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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

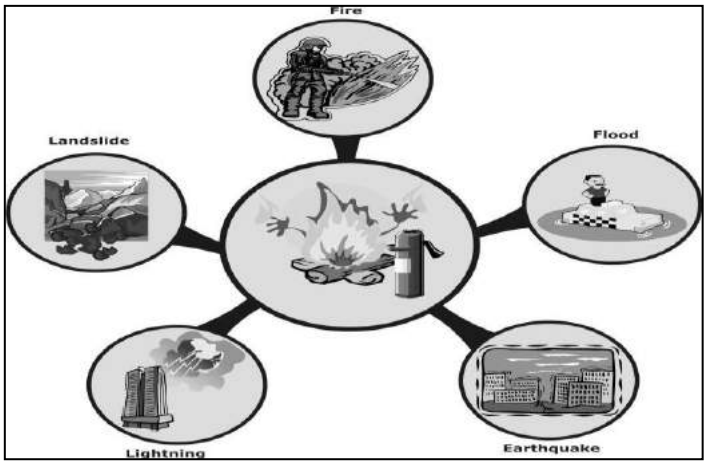
G. Role of Insurance in the Society

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
Bombay Mutual Assurance Society Ltd.	The first Indian insurance company. It was formed in 1870 in Mumbai

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

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

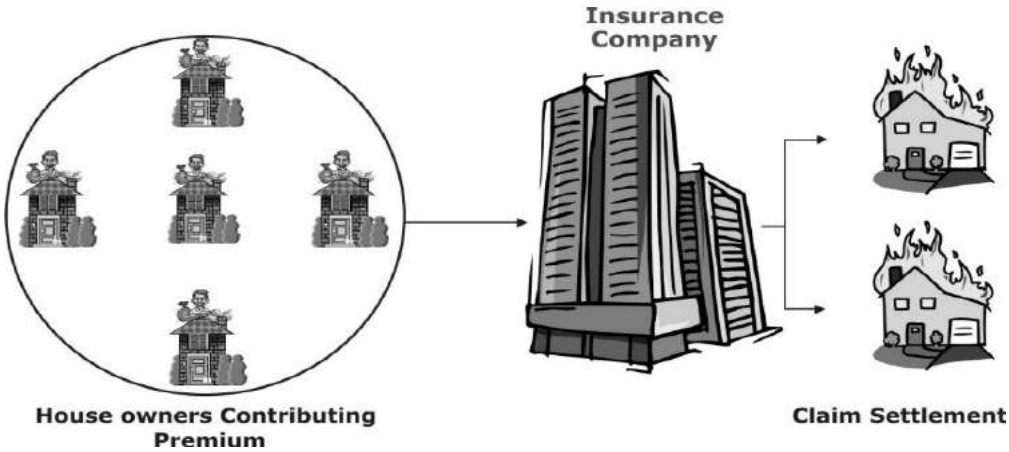
Modern commerce was founded on the principle of ownership of property. When an asset loses value (by loss or destruction), the owner of the asset suffers an economic loss. This loss can be compensated from a common fund made up of small contributions from many similar asset owners. This process of transferring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

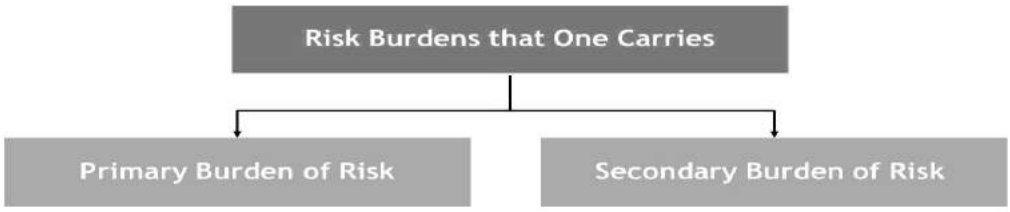
e) This process of pooling funds and compensating the unfortunate few is carried out through an institution known as the **insurer** (Insurance Company).

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

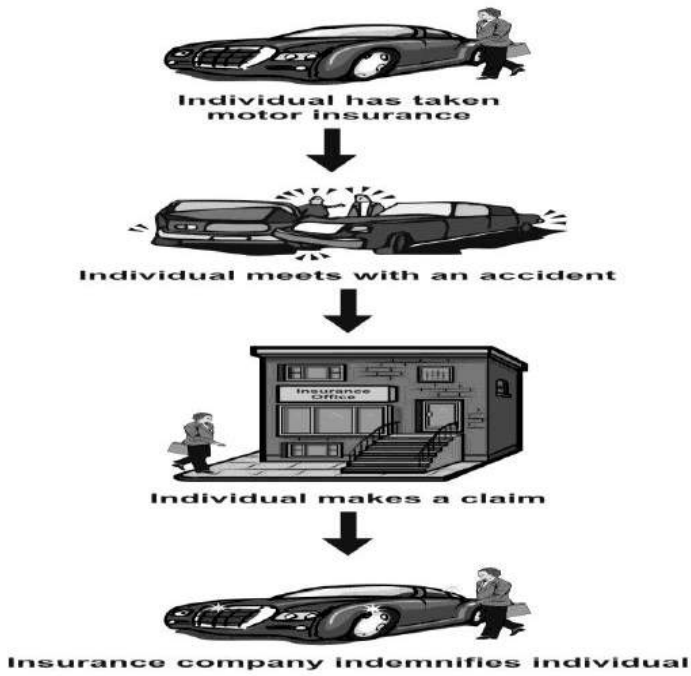
Insurance is used for most General insurance contracts which provide protection against an event that may or may not happen, and where the loss amount can be assessed only after the event.

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:

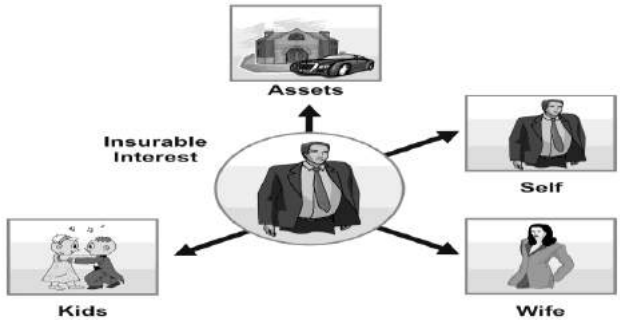
- ✓ Does he have an insurable interest in their well-being?
- ✓ Does he stand to financially lose if any of them are hospitalised?
- ✓ What about his neighbour's kids? Would he have an insurable interest in them?

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.

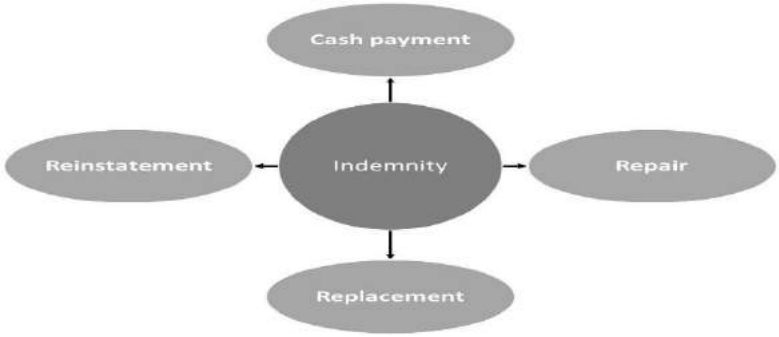
Example

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

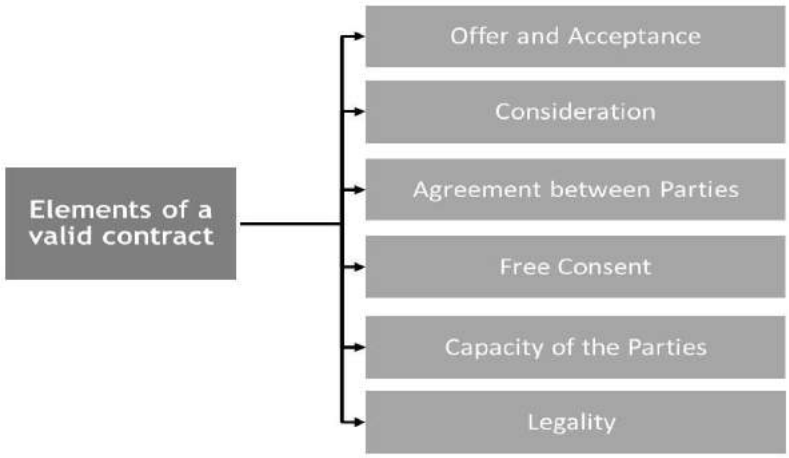
A contract is an agreement between parties, enforceable at law. The provisions of the Indian Contract Act, 1872 govern all contracts in India, including insurance contracts.

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:

$M = \frac{L \times 100}{V}$	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

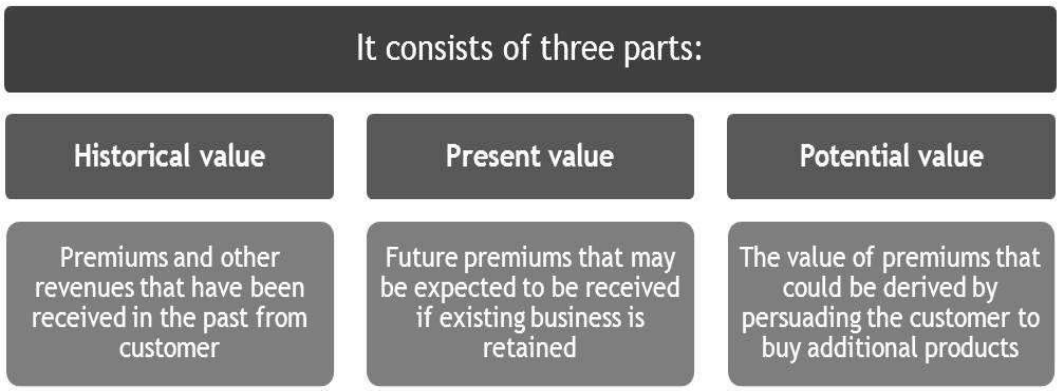
Leading sales producers in the insurance industry state that the secret of reaching the top and staying there is in getting the patronage and support of a large number of existing clients with whose help the business gets built. These clients are a source of commissions from renewal of existing contracts.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

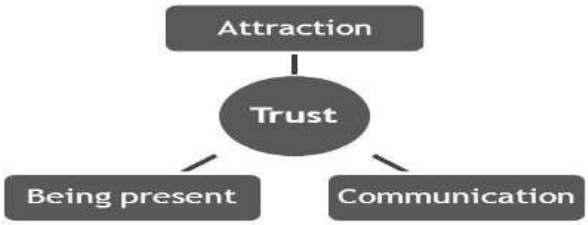
I. Sum of costs incurred while servicing the customer over his lifetime
II. Rank given to customer based on business generated
III. Sum of economic benefits that can be achieved by building a long term relationship with the customer
IV. Maximum insurance that can be attributed to the customer

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

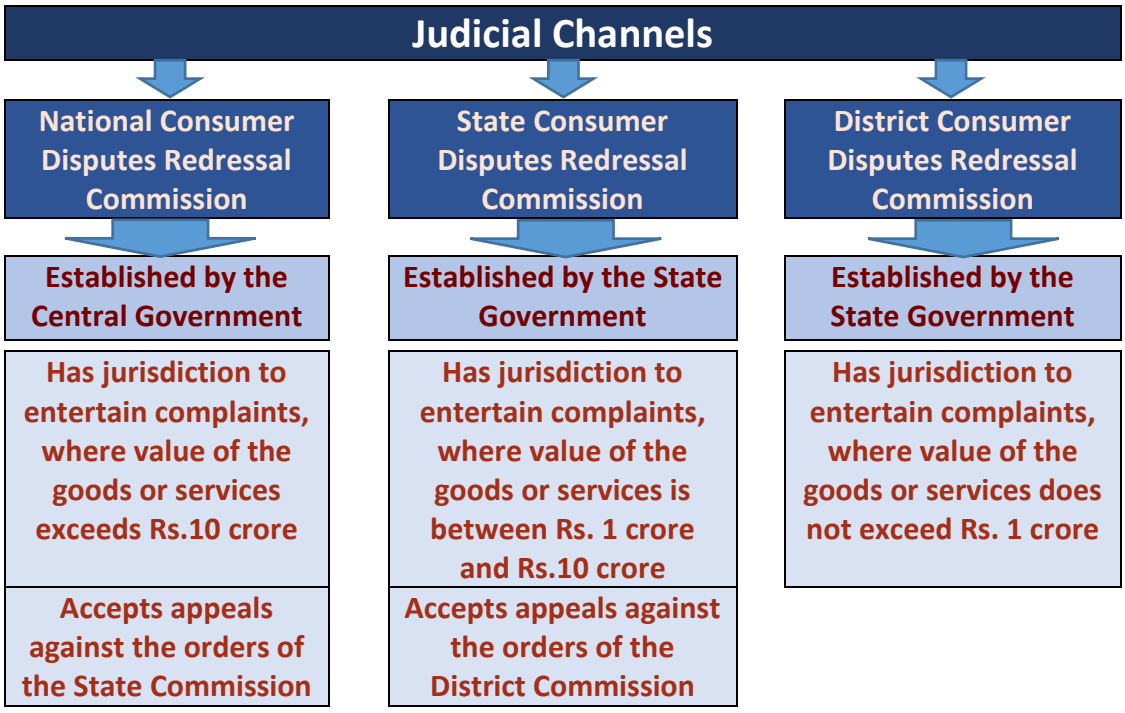
- ✓ The State Consumer Disputes Redressal Commission (State Commission) has original jurisdiction to entertain complaints where the value of goods/ service and compensation, if any claimed exceeds Rs. 1 crore but does not exceed Rs.10 crores.
- ✓ It also has appellate and supervisory jurisdiction to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

Chapter Introduction

In this chapter, we discuss Regulatory aspects of corporate agents.

Learning Outcomes

Regulations of Corporate Agents

The IRDAI (Registration of Corporate Agent) regulations,2015 has come into effect from 1st April, 2016.
Before this the IRDAI (Licensing of Corporate Agents) regulations,2002 was dealing with Corporate Agency licencing, etc.,

Corporate Agents

The IRDAI (Registration of Corporate Agent) regulations, 2015. These regulations deal with matters relating to who can Corporate Agent, Scope and applicability of the regulations, Registration, Arrangement with Insurers for distributions products, remuneration, code of conduct, etc..

The following definitions are relevant.

1. Definitions:

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

(b) "Applicant" means -

- (i) A company formed under the Companies Act, 2013 (18 of 2013) or any enactment thereof or under any previous company law which was in force; or
- (ii) A limited liability partnership formed and registered under the Limited Liability Partnership Act, 2008; or
- (iii) A Co-operative Society registered under Co-operative Societies Act, l9l2 or under any law for registration of co-operative societies, or
- (iv) a banking company as defined in clause (4A) of section 2 of the Act; or
- (v) a corresponding new bank as defined under clause (da) of sub-section (1) of section 5 of the Banking Companies Act, 1949 (10 of 1949); or
- (vi) a regional rural bank established under section 3 of the Regional Rural Banks Act, 1976 (21 of 1976): or
- (vii) a Non-Governmental organisation or a micro lending finance organization covered under the Co-operative Societies Act, 1912 or a Non-Banking Financial Company registered with the Reserve Bank of India; or
- (viii) Any other person as may be recognized by the Authority to act as a corporate agent.

(c) “Approved Institution" means any institution engaged in education and/or training particularly in the area of insurance sales, service and marketing, approved and notified by the Authority from time to time, and includes Insurance Institute of India, Mumbai.

(d) "Authorized Verifier" means a person employed by a Telemarketer for the purpose of solicitation or sale over telephonic mode and shall fulfill the requirements as specified under regulation 7(3) of these regulations for a specified person;

(e) "Authority" means the Insurance Regulatory and Development Authority of India established under the provisions of Section 3 of the Insurance Regulatory and Development Authority Act, 1999 (41 of 1999).

(f) "Corporate Agent" means any applicant specified in clause (b) above holds a valid certificate of registration issued by the Authority under these regulations for solicitation and servicing of insurance business for any of the specified category of life, general and health.

(g) “Corporate Agent (Life)" means a corporate agent who holds a valid certificate of registration to act as such, for solicitation and servicing of insurance business for life insurers as specified in these regulations;
(h) "Corporate Agent (General)" means a corporate agent who holds a valid certificate of registration to act as such, for solicitation and servicing of insurance business for general insurers as specified in these regulations;
(i) "Corporate Agent (Health)" means a corporate agent who holds a valid certificate of registration to act as such, for solicitation and servicing of insurance business for health insurers as specified in these regulations;
(j) "Corporate Agent (Composite)" means a corporate agent who holds a valid certificate of registration to act as such, for solicitation and procurement of insurance business for life insurers, general insurers and health insurers or combination of any two or all three as specified in clauses (f) above:
(k) “Examination Body” for the purpose of these Regulations is Insurance Institute of India, Mumbai or any other body approved and notified by the Authority for conducting certification examination for principal officer and specified persons of the corporate agents.
(l) Fit and Proper" is the criteria for determining the suitability for registering an Applicant including his principal officer, directors or partners or any other employees to act as Corporate Agent.
(m) “Principal Officer" of a Corporate Agent means a director or a partner or any officer or employee so designated by it, and approved by the Authority, exclusively appointed to supervise the activities of Corporate Agent and who possesses the requisite qualifications and practical training and has passed examination as required under these Regulations.
(n) "Registration" means a certificate of registration to act as a corporate agent issued under these regulations.
(o) "Regulations" means Insurance Regulatory and Development Authority of India (Registration of Corporate Agent) Regulations, 2015.
(p) "Specified Person" means an employee of a Corporate Agent who is responsible for soliciting and procuring insurance business on behalf of a corporate agent and shall have fulfilled the requirements of qualification, training and passing of examination as specified in these regulations;
(q) "Telemarketer' means an entity registered with Telecom Regulatory Authority of India under Chapter III of the Telecom Commercial Communications Customer Preference Regulations, 2010 to conduct the business of sending commercial communications and holding a certificate issued by the Authority;
(r) Words and expressions used and not defined in these Regulations but defined in the Act, as amended from time to time, the Insurance Regulatory and Development Authority Act, 1999 or in any of the Regulations / Guidelines made there under shall have the meanings respectively assigned to them in those Acts / Regulations / Guidelines.

2. Scope and applicability of these Regulations:

(1) These regulations shall cover Registration of Corporate Agents for the purpose of soliciting, procuring and servicing of Insurance business of life insurers, general insurers and health insurers during the validity of certificate of registration as follows.

(a) A Corporate Agent (Life), may have arrangements with a maximum of three life insurers to solicit, procure and service their insurance Products.
(b) A Corporate Agent (General), may have arrangements with a maximum of three general insurers to solicit, procure and service their insurance products. Further, the Corporate Agent (General) shall solicit, procure and service retail lines of general insurance products and commercial lines of such insurers having a total sum insured not exceeding rupees five crores per risk for all insurances combined.
(c) A Corporate Agent (Health), may have arrangements with a maximum of three health insurers to solicit, procure and service their insurance products.
(d) In the case of Corporate Agent (Composite), the conditions as specified in clauses (a) to (c) shall apply.
(e) any change in the arrangement with the insurance companies shall be done only with the prior approval of the Authority and with suitable arrangements for servicing existing policyholders.

3. Consideration of application –

(1) The Authority while considering an application for grant of registration shall take into account, all matters relevant for carrying out the activities of a corporate agent.

(2) Without prejudice to the above, the Authority in particular, shall take into account the following, namely:-
(a) whether the applicant is not suffering from any of the disqualifications specified under sub-section (5) of section 42 D of the Act;
(b) whether the applicant has the necessary infrastructure, such as, adequate office space, equipment and trained manpower on their rolls to effectively discharge its activities;
(c) whether any person, directly or indirectly connected with the applicant, has been refused in the past the grant of license/registration by the Authority.

(d) Whether the principal officer of the applicant is a graduate and has received at least fifty hours of theoretical and practical training from an approved institution according to a syllabus approved by the Authority, and has passed an examination, at the end of the period of training mentioned above, conducted by the examination body.
In case where the principal officer of the applicant is an Associate/ Fellow of the Insurance Institute of India, Mumbai; or Associate/Fellow of the CII, London; or Associate/Fellow of the institute of Actuaries of India; or holds any post graduate qualification of the Institute of Insurance and Risk Management, Hyderabad, the theoretical and practical training shall be twenty five hours.
(e) whether the principal officer' directors and other employees of the applicant have not violated the code of conduct as specified in Schedule III to these regulations during the last three years;

(f) Whether the applicant, in case the principal business of the applicant is other than insurance' maintain an arms-length relationship in financial matters between its activities as Corporate Agent and other activities.

(g) Whether the Principal Officer/Director(s)/Partner(s)/Specified Persons is/are Fit and Proper based on the statement in Annexure I of these regulation; and

(h) the Authority is of the opinion that the grant of registration will be in the interest of policyholders.

(3) The specified persons of the applicant shall fulfill the following requirements –

a. Having passed minimum of l2th Class or equivalent examination from a recognized Board/Institution:

b. (i) The specified person shall have undergone at least fifty hours of training' for the specified category of life, general, health for' which registration is sought for, from an approved institution and shall have passed the examination conducted by the examination body;

(ii) The specified person of corporate agent (composite) shall have undergone at seventy five hours of training from an approved institute and shall have pass the examination conducted by the examination body;

c. the specified persons engaged by the corporate agent to solicit and procure insurance business shall have valid certificate issued by the Authority as, specified in these Regulations.

The certificate shall be valid for a period of three years from the date of issued subject to the valid registration of the corporate agent;

The specified person shall apply through the principal officer of the corporate agent to the Authority in the format specified in Annexure 3 of these regulations for issuance of certificate.

d. A specified person of a corporate agent wishes to switch over to any other corporate agent, shall do so by applying to the Authority through the new corporate agent along with a no objection certificate issued by the present corporate agent. In case, the present corporate agent does not issue a no objection certificate within 30 days, it shall be deemed that the said corporate agent has no objection to his switching over. The Authority after receipt of request from the corporate agent, issue a revised certificate changing the name of the corporate agent indicating the switching over.

4. **Renewal of registration** –

(1) As per this regulation a corporate agent may, within thirty days before the expiry of the registration, make an application in Form A along with requisite fee to the Authority for renewal of registration.

Provided however that if the application reaches the Authority later than that period but before the actual expiry of the current registration, an additional fee of rupees one hundred, plus applicable taxes, shall be payable to the Authority.

Provided further that the Authority may for sufficient reasons offered in writing by the applicant for a delay not covered by the previous proviso, accept an application for renewal after the date of the expiry of the registration on payment of an additional fee of seven hundred and fifty rupees, plus applicable taxes, by the applicant.

Note: A corporate agent is permitted to submit the application for renewal of registration ninety days prior to the expiry of the registration.

(2) Principal Officer and specified persons before seeking a renewal of registration shall have completed, at least twenty five hours of therefore local and practical raining, imparted by an approved institution.

(3) The Authority, on being satisfied that the applicant fulfills all the conditions specified for a renewal of the registration, shall renew the registration in Form C for a period of three years and send intimation to the applicant.

5. Procedure where a registration is not granted -

(1) Where an application for grant of a registration under regulation 4 or renewal thereof under regulation 11, does not satisfy the conditions set out in regulation 7, the Authority may refuse to grant or renew the Certificate of Registration.

Before the application is rejected the applicant has to be given a reasonable opportunity of being heard.

(2) The refusal to grant or renew a Certificate of Registration shall be communicated by the Authority within thirty days of such refusal to the applicant stating therein the grounds on which the application has been rejected.

(3) Any applicant aggrieved by the decision of the Authority may make an appeal to Securities Appellate Tribunal, within a period of forty-five days from the date on which a copy of the order made by the Authority under sub-regulation (2) above is received by it.

6. **Effect of refusal to grant registration-** An applicant, whose application for grant of registration under regulation 4 or of a renewal thereof under regulation 11 has been refused or rejected by the Authority, shall, on and from the date of the receipt of the communication under regulation 12(2) cease to act as a corporate agent.
He, however, shall continue to be liable to provide services in respect of contracts already entered into through him.
Such a service shall continue upto the period of expiry of those existing contracts, which have already been closed, or for a period of six months, whichever is earlier within which time they shall make suitable arrangements with the concerned insurer.

7. **Conditions of grant of registration to Corporate Agent:**

The registration granted under regulation 9 or the renewal granted under regulation 11 shall be subject to the following conditions:-

(i) The corporate agent registered under these regulations shall be permitted to solicit and service insurance business as specified in regulation (3) above only;
(ii) The corporate agent shall comply with the provisions of the Act, Insurance Regulatory and Development Authority Act, 1999 and the Regulations, Circulars, Guidelines and any other instructions issued there under from time to time by the Authority;
(iii) The corporate agent shall take adequate steps for redressal of grievances of its clients within 14 days of receipt of such complaint and keep the Authority informed about the number, nature and other particulars of the complaints received from such clients in format and manner as may be specified by the Authority;
(iv) The corporate agent shall solicit and procure reasonable number of insurance policies commensurate with their resources and the number of specified persons they employ.
(v) The corporate agent shall maintain records in the format specified by the Authority which shall capture policy-wise and specified person-wise details wherein each policy solicited by the corporate agent is tagged to the specified person, except for those products which are simple, sold over the counter and specifically approved by the Authority. The corporate agent shall put in place systems which allow regular access to such records and details by the Authority.
(vi) The corporate agent under no circumstance shall undertake multi-level marketing for solicitation of insurance products;
(vii) The Corporate Agent shall ensure compliance of Code of Conduct applicable to its directors, principal officer and specified persons;
(viii) The corporate agent shall maintain separate books of accounts for their corporate agency business as specified in regulation 31;

8. Payment of fees and the consequences of failure to pay fees –

(1) Every corporate agent shall at the time of application of registration and renewal thereof pay non refundable application fee of Rs.10,000/-, plus applicable taxes. No application shall be processed without the application fee.

(2) Upon receipt of communication for grant of registration from the Authority, the applicant shall pay a fee of Rs.25,000/-, plus applicable taxes, within 15 days of receipt of such communication. On receipt of the fee and on satisfactory compliance of terms and conditions for grant of registration, the Authority shall grant the registration to act as a corporate agent under the category for which an application is made.

(3) A corporate agent desirous of applying for renewal shall make an application for renewal in the prescribed format along with a fee of Rs.25, 000/-, plus applicable taxes.

9. **Remuneration-**

The payment of remuneration to or receipt of remuneration by a corporate agent shall be governed by the regulations notified in this behalf by the Authority from time to time.

10. Conflict of interest -

While soliciting and procuring the insurance business, the corporate agent shall comply with the following:

(i) The corporate agent having tie-ups with more than one insurer in a particular line of business, disclose to the prospective customer the list of insurers, with whom they have arrangements to distribute the products and provide them with the details such products. Further, disclose the scale of commission in respect of the insurance product offered, if asked by the prospect;

(ii) Where the insurance is sold as an ancillary product along with a principal business product, the corporate agent or its shareholder or its associates shall not compel the buyer of the principal business product to necessarily buy the insurance product through it.
The Principal Officer and CFO (or its equivalent) of the corporate agent shall file with the Authority a certificate in the format given in the Schedule VIII on half-yearly basis, certifying that there is no forced selling of an insurance product to any prospect.

11. Disclosures to the Authority-

(1) An applicant desires to become a corporate agent shall disclose to the Authority at the time of filing application all material facts relevant for consideration of application, on its own. In case of any change in the information provided for consideration of their application, subsequent to filing of application or during the processing of application, such change shall be disclosed to the Authority, voluntary by the applicant, for consideration of the Authority.

(2) Similarly, a corporate agent disclose, to the Authority voluntarily, any change in material facts, based on which a registration was made to them, within a reasonable time but not later than 30 days from the happening of such change.

(3) A corporate shall disclose to the Authority proceedings initiated against them by other regulatory or Government bodies within a reasonable time but not later than 30 days from the initiation of such proceedings. Any action or direction issued by such other bodies shall also be disclosed to the Authority within the time limits prescribed above

(4) The corporate agent shall disclose to the Authority the details of its offices in which they propose to distribute insurance products and details of Specified Persons along with their certificate number issued by the Authority. Further, any opening or closure of an office by a corporate agent shall be informed to the Authority.

(5) Failure to adhere to the conditions set out above shall attract regulatory actions such as suspension or cancelation of registration, imposition of monetary penalty or any other action.

12. Arrangements with insurers for distribution of products

a) Corporate agents registered under these regulations shall have to enter into arrangements with insurers for distribution of products. These arrangements shall have to be disclosed to the Authority within 30 days of entering into such arrangements. The minimum period of such arrangement shall be for one year;

(b) while entering into such arrangements, no corporate agent shall promise nor shall any insurer compel the corporate agent to distribute the products of a Particular insurer;

(c) Arrangements shall have provisions to include duties and responsibilities of corporate agents towards the policyholders, duties and responsibilities of insurers and corporate agents, terms and conditions for termination of arrangements;

(d) No arrangements shall be made against the interests of Policyholders;

(e) In case a corporate agent wishes to terminate arrangement with any insurer, they may do so after informing the insurer and the Authority, the reasons or termination of arrangement. In such cases, they shall ensure that the policies solicited and placed with the insurer are serviced till the expiry of policies, or for a Period of six months, whichever is earlier with in which time they shall make suitable arrangements with the concerned insurer;

(f) In case an insurer wishes to terminate the arrangement with any corporate agent, they may do so after informing the corporate agent and the Authority, the reasons for termination of arrangement.
In such cases, the concerned insurer shall take the responsibility of servicing the policies Procured by the corporate agent. In all such cases, the insurer shall inform the policyholder concerned of the changes made in servicing arrangements;

(g) No insurer shall directly pay incentives (cash or non-cash) to the principal officer, specified persons and other employees of the corporate agents;

13. Servicing of policyholders-

(1) A corporate agent registered under these regulations shall have the duty to service its policyholders during the entire period of contract. Servicing includes assisting in payment of premium required under section 64VB of the Act, providing necessary assistance and guidance in the event of a claim.

14. Sale of Insurance by tele-marketing mode and distance marketing activities of a corporate agent –

(1) A corporate agent who intends to engage the services of a telemarketer or engage in distance marketing activities for the purpose of distribution of insurance products shall follow the instructions as laid down in Schedule VII.

(2) A corporate agent shall have to comply with the following additional conditions for engaging the services of a telemarketer:

a. The telemarketer engaged by the corporate agent shall comply with various circulars and/or guidelines or any other direction issued by Telecom Regulatory Authority of India in the matter;

b. A corporate agent intends to undertake telemarketing activities for insurance intermediation shall seek prior approval of the Authority in the form specified by the Authority at Annexure 4 of these regulations. The Authority on verification of the same issue a certificate to the telemarketer;
c. Further, the corporate agent shall file with the Authority the names of Authorised verifiers engaged/proposed to be engaged by the telemarketer in the form specified at Annexure 5 of these regulations,.
d. The Authority on verification of the same issue a certificate to the Authorised verifier.
e. In case an Authorised Verifier intends to switch to another telemarketer who is also dealing with insurance intermediation, they shall obtain a No Objection Certificate from the erstwhile telemarketer and submit the same to the Authority for issuing a fresh certificate. In case, the present telemarketer does not issue a no objection certificate within 30 days from the date of application for the same, it shall be deemed that the telemarketer has no objection to his switching over;
f. Application for removal or addition of Authorised Verifiers shall be made by the Corporate Agent concerned through the Principal Officer;
g. In case the corporate agent registers as telemarketer with TRAI, the corporate agent shall act as telemarketer for only those insurers with whom he has arrangements;
h. No corporate agent or its telemarketer shall make outbound calls to any person unless he or she has shown interest in buying an insurance policy by making enquiries to that effect. They shall maintain the database of such persons and the enquiry made for verification and checking by the Authority or any person authorized by it.
i. The telemarketer shall disclose to the prospective customer the following information
   (a) The name of the corporate agent they represent;
   (b) The registration number of the corporate agent;
   (c) Contact number of the telemarketer and-/or corporate agent in case the customer desires to call back or verify the telesales information;

(d) Name and identification number of the person (Authorised Verifier) making the tele-call.

j. A corporate agent engaging a telemarketer shall enter into an agreement with the telemarketer and the agreement shall provide the details such as source of the database, duties and responsibilities, payment details, period of agreement, actions to be taken in case of violation of Act, regulations, guidelines, circulars, directions issued by the Authority, Code of Conduct of Authorised Verifiers. The agreements shall be made available to the Authority or any person authorized by the Authority for verification as and when required;
k. Every telemarketer and the authorized Verifier shall abide by the Code of Conduct applicable to corporate agents as specified in Schedule III of these regulations.
l. The Authority shall have the power to inspect the premises of the telemarketer or any other premises, which the Authority feels necessary for the verification of records / documents, and seek any document/record, record statements of any employee of the telemarketer or make copies of any documents/records at its discretion:
m. The telemarketer shall have to comply with any other terms and conditions as may be prescribed by the Authority from time to time in the matter.

(3) A telemarketer shall not be engaged with more than three insurers or insurance related entities

15. Code of conduct for Corporate Agents-

(1) Every Corporate Agent shall abide by the Code of Conduct as specified in Schedule III of these regulations,

(2) The corporate agent shall be responsible for all (the acts and omissions of its principal officer, specified persons and other employees including violation of code of conduct specified under these regulations and liable to a penalty which may extend to one crore rupees under the provisions of Sec.102 of the Act.

16. Maintenance of Records

A Corporate Agent shall maintain the following records including in electronic form and shall be made available as and when required by the Aurhority –

(i) Know Your Client (KYC) records of the client, as required under the relevant Authority's guidelines and provisions of Prevention of Money Laundering Act;
(ii) Copy of the proposal form duly signed by the client and submitted to the insurer with ACR signed by the specified person of corporate agent;
(iii) A register containing list of clients, details of policy such as type of policy, premium amount, date of issue of the policy, charges or fees received;

(iv) A register containing details of complaints received which include name of the complainant, nature of complaint, details of policy issued/solicited and action taken thereon;
(v) A register which shall contain the name, address, telephone no, photograph, date of commencement of employment, date of leaving the service, if any, monthly remuneration paid to the specified person;
(vi) Copies of the correspondence exchanged with the Authority;
(vii) Any other record as may be specified by the Authority from time to time.

17. Maintenance of books of account, records, etc. -

(1) A corporate agent, which is incorporated exclusively for the purposes of insurance intermediation, shall prepare the following books of accounts for every financial 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 as may be required by the Authority from time to rime.

Note.1: For purposes of this regulation, the financial 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.

Note.2: There shall be a schedule to their financial statements or providing the details of all the incomes received from insurers and insurer's group companies, insurer-wise, by the corporate agent, and also the details of payments received by the group companies and/or associates of the corporate agent from any insurer and the details thereof.

(a) A copy of the audited financial statements as stated in sub-regulation (1) along with the auditor's report thereon shall be submitted to the Authority before 30th September every 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.

(b) Within ninety days from the date of the Auditor's report necessary steps to rectify any deficiencies, made out in the auditor's report, be made and informed to the Authority.

(c) All the books of account, statements, document, etc., shall be maintained at the head office of the corporate agent or such other branch office as may be designated and notified to the Authority, and shall be available on all working days to such officers of the Authority, and authorised in this behalf for inspection.

(d) All the books, documents, statements, contract notes etc., referred to in this regulation and maintained by the corporate agent shall be retained for a minimum period of ten years from the end of the year to which they relate. However, the documents pertaining to the cases where claims are reported and the settlement is pending for a decision from courts, the documents are required to be maintained till the disposal of the cases by the court.

(2) In the case of corporate agents whose principal business is other than insurance intermediation, they shall maintain segment wise reporting capturing the revenues received for insurance intermediation and other income from insurers.

(3) Every insurer who is engaging the services of a corporate agent shall file with the Authority a certificate, separately for all such corporate agents, in the format given in the Schedule VIA to be signed by the CEO and CFO. A similar certificate from the Principal Officer and CFO (or its equivalent) of the corporate agent specifying the commission/ remuneration received from the insurer shall be filed with the Authority as given in Schedule VlB.

Code of Conduct

I. General Code of Conduct

1. Every corporate agent shall follow recognised standards of professional conduct and discharge their duties in the interest of the policyholders. While doing so-

a) conduct its dealings with clients with utmost good faith and integrity at all times;
b) act with care and diligence;
c) ensure that the client understands his relationship with the corporate agent and on whose behalf the corporate agent is acting;
d) treat all information supplied by the prospective clients as completely confidential to themselves and to the insurer(s) to which the business is being offered;
e) take appropriate steps to maintain the security of confidential documents in their possession;
f) No director of a company or a partner of a firm or the chief executive or a principal officer or a specified person shall hold similar position with another corporate agent;

2. Every Corporate Agent shall

a) be responsible for all acts of omission and commission of its principal officer and every specified person;
b) ensure that the principal officer and all specified persons are properly trained, skilled and knowledgeable in the insurance products they market;
c) ensure that the principal officer and the specified person do not make to the prospect any misrepresentation on policy benefits and returns available under policy;
d) ensure that no prospect is forced to buy an insurance product;
e) give adequate pre-sale and post-sale advice to the insured in respect of the insurance product;
f) Extend all possible help and cooperation to an insured in completion of all formalities and documentation in the event of a claim;
g) give due publicity to the fact that the corporate agent does not underwrite the risk or act as an insurer;
h) enter into agreements with the insurers in which the duties and responsibilities of both are defined

II. Pre-sale Code of Conduct

3. Every corporate agent or principal officer or a specified person shall also follow the code of conduct specified below:

i) Every corporate agent/principal officer/ specified person shall,-

a) identify himself and disclose his registration/ certificate to the prospect on demand;
b) disseminate the requisite information in respect of insurance products offered for sale by the insurers with whom they have arrangement and take

into account the needs of the prospects while recommending a specific insurance plan;

c) disclose the scales of commission in respect of the insurance product offered for sale, if asked by the prospect;
d) indicate the premium to be charged by the insurer for the insurance product offered for sale;
e) explain to the prospect the nature of information required in the proposal form by the insurer, and also the importance of disclosure of material information in the purchase of an insurance contract;
f) bring to the notice of the insurer any adverse habits or income inconsistency of the prospect, in the form of a Confidential Report along with every proposal submitted to the insurer, and any material fact that may adversely affect the underwriting decision of the insurer as regards acceptance of the proposal, by making all reasonable enquiries about the prospect;
g) inform promptly the prospect about the acceptance or rejection of the proposal by the insurer;
h) obtain the requisite documents at the time of filing the proposal form with the insurer, and other documents subsequently asked for by the insurer for completion of the proposal;

ii) No corporate agent/ principal officer/ specified person shall,-----

a) solicit or procure insurance business without holding a valid registration/certificate;
b) induce the prospect to omit any material information in the proposal form;
c) induce the prospect to submit wrong information in the proposal form or documents submitted to the insurer for acceptance of the proposal;
d) behave in a discourteous manner with the prospect;
e) interfere with any proposal introduced by any other specified person or any insurance intermediary;
f) offer different rates, advantages, terms and conditions other than those offered by the insurer;
g) force a policyholder to terminate the existing policy and to effect a new proposal from him within three years from the date of such termination;
h) No corporate agent shall have a portfolio of insurance business from one person or one organization or one group of organizations under which the premium is in excess of fifty percent of total premium procured in any year ;
i) become or remain a director of any insurance company, except with the prior approval of the Authority,
j) indulge in any sort of money laundering activities;
k) indulge in sourcing of business by themselves or through call centers by way of misleading calls or spurious calls;
l) undertake multi-level marketing for soliciting and procuring of insurance products;
m) engage untrained and unauthorised persons to bring in business;
n) provide insurance consultancy or claims consultancy or any other insurance related services except soliciting and servicing of insurance products as per the certificate of registration.

o) Engage, encourage, enter into a contract with or have any sort of arrangement with any person other than
a specified person, to refer, solicit, generate lead, advise, introduce, find or provide contact details of prospective policyholders in furtherance of the distribution of the insurance product;
p) Pay or allow the payment of any fee, commission, incentive by any other name whatsoever for the purpose of sale, introduction, lead generation, referring or finding to any person or entity

III. Post-Sale Code of Conduct

4. Every Corporate Agent shall -
a) advise every individual policyholder to effect nomination or assignment or change of address or exercise of options, as the case may be, and offer necessary assistance in this behalf, wherever necessary;
b) with a view to conserve the insurance business already procured through him, make every attempt to ensure remittance of the premiums by the policyholders within the stipulated time, by giving notice to the policyholder orally and in writing.
c) ensure that its client is aware of the expiry date of the insurance even if it chooses not to offer further cover to the client:
d) ensure that renewal notices contain a warning about the duty of disclosure including the necessity to advise changes affecting the policy, which have occurred since the policy inception or the last renewal date;
e) ensure that renewal notices contain a requirement for keeping a record (including copies of letters) of all information supplied to the insurer for the purpose of renewal of the contract;
f) ensure that the client receives the insurer’s renewal invitation well in time before the expiry date.
g) render necessary assistance to the policyholders or claimants or beneficiaries in complying with the requirements for settlement of claims by the insurer;
h) explain to its clients their obligation to notify claims promptly and to disclose all material facts and advise subsequent developments as soon as possible;
i) advise the client to make true, fair and complete disclosure where it believes that the client has not done so. lf further disclosure is nor forthcoming it shall consider declining to act further for the client;
j) give prompt advice to the client of any requirements concerning the claim;
k) forward any information received from the client regarding a claim or an incident that may give rise to a claim without delay, and in any event within three working days;
l) advise the client without delay of the insurer's decision or otherwise of a claim; and give all reasonable assistance to the client in pursuing his claim.
m) shall not demand or receive a share of proceeds from the beneficiary under an insurance contract;
n) ensure that letters of instructor, policies and renewal documents contain details of complaints handling procedures:
o) accept complaints either by phone or in writing:

p) acknowledge a complaint within fourteen days from the receipt of correspondence, advise the member of staff who will be dealing with the complaint and the timetable for dealing with it;
q) ensure that response letters are sent and inform the complainant of what he may do if he is unhappy with the response;
r) ensure that complaints are dealt with at a suitably senior level;
s) Have in place a system for recording and monitoring complaints.