Kit	Total Value	IDV

This is the basis for claim settlement and premium

History of the Vehicle

Previous Policy No	Type of Cover	Name of Insurer & Address	Entitlement of No Claim Bonus	Date of Policy Expiry	Claim Experience for last 3 years	Date of first Purchase & Regn.

Underwriting factors - bearing on rating

Usage of the Vehicle:

Purpose of Use	Details of Vehicle Parking	Details of Driver	Average km run in a year
Pleasure	Covered Garage	Self	
Professional	Uncovered Garage	Paid Driver	
Business/Trade	Within the Compound	Relatives	
Corporate	Roadside	Friends	

Helps insurer to understand the risk accepted

To know Risk Mitigation / Adverse Risk

Discounts & Loading:

Voluntary Excess: Do you wish to Opt for Voluntary Excess over and above the Compulsory Policy Excess	Yes/No - If yes, please specify the amount Two Wheeler - Rs.500/700/1000/1500/3000 Private
Are you a member of Automobile Association of India	Yes/No If yes, please State: 1. Name of Association 2. Membership No: Date of Expiry :
Is the vehicle fitted with the any Anti-Theft Device approved by ARAI	Yes/No If yes, attach certificate of installation issued by AASI
Whether the vehicle is driven by non-conventional source	Yes/No If yes, please specify the details
Whether the vehicle is driven by Bi--fuel kit / Fiber Glass Tank Fitted	Yes/No If yes, please specify the details
Do you wish to restrict TPPD cover to Statutory limit of Rs.6000/-only	Yes / No

Underwriting factors considered for loading and discount as per company policy

Additional covers required

Theft of Accessories (Two wheelers only)	
Legal Liability to Driver	
PA for paid driver	

Compulsory: Personal Accident Cover for Owner Driver

Personal Accident Cover for Owner Driver is compulsory. Please give details of nomination :

(a) Name of the Nominee & Age:
(b) Relationship :
(c) Name of the Appointee (If Nominee is a Minor) :
(d) Relationship to the Nominee :

Additional coverage subject to additional premium

1. Compulsory PA is Rs.15lakh

2. Compulsory PA cover to owner driver cannot be granted where a vehicle is owned by a company, a partnership firm or a similar body corporate or where the owner-driver does not hold an effective driving license)

P.A. Cover for Named Persons

Named Occupants PA Cover for	(IMT-15)	Do you wish to include Personal Accident cover for named persons?			
		Name	CSI Opted (Rs.)	Nominee	Relationship
		1)			
		2)			
		3)			
		YES / NO, If YES, give name and Capital Sum Insured (CSI) opted for: (Note: The maximum CSI available per person is Rs.2 Lakhs in case of Private Cars and Rs.1 Lakh in the case of Motorized Two Wheelers)			

P A cover for unnamed Persons/Pillion / unnamed passengers		
	Add on Cover	
Nil Depreciation		
Courtesy Car		
Medical Expenses		
Personal Effects		

Information which may have a bearing on rating, also for the purpose of some statistics

Other Details

Add on Covers continued

Whether use of vehicle is limited to own premises	Yes/No
Whether the vehicle belongs to foreign embassy	Yes/No
Whether the Car is certified as Vintage Car	Yes/No
Whether the vehicle is designed for use of blind/handicapped persons	Yes/No If yes, please specify the details of Endorsement by RTA
Whether the vehicle is used for Driving Tuitions	Yes/No
Whether extension of Geographical Area is required	Nepal, Bangladesh, Bhutan, Maldives, Pakistan, Sri Lanka.

Do you wish to have a One Page Policy? Yes / No

Based on principle of utmost good faith

DECLARATION BY THE INSURED

I/We hereby declare that the Statements made by me/us in this Proposal Form are true to the best of my/our knowledge and belief and I/We hereby agree that his declaration shall form the basis of the contract between me/us and the _____

I/We also hereby declare that any additions or alterations carried out after the submission of this Proposal Form then the same would be conveyed to the Insurers immediately.

I/we wish to confirm that there has been no accident to my/our vehicle since the last Policy Expiry Date till now. I/We confirm that I/We have remitted the premium at.....on.....

For the insurance of the above vehicle with you. It is understood and agreed that you have no liability or whatsoever nature for any Loss/Damage/Liability arising out of any accident earlier to..... (time).

I/We declare that the vehicle is in perfect state and roadworthy condition.

Place:

Date :

SIGNATURE OF THE PROPOSER

Proposal Forms of Bharat Griha Raksha, Bharat Sookshma & Bharat Laghu Udyam

For a better understanding of standard products and their respective proposal forms, i.e. Bharat Griha Raksha, Bharat Sookshma and Bharat Laghu Udyam, please check the following link to the IRDAI website.

https://www.irdai.gov.in/ADMINCMS/cms/Uploadedfiles/StandardProducts/Annexure-I-BharatGrihaRaksha.pdf