
STUDY MATERIAL

PROFESSIONAL PROGRAMME

INSURANCE - LAW & PRACTICE

MODULE 3 ELECTIVE PAPER 9.2



**THE INSTITUTE OF
Company Secretaries of India**

भारतीय कम्पनी सचिव संस्थान

IN PURSUIT OF PROFESSIONAL EXCELLENCE

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PROFESSIONAL PROGRAMME INSURANCE – LAW & PRACTICE

The world we live in is full of uncertainties and risks. Individuals, families, businesses, properties and assets are exposed to different types and levels of risks. These include risk of losses of life, health, assets, property, etc. While it is not always possible to prevent unwanted events from occurring, financial world has developed products that protect individuals and businesses against such losses by compensating them with financial resources. Insurance is a financial product that reduces or eliminates the cost of loss or effect of loss caused by different types of risks. In order to safeguarding the interest of people from loss and uncertainty, Insurance has evolved as a process of indemnifying the people against the loss and uncertainty. It may be described as a social device to reduce or eliminate risk of loss to life and property.

Apart from protecting individuals and businesses from many kinds of potential risks, Insurance contributes a lot to the general economic growth of the society by provides stability to the functioning of process. The insurance industries develop financial institutions and reduce uncertainties by improving financial resources. It also provides stability to the functioning of businesses and generating long-term financial resources for the industrial projects. Among other things, Insurance sector also encourages the virtue of savings among individuals and generates employments for millions, especially in a country like India, where savings and employment are important.

Considering the various recommences the insurance industry provides to the society, economy, businesses and people on one side and considering the capital invested by the people by the people through the instrument of insurance on other side, it is mandated to regulate insurance sector.

Though since ages, regulation exists for ensuring the maximum utilization of the insurance sector for the benefit of the society and for avoiding the probability of misuse of the insurance as a instrument related to finance and capital, yet the privatization of insurance sector in early 90s has made it compulsory to have stricter standards of laws and regulation over insurance sector.

In order to realize the benefits of insurance, one should be through in adhering the compliances related to insurance and related products.

Considering the significance of the Insurance Sector for the Company Secretaries as a specialized area of their expertise and also the plethora of laws and regulation governing the Insurance sector in India, this Study material aims as guiding the consolidated understanding of Insurance, the sector, and the laws and practices related to insurance industry in India.

The legislative changes made up to December, 2019 have been incorporated in the study material. However, on one hand, where the subject of Intellectual Property Rights: Laws and Practice is inherently fundamental to understand the basics and advanced principles related to Intellectual Property Rights and on the similar end it is subject to the refinement of Legislation, Rules and Regulations. Henceforth, it becomes necessary for every student to constantly update with legislative changes made as well as judicial pronouncements rendered from time to time by referring to the Institute's monthly journal 'Chartered Secretary', E-Bulletin 'Student Company Secretary' as well as other legal and professional journals along with the aid of reference books related to the subject.

In the event of any doubt, students may write to the Directorate of Academics of the Institute for clarification at academics@icsi.edu.

Although due care has been taken in publishing this study material, the possibility of errors, omissions and /or discrepancies cannot be rules out. This publication is released with an understanding that the Institute shall not be responsible for any errors, omissions and /or discrepancies or any action taken in that behalf.

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PROFESSIONAL PROGRAMME
MODULE 3
ELECTIVE PAPER 9.2
INSURANCE – LAW & PRACTICE (Max Marks 100)

SYLLABUS

Objective

To impart knowledge on insurance related concepts to the students with the aim of broadening professional opportunities in the arena of insurance.

Detailed Contents

1. Concept of Insurance: Risk Management; The Concept of Insurance and its Evolution; The Business of Insurance; The Insurance Market; Insurance Customers; The Insurance Contract; Insurance Terminology; Life Assurance products; General Insurance Products.

2. Regulatory Framework of Insurance Business in India: Development of Insurance Legislation in India and Insurance Act 1938; Insurance Regulatory and Development Authority of India (IRDAI) Functions and Insurance Councils; IRDAI and its Licensing Functions; Policy Holders Rights of Assignment, Nomination and Transfer; Protection of Policy Holders Interest; Dispute Resolution Mechanism; Financial Regulatory Aspects of Solvency Margin and Investments; International Trends In Insurance Regulation.

3. Life Insurance – Practices: Life Insurance Organization; Premiums and Bonuses; Plans of Life insurance; Annuities; Group Insurance; Linked Life Insurance Policies; Applications and Acceptance; Policy Documents; Premium payment, Life Insurance Corporation (L.I.C) of India; Policy Lapse and Revival; Assignment, Nomination and Surrender of policy; Policy Claims.

4. Life Insurance – Underwriting: Underwriting: Structure and Process; Financial Underwriting; Occupational, A vocational and Residential Risks; Reinsurance; Blood Disorders; Nervous System; Diabetes Mellitus; Thyroid diseases; Urinary system; The Respiratory System; Gastrointestinal (Digestive) System; Cardiovascular system; Special Senses: Disorders of the eyes, ears and nose; Law of contract; Life Insurance Contract; Protection of Interest of Consumers.

5. Applications of Life Insurance: Financial Planning and Life Insurance; Life Insurance Planning; Health Policies; Pensions and Annuities; Takaful (Islamic Insurance).

6. Life Insurance – Finance: Accounting Procedures - Premium Accounting; Accounting Procedures– Disbursements; Accounting Procedure: Expenses of Management; Investments; Final Accounts, Revenue Account and Balance Sheet; Budget and Budgetary Control; Innovative Concepts in Financial Reporting; Accounting Standard Applicable to Life Insurance Companies; Financial Analysis; Management Environment in India; Application of Financial Management Concepts in Insurance Industry; Taxation New Syllabus for Executive and Professional Programme S (Current Scenario); Anti-Money Laundering Guidelines and PML Act.; Compliance with IFRS (Involving Broader Concepts).

7. Health Insurance: Introduction to Health Insurance and the Health system in India; Health Financing

Models and Health Financing in India; Health Insurance Products in India; Health Insurance Underwriting; Health Insurance Policy Forms and Clauses; Health Insurance Data, Pricing & Reserving; Regulatory and legal aspects of health insurance; Customer service in health insurance; Health Insurance fraud; Reinsurance.

8. General Insurance - Practices and Procedures: Introduction to General Insurance; Policy Documents and forms; Underwriting; Ratings & Premiums; Claims; Insurance Reserves & Accounting.

9. Fire & Consequential Loss Insurance: Basic Principles and the Fire Policy; Add On Covers and Special Policies; Fire Hazards and Fire Prevention; Erstwhile Tariff – Rules and Rating; Documents; Underwriting; Claims – Legal & Procedural Aspects; Consequential Loss Insurance; Specialised Policies and Overseas Practice.

10. Marine Insurance: Basic Concepts; Fundamental Principles; Underwriting; Types of Covers; Marine Claims; Marine Recoveries; Role of Banker's in marine Insurance; Loss Prevention, Reinsurance, Maritime Frauds.

11. Agricultural Insurance: Glossary of Terms for Agriculture Insurance; Introduction to Indian Agriculture; Risk in Agriculture; History of Crop Insurance in India; Crop Insurance Design Considerations; Crop Insurance - Yield Index based Underwriting and Claims; Weather Based Crop Insurance; Traditional Crop Insurance: Underwriting and Claims; Agriculture Insurance in Other Countries; Livestock / Cattle Wealth in Indian Economy; Types of Cattle & Buffaloes; Cattle Insurance in India; Poultry Insurance in India; Miscellaneous Agriculture Insurance Schemes; Agriculture Reinsurance.

12. Motor Insurance: Introduction to Motor Insurance; Marketing in Motor Insurance; Type of motor vehicles, documents and policies; Underwriting in Motor Insurance; Motor Insurance Claims; IT Applications in Motor Insurance; Consumer Delight; Third Party Liability Insurance; Procedures For Filing And Defending; Quantum Fixation; Fraud Management and Internal Audit; Legal aspects of Third party claims; Important Decisions on Motor Vehicle Act.

13. Liability Insurance: Introduction to Liability Insurance; Legal Background; Liability Underwriting; Statutory Liability; General Public Liability (Industrial/Non-industrial Risks); Products Liability Insurance; Professional Indemnity Insurance; Commercial General Liability; Directors and Officers Liability; Other Policies & Overseas Practices; Reinsurance.

14. Aviation Insurance: Introduction; Aviation Insurance Covers; Underwriting-General Aviation; Underwriting Airlines; Underwriting-Aerospace; Aviation Laws; Aviation Claims; Aviation Finance.

15. Risk Management: Risk and Theory of Probability; Risk Management Scope and Objectives; Building up an Effective Risk Management Programme; Important Steps in Risk Management Decision Making Process; Alternative Risk Management; Enterprise Risk Management; Business Continuity Management and Disaster/ Emergency / Catastrophe Recovery Planning; Loss Exposures for Major Classes; Risk Management Checklists.

16. Corporate Governance for Insurance Companies.

LESSON WISE SUMMARY

INSURANCE – LAW & PRACTICE

Lesson 1 - Concept of Insurance

Insurance is form of contract or an arrangement where one party agrees in return for a consideration to pay an agreed amount of money to another party to make good the loss, damage or injury to something of value in which the insured has an interest. Being a contract of indemnity, it is based on the principle of utmost good faith. In today's world, insurance companies offer retail insurance policies of varied nature including life, health, fire, marine, etc. Individuals purchase such policies either in their individual capacity or the employee friendly organizations may extend such cover as perks of the employment.

Lesson 2 - Regulatory Framework of Insurance Business in India

Regulatory Framework of Insurance Business in India: The process of re-opening of the sector had begun in the early 1990s and the last decade and more has seen it been opened up substantially. In 1993, the Government set up a committee under the chairmanship of R N Malhotra, former Governor of RBI, to propose recommendations for reforms in the insurance sector. The objective was to complement the reforms initiated in the financial sector. The committee submitted its report in 1994 wherein, among other things, it recommended that the private sector be permitted to enter the insurance industry. They stated that foreign companies be allowed to enter by floating Indian companies, preferably a joint venture with Indian partners. Following the recommendations of the Malhotra Committee report, in 1999, the Insurance Regulatory and Development Authority (IRDA) was constituted as an autonomous body to regulate and develop the insurance industry.

Lesson 3 - Life Insurance – Practices

Life Insurance Organisation comprises of the various functions comprised within a Life Insurance organisation. Insurance as a protection against natural calamities was first conceived by the adventurous travellers of the sea who carried goods of value to faraway places, braving all the perils of the sea, in anticipation of handsome profits in the trade. Life insurance is meant to provide financial assistance to the dependents of the life assured in the event of his death. Earliest form of life assurance was a lump sum payment at the time of death of person whose life was insured. The amount of payment used to be fixed arbitrarily depending on the resources of the organisation. Recreation clubs having large memberships adopted this type of inducement to the existing members to continue their membership of the club or to attract new members by offering some incentive out of the surplus funds they had.

Lesson 4 - Life Insurance – Underwriting

Insurance is transfer of risk and Insurance companies are in the business of accepting the risks. Underwriting denotes acceptance of risk on a Proposal. It is the judgement of the insurance company to take the risk based on the assessment of the extent of risk. Insurance contracts are based on the principle of "uberrimaefidei", meaning utmost good faith. The person taking the insurance policy is required to disclose all the facts impacting the assessment of risk truthfully and completely about the subject matter of insurance, to the Insurer in order to enable the insurer to correctly assess the risk on hand. If the principle of utmost good faith is vitiated, insurer has the right to cancel the contract or deny payment of Policy benefits.

Lesson 5 – Applications of Life Insurance

"Financial planning is the process of identifying a person's financial goals, evaluating existing resources and designing the financial strategies that help the person to achieve those goals". Financial Planning is the process

of examining a client's personal situation, financial resources, financial objectives and financial problems in a comprehensive manner, developing an impartial, integrated plan to utilise the resources to meet objectives and solve problems, taking the steps to implement that plan once approved by the client, and monitoring the plan performance to take corrective action as necessary to assure that results match the plan projections". Financial planning is the process of meeting life goals through the proper management of finances". Life goals can include buying a home, Children's education or planning for retirement.

Lesson 6 - Life Insurance – Finance

As per Section 129 of the Companies Act, the Financial Statements of any Company shall give a true and fair view and shall comply with the Accounting Standards as notified under Section 133 of the Companies Act, 2013. Under Section 133 of the said Act, the Central Government have prescribed the Accounting Standards of the Institute of Chartered Accountants of India for compliance with Accounting Standards as specified in Section 129.

Lesson 7 - Health Insurance

Health insurance is insurance that covers the whole or a part of the risk of a person incurring medical expenses, spreading the risk over a large number of persons. By estimating the overall risk of health care and health system expenses over the risk pool, an insurer can develop a routine finance structure, such as a monthly premium or payroll tax, to provide the money to pay for the health care benefits specified in the insurance agreement. The benefit is administered by a central organization such as a government agency, private business, or not-for-profit entity. Health insurance in India typically pays for only inpatient hospitalization and for treatment at hospitals in India. Outpatient services were not payable under health policies in India. The first health policies in India were Mediclaim Policies. In Year 2000, Government of India liberalized insurance and allowed private players into the insurance sector. The advent of private insurers in India saw the introduction of many innovative products like family floater plans, top-up plans, critical illness plans, hospital cash and top up policies.

Lesson 8 - General Insurance – Practices and Procedures

In today's age of consumerism, insurance requirements have expanded to keep pace with the increasing risks. Gone are the days when life insurances ruled the roost; today we have a wide assortment of risk coverage commencing from health insurance to travel insurance to theft insurance to even a wedding, film or event cancellation insurance. With affluence and spending capacity on the surge there is a growing trend to fulfill needs, deal with responsibilities and secure one's possessions, be it good health or worldly wealth. General insurance companies have willingly catered to these increasing demands and have offered a plethora of insurance covers that almost cover anything under the sun. General insurance products and services are being offered as package policies offering a combination of the covers mentioned above in various permutations and combinations. There are package policies specially designed for householders, shopkeepers, industrialists, agriculturists, entrepreneurs, employees and for professionals such as doctors, engineers, chartered accountants etc. Apart from standard covers, General insurance companies also offer customized or tailor-made policies based on the personal requirements of the customer.

Lesson 9 – Fire & Consequential Loss Insurance

A fire insurance is a contract under which the insurer in return for a consideration (premium) agrees to indemnify the insured for the financial loss which the latter may suffer due to destruction of or damage to property or goods, caused by fire, during a specified period. The contract specifies the maximum amount, agreed to by the parties at the time of the contract, which the insured can claim in case of loss. This amount is not , however , the measure of the loss. The loss can be ascertained only after the fire has occurred. The insurer is liable to make good the actual amount of loss not exceeding the maximum amount fixed under the policy.

Any property damage, due to break down of the machinery/electronic equipment or explosion of a boiler covered under the respective material damage policies, there may be an interruption in the operations and leading to loss of gross profits during such interruption periods. Such loss of gross profit is covered under business interruption policies.

Lesson 10 - Marine Insurance

A contract of marine insurance is an agreement whereby the insurer undertakes to indemnify the insured, in the manner and to the extent thereby agreed, against transit losses, that is to say losses incidental to transit. Marine insurance plays an important role in domestic trade as well as in international trade. Most contracts of sale require that the goods must be covered, either by the seller or the buyer, against loss or damage. The normal practice in export /import trade is for the exporter to ask the importer to open a letter of credit with a bank in favour of the exporter. As and when the goods are ready for shipment by the exporter, he hands over the documents of title to the bank and gets the bill of exchange drawn by him on the importer, discounted with the bank. In this process, the goods which are the subject of the sale are considered by the bank as physical security against the monies advanced by it to the exporter. A further security by way of an insurance policy is also required by the bank to protect its interests in the event of the goods suffering loss or damage in transit, in which case the importer may not make the payment. The terms and conditions of insurance are specified in the letter of credit.

Lesson 11 - Agriculture Insurance

India's heart beats in the rural segment where more than half of our population lives and toils to enrich our country. Agriculture and rural insurance schemes are very important for the people living in the rural sectors. These schemes provide the economic security to the people against the perils such as floods, fire, etc. Agriculture Insurance Company Of India Limited was incorporated on 20th December, 2002 to exclusively cater to the insurance needs of the farming community.

Lesson 12 - Motor Insurance

Motor third-party insurance or third-party liability cover, which is sometimes also referred to as the 'act only' cover, is a statutory requirement under the Motor Vehicles Act. It is referred to as a 'third-party' cover since the beneficiary of the policy is someone other than the two parties involved in the contract i.e. the insured and the insurance company. The policy does not provide any benefit to the insured; however it covers the insured's legal liability for death/disability of third party loss or damage to third party property.

Lesson 13 - Liability Insurance

Liability insurance is a part of the general insurance system of risk financing to protect the purchaser (the "insured") from the risks of liabilities imposed by lawsuits and similar claims. It protects the insured in the event he or she is sued for claims that come within the coverage of the insurance policy. There are several types of liability insurances which includes Public Liability insurance, Product Liability insurance, Professional Liability Insurance, Directors and Officers Liability Insurance (D&O), Lift (Third Party) Insurance.

Lesson 14 - Aviation Insurance

The aviation industry is susceptible to a series of risks and threats, especially with respect to technical operations of an aircraft, and the associated dangers. Aviation insurance is a specialised insurance which has been formulated to provide coverage to the specific operations of an aircraft and other possible risks in aviation. This type of insurance is quite different from other types of transportation insurance. The clauses, terms, limits in aviation insurance are quite unique.

Lesson 15 – Risk Management

Risk, in insurance terms, is the possibility of a loss or other adverse event that has the potential to interfere with an organization's ability to fulfill its mandate, and for which an insurance claim may be submitted'. Risk management ensures that an organization identifies and understands the risks to which it is exposed. Risk management also guarantees that the organization creates and implements an effective plan to prevent losses or reduce the impact if a loss occurs. A risk management plan includes strategies and techniques for recognizing and confronting these threats. Good risk management doesn't have to be expensive or time consuming.

Lesson 16 – Corporate Governance for Insurance Companies

Corporate Governance may be defined as a set of systems, processes and principles which, while enabling conduct of business within the applicable regulatory norms, ensure that a company is governed in the best interest of all stakeholders. It is the system by which companies are directed and controlled. It is about promoting corporate fairness, transparency and accountability. Corporate Governance involves regulatory and market mechanisms and the roles and relationships between a company's management, its board, its shareholders and other stakeholders and the goals for which the Company is governed.

LIST OF RECOMMENDED BOOKS

INSURANCE – LAW & PRACTICE

BOOKS FOR READINGS

1. M. N. Srinivasan : Principles of Insurance Law, Wadhwa & Co.
2. Rajiv Jain : Insurance Law and Practice, Vidhi Publication Private Limited
3. Taxmann : Insurance Manual, Taxmann Publication Private Limited
4. Bharat : Manual of insurance Laws, Bharat Publication Private limited
5. Dr. Avtar Singh : Law of Insurance, Universal Publication Pvt. Limited
6. George E. Rejda : Principles of Risk Management and Insurance

ARRANGEMENT OF STUDY LESSON

Module-3 Elective Paper-9.2

INSURANCE – LAW & PRACTICE

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1.	Concept of Insurance
2.	Regulatory Framework of Insurance Business in India
3.	Life Insurance – Practices
4.	Life Insurance – Underwriting
5.	Applications of Life Insurance
6.	Life Insurance – Finance
7.	Health Insurance
8.	General Insurance - Practices and Procedures
9.	Fire & Consequential Loss Insurance
10.	Marine Insurance
11.	Agricultural Insurance
12.	Motor Insurance
13.	Liability Insurance
14.	Aviation Insurance
15.	Risk Management
16.	Corporate Governance for Insurance Companies

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Lesson 1

Concept of Insurance

LESSON OUTLINE

- Concept of Insurance
- History of Insurance
 - Life Insurance
 - General Insurance
- Insurance Act and Rules
- Role of Regulator
- Stakeholders and Channel Partners
- Insurance Contract
- Insurance Terminologies
- Insurance Products
 - Life Insurance Products
 - Health Insurance Products
 - General Insurance Products
- LESSON ROUND UP
- SELF TEST QUESTIONS

LEARNING OBJECTIVES

We live in a risky world. Forces that threaten our financial well being constantly surround us and are largely outside our control. Some people experience the premature and tragic death of a beloved family member, loss or destruction of their property from both manmade and natural disasters. There is other group of people where there is no accident but are exposed to the traumatic effects of a liability lawsuit.

Insurance is a very technical subject. In many cases, insurance claims are rejected by the Insurance Companies on some technical grounds. So, while dealing in insurance matters, finance professional or an investor should understand the basic concepts and principles of insurance. This lesson has been prepared so as to enable the students to understand:

- The need of studying principles of insurance
- Meaning of insurable interest in insurance agreements and its importance
- Insurance Act and Rules
- Role of Regulator
- Stakeholders and Channel Partners
- Insurance Contract
- Insurance Technologies
- Insurance Products
 - Life Insurance Products
 - Health Insurance Products
 - General Insurance Product

“There is nothing certain in this world except the death and the Tax; yet the Death and Tax are uncertain as no body knows when will he die or when the tax will change” – Benjamin Franklin

CONCEPT OF INSURANCE

Concept of insurance and its evolution

Insurance is form of contract or an arrangement where one party agrees in return for a consideration to pay an agreed amount of money to another party to make good the loss, damage or injury to something of value in which the insured has an interest. Being a contract of indemnity, it is based on the principle of utmost good faith. In today's world, insurance companies offer retail insurance policies of varied nature including life, health, fire, marine, etc. Individuals purchase such policies either in their individual capacity or the employee friendly organizations may extend such cover as perks of the employment.

The business of insurance extends to protection of the economic value of assets. The owner of an asset attaches a value to the property since it gives them some benefit in the form of income or the loss of which could cause irreparable loss to the owner. For example, owning a car for self-use may not give any monetary benefit but it is more for the pleasure of comfort it provides to the owner. If the vehicle is damaged due to say, water logging due to heavy rains, the Car will have only scrap value - a need for covering this risk arises in such unforeseen situations.

Alternatively, a Company which is in the business of transportation may own a fleet of lorries which are given on lease for others who want to transport goods. In this scenario, there could be a reduction on the revenue if there is an accident to the lorry due to which the transportation business is affected - need for insurance as a risk management tool arises.

Similarly, disablement – permanent or temporary nature or a death of a sole breadwinner in a family may bring down the standard of living of the family. Therefore there is a need to give financial protection in the form of monetary compensation on disablement or death of the breadwinner to the members of the family – need for life insurance arises.

In all the above scenarios, the beneficiary (owner himself or the nominee in the case of life insurance) would be compensated.

Therefore, insurance is a tool of risk management to cover the uncertainties – the risk of loss of assets or human life.

EVOLUTION OF INSURANCE

The idea of insurance took birth thousands of years ago. Insurance practices in earlier days used to be based on the concept of 'pooling of risks'. A common fund was created, often at the Village Panchayat or equivalent levels into which small contributions from many people was pooled and the amount so collected be used to compensate for the loss suffered by the unfortunate few out of those who contributed. The contribution to be made by each person is determined on the assumption that while it may not be possible to tell beforehand which person will suffer, it will be possible to tell, on the basis of past experiences, how many persons on an average may suffer losses.

For example, in a Village, there are 500 houses, each valued at ₹200,000. Every year, on an average 4 houses get burnt, resulting into a loss of ₹800,000. If all the 500 house-owners come together and contribute ₹1,600 each, that will be sufficient to cover the risk of up to 4 houses getting damaged on fire. Thus the risk of 4 house-owners gets distributed to 500 house-owners.

In other words, the risk of suffering an economic loss and its consequence could be transferred from one individual to many, through the mechanism of pooling. Thus, insurance is often described as a Risk Transfer through Risk Pooling.

There is an element of uncertainty in life as well as business. Human beings are exposed to various risks such as risk of contracting illnesses, risk of dying through accident or normal death etc. Similarly, a business is also exposed to risks such as destruction of assets by fire and other natural causes, risk of damage to goods during transportation of goods, etc. Therefore insurance evolved as a Risk transfer mechanism to person/entities who have the capacity to undertake the risk.

Over 5,000 years back, Chinese traders used insurance as a preventive measure against piracy. Cargo of each ship used to be distributed among other ships, so that if one ship gets lost or captured by pirates, the loss would only be partial.

The first known written insurance policy was on Babylonian obelisk monument with the code of King Hammurabi. The Hammurabi Code was one of the first forms of written laws. The basic insurance gave the Babylonian traders protection against loss of cargo. If a merchant received a loan to fund his shipment, he would pay the lender an additional sum in exchange for the lender's guarantee to cancel the loan should the shipment be stolen or lost at sea.

The law of general average is a legal principle of maritime law according to which all parties in a sea venture proportionally share any losses resulting from a voluntary sacrifice of part of the ship or cargo to save the whole in an emergency. For instance, when the crew throws some cargo overboard to lighten the ship in a storm. The first codification of general average was the York Antwerp Rules of 1890. American companies accepted in 1949. General average requires 3 elements as follows:

- (i) A common danger in which a vessel, cargo and crew all participate – a danger which is imminent or inevitable, except by voluntarily incurring the loss of a portion of the whole to save the remainder.
- (ii) There must be a voluntary jettison, jactus or casting away of some portion of the joint concern for the purpose of avoiding the imminent peril.
- (iii) Attempts to avoid the imminent common peril must be successful.

In 1666, the Great Fire of London destroyed more than 13,000 houses. To counter such events in future, Fire Office, the first insurance company was started in 1680.

Traders in London used to gather at Lloyd's Coffee House and agree to share losses of goods due to piracy or the ship sinking due to bad weather or other reasons. Edward Lloyds coffee house became recognised as the place for obtaining marine insurance this is where the Lloyds as an Insurance market began. From those beginnings in a coffee house in 1688, Lloyds has been a pioneer in insurance and has grown over 332 years to become the world's leading marketing for specialist insurance.

A contract of insurance is an agreement whereby one party, called the insurer, undertakes, in return for an agreed consideration, called the premium, to pay the other party, namely the insured, a sum of money or its equivalent in kind, upon the occurrence of a specified event resulting in a loss to him. The policy is a document, containing the terms and conditions, which is an evidence of the contract of insurance.

As per Anson, a contract is an agreement enforceable at law made between two or more persons by which rights are acquired by one more persons to certain acts or forbearance on the part of other or others.

The Indian Contract Act, 1872, sets forth the basic requirements of a Contract. As per Section 10 of the Act:

- "All agreements are contracts if they are made by the free consent of parties competent to contract, for a lawful consideration and with a lawful object, and are not hereby expressly declared to be void.....".
- An Insurance policy is also a contract entered into between two parties, viz., the Insurance Company and the Policyholder and fulfills the requirements enshrined in the Indian Contract Act.

HISTORY OF INSURANCE IN INDIA

In India, insurance has a deep-rooted history. It finds mention in the writings of Manu (Manusmriti), Yagnavalkya (Dharmasastra) and Kautilya (Arthashastra). The writings talk in terms of pooling of resources that could be re-distributed in times of calamities such as fire, floods, epidemics and famine. This was probably a pre-cursor to modern day insurance. Ancient Indian history has preserved the earliest traces of insurance in the form of marine trade loans and carriers' contracts. Insurance in India has evolved over time heavily drawing from other countries, England in particular. Now, we will be discussing in brief about the history of Life Insurance and General Insurance in India.

Life Insurance

Year 1818 saw the advent of life insurance business in India with the establishment of the Oriental Life Insurance Company in Calcutta. This Company however failed in 1834. In 1829, the Madras Equitable had begun transacting life insurance business in the Madras Presidency. 1870 saw the enactment of the British Insurance Act and in the last three decades of the nineteenth century, the Bombay Mutual (1871), Oriental (1874) and Empire of India (1897) were started in the Bombay Residency. This era, however, was dominated by foreign insurance offices which did good business in India, namely Albert Life Assurance, Royal Insurance, Liverpool and London Globe Insurance and the Indian offices were up for hard competition from the foreign companies.

In 1914, the Government of India started publishing returns of Insurance Companies in India. The Indian Life Assurance Companies Act, 1912 was the first statutory measure to regulate life business. In 1928, the Indian Insurance Companies Act was enacted to enable the Government to collect statistical information about both life and non-life business transacted in India by Indian and foreign insurers including provident insurance societies. In 1938, with a view to protecting the interest of the Insurance public, the earlier legislation was consolidated and amended by the Insurance Act, 1938 with comprehensive provisions for effective control over the activities of insurers.

The Insurance Amendment Act of 1950 abolished Principal Agencies. However, there were a large number of insurance companies and the level of competition was high. There were also allegations of unfair trade practices. The Government of India, therefore, decided to nationalize insurance business.

An Ordinance was issued on 19th January 1956 nationalising the Life Insurance sector and Life Insurance Corporation came into existence in the same year. The LIC absorbed 154 Indian, 16 non-Indian insurers as also 75 provident societies—245 Indian and foreign insurers in all. The LIC had monopoly till the late 90s when the Insurance sector was reopened to the private sector.

General Insurance

The history of general insurance dates back to the Industrial Revolution in the west and the consequent growth of sea-faring trade and commerce in the 17th century. It came to India as a legacy of British occupation. General Insurance in India has its roots in the establishment of Triton Insurance Company Ltd., in the year 1850 in Calcutta by the British. In 1907, the Indian Mercantile Insurance Ltd, was set up. This was the first company to transact all classes of general insurance business.

1957 saw the formation of the General Insurance Council, a wing of the Insurance Association of India. The General Insurance Council framed a code of conduct for ensuring fair conduct and sound business practices. In 1968, the Insurance Act was amended to regulate investments and set minimum solvency margins. The Tariff Advisory Committee was also set up then.

In 1972 with the passing of the General Insurance Business (Nationalisation) Act, general insurance business

was nationalised with effect from 1st January, 1973. 107 insurers were amalgamated and grouped into four companies, namely National Insurance Company Ltd., the New India Assurance Company Ltd., the Oriental Insurance Company Ltd. and the United India Insurance Company Ltd. The General Insurance Corporation of India was incorporated as a company in 1971 and it commence business on January 1st 1973.

Recently, the Central Government has proposed merger of 3 Public Sector General Insurance Companies, except New India Assurance Company Limited, paving the way for consolidation in Government-run general insurance companies.

REGULATION OF INSURANCE BUSINESS IN INDIA

This millennium has seen insurance come a full circle in a journey extending to nearly 200 years. The process of re-opening of the sector had begun in the early 1990s and the last decade and more has seen it been opened up substantially. In 1993, the Government set up a committee under the chairmanship of RN Malhotra, former Governor of RBI, to propose recommendations for reforms in the insurance sector. The objective was to complement the reforms initiated in the financial sector. The committee submitted its report in 1994 wherein, among other things, it recommended that the private sector be permitted to enter the insurance industry. They stated that foreign companies be allowed to enter by floating Indian companies, preferably a joint venture with Indian partners.

Following the recommendations of the Malhotra Committee report, in 1999, the Insurance Regulatory and Development Authority (IRDA) was constituted as an autonomous body to regulate and develop the insurance industry. The IRDA was incorporated as a statutory body in April, 2000. The key objectives of the IRDA include promotion of competition so as to enhance customer satisfaction through increased consumer choice and lower premiums, while ensuring the financial security of the insurance market.

The IRDA opened up the market in August 2000 with the invitation for application for registrations. Foreign companies were allowed ownership of up to 26% in the equity share capital of the Insurer. This limit was later raised to 49% during the year 2016. The limit of foreign investments in intermediaries has increased from 49% to 100% in year 2019. The Authority has the power to frame regulations under Section 114A of the Insurance Act, 1938 and has from the year 2000 onwards various regulations ranging from registration of companies for carrying on insurance business to protection of policyholders' interests were framed.

In December, 2000, the subsidiaries of the General Insurance Corporation of India were restructured as independent companies and at the same time GIC was converted into a national re-insurer. Parliament passed a bill de-linking the four subsidiaries from GIC in July, 2002.

Today there are 31 General Insurance Companies including 7 Health Insurance Companies and 24 Life Insurance Companies operating in the country.

Beside IRDA Act, 1999 and Insurance Act, 1938, there are some common Act/Regulation to the General and Life Insurance Business in India and some Acts have been made for specific requirement of Life Insurance/ General Insurance.

Acts/Regulations Governing Both Life & General Insurance Business in India

The following Acts regulate the Insurance Business in India:

- Insurance Act, 1938.
- IRDA Act, 1999 & Regulations passed thereunder.
- Insurance Amendment Act, 2002.

6 PP-IL&P

- Exchange Control Regulations (FEMA).
- Indian Stamp Act, 1899.
- Consumer Protection Act, 1986.
- Insurance Ombudsman Rules, 2017.
- Labour Law legislations.

Regulations Governing/Affecting Life Insurance Business in India

The following Acts govern/regulate the life insurance business in India:

1. LIC Act, 1956.
2. Amendments to LIC Act.

Regulations affecting General Insurance Business in India

The following Acts affect, circumscribe or regulate in some way or the other, some aspect of the General Insurance Business in India:

- General Insurance Nationalization Act, 1972.
- Amendments to GIN Act, 1972.
- Multi-Modal Transportation Act, 1993.
- Motor Vehicles Act, 1988.
- Inland Steam Vessels Amendment Act, 1977.
- Marine Insurance Act, 1963.
- Carriage of Goods by Sea Act, 1925.
- Merchant Shipping Act, 1958.
- Bill of Lading Act, 1855.
- Indian Ports (Major Ports) Act, 1963.
- Indian Railways Act, 1989.
- Carriers Act, 1865.
- Indian Post Office Act, 1898.
- Carriage by Air Act, 1972.
- Public Liability Insurance Act, 1991.
- Employee State Insurance Act, 1948
- Aircraft Act, 1934.

Role of Regulator

Insurance Regulatory and Development Authority of India ('IRDAI') is the Regulator for Insurance Companies operating in India. The mission of IRDAI is to protect the interests of Policyholders and to promote orderly growth of the Indian insurance industry. Every Insurance Company will have to register themselves with

IRDAI and obtain a Certificate of registration for doing insurance business in India. Besides the Insurance Companies, IRDAI also regulates the Insurance Intermediaries like Corporate Agents, Insurance Brokers and other intermediaries by requiring them to have a Certificate of registration before they start doing any insurance solicitation. IRDAI have issued many Regulations and Guidelines under the framework provided under the Insurance Act, 1938. They have powers of inspection and investigation and to prevent any insurer or intermediary to stop doing business if it is expedient to do so in the interests of the Policyholders or in Public interest.

The Insurance Market

An Insurance Marketing typically comprises of the following three stakeholders:

- Policy holder
- Insurance Agent, Intermediary or Insurance Intermediary
- Insurance Company/Insurer

Policyholder is the Customer to whom the Policy is issued. The Policyholder can be an Individual Policyholder or a Corporate Policyholder. Individual Policyholders are also called the Retail segment and constitutes the biggest chunk of Customers. For example, during the year 2016-17, all Life insurance companies issued 264.20 lakh Policies to various individual Policyholders. Corporate Policyholders comprise of Business entities that purchase insurance cover for various business needs. In the Life insurance segment it can be Group Term Life Insurance policies, Group Superannuation Policies, Group Credit Life Policies.

Insurance companies/Insurers

Insurance companies provide the service of insurance coverage to the Policyholders. They accept the premiums from the Policyholders who take Insurance Policies through the registered intermediaries and provide the Insurance cover by issuing Insurance Policy documents, which constitute the contract between the Insurance companies and the Policyholders. Insurance Policy specifies various terms and conditions governing the insurance coverage.

Upon happening of the insured event, the Claim amount is paid to the Policyholder. For example, in the case of a Life Insurance Policy, upon death of the Life assured (the person whose life is covered), the Sum Assured (which is a lump sum) is paid to the Nominee (who is appointed at the time of making application for insurance by the Policyholder).

Similarly, in the case of Vehicle Insurance (also called Motor insurance), upon accident to say, the Motor car, an assessment of the loss is undertaken, and the actual amount of loss in terms of the policy conditions is reimbursed as per the Policy document.

In case of a Motor Third Party Claim (A Motor vehicle hitting another third person), the Claim is paid to the injured person or the nominee in case of the accident results in death of the third person.

Insurance contract

A contract of insurance is an agreement whereby one party, called the insurer, undertakes, in return for an agreed consideration, called the premium, to pay the other party, namely the insured, a sum of money or its equivalent in kind, upon the occurrence of a specified event resulting in a loss to him. The policy is a document which is an evidence of the contract of insurance.

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As per Anson, a contract is an agreement enforceable at law made between two or more persons by which rights are acquired by one more persons to certain acts or forbearance on the part of other or others.

The Indian Contract Act, 1872, sets forth the basic requirements of a Contract. As per Section 10 of the Act:

- “All agreements are contracts if they are made by the free consent of parties competent to contract, for a lawful consideration and with a lawful object, and are not hereby expressly declared to be void.....”.
- An Insurance policy is also a contract entered into between two parties, viz., the Insurance Company and the Policyholder and fulfills the requirements enshrined in the Indian Contract Act.

Essentials of a valid Insurance contract

1. **Proposal:** When one person signifies to another his willingness to do or to abstain from doing anything, with a view to obtaining the assent of that other to such act or abstinence, he is said to make a proposal (“Promisor”).

In Insurance parlance, a Proposal form (also called application for insurance) is filled in by the person who wants to avail insurance cover giving the information required by the insurance company to assess the risk and arrive at a price to be charged for covering the risk (called “premium). The insurance company, based on the information furnished in the proposal form, assesses the risk (also called underwriting), and conveys the decision – if accepted, at what premium and on what terms and conditions. This is also called “counter offer” in insurance terminology by the insurance company to the Customer. A medical examination is also conducted, where necessary, before making the counter offer.

Where the insurance company cannot accept the risk, the proposal is declined. Where the insurance company conveys its decision to accept the risk quoting a premium, a proposal is made.

2. **Acceptance:** When a person to whom the proposal is made, signifies his assent thereto, the proposal is said to be accepted (“Promisee”). A proposal, when a accepted, becomes a promise;
3. **Consideration:** When, at the desire of the promisor, the promisee or any other person has done or abstained from doing, or does or abstains from doing, or promises to do or to abstain from doing, something, such act or abstinence or promise is called a consideration for the promise;

As can be seen from the above, amount equal to Premium paid by the Customer becomes the consideration for the contract.

Every promise and every set of promises, forming the consideration for each other, is an agreement;

4. **Competency to contract:** Every person is competent to contract who is of the age of majority according to the law to which he is subject, and who is sound mind and is not disqualified from contracting by any law to which he is subject.

In the case of Insurance the person with whom the Contract is entered into is called “Policyholder” or “Policy Owner” who could be different from the subject matter which is insured. In Life insurance contracts, for example, the person whose life is insured could be different. For example, the Policyholder could be the Father and the Life assured could be the son. In the case of Fire insurance, the Policy owner could be the Owner of a building and the subject matter of insurance would be the building itself.

The Policyholder must have attained the age of majority at the time of signing the proposal and should be of sound mind and not disqualified under any law. However, the life assured could suffer from the above infirmities.

5. **Consensus ad idem:** Two or more person are said to consent when they agree upon the same thing in the same sense.

Both the insurance company and the Policyholder must agree on the same thing in the same sense. The Policy document issued to the Policyholder (“Customer”) clearly defines the obligations of the insurer and the terms and conditions upon which the Insurance contract is issued.

Free consent: Consent is said to be free when it is not caused by –

1. Coercion, or
2. Undue influence or
3. Fraud, or
4. Misrepresentation, or
5. Mistake

The third and fourth grounds which vitiate consent are more relevant in insurance. Insurance contracts are based on the principles of ‘utmost good faith’. The Policyholder is expected to disclose about the status of his health, family history, income, occupation or about the subject matter insured truthfully without concealing any material fact to enable the underwriter to assess the risk properly. In case it is established by the insurance company that the Policyholder did not truthfully disclose any fact in the Proposal form which had a material impact on the decision of the underwriter, the insurance company has a right to cancel the contract.

When consent to an agreement is caused by coercion, fraud or misrepresentation, the agreement is a contract voidable at the option of the party whose consent was so caused.

6. **Lawful object:** The consideration or object of an agreement must be lawful, The consideration or object of an agreement is unlawful under the following circumstances:

- (a) Where a contract is forbidden by law; or
- (b) Where the contract is of such nature that, if permitted, it would defeat the provisions of any law or is fraudulent;
- (c) Where the contract involves or implies, injury to the person or property of another; or
- (d) Where the Court regards it as immoral, or opposed to public policy. Every agreement of which the object or consideration is unlawful is void.

The object of an insurance contract, i.e. to cover the risk by taking out an insurance policy, is a lawful object.

7. **Agreement must not be in restraint of trade or legal proceedings:** Every agreement by which anyone is restrained from exercising a lawful profession, trade or business of any kind, is to that extent void. Every agreement, by which any party thereto is restricted absolutely from enforcing his rights under or in respect of any contract, by the usual legal proceedings in the ordinary tribunals, or which limits the time within which he may thus enforce his rights, is void to the extent.
8. **Agreement must be certain and not be a wagering contract:** Agreements, the meaning of which is not certain, or capable of being made certain, are void. Agreements by way of wager are void; and no suit shall be brought for recovering anything alleged to be won on any wager, or entrusted to any person to abide the result of any game or other uncertain event on which may wager is made.

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Anson defined wager as “a promise to give money or money’s worth upon the determination or ascertainment of an uncertain event”. For example, if A agrees to pay B ₹1,000, if it rains tomorrow, it becomes a gambling, since there is no certainty that it will rain tomorrow. A wagering contract is void, it is not illegal. Further a contingent contract is defined under Section 31 of the Act as “a contract to do or not to do something, if some event collateral to such contract, does or does not happen”. For example, A contracts to pay B ₹10,000 if B’s house is burnt. This is a contingent contract. An insurance contract is a contingent contract and the example given above is nothing but Fire insurance. While all Wagering contracts are Contingent contracts, Section 30 of the Act has declared all Wagering contracts to be void.

Features of an Insurance Contract

Though all contracts share fundamental concepts and basic elements, insurance contracts typically possess a number of characteristics not widely found in other types of contractual agreements. The most common of these features are listed here:

(a) Aleatory

If one party to a contract might receive considerably more in value than he or she gives up under the terms of the agreement, the contract is said to be aleatory. Insurance contracts are of this type because, depending upon chance or any number of uncertain outcomes, the insured (or his or her beneficiaries) may receive substantially more in claim proceeds than was paid to the insurance company in premium. On the other hand, the insurer could ultimately receive significantly more money than the insured party if a claim is never filed. However, Insurance contracts are based on the concept of “pooling of risks”. While Insurance companies may pay claim in some cases, it may not pay claim in many other cases. On an overall basis, if the Premiums received are sufficient to cover the remuneration paid to intermediaries, expenses, management expenses, profit-margins as well as Claims, insurance business would be viable.

(b) Adhesion

In a contract of adhesion, one party draws up the contract in its entirety and presents it to the other party on a ‘take it or leave it’ basis; the receiving party does not have the option of negotiating, revising, or deleting any part or provision of the document. Insurance contracts are of this type, because the insurer writes the contract and the insured either ‘adheres’ to it or is denied coverage. In a court of law, when legal determinations must be made because of ambiguity in a contract of adhesion, the court will render its interpretation against the party that wrote the contract. Typically, the court will grant any reasonable expectation on the part of the insured (or his or her beneficiaries) arising from an insurer-prepared contract.

(c) Utmost good faith

Although all contracts ideally should be executed in good faith, insurance contracts are held to an even higher standard, requiring the utmost of this quality between the parties. Due to the nature of an insurance agreement, each party needs - and is legally entitled - to rely upon the representations and declarations of the other. Each party must have a reasonable expectation that the other party is not attempting to defraud, mislead, or conceal information and is indeed conducting themselves in good faith. In a contract of utmost good faith, each party has a duty to reveal all material information (that is, information that would likely influence a party’s decision to either enter into or decline the contract), and if any such data is not disclosed, the other party will usually have the right to void the agreement.

(d) Executory

An executory contract is one in which the covenants of one or more parties to the contract remain partially or completely unfulfilled. Insurance contracts necessarily fall under this strict definition; of course, it's stated in the insurance and agreement that the insurer will only perform its obligation after certain events take place (in other words, losses occur).

(e) Unilateral

A contract may either be bilateral or unilateral. In a bilateral contract, each party exchanges a promise for a promise. However, in a unilateral contract, the promise of one party is exchanged for a specific act of the other party. Insurance contracts are unilateral in nature; the insured performs the act of paying the policy premium, and the insurer promises to reimburse the insured for any covered losses that may occur. It must be noted that once the insured has paid the policy premium, nothing else is required on his or her part; no other promises of performance were made. Only the insurer has covenanted any further action, and only the insurer can be held liable for breach of contract.

(f) Conditional

A condition is a provision of a contract which limits the rights provided by the contract. In addition to being executory, aleatory, adhesive, and of the utmost good faith, insurance contracts are also conditional. Even when a loss is suffered, certain conditions must be met before the contract can be legally enforced. For example, the insured individual or beneficiary must satisfy the condition of submitting to the insurance company sufficient proof of loss, or prove that he or she has an insurable interest in the person insured.

There are two basic types of conditions: conditions precedent and conditions subsequent. A condition precedent is any event or act that must take place or be performed before the contractual right will be granted. For instance, before an insured individual can collect medical benefits, he or she must become sick or injured. Further, before a beneficiary will be paid a death benefit, the insured must actually become deceased. A condition subsequent is an event or act that serves to cancel a contractual right. A suicide clause is an example of such a condition. Typical suicide clauses cancel the right of payment of the death benefit.

(g) Personal contracts

Insurance contracts are usually personal agreements between the insurance company and the insured individual, and are not transferable to another person without the insurer's consent. (Life insurance and some maritime insurance policies are notable exceptions to this standard.) As an illustration, if the owner of a car sells the vehicle and no provision is made for the buyer to continue the existing car insurance (which, in actuality, would simply be the writing of the new policy), then coverage will cease with the transfer of title to the new owner.

(h) Warranties and Representations

A warranty is a statement that is considered guaranteed to be true and, once declared, becomes an actual part of the contract. Typically, a breach of warranty provides sufficient grounds for the contract to be voided. Conversely, a representation is a statement that is believed to be true to the best of the other party's knowledge. In order to void a contract based on a misrepresentation, a party must prove that the information misrepresented is indeed material to the agreement. According to the laws of most states and in most circumstances, the responses that a person gives on an insurance application are considered to be a representations, and not warranties.

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As an example, consider an individual seeking life insurance coverage. He or she would routinely be required to complete an application, on which the applicant's sex and age would be requested. The accuracy of this information is necessary for the insurer to correctly ascertain its risk and determine the policy premium. If the applicant gives these responses incorrectly, they would likely be deemed (in the absence of outright fraud) as misrepresentations, and could possibly be used by the insurance company as grounds for voiding the policy.

There is, however, a difference between the representation (or misrepresentation) of a fact and the expression of an opinion. Take, for instance, a common insurance application question such as, "To the best of your knowledge, do you now believe yourself to be in good health?" An applicant answering 'yes' while knowing that he or she suffers from a particular condition would be guilty of misrepresenting an actual fact. However, if the applicant had no symptoms of any kind that would be recognizable to an average person and no doctor's opinion to the contrary, he or she would simply be stating an opinion and not making a misrepresentation.

(i) Misrepresentations and Concealments

A misrepresentation is a statement, whether written or oral, that is false. Generally speaking, in order for an insurance company to void a contract because of misrepresented information, the information in question must be material to the decision to extend coverage.

Concealment, on the other hand, is the failure to disclose information that one clearly knows about. To void a contract on the grounds of concealment, the insurer typically must prove that the applicant willfully and intentionally concealed information that was of a material nature.

(j) Fraud

Fraud is the intentional attempt to persuade, deceive, or trick someone in an effort to gain something of value. Although misrepresentations or concealments may be used to perpetrate fraud, by no means are all misrepresentations and concealments acts of fraud. For instance, if an insurance applicant intentionally lies in order to obtain coverage or make a false claim, it could very well be grounds for the charge of fraud. However, if an applicant misrepresents some piece of information with no intent for gain (such as, for example, failing to disclose a medical treatment that the applicant is personally embarrassed to discuss), then no fraud has occurred.

(k) Impersonation (false pretenses)

When one person assumes the identity of another for the purpose of committing a fraud, that person is guilty of the offense of impersonation (also known as false pretenses). For instance, an individual that would likely be turned down for insurance coverage due to questionable health might request a friend to stand in for him (or her) in order to complete a physical examination.

(l) Parol (or Oral) evidence rule

This principle limits the effects that oral statements made before a contract's execution can have on the contract. The assumption here is that any oral agreements made before the contract was written were automatically incorporated into the drafting of the contract. Once the contract is executed, any prior oral statements will therefore not be allowed in a court of law to alter or counter the contract.

Insurance Terminologies

Proposal (or) Proposal form denotes the application for insurance contains which solicits information from the **Proposer to enable the Insurer** to take a decision on whether to accept the risk or not.

Proposer is the person who submits Proposal form for insurance to the insurance company and who is interested in taking an Insurance Policy.

Underwriting is the process of assessment of risk on a proposal by the Insurance company and arriving at the decision (to accept, reject, rate-up, postpone) and the terms and conditions upon which an insurance contract may be accepted.

Policyholder is the person who is issued an Insurance Policy document by the Insurance Company consequent to underwriting and issuance of Insurance Policy to cover the risk stated in the Proposal form on such terms and conditions as mentioned in the Insurance Policy document issued by the Insurer to the Policyholder.

Insurance Policy document (or) Policy document (or) Policy constitutes the contract between the Insurance company and the Policyholder, stating the terms and conditions of the Insurance coverage provided by the Insurance company to the Policyholder.

Subject matter of insurance is the Person or object upon whose loss or upon the loss of which object the insurance company agrees to pay a specified sum as the compensation to the Policyholder.

Life insured (or) Life assured under a Life insurance Policy is the subject matter of insurance on whose death a specified sum of money is paid by the Life insurance company.

A Policyholder and Life assured may be the same person or different persons. Where a person takes a Policy on his own life, both Policyholder and Life assured constitute the same person. Where a Policyholder takes a Policy on another's person's life (on whom the Policyholder has insurable interest), the Policyholder and Life assured can be different persons.

Sum Assured (or) Sum Insured means the amount promised to be paid by the Insurer upon the death of the Life insured.

Nominee is the person appointed, only for Policies taken on one's own Life, by the Policyholder to receive the Sum Assured or any other policy benefit upon death of the Life assured.

Where Policyholder and Life assured are different persons, upon death of the Life assured, the Policyholder is the person entitled to receive the Sum assured or other Policy benefits.

In General insurance, since the subject matter of insurance can be anything other than one's life, the Policyholder always receives the benefit upon loss or damage to the subject matter of insurance, subject to establishing the insurable interest at the time of claim.

Counter offer denotes the extra premium proposed by the Insurer upon underwriting the proposal to accommodate for the extra risk taken by the insurance company on a Proposal.

Benefits illustration is the document provided to the Policyholder at the point of sale giving the details of premiums payable by the Policyholder year-wise along with the benefits payable at the end of each Policy year. This is provided to Policyholder before a sale is completed and signed by the Policyholder in confirmation of his/her understanding of the Policy benefits.

Assignment is transfer of Insurance Policies to another person with or without consideration.

Mortality is the rate of death of the population. It is usually calculated for every thousand of population. The Mortality Table of Indian Assured lives is published based on the investigation of mortality of Indian lives and this Table forms the basis for calculation of premiums for Life insurance Policies.

Morbidity measures the rate of contraction of illnesses by the population and serves as the basis for calculation of premiums under Health insurance policies and Critical illness benefits.

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Annuity is a series of regular and periodic payment payable in consideration of usually a lump sum. For example, under Pension Policies, upon the attainment of superannuation age, the corpus available is utilised to purchase a Single premium (lump sum) Annuity Policy under which the Policyholder gets a periodic payout on a monthly basis till his survival.

Annuities are also life insurance policies as they cover the risk of living longer and the continuation of benefits payable is contingent upon human life.

Participating products (With profits products) are Life insurance products which are eligible for Policyholder bonus as and when declared. A bonus is declared to Policyholder if there is a surplus which emerges from the Participating line of business and is decided by the Appointed Actuary. If a Policyholder takes a Life insurance product which is eligible for bonus, he/she is eligible, along with other such Policyholders, to a share in the surplus – not less than 90% of the Surplus emerging in Participating business shall be distributed as Bonus and the balance 10% goes to the Shareholders as their share in the business. While such bonuses are declared every year, a Reversionary bonus is payable only upon death or maturity. However, a Life insurer may declare an Interim cash bonus as well.

Under Participating products, share in the surplus mentioned above, are in addition to the guaranteed benefits payable (upon death or maturity, as the case may be).

Non participating products (Without profits products) are those Life insurance products which are not eligible for any surplus and are eligible only for the guaranteed benefits payable upon death, survival etc.

Linked Insurance products are those life insurance products which combine a Term insurance policy with investments. Under Linked insurance products, the benefits payable are a Sum Assured on death plus the marked-to-market value of the investments made on behalf of the Policyholder by the Life Insurance Company. The risk on investments portion is borne by the Policyholder and not by the Life Insurance Company.

Individual insurance products are Insurance Policy contracts entered into directly by the Individual Policyholder with the Insurance company. This can be compared for example, with equity shares directly purchased in the secondary market by an Investor.

Group insurance products are Insurance Policy contracts entered into by an Organisation with the Insurance Company. The organisation covers the members of the Group under the Group insurance policy by contributing premiums to the Insurance company who in turn provides benefits upon death or other contingencies covered under the Group Policy, to the Nominee or beneficiary.

For example, a Bank, as a Lender, may take a Group insurance policy with a Life insurer for covering all the borrowers to whom it has lent money. Upon death of the borrower, the Sum assured to the extent of outstanding loan is paid to the Bank, and the balance, if any, is paid to the Nominee of the deceased borrower.

A group insurance policy can be compared to a Mutual fund, under which the subscribers contribute to a Mutual fund which pools the contributions and invests on behalf of the unit holders.

LIFE ASSURANCE PRODUCTS

Term Insurance Product

These are pure life insurance products where the benefit (lump sum) is payable only on the happening of death during the term of the life insurance policy. These policies cover the risk of dying early and provide a lump sum to the Nominee (usually a Family member) to take care of their future needs.

In case the Life assured survives the Term of the Policy, nothing is payable. However, there are options available for return of premiums paid in case the Life assured survives the term of the Policy. These Policies are taken for a fixed term.

Premiums under Term insurance products are relatively the lowest as they do not have any savings component. This is the cheapest of all the Life insurance policies. Premium depends upon the age of the life insured. Higher the age, higher the premium, as the risk taken by the life insurance company increases with age.

Term insurance policies are still not popular as the level of insurance awareness in India is very low. Generally, Policyholders expect a benefit payable during their lifetime. Since Term insurance products do not provide any benefit during survival of the Life assured (except for Return of premiums upon survival till the end of the term of the Policy), these products are still unpopular.

Whole Life Insurance Products

As the name suggests, whole life insurance products cover the risk of dying early till the person's death, as compared to a Term where the risk coverage is available only till the expiry of the term mentioned in the Policy, say 5 years, 10 years, 15 years etc., as chosen by the Policyholder.

Essentially, Whole Life insurance products are extensions of Term insurance products and also provide benefits (usually lump sum) payable only on the death of the life assured. But the coverage is available through out the life. However, generally across various life insurance companies, where the life assured attains the age of 85, the Sum assured is paid to the Policyholder if he/she survives age 85. In case of Participating products, bonuses are also paid.

For the reasons mentioned under Term insurance products, even Whole Life insurance products are also not popular.

Endowment Products

Under Endowment products, the benefits (Sum assured) are payable either upon death during the term of the Policy or if the Life assured survives the maturity of the Policy, upon maturity of the policy, whichever is earlier. Therefore, at the end of the Policy term, in case the Life assured survives, the Policyholder gets a lump sum benefit. In case of Participating products, the Bonuses declared are also paid upon the death or maturity (reversionary bonuses).

Money Back Products

These are extensions of Endowment products where under, the Policyholder is entitled to periodic payouts, if he survives specified terms during the tenure of the Policy. For example, if the Life assured survives 10 years from the date of taking the Policy, 25% of the Sum Assured shall be paid, 50% at the end of 15 years and the balance on Maturity. Under these products, the Sum Assured, instead of being paid only upon survival on maturity, is accelerated and paid in installments. However, in the event of death anytime during the term of the Policy, full Sum Assured is paid, irrespective of the installments that may have been paid already.

Annuity Products

Annuities are periodic (usually monthly) payouts made in consideration of a lump sum amount deposited in the beginning of the Policy. Annuity products come in handy for Pension Policies which are used to plan post-retirement income.

For example, under the New Pension Scheme run by Pension Funds Regulatory and Development Authority,

a member of the Scheme saves money through the Scheme by making periodic contribution which is invested by NPS in market-linked instruments and the corpus grows like a mutual fund. Upon the member attaining the age of Superannuation, NPS utilizes the entire lump sum (or up to 2/3rds, if the member wants to commute 1/3 of the corpus) to purchase an annuity policy from a Life insurance company. Thereafter, the Life insurer starts paying an immediate annuity to the purchaser till his/her death (or after his/her death to Spouse etc., depending upon the nature of annuity option).

Linked Life Insurance Products

These are Life insurance products which are a combination of Term insurance plus Investments. Under Linked insurance products, after deducting the premium towards mortality (risk premium) for covering the benefit payable on death, the Life insurer allocates the balance premium available for investments in market-linked instruments (like Mutual fund) and declare Net Asset Value of the investment portion. Life insurer is eligible to deduct charges like Premium allocation charges, Policy administration charges, Fund management charges etc., for administering and managing the investment portion of the premium. On death, the Nominee usually gets the Sum Assured + Fund value on date of death. However, there are other options available. Upon maturity, usually only the Fund value is paid.

Variable Life Insurance Products

These are also called Universal Life Products, which provide a guaranteed interest credits (like a Bank account) in addition to Life insurance cover. These are in the nature of Deposit-linked-life insurance products. However these products are not popular in India.

HEALTH INSURANCE PRODUCTS

Health insurance products cover the risk of hospitalisation and provide financial support upon hospitalisation of the life assured. There are 2 types of health insurance products:

1. Indemnity based health insurance products
2. Fixed benefit based health insurance products

Indemnity based health insurance products are sold by Non-life insurance companies and Standalone health insurance companies. Under these products, the actual amount spent by the Life assured is paid by the Insurance Company within the limits of the Sum assured selected. Either the amount is reimbursed to the Life assured or the amount is paid directly to the Hospital (Cashless scheme) by the Insurance Company

Fixed benefit based health insurance products are usually critical illness policies under which a fixed amount is paid to the Life insured upon proof of hospitalisation and the proof of having spent the money for diagnosis, medicines etc., is usually not insisted.

By definition, Travel insurance is also included in the definition of health insurance products.

GENERAL INSURANCE PRODUCTS

Fire insurance policies cover the risk of loss arising out of unforeseen fire accidents with the limit of the Sum assured. These products are more popular in Corporates than with individuals. They are designed to provide financial protection for property against loss or damage by fire and other specified perils. Reinstatement value clauses are attached to Fire policies under which the amount payable is the cost of reinstating property of the same kind or type, by new property.

Marine insurance policies comprise of Cargo insurance and hull insurance. Cargo insurance provides insurance

cover in respect of loss of or damage to goods during transit by rail, road, sea or air. Hull insurance on the other hand, concerns the insurance of ships (hull, machinery etc.).

Motor insurance

Motor insurance, as the name suggests, is insurance of motor vehicles and are broadly classified as follows:

1. Private Cars
2. Motor cycles and Motor scooters
3. Commercial vehicles – sub divided into Goods carrying vehicles, Passenger carrying vehicles and Miscellaneous vehicles.

Insurance of Motor Vehicles are covered under the Motor Vehicles Act 1939. Insurance of motor vehicles against damage is not made compulsory, but the insurance against third party liability arising out of the use of motor vehicles in public places is made compulsory. Insurance Cover against damage is known as “Own Damages” and against injury or death to a third party is known as “Third Party” claim. No motor vehicle can ply in a public place without such insurance. Recently, pursuant to a Supreme Court decision, all Insurers are mandated to issue Long term policy for Third Party risks- Three years for new private cars and five years for new two wheelers.

Personal Accident Insurance

The Policy provides that, if the insured shall sustain any bodily injury resulting solely and directly from accident caused by external, violent and visible means, then the Insurance company shall pay to the insured or his legal personal representative(s), as the case may be, a Sum assured under the Policy. The Policy covers the contingency of death, loss of body parts and Permanent and Temporary disablements.

Liability Insurance

The purpose of liability insurance is to provide indemnity in respect of damages payable under law for personal liability of any nature. This legal liability may arise under the common law on the basis of negligence or under statutory law (e.g. Public Liability Insurance Act or workman’s Compensation Act) on ‘no fault basis’, i.e. even when there is no negligence.

Engineering Insurance

Engineering insurance covers the various risks in a manufacturing organisation, especially plants. The various categories of Engineering insurance are as follows:

- (a) Contractors All Risks Policy – designed to protect the interests of contractors and principals in respect of civil engineering projects like buildings, bridges, tunnels etc.
- (b) Erection All Risks Policy – is concerned with erection of electrical plant and machinery and equipment and structures involving no or very little civil engineering work.
- (c) Marine-cum-erection Policy – comments with the delivery of the first consignment of plant and machinery at the site of erection.
- (d) Machinery breakdown Policy – Insurable property include boilers, electrical, mechanical and lifting equipment.
- (e) Contractors Plant & Machinery Policy – Policy given to a Contractor who may be using his plant and machinery at different projects during the course of the year.

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- (f) Boiler & Pressure Plant Policy.
- (g) Machinery Loss of Profits Policy or Machinery insurance indemnify an insured against material damage resulting from breakdown or explosion or collapse of machinery – such damage may also result in business interruption at the Insured's premises.
- (h) Advance Loss of Profits Policy – risk of delay of project due to accidental damage to project materials.
- (i) Deterioration of Stock Policy – covers loss due to breakdown of refrigeration.
- (j) Electronic Equipment Policy - physical loss or damage necessitating repairs or replacement.
- (k) External Data Media – covers cost of replacing damaged external storage media.
- (l) Increased cost of working – indemnifies against all additional cost incurred to ensure continued data processing on substitute equipment if such costs are incurred as an unavoidable consequence of loss or damage indemnifiable under material damage section of the policy.

Miscellaneous Insurance

Miscellaneous Insurance products include the following products:

- (a) Burglary insurance
- (b) Householders' Insurance
- (c) Shopkeepers' Insurance
- (d) Bankers' Blanket Policies
- (e) Jewellers' Block Policies
- (f) Blood Stock (Horse) Insurance
- (g) All Risks Insurance Policy – includes jewellery, valuables, antiques, paintings, watches, cameras etc.
- (h) Money insurance – covers the risk of loss of money in transit
- (i) Fidelity guarantees – covers the risk of arising out of dishonesty of employees
- (j) Television insurance
- (k) Pedal cycle insurance
- (l) Plate Glass insurance – breakage of plain glass
- (m) Neon sign insurance

Rural Insurance

Rural insurance includes the following categories of products:

- (a) Cattle Insurance
- (b) Sheep and Goat Insurance
- (c) Poultry Insurance
- (d) Dog Insurance
- (e) Silk Worm Insurance

- (f) Honey Bee Insurance
- (g) Horticulture/Plantation Insurance Scheme
- (h) Comprehensive Floriculture Insurance
- (i) Agriculture Pump set Policy
- (j) Salt Works Insurance
- (k) Cycle Rickshaw Policy
- (l) Animal Driven Cart Insurance
- (m) Gobar Gas Insurance
- (n) Hut Insurance
- (o) Weather/Crop Insurance

LESSON ROUND UP

- Insurance is form of contract or an arrangement where one party agrees in return for a consideration to pay an agreed amount of money to another party to make good the loss, damage or injury to something of value in which the insured has an interest.
- In India, insurance has a deep-rooted history. It finds mention in the writings of Manu (Manusmriti), Yagnavalkya (Dharmasastra) and Kautilya (Arthasastra).
- Year 1818 saw the advent of life insurance business in India with the establishment of the Oriental Life Insurance Company in Calcutta.
- General Insurance in India has its roots in the establishment of Triton Insurance Company Ltd., in the year 1850 in Calcutta by the British. In 1907, the Indian Mercantile Insurance Ltd., was set up. This was the first company to transact all classes of general insurance business.
- In 1972 with the passing of the General Insurance Business (Nationalisation) Act, general insurance business was nationalised with effect from 1st January, 1973.
- 107 insurers were amalgamated and grouped into four companies, namely National Insurance Company Ltd., the New India Assurance Company Ltd., the Oriental Insurance Company Ltd and the United India Insurance Company Ltd.
- In 1999, the Insurance Regulatory and Development Authority (IRDA) was constituted as an autonomous body to regulate and develop the insurance industry. The IRDA was incorporated as a statutory body in April, 2000.
- Foreign companies were allowed ownership of up to 26% in the equity share capital of the Insurer. This limit was later raised to 49% during the year 2016
- In December, 2000, the subsidiaries of the General Insurance Corporation of India were restructured as independent companies and at the same time GIC was converted into a national re-insurer.
- Important Acts/Rules/Regulations governing Insurance Companies:
 - Insurance Act, 1938 and Insurance Laws (Amendment) act, 2015
 - Insurance Rules 1939

- IRDA Act, 1999 Insurance Amendment Act, 2002
- Rules and Regulations Framed under Insurance Regulatory and Development Authority (IRDAI) Act, 1999
- Insurance Regulatory and Development Authority of India ('IRDAI') is the Regulator for Insurance Companies operating in India. The mission of IRDAI is to protect the interests of Policyholders and to promote orderly growth of the Indian insurance industry.
- Main stakeholders in Insurance are (i) Policyholder (ii) Insurance Intermediary and (iii) The Insurance Company/Insurer.
- Insurance Policy specifies various terms and conditions governing the insurance coverage
- Essentials of Valid Insurance Contract:
 - Proposal
 - Acceptance
 - Consideration
 - Competency to contract
 - Consensus ad idem
 - Lawful object
- Types of Life Insurance Products:
 - Term Insurance Product
 - Whole life Insurance Product
 - Endowment Product
 - Money back product
 - Annuity Product
 - Linked Life Product
 - Variable Life Insurance Product
- Types of Health Insurance Product:
 - Indemnity based health Insurance Product
 - Fixed benefit health Insurance Product
- Types of General Insurance Product:
 - Fire Insurance Product
 - Marine Insurance Product
 - Motor Insurance Product

Private Cars

Motor Cycles and Motor Scooters

- Commercial Vehicles:

Goods Carrying Vehicles

Passenger Carrying Vehicles

Miscellaneous Vehicles

- Personal Accident Insurance
- Liability Insurance
- Engineering Insurance
- Miscellaneous Insurance
- Rural Insurance

SELF TEST QUESTIONS

(These are meant for re-capitulation only. Answers to these questions are not to be submitted for evaluation)

1. Multiple Choice Questions:
 - (a) Insurance is a form of (i) Wager (ii) Investment (iii) Contract
 - (b) In India, Insurance activities are regulated by (i) SEBI (ii) Stock Exchange (iii) RBI (iv) IRDAI
 - (c) Mission of IRDAI is to (i) Protect the interests of the investors (ii) Protect the interest of the policyholders (iii) Protect the interest of Fixed Deposit holders
 - (d) IRDAI was established in the year (i) 1938 (ii) 1999 (iii) 2003
2. State whether the following are true or false:
 - (a) Life Insurance Companies can issue Motor Policies
 - (b) General Insurance Companies can issue Health Insurance products
 - (c) Foreign Insurance Companies can hold 100% of equity shares in Indian Insurance Companies
3. Write Short notes on:
 - (a) Difference between Life Insurance and General Insurance Companies
 - (b) Essentials of a valid insurance contract
 - (c) Role of IRDAI in regulating Insurance Companies'

For Further Reading

IRDAI functions, Regulations/circulars etc., on www.irdaiindia.gov.in

Lesson 2

Regulatory Framework of Insurance Business in India

LESSON OUTLINE

- Insurance Regulatory and Development Authority of India ('IRDAI')
- Life Insurance Council
- General Insurance Council
- Individual Agents
- Corporate Agents
- Insurance Brokers
- Web Aggregators
- Micro Insurance Agents
- Common Service Centres
- Point of Sales Persons
- Nomination & Assignments
- Other Areas of Protection of Policyholders Interest
- Insurance Ombudsmen Rules,2017
- Consumer Courts
- Investment Regulations Framework In India
- International Trends in Insurance regulations
- Insurance Core Principles
- LESSONS ROUND UP
- SELF TEST QUESTIONS

LEARNING OBJECTIVES

The Insurance Amendment Act of 1950 abolished Principal Agencies. However, there were a large number of insurance companies and the level of competition was high. There were also allegations of unfair trade practices. The Government of India, therefore, decided to nationalize insurance business. The history of general insurance dates back to the Industrial Revolution in the west and the consequent growth of sea-faring trade and commerce in the 17th century. It came to India as a legacy of British occupation. General Insurance in India has its roots in the establishment of Triton Insurance Company Ltd., in the year 1850 in Calcutta by the British. Following the recommendations of the Malhotra Committee report, in 1999, the Insurance Regulatory and Development Authority (IRDA) was constituted as an autonomous body to regulate and develop the insurance industry. Today there are 24 general insurance companies including the ECGC and Agriculture Insurance Corporation of India and 23 life insurance companies operating in the country. Beside IRDA Act and Insurance Act, 1938, there are some common Act/Regulation to the General and Life Insurance Business in India and some Acts have been made for specific requirement of Life Insurance/General Insurance. In this chapter, we will study the following topics

- Life insurance
- General insurance
- Consumer courts
- POSP
- Insurance Ombudsmen Rules,2017
- Investment regulation framework in India and international jurisdiction

INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY OF INDIA ('IRDAI')

The IRDAI Act, 1999, established the Insurance Regulatory and Development Authority of India ("IRDAI" or "Authority") as a statutory regulator to regulate and promote the insurance industry in India and to protect the interests of holders of insurance policies. The IRDAI Act also carried out a series of amendments to the Act of 1938 and conferred the powers of the Controller of Insurance on the IRDAI. The members of the IRDAI are appointed by the Central Government from amongst persons of ability, integrity and standing who have knowledge or experience in life insurance, general insurance, actuarial science, finance, economics, law, accountancy, administration etc. The Authority consists of a chairperson, not more than five whole-time members and not more than four part-time members.

Every Chairperson and member of IRDAI appointed shall hold office for a term of five years. However, Chairperson shall not hold office once he or she attains 65 years while whole time members shall not hold office beyond 62 years.

Central Government may remove any member from office if he or she is adjudged insolvent or is physically or mentally incapacitated or has been convicted of an offence involving moral turpitude or has acquired financial or other interests or has abused his position. Chairperson and the whole time members shall not for a period of two years from the date of cessation of office in IRDAI, hold office as an employee with Central Government or any State Government or with any company in the insurance sector.

Under Section 14 of the IRDAI Act, 1999, IRDAI has the following powers:

- (a) Issue of Certificate of Registration to insurance companies, renew, modify, withdraw, suspend or cancel the certificate of registration.
- (b) Protection of interests of policy holders in matters concerning assignment of policies, nomination, insurable interest, claim settlement, surrender value and other terms and conditions of insurance contract.
- (c) Specification of requisite qualifications, practical training and code of conduct for insurance agents and intermediaries.
- (d) Specification of code of conduct for surveyors and loss assessors.
- (e) Promoting efficiency in the conduct of insurance business.
- (f) Promoting and regulating professional organizations connected with insurance and reinsurance business.
- (g) Levying fees and other charges for carrying out the purposes of the Act.
- (h) Calling for information from or undertaking inspection of insurance companies, intermediaries and other organisations connected with insurance business.
- (i) Control and regulation of rates, advantages, terms and conditions that may be offered by general insurance companies.
- (j) Specifying the form and manner in which books of account shall be maintained by insurance companies and intermediaries.
- (k) Regulation of investments of funds by insurance companies.
- (l) Regulation of maintenance of margin of solvency.
- (m) Adjudication of disputes between insurers and insurance intermediaries.

- (n) Supervising the functioning of Tariff Advisory Committee.
- (o) Specifying the percentage of premium income of the insurer to finance schemes for promoting and regulating professional organizations.
- (p) Specifying the percentage of insurance business to be undertaken by insurers in rural or social sectors.
- (q) Such other powers as may be prescribed.

LIFE INSURANCE COUNCIL AND GENERAL INSURANCE COUNCIL

Constitution of Life Insurance Council

As per Section 64F(1) of the Insurance Act, 1938, an Executive Committee of the Life Insurance Council shall be formed comprising of the following persons, namely: –

- (a) four representatives of members of the Life Insurance Council elected in their individual capacity by the members in such manner as may be laid down in the bye-laws of the Council. One of the four representatives shall be elected as the Chairperson of the Executive Committee of Life Insurance Council;
- (b) an eminent person not connected with insurance business, nominated by IRDAI;
- (c) three persons to represent Insurance agents, Intermediaries and Policyholders, respectively, as may be nominated by the Authority; and
- (d) one representative each from Self-help groups and Insurance Co-operative Societies.

Constitution of General Insurance Council

Similarly, as per Section 64F(2) of the Insurance Act, 1938, an Executive Committee of the General Insurance Council shall consist of the following persons, namely: –

- (a) four representatives of members of the General Insurance Council elected in their individual capacity by the members in such manner as may be laid down in the bye-laws of the Council. One of the four representatives shall be elected as the Chairperson of the Executive Committee of General Insurance Council;
- (b) an eminent person not connected with insurance business, nominated by the Authority; and
- (c) four persons to represent Insurance agents, Third party administrators, Surveyors and Loss Assessors and Policyholders respectively, as may be nominated by the Authority.

Term of office of the Executive Committees

Members of the Executive Committees constituted as per Section 64F of Insurance Act, 1938 would serve for a period of 3 years after which the Executive Committee would be dissolved and fresh elections will be held to elect new Members

Powers of IRDAI to fill vacancy of Members in Life or General Insurance Councils

If the General body of Life or General insurance companies fail to elect any of the members of the Executive Committees of the Life Insurance Council or the General Insurance Council, IRDAI has the powers to nominate any person to fill the vacancy, and any person so nominated shall be deemed to be a member of the Executive Committee of the Life Insurance Council or the General Insurance Council, as the case may be, as if he had been duly elected thereto.

Bye-laws for transacting any business at Executive Committee meeting to be drafted by the Executive Committee

Each of the said Executive Committees may make bye-laws for the transaction of any business at any meeting of the said Committee.

Formation of Sub-Committees by Executive Committees

The Life Insurance Council or the General Insurance Council may form such other committees consisting of such persons as it may think fit to discharge such functions as may be delegated thereto.

Appointment of Secretary for Life Insurance Council and General Insurance Council

The Secretary of the Executive Committee of the Life Insurance Council and of the Executive Committee of the General Insurance Council shall in each case be appointed by the Executive Committee concerned. The powers of the Secretary and the acts which he or she is authorised to do would also be determined by the Executive Committee.

Functions of the Executive Committee of Life and General Insurance Councils

As per Section 64J, read with Section 64L of Insurance Act, 1938, the following are the functions of the Executive Committee of the Life and General Insurance Council:

- (a) to aid, advise and assist insurers carrying on life/general insurance business in the matter of setting up standards of conduct and sound practice and in the matter of rendering efficient service to holders of life insurance policies;
- (b) to render advice to the Authority in the matter of controlling the expenses of insurers in respect of their life/general insurance business in India, respectively; in addition in respect of general insurers, Executive Committee of General insurance council may also advise on Commission and other expenses;
- (c) to bring to the notice of the Authority the case of any insurer acting in a manner prejudicial to the interests of holders of life/general insurance policies, respectively; and
- (d) to act in any matter incidental or ancillary to any of the matters specified in Clauses (a) to (c) as, with the approval of the Authority, may be notified by the Life/General Insurance Council, as the case may be, in the Gazette of India.

For the purpose of enabling it effectively to discharge its functions, the Executive Committee of the Life/General Insurance Council may collect such fees from Life/General insurance companies, as may be specified in the bye-laws of the respective Councils.

Powers of Life & General Insurance Councils

For the efficient performance of its duties, the Life Insurance Council or the General Insurance Council, as the case may be, may

- (a) appoint such officers and servants as may be necessary and fix the conditions of their service;
- (b) determine the manner in which any prescribed fee may be collected;
- (c) keep and maintain up-to-date, a copy of list of all insurers who are members of the either Council;
- (d) make bye-laws for:
 - (i) the holding of elections other than the first elections;

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- (ii) the summoning and holding of meetings, the conduct of business thereat and the number of persons necessary to form a quorum;
- (iii) the submission by insurers to the Executive Committee of the Life Insurance Council, or the General Insurance Council of such statements or information as may be required of them and the submission of copies thereof by the insurers to the Authority;
- (iv) the levy and collection of any fees;
- (v) the regulation of any other matter which may be necessary for the purpose of enabling it to carry out its duties under this Act.

Further, the Life Insurance Council or the General Insurance Council may authorise the Executive Committee concerned to exercise any of the powers conferred on the Life Insurance Council or the General Insurance Council, as the case may be, under Clauses (a), (b) or (c) mentioned above.

Duty of the Life/General insurance council to advise IRDAI in the matter of controlling expenses

By virtue of the powers vested on them under Section 40B of the Insurance Act, 1938, IRDAI have passed the following 2 Regulations to control the Expenses of Management of Life and General Insurance Companies:

1. IRDAI (Expenses of management for insurers transacting life insurance business) Regulations, 2016.
2. IRDAI (Expenses of management for insurers transacting General or Health insurance business) Regulations, 2016.

The above two Regulations have fixed ceilings on Expenses of management incurred by Insurance companies which is calculated as a percentage of the Premiums received by such insurance companies from Policyholders. The intention behind these Regulations is to ensure that Insurance companies are prudent in their spending and restrict their expenses based on the Income which they earn. It is also intended to protect the interests of Participating Policyholders in Life insurance who earn bonuses on their Policies which is dependent on the Surplus generated in Life insurance business.

The above Regulations vest IRDAI with the power to grant Forbearance (excusing non-compliance with ceilings on expenses by insurance companies) up to a period of 5 years from inception for General and Health Insurance companies and 10 years from inception for Life insurance companies. In this context, the Life and General Insurance Council will have to advise IRDAI on the extent up to which insurance companies can exceed the limits fixed under the above Regulations, so that IRDAI can consider the Forbearance request from Insurance companies accordingly.

It may be noted from the powers granted to them under Section 64J and Section 64L above, the Councils will have to advise IRDAI in the matter of controlling expenses of management of insurers.

In this context, Section 64K read with Section 64M of the Insurance Act states that it shall be the duty of the Executive Committee of the Life/General Insurance Council to meet at least once before the 31st day of March every year to advise IRDAI in fixing the limits by which the actual expenses incurred by an insurer carrying on life/general insurance business in respect of such business in the preceding year may exceed the limits prescribed under the IRDAI regulations, and in fixing any such limits, IRDAI shall have due regard to the conditions obtaining in life/general insurance business generally during that year and IRDAI may fix different limits for different groups of insurers.

Based on the advice of the Council, IRDAI may consider the Forbearance request of the insurance companies which fail to comply with the ceilings as per the Expenses of Management Regulations.

Joint-meeting of Life and General Insurance Councils

As per Section 64N of Insurance Act, 1938, IRDAI may prescribe the circumstances in which, the manner in which, and the conditions subject to which, the Executive committee of the Life Insurance Council and the Executive Committee of the General Insurance Council may hold joint meetings for the purpose of doing with any matter of common interest to both Committees, and it shall be lawful for the two Committees at any such joint meeting to delegate any matter under consideration for the determination of a Sub-committee appointed for this purpose from amongst the members of the two Committees.

IRDAI’s role as Regulator of Insurance Agents & Intermediaries

IRDAI have been vested with the following powers under the IRDAI Act, 1999 to regulate the Distributors of Insurance Policies:

1. Specification of requisite qualifications, practical training and code of conduct for insurance agents and intermediaries.
2. Specification of code of conduct for survey or sand loss assessors.
3. Promoting efficiency in the conduct of insurance business.
4. Calling for information from or undertaking inspection of insurance companies, intermediaries and other organisations connected with insurance business.
5. Control and regulation of rates, advantages, terms and conditions that may be offered by general insurance companies.
6. Specifying the form and manner in which books of account shall be maintained by insurance companies and intermediaries.

As a step in the above direction, IRDAI have framed regulations to regulate the various distributors who are engaged in selling insurance. Let us now look at the Distribution compliance architecture in insurance in the following pages.

Insurance Distributors recognised by IRDAI can be classified as follows:

Front-end (persons authorised to sell insurance policies)
<ul style="list-style-type: none"> ● Individual Agents ● Corporate Agents ● Insurance Brokers ● Telemarketing (Authorised Verifiers) ● Web Aggregators (through Distance marketing) ● Direct Marketing (Authorised employees of insurer) <ul style="list-style-type: none"> – Micro Insurance Agents & Common Service Centres – Insurance Marketing Firms – Point of Sales Persons – Motor Insurance Service Providers

IRDAI have framed Regulations/Guidelines and provided a framework for the above Distributors to operate in the insurance market. Let us look at the Regulatory framework concerning these Distributors.

INDIVIDUAL AGENTS

These are individuals who can be appointed by an insurance company to sell insurance policies on their behalf.

As per Section 42 of the Insurance Act, 1938, an insurer may appoint any person to act as insurance agent for the purpose of soliciting and procuring insurance business.

No person shall act as an insurance agent for more than one life insurer, one general insurer, one health insurer at a time.

Provided that the Authority shall, while framing regulations, ensure that no conflict of interest is allowed to arise for any agent in representing two or more insurers for whom he may be an agent.

Following are the disqualifications of an Insurance Agent:

- (a) that the person is a minor;
- (b) that he is found to be of unsound mind by a court of competent jurisdiction;
- (c) that he has been found guilty of criminal misappropriation or criminal breach of trust or cheating or forgery or an abetment of or attempt to commit any such offence by a court of competent jurisdiction;

Provided that where at least five years have elapsed since the completion of the sentence imposed on any person in respect of any such offence, the Authority shall ordinarily declare in respect of such person that his conviction shall cease to operate as a disqualification under this clause;

- (d) that in the course of any judicial proceeding relating to any policy of insurance or the winding up of an insurer or in the course of an investigation of the affairs of an insurer it has been found that he has been guilty of or has knowingly participated in or connived at any fraud, dishonesty or misrepresentation against an insurer or insured;
- (e) that he does not possess the requisite qualifications or practical training or passed the examination, as may be specified by the regulations;
- (g) that he has not passed such examination as may be specified by the regulations;
- (h) that he has violated the code of conduct as may be specified by the regulations.

Pursuant to the powers given under Section 42 of Insurance Act, 1938, IRDAI have framed Regulations for regulating the Individual Insurance Agents. Key highlights of the Regulations are given hereunder:

- Every insurer to have a Policy on Individual Agents approved by Board to be in place specifying:
 - Minimum age;
 - Qualifications - minimum X passed recommended;
 - Pre-recruitment Training requirements & Skill development training by Insurer (not less than 25 hours for Pre-recruitment Training);
 - Remuneration to Individual Agents.
- Every insurer to also have a Board approved Policy on Commission & remuneration to Agents & Intermediaries, giving broad framework on Commission & Rewards to Agents, Eligibility for Commission after Termination, Orphan Policies allocation etc.

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- Interview procedure shall also specified by the Policy.
- PAN mandatory for appointment of Insurance Agents.
- All candidates to undergo 50 hours pre-recruitment training to be conducted by an Authorised body and pass an examination to be conducted by Insurance Institute of India/authorised body.
- Registration Certificate issued by IRDAI to Agents.
- Insurer to screen the names of candidates with the with prohibited lists – Centralized list of blacklisted agents, Agents working with other Companies – to ensure that there is no backdoor entry by persons who have committed fraud in the past.
- Appointment letter & ID card to be issued by the Company.
- Insurance companies may refuse to appoint an Agent. Agents may appeal against refusal to the Appellate Authority appointed within the Insurance company.
- Procedure for Agency Performance Review, Suspension & Resignation of Agents to be laid down.
- Details of Individual Agents (as well as corporate /agents) to be published on Insurer's website.

CORPORATE AGENTS

In the case of a Corporate Agency, a Partnership firm or a Company may apply for doing insurance agency, as against individuals which we saw earlier. However, unlike Individual agent who can work for only 1 insurer in a line of business (Life/Non-Life/Standalone health), a Corporate agent is allowed to work for upto 3 insurers in each line of business. Therefore, a Corporate agent can work up to a maximum of 9 insurers, with a cap of 3 insurers in each line of business.

Following are the key provisions under the IRDAI (Registration of Corporate Agents) Regulations, 2015:

- Maximum tie ups for a Corporate Agent: Maximum 3 insurance companies – in life, non-life and Health insurance separately or a Composite licence for all categories.
- Two types of Corporate agencies: Exclusive & non-exclusive corporate agencies - An exclusive corporate agent is one who does only insurance solicitation and a non-exclusive corporate agent is one whose primary business is something different and insurance solicitation is a secondary line of business. For example, Banks are Non-exclusive Corporate agents whose primary business is banking and secondary business is insurance solicitation.
- Minimum capital and net worth requirement: only for exclusive corporate agents: ₹50 lakhs.
- At least 1 Principal Officer & as many Specified Persons as required to be appointed: A Principal Officer, an employee of the Corporate agent, is the Primary person responsible for the Corporate Agency and shall be accountable to IRDAI for compliance with the Regulations. He may be the CEO for the Corporate agency business. A Specified Person is an employee of the Corporate agency entity responsible for solicitation of insurance business. Only Specified Persons and Principal Officers are eligible to sell on behalf of the Corporate agent.
 - Principal Officer is a Director, Partner or a designated employee of the Corporate Agent who:
 - is at least a Graduate;
 - Is responsible for overall supervision of the Corporate Agent;

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- has undergone 50 hours Practical Training (25 hours for those possessing insurance qualifications) at recognised Training Institutes;
- has passed the examination conducted by the approved examination body.
- Specified Person ('SP') is an employee of the Corporate Agent responsible for soliciting or procuring insurance business on behalf of the Corporate Agent and who:
 - Is at least 12th Standard passed.
 - has undergone the 50 hours training (75 hours for composite) from approved training institution.
 - and passed the examination as specified above.
- Certificate issued to Specified Person valid for 3 years.
- Common Directors, Principal Officers & SPs between Corporate agents prohibited
- Foreign equity for Exclusive Corporate Agents capped at 49% subject to the condition that the Exclusive Corporate Agent shall be "Indian owned and controlled", However, for non-exclusive Corporate Agents like Banks, foreign equity allowed to be more than 49%, provided their income from non-insurance business remains above 50% in any financial year.
- Any change in ownership of an exclusive corporate agent beyond 25% requires prior IRDAI approval.
- Separate books of account to be maintained for corporate agency business
- Corporate agent subject to direct supervision and inspection by IRDAI (erstwhile regulations provided supervision through the insurer with whom the Corporate agent had tied up).
- Professional Indemnity Insurance Policy to be taken by every Corporate Agent whose revenue from Corporate agency is more than 50% of their total revenues:
 - Limits to indemnity: 2 times the remuneration of the Corporate Agent subject to a minimum of Rs.15 lakhs and maximum of Rs.100 Crores.
- Board approved Policy for Open architecture
 - To cover the manner of soliciting or procuring insurance business.
 - Philosophy of open architecture and methodology – i.e. in what manner will the Corporate Agent work for up to 3 insurers including selling process, recommending the right insurance product to customer etc.
 - Business mix, products sold, grievances handling mechanism etc. to also be included in the Policy.
- Filings with the Authority:
 - Board approved Policy for Open architecture.
 - Half yearly returns on business sourced insurer-wise in Life, Non-Life and Health lines of businesses separately.
- Disclosures to IRDAI by the Corporate Agent:
 - Any material change to the information provided at the time of registration shall be notified within

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30 days of change.

- Intimation about initiation of proceedings by any other regulator or Government body within 30 days of such initiation.
 - Details of opening and closing of Branch offices.
 - Details of specified person Branch office-wise along with their Certificate number.
 - Distribution agreements with insurers to be intimated within 30 days of entering into agreement – minimum period 1 year – no insurer can compel a corporate agent to sell for an insurer.
 - Yearly filing of the Annual Accounts by 30 September for the previous financial year along with remarks/observations of Statutory Auditors.
- Records to be maintained by the Corporate Agent:
 - Records of KYC as required under the Prevention of Money Laundering Rules;
 - Copy of Proposal form, with Agent's Confidential Report duly signed by the concerned Specified Person;
 - Policy Register;
 - Complaints Register;
 - Specified Persons Register;
 - Copies of correspondence exchanged with IRDAI;
 - Financial Statements – including annual Balance Sheet, Profit and Loss account etc. – details of payments made to and payments received from Group entities of Corporate agents to be separately disclosed in the accounts – Non-exclusive corporate agents to separately capture the income from insurance intermediation in their books of account;
 - Records to be maintained for a minimum period of 10 years.
 - Remuneration to Corporate Agent paid by the Insurer for soliciting insurance business:
 - Payment of remuneration to be governed by IRDAI by way of ceilings under Commission Regulations, subject to Commission as per "file & use" for each Product approved by IRDAI.
 - No signing fee or any other similar charges can be paid by insurer to Corporate agent.
 - No insurer shall directly pay incentives (cash or non-cash) to the Principal Officer, Specified Persons or any other employee of a Corporate Agent.

INSURANCE BROKERS

An Insurance Broker represents a Client and not insurer and is therefore independent of the insurer. Unlike a Corporate Agent who can represent upto 3. insurers, Brokers can sell the products of any number of insurance companies. Sales practices of Broker do not bind the insurer, even though the insurer is liable on the contract issued to the customer. However, Consumer Courts & Ombudsmen hold insurers responsible for misrepresentation of Brokers. Following are the other features of the Insurance Broking model:

- 3 types of Brokers recognised – Direct, Reinsurance & Composite.
- Framework of training, examination and registration similar to that of Corporate agent.

- Principal Officer to be appointed (equivalent of CIE).
- Only employees who have undergone training, examination and are registered can sell on behalf of an insurance broker (equivalent of SP).
- No compensation permitted other than Brokerage.
- Broker cannot appoint agents or canvassers to bring in business.
- Minimum capital – ₹50 lakhs (Direct Broker).
- Shall exclusively carry on insurance broking business.
- Foreign equity in insurance broking restricted to 49% subject to the insurance broking entity being “Indian owned and controlled”.
- Client concentration: Business from one client not to exceed 50% of total premium.
- Group company concentration: A Broker cannot place more than 25% of the total business in a year with an insurance company within its Group.
- Deposit in Bank a sum equivalent to 20% of initial capital.
- Maintenance of minimum Professional indemnity cover of ₹50 lakhs.
- Submission of half yearly unaudited and yearly audited financial statements to the Authority.
- Approval of authority for changes to shareholdings and changes to Principal Officer.
- Claims consultancy services may be offered by a Broker to Policyholders for claim amounts not exceeding Rs.1 Crore (excluding policies sourced by the Broker) for a fee which cannot be expressed as a % of claim amount.
- **One Branch one qualified employee:** Each Branch of the Insurance Broker shall have a qualified person to sell insurance on behalf the Insurance Broker.
- **Transfer of shares:** Transfer in favour of any person acquiring more than 5% shareholding after the transfer in the Broker entity shall be done only after prior IRDA approval.
- **Minimum net worth at all times:** Net worth of the Broker shall not fall at any time below the Capital (₹50 lakhs in the case of Direct Broker).
- **Delay beyond 60 days for licence renewal:** If the application for renewal of licence by a Broker is received by IRDA 60 days after expiry of the date of licence, renewal will be considered only 12 months after the date of expiry of the licence. In the interim, no new business can be logged in by the Broker, except for servicing of existing policies.
- **Online sales by Brokers:** Brokers can sell online by linking their website with the website of insurers.
- **Distance marketing by Brokers:** Brokers can engage in telemarketing either through authorised employees of the broker or outsourcing lead generation to telemarketing companies as per Distance Marketing Guidelines.
- **Auditors Report:** Auditors Report of the Broker entity shall also include status of compliance of the Broker with the Regulations.
- **Due date for submission of financial statements:** Due date for submission of financial statements extended to 30 September (earlier it was 30 June).

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- **Half-yearly Chartered Accountant ('CA') Certificates:** Half yearly CA certificate to confirm compliance with key compliances including receipt of remuneration within the limits, minimum capital requirements, professional indemnity insurance policy etc.
- **Co-broking recognised:** Two or more Brokers can advise a client on purchase of insurance – sharing of remuneration between co-brokers to be done within the limits as per Regulations, as per Client's instructions.
- **International reinsurance broking:** Broking services for international reinsurances can be availed only through IRDA registered reinsurance brokers.
- **One group shall be issued only one Broker licence.**
- **Disclosure on material changes to IRDA:** Brokers required to disclose any material changes impacting their licence to IRDA.
- **Notification of changes:** Changes to Principal Officers, Directors etc. of Insurance Brokers, requires prior IRDA approval – intimation about opening/closure of offices, acquisition of immovable property etc. to be notified to IRDA.
- **Compliance Officer for Insurance Brokers to be appointed.**

Distance marketing

Distance marketing is a non-face-to-face method of selling insurance and includes telephonic mode of sale, through internet, emails, SMS and other forms of non-personal sales methods by insurers or brokers.

- 3 models through Distance marketing:
 - Only lead generation (generating interest in buying insurance, no selling insurance).
 - Only solicitation (selling insurance).
 - Lead generation and solicitation (both generating interest and selling insurance).
- Insurer can do distance marketing in the following ways:
 - Engage insurer's own authorised sales employees.
 - Sign up with a Call centre (Tele marketer) whose employees can do telemarketing.
- An Corporate Agent/Insurance broker can do distance marketing in the following ways:
 - Engage Corporate Agent/Broker's own employees (Specified Persons in the case of Corporate Agent) who are authorised to sell.
 - Sign up with a Call centre (Tele marketer) for lead generation. In such cases the solicitation (closure of sale) can be done only by an authorised employee of the Broker.
 - Lead generation through employees called Tele callers, subject to:
- Telecallers to undergo 25 hour training and pass the assessment test conducted by Insurer or Broker.
- Selling can be done through employees of Call Centres called Authorised verifiers, subject to:
 - Authorised verifiers to undergo 50 hour training as applicable to SPs.
 - Pass the examination prescribed for SPs.
 - Telecallers can only do lead generation to collect details of the client and their intention to purchase

insurance and includes all activities preceding solicitation.

- Authorised verifiers alone permitted to solicit and conclude the sale under the Distance marketing by a Call Centre.
- Where an insurer engages Telemarketer only for lead generation, the leads obtained from Telemarketer can be passed on to insurer's own employees or to a Corporate Agent or to an Insurance Broker for closure of sale.
- A Broker by his nature, cannot push or promote products of only one or few insurers as this could be serve counter-productive to customer's interests.
- Scripts used by Telemarketers to be approved by Compliance Officers of insurer for lead generation and solicitation & filed with IRDA within 15 days.
- Script to contain questions on customer consent, informing recording of conversation, language options, product features, benefits, exclusions, freeloop options (30 days for distance marketing), toll free number.
- Tele-caller lead generation script cannot contain questions specific to solicitation.
- Specific responses of client in the form "Yes/No", "Agree/Disagree", "Understand/Don't understand" to be recorded.
- Product restrictions in Telephonic mode:
 - Non-single Premium ULIPs – maximum premium – ₹50,000.
 - Single Premium ULIPs – maximum premium – ₹1,00,000.
 - No Variable Insurance Product can be sold under Distance marketing.
- All voice recordings to be preserved till 6 months beyond term of the policy or till satisfactory settlement of claim.
- Proposal form can be in the form of voice record (if approved under 'file & use') and verbal transcript to be forwarded along with policy bond.
- Email communications to have a provision for "unsubscribing".
- Call verification by insurers:
 - 1% of live call monitoring - i.e. listening to live conversations as they happen.
 - 3% of calls leading to sales (observations made to be preserved for 3 years).
 - 3% of Policyholders under Distance marketing – verification calls (to be preserved for 3 years).

WEB AGGREGATORS

A Web Aggregator is an online seller of insurance products – allowed to sell insurance products of multiple insurance companies. Example: Policy Bazaar. They are permitted to do only online sales, though telephonic solicitation is also allowed. Since the Web Aggregator aggregates the insurance products of multiple insurance companies through internet (Web), they are called Web Aggregators. Salient features of this model are as follows:

- A Web Aggregator is a Company having its own website providing.

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- Product information of various insurers with price comparisons.
- leads to Insurers from customers who access the website.
- No ranking, rating or endorsement of any insurer allowed.
- Minimum capital & Networth of ₹25 lakhs and cannot act as agent, broker, TPA surveyor or be their related party.
- All Web Aggregators shall get approval from IRDA valid for 3 years.
- An insurance broker who provides product comparisons in his website shall also follow the web aggregator guidelines pertaining to display of product comparisons on website.
- Telemarketing by Web Aggregators through Authorised Verifiers who have to undergo IRDAI training and examination – telephone solicitations allowed only for leads generated on the Web aggregator site.
- Product restriction over telemarketing mode – not more than ₹1,50,000 of annualised premium.
- Customer visits the website of the aggregator selects the product category, e.g. Endowment, Whole Life, Term, ULIPs etc.
- Once the visitor selects the product category, the website will ask for his basic details such as age, health and personal details, term, sum assured required etc.
- Once the visitor gives the details, the product comparison chart is displayed, alongwith the default underwriting requirements such as medical examinations required, exclusions, limits and other conditions and key features of the product chosen.
- Visitor may select the insurer with whom his information can be shared as a lead, else the Web Aggregator can transmit the lead to not more than 3 insurers (life or non-life as the case may be).
- Insurer can in turn pass on the lead to a Corporate Agent or an Authorised Person of a Telemarketer or an Insurance Broker or to their own employees or Web Aggregator can use distance marketing for closure of sale.
- Visitor is either called over phone or visited by person closing the sale (either authorised employee of Web Aggregator or Insurer or Broker) and the solicitation is completed.
- Policies procured by Web Aggregators to be commensurate with their resources and number of Authorised verifiers.
- A Web Aggregator is allowed to provide product comparisons as well as solicit insurance business – entity licensed cannot do any other business, including corporate agency, broking.
- A Company or a partnership firm can act as Web Aggregator after procuring IRDA licence with a networth of ₹25 lakhs to be maintained at all times – foreign equity restricted to 26%
- Principal Officer and the Employees who solicit insurance business should have undergone 50 hours training and passed the examination conducted by National Insurance Academy, Pune.
- Professional indemnity insurance 3 times the remuneration subject to a minimum of Rs.10 lakhs mandatory.
- Web Aggregator shall ensure that their systems comply with the generally accepted information security standards.

- Ratings or rankings or endorsements of products prohibited while doing product comparisons.
- Customer's lead shall be shared with the insurer of customer's choice. If customer has no choice of a specific insurer, the lead can be shared with up to 3 insurers by the Web Aggregator.
- Once a policy is sold out of the lead provided by insurer, it shall be fed into the Lead management system ('LMS') by the concerned insurer – yearly audit of the LMS prescribed.
- Board approved policy for comparison and distribution of products.

Insurance Marketing Firms

An Insurance Marketing Firm is allowed to sell Insurance Products as well as other Financial products under one entity. Apart from Insurance Products, they are also allowed to sell other financial products like Mutual funds, Small savings etc. Salient features are given below:

- Entity which is permitted to solicit insurance products by employing Insurance Sales Persons for 2 life, 2 non-life and 2 health insurance companies at a time.
- For non-life insurance companies only retail products, e.g. motor, health, allowed to be sourced.
- Solicit other financial products by employing Financial Service Executives for:
 - mutual funds of mutual fund companies regulated by SEBI;
 - pension products regulated by PFRDA;
 - other financial products distributed by SEBI licensed Investment Advisors;
 - banking/ financial products of banks/ NBFC regulated by RBI;
 - non-insurance products offered by Department of Posts, Government of India;
- Other Insurance Servicing Activities allowed to be undertaken:
 - back office activities of insurers as allowed in Outsourcing Guidelines;
 - acting as approved person of Insurance Repositories;
 - survey and loss assessment work by employing on their rolls licensed surveyor & loss assessors;
- IMFs to have 1 Principal Officer (Associate, Fellows of Insurance Institute, Actuaries' Institute, Institute of Insurance & Risk Management, Graduates with 5 years insurance/10years financial sector experience) and as many number of Insurance Sales Persons ('ISPs')/Financial Service Executives ('FSEs') as required (ISPs minimum XII passed).
- Insurance Sales Persons call insurance products on behalf of the IMF, while Financial Service Executives can sell other Financial products on behalf of the IMF.
- Principal Officer and ISPs to undergo the prescribed training and examination.
- FSPs shall possess the necessary qualifications, experience as may be specified by the respective regulators (e.g. SEBI).
- Minimum capital: ₹10 lakhs – foreign equity not exceed 49%.
- Remuneration:
 - To be specified by Regulations by IRDAI.

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- Fees for training, mentoring ISPs – 50% of FYC and 10% of RC.
- Reasonable fees to be agreed with insurers for the various other Insurance Servicing activities (listed in the previous slide).
- Applicable Service charges from other Financial entities (like Mutual Funds) for whom the FSE solicits business.
- Professional indemnity insurance – twice the total remuneration – minimum ₹10 lakhs.
- Area restrictions:
 - ISPs are domiciled in the district in which they are allowed to operate.
 - At the time of registration, IMF also will be permitted to operate only in one district of its choice.
 - At the time of renewal, further districts can be allotted.

MICRO INSURANCE AGENTS

As the name suggests, a Micro Insurance Agent is recognised to sell insurance products predominantly in Rural areas and to the under privileged sections of the Society. Salient features of this model are given below:

- Who can become a Micro Insurance Agent:
 - Non-Governmental Organisations or Self Help Groups or Micro Finance Institutions or Reserve Bank of India regulated Non Banking Finance Companies-Micro Finance Institutions,
 - District and Urban Cooperative Banks,
 - Primary Credit Cooperative Societies,
 - District Co-operative Banks, Regional Rural Banks and Urban Cooperative Banks,
 - Primary Agricultural & other Co-operative Societies and
 - Banking Correspondents.
- Micro Insurance Products – only simple products allowed to be sold:
 - Life companies – Life, Pension or Health products with a maximum Sum Assured of ₹2 lakhs. Riders allowed. For Variable Insurance Products, maximum premium of ₹6,000 p.a.
 - Non-life companies – 1 year Health insurance (individual) – Rs.1 lakh; Family ₹2.50 lakhs; Personal accident ₹1 lakh
- Micro insurance agent can work with 1 life, 1 non-life, 1 health and Agriculture Insurance Company
- Tie-up between Life and Non-life insurers for marketing Micro insurance policies allowed
- Following flexibilities provided to Non-life insurers while appointing Micro insurance agents:
 - Life companies – Life, Pension or Health products with a maximum Sum Assured of ₹2 lakhs. Riders allowed. For Variable Insurance Products, maximum premium of ₹6,000 p.a.
 - Non-life companies – 1 year Health insurance (individual) – Rs.1 lakh; Family ₹2.50 lakhs; Personal accident ₹1 lakh.
- Micro insurance agent can work with 1 life, 1 non-life, 1 health and Agriculture Insurance Company.
- Tie-up between Life and Non-life insurers for marketing Micro insurance policies allowed.

- Following flexibilities provided to Non-life insurers while appointing Micro insurance agents:
 - Appointing Micro insurance agents for Medium, Small or Micro insurance sectors or any combination of them (subject to Micro insurance agent undergoing additional training in MSME sector).
 - Appointing Micro insurance agents for various lines of business or any combination of them.
 - Appointing Micro insurance agents for manufacturing or service sector or both.
- While a Micro Insurance Agent can sell only Micro insurance product, any licensed agent or a Broker can sell Micro insurance products also.
- A Micro insurance agent can work only for one life and one non-life insurer.
- A Micro insurance Agent can sell through a Specified persons employed by the said Agent with the prior approval of the concerned insurer(s).
- Insurer can appoint a Micro insurance agent by a deed of agreement - 25 hours training to be imparted by insurer to Micro insurance agent and Specified persons.
- Limits to commission – 20% of the premiums paid for all the policy years; 10% of single premium ; 15% for non-life micro insurance policies.
- A micro insurance policy issued to a life assured residing in Rural area and engaged in a social sector occupation, can be reckoned both for Rural and Social sector compliances separately.
- 3 months' cooling off period for Micro insurance agents and Specified Persons of such Agents moving from one insurer to another insurer.
- Prohibition of Micro insurance agents terminated on the grounds of fraud till they are exonerated.
- Provisions for allotting the orphan Micro insurance policies to other in-force Micro insurance agents
- Prohibition of common specified persons of Micro insurance agents, prohibition of individual agents, SPs of Corporate agents and authorised employees of Brokers holding specified person position with Micro insurance agents.
- Micro insurance agents allowed to print policy documents on A-4 size paper with evidence of stamp duty, on behalf of the insurers – policy document should be in simple, understandable and local language.
- Not less than 12.5 hours training every 3 years to be imparted by insurers to the Micro insurance agents.

COMMON SERVICE CENTRES

Under this model Village Level Entrepreneurs ('VLEs') who offer certain services to the Villagers like payment of utility bills, booking of train tickets, selling of manures and fertilizers etc., are also permitted to sell insurance products. They typically have a 100 to 200 sq. ft. offices with computer systems and internet connectivity. Under this model the VLE network is used to sell insurance in rural areas. This measure is intended to increase the insurance penetration in the country.

- All VLEs are linked to an CSC Special Purpose Vehicle (CSC-SPV), a Central organisation created under the National e-Governance initiative of the Government of India.
- A VLE registered who is at least X passed, undergoes a 20 hour training through digital means and passes special examination by NIELIT.

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- VLE would be authorised to sell on behalf of the CSC-SPV as Rural Authorised Persons ('RAP').
- More than 100,000 VLEs across the country eligible to become RAPs.
- Insurers can tie up with RAPs for sale of insurance policies.
- RAP to be guided by the needs of the customers and recommend appropriate insurance products.
- Remuneration to CSC-SPV is paid as Commission on products sold by the RAP ('VLEs') – 80% of the remuneration to be passed on to the RAP by CSC-SPV.
- Only special products designed for CSCs can be sold – Sum Assured not to exceed Rs.2 lakhs, except for Motor insurance.
- Facility to fill the proposal forms online and upload the document to insurance company available with CSCs.
- Customer consent can be obtained through scanned signature or through biometric thumb print.
- CSCs to also assist nominees in claims settlement operations.

POINT OF SALES PERSONS

A Point of Sales Persons ('POSP') model is a recent innovation and is intended to sell simplified products in any area – Urban or Rural.

POSP can be appointed by an Insurer or Intermediary subject to the following conditions:

- Every POSP shall be identified by an Aadhaar Number or PAN.
- POSP shall be at least 10th pass.
- POSP shall undergo the 15 hour in-house training and pass the examination conducted by the concerned Insurer or intermediary – model syllabus prescribed by IRDAI.
- Insurer or Intermediary shall upload the details of the POSP appointed in the Insurance Information Bureau database and preserve records for 5 years.
- Restriction on products which can be sold by POSP – Products to be specially approved by IRDAI for POSPs:
- General Insurance:
 - Motor Comprehensive Package policy & Third Party Liability covers for 2 wheeler, Private Car and Commercial vehicles
 - Personal Accident
 - Travel Insurance
 - Home Insurance
 - Indemnity-based Health insurance products (Maximum Sum Assured: Rs.5 lakhs; Maximum: 3 products)
- Life Insurance:
 - Pure Term Insurance with or without return of premium – no limit to Sum Assured (only Non-medical)

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- Non-par Non-linked Endowment policies (including Money back) & Health products (fixed benefits) only Non-medical – maximum Sum Assured – Rs.10 lakhs (excluding ADB);
- Immediate Annuities
- All Proposal forms and Policy documents to contain the Aadhaar Card or PAN of POSP
- Insurance company/Insurance Broker responsible for the acts of the POSP and liable for penal provisions under the Insurance Act in case of misconduct of POSP appointed by the Insurance company/Insurance Broker
- POS Products can be sold by POS Persons, Individual Agents, Intermediaries & Insurers

Motor Insurance Service Providers (only Non-life)

- Who is a Motor Insurance Service Provider ('MISP').
 - Any automobile dealer (authorised dealer or sub-dealer) of automobile manufacturer, for selling new or used automotive vehicles.
 - Authorised to sell only Motor Insurance Policies, including add-ons.
- Either an Insurer or an Intermediary can sponsor a MISP.
- MISP can work for any number of insurers of Intermediaries.
- Sponsoring insurer/Intermediary to issue a Permission Letter to MISP authorising MISP to act on their behalf and sell Motor insurance policies.
- MISP shall appoint a Designated Person responsible for compliance of the Guidelines.
- Any person distributing Motor insurance policies shall be at least 12th passed and shall undergo the training and examination applicable to Point-of-sales Persons.
- Distribution Fees to MISP, if directly engaged by insurer:
 - For 2 wheelers – 22.5% of Own Damage portion
 - For other than 2 wheelers – 19.5% of Own Damage portion

Note: If engaged by intermediary, the Commission ('Remuneration and Reward') payable to intermediary shall not exceed limits specified above.

- Payment under any other head like fees, charges, infrastructure expenses, advertising expenses, documentation charges, legal fees, advisory fees etc. to MISP or intermediaries or their associate companies by insurer prohibited.
- Both Commission & Distribution Fees cannot be paid under the same policy.
- Existing automotive dealers who are intermediaries, shall surrender their certificate of registration and become MISP.

NOMINATION AND ASSIGNMENT

Nomination

Under Life insurance Policies, upon death of the life assured, the Sum Assured is required to be paid to the Legal heirs of the deceased life assured. However, if there is a dispute between legal heirs, the benefits may

not reach the intended beneficiaries on time.

To avoid the above scenario, the facility of nomination is provided to the Person who is taking the Policy at the time of taking the Policy, by filling the names of Nominee(s) in the Proposal form and his/her relationship to the Life assured.

Therefore, nomination is the right of the Policyholder to designate a beneficiary who will receive the Sum assured and other benefits under the Life insurance policy from the Insurance company in the event of his unfortunate death during the term of the Insurance Policy.

The role of Nominee is restricted to receiving benefits only upon death of the life assured. However, where the Life assured survives the date of maturity of the Policy, but dies before the maturity proceeds could be paid to him, the Maturity proceeds shall be paid to the Nominees.

The Person taking the Policy (Policyholder) can be the Life assured himself (own life policy) or the Person taking the Policy can be different from the Life assured. For example, if Wife is the Policyholder, Husband can be the Life assured. Nomination is required only if a person takes own life policy. Where the Policyholder and Life assured are different, upon death of the Life assured, the death benefits are payable only to the Policyholder.

It is to be noted that there is no death claim under a Policy upon death of the Policyholder, unless he himself is the life assured as well. Only upon death of the life assured, the question of payment of death claim arises.

Who can be a Nominee?

Any person who is a relative of the Life assured is generally the Nominee. However, a third party can also be nominated. But the Insurance company can question the third party nomination from insurable interest angle.

Insurable interest is the interest which the Policyholder has on the life to be insured. A person is deemed to be having infinite insurable interest on one's own life. However, where the Life assured is different from the Policyholder, insurable interest has to be established. Otherwise the Policy contract, if issued, becomes void as a Wagering Contract under Section 30 of the Indian Contract Act, 1872. Where a third party is nominated (an outsider), the purpose of establishing insurable interest could be defeated. Hence third party nominations can be questioned from insurable interest angle.

Types of Nominees

Generally, the role of Nominee is that of a Trustee and he can give a valid discharge upon settlement of dues under a Life insurance policy to him. However, a Nominee as a Trustee is accountable to the legal heirs and such legal heirs can claim from Nominees.

There were many legal disputes in the past where Legal heirs made a counter-claim with the Life insurance companies for their share in the proceeds of death claim benefit and this resulted in delays in settlement of the claim till the legal dispute is resolved in the Court of law. As a result, the intended objective of providing an immediate succour to the bereaved family upon the death of the bread-winner was not achieved in many cases.

Therefore, the Government amended Section 39 of Insurance Act, 1938, by recognising 2 types of Nominees – a Beneficial Nominee and a Collector Nominee.

As per Section 39(7) of Insurance Act, 1938, the following relatives of Life assured are categorised as Beneficial Nominees who are beneficially entitled to the proceeds of Life insurance policy to the exclusion of other legal heirs:

- Spouse

- Children
- Parents

Where a person nominates any of the above relatives, even if there is a rival claim from other legal heirs, Insurance companies can proceed with settlement of claims in favour of the above category of Nominees.

Further, Section 39(8) provides that even if such Beneficial nominees die after the death of the life assured, but before receiving the death benefit, the legal heirs of such Beneficial nominees shall be entitled to the Claim proceeds. This goes to prove that the death claim amount for a Beneficial nominee vests in the estate of such Beneficial nominee and shall become their asset. However, a Collector Nominee does not have such a vested right.

The provisions of Section 39(7) & (8), which were inserted under the Insurance Laws (Amendment) Act, 2015, have been made applicable even for Insurance Policies issued before the said Amendment Act.

- Where the Nominee is any other person not covered under the above 3 relationships, he is called a Collector Nominee who merely acts as a Trustee for other Legal heirs. While Insurance companies can settle the claim in favour of such Collector Nominees, his claim is subject to claim, if any, by other legal heirs.
- Other points to be noted concerning Nominations:
- Where Minor is appointed as Nominee, an Appointee (Guardian) has to be appointed in the Proposal form. Such Appointees are entitled to receive Policy benefits during the minority of the Nominee as Trustees for the Minors.
- Nomination made in proposal or can be made (or changed) subsequently
- For Policies issued under Section 6 of the Married Women's Property Act, 1874, only Wife and/or Children can be Nominees and the Policy benefits cannot be attached even by the Creditors of the husband-Life assured. The provisions of Section 39 of Insurance Act are not applicable to such Policies and vice versa
- Nomination to be recorded in the Policy. document by Insurer, based on the nomination details provided by the Proposer in the Proposal form
- Nomination can be changed subsequent to issuance of Policy – Insurer shall register changes to nominations and shall issue an acknowledgement.
- If the Nominee(s) pre-decease the Life assured and no fresh nomination made thereafter, the benefits payable upon subsequent death of the life assured shall accrue to the legal heirs of the deceased life assured.

Assignments

Assignments are transfers of Insurance ownership from one person to another person. It is to be noted only the ownership of the Policy is transferred, but the subject matter of insurance (e.g. Life assured for Life Policy of Motor Car in Motor insurance) cannot be changed.

In Life insurance Policies, unlike General insurance policies, continuance of insurable interest is not necessary after the policy is issued – can be assigned (transferred) after issuance of policy. In General insurance policies, Insurable interest needs to be present both at the time of taking the Policy as well as at the time of claim. Therefore, where, for example, if a Motor car is involved in an accident, the Person claiming motor car insurance benefit will have to be owner at the time of accident.

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Therefore, ownership under Life insurance Policies can be transferred to another person freely, like any other Financial asset. However, there was an instance where LIC refused to register assignment of Life insurance policy on the ground that there was trading in insurance policies through multiple assignments. In the case of LIC of India Vs. Insure Policy Plus Services (SC 8542 of 2009), Hon'ble Supreme Court of India held that LIC had no powers to reject assignments under the old Section 38 of Insurance Act, 1938.

Consequent to the above case, the Insurance Laws (Amendment) Act, 2015 have vested powers with Insurers to refuse assignments if such assignments are against Policyholder/ Public interest or if such assignments would result into Trading in Insurance Policies. Reasons for refusal of assignments shall be communicated within 30 days to the Policyholder. A Policyholder who is aggrieved by the decision of refusal to register assignment, may prefer an appeal with IRDAI.

Other provisions regarding assignment of insurance policies are given below:

- Notice of assignment to insurer and registration of assignment mandatory – no transfer of an Insurance Policy is valid unless notice of such assignment is given to the Insurer along with the Deed of assignment (forms provided by the Insurer) and such assignment is registered in the records of the insurer.
- Conditional assignment recognised – i.e. transfers of insurance policies on the condition that the assigned Policy would be re-transferred to the original Policyholder or to another person upon happening of an event during the life time of the Person whose life is insured.
- KYC of assignee mandatory – Assignee shall produce KYC before an assignment can be registered.
- Partial assignments of Insurance Policies recognised – where the partial assignment of rights under an insurance policy is enabled.

Assignment of Policies – impact on existing Nomination.

Assume that Life Assured A, who has taken a Life insurance Policy on his own life, has nominated X as the Nominee at the time of taking the Policy. Subsequently, A transfers (assigns) the Policy to Y and gets the assignment registered in favour of Y with Insurance company. Now Y is the new Policyholder (Assignee) and A continues to be the Life assured (Assignor). If A dies, who will get the death benefit? Y, the new Policyholder (Assignee) or X (the Nominee)?

The answers to the above question are discussed in the following points:

- As per Section 39(4) of Insurance Act, 1938, as a rule, assignment of an Insurance Policy automatically cancels nomination, subject to some exceptions given below
- Under the following circumstances, an Assignment does not automatically cancel nomination:
 - Where Policy Loan is taken from the Life insurer who issues the Policy, as a pre-condition of sanction of Loan, the Policy has to be assigned in favour of the Life insurer. Under such circumstances, such assignment in favour of Life insurer does not automatically cancel subsisting Nomination. But in the event of death while the Loan subsists, the rights of Nominee is subject to satisfaction of the outstanding loan and interest and only the balance amount, if any, can be paid to the Nominee.
 - Similarly, where the Policy is assigned by a Debtor (Policyholder/Borrower/Assignor) to Creditor (Lender/Assignee) as a collateral security for the loan taken by the Policyholder from the Assignee, the Nomination is not cancelled, but only the residual amount, if any, after satisfaction of the outstanding amount on death, to the assignee, shall be paid to the Nominee.

- The nomination which was cancelled automatically upon assignment, shall stand automatically reinstated upon reassignment in favour of the Policyholder (Original Assignor). There is no need for making fresh nomination and pre-assignment nomination stands automatically reinstated, unless the Policyholder wants to change the Nomination.

OTHER AREAS OF PROTECTION OF POLICYHOLDERS INTERESTS

Claims under Life insurance policies

Upon death of the Life assured, the Nominee shall prefer a claim with the insurance company submitting certain claim documents. A life insurance company may investigate a claim to rule the possibility of any frauds, especially for early claims. Any claim occurring within 2 years of taking a Life insurance policy is categorised as 'Early claims'. This raises a suspicion of breach of the condition of 'utmost good faith', the obligation on the part of the Life assured to disclose the status of his/her health in the Proposal form correctly and without hiding any material information. Therefore, an investigation is undertaken by Life insurance companies with the probable Hospitals, Clinics, Diagnostic Centres, Treating Doctors etc., to verify the status of health of the Life assured at the time of taking the Policy. If the investigation reveal any adverse findings which were not disclosed in the Proposal form for Life insurance, the claim may be repudiated in terms of Section 45 of the Insurance Act, 1938.

Following are the procedural compliance requirements under the IRDAI (Protection of Policyholders' Interests) Regulations, 2017:

- Customer requirements must be raised by Life insurance companies within 15 days of receipt of intimation.
- Non-investigation Claims shall be paid or rejected or repudiated within 30 days of receipt of receipt of all papers & clarifications.
- Time limit for completion of investigation – 90 days – claim to be decided within 30 days of receipt of investigation report.
- For delays in settlement of claims, interest @ 2% above bank rate shall be payable from the date of receipt of last necessary document.
- For disputes in title, payment can be made to Court (Section 47 of Insurance Act, 1938).
- Except claims under Section 47, where claim cannot be paid for want of identification of payee, interest at bank rate payable from the date when claim is ready for payment.
- Where nominee not traceable, claim cannot be written back.
- For deaths due to suicide, 80% of the premiums paid payable (for reinstated cases, higher of 80% or surrender value whichever is higher; for ULIPs fund value).
- Where fraud or misrepresentation is established, surrender value shall be paid.
- For maturity/survival benefit settlement to be made on or before due date. For delays interest at Bank rate+2% from due date or date of receipt of last necessary document from insured/claimant, whichever is later.
- For delays in processing Freelook cancellation, Surrender, Withdrawal, request for refund of Proposal deposit, refund of Proposal deposit, interest at Bank rate+2% from date of receipt of request or receipt of last necessary document, if any, whichever is later.

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- If the customer expresses reluctance, Discharge voucher cannot be insisted as a precondition to settlement of claims.
- In Group Credit Life Policies (Lender-Borrower Groups), payment of claim amount to the extent of outstanding loan amount as per the books of the Lender (Group Policyholder) and balance amount should be paid to the Nominee.

General Insurance/Health Insurance Claims

- On receipt of claims intimation, General insurer to intimate the claims procedure to claimant.
- Surveyor, where required, to be appointed within 72 hours & details of Surveyor to be communicated to claimant.
- Within 7 days of claim intimation, Surveyor to inform claimant about the documents required – where claimant submit full information or does not cooperate, the Surveyor Insurer shall inform the claimant about possible delays in processing the claim – insurer and surveyor duty bound to followup with claimant for submission of documents.
- Surveyor to commence work within 48 hours of appointment.
- Interim report to be submitted within 15 days of first visit by Surveyor to insurer, with a copy to claimant if desired by the claimant.
- Final report within 30 days of appointment to insurer, with a copy to the insured – 90 days for commercial and large risks.
- Insurer can demand additional report from surveyor – within 15 days of receipt of Surveyor's report, with intimation to claimant.
- Additional report to be submitted by Surveyor within 3 weeks
- Settlement or rejection of claim – within 30 days of receipt of Final Surveyor's report/Additional survey report.
- Where claim is part-settled, basis for part-settlement and where the claim is rejected, reasons thereof with references to clauses in policy document shall be given to claimant.
- For delays in settlement of claim beyond 30 day period, interest payable @ 2% above bank rate from the date of submission of last requirement by the claimant till date of settlement.
- **Health insurance claims:**
 - Every health insurance claim shall be settled within 30 days of receipt of last necessary document.
 - Where investigation deemed necessary by insurer, it shall be completed within 30 days of receipt of last necessary document and claim settled within 45 days of receipt of last necessary document.
 - For any delay beyond the 30/45 day period, interest @2% above bank rate payable from the date of receipt of last necessary document.

Implications of Section 45 of the Insurance Act (as amended by the Insurance Laws (Amendment) Act, 2015)

Section 45 of the Insurance Act, 1938 provides the remedy to a Life insurer for breach of the condition of utmost good faith ('uberrimaefidei') on the part of the life assured. It gives the right to the Life insurer to repudiate (not

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to pay) a claim under a Life insurance policy if there was a misstatement, concealment or misrepresentation on any fact which was material to consideration of the risk by a Life insurer.

Section 45 as it stood before the Insurance Laws (Amendment) Act, 2015, gave powers to cancel a Policy or repudiate a claim on the establishment of misstatements, concealments or misrepresentation by the Life assured any time after the issue of the Policy. However, after a period of 2 years from taking the policy or reinstatement of a lapsed Policy, only if fraud is established on the part of the life assured, cancelling a Policy or repudiation of the claim was possible.

However, in the amended Section 45 by the above amendment act, a 3 year time-limit has been fixed for any cancellation of Policy or repudiation of claim on the above grounds. After the passage of the amendment act (which was preceded by an Insurance Laws Amendment Ordinance on 26 December 2014), no Life insurer can call in question a life insurance Policy (cannot cancel or repudiate a policy) on any ground whatsoever (whether for misrepresentation, concealment or misstatement on the grounds of fraud or even otherwise), after a period of 3 years from the date of taking the Life insurance policy (3 years from the date of commencement of Policy) or 3 years from the date of reinstatement of a lapsed Policy whichever is later.

This is a Policyholder protection initiative, intended to advise Life insurers to tighten their underwriting and placing a time limit for such cancellations and repudiations for any reason whatsoever.

However, within the above 3 years period, Life insurance companies are well within their right to call such Policies in question if they are able to prove with documentary evidence that such misstatements etc., were material to the Underwriter for consideration of the risk and could have significantly impacted the decision of the Underwriter. Where Fraud is established, premiums paid till the date of such cancellation or repudiation can be forfeited. However, where the mis-statements were proved to be unintentional, premiums paid by the Life assured till the date of cancellation or repudiation will have to be refunded.

Amended Section 45 states that no policy of life insurance shall be called in question for any reason whatsoever after a period of 3 years from the date of commencement, date of issuance, date of reinstatement, date of rider, whichever is later.

- Within 3 years, claim can repudiated on the grounds of fraud, misrepresentation (or) on the grounds of incorrect misrepresentation (no fraud).
- Refund of premium mandated where repudiation is on the grounds of incorrect misrepresentation.
 - grounds and materials based on which repudiation made to be communicated to the Claimant.
 - For ULIPs, repudiated within 3 years from the date of revival, Fund value on the date of revival + premiums collected upon reinstatement + premiums collected subsequent to revival to be refunded.
 - In the case of Money back policies where repudiation happens due to misrepresentation at the time of reinstatement, premiums from the date of reinstatement of a lapsed policy, till the date of repudiation to be refunded after adjusting any Survival Benefits, if any, paid after the date of revival.
 - No repudiation possible if the reinstatement was made just by paying arrears of premium with or without interest, but without any Declaration of Good Health.
- No repudiation possible if the facts alleged to have been misrepresented by the Life assured were within the knowledge of the Agent who had sourced the Policy from the Customer.

Treatment of Unclaimed amounts of Policyholders

These are amounts due to Policyholders which cannot be paid for certain reasons such as Disputes between Legal heirs Vs. Nominees, Cheques issued by not encashed, failure of NEFT etc. The regulatory provisions in this regard are summarised below:

- Names & address of holders of unclaimed policy amounts pending for more than 6 months to be displayed in insurer's website with half yearly updates.
- All policy benefit payments to be made only through NEFT/RTGS/ECS/ACH except for payments up to ₹10,000.
- Unclaimed amounts to be invested in money market instruments or Fixed Deposits and shall be kept in a separate Fund.
- Fund management expenses of insurer not to exceed 20 basis points.
- As and when Customer identified, the fund value shall be paid to the Customer.
- Any amount lying in Unclaimed account for more than 10 years shall be transferred to "Senior Citizens Welfare Fund" on or before 01 March 2018 (Senior Citizens' Welfare Fund Rules 2016 read with IRDAI Circular dated 25 July 2017).
- Transfers to the above Fund shall be on net basis, viz., Unclaimed amounts minus the claims accepted and paid out of already transferred unclaimed amounts.
- Insurer to try to contact Policyholders at least 2 times within a period of 6 months of becoming overdue.
- If no claim is made by the Claimant within a period of 25 years from the date of transfer to Senior Citizens Welfare Fund, the amount stands forfeited to the Central Government.

Dispute Resolution Mechanisms

A Policyholder or Nominee may have a complaint on the Insurance Policy he has purchased or on the benefits paid/payable under the Policy. These are the 2 main category of complaints, viz., Policy he has purchased, e.g. Mis-selling by distributor, misunderstanding on terms and conditions or non-receipt of Policy bond. On the Benefits paid/payable, it could be on non-payment, short-payment or delayed payment of Policy benefits.

A Grievance is defined as an expression of dissatisfaction by a customer on the action or inaction on the standard of service or deficiency of service of an insurance company or any intermediary and asks for remedial action. It is distinguished from inquiry or a request which is seeking information or requesting for a service and are not considered as Grievances.

Every insurance company shall have a designated senior officer at the level of CEO or Compliance Officer of the Company as the Grievance Officer. Further every office of the insurer shall also have a designated Grievance officer for such office.

The process for handing a Grievance is as follows:

- (a) Every grievance shall be acknowledged within 3 working days of receipt of grievance, containing the name and designation of the person who will deal with the grievance.
- (b) The Grievance redressal procedure including the time taken for resolution of disputes shall be mentioned in the acknowledgement.
- (c) Normally a Grievance shall be resolved within 3 days. However, where it is not possible to resolve

within 3 days, the insurer shall resolve the complaint within 2 weeks and shall send a final letter of resolution.

- (d) Where a complaint is rejected, the reasons shall be clearly stated along with the recourse available if the customer is still dissatisfied.
- (e) Further if the insurer shall inform the customer that if the customer does not come back within 8 weeks from the date of providing resolution, the grievance shall be treated as closed.
- (f) A grievance can be closed only if the following conditions are satisfied:
 1. Where the insurance company has acceded to customer's grievance, upon acceding to the request of the customer.
 2. Where the insurance company rejects the customer's grievance, upon receipt of a communication from customer accepting the company's resolution.
 3. Where the insurance company rejects the customer's grievance and the customer does not respond within 8 weeks of receipt of resolution, upon completion of the 8 weeks.
 4. In all the above instances, the Grievance Redressal Officer shall certify that the Insurance company has discharged its contractual, statutory or regulatory obligations.

Every insurance company shall publish the Grievance Redressal Procedure in the website of the insurance company. The Policy holders Protection Committee of the Insurance Company shall receive reports concerning Grievances and shall monitor the process of handling grievances.

INSURANCE OMBUDSMEN RULES, 2017

The object of these Rules is to resolve all complaints of all personal lines of insurance, group insurance policies, policies issued to sole proprietorship and micro enterprises on the part of insurance companies and their agents and intermediaries in a cost effective and impartial manner. These rules shall apply to all insurers and their agents and intermediaries in respect of complaints of all personal lines of insurance, group insurance policies, policies issued to sole proprietorship and micro enterprises.

The ultimate objective of these Rules is to provide for a speedy redressal of certain grievances specific to insurance sector. This is an alternative dispute resolution mechanism which is managed by insurance companies to solve the disputes arising within the industry.

- (a) An Executive Council of Insurers shall be established under these Rules comprising of the following representatives:
 - (b) Executive Council of Insurers shall comprise of 9 members including the Chairperson
- Members of the Executive Council of Insurers shall comprise of:
- (i) 2 persons representing life insurers to be nominated by the Life Insurance Council;
 - (ii) 2 persons representing General insurers, other than stand-alone health insurers, to be nominated by the General Insurance Council;
 - (iii) 1 person representing stand-alone health insurers to be nominated by the General Insurance Council;
 - (iv) 1 representative of the IRDAI; and

- (v) 1 representative of the Central Government in the Ministry of Finance from the Department of Financial Services not below the rank of Director.
- (vi) Chairman, Life Insurance Corporation of India (LIC of India) established under the Life Insurance Corporation Act, 1956 (31 of 1956) or the Chairman, General Insurers' (Public Sector) Association of India (GIPSA) established under the General Insurance Business (Nationalisation) Act, 1972 (57 of 1972) provided they are not acting as Chairperson of the Executive Council of Insurers.

The Chairperson of the Executive Council of Insurers shall be either the Chairman of the LIC of India or the Chairman of the GIPSA by rotation.

The term of the Chairperson and members of the Executive Council of Insurers shall be three years from the date of assumption of charge.

The nominations to the Executive Council of Insurers shall be revised every three years or as and when the vacancy arises, whichever is earlier.

A member of the Executive Council of Insurers shall not be eligible for re-nomination for a period of three years from the date he ceases to be a member (not applicable to IRDAI representative, Central Government representative, LIC & GIPSA representatives)

Functions of the Executive Council of Insurers

The functions of the Executive Council of Insurers are as follows:

- (a) issue such guidelines, including, inter-alia, relating to the procedure for the day to day administration, secretariat staffing, secretariat administrative infrastructure, and such other related aspects of functioning of insurance Ombudsman system.
- (b) In case any vacancy arises in any Insurance Ombudsman due to resignation or retirement or death of the Ombudsman, the Executive Council of Insurers shall direct an Ombudsman of such other territorial jurisdiction to hold additional charge of the Insurance Ombudsman where such vacancy may arise.
- (c) The Executive Council of Insurers may constitute such committees and as and when deemed necessary obtain the assistance of outside expertise for preparing the guidelines referred to in sub-rule (1).

Establishment of Ombudsmen Offices and process of selection of Insurance Ombudsmen

There shall be established such number of Insurance Ombudsman for such territorial jurisdiction as the Executive Council of Insurers may specify, for discharging the duties and functions prescribed under the Insurance Ombudsmen Rules, 2017.

An Ombudsman shall be selected from amongst persons having experience of the insurance industry, civil service, administrative service or judicial service.

An Ombudsman shall be selected by a Selection Committee comprising of:

- (a) Chairperson of the IRDAI, who shall be the Chairman of the Selection Committee.
- (b) one representative each of the Life Insurance Council and the General Insurance Council from the Executive Council of Insurers – members.
- (c) A representative of the Government of India not below the rank of a Joint Secretary or equivalent, in the Ministry of Finance, from the Department of Financial Services-member.

The Executive Council of Insurers shall prepare a panel through an open process by inviting applications from

amongst the eligible candidates and the selection process shall be in accordance with the selection criteria finalised by the Executive Council of Insurers with the approval of the Central Government in the Ministry of Finance.

An Ombudsman shall be appointed after satisfactory vigilance clearance from the immediate previous employer and medical fitness report from an authorised doctor.

Term of office of Insurance Ombudsmen

An Insurance Ombudsmen is appointed for a term of 3 years. However, no person can continue as Insurance Ombudsman after he/she has attained 70 years of age

Remuneration of Insurance Ombudsmen

The Ombudsman shall be allowed a fixed pay of two lakh twenty-five thousand rupees per month and any pension to which he is entitled from the Central Government or a State Government shall be deducted from his salary. Other allowances and perquisites as may be determined by the Executive Council of Insurers with the prior approval of Central Government, shall also be payable to the Ombudsman.

Territorial jurisdiction of Ombudsmen

The office of the Insurance Ombudsman shall be located at such places and shall have such territorial jurisdiction as may be specified by the Executive Council of Insurers from time to time.

Duties and functions of Insurance Ombudsman (Rule 14)

The Ombudsman shall receive and consider complaints or disputes relating to:

- (a) delay in settlement of claims, beyond the time specified in the regulations, framed under the Insurance Regulatory and Development Authority of India Act, 1999;
- (b) any partial or total repudiation of claims by the life insurer, General insurer or the health insurer ;
- (c) disputes over 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 in so far as the dispute relates to claim;
- (f) policy servicing related grievances against insurers and their agents and intermediaries;
- (g) 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;
- (h) non-issuance of insurance policy after receipt of premium in life insurance and general insurance including health insurance; and
- (i) 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 Ombudsman shall act as counsellor and mediator relating to matters specified in the above Section provided there is written consent of the parties to the dispute.

The Ombudsman shall be precluded from handling any matter if he is an interested party or having conflict of interest.

The Central Government or as the case may be, the IRDAI may, at any time refer any complaint or dispute relating to insurance matters specified in sub-rule (1), to the Insurance Ombudsman and such complaint or dispute shall be entertained by the Insurance Ombudsman and be dealt with as if it is a complaint made under rule 14.

Procedure before Ombudsmen

- (1) Any person who has a grievance against an insurer, may himself or through his legal heirs, nominee or assignee, make a complaint in writing to the Insurance Ombudsman within whose territorial jurisdiction the branch or office of the insurer complained against or the residential address or place of residence of the complainant is located.
- (2) The complaint shall be in writing, duly signed by the complainant or through his legal heirs, nominee or assignee and shall state clearly the name and address of the complainant, the name of the branch or office of the insurer against whom the complaint is made, 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 from the Insurance Ombudsman.
- (3) No complaint to the Insurance Ombudsman shall lie unless:
 - (I) the complainant makes a written representation to the insurer named in the complaint and:
 - (a) either the insurer had rejected the complaint; or
 - (b) the complainant had not received any reply within a period of one month after the insurer received his representation; or
 - (c) the complainant is not satisfied with the reply given to him by the insurer;
 - (II) the complaint is made within one year:
 - (a) after the order of the insurer rejecting the representation is received or
 - (b) after receipt of decision of the insurer which is not to the satisfaction of the complainant;
 - (c) after expiry of a period of one month from the date of sending the written representation to the insurer if the insurer named fails to furnish reply to the complainant .

The Ombudsman shall be empowered to condone the delay in such cases as he may consider necessary, after calling for objections of the insurer against the proposed condonation and after recording reasons for condoning the delay and in case the delay is condoned, the date of condonation of delay shall be deemed to be the date of filing of the complaint, for further proceedings under these rules.

Prohibition of simultaneous remedies in multiple fora

No complaint before the Insurance Ombudsman shall be maintainable on the same subject matter on which proceedings are pending before or disposed of by any court or consumer forum or arbitrator.

Proceedings before the Ombudsmen

The Ombudsman may, if he deems fit, allow the complainant to adopt a procedure other than under sub-rule (1) or sub-rule (2) of rule 14 for making a complaint, after notifying the parties to the dispute.

During the course of proceedings before him, the Ombudsmen has the following powers:

- (a) The Ombudsman shall have the power to ask the parties concerned for additional documents in

support of their respective contentions and wherever considered necessary, collect factual information relating to the dispute available with the insurer and may make available such information to the parties concerned.

- (b) The Ombudsman may obtain the opinion of professional experts, if the disposal of a case warrants it.
- (c) The Ombudsman shall dispose of a complaint after giving the parties to the dispute a reasonable opportunity of being heard

DECISIONS OF OMBUDSMEN – RECOMMENDATIONS & AWARDS

(a) Recommendations made by the Insurance Ombudsman

Where a complaint is settled through mediation, the Ombudsman shall make a recommendation which it thinks fair in the circumstances of the case, within one month of the date of receipt of mutual written consent for such mediation and the copies of the recommendation shall be sent to the complainant and the insurer concerned.

If the recommendation of the Ombudsman is acceptable to the complainant, he shall send a communication in writing within fifteen days of receipt of the recommendation, stating clearly that he accepts the settlement as full and final.

The Ombudsman shall send to the insurer, a copy of its recommendation, along with the acceptance letter received from the complainant and the insurer shall, thereupon, comply with the terms of the recommendation immediately but not later than fifteen days of the receipt of such recommendation, and inform the Ombudsman accordingly.

(b) Awards by Ombudsmen

Where the complaint is not settled by way of mediation under rule 16, the Ombudsman shall pass an Award, based on the pleadings and evidence brought on record.

The Award shall be in writing and shall state the reasons upon which the award is based. Where the Award is in favour of the complainant, it shall state the amount of compensation granted to the complainant after deducting the amount already paid, if any, from the award.

However, the Ombudsman shall not award any compensation in excess of the loss suffered by the complainant as a direct consequence of the cause of action or shall not award compensation exceeding ₹30 lakhs (including relevant expenses, if any).

The Ombudsman shall finalize its findings and pass an award within a period of 3 months of the receipt of all requirements from the complainant.

A copy of the award shall be sent to the complainant and the insurer named in the complaint.

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 complainant shall be entitled to such interest at a rate per annum as specified in the regulations, framed under the Insurance Regulatory and Development Authority of India Act, 1999, from the date the claim ought to have been settled under the regulations, till the date of payment of the amount awarded by the Ombudsman.

The award of Insurance Ombudsman shall be binding on the insurers.

Annual Report on Ombudsmen activities

The Ombudsman shall prepare an annual report detailing the activities undertaken during the previous financial

year under their jurisdiction, statement of accounts and any other relevant information and submit to the Executive Council of Insurers with a copy to the IRDAI by the 30th June every year

The Executive Council of Insurers shall on receipt of annual reports of all Insurance Ombudsman, furnish a report containing a general review of the activities of Insurance Ombudsman during the preceding financial year and such other information as it may consider necessary, to the Central Government and to the IRDAI any time after the 30th June but not later than the 30th September, every year.

The IRDAI shall consider the annual reports and the report of the Executive Council of Insurers and take suitable steps as it deems fit and necessary.

Advisory Committee on Ombudsmen

An Advisory Committee consisting of eminent persons not exceeding five and including one Central Government nominee shall be constituted by the IRDAI to review the performance of the Insurance Ombudsman from time to time.

The IRDAI shall decide the time, venue and quorum of the meeting of the Advisory Committee.

The Advisory Committee shall submit its report to the IRDAI for review and further action as deemed necessary

CONSUMER COURTS

Consumer Protection Act is an act of Parliament enacted in 1986 to protect interests of consumers in India. It makes provision for the establishment of consumer councils and other authorities for the settlement of consumers' disputes and for matters connected therewith. Consumer Protection Councils are established at the national, state and district level to increase consumer awareness. The Central Consumer Protection Council is established by the Central Government which consists of the Minister of Consumer Affairs as the chairman and such number of other official or non-official members representing such interests as may be prescribed. The State Consumer Protection Council consists of the Minister in charge of consumer affairs in the State Government as the Chairman and such other officials appointed by the Central and State Government.

The word complainant means:

- (a) A Consumer
- (b) A voluntary consumer association
- (c) Central Government or State Government
- (d) One or more consumers where there are numerous consumers having the same interest
- (e) In the case of death of a consumer, his or her legal heir or representative.

Definition of Consumer

Consumer means any person who:

- (a) Buys any goods for a consideration which has been paid or promised or partly paid and partly promised or under any system of deferred payment.
- (b) Any user of the such goods other than the person who buys such goods as above if such use is made with the approval of the person who has bought it.
- (c) Hires or avails of any services for a consideration which has been paid or promised or partly paid and partly promised or under any system of deferred payment and includes any beneficiary of such

services other than the person who hires or avails of the services for consideration paid or promised or partly paid and partly promised or under any system of deferred payment with the approval of the first mentioned person. It does not include a person who avails of such services for any commercial purposes.

What is a Complaint

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

- (a) An unfair trade practice or a restrictive trade practice has been adopted by any trader or service provider;
- (b) The goods bought by him or agreed to be bought by him suffer from one or more defects.
- (c) The services hired or availed of or agreed to be hired or availed off by him suffer from deficiency in any respect;
- (d) A trader or service provider as the case may be has charged for the goods or for the services mentioned in the complaint, a price in excess of the price fixed by or under any law for the time being in force displayed on the goods or any package containing such goods, displayed on the price list exhibited by him by or under any law for the time being in force, agreed between the parties;
- (e) Goods which will be hazardous to life and safety when used are being offered for sale to the public –In contravention of any standards relating to safety of such goods as required to be complied with, by or under any law for the time being in force; If the trader could have known with due diligence that the goods so offered are unsafe to the public;
- (f) Service which are hazardous or likely to be hazardous to the life and safety of the public when used, are being offered by the service provider which such person could have known with due diligence to be injurious to life and safety.

Who is a Consumer?

Any person who buys goods or avails services for consideration. Consideration may be fully paid, partially paid or fully promised to be paid or partially promised to be paid. Consumer also include any body who uses the goods or services with the consent of the consumer.

What is a Defect?

Fault, imperfection or a shortcoming in the quality quantity potency purity or standards which is required to be maintained by or under any law for the time being in force.

What is Service?

“Service” means service of any description, which is made available to potential users and includes, but not limited to the provisions of the facilities in connection with 1) banking 2) financing 3) insurance 4) transport processing 6) supply of electrical or other energy 7) boarding or lodging or both 8) house construction 9) entertainment 10) amusement or 11) the purveying or new or other information But does not include the rendering of any service free of charge or under a contract of personal service.

Consumer for a and their jurisdiction:

- (a) District Consumer Disputes Redressal Forum established by the State Government in each district of the State. The State Government may establish more than one District Forum in a district. It is a district

level court that deals with cases valuing up to Rs.20 lakhs.

- (b) State Consumer Disputes Redressal Forum established by the State Government takes up cases valuing less than ₹1 Crore.
- (c) National Consumer Disputes Redressal Commission established by the Central Government, which works as a national level Court and deals with amounts more than ₹1 Crore.

None of the above fora can entertain a complaint unless it is filed within two years from the date on which the cause of action had arisen. Notwithstanding the above, a complaint may be entertained after the period of two years, if the complainant satisfies the concerned forum that he had sufficient cause for not filing the complaint within such period and the reason for condonation of the delay is recorded by the concerned forum.

Filing of complaints

A complaint may be filed by the consumer to whom the goods are sold or services are provided. Any recognised consumer association one or more consumers with same interest.

Power of Civil Court to District Forum

The District Forum shall have the powers of Civil Court while trying a suit in respect of the following matters:

- (a) The summoning and enforcing attendance of any defendant or witness and examining the witness on oath.
- (b) The discovery and production of any document or other material object producible as evidence.
- (c) The reception of evidence on affidavit.
- (d) The requisition of the report of the concerned analysis or test from the appropriate laboratory or from any other relevant source.
- (e) Any other matter which may be prescribed.

Relief to the Complainant

If the complaint is proved the Forum shall order to remove defect pointed out by the appropriate laboratory from the goods in question or to replace the goods with new goods of similar description which shall be free from any defect or to return to the complainant the price, or, as the case may be, the charges paid by the complainant or to pay such amount as may be awarded by it as compensation to the consumer for any loss or injury suffered by the consumer due to negligence of the opposite party or to remove the defect in goods or deficiency in the services in question. The following relief may be provided to the Complainants:

- (a) To discontinue the unfair trade practice or the restrictive trade practice or not to repeat them;
- (b) Not to offer hazardous goods for sale;
- (c) To withdraw the hazardous goods from being offered for sale;
- (d) To cease manufacture of hazardous goods and to desist from offering services which are hazardous in nature;
- (e) To pay such sum as may be determined by it, if it is of the opinion that loss or injury has been suffered by a large number of consumers who are not identifiable conveniently;
- (f) To issue corrective advertisements to neutralize the effect of misleading advertisement at the cost of

the opposite party responsible for issuing such misleading advertisement;

- (g) To provide for adequate cost to parties.

Appeals

An appeal shall be filed within thirty days. Delay in filing appeal may be condoned if there is sufficient cause.

Regulatory aspects of Solvency margin

Solvency Margin denotes the excess of assets over liabilities of an insurance company. This is equivalent of Net worth which denotes the financial health of the Company. As per IRDAI Regulations, the minimum statutory solvency ratio must be 1.5 at all times for an insurance company. That is to say, the Assets must be 1.5 times of Liabilities at all times. If there is a threat of solvency margin falling below the threshold level of 1.5, the Shareholders will have to bring in extra capital to boost solvency. This usually happens in the initial period of an insurance company and Companies which are growing significantly without a good Renewal premium book. Under such circumstances, the Company would burn more expenses without corresponding income (which can come in future years) and therefore increasing losses. If the loss increases, Solvency will be impacted as the Net worth will decrease.

IRDAI have issued separate Regulations on Assets, Liabilities and Solvency Margins. These Regulations give the method of valuation of Assets and Liabilities of Insurance companies.

On Valuation of Assets, the above Regulations provides as follows:

The following assets shall valued at 'zero value':

- (a) Agents balances and outstanding premiums in India to the extent they are not realised within a period of 30 days;
- (b) Agents balance and outstanding premiums outside India to the extent they are not realisable
Sundry debts to the extent that they are not realisable;
- (c) Advances of unrealisable character;
- (d) Furniture, Fixtures, Dead stock and Stationery;
- (e) Deferred expenses;
- (f) Profit & Loss account and any other fictitious assets other than Prepaid expenses;
- (g) Reinsurers' balances outstanding for more than 3 months;
- (h) Preliminary expenses in the formation of the Company;

Computer equipments, including Software shall be valued as follows:

- (a) 75% of its cost in the year of purchase;
- (b) 50% of its cost in the second year;
- (c) 25% of its cost in the third year;
- (d) 0% thereafter.

All other assets shall be valued as per IRDAI Regulations on Financial Statements and Auditors' Report for Insurance Companies.

Method of calculation of Liabilities

Mathematical Reserves

Mathematical reserves denote the liability on the books of the insurance company on the Policies already issued by the Insurance company and in-force in the books of the insurance company.

Reserves for each Policy contract shall be calculated separately by a prospective method of valuation. The valuation method shall take into account all prospective contingencies under which any premiums (by the Policyholder) or benefits (to the Policyholder/beneficiary) may be payable under the Policy as per Policy conditions. The levels of benefits shall take into account the reasonable expectations of Policyholders with regard to payment of bonuses of Policyholders and any established practices of an insurer for payment of benefits.

If any options are available under the Policy under the terms of contract, such options shall also be considered.

Prudent assumptions shall be made for relevant parameters. The value of such parameter shall be based on insurer's expected experience and shall include an appropriate margin for adverse deviations, which will increase the Mathematical reserves.

Where there is a negative mathematical reserve for a Policy, such negative reserves shall be ignored. However, where the mathematical reserve is less than guaranteed surrender value, to such guaranteed surrender value.

The above method is called Gross Premium Method. However, Appointed Actuary, as he deems fit, use other methods as well, e.g. retrospective method. However, the amount of mathematical reserve shall not be less than the reserves calculated as per the Gross Premium Method.

The determination of the amount of mathematical reserves shall take into account the nature and term of the assets representing those liabilities and the value placed upon them and shall include prudent provision against the effects of possible future changes in the value of assets on the ability of the insurer to meet its obligations arising under policies as they arise.

Policy Cash Flows

The gross premium method of valuation shall discount the following future policy cash flows at an appropriate rate of interest:

- (a) premiums payable, if any, benefits payable, if any, on death; benefits payable, if any, on survival; benefits payable, if any, on voluntary termination of contract, and the following, if any:-
 - (i) basic benefits,
 - (ii) rider benefits,
 - (iii) bonuses that have already been vested as at the valuation date,
 - (iv) bonuses as a result of the valuation at the valuation date, and
 - (v) future bonuses (one year after valuation date) including terminal bonuses (consistent with the valuation rate of interest).
- (b) commission and remuneration payable, if any, in respect of a policy (This shall be based on the current practice of the insurer). No allowance shall be made for non-payment of commissions in respect of the orphaned policies;
- (c) policy maintenance expenses, if any, in respect of a policy;

- (d) allocation of profit to shareholders, if any, where there is a specified relationship between profits attributable to shareholders and the bonus rates declared for policyholders, after allowance for Income-tax.

Policy Options

Where a policy provides built-in options, that may be exercised by the policyholder, such as conversion or addition of coverage at future date(s) without any evidence of good health, annuity rate guarantees at maturity of contract, etc., the costs of such options shall be estimated and treated as special cash flows in calculating the mathematical reserves.

Valuation Parameters

The valuation parameters shall constitute the bases on which the future policy cash flows shall be computed and discounted. Each parameter shall have to be appropriate to the block of business to be valued. An appointed actuary shall take into consideration the following:

- (a) The value(s) of the parameter shall be based on the insurer's experience study, where available. If reliable experience study is not available, the value(s) can be based on the industry study, if available and appropriate. If neither is available, the values may be based on the bases used for pricing the product. In establishing the expected level of any parameter, any likely deterioration in the experience shall be taken into account.
- (b) The expected level, as determined in clause (a) of this sub-para, shall be adjusted by an appropriate Margin for Adverse Deviations (MAD), the level of MAD being dependent on the degree of confidence in the expected level, and such MAD in each parameter shall be based on the Guidance Notes issued by the Institute of Actuaries of India, with the concurrence of the Authority.
- (c) The values used for the various valuation parameters should be consistent among themselves.

Mortality and Morbidity rates

Mortality rates denote the rate of death of assured lives for various ages. These mortality tables are published by Mortality and Morbidity Insurance Centre. Morbidity rates denote the rate of sickness for various ages. Morbidity Table is useful for calculating the Premiums for Hospitalisation benefits, including Critical illness benefits under Insurance Policies.

The Mortality and Morbidity Tables to be used shall be by reference to a published table, unless the insurer has constructed a separate table based on his own experience. However, such published table shall be made available to the insurance industry by the Institute of Actuaries of India, with the concurrence of the Authority. Moreover, such rates determined by reference to a published table shall not be less than hundred per cent. of that published table, unless the appointed actuary can justify a lower per cent.

Policy maintenance expenses

Policy maintenance expenses incurred by the Insurer in maintaining a Policy, such as collection of renewal premium, payment of renewal commission etc.

Policy maintenance expenses shall depend on the manner, in which they are analysed by the insurer, viz., fixed expenses and variable expenses. The variable expenses shall be related to sum assured or premiums or benefits. The fixed expenses may be related to sum assured or premiums or benefits or per policy expenses. All expenses shall be increased in future years for inflation, the rate of inflation assumed should be consistent with the valuation rate of interest.

Valuation rates of interest

Valuation rates denote the rates of interest assumed by the Appointed Actuary in calculating the reserves.

The Valuation rates of interest to be used by appointed actuary –

- (e) shall be not higher than the rates of interest, for the calculation of the present value of policy cash flows, determined from prudent assessment of the yields from existing assets attributable to blocks of life insurance business, and the yields which the insurer is expected to obtain from the sums invested in the future, and such assessment shall take into account –
 - (i) the composition of assets supporting the liabilities, expected cash flows from the investments on hand, the cash flows from the block of policies to be valued, the likely future investment conditions and the reinvestment and disinvestment strategy to be employed in dealing with the future net cash flows;
 - (ii) the risks associated with investment in regard to receipt of income on such investment or repayment of principal;
 - (iii) the expenses associated with the investment functions of the insurer;
- (f) shall not be higher than, for the calculation of present value of policy cash flows in respect of a particular category of contracts, the yields on assets maintained for the purpose of such category of contracts;
- (g) in respect of non-participating business, shall recognise the risk of decline in the future interest rates;
- (h) in respect of participating business, shall be based on the assumption (with regard to future investment conditions), that the scale of future bonuses used in the valuation is consistent with the valuation rate of interest, and
- (i) in respect of single premium business, shall take into account the effect of changes in the risk-free interest rates.

The objective behind this classification is to categorise the investments based on the avenues where investments are made and place a ceiling (cap) or floor (minimum) depending on the type of investment. Investments of insurers are categorised into the following buckets:

- (a) **Government Securities** – these are predominantly Securities issued by Central Government or State Government which have a sovereign rating and carry a Very high safety.
- (b) **Approved Securities** include securities issued by an authority constituted under a Central or State Legislature or by a Corporation.
- (c) **Approved Investments** are controlled investments which satisfy any of the conditions mentioned in Section 27A (for Life) and 27B (Non-Life) of the Insurance Act. Further, IRDA have also specified additional investments as “Approved investments” under the Regulations.
- (d) **Other investments** – these are investments which are ‘other category of investments’, other than the ones specified above and which are not prohibited investments.
- (e) **Prohibited investments** – investments in Private Limited Companies and investments out of Policyholders funds outside India.

Investment categories based on type of business

Investment assets of an insurer have broadly been classified as follows for the purpose of regulating investments:

- (a) **Unit reserves of unit linked business** – These constitute the reserves against the units of a unit linked insurance business which are dependent upon the investment pattern chosen by the Policyholders. Hence these investments are classified separately.
- (b) **Pension & Annuity business** – Pension & Annuity business are relatively long term in nature and guarantee annuity over a fairly long period of time and hence requires to be treated differently. Group business other than unit linked and One year Renewal Group Term insurance also fall under this category.
- (c) **Life insurance business** – this is the residual category which comprises of:
 - a. Shareholders' funds representing solvency margin;
 - b. Participating and Non-participating Policyholders funds;
 - c. One year Renewable Group Term Insurance;
 - d. Non-unit reserves of unit linked insurance business.

For a Non-life insurer (including Health business), there is only one category of investible funds – which includes both shareholders funds and policyholders funds.

Prescription of floor and ceiling for investment categories (based on type of business)

- (a) **For unit reserves of unit linked business** – the investments are required to be made in such forms of instruments in such proportion as per the pattern of investment for the fund selected by the Policyholders. However, atleast 75% of the investments made as per the pattern shall be in such instruments which belong to “Approved investment” category.
- (b) **For Pension & Annuity business** – a minimum of 40% of the funds in this category will have to be invested in Central government, State government or other Approved Securities (out of which 20% shall be Central Government Securities). At the same time not more than 60% is allowed in Approved investment categories. Investments in “Other investments” prohibited for Pension & Annuity business.
- (c) **For Life insurance business (other than (a) and (b) above):**

Out of the total funds in this category of business:

Mandatory investments:

- (a) a minimum of 50% to be invested in Central or State Government or Approved Securities (out of which 25% shall be Central Government Securities).
- (b) a minimum of 15% to be invested in Housing & Infrastructure investments.

Optional investments:

- (a) upto 50% allowed in Approved investments.
- (b) upto 15% allowed in “Other Investments”.

Note: The pattern of investments is not applicable for Shareholders funds held in excess of the solvency margin, provided they are kept separately and based on an Actuarial certification filed with the Authority and provided the Shareholders funds held to support solvency margin are invested as per the investment pattern as above.

HOUSING & INFRASTRUCTURE INVESTMENTS

Bonds or debentures issued by HUDCO or National Housing Bank or Housing Finance Companies accredited by the Bank for housing finance activities or carrying Government guarantee of a rating of not less than AA only would qualify. If an Asset backed Security is backed by an underlying housing loan which satisfies the above condition, such a Security would also qualify under this category.

If a Central or State Government Security is issued to specifically meet the needs of a sector falling under infrastructure facility, such a security shall qualify for the purpose of investments in "Housing and Infrastructure" investment category

All investments in Approved investments and "Other Investments" shall be subject to Exposure and Prudential norms, including housing and infrastructure investments.

Investment controls based on rating of instruments

A credit rating evaluates the credit worthiness of a debtor, especially a business (company) or a government. It is an evaluation made by a credit rating agency of the debtor's ability to pay back the debt and the likelihood of default.

As a general rule, no investment can be in an instrument which is capable of being rated, but is not rated for some reason. Also, the rating must be done by an authorised Credit Rating agency under the SEBI Regulations.

Classification as Approved investments based on rating

The following investments shall be classified as "Approved investments" based on Credit rating as follows:

S. No.	Nature of Security	Credit rating	Type of investment/ Category recognised	Remarks
1.	Corporate bonds or debentures	Minimum 'AA' or equivalent	Approved investments	Nil
2.	Short term bonds, debentures, Certificate of deposits, Commercial papers	Minimum 'P1' or equivalent	Approved investments	Nil
3.	Debt instruments issued by All India financial institutions	Minimum 'AA' or equivalent rating	Approved investments	If investments in 'AA' not allowed, 'A+' allowed with Investment Committee approval

Minimum and maximum investments based on Credit rating

Minimum investments in 'AAA', Sovereign or 'P1' rating for Debt instruments

A minimum of 75% (65% in the case of non-life) of Debt instruments (including Government and Approved Securities) shall be invested in instruments with sovereign rating or 'AAA' or equivalent for long term and sovereign debt and 'P1' or equivalent for short term instruments. For unit linked business, at each segregated fund level, the above condition must be satisfied. Investments in Reverse repo backed with underlying corporate bonds, Fixed Deposits, Promoter group Mutual Funds and unrated Mutual Funds must not be considered while calculating the above percentage.

Maximum investments in 'A' or below for Debt instruments

A maximum of 5% (8% in the case of non-life) of Debt instruments (including Government Securities and Approved Securities) can be invested in instruments having a rating of 'A' or below or equivalent for the long term, out of life insurance fund and unit linked fund for a life insurer (and overall funds of a non-life insurer). However, no part of the Pension and Annuity Fund of a life insurer can be invested in such instruments.

In other words, while investments in long term debt instruments in 'AAA' rated shall be 75% in each category of investments, investments in debt instruments rated 'A' or below cannot be more than 5%, which means the remaining 20% is required at the minimum to be rated between 'AA+' to 'A+'. The rating of the remaining 20% has to be decided keeping in mind the overall limit of 15% for investments in "Other investments" out of Life insurance funds.

In respect of short term debt securities, not less than 75% shall be invested in securities rated 'P1+' and above while short term corporate bonds and debentures rated 'P1' and above shall be rated as 'Approved investments'. This would mean that short term debt securities rated less than 'P1' cannot exceed 15% (limit for 'Other investments').

Listed equities – investments only in “actively traded scrips”

All listed equity investments to be made only in those securities which are actively traded in stock exchanges, i.e. other than ones which are classified as “thinly traded” as per SEBI Regulations.

Investment controls based on Exposure norms

These norms aim to control the investment risk by limiting the exposure to the Company where the funds are invested, limiting the exposure to a Group of companies to which the Investee company belongs to and also limits the exposure to one industry. This follows the golden principle “do not put all your eggs in one basket”.

Exposure norms are applicable to all the three investment categories based on the types of business given above and shall be calculated for the following types of investments:

- (a) Approved investments;
- (b) 'Other investments';
- (c) Housing & infrastructure investments.

Investee company limits:

There are 2 limits for calculation of exposure norms to an Investee company:

- (a) Overall exposure limit of all the funds of the insurer in all types of Securities in a Single Company.
- (b) Security-wise exposure limit for each Investee company for each type of investment category.

The lower of (a) or (b) above determines the exposure limit for an Investee Company.

(a) Overall exposure limit

The overall exposure limit is calculated as follows:

- (i) Aggregate all types of investments, viz., equity, debt etc. in a Single investee company.
- (ii) Aggregate investment assets of the insurer (i.e. addition of unit reserves, pension and annuity including Group and Life insurance funds).

- (iii) (i) divided by (ii) shall not exceed 10%.

In the case of non-life insurers the limit is 10% of their total funds.

(b) Exposure limit based on nature of security for each type of fund

(i) For investment in equity, preference shares and convertible debentures

The limit is calculated as 10% of the outstanding face value of equity shares of the Investee company or 10% of assets belonging to each investment category based on type of business (unit reserves, Pension and Annuity including Group and Life insurance business). For non-life, total investment assets (policyholders' funds and shareholders' funds) are considered.

The lower of (a)(iii) and (b)(i) is the Investee company limit.

(ii) For investments in Debentures, loans and other permitted investments (other than mentioned in (i) above)

The limit is calculated as 10% of the Capital, Free reserves, Debentures and Bonds of the investee company or 10% of each investment category based on type of business, as mentioned in (i) above.

The lower of (a)(iii) and (b)(ii) is the Investee company limit.

Increase in the limit of 10% based on the size of investment assets

If the size of investment assets for an insurer touches ₹50,000 Crores, the investee company limit (on outstanding face value of equity shares for equity and Paid-up capital, free reserves, debentures and bonds for Debt, loans and other permitted investments) stands increased to 12% and if the amount touches ₹2,50,000 Crores, the limit stands further enhanced to 15%

Therefore, even though as per one rule, a limit of 10% for equity shares and 10% for debentures for each investment asset category is allowed, the overall exposure limit under (a) above, would bring down the exposure to 10% of all the funds. On the other hand, even though an insurance company is within 10% on the overall exposure limit under (a) above, it still will have to be within the limit of 10% for equity shares and 10% for debentures separately for each investment asset category. Thus, the investee company limits aims to achieve two objectives:

- (a) Limiting the investment in each type of security, viz., equity, debt in each investee company to 10% of each type of investment category, i.e. unit reserves, pension & annuity and life insurance business.
- (b) Limiting the overall exposure (all investments put together) to one investee company to 10% of overall investment assets.

The above 2 limits are subject to a further limit of 10% (of 12% or 15% in some cases as explained above) of outstanding face value of equity shares of the investee company (for equity investments) or Share capital, free reserves, bonds, debentures (for Debentures, loans and other permitted investments), as the case may be.

Special dispensation for Infrastructure related investments

Exposure to a Public Limited Infrastructure investment company can be increased to 20% of the Equity capital at face value for equity investments and 20% of equity plus free reserve plus debentures and bonds in the case of debt. However, this is subject to the overall exposure (all investments put together) at 10% of overall investment assets.

A special dispensation has also been given to Public Sector Special Purpose Vehicle engaged in infrastructure

sector by allowing an investment upto 20% of the project cost, which is categorised as Approved investments, subject to the limit of 10% of overall investment assets.

Investment in Immovable Properties

The limit for investments in immovable property is 5% of the aggregate of life funds, pension and annuity funds and group funds in the case of life insurers and 5% of investment assets in the case of general insurer.

Investments in Promoter Group companies of insurer

The overall limit for investments in all the Promoter Group companies of the insurer is set at 5% of the aggregate funds of the insurer. Investments in Private equities prohibited. However investments in subsidiary companies allowed in terms of the provisions of Section 27A or 27B of the Insurance Act, 1938.

Investment in Securitised Assets, e.g. Asset backed securities

The limit is 10% of investment assets for Life insurers and 5% for Non-life insurers.

Exposure to financial and insurance activities

The exposure to these activities under the Industry exposure norms cannot exceed 25% of investment assets. However, this limit excludes Bank deposits in terms of Section 27A or 27B.

Limits for Group to which Investee Company belongs to

The limit to a Group to which the Investee company belongs shall be the least of the following:

- (a) 15% of each of the investment asset categories.
- (b) 15% of investment assets in all Companies belonging to the Group.

Industry exposure limits

The limit to the industry to which the investee company belongs to shall be the least of the following:

- (a) 15% of each of the investment asset categories.
- (b) 15% of investment assets.

GOVERNANCE RELATED CONTROLS

Investment Committee

Every insurer is required to form an Investment Committee which consists of a minimum of 2 non executive directors, Chief Investment Officer, Chief Financial Officer and Appointed Actuary to oversee the performance of the Investment function.

Investment Policy

The Board, on the basis of approval of Investment Committee, has to approve an Investment Policy for the Company on an yearly basis, with a half yearly review mechanism. The policy shall address the issues relating to prudential norms, liquidity, management of assets and liabilities, scope of internal and concurrent audit and all other internal control of investment operations. It shall ensure adequate return on policyholders' funds and shareholders' funds.

Board shall review fund wise and product wise investment performance on a quarterly basis. The Board shall also lay down the norms for investing in "Other investments" category.

Operational Level Controls

Segregation of Front office, Mid office and Back office

Every insurer is required to segregate Front office, Mid office and Back office and clearly lay down the roles and responsibilities. The Chief Investment Officer shall report to the Chief Executive Officer. No function falling under any of these three sub units can be outsourced. Further data servers for the investment management system shall be within India.

Risk Management systems review

The Board shall implement a Investment Risk Management Systems and Process which shall be certified by a Chartered Accountant as per the Technical guide issued by the Institute of Chartered Accountants of India. This shall be reviewed once in 2 years by the Chartered Accountant and the Report be filed with IRDA.

Further a quarterly internal/concurrent audit is mandated (if Assets under management crosses ₹1,000 crores concurrent audit by external auditor required).

Qualifications and experience for Risk Management Auditors as well as Concurrent Auditors prescribed. Necessary certification shall be taken from them before appointment and filed with IRDA.

Returns, offsite monitoring and onsite inspections

The Regulations provide for filing of various returns on investments which enable offsite monitoring from time to time. Further IRDA also conducts onsite investment audit to ensure that compliance with the Regulations are in place.

Conclusion

The Regulations envisages protection the interests of Policyholders through the following ways:

- (1) Segregation of Life funds into 3 investment categories based on nature of business;
- (2) Fixation of limits for investments based on G-Sec., Approved investments etc. for each of the investment category;
- (3) Fixation of exposure limits at the investee company, Group and Industry levels;
- (4) Limits for exposure to insurer's promoter groups, immovable properties etc.
- (5) Floor and ceiling for investments based on Credit ratings;
- (6) Investment Governance;
- (7) Concurrent & Risk management investment audits;
- (8) Offsite & Onsite inspection.

While the regulations provide the right framework, the ultimate objective can be achieved only if the insurance companies to exercise care and due diligence to ensure that the Guidelines are followed at all times.

INTERNATIONAL TRENDS IN INSURANCE REGULATIONS

International Association of Insurance Supervision ('IAIS')

IAIS represents insurance regulators and supervisors of some 190 jurisdictions in nearly 140 countries, constituting 97% of the world's insurance premiums. It also has more than 120 observers. The objective of IAIS

is to promote consistent insurance supervision across the globe to promote stable insurance markets.

Let us look at the Insurance Core Principles which provide the globally accepted framework for insurance sector.

INSURANCE CORE PRINCIPLES ('ICP')

- ICP material contain:
 - ICP statements – which are the essential elements which must be present in a sound insurance sector for policyholder protection.
 - Standards which set out high level statements fundamental to implementation of ICP statements.
 - Guidance material at the lowest level which support ICP statements and standards.

Some Key Insurance Core Principles (ICPs)

- Licensing requirement for entities engaged in insurance activities.
- Suitability of Board members, senior management, Key persons & Control functions.
- Supervisory approval required for significant changes in ownership of an insurer.
- Supervisor requires insurers to establish a Corporate governance framework.
- Institution of an effective enterprise risk management & compliance framework by insurers.
- Supervisor has risk based monitoring through offsite and onsite inspections.
- Supervisor imposes sanctions and enforces corrective action based on published criteria.
- Protection of policyholders upon insurer's exit from the market.
- Establishing a system of valuation of insurer's assets & liabilities and investment guidelines for solvency purposes.
- Specification of Capital adequacy norms to maintain solvency at any time.
- Regulation of conduct of insurance intermediaries.
- Proper conduct of insurers to ensure fair treatment of customers both before and after sale of an insurance policy.
- Promote Public Disclosure norms to promote transparency on risk exposure and assessment.
- Countering fraud in insurance.
- Anti money laundering and combating financing of terrorism.
- Promotion of Group wide supervision.
- Macro prudential surveillance and insurance supervision.
- Supervisory cooperation and coordination, including cross border cooperation in times of crisis.

Given the above background, let us have an overview of the regulatory framework in insurance in some of the international jurisdictions.

Financial Services Authority (UK)

- FSA regulates the UK financial markets and is a common Regulator for Banking, Securities & Insurance

- Four statutory objectives of FSA:
 - Market confidence - Maintaining market confidence in the UK's financial system.
 - Financial stability – Protection & enhancement of stability of UK's financial system.
 - Consumer protection – securing appropriate degree of protection for consumers.
 - Reduction in Financial crimes – reducing the extent to which a financial entity can be used for financial crimes.
- Other objectives of FSA:
 - Political & Public accountability – Annual Report of FSA contains a self-assessment to the extent to which objectives have been met.
 - Demonstrate how the Rules relate to Statutory objectives.
 - Legal accountability – Judicial review of decisions in Courts.

FSA's Principles of Good Regulation

- **Efficiency & economy** – the need to use the Authority's resources in efficient and economic way.
- **Role of management** – holding senior management responsible for risk management.
- **Proportionality** – the burdens or restrictions imposed on an industry to be proportionate to the benefits expected to result to firms and consumers.
- **Innovation** – desirability of innovation in connection with regulated activities.
- **International character** – Maintaining competitive position of UK financial markets through multi national cooperation.
- **Competition** – the desirability to promote competition between regulated entities.
- **Public awareness** – the desirability of enhancing public knowledge on financial matters.

Department of Financial Services, New York

- Mission:
 - To reform the regulation of financial services in New York:
 - to keep pace with the rapid and dynamic evolution of these industries.
 - to guard against financial crises, and
 - to protect consumers and markets from fraud.
- Policy:
 - Foster growth of financial services in New York;
 - Ensuring solvency, safety, soundness & prudent conduct of financial services providers;
 - Fair, timely and equitable fulfillment of obligations of such financial service providers;
 - Protect consumers from financial insolvent or impaired service providers;
 - Encourage high standards of honesty, transparency and fair business practices and public responsibility;

- Eliminate financial fraud, criminal abuse and unethical conduct;
- Protect end users by providing understandable information for making informed decisions.

Insurance Board of Sri Lanka

- Registration of insurers and licence for carrying on long term insurance or general insurance business, with 100% Foreign direct investment;
- Minimum Paid up capital of Rupees LKR 500 million for each class of business;
- Compulsory listing of insurance companies on a licensed stock exchange within 3 years of issuing a licence;
- Maintenance of a minimum solvency margin at all times;
- Prohibition of common directors between insurers – employee directors of insurers not to exceed one-third;
- Prior approval of the Sri Lankan Board for appointment of Directors;
- Maintenance of separate funds for each line of business;
- Provisions on nominations, assignments, surrender value;
- Power to call a policy in question beyond 2 years only on the grounds of fraud;
- Powers of inspection and investigation vested with the Board;
- Both insurers and brokers are empowered to appoint Agents;
- Citizens in Sri Lanka prohibited from taking out insurance policies from Overseas insurers;
- General provisions on amalgamations and mergers;
- Prohibition on Loans to Directors & their Companies.

Bima Samiti (Insurance Board of Nepal)

- Registration with the Board to carry on insurance business – minimum paid up capital of 50 million Nepali Rupees for Life insurance business and 100 million Nepali Rupees for Non-Life insurance business (separate organisations for Life and Non-Life);
- Prohibition of loans or guarantees or security to Director or his/her family members or corporate body where the Director or relative is a Managing Agent or Partner;
- Board can hear customer complaints and award compensation for losses caused due to insurer or its agents;
- Maintenance of separate accounts for each line of insurance business;
- Limits on expenses of management (25% of Total Premium for Marine and 30% of premium for Other businesses);
- Agents and Brokers recognised as the Primary Distributors;
- Limits on commission payable to Insurance Agents;
- Provisions relating to appointment and regulation of Surveyors;

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- Prohibition of assumption of risk without getting the premium;
- Provisions relating to payment of Claims;
- Only Whole Life, Endowment and Term Life Insurance permitted;

Royal Monetary Authority (Bhutan)

- All insurers to possess a licence from RMA for carrying on insurance business;
- Initial minimum paid up capital is Nu. 100 million (to be raised to Nu.200 million within 3 years of commencement) – 10% to be deposited with RMA;
- Public contribution to be not less than 30%;
- Corporate Governance Regulations - minimum 2 independent directors, Audit committee, Risk management committee;
- Every 2 of 5 Directors on the Board to have insurance or investment or underwriting or finance experience for 5 years;
- Provisions relating to rights of shareholders (e.g. persons holding more than 5% can add items to the agenda for the shareholders meetings) – dissolution of companies not holding shareholders meetings within 13 months of the required date;
- Board to issue annual strategy policy statement and remuneration policy statement – establishment of Audit and Governance Committees (Risk Management Committee in some cases);
- Codes of Ethics and Fit & Proper qualifications for Directors of Regulated entities prescribed;
- Extensive Insurance Brokers Regulations (similar to Indian Regulations);
- Guidelines on Anti-money laundering and Combating Financing of Terrorism;
- Investment Guidelines for Insurance business – Investment Committee, Ceilings for investments for General insurance and reinsurance companies;

Monetary Authority of Singapore ('MAS')

- Registration and authorisation of insurers;
- Fund solvency and capital adequacy requirements;
- Control of take-overs of insurers;
- Control of substantial shareholdings of insurers;
- 'Fit and proper' requirement for Principal Officer and Directors;
- Restrictions on granting unsecured loans to directors and employees;
- Business conduct of insurance intermediaries;
- Inspections and investigations of insurers;
- Corporate governance regulations (significant insurers to have atleast majority of directors as independent directors, formation of Audit Committee, Risk Management Committee etc.);
- Antimoney laundering/Counter Terrorist Financing announcements;

- Guidelines on Risk management, Internal controls & Financial stability.

Bank Negara, Malaysia

- Requirement of licence for carrying on insurance, broking, adjusting and financial advisory business;
- Minimum share capital prescribed for insurers;
- Segregation of insurance fund and shareholders fund;
- Maintenance of minimum solvency at all times;
- Creation of charge of pledging of any asset prohibited with the Bank's approval;
- Prior approval of the Bank for acquiring or disposing off shares in excess of 5% in any insurer;
- Appointment of any director or CEO or Appointed Actuary require prior approval of the Bank;
- Qualifications and disqualifications for Directors and Auditors;
- Annual actuarial investigation and Financial condition report;
- Powers of inspection and investigation;
- Risk based capital framework for insurers;
- Anti money laundering provisions;
- Guidelines on Risk management in internet insurance;
- Guidelines for Takaful operators.

LESSON ROUND UP

- In India, insurance has a deep-rooted history. It finds mention in the writings of Manu (Manusmrithi), Yagnavalkya (Dharmasastra) and Kautilya (Arthasastra).
- 1870 saw the enactment of the British Insurance Act and in the last three decades of the nineteenth century, the Bombay Mutual (1871), Oriental (1874) and Empire of India (1897) were started in the Bombay Residency.
- The Indian Life Assurance Companies Act, 1912 was the first statutory measure to regulate life business.
- The Insurance Amendment Act of 1950 abolished Principal Agencies.
- The General Insurance Council framed a code of conduct for ensuring fair conduct and sound business practices.
- Following the recommendations of the Malhotra Committee report, in 1999, the Insurance Regulatory and Development Authority (IRDA) was constituted as an autonomous body to regulate and develop the insurance industry.
- Today there are 24 general insurance companies including the ECGC and Agriculture Insurance Corporation of India and 23 life insurance companies operating in the country.
- The following Acts regulate the Insurance Business in India.
 - Insurance Act, 1938
 - IRDA Act, 1999 & Regulations passed thereunder
 - Insurance Amendment Act, 2002

- Exchange Control Regulations (FEMA)
 - Indian Stamp Act, 1899
 - Consumer Protection Act, 1986
 - Insurance Ombudsman Rules, 2017
- The IRDAI Act, 1999, established the Insurance Regulatory and Development Authority of India (“IRDAI” or “Authority”) as a statutory regulator to regulate and promote the insurance industry in India and to protect the interests of holders of insurance policies
 - Front-end (persons authorised to sell insurance policies) are Individual Agents, Corporate Agents, Insurance Brokers, Telemarketing (Authorised Verifiers), Web Aggregators (through Distance marketing) ,Direct Marketing (Authorised employees of insurer), Micro Insurance Agents & Common Service Centres, Insurance Marketing Firms, Point of Sales Persons, Motor Insurance Service Providers
 - A Point of Sales Persons (‘POSP’) model is a recent innovation and is intended to sell simplified products in any area – Urban or Rural.
 - Under Life insurance Policies, upon death of the life assured, the Sum Assured is required to be paid to the Legal heirs of the deceased life assured.
 - The Person taking the Policy (Policyholder) can be the Life assured himself (own life policy) or the Person taking the Policy can be different from the Life assured.
 - Section 45 of the Insurance Act, 1938 provides the remedy to a Life insurer for breach of the condition of utmost good faith (‘uberrimaefidei’) on the part of the life assured.
 - The object of Insurance Ombudsmen Rules, 2017 is to resolve all complaints of all personal lines of insurance, group insurance policies, policies issued to sole proprietorship and micro enterprises on the part of insurance companies and their agents and intermediaries in a cost effective and impartial manner.
 - An Insurance Ombudsmen is appointed for a term of 3 years. However, no person can continue as Insurance Ombudsman after he/she has attained 65 years of age
 - The office of the Insurance Ombudsman shall be located at such places and shall have such territorial jurisdiction as may be specified by the Executive Council of Insurers from time to time.
 - The Ombudsman shall act as counsellor and mediator relating to matters specified provided there is written consent of the parties to the dispute
 - Where the complaint is not settled by way of mediation under rule 16, the Ombudsman shall pass an Award, based on the pleadings and evidence brought on record.
 - Consumer Protection Act is an act of Parliament enacted in 1986 to protect interests of consumers in India. It makes provision for the establishment of consumer councils and other authorities for the settlement of consumers’ disputes and formatters connected therewith. Consumer Protection Councils are established at the national, state and district level to increase consumer awareness
 - Defect means Fault, imperfection or a shortcoming in the quality quantity potency purity or standards which is required to be maintained by or under any law for the time being in force
 - Mathematical reserves denote the liability on the books of the insurance company on the Policies already issued by the Insurance company and in-force in the books of the insurance company

- The valuation parameters shall constitute the bases on which the future policy cash flows shall be computed and discounted. Each parameter shall have to be appropriate to the block of business to be valued.
- Investment assets of an insurer are Unit reserves of unit linked business , Pension & Annuity business, Life insurance business.
- Bonds or debentures issued by HUDCO or National Housing Bank or Housing Finance Companies accredited by the Bank for housing finance activities or carrying Government guarantee of a rating of not less than AA only would qualify.
- A credit rating evaluates the credit worthiness of a debtor, especially a business (company) or a government. It is an evaluation made by a credit rating agency of the debtor's ability to pay back the debt and the likelihood of default.
- All listed equity investments to be made only in those securities which are actively traded in stock exchanges, i.e. other than ones which are classified as "thinly traded" as per SEBI Regulations
- The overall limit for investments in all the Promoter Group companies of the insurer is set at 5% of the aggregate funds of the insurer. Investments in Private equities prohibited. However investments in subsidiary companies allowed in terms of the provisions of Section 27A or 27B of the Insurance Act, 1938
- Every insurer is required to form an Investment Committee which consists of a minimum of 2 nonexecutive directors, Chief Investment Officer, Chief Financial Officer and Appointed Actuary to oversee the performance of the Investment function
- IAIS represents insurance regulators and supervisors of some 190 jurisdictions in nearly 140 countries, constituting 97% of the world's insurance premiums.
- Four statutory objectives of FSA are Market confidence, Financial stability, Consumer protection, Reduction in Financial crimes.

GLOSSARY

- **IRDA** – Insurance Regulatory and Development Authority
- **GIC**- General Insurance Corporation of India
- **ECGC**
- **LIC**- Life Insurance Corporation of India
- **CEO**- Chief Executive Officer
- **SP**- Specified Person
- **ISP**- Insurance Sales Persons
- **VLEs**- Village Level Entrepreneurs
- **SPV**- Special Purpose Vehicle
- **POSP**- Point of Sales Persons
- **GIPSA**- General Insurers' (Public Sector) Association of India
- **IAIS**- International Association of Insurance Supervision
- **ICP**- Insurance Core Principles

Lesson 3

Life Insurance – Practices

LESSON OUTLINE

- Life Insurance Organisation
- Premiums and Bonuses
- Mortality Tables
- Risk & Net/Pure Premium
- Plans of Life insurance
- Application, Acceptance, Premium payment, Policy document
- Policy Contract
- Endorsements
- Duplicate Policy
- Policy Lapsation and Renewal
- Assignments and Nominations
- Surrender of a Policy
- Claims
- LESSON ROUND UP
- SELF TEST QUESTIONS

LEARNING OBJECTIVES

Life Insurance Organisation comprises of the various functions comprised within a Life Insurance organisation. Insurance as a protection against natural calamities was first conceived by the adventurous travelers of the sea who carried goods of value to faraway places, braving all the perils of the sea, in anticipation of handsome profits in the trade. Premiums are therefore the selling price charged by the insurers for providing the service of insurance covers. Policyholder Bonus is a unique concept only to Life insurance business. Generally in any business, a product or service is sold to the Customer for which the Customer pays a consideration which is the income for the business. After paying for the expenses for running the business, the Shareholders take the profit or loss which arises therefrom. Policy document is a detailed document and it is the Evidence of the insurance contract which mentions all the terms and conditions of the insurance. A Claim for death sum assured shall be raised by the Nominee with the Life insurance company along with the basic documents like Intimation of death, Death certificate, attending Doctor's certificate etc.

INTRODUCTION

Life Insurance Organisation comprises of the various functions comprised within a Life Insurance organisation. Before we go into the organisational aspects it is important to understand the workflow within a Life insurance company. Typically, the following workflows can be seen in any Life insurance company on the core business of solicitation and servicing insurance:

- (1) Solicitation of insurance business by an Insurance Agent or Registered Intermediaries ('Distributor')
- (2) Form-filling by the Distributors
- (3) Registration of New Business in a Branch office of an Insurer
- (4) Scrutiny of Proposal forms and documents annexed thereto
- (5) Data-entry of information contained in Proposal form in Insurer's Policyholder Administration System
- (6) Underwriting of Proposals
- (7) Issue of Policy Insurance contracts
- (8) Collection of Renewal Premiums of Policies issued
- (9) Policy servicing activities, including Surrenders, Loans etc.
- (10) Claims processing

While the above activities constitute core day-to-day work for a Life insurance, there are various other support functions which enable the above core activities. Based on the above, broadly the functions within a Life Insurance Organisation are classified as follows:

- (1) Human Resources
- (2) Finance & Accounts
- (3) Investments
- (4) Actuarial & Products
- (5) Distribution:
 - a. Individual Agency
 - b. Third Party Distribution – Corporate Agent, Broking etc.
 - c. Direct Distribution including Online Business
 - d. Rural Business
 - e. Sales Training
- (6) Marketing
- (7) Information Technology
- (8) Operations:
 - a. New Business & Underwriting
 - b. Policy Servicing
 - c. Persistency & Renewal Premiums Management

- d. Claims
 - e. Handling Customer Grievances
 - f. Distributor Appointment, Training and Termination
 - g. Branch Operations
- (9) Legal & Compliance
 - (10) Risk Management
 - (11) Internal audit
 - (12) Infrastructure & General Administration

Each one of the above functions is generally headed by a Senior Management Person who normally reports to the CEO. However, for the sake of operational convenience, some of the functions may be combined in a Life insurance company. However, under such circumstances, there should not be any conflicts of interest.

Let us briefly see the various activities carried out by each of the above 12 functions.

(1) **Human Resources** – Also called HR function carries out the following activities:

- (a) *Recruitment of Employees* – HR function is responsible for hiring the human resources with appropriate skill sets required by the entire organisation for discharging the day to day activities. They source the employees with the right qualifications, skills, experience to suit the role description for a role. They use the assistance of search firms who assist not only in identification but also in interviewing and selecting the right candidate.
- (b) *Training of Employees* – While on the job training is the responsibility of the concerned Functional head, HR is responsible for sharpening soft skills such as People management skills, Communication skills, Leadership skills, Emotional intelligence, Interpersonal relationships etc. which are equally important from a HR perspective.
- (c) *Retention of Employees & Talent Management* – One of the critical roles of HR is to keep the employee attrition within tolerance limits. They have to study the root causes for employee attrition and take corrective action to keep the attrition under control. A sub-set of retention is to prevent talent-flight. Insurance is a highly competitive industry and talents can be poached very easily. Therefore, long term retention plans are important to keep the employee engaged and retained.
- (d) *Termination & Exit Management* – It is important to properly manage the process of employee attrition, if unavoidable. Every employee is a spokesperson of the Company, more so in the case of exiting employee, who can speak good or ill about the Company he or she is exiting. It is important to handle the process of exit management properly including the process of Full & final settlement of dues to the employees and settle them correctly and within an agreed timeline which usually does not exceed 30 days from the date of relief.

(2) **Finance & Accounts**

Finance & Accounts function is largely responsible for the following activities:

- (a) Receiving and accounting New Business Collections & Renewal Premiums.
- (b) Identifying Surplus funds and making them available for Investments.
- (c) Accounting of Investments.

- (d) Timely processing of expenses of management, including processing of payment to employees and Vendors.
- (e) Vendor Management including Procurement.
- (f) Compliance with the ceilings on Expenses of Management of IRDAI.
- (g) Reporting to IRDAI, Shareholders, and Board etc.
- (h) Disclosure of Company information in Websites, Newspapers etc. as required by IRDAI regulations on Disclosure norms.
- (i) Maintenance of Financial assets of the Company.
- (j) Maintenance of Bank accounts & reconciliation.
- (k) Ensuring that Internal Financial Control systems are in place.
- (l) Compliance with IRDAI Regulations on Presentation of Financial Statements and the Accounting Standards of Institute of Chartered Accountants of India, including timely implementation of Indian Accounting Standards.

(3) Investments

- (a) Investment of Policyholders funds and Shareholders funds' as per the Board-approved Investment Policy designed within the IRDAI Regulations on Investments – with compliance with ceilings on Government Securities, Approved Securities, and Approved Investments etc.
- (b) Asset-liability management – to ensure that assets are invested in such a way that their tenor, yield, maturity etc., match with the funds required for meeting liabilities of an Insurance company from time to time.
- (c) Review of Asset allocation from time to time keeping in mind the changing interest rate scenarios.
- (d) Review of performance of Investments from time to time and presenting the results to Shareholders and Board of Directors.

(4) Actuarial and Products

- (a) Design of Insurance Products as per the requirements of the Distributors and Customer needs from time to time.
- (b) Procuring IRDAI approval for launch of each Product of the Insurance Company.
- (c) Ensuring that the Company's solvency from time to time.
- (d) Valuation of Assets and Liabilities every year.
- (e) Submission of Financial Condition Report to the Board of Directors.
- (f) Execution of Reinsurance arrangements and ensuring that the reinsurance is done as per the risk appetite of the Insurance Company.
- (g) Declaration of Bonus on 'With profit' products.
- (h) Review of assumptions in Products and validating their continuity.
- (i) Monitoring compliance with "file and use" approved by IRDAI for every insurance product.

(5) Distribution

- (a) Finalisation of business plan for every distributor and monitoring their performance.
- (b) Design of Reward & Recognition programs for motivation of Distributors.
- (c) Monitoring quality of business from the point of view of persistency, customer complaints, cancellation of policies, claims etc.
- (d) Relationship management with Third party distributors.
- (e) Individual Agency engagement and management.

(6) Marketing

- (a) Launching Marketing campaigns to popularise the Company's brand as well the Insurance products through Media.
- (b) Monitoring the reputation risk for the Company – especially in the social media.
- (c) Design of marketing materials for Distribution including pamphlets, leaflets etc. from time to time.
- (d) Online business management – where customers purchases insurance through online.
- (e) Direct business through employees of Insurance Company.

(7) Information Technology

- (a) Maintenance of the core Policyholders' Administration System and other peripheral IT systems to support the Company's processes.
- (b) Designing the product features, including product design as well policy servicing related into the Company's IT systems.
- (c) Delivery of MIS from the systems as required by the various stakeholders within the Company.
- (d) Information Security Risk Management.
- (e) Business Continuity Planning for IT function, including Disaster Recovery process.

(8) Operations

- (a) New business registration from Distributions – verification and scrutiny of Proposal forms.
- (b) Data entry of information from Proposal forms to the core Policy Administration System.
- (c) Underwriting of New business – which is taking the decision to accept, reject, modify the terms of the offer for acceptance of risk under an insurance policy.
- (d) Printing of Policy bonds (Insurance contracts) and dispatch to the Policyholders.
- (e) Handling Free look cancellations requests and other Customer grievances from time to time.
- (f) Collection of Renewal premiums by appointing various touch points for Policyholders, including Branch offices and other collection centres.
- (g) Receipt and management of Policy servicing requests like Surrender requests, Policy Loan requests, Requests for change of address, change of nomination etc.
- (h) Claims management – receipt of claim intimations, calling for documents required for processing a claim, arranging for claims investigations, taking decisions on payment of claims within the agreed deadlines.

- (i) Appointing of distributors, giving codes and termination of appointments.
- (j) Management of Branch offices.

(9) Legal & Compliance

- (a) Drafting Contracts with various vendors and their renewal from time to time.
- (b) Managing litigations – Policyholder litigations before Insurance Ombudsmen, Consumer Courts etc. Employee litigations before Fora like Civil courts, Labour law courts etc.
- (c) Implementation of various regulatory requirements from time to time.
- (d) Coordination with IRDAI on various regulatory matters.
- (e) Handling Board, Shareholder and other Secretarial matters.

(10) Risk Management

- (a) Instituting Risk management control framework across the organisation.
- (b) Overseeing following Risks within the Company:
 - i. Operational Risks
 - ii. Actuarial Risks
 - iii. Financial Risks
 - iv. Strategic Risks
 - v. Reputational Risks
- (c) Risk appetite framework – performing tolerance tests for shocks.
- (d) Reviewing adequacy of insurance covers within the Company.
- (e) Identification of risks by various functional heads, existing controls and proposed controls to mitigate the risks.
- (f) Review of Key risks within the Company.

(11) Internal Audit

- (a) Internal audit function is independent of the management, responsible for providing independent assurance to the Audit Committee on the effectiveness of the operational and financial controls.
- (b) Reports usually to the CEO with a dotted line to the Audit Committee Chairperson.
- (c) Performs examination of various controls within the organisation and presents Audit report with a rating and corrective actions required.
- (d) Follow up with functions with implementation of corrective actions agreed.
- (e) Presenting audit reports and status of implementation of corrective actions to the Audit committee.
- (f) Receiving and investigating Whistleblower complaints and reporting to the Audit committee.

(12) Infrastructure and administration

- (a) Responsible for upkeep and maintenance of office infrastructure.

- (b) Review of readiness of Maintenance equipments in Branch offices, including Fire extinguishers, CCTV cameras etc.
- (c) Security of offices.
- (d) Identification of new premises and negotiation of rent etc. with the Owner.
- (e) Design of offices and provision of ideal working environment.
- (f) Provision of Cafeteria and maintenance of healthy environment and hygiene in offices.

Premiums and Bonuses

Insurance as a protection against natural calamities was first conceived by the adventurous travelers of the sea who carried goods of value to faraway places, braving all the perils of the sea, in anticipation of handsome profits in the trade. The system of sharing of such losses of a few amongst all members engaged in the trade, by way of insurance, saved many families from utter ruin and further encouraged the application of the principle of security through insurance to other hazards. Life insurance is meant to provide financial assistance to the dependents of the life assured in the event of his death. Earliest form of life assurance was a lump sum payment at the time of death of person whose life was insured. The amount of payment used to be fixed arbitrarily depending on the resources of the organisation. Recreation clubs having large memberships adopted this type of inducement of the existing members to continue their membership of the club or to attract new members by offering some incentive out of the surplus funds they had. This type of benefit payable at the time of death is Whole Life Assurance as the full time of the assured should be over before the benefit of assurance can be had.

This system of Whole Life Assurance did not meet all the needs of the insuring public. People wanted financial security in old age, after retirement. At the same time, they desired protection for dependents in the event of their unfortunate death during the useful working period. This desire brought Endowment Assurances in vogue wherein assurance is for a fixed period, the sum assured being payable either on death before the expiry of the fixed period or on surviving the period selected.

No benefit can be secured without paying for it. When a person is desirous of having protection for his family in case of death, he has to pay for it. Mode of payment of the cost can always be arranged according to the convenience of the person seeking the benefit.

He may pay the full cost of the benefit straightaway in which case it is called a single premium. The cost of benefit can be paid in equal yearly installments for life, if it is a benefit payable at the time of death. These installments are called annual premiums. On the other hand, it can be paid equal annual installments over a selected period or till the death of life assured, if earlier. Instead of paying the cost of assurance benefit by yearly installments, half-yearly, quarterly or monthly installments can also be arranged. These are called half-yearly, quarterly or monthly premiums.

Premiums are considerations for insurance benefits. They are always payable in advance. A single premium is paid at the commencement of insurance (only once during the entire Policy period). An yearly premium is paid at the beginning of each (Policy) year. A half-yearly premium is paid at the beginning of each half-year.

Mortality Tables – basis for fixing the premiums by Insurers

Premiums are therefore the selling price charged by the insurers for providing the service of insurance covers. In any business, the selling price is determined based on the cost of inputs plus a margin of a profit for the businessman. In insurance as well, there are direct costs, indirect costs and overheads which have to be factored into the pricing. The following are basic elements of premiums for an insurer:

- (a) **Mortality/Morbidity Costs** – this is the fundamental element of estimating how many persons out of the insured lives will die and therefore what would be outgo on account of claims for a life insurer. Morbidity costs determine the probability of Lives covered contracting illnesses – relevant for health insurance policies.
- (b) **Other Direct Costs** – like payment of commission for the Policies procured by distributors, Stamp duty on policies etc. which are directly linked to the business sourced. This would also include Charges in Unit linked Life Insurance Policies which are directly attributable to the Polices, such as Premium allocation charges, Policy administration charges etc.
- (c) **Indirect Costs** – cost of administration of an insurance company like payment of salaries to employees, infrastructure costs etc.
- (d) **Cost of Bonus** – In the case of Participating policies, the cost of distribution of surplus to Participating Policyholders.
- (e) **Profit Margins** – also called Value of New Business margins which are the loading on account of profit margins expected by a Shareholder from the Insurance business.

Out of all the above, Mortality costs or loading is the fundamental cost. This is unique to life insurance business and is based on the Statistical probability theorems. The fundamental principle of life insurance business is distribution of risk of paying claims to a few out of the total population which gets insured. In other words, it operates on the principle of sharing of risks. Therefore, the basic data required for calculating premiums are the Mortality Tables which give the number of persons dying and living at age out of the total population. The probability of death at each age becomes the basis for assumptions by a life insurer in calculating their premiums and thus becomes the basis for determining the estimated claim payouts on account of death and the discounted value of estimated claims becomes an integral component in calculating the premiums.

Therefore, the insurer while fixing the premium rates has to make certain assumptions regarding interest rates, mortality rates and expenses which will be experienced in the years to come. It is important to have a correct estimate of these factors as otherwise the results deduced from the assumptions made may not be reasonably close to the actual experience of the insurer.

Mortality experience of the general population which is commonly known as census mortality is not directly of much use to an insurer whose main interest is to find out of the mortality that its insured lives are likely to experience. The insurer depends upon the mortality experience of the insured lives observed in the recent past as a basis for estimating the probabilities of survival and deaths.

If it is observed that out of 10,000 lives all aged 35, 18 die within one year, i.e. before attaining age 36, the observed mortality rate at age 35 works out to $18/10,000 = 0.0018$.

The mortality rates at various ages are determined in the above manner, by using the data of recent past by the insurer. The observed rates of mortality, say from age 15 till extreme age, are then subjected to a process of graduation. The process of graduation enables the insurer to find the limiting values of the mortality rates, when the data is increased infinitely. These graduated values of mortality are used for constructing a mortality table which contains mortality functions for successive ages.

Therefore, Mortality Tables showing the mortality rates (number of persons dying at each age) is essential for generating mortality assumptions for calculating Premiums. The various stages involved in the process of constructing a Mortality table are as follows:

- (1) Deciding upon the data to be used

- (2) Choosing the period of investigation
- (3) Deciding the unit of investigation
- (4) Deciding the method of investigation to be followed
- (5) Determination of “Exposed to risk” and enumeration of deaths
- (6) Obtaining observed rates of mortality
- (7) Graduation of observed death rates
- (8) Constructing the mortality table from the graduated rates

The mortality tables can be classified into 3 categories:

- (a) Those prepared from population data;
- (b) Those prepared from life assurance data; and
- (c) Those prepared from life annuitant’s data.

Examples of Mortality Investigation Tables:

- (a) LIC Mortality Investigation (1994-96)
- (b) Indian Assured Lives Mortality (1994-96) (Modified)
- (c) Northampton Table (UK)
- (d) English Life Tables (ELT)
- (e) British Tables on Annuitant lives

Schemes of insurance operate on the assumption that a large number of persons desiring insurance benefits would insure their lives.

Consider that 1,000 persons all aged 40 years are insured for ₹10,000 each for one year. If the rate of mortality is .003 per 1,000 lives at the age 40, the expected number of claims will be $.003 \times 1,000 = 3$ and the amount of claim payable would be ₹30,000. Therefore, the insurer should charge a single premium of $30,000/1,000$, i.e. ₹30 to each person for insurance.

Thus, the premium required to be charged is independent of the number of persons taking insurance, provided that the rate of mortality remains the same.

Insurance started in the form of sharing the loss of a few by many. Thus, in the above example, the calamity on 3 families is shared by 1,000 persons (through insurer) to the extent of providing relief of ₹10,000 to the family of each deceased person.

Simple Mortality table

The table given below is an example of a Simple Mortality Table giving the number of survivors and deaths from ages 35 to 44 based on a mortality investigation:

Age	Number of persons surviving	Number of persons dying
35	10,000	28
36	9,972	31

37	9,941	34
38	9,907	38
39	9,869	42
40	9,827	47
41	9,780	52
42	9,728	57
43	9,671	63
44	9,608	70
TOTAL		462

Total expected number of deaths among 10,000 persons all aged 35, before they attain age 45, is 462.

Therefore total expected claim amount, if the claim amount payable on death of each individual covered is Rs.1,000, works out to ₹46,20,000 (462 x 1,000)

If single premium (in one instalment) is to be charged to each of the 10,000 persons for securing an insurance cover of ₹10,000 each for 10 years, the premium works out to:

$$46,20,000/10,000 = ₹462 \text{ per person}$$

The insurance cover described above is called a temporary assurance for a period of 10 years wherein the benefit is payable only in case of death of a person during the given period. The person whose life is insured is known as life assured.

We have not taken into account the interest and expense factors. Since the deaths occur each year the claim payable varies year after year and the present value of claims payable at the end of each year has to be calculated and then divided among the 10,000 persons. Assuming expenses of insurer are 'nil', the present value factors are applied to find out the present values of claim payable every year.

The above example gives a fair idea as to how the mortality tables are designed as the fundamental basis for calculation of premium. There are loadings on account of expenses and profit margins for the Shareholders. All these form part of the "file and use" document for every product which has to be filed by the Appointed Actuary of Insurance Company with IRDAI for their approval before a Product is launched for sale to the public.

Risk, Net/Pure Premium

Risk Premium

The pure premium needed to cover the expected risks but with no allowance for expenses, commission or contingencies is to be made. Thus the cost to meet the risk of death for one year at a particular age is known as risk premium. The risk premium is based on the probabilities of death at various ages.

Net Premium or Pure Premium

A net premium is the premium calculated on the basis of the valuation assumptions to provide the contractual benefits at outset. Its calculation only allows explicitly for interest and mortality. Thus the net premium covers

the risk factor as well as interest earned on investment of fund by the insurers. Net premium is always less than the risk premium.

Loading

As explained before the administrative expenses of the insurer have to be borne out of the premium received from the insured. The amount added to the pure premium to cover the administrative expenses is known as loading. When these expenses are added to the net/pure premium it becomes the gross premium/office premium which is actually charged from the customer.

Level Premium

Premium keeps on increasing as the age increases and this is the natural premium paying system but it is impractical because the insurer cannot ask the insured to pay extra premium every year and moreover in the latter years the cost of insurance would become unaffordable resulting in lapse of policies. In view of this insurers charge a level premium and the cost is distributed evenly over the period during which premiums are paid. The premium remains the same, and is more than the actual cost of protection in the earlier years of the policy and less than the actual cost in the latter years. The excess paid in the early years builds up the reserve.

Actuarial Valuation

As discussed before premium is calculated based on some assumptions. The experience in future may not be exactly as assessed. So the process of checking the validity of assumptions from time to time is known as actuarial valuation. The main objects of conducting the valuations being:-

Future projections to be made on the basis of past experience:

- Determine the long term consequences.
- The analysis should always be as thorough as the information allows and not based on superficial appearances.
- Using Mathematical modeling for handling the interactions of probability and investment return.
- Further experience should be fed back to aid the subsequent development of the model and the assumptions.
- In India the Insurance Act requires actuarial valuations to be done every year.

Calculation of Age

The rate table as published by Insurers gives the rate of premium per thousand sum assured, for different ages nearer birthday. The tabular premium is also different for different premium payment terms. In case of whole life policies, as the premium has to be paid for the whole life, the premium is mentioned only for various ages nearer birthday.

Age nearer birthday means that if the actual age is up to 21 years 5 months 29 days the age for the purpose of calculation of premium is to be treated as 21 years only. However, if the age is 21 years 6 months or more it is to be taken as 22 years. In other words if the age is 21 years 11 months and 29 days the age is taken as 22 years.

The method for calculation of age is explained by an example:

	Day	Month	Year
Date of Calculation	21	08	2000

Date of Birth	02	01	1964
	19	07	36

Age is 36 years 7 months and 19 days. Therefore the age last birthday is 36, the age nearer birthday is 37 and the age next birthday is also 37.

Another Example

	Day	Month	Year
Date of Calculation	02	03	2000
Date of Birth	19	09	1964
	13	05	35

Age is 35 years 5 months and 13 days. Therefore the age last birthday is 35, the age nearer birthday is 35 and the age next birthday is 36.

Computation of extra premium

Mortality as explained above relates to the death rate of a very large group of people of different ages over a long period of time. These people are usually selected people, who are also called standard lives. A separate mortality study is done for people who are rated substandard. In other words these rated people suffer from some disease or other physical deformity because of which the expected mortality rate for these people would be higher than what is expected of standard lives.

This special study by actuarial method thus leads to an estimation of extra premium which shall adequately take care of the extra mortality in this substandard group. In view of such study, extra premium is imposed on people suffering from diabetes or blood pressure etc. It is true that in view of the progress made in the medical science, these diseases are gradually not considered as dreadful as they used to be. Most insurers, therefore, keep on updating their experience relating to mortality of different groups and revise the rates of extra premium also.

Rider premiums

There are also extra premiums, for conferring extra benefits, to the insured. For example, a prospect wants to get double the sum assured, in case of a death due to accident. This benefit is allowed by charging an extra premium.

The insurers usually charge extra premium for riders attached to the policy. One can opt to take death benefit five or even ten times of the basic sum assured and may pay for such extra term rider benefit.

Suppose a Life Insurance Company is providing the following riders

- Term Cover
- Accident Death Benefit

The extra premium for Term cover rider is ₹400 and the Accident benefit is ₹300. The premium under the policy is ₹2,050. So the premium payable by the insured will be ₹2,050 + ₹300 + ₹400 = ₹2,750.

Thus the rider premiums are payable separately under the policy.

BONUSES TO POLICYHOLDERS

Policyholder Bonus is a unique concept only to Life insurance business. Generally in any business, a product

or service is sold to the Customer for which the Customer pays a consideration which is the income for the business. After paying for the expenses for running the business, the Shareholders take the profit or loss which arises therefrom.

In Life insurance, there is line of business called Participating business. Under this line, the Products approved by IRDAI as “With profits” Products are eligible for a share in the profits arising from the Participating line of business, besides the amounts guaranteed to be paid as per the Policy contract. The surplus arising from the Participating line of business is distributable as follows:

- (a) Not less than 90% of the surplus is distributed to the Policyholders as Bonus
- (b) Not more than 10% of the surplus is distributed to the Shareholders as their share of the Surplus

Normally, bonuses are paid to Policyholders as “Reversionary bonus” which is paid only upon the happening of the insured event, i.e. death or maturity of the Policy. However, such bonuses are declared by the Appointed Actuary from time to time. Such declared Reversionary bonuses get attached to the Policy and shall become payable along with other benefits payable on the happening of the insured event.

Bonuses are not guaranteed and depends on the actual performance of the Participating line of business. In some years, there may not be surplus at all. This happens usually in the initial years of a life insurance business, when the expenses are more than the income. Under such circumstances, a Life insurance company cannot normally declare any bonus. However, given the intense competition in the life insurance segment, the IRDAI regulations permit a Life insurer to declare a bonus even if there is no surplus, provided an amount equal to the deficit is transferred from Shareholders account to Policyholders account. Further the cost of bonus shall also be funded by the Shareholders. After doing the above, the Life insurers are permitted to declare bonus to Policyholders.

As per the IRDAI (Non-linked Insurance Products) Regulations, 2013, every Life insurer shall constitute a “With Profits Committee” which shall comprise of the Appointed Actuary, an Independent Practising Actuary, an Independent Director. The purpose of this Committee is to determine the asset share for the Participating segment, the investment income and decide the appropriateness. This Committee is intended to take care of the interests of the Participating Policyholders.

Interim Bonus

Bonus is normally declared on a valuation date say for 31.3.2007 the valuation may be declared sometimes in October 2007. In case of policies which result into claim after 31.3.2007 but before the declaration of the bonus would not get the benefit of the bonus. Hence to resolve such situation companies declare interim bonus for policies which become claims during two valuation dates.

As any premium rate decided today, remains constant for the entire duration of the policy which can be upto 50 years or more, the insurer normally takes a very conservative outlook and provides for substantial reserves to take care of any adverse deviation from the originally assumed standard.

Terminal Bonus

This is a one time bonus declared by some companies for policies which have run for 15 years or more. In simpler words it can be said it is a loyalty bonus.

Bonus under ULIP Policies

In case of Unit Linked Plans the policyholders get the fund accumulated in their account. The NAV of the

fund multiplied by the number of units, the policyholder has, is known as Fund Value. In ULIP policies, the policyholders are not entitled to bonus. As in endowment policies these kinds of policies are not entitled to bonus. However, the company may pay the policyholder a loyalty bonus at the end of the policy.

PLANS OF LIFE INSURANCE

Term Insurance

Under the Term Insurance plans, the Sum Assured is paid only on the happening of the insured event which is death of the life assured. There is an option to return the premium if the Life assured survives the term of the Policy. The Term of the Policy may be 5 years, 10 years, 15 years etc. as selected by the Policyholder. This is the cheapest form of life insurance available as only the mortality risk (risk of dying early) is covered.

Term Insurance is a unique product for life insurance in the financial services products portfolio as no other Service provider can provide a pure life insurance risk cover.

Whole Life Insurance

Whole life insurance is an extension of Term Insurance. Unlike a Term Insurance plan which covers the insured event only if it happens within the term of 5 years, 10 years etc., a Whole life insurance product covers the risk till death without any term restriction. This is the most ideal plan for someone who wants to take care of risk cover for ever. Whole life is also a pure life insurance policy and some of the Whole life insurance products come with an option of participation in bonus (With Profits Policies).

Both term insurance and whole life insurance are not popular because of the low insurance awareness in India. Generally, there is a tendency to avoid pure life insurance policies as the Customer does not see any benefit during his survival. There is little appreciation of the Human life value and the lump-sum benefit which family gets upon death of the breadwinner – which will help a family to survive.

Endowment Policies

In order to facilitate some payment during survival of the life assured at the end of the term (maturity of the policy), an Endowment Policy provides a Sum Assured either on death or on maturity of the policy, whichever is earlier. Some of these Products also have the option of participation in bonus (With Profits Policies).

This gives the Policyholder an option to get a defined benefit in case he survives the maturity which is normally equal to the Sum Assured which is payable on death.

In view of the Survival benefit on maturity, the premiums payable for Endowment Policies are relatively higher.

Money Back Policies

Money Back Policies are a variant of Endowment Policies in as much as there are periodic benefits (instead of lump sum maturity benefit) payable at the end of say, 5th year, 10th year, 15th year and 20th year. For example, if the Life assured survives 5th year, 25% of Sum assured is paid, at the end of 10th year another 25%, at the end of 15th year another 25% and the balance 25% on maturity. However, if death happens any time during the term of the Policy, full Sum assured is paid without deducting any survival benefits which have been paid prior to death.

These plans also carry relatively higher premiums.

Children's Benefit Policies

These Policies are generally built on Endowment Policies platform in such a way that the lump sum benefit is payable to take care of the needs of Children's education, marriage needs etc. Under these policies, the life assured is usually the child and the Policyholder is the Parent. Upon the child attaining the majority, usually there is an option of automatic vesting, under which the ownership of the Policy gets transferred to the child-life assured. Thereafter it becomes an own life Policy on the life of the child which has attained the age of majority.

There are benefits of Premium Waiver, as per which if the Parent dies, the future premiums are waived and the Policy continues to be in force for full benefit which is payable to the Child as specified in the Policy document.

Pension and Annuity Policies

A Pension Policy helps a person to plan his retirement by building a corpus during a person's active life, which will be utilised to buy an annuity policy under which periodic benefit is paid (usually monthly) to the Policyholder till his life time (life annuity option). If a Pension Policy is taken, say, at the age of 30 for a period of 28 years, the premiums are usually paid during these 28 years to build the corpus (also called the deferment period). On attaining age 58, the Policy matures for payment. Out of the corpus available at that time, the Policyholder is allowed commute (withdraw as lump sum) upto 1/3rd of the corpus and the remaining 2/3rd are utilised to purchase an annuity under an Immediate Annuity Policy.

Under the Immediate Annuity Policy, the lump sum is paid as a Single Premium and the annuity payment starts immediately thereafter every month. There are various annuity options like Life annuity option, Annuity certain for, say 5 years, Widow's Pension, Annuity with return of corpus on death etc. Under Life annuity option, the annuity is paid as long as the person lives while under Annuity certain for, say 5 years, even if the Annuitant dies any time within 5 years from the start of the annuity policy, the annuity amount is payable for the remainder period till completion of 5 years and then the annuity will stop. Under Widow's Pension, after the annuitant's death, the annuity payments will continue to be paid to wife till her death. Lastly, under the Annuity with return of corpus option, upon death of the annuitant, the corpus invested as a lump sum. The quantum of benefit will vary depending on the type of annuity option selected.

Health Insurance Plans

Health insurance plans are of two types – indemnity based health insurance products which are offered only by Non-life and Standalone health insurance companies and secondly, fixed benefit based health insurance plans offered by Life insurance companies.

All non-life insurance contracts are contract of indemnities and the benefits paid cannot exceed the exact loss incurred. Life insurance contracts are not contracts of indemnity – only a fixed amount is paid which more or less will compensate the life assured. Therefore, under Medi-claim Policies offered by Non-life and Standalone health insurance companies, upon hospitalisation and treatment, the exact amount of bills payable will be paid, subject to the overall sum assured limits. However, in the case life insurance companies, for example, a Critical illness Rider, a fixed amount of Sum assured is paid on proof of hospitalisation. Proof of actual amount spent is not necessary.

Group Insurance Policies

As distinguished from individual policies, which are a contract between an individual policyholder and a life insurance company and covers the risk on the life only the individual, under Group insurance policies, a group of lives are covered under an umbrella Group insurance policy taken by an organisation of which lives assured are members.

For example, the borrowers of a Bank can be covered under a Group Life insurance policy taken by the Bank with a Life insurance company. Upon death of the borrower, the outstanding loan amount is paid by the Life insurance company to the Bank and the balance amount is paid to the Nominee. By doing so, the Asset (e.g. House) against which a loan was taken becomes encumbrance-free for the Nominee.

Premiums under Group insurance policies are cheaper since the risk assessment of the overall profile of the customers insured is taken into consideration, rather than individual's risk assessment under Individual contracts. Therefore, even a sub-standard life can get the benefit of an average premium fixed based on the overall risk profile of the group.

There has to be a subsisting relationship between the organisation taking the Group insurance policy and the lives covered under a Group insurance policy.

Premiums can be contributory or non-contributory. Under the contributory schemes, the premiums are shared between the Group policyholder and the life assured whereas under the non-contributory schemes, the entire premium is paid by the Life assured.

A Group policyholder can act as the servicing point for the lives covered under a Group policy taken by them. They are allowed to render data management services, Premium collections, Claims assistance etc. on behalf of the Life Insurance Company and can collect a small fee as a consideration for the services rendered to the Life insurer.

While a Group Master Policy is issued to the Group Policyholder (Organisation), the individual lives covered under the Group Policy are issued a "Certificate of insurance" which is an evidence of insurance cover provided by the Life insurer. This is equivalent of a Policy document issued under an individual Policy contract. Normally only the Life insurer is allowed to issue Certificate of insurance. However, the service of issuance of a Certificate of insurance can also be performed by the Group policyholder (especially larger Groups under which the lives assured are spread across various geographical locations). However, the control over issue of Certificates of insurance lies with the Life insurer who is expected to conduct inspection of the Group policyholders to check adherence to the guidelines of IRDAI on Group insurance as applicable to Group policyholders.

Linked Life Insurance Policies

Also called Unit Linked Life Insurance Policies (ULIPs), these Policies combine a Term insurance with an investment option. Under ULIPs, out of the Premiums collected from the Policyholder, after deducting the charges applicable towards risk cover and charges for administration and management of investments, the balance amount is invested in market linked instruments.

Therefore, the Customer has 2 benefits – a Sum assured payable upon death plus the marked to market value of the investments made on behalf of the Policyholder by the Life Insurance Company.

Under ULIPs, the risk on investment portion is borne by the Policyholder. The investment portion of ULIPs works like a Mutual fund as follows:

- (1) Customer selects the fund option – Equity based, Debt based, balanced fund etc.
- (2) Life insurance company invests in instruments as per the option selected in (1) above.
- (3) Units are created to represent the investments made.
- (4) Daily Net asset value (NAV) is declared which will reflect the marked-to-market value of the units.
- (5) On death or maturity, the units are sold and the marked-to-market value is paid.

Usually, the following 2 typical benefit options are available to the Policyholder upon death:

- (1) Get the Sum Assured + Fund value (Marked-to-market value of the units)
- (2) Higher of Sum Assured (or) Fund Value

Risk premium (also called mortality charges) is usually calculated on a daily basis and deducted by selling appropriate units.

Following are the charges generally applicable in ULIPs:

- (1) Charges deducted from Premium:
 - a. Premium allocation charges – under which a percentage of premium is deducted upfront from the premiums paid
- (2) Charges deducted by cancellation of units:
 - a. Policy administration charges – which is usually a fixed amount per month (e.g. Rs.40 per month)
 - b. Mortality charges – represents the risk premium
 - c. Surrender or discontinuance charges – payable upon surrender or exit from an ULIP contract
 - d. Switching charges – where the Policyholder is allowed to switch from one fund to another fund
 - e. Rider charges – to cover the risk coverage provided under a Rider benefit
 - f. Partial withdrawal charges – leviable whenever a Policyholder withdraws an amount from his unit linked fund
- (3) Charges appropriated from Fund value:
 - a. Fund management charges – which will not exceed 1.35% and is adjusted from NAV
 - b. Guarantee charges – cost of any guarantees given on the ULIPs – also adjusted from NAV

MINIMUM LIFE COVER (SUM ASSURED) UNDER ULIPS

Since ULIPs combine Pure risk + investments, in order that ULIPs do not partake the character of a Mutual fund, the Product Regulations of IRDAI prescribe a minimum Sum Assured in any ULIP calculated as follows:

For Life insurance Regular Premium (or Limited Pay Premium Products) : 10 times the Annualised Premium (or) 0.5 of Term multiplied by Annualised Premium, whichever is higher

Under Regular Premium Policies, the policies are payable in one of the modes, viz., monthly, quarterly, half-yearly or yearly for the Policy term. Under Single premium policies, only one lump sum amount is paid as premium at the beginning of the Policy and no other amount is payable by the Policyholder thereafter as Premium.

Policy term is the period for which the insurance cover is available. Premium term is the period for which the premiums are payable. Premium term is generally equal to the Policy term, but can be lesser than Policy term, but not more. Limited Pay premiums are those Policies under which the Premium term is less than the Policy term. For example, premiums are payable only for a limited period, say 5 years, whereas the Policy term can be for a longer period, say, 10 years.

Annualised Premium is the Premium payable across all modes in a Policy year. Policy year starts from the date of commencement of an insurance Policy and expires after a period of 365 days. Every subsequent such period of 365 days is also called Policy year.

For example, for Annual Mode, Annual Premium = Annualised Premium, for Half yearly mode – half yearly premium multiplied by 2, quarterly multiplied by 4 and for monthly multiplied by 12.

Under Life insurance contracts premiums are fixed in advance and are called Level Premiums – which means the Premiums payable will be the same across all years. Therefore, Annualised Premiums will be the same amount across all Policy years.

MINIMUM POLICY AND PREMIUM TERMS FOR ULIPS

Top-up premiums under ULIPs

There is a facility to invest additional amounts over and above the Regular/Single Premium, at the option of the Policyholder. Every such Top-up premium shall have a risk cover equivalent to 125% of the Top-up premium and appropriate mortality (risk premium) will be deducted and the balance after deducting any other charges will be invested as per the Customer's investment option.

Every top-up premium has a 5 year lock-in – meaning no withdrawal of the topped up amount (invested amount) shall be allowed within a period of 5 years from the date of payment of top-up premium. However, this rule is not applicable in the case of surrender of a Policy, i.e.. where the Policyholder wants to completely terminate the contract and exit.

Except for Unit linked Pension policies, no Top-up premiums are allowed during the first five Policy years.

Partial withdrawal from Fund value under ULIPs

A Policyholder has the option to withdraw a portion of the fund value, by selling appropriate units at the then prevailing market value on the date of partial withdrawal. This may be utilised for any urgent needs of the Policyholder.

No partial withdrawals are allowed from Unit linked Pension products. A partial withdrawal should first be made from the investments made out of the Top-up premiums followed by the investments made from the base premiums (Regular/Single premiums)

No partial withdrawals are allowed during the first 5 policy years and the partial withdrawals made. Upon death of the life assured, from the death benefit payable, all partial withdrawals made by the Policy holder upto 2 years preceding the date of death shall be deducted. If the death happens after attaining age 60, in addition to deduction of partial withdrawals made before attaining age 60, all partial withdrawals made after attaining age 60 shall also be deducted.

Discontinuance of an ULIP

Customers have the option to stop paying the premiums under any life insurance policy. Under ULIPs, since there is a term insurance portion and investment portion, for the investment portion, the investments have already been made and the fund value which represents the marked to market value of the investments is payable to the Policyholder. However, there are certain rules attached to such discontinuance as follows:

- (1) For every premium there is a grace period which is 30 days for all modes, except for monthly modes for which the grace period is 15 days
- (2) During the period of grace, the Customer has the full life cover and if death happens, full sum assured is paid subject to deduction of unpaid premiums. If the premiums are not paid within days of grace, the policy shall lapse and the benefits payable under the Policy will get restricted.

- (3) If the premiums are not paid after the days of grace, a Notice is sent within 15 days of expiry of days of grace to the Customer giving 2 options – either to revive the Policy within a period 2 years from the date of lapsation of the Policy (or) to completely withdraw from the Fund. The customer is required to exercise the option within a period of 30 days of receipt of the Notice. Revival is the option given to Customer to pay all the arrears of premiums payable and reinstate the Policy for its full benefits.
- (4) If the customer exercise option 2 or does not exercise any option, the proceeds under the ULIP (fund value representing the marked-to-market value of investments) shall be transferred to a Discontinuance Fund, after deduction of discontinuance charges which at the maximum shall not exceed Rs.6,000. The Discontinuance Fund is not a protected fund where investments made in money market instruments/ secured instruments with the intention of protecting the capital for a temporary period. At the end of 5 years, the proceeds from the Discontinuance Fund is paid to the Customer.
- (5) If the Customer wants to revive the Policy within 2 years, then also the funds are moved from active ULIP fund to Discontinuance fund and remains in the Discontinuance fund till the completion of the 2 year period given for the Customer for exercising the option of revival.

Therefore, under ULIPs, even upon discontinuance, no payout is possible till completion for five Policy years from the date of commencement of Policy.

In summary, no benefit can be paid to the Policyholder under ULIPs till completion of 5 Policy years. This is primarily intended to distinguish ULIPs from Mutual Fund – Life insurance ULIPs are long term in nature whereas Mutual funds are short term.

APPLICATION, ACCEPTANCE, PREMIUM PAYMENT AND POLICY DOCUMENT

We now deal with the initial stages of a Life insurance policy cycle which starts with solicitation of insurance business by a Distributor. A Distributor can be an Individual Agent, Corporate Agent, Insurance Broker, Web Aggregator etc. Once they convince the Customer to buy an insurance product which suits the needs of the Customer, an application form (usually called the Proposal form) is filled by the Customer giving the personal details like Name, Date of birth, address, Gender, Name of the Nominee and other personal health and family history details. Since Insurance contracts are based on the principles of utmost good faith, the Customer (also called Proposer) is expected to disclose about the status of his/her health completely in the Proposal form. There will be questions in detail asking the Proposer to confirm the exact status of health as known to the Proposer including past history of any illnesses, hospitalisation etc. The details of family history including details about parents, siblings etc. are also equally important. All these factors impact the mortality and therefore a truthful disclosure is expected to correctly assess the risk taken by the Insurer.

The Proposer is expected to diligently and truthfully disclose the full particulars in the Proposal form, especially the questions relating to personal and family health and income and occupation of the Proposer. If there are any misstatements or non-disclosure on any of the material facts (i.e. facts which could have impacted the decision of the Insurer to accept, reject or postpone a proposal), then the benefits under the Policy may be denied by the Insurer. This is based on the concept of Utmost good faith.

Once the Proposal form is signed, it is submitted along with the Age proof, Aadhaar & PAN. Once Aadhaar number is authenticated and details verified with reference to Aadhaar, the KYC of the customer is complete. If the current address of the Customer is different from the address as per Aadhaar, an address proof for the current residence of the Customer would be mandatory. Further, an amount equal to the First Premium is also tendered along with the Proposal form. It is called Proposal deposit and can be in Cash, cheque, demand-draft or even payment through electronic means.

Under life insurance, up to a certain limit, Proposal forms are underwritten (the act of taking a decision on a Proposal form) without any medical examination. These are called Non-medical Proposals. The Non-medical limits depend on the age and the Sum assured.

Beyond the non-medical limits, Medical examination of the Customer is mandatory before the Proposal is underwritten. The nature of medical reports required depend on the age and health condition of the Life assured. Cost of medical examination is borne by the Life insurer if a Policy is ultimately issued.

If the medical report is clean and there are no adverse noting from the Proposal form, the Underwriting decision is "Accept at Ordinary rates". This means that the Policy document can be issued without imposing any extra premium on the Customer. Where situation warrants, an extra premium may be imposed by the Underwriter to compensate for the additional risk taken by the Life insurer. The amount paid as Proposal deposit is then adjusted towards First Premium.

The next stage would be issue of Policy document to the Customer. This a Contract which outlines various terms and conditions of issue of a Policy document, the benefits payable, the premiums to be paid, exclusions (situations when claims are not payable) etc.

Every Policyholder has the right to ask for cancellation of a Policy document in case he does not agree with the terms and conditions, within a period of 15 days from the date of receipt of the Policy document. For policies sourced through Distance marketing (e.g. Telephone based solicitation), the Free look period is 30 days.

Premiums are payable in advance at the end of every month, quarter, half-year and year, depending on the mode of payment of premium. Under Single premium contracts, the amount is paid only once at the time of commencement of Policy. A Policy document can be in physical form or electronic form. Electronic policies are issued through an Insurance Repository who is like a Depository Participating for holding shares in electronic form. In the case of Insurance Repository, the Insurance policies are held in electronic form and the Customer can access the Policy document online.

POLICY CONTRACT

Policy document is a detailed document and it is the Evidence of the insurance contract which mentions all the terms and conditions of the insurance. The insured buys not the policy contract, but the right to the sum of money and its future delivery. The insurer on its part promises to pay a sum of money, provided of course the insured keeps its part of promise of paying the installments of premium as scheduled.

The pre-amble to the insurance contract makes the above statement clear and states that this policy is issued subject to the conditions and privileges printed on the back of the policy. The endorsements placed on the policy shall also be part of the policy and it also makes a reference to the proposal form saying that that the statements given in the proposal form are the basis of the contract.

The schedule which is printed on the policy document identifies the office which has issued the policy. It states the name of the policyholder, the date of commencement of the policy, an identification number of the policy called policy number. This number is extremely useful for making any reference to the insurer relating to this policy. This shall avoid needless delay.

It is necessary to check that it is correct and any mistake should be immediately pointed out for correction. A mistake in the address may misdirect the premium notices and any other future correspondence. It also states the name of the nominee and the date up to which premium has to be paid. The schedule goes on to mention, the type of policy, on the happening of which, the sum assured is payable and to whom it is payable. It of course also mentions when and how long the premium is to be paid.

The policy document is signed by an official of the insurer and dated and stamped as per the provision of the Stamp Act to make it a completely legally enforceable document.

ENDORSEMENTS

Life insurance policy being a long term contract, it is quite likely that the conditions may so change over the time that an alteration or change in the policy conditions may be required. The insurers normally permit such changes which are in the interest of the policyholders and also simultaneously do not adversely affect the insurer's interest.

It has to be noted however, that the insurer is not authorized to make any change in the conditions of the policy during its continuance except such which has been agreed to in the beginning of the policy. An insurance policy, in this sense is called an unilateral contract.

All such alterations as are discussed hereafter are effected by endorsements on the policy document.

The following alterations are not permitted:

- (1) Alterations during the first year.
- (2) Alteration from one class of assurance to another where the premium scale is reduced.
- (3) Alteration to another plan which is more risk oriented.
- (4) Increase in sum assured in the same policy.

The following alterations are allowed:

- (1) Limiting the premium paying period, but date of maturity remaining unaltered;
- (2) Change in the mode of payment of premium e.g. half yearly to yearly or half-yearly to quarterly;
- (3) Alteration due to age admission, if required, has to be compulsorily done;
- (4) Alteration or correction in the name of the assured/ nominee;
- (5) Bringing the policy under salary savings scheme;
- (6) Replacing a limiting clause by an extra premium. For example the first pregnancy clause can be replaced by an one time extra premium of Rs.5/- per thousand; and
- (7) An extra premium imposed for specific impairment or occupational reasons can be removed or reduced. For example, an extra premium imposed for hernia or hydrocele can be removed after surgical operation. Similarly, an occupational extra premium can be removed, if there is change in occupation to a less hazardous one. However an occupational extra premium cannot be imposed, after the policy has been issued, even if the policyholder takes up a more hazardous job.

All such alterations are effected by an endorsement on the back of the policy or by a separate memo which becomes a part of the policy.

DUPLICATE POLICY

A policy document is a valuable document and can be used for mortgage etc. Loss of policy document does not absolve the insurer from the liability of payment of policy proceeds when the claim arises. The claim can be settled on the claimants, furnishing an indemnity bond jointly with one surety.

If a policy is irrevocably lost, a duplicate policy can be issued, after following a certain procedure. The insurer

satisfies itself of the circumstances leading to loss. Being so satisfied the insurer insists upon an advertisement in a news paper, production of an indemnity bond and payment of policy preparation charges and there after a duplicate policy is issued. The duplicate policy is stamped "Duplicate Policy".

POLICY LAPSE AND RENEWAL

Generally, Premium in life insurance should increase with the age, as the mortality risk increases with the age. However, in Life insurance, all premiums payable (other than Single Premiums) are Level Premiums – meaning an uniform premium is payable throughout the entire Premium paying term. Therefore, the premiums paid in the initial years would be slightly higher than the required premium and thus a reserve builds up. As the age advances, the risk premium portion of the premium would increase. The reserve which is built up in the initial years would make up for the deficit which would come up in the higher ages. This is called the Level premium principle in Life insurance. However, besides the Risk premium, the Life insurer incurs heavy expenses in the first year in the form of Stamp duty for Policies, higher first year's commission to distributors, Cost of dispatching Policy document to Customer etc. Therefore, the mortality reserve gets wiped out by the other high initial costs of the life insurer. In effect, the cost of servicing a Policy is very high in the first Policy year which can be recouped only from the Renewal premiums of subsequent year(s).

Every Policy has a due date for payment of renewal premiums (other than Single premium). If the Policyholder is not able to pay the premium by the due date, additional period called Days of grace is allowed. For yearly, half-yearly, quarterly and monthly modes, the Grace period is 30 days, while for monthly mode the grace period is 15 days. During the grace period, if the life assured dies, full sum assured is payable, subject to deduction of unpaid premiums.

If the Policy-holder does not pay the premium even after the days of grace, the Policy lapses. Upon lapsation, the full benefits are not payable. If the Policy lapses within 3 years and which have not acquired surrender value (other than ULIP Policies), normally nothing is payable. Some Policies acquire Surrender value within 2 years as well. If the Policy lapses after acquiring surrender value and if the Policy is not revived and there is a death claim, pro-rata sum assured is paid. This is called Paid up value. Under Participating Policies, where annual reversionary bonuses are declared, the bonuses accrue only whilst the Policy is in force. Such vested bonuses are also payable. Under Unit linked life insurance policies which lapse within 5 years, as discussed earlier, the fund value is moved to a discontinuance fund and the proceeds are paid at the expiry of 5 policy years.

Policyholders have the option to revive/reinstate a Life insurance Policy, during the revival period. For Unit Linked Life Insurance Policies, as stated earlier, 2 year period is given for reinstatement. For other Policies, a 3 year period from the date of first unpaid premium is given for reinstating a Policy. If the Policy is reinstated within 6 months of Unpaid premium, normally, only a Declaration of Good health by the Life assured is required. For Policies which are reinstated after a period of one year from the date of first unpaid premium, a Full Medical Report from a Medical Examiner is normally insisted and only if the Medical report and Declaration of Good health do not have any adverse findings, the Policy is reinstated or reinstated with appropriate extra premiums.

ASSIGNMENTS AND NOMINATIONS

In life insurance, insurable interest not necessary once policy is issued. Therefore, a Life insurance policy can be assigned (transferred) after issuance of policy. An assignment is transfer of rights under a Life insurance policy to another person for a valid consideration. However no consideration is required for transfer out of love and affection between parties standing in close relation to each other.

Life Insurance company vested with powers to refuse assignments if against Policyholder/Public interest or if such assignment results in trading in insurance policies. The transfer or assignment shall be complete and

effectual upon the execution of such endorsement or instrument duly attested but except wherethe transfer or assignment is in favour of the insurer shall not be operative as against an Insurer and shall not confer upon the transferee or assignee, or his legal representative, any right to sue for the amount of such policy or the moneys secured thereby until a notice in writing of the transfer or assignment if and either the said endorsement or instrument itself or a copy thereof certified to be correctby both transferor and transferee or their duly authorised agents have been delivered to the insurer. Therefore, until and unless the assignment is registered by the insurer and an endorsement is placed on the Policy document, an assignment is ineffective.

Conditional assignment is a scenario where a Life insurance Policy is assigned to another person on the condition that the Policy will be re-assigned upon happening of an event during the life time of the Life assured.

KYC of assignee mandatory for registration. Partial assignments of life insurance policies have also been recognized.

Nominations are made when the Proposal for Life insurance is submitted by the Proposer. Only a person who has taken a Policy on his own life can effect Nomination. In Life insurance, Nominees act as “Trustees” accountable to the legal heirs. However, Parents, Spouse and Children recognised as Beneficial Nominees and are entitled to the Policy benefits to the exclusion of other legal heirs.

A minor can be appointed as a Nominee. However, under such circumstances, an Appointee shall be named in the Proposal form, who shall be entitled to receive the Policy benefits upon death of the Life assured during the minority of the Nominee.

Nomination made in proposal can be changed subsequently

Assignment automatically cancels nomination, except where the Policy is assigned for the purpose of securing a loan. In such cases, the nominee’s interest is impacted only to the extent of the outstanding loan. Upon re-assignment, the nomination stands automatically reinstated

Under the Life Insurance Policies taken under Section 6 of the Married Women’s Property Act (which gives special protection to Married Women), the Nominee can only be the named Wife or Children. Husband’s Creditors cannot attach a Life insurance Policy taken under Section 6 of the above Act as this is a special dispensation provided to Women.

SURRENDER OF A POLICY

Surrender is voluntary termination of a Policy contract only by the Policyholder. If the Policy has acquired surrender value, then surrender value is paid to the Policyholder and the Contract comes to an end.

Under Traditional products, the rules for Surrender value are as follows:

- (a) No Surrender Value for Term, Health & Annuity products.
- (b) For Premium paying term (PPT) of 10 years or more, Surrender value gets acquired after paying 3 years’ premiums.
- (c) For PPT less than 10 years, Surrender value gets acquired after 2 years premium.
- (d) Minimum amount payable as Guaranteed Surrender value (Non-single):
 - 30% of premiums paid (less survival benefits paid) if surrendered in second and third policy years
 - 50% if surrendered between fourth and seventh
 - 90% of surrendered in last 2 years (for less than 7 year)

- Beyond 7 year term, to be decided in file & use document (which gives the product features including policy benefits and premiums payable) to be filed by the Life insurer with the Regulator

Generally Surrender Value is a loss to the Policyholder – the reason being life insurance are long term contracts and there would be a loss to the insurer if surrender value is higher in initial years given the higher cost in the first policy year.

Under Unit linked life insurance policies, since the term insurance component does not carry any surrender value, only the fund value is payable as surrender value after deducting surrender charges.

Paidup Value

Where a policy lapses after acquisition of surrender value, but is not surrendered, the policy does not lose all its benefits. Sum assured shall be reduced in the same ratio as the number of years the premiums actually paid bears to the total number of years for which premiums are payable. Subsisting bonus already declared shall attach – however, no eligibility for future bonuses. Yearly intimation of bonus accrual to Participating Policyholders.

CLAIMS

A Claim for death sum assured shall be raised by the Nominee with the Life insurance company along with the basic documents like Intimation of death, Death certificate, attending Doctor's certificate etc. Additional documents may be called for by the Life insurance company. If the Life insurer has additional pending documents to be submitted by the Nominee, the requirements must be raised within 15 days of receipt of intimation of death.

Depending on whether the claim is early claim or not an investigation of the claim is normally conducted. Any death claim which is submitted within 2 years of date of commencement of the policy is referred to as early claims. In all such cases, most life insurers invariably conduct an investigation which is done either a senior employee of the life insurer or outsourced to an independent outside investigator. The reason for referring such cases to investigation is to rule out the possibility of any moral hazard of non-disclosure of any pre-existing illnesses or treatments taken by the part of the life assured when the policy was taken. The investigator conducts enquiries with the neighborhood of the place where the life assured had lived, visits hospitals and Doctors to check whether the life assured had taken any treatment. They procure copies of medical reports and submit to the Life insurance company. They also check the authenticity of the Death claim certificate by verifying with the issuing authorities. Also, the KYC documents submitted by the Life assured/Nominee are also verified to rule out frauds.

It is not surprising that life insurance industry has faced serious frauds by persons taking life insurance policy on persons who are not in good health by giving false declarations. In all such cases, death usually happens soon after the Policy is taken. In extreme cases, Life insurance companies have also faced cases of taking life insurance policies on the lives of persons who were already dead even before the Policy was taken, by forging documents. Therefore, claim investigation is very important especially in the case of early claims.

However, claims which normally come after a period of 2 years are generally not investigated. However, in case of any suspicion, Life insurance companies have the right to investigate even claims arising after 2 years.

Claims which are not investigated shall be paid or rejected or repudiated within 30 days of receipt of receipt of all papers & clarifications from the Nominee.

Life insurer has a time limit of 90 days for completion of investigation. Once the investigation report is received, the claim to be decided within 30 days of receipt of investigation report. For delays in settlement of claims,

interest @ 2% above bank rate shall be payable from the date of receipt of last necessary document. For disputes in title, payment can be made to Court (Section 47). Except claims under Section 47, where claim cannot be paid for want of identification of payee, interest at bank rate payable from the date when claim is ready for payment.

Where nominee not traceable, claim cannot be written back. Any claim which cannot be paid for any reason such as want of proper title, disputes between legal heirs etc. will have to be moved to a separate account called "Unclaimed account" which will be invested as per IRDAI's guidelines for the benefit of the Claimant. If even after 10 years from the date of claim intimation, the claim amount is not settled, the proceeds shall be transferred to Senior Citizens Welfare Scheme. After 25 years from the date of such transfer, the proceeds shall be forfeited to Central Government.

If death of the life assured happens due to suicide committed by the Life assured within 12 months from the date of commencement of the Policy, Sum Assured shall not be paid. However, 80% of the premiums paid payable (for reinstated cases, higher of 80% or surrender value whichever is higher; for ULIPs fund value) to the Nominee in such cases.

Where, as a result of the investigation conducted by the Life insurer, it is established that a material fact which was critical for assessment of the risk was not disclosed at the time of application in the Proposal form, the Life insurance company has the right to re-assess the underwriting keeping in mind the facts revealed by the Investigation Report. For example, if the investigation report reveals that the Life assured had taken treatment for say, 3 years prior to taking the Policy, for some ailment in an Hospital, the Life insurance company shall re-assess the underwriting keeping in mind this fact. Had this fact been revealed to the insurance company at the time of submitting the Proposal form -what would have been the impact of underwriting (decision to accept the risk and issue a Policy) where fraud or misrepresentation is established, surrender value shall be paid.

As per Section 45 of the Insurance Act, 1938, no claim shall be repudiated on any reason such as non-disclosure or misstatement in the Proposal form, after a period of 3 years from the date of commencement of policy or after 3 years from the date of reinstatement of a Policy. However, this does not preclude an insurer from rejecting a claim where the Policy is in a lapsed condition or covered by exclusions specified in the Policy document, e.g. Suicide exclusion (seen earlier). Therefore, the Life insurer is expected to conduct due diligence at the time of underwriting or at any time within 3 years from the date of commencement of the Policy. A policy also can be cancelled within 3 years, if the Life insurer is able to establish fraud or misrepresentation or misstatements in the Proposal form (even if there is no claim).

For maturity/survival benefits, settlement to be made on or before the due date (i.e. date of maturity or due date for survival benefit as per Policy document). For delays interest at Bank rate+2% from due date or date of receipt of last necessary document from insured/claimant, whichever is later. For delays in processing Free look cancellations, Surrender, Withdrawal, request for refund of Proposal deposit, refund of Proposal deposit, interest at Bank rate+2% from date of receipt of request or receipt of last necessary document, if any, whichever is later, is payable. Usually for settlement of a claim, a Discharge Voucher (which lists down the claim amount paid along with the break up – giving additions and deductions) signed by the Claimant is insisted. However, if the customer expresses reluctance or does not submit, Discharge voucher cannot be insisted as a precondition to settlement of claims.

In Group Credit Life Policies (Lender-Borrower Groups), payment of claim amount to the extent of outstanding loan amount as per the books of the Lender (Group Policyholder) and balance amount should be paid to the Nominee.

LIFE INSURANCE CORPORATION OF INDIA

Life Insurance Corporation of India was formed in the year 1956 by amalgamating about 245 life insurance companies then in existence. From the pre-independence days, private Indian and Foreign life insurance companies were operating in India. However after independence, under the leadership of the then Prime Minister, Pandit Jawaharlal Nehru, it was thought prudent to nationalise the life insurance industry by transferring the powers to the Central Government. Accordingly LIC Act, 1956 was passed by the Indian Parliament and Life Insurance Corporation of India (LIC) was established as a Statutory Corporation with Central Government as a Shareholder. Since then, LIC of India had the exclusive privilege of running Life insurance business in India. LIC has established over 2,000 branch offices across with country with Zonal and Divisional offices under a decentralized set up. The head office of LIC is located at Mumbai.

Controller of Insurance was the authority whose primary responsibility was to provide licences to Individual Agents who sold policies for LIC.

The General insurance business was nationalised in the year 1972 with the passage of General Insurance Business Nationalisation Act, 1972, paving the way for formation of 4 Public Sector General Insurance Companies, viz., New India Assurance Company Limited, Oriental General Insurance Company Limited, National General Insurance Company Limited and United India General Insurance Company Limited, with headquarters at Mumbai, Delhi, Kolkata and Chennai, respectively.

With the unleashing of the economic reforms in 1991 under the leadership of the then Prime Minister, Dr. Manmohan Singh, the Central Government formed a Committee under the leadership of the ex-RBI Governor, Mr. R.N. Malhotra to introduce reforms in the Insurance industry. Accordingly, the Insurance Regulatory Bill in 1997-98 aimed at forming an interim Regulatory authority for insurance business was introduced simultaneous to opening up the Indian insurance sector to private sector as well. Due to opposition from Communist Parties, the Bill had to be deferred and even withdrawn on some occasions in the Parliament. Finally, the Insurance Regulatory and Development Authority Bill, 1999 was introduced by the Union Government which passed by the Indian Parliament, ending the monopoly of Government owned Institutions in insurance and paving the way for private participation in Insurance, allowing foreign equity up to 26% in Insurance Sector. Controller of Insurance was abolished and Insurance Regulatory and Development Authority was established as the Regulatory body for the Indian Insurance Industry by passing the IRDA Act, 1999.

In the year 2015, the Insurance Laws (Amendment) Act 2015, among other things, increased the foreign equity in insurance to 49% with Indian ownership and control of the Insurance companies. It also paved the way for Lloyds of London entering Indian market.

Since then, many about 25 life insurance companies and about 27 general insurance companies have been incorporated for doing insurance business in India.

Individual Agents used to be the only distributors before the privatization. However, after formation of IRDAI, many new forms of distributors like Corporate Agents, Insurance Brokers, Web Aggregators, Insurance Marketing Firms were recognised and registered by the Regulatory Authority.

New products like Unit linked Insurance Products were introduced by Private Sector Life insurance companies. New techniques including digital insurance gained prominence and the insurance industry also developed. However, life insurance penetration which measures the extent of insurance depth in India went up to 2010 and then dropped. Life insurance penetration is around 3% of the Gross Domestic Product still way below the level of insurance penetration in advanced countries (around 10%).

LESSON ROUND UP

- Premium is consideration money for the benefit of a lump sum payment by the insurer on the happening of a specified event. The amount of premium is dependent upon age of the prospect, the policy conditions, the term etc. Premium is calculated separately in each case when a proposal is submitted. For extra benefits, extra premium is charged.
- The basic premium is, however, decided on the basis of three factors - mortality, expenses and yield on investment. While mortality and expenses increase the premium, investment yield reduces the premium.
- All life insurance companies charge level premium i.e. the same premium through out the duration of policy. This practice leads to the generation of some surplus in the initial period of the policy. Hence a portion of this surplus can be paid to a policyholder if he wants to surrender the policy before the maturity date.
- Life insurance being a legally enforceable contract needs to be documented with details of the rights and obligations of the parties to the contract. Proposal form duly filled in and signed by the proposer is the first document which forms the basis of the contract.
- Every time, the insured pays the premium, he receives a premium receipt. The premium needs to be paid in time, nonpayment of premium leads to policy-lapses. Re-instatement of the cover is called revival of the policy.
- If the policy is not revived, the policy can become a paid up policy for a reduced sum assured under certain conditions.
- The policy document mentions in detail all the rights and obligations of the policyholder. The agent is advised to explain the various provisions of the policy to the policyholder.
- The wordings in the policy document are of technical nature and hence the need for explaining. If there are certain endorsements on the policy, that need to be explained too.
- It needs to be explained that the policy is a valuable document and needs to be kept in safe custody and in the knowledge of the close relatives.
- Age is the basis for determining premium. Lower age means less premium and higher age means higher premium, everything else, like table being the same. Therefore, the proposer must submit reliable proof of age to the insurer at the time of the proposal itself.
- The days of grace are one month but not less than 30 days in all modes of payment except monthly where the days of grace are reduced to 15 days. During the days of grace, the policy remains in force and the claim is payable if the death occurs and the due premium has not yet been paid.
- Revival is a need whenever the policy has lapsed for nonpayment of premium. The process of revival is kept easy subject to necessary caution.
- Assignment is a procedure to transfer the ownership of the policy, which is a property, to another for a consideration. It is free of normal hassles usual to transfer of property.
- The value which is now payable in cancellation of the policy contract is called the Surrender Value.
- Loan can be taken against some life insurance Policies. Policyholder may make the interest payment

to the insurer and if he wishes the loan and interest gets deducted from the final benefit payable to him.

- Group insurance is a contract of insurance with a company, or association covering a group of people who are engaged in the similar occupations. The group should be such that there would be continuous flow of new members while old members would retire. Individual members do not have to sign any papers and the benefit would be available uniformly to the entire group.
- There could be a variety of group schemes, some relating to the legal requirements and some voluntary. The Group Gratuity Scheme is one such scheme in which the legal liability of gratuity to ones employees can be insured by the employer with the insurer. Similarly superannuation liability of any employer can be met by ensuring it through a Group Superannuation Scheme. Group Savings Linked Insurance Scheme is intended to provide low cost life insurance and inculcate a habit of savings in the employees and provide insurance benefit to the family in case of untimely death.
- Group insurance can be designed to meet a variety of needs of a group indeed of an individual. The benefits paid through group insurance enjoy the Income Tax benefit similar to the individual insurance schemes.

GLOSSARY

- Proposal form is the basic format which is filled in by the proposer who wants to take an insurance policy.
- First Premium Receipt is the confirmation of a concluded insurance contract. Policy document is the evidence of the insurance contract and is a detailed document which mentions all the terms and conditions of the insurance
- Duplicate Policy: If a policy is irrevocably lost, a duplicate policy can be issued, after following a certain procedure. The insurer satisfies itself of the circumstances leading to loss. Being so satisfied the insurer insists upon an advertisement in a news paper, production of an indemnity bond and payment of policy preparation charges and there after a duplicate policy is issued. The duplicate policy is stamped "Duplicate Policy".
- Assignment - An assignment of a policy in favour of another person or institution can be effected by an endorsement on the policy. Re-assignment can also be done by a subsequent endorsement on the same policy.
- Mortality/Morbidity costs – this is the fundamental element of estimating how many persons out of the insured lives will die and therefore what would be outgo on account of claims for a life insurer. Morbidity costs determine the probability of a Lives covered contracting illnesses – relevant for health insurance policies
- Risk Premium: The pure premium needed to cover the expected risks but with no allowance for expenses, commission or contingencies is to be made. Thus the cost to meet the risk of death for one year at a particular age is known as risk premium. The risk premium is based on the probabilities of death at various ages
- Actuarial Valuation: The experience in future may not be exactly as assessed. So the process of checking the validity of assumptions from time to time is known as actuarial valuation.

Lesson 4

Life Insurance – Underwriting

LESSON OUTLINE

- Introduction
- Concept of Standard lives & Sub-standard lives
- Factors Considered While Underwriting Lives
- Types of Risks
- Underwriting Process
 - Automated Underwriting
 - Non-Medical Underwriting
 - Medical Underwriting
 - Financial Underwriting
- Concept of Human life value and Insurable interest
- Insurance on Minor lives
- Key person (or Keyman) insurance
- Partnership insurance
- Employer-employee insurance
- Insurance under Hindu Undivided Family ('HUF')
- Insurance under Married Women's Property Act ('MWP Act')
- Occupational, Avocational and Residential risks
- Reinsurance
- Types of Reinsurance Treaties
- Underwriting considerations for certain specific illnesses and disorders
- LESSONS ROUND UP
- SELF TEST QUESTIONS

LEARNING OBJECTIVES

The main objective of this chapter is to make students aware about the why underwriting is important in life insurance. Underwriting denotes acceptance of risk on a proposal. After studying this chapter student will be able to understand:

- The judgement of the insurance company to take the decision based on risk assessment.
- Know the factors affecting mortality of life assured.
- The concept of Standard lives & Sub-standard lives
- Factors considered while underwriting lives under medical & non-medical limits.

INTRODUCTION

Insurance is transfer of risk and Insurance companies are in the business of accepting the risks. Underwriting denotes acceptance of risk on a Proposal. It is the judgement of the insurance company to take the risk based on the assessment of the extent of risk and taking one of the following decisions:

- Acceptance of risk and issuing a Policy
- Whether the premiums to be charged should be normal or extra premiums considering the increased risk on proposal. For example, insuring persons with history of certain illnesses or disorders
- Whether the risk on Proposal should be deferred – Postponement of the Proposal considering the present state of health
- Whether the risk on Proposal should be declined considering severity of the risk
- Circumstances when the Proposal may be accepted subject to exclusion of payment of benefits under certain circumstances, for example, no payment of any benefit if death occurs due to suicide within 1 year from the date of taking the Policy or date of reinstatement of a Policy
- Circumstances when Proposal can be accepted subject to co-sharing basis (usually in Medi-claim Policies), i.e. where some portion of the benefit is not paid. For example, under Mediclaim policies with co-sharing option, only 80% of the claim amount is paid under the insurance policy. This could be done to prevent a Moral Hazard
- Imposing a reducing lien on benefits – i.e. on Policies where the extra risk subsides over a period, imposition of a lien (non-payment or reduction of benefit payments) till such time the risk persists

Insurance contracts are based on the principle of “uberrimaefidei”, meaning utmost good faith. The person taking the insurance policy is required to disclose all the facts impacting the assessment of risk truthfully and completely about the subject matter of insurance, to the Insurer in order to enable the insurer to correctly assess the risk on hand. If the principle of utmost good faith is vitiated, insurer has the right to cancel the contract or deny payment of Policy benefits.

The tendency on the part of the Proposer (Prospective Customer) to conceal or make misstatements or not making complete disclosures about the subject matter of insurance, in order to get insurance at favourable terms is called “adverse selection”. This is a risk which insurer has to counter by putting effective risk control measures.

For example, if a Person taking Life insurance policy does not disclose correctly about this health-related condition before taking a Life insurance policy, it will have an impact on the mortality and consequently the insurer’s decision on the terms and conditions for issuing an insurance contract. Insurer may, for example, call for medical examination beyond a particular age or where there is suspicion based on disclosures made in the Proposal form (Application form) for Life insurance.

However, undergoing Medical examination does not take away the obligation of utmost good faith on the part of the person taking life insurance cover. Medical examinations could be momentary and the results need not necessarily reflect the general health condition. For example, if a Person has high Cholesterol levels, the reading would be normal during medical examination. It does not necessarily mean that generally the Life assured has no Cholesterol.

MORTALITY & MORBIDITY RISKS

Mortality denotes the death rate which is the risk of persons dying at each age. It is relevant for Term, Whole Life and Endowment Policies or any other life insurance policy where a Sum assured is payable on death.

While mortality denotes the risk of dying early, morbidity denotes the risk of contracting illness – which is relevant for Critical illnesses and hospitalisation under Medi-claim Policies. Morbidity is defined as expected number of people becoming ill or sick over a defined period, usually a year. It also means the frequency with which a disease appears in a population. Morbidity rates help insurers predict the likelihood that an insured will contract or develop any number of specified diseases. The morbidity tables used by actuaries for pricing insurance products are prepared separately for males, females and children and for different ages.

Concept of Standard lives & Sub-standard lives

A Standard life is one which exposes to the insurer to a normal risk, i.e. the predictive mortality on the life does not deviate significantly when compared to the mortality indicated in the mortality table. A mortality table is one which gives the statistics on number of persons dying at each age which is used as the basis for calculating the base premiums.

However, if the individual life which is considered by the insurer, shows a higher mortality than the standard lives in the mortality table, it would be termed as a Sub-standard life and the insurer takes extra risk and will have to therefore put additional risk controls like imposing extra premiums etc. Under certain circumstances, risk under Sub-standard lives can also be postponed and in extreme cases can also be declined if the risk is adverse.

FACTORS CONSIDERED WHILE UNDERWRITING LIVES

- **Personal health history** – This is the most important factor which directly impacts the underwriting. This section in the Proposal form comprises of whole list of questions concerning the various Systems in the human body and whether the Life assured has undergone any treatment or taking medicines or underwent diagnostic test or is aware of any abnormality etc. This section must be carefully answered by the Life assured
- **Family history** – Medically, it has been proved that genes play an important role in certain lifestyle related ailments and Family history assumes significance in assessing mortality. Details include the age at death of the parents and siblings and whether there has been any medical history for these close relatives
- **Occupation history** – Occupational hazards play an important role in mortality assessments. Since a Person majority of his time during his life in his workplace, the hazards related to occupation have an important bearing on mortality. For example, persons who are engaged in professional sports like Motor car racing, are exposed to higher risks
- **Personal habits and life style** – Habits like Smoking and Drinking have an impact. Therefore, information on these habits are also solicited in the Proposal form
- **Financial status and capacity to pay** – Also called Financial underwriting, this aspect reviews the capacity of the Customer to repay the Premiums over the Premium paying period. Though not as stricter as assessment of repaying capacity for a Loan, it is a factor considered based on a simple formula – under which Sum Assured is calculated as a multiple to Annual income of the Proposer – to check over-insurance. Further, the Premium paying capacity is measured by dividing the Annualised Premium under all Life insurance policies (including the proposed one) by Total Annual Income of the Proposer. If the ratio is more than 50%, additional income proofs solicited by the Insurer
- **Country or Place risk** – Persons residing in high risk locations face higher mortality risks. Therefore,

countries which are prone to frequent wars, civil commotions, riots etc. could attract higher premium. In addition, the location of the Life insured in a high-risk location also becomes important. Of late, Private Life insurance companies are facing the risk of persons residing in certain pockets which is known for persons with high mortality risks and who seek life insurance cover and the death claim is filed very soon after taking the Policy. There are instances of even seeking life insurance covers on dead persons by forging signatures and documents in certain pockets. Therefore, Life insurers have banned certain locations for giving insurance cover.

NON-MEDICAL LIMITS

Since the mortality and morbidity risks increase with the age and lesser at younger ages, it is not necessary to make every person taking a life insurance policy to undergo a medical examination. For example, the probability of persons aged between 20 to 30 having medical history is very low, when assessed on a Pool of say 1,000 customers who are taking insurance. If the number increases, statistically the number becomes insignificant. Since insurance companies insure Customers in large numbers, the insignificance for this age group, it makes logical sense to exempt this age group from Medical examination, subject to all disclosures in the Proposal form being normal.

Therefore, limits are fixed by Life insurance companies for allowing Customers to take life insurance policies without medical examination and only based on a self-declaration in the Proposal, confirming declaration of good health are called non-medical limits.

Non-medical limits are generally fixed based on two factors - Age as well as Sum Assured. Higher the age and/or higher the Sum assured, lesser is the non-medical limit. Each Life insurer fix their own Non-medical limits based on their own experience. However, generally they are guided by Reinsurers who help them with the Non-medical limits.

ASSESSING THE INDIVIDUAL RISK

Based on the mortality assumptions the underwriter assesses the risk as per the standards laid down by the Company. As per IRDAI Guidelines, there has to be a Board-approved Underwriting Policy in place. This Policy gives broad framework for Underwriting, within which the Company's Chief Underwriter will have to finalise his/her Underwriting manual.

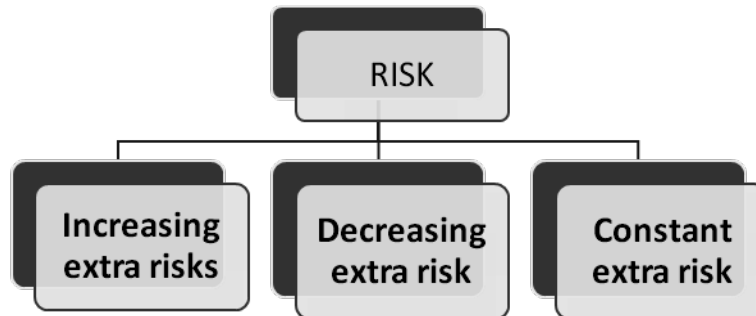
If the Sum assured is greater than the routine non-medical limits of the insurer, then depending upon the level of sum assured, various forms of medical evidence are obtaining, e.g. existing or past health condition of the person whose life to be insured. Medical evidence may also be obtained when a disclosure is made on the proposal which requires further assessment.

Most of the Proposals are accepted at standard rates of premiums and other terms and conditions. However, there are cases which cannot be accepted on these terms due to an adverse medical condition or for some other reason. The underwriter evaluates whether a case can be accepted at standard rates or not, based on all the factors mentioned in the preceding paragraphs. If the risk is found to be on the higher side, altered acceptance methods with adequate loading are applied or at times the risk may be declined. There could be medical conditions or impairments that are so severe at the time of initial underwriting, that terms cannot be offered even with extra premium as the risk of mortality is very high (and remains so or may worsen with time) as no amount of extra premium can take care of the extra risk and such cases are declined.

For example, if a Person is suffering from say, AIDS, then given the view that there is a high degree of mortality in such cases, a Life insurer may tend to decline such cases. However, it is interesting to note that HIV & AIDS

(Prevention & Control) Act 2017, states that no denial or unfair treatment in the matter of provision of insurance to the Persons protected under the Act shall be done by an Insurer, unless supported by actuarial studies. Similarly, in the Hon'ble Delhi High Court exclusion of benefits arising out of Genetic disorders by an Insurer have been struck down as discriminatory. However, this case is now pending on appeal before the Hon'ble Supreme Court of India. Even in the case of Genetic disorder exclusions, the Hon'ble Delhi High Court pointed out the absence of empirical evidence of the mortality impact of such disorders.

TYPES OF RISKS



Increasing extra risks

These types of risks may or may not be major risk sat the time of commencement of the policy, but as time goes by its effect is likely to become more significant, for example, high blood pressure or obesity. The proposer may not symptomatic at the time of commencement or risk, but his condition of hypertension or obesity is likely to have an adverse impact on the cardio vascular system.

Decreasing extra risk

This is exactly the reverse of an increasing risk mentioned above. The risk of recurrence of risk is maximum at the time the individual applies for insurance cover and decreases over a period of time, with proper supervision and medication.

Constant extra risk

This is kind of an extra risk, wherein the mortality risk remains constant throughout the term of the Policy. E.g. an occupational risk such as pilot in an airline. SO long as the Person's occupation continues to be in the Air force, there is no decrease in the risk. However, if this Pilot pursues another job-profile, like working in an administrative office in lieu of a pilot's job, like working in an administrative office in lieu of a Pilot's job, his risk profile changes drastically and favourably.

Acceptance with a level extra premium throughout the tenure of the Policy

In this type, a level extra premium system is used to charge the applicants for constant or increasing extra risks throughout the policy term. If an increasing extra is charged, it would be very difficult to operationally administer it, as it would be then necessary to monitor the health of each individual.

Temporary extra premium

Where the extra risk is of a reducing kind, it would not be fair to charge a level extra premium to this individual as he would discontinue the policy. Hence, a temporary extra may be charged for a short pre-determined period, until which the extra risk would have either diminished or ceased to exist.

Diminishing lien

In this method of acceptance, a reduced basic sum assured is paid, if death occurs during lien period. In other words, a debt created as a pre-determined amount if death were to occur within stipulated period.

Acceptance at ordinary rates with exclusion imposed on the cover

This clause restricts the pay-out of a claim for the full cover if death were to occur under certain specified conditions or denies claim payment under certain conditions. For example, special exclusions for persons who are on aviation duties – where claim is not paid upon death happening whilst on aviation duties. But claim is payable when the life assured is travelling as fare-paying passenger.

Postponement or deferment of acceptance of risk

There could be situations where the health condition of a customer is currently risky or uninsurable at the time of application, as he has been medically advised to undergo a surgery and post-operative treatment. Since there exists a possibility of improvement in his health after the surgery and necessary treatment, it would not be fair to decline the proposal. It is therefore deferred or postponed for a specified period. This would benefit both the client who gets a fair premium charged to him post the change in his health into a favourable position and the insurer, who is absolved from accepting a very high-risk profile at the policy commencement stage.

It is important to note that the proponent is re-evaluated and the proposal re-underwritten after the postponement period and is not accepted automatically. This may require pre-insurance medical screening once again, even if the medical examination in the first instance was done in the last 2 to 3 months.

Declinature of acceptance of risk

There are some proposals which are not acceptable on any terms and for which there is no possibility of improvement in their medical condition, which makes them not conducive for acceptance even with suitable loadings and exclusions in the future. These proposals need to be delinked. Each insurer has its own standard of underwriting and therefore, thresholds for declinature vary from product to product and company to company. For reinsured cases, it is the re-insurer who decides declinature of a proposal which is reinsured.

Numerical rating method

Mortality risk of an individual is determined by personal information of an individual's past current and genetic health situation. The current health status is indicative of future health risks and to a large extent subsequent mortality. This system is based on statistical mortality rates that essentially group individual into mortality classes using a numerical rating system. Health factors are considered individually and can affect one's mortality in neither a positive or negative way. Depending on the value of one's final health rating, the cost of a life insurance premium may be higher or lower. It is important to remember that every individual comes with a different health status and hence risks may be different for every individual. If the numerical rating method applicants are classified according to certain factors and assigning credit or debit points to each of these attributes or factors based on underwriting guidelines. Rating guides and manuals are formulated by an insurer and reinsurance professionals. These manuals are based on the results of extensive medico-actuarial research and mortality studies. The underwriting manual contains description of various impairments, medical documents that would be required to assess the risk profile of the applicant and gives details on the favourable and unfavourable states of the impairments along with suggested ratings to support the risk profile. The factors that are evaluated are physical condition, build, family history, personal history, habits and moral hazard etc. Favourable factors earn debits, while unfavourable attributes mandate credit points. The standard live, is

known to be accepted at ordinary rates and is assumed have a value of 100. Thereafter, every favourable attribute is a credit and is expressed numerically as a percentage of this value and deducted from the total. In case of any unfavourable factor in the application, it is treated as a debit and necessary points are added to the total. The final extra mortality rating will be equivalent to the percentage total mortality of the group in which that particular proposer has been classified.

Each application is underwritten based on this method and the mortality class of each of the individuals is assessed. Thus, the numerical rating system attempts to estimate the likely mortality of each life proposed for assurance with the aid of well-defined and documented by underwriting manuals and thus helps to ensure consistency in risk classification.

For example, if the applicant is 5 feet 8 inches and weighs 115 kgs. his mortality expectation based on the norms of height-weight ratio may be 160% of a standard risk who weighs 72 kgs. for that height. Similar credits and debits are given for various parameters like occupation, family history, age, medical factors, duration of cover requested, smoking history of applicant, type of plan applied etc. Upon completion of the debiting/crediting process, these debits and credits are totalled for a final rate, which would then classify the applicant as standard, substandard or a highly sub-standard risk. Highly substandard extra risk is generally postponed or declined, depending upon whether the extra risk is increasing, decreasing or constant extra risk. Also considered for arriving at the total extra mortality rating (EMR) is the personal health history and habits of the applicant, the health history of his immediate family members and his occupation and financial status. Hobbies, especially hazardous ones, military series and the country/city where one resides are also major considerations to arrive at the extra mortality rating.

An example would be that if an applicant is a heavy smoker, the underwriter might add 20 points to the individual's score. Like-wise some credit points may be given for favourable factors. If, however, the same person has a favourable family history of good health and longevity it is possible that between 5 and 10 points would be deducted from the total. The lowest possible score that is arrived at gets him the final score of mortality class for that applicant. It may be noted that a standard life is one with a minimum extra mortality score, while the one extra risk goes higher and higher as the number of credit points increase. It must be remembered that Extra mortality is usually expressed in % of Standard mortality.

It is important to note that each impairment in an individual may attract a different rating. However, when there are multiple factors, which co-exist in an applicant, the extra risk is much more than the two impairments considered in isolation. It indicates that the effect is multiplicative and not purely additive, as the extra mortality is very high when two or more adverse factors co-exist. For example, certain impairments, such as obesity and high blood pressure, when they co-exist in an individual, they do exert a strain on an individual's cardio vascular system and cerebro-vascular system which is much greater than the sum of the two individual extras, hence an additional rating for the combination factor will be required, if the extra risk is to be classified appropriately. In the numerical rating system, each of the factors which impact the risk are evaluated and rated appropriately as per the underwriting manual.

UNDERWRITING PROCESS

Underwriting process denotes the steps involved in considering a risk on the Proposal. Insurance Business is solicited by registered Insurance Agents or Intermediaries who speak to the Customer, explain the Product features, do the Suitability and Needs analysis and recommend the right insurance product which suits the needs of the Customer. At this stage, they also get the Proposal form (which is the Application form for Life insurance) filled up by the Customer (or the Agent or intermediary fills the Form for the Customer) and signed by the Customer and submitted along with other documents. Where the Customer fills the Proposal form online,

electronic version of the Proposal forms is also accepted.

Usually physical proposal forms along with other documents are submitted at the Branch offices of the Insurer to which the Agent is attached. However, every Branch office of the insurer normally accepts Proposal forms.

In the branch office of insurers, the Forms submitted are subject to initial scrutiny and basic underwriting checks. In bigger insurance companies, complete underwriting takes place in the Branch office up to a certain Sum assured limit beyond which it moves to higher offices.

Initial scrutiny done at the Branch offices include the following:

- (a) Receipt of Proposal form and all other documents required to be attached with the Proposal form. Typically, the documents submitted include the following:
 - (i) Proposal form duly filled in and signed by the Proposer and the Life assured
 - (ii) Age proof of the Life assured
 - (iii) KYC documents – 1 identity proof, 1 residence proof and 1 photograph of the Life assured. Identity proof can be Aadhaar card, Passport copy, Driving licence copy or Voter's Identity card copy or PAN – all documents to be self-attested by the Policyholder. Additionally, residence proofs like rent agreement not older than 6 months, Utility bills such as Gas bill, Electricity bill etc. can also be considered. An identity proof may also serve as the residence proof, if the Policyholder resides in the same address mentioned in the identity proof. e.g. Passport.
 - (iv) PAN is a mandatory if the Annualised premium payable on the Application exceeds ₹50,000
 - (v) Cheque or cash or demand draft equal to the First instalment of premium payable. Under Section 269ST of Income-tax Act, 1961, any cash collection in excess of Rs.2 lakhs per person per day or per transaction or transactions relating to an event, is prohibited. Collection above the limit of Rs.2 lakhs can be made only by Account payee Cheque or through Account Payee Demand-draft or through online banking channels
 - (vi) Income-proof if the Annualised Premium payable exceeds Rs.1 lakh. Income proof can be in the form of documents like Salary slip, Form 16 for Salaried persons or Income-tax returns for Business professionals. The purpose of income proof is to (a) check the extent of insurance cover which is linked to earning capacity and (b) ability to pay the Premium over the term of the Policy

Section 64VB of Insurance Act, 1938, states that no risk on an insurance proposal can be accepted by the Insurer, unless, among other things, an amount equal to First premium is received by the Insurer in advance. Therefore, an amount equal to First premium is usually accepted along with the Proposal form as mentioned above.

The Branch offices scrutinise whether the form has been completely filled up, whether there is any overwriting and if so, whether it has been authenticated by the Proposer and whether the document has been signed by the Proposer as well as the Life assured.

Where the Proposer signs the Proposal form in vernacular language (Proposal form in English, whereas the Customer signs say in Telugu language), a Vernacular declaration and signature of an English knowing person confirming that he has explained the questions in the Proposal form and has recorded the answers as told by the Proposer, is included in the Proposal form. The form also needs to be witnessed at least by 1 witness, which can be the Agent or the Intermediary.

Along with every Proposal form, an Agent's Confidential Report is attached, which is required to be filled and

signed by the soliciting Agent or Intermediary. Agent or the Intermediary is the first level underwriter and is expected to give a Confidential Report to the Insurer about the general status of health, appearance of the Life assured, certain physical measurements like Height, weight etc. This document is very important as it is the Agent or Intermediary who meets the Life assured in person. By meeting the Life assured, lot of information can be gathered which are critical for underwriting. For example, the physical appearance of the Life assured can give lot of information about the general status of health of the Life assured. There are insurance frauds which happen today, by insuring persons with terminal illnesses or even insuring dead persons by submitting fake documents. Under such circumstances, the Agent's Confidential Report is the source from which Insurer draws comfort about the existence and general state of health as revealed by the physical appearance. Hence this document is very important from underwriting standpoint.

With the advent of e-commerce, Insurers have enabled online electronic fulfilment of Proposals forms by Agents and Intermediaries using Tablets and Mobile phones.

After verification of documents, data is entered in the Insurer's central Policy administration system through user name and password access provided to the Branch employees. All the details of the Life assured and Policyholder as mentioned in the Proposal form is entered into the system by the Branch office employee and an online receipt is generated and issued to the Customer or the Distributor, as the case may be.

Some insurance companies outsource the activity of basic scrutiny of Proposal form and related documents to a third party Vendors who specialise in this area. However, it is to be noted that verification of AML compliance, i.e. verification of identity proof, residence proof and photograph, income-proof etc., cannot be outsourced.

AUTOMATED UNDERWRITING

Also called 'Jet underwriting', it is a process which is automated based on a rule engine built into the system. If there are no adverse deficiencies in the document and the information given the Proposal form as entered by the Branch office makes the Life assured eligible for insurance at standard rates, without any further medical examination or further documents, such cases are underwritten as per System rule engine and the Proposal stands accepted, subject to clearance of the cheque towards First Premium and subject to the name of the Customer not figuring in the list of Sanctioned Persons (Persons prohibited from granting insurance under AML guidelines).

NON-MEDICAL UNDERWRITING

Underwriting of policies is done either on Non-medical basis or medical basis. Each company for each of its products lays down the non-medical criteria. These non-medical limits/grids are generally function of the age and sum assured. However, in some cases, even though the client falls under the norms applicable for non-medical acceptance as per the non-medical grid, the underwriter may treat these cases under the Medical scheme, if the client has some adverse medical history or very high or very low Body Mass Index ('BMI') as per the Underwriting guidelines of the Company. In addition to BMI, other factors and details (including family history), his life style, his personal and medical history, occupation, residence, moral hazard reports, if any, form an important part of evaluation of the risk suitably. His existing insurance with all insurance companies and also that he has applied concurrently are also important part of the risk-selection process. The ACR also becomes an important tool for assessing the risk in the absence of a medical screening process.

Risk under a Proposal increases proportionate to the increase in Sum assured and age of the client. To determine whether a proposal is to be underwritten on non-medical basis, the insurer first evaluates whether the applicant falls under the mandatory medical scheme or non-medical norms laid down by the insurance company, i.e. s per the grid, the age of the life to be assured and the total Medical Sum-at-risk ('MSAR'). The definition of MSAR

may vary from one insurer to another, but the one which is commonly accepted by most of the insurers is “the total face value or sum assured under risk under a certain policy. It is generally calculated as the total sum assured under all policies and riders (except Premium Waiver Benefit and Accident Benefit) on one life, issued by the insurer with whom he is applying. IT does not include the amount within a period of 24 months preceding and including the current proposal or application. The medical test requirements will be based on this MSAR. It should be noted that underwriting is also done during the revival of a lapsed policy based on specific rules applicable at that point of time, as documented in the reinstatement norms of the insurance company.

The medical history and insurance history of the client with other companies should also be carefully checked in the responses given in the proposal form for any adverse factors like proposals declined, extra premiums charged etc. and such proposals need to be underwritten with caution to eliminate adverse selection at the underwriting stage.

Another important aspect that is considered at the underwriting state is calculation of FSAR, viz., Financial Sum at risk. This differs from MSAR and FSAR is used for Financial underwriting and covers the total sum assured existing and proposed with all companies put together and not restricted only to the companies that the client is currently applying for.

MEDICAL UNDERWRITING

Generally underwriting of Proposals subject to medical examination is done at the Head office of the Insurer, though bigger insurers do such underwriting locally at a Branch office or Regional office depending on the Sum assured limits.

Where the risk on a Proposal, measured by Sum assured, is beyond the limits for Non-medical cases, the Life assured is required to undergo a medical examination. The extent of medical examination depends on the Sum assured – higher the Sum assured, higher the level of medical check-ups.

Medical examination is conducted through Medical practitioners empanelled with Insurance companies. Under the IRDAI Regulations, Third Party Administrators (‘TPAs’) who generally administer servicing of Mediclaim Policies, are also allowed to manage medical examinations on behalf of an Insurance company. They coordinate with the Life assured and arrange for medical examinations.

Once the medical examination has been ordered, the life assured is contacted within 2 to 3 business days to schedule the medical examination. The costs of medical tests are generally borne by the insurance companies and is completed at the convenience of the client. However, if the Proposal is subsequently declined or withdrawn or Policy cancelled during Freelook period, cost of medical examination is usually deducted while refunding the First Premium to the Proposer. Some insurers also have arrangements for medical examination conducted at Life assured’s premises. Under such circumstances, the medical examination or certain diagnostic tests like drawing blood and urine samples are done at Life assured’s premises.

The medical examination involves measuring height, weight, blood pressure and examination of all the organs and systems of the human body. It may also entail taking of body fluids such as blood and urine sample along with cardiological tests like ECG or TMT, X-rays etc. The tests that need to be conducted are based on the underwriting rules applicable to the product that the client has applied for and the medical conditions of the applicant at the point of sale.

For example, under a Unit linked Life insurance Policy, the risk coverage is very low when compared to the investment component. For example, if the death benefit is higher of the Sum assured or Fund value, the risk on a life insurer is low and therefore may attract lenient underwriting requirements.

Based on medical conditions and history of medical treatments, Life assured may be requested to complete certain questionnaires. The objective behind having separate questionnaires is to elicit information only from those lives assured who report some medical history subject to higher risk from underwriting angle.

Underwriting a Proposal

As per the Outsourcing Regulations of IRDAI, the activity of Underwriting, viz., acceptance of risk on a Proposal form, cannot be outsourced to a third party, but has to be undertaken within the insurance company only. Moreover, IRDAI regulations on Policyholders' Protection requires every Insurance company to convey the decision on a Proposal within 15 days of receipt of all requirements from the Proposer.

Once the completed life insurance application is received and the medical examination is conducted, they are sent for further processing. The preliminary documents once received will trigger the underwriting process of selecting and classifying risks with respect to the client.

Counter offer

Where after assessment of risk, a Life insurer proposes to offer terms which are different from the standard terms, then a “counter-offer” is sent to the Proposer for acceptance. For example, if a health-related extra premium is proposed to be imposed keeping the status of health of the Proposer, a specific consent is taken in writing from the Proposer seeking his/her agreement for payment of the extra premium. This process is called counter-offer and only after acceptance of the counter-offer, the extra premium can be imposed. If the Proposer refuses to accept or sign the counter-offer, the Proposal stands cancelled and the Insurer shall refund the premiums to the Proposer.

Policy issuance

Thereafter the Proposal moves to the Policy issuance stage which involves printing and despatch of the Policy document. Where the Customer has opened e-insurance account (through Insurance repository), no physical document is issued and an electronic policy is credited to the e-insurance account of the Customer.

As per the IRDAI Regulations on Electronic policies, any Life insurance policy with a Sum Assured exceeding Rs.10 lakhs (exceeding Rs.1 lakh for Term insurance Policies) or with an Annualised/Single Premium exceeding ₹10,000, shall mandatorily be issued in electronic form in addition to sending a physical policy document. Electronic form includes sending through an email or through an Insurance Repository by crediting electronic version of the Policy to an e-insurance account maintained with an Insurance Repository. However, where the Policies are credited electronically through an Insurance Repository, sending physical Policy documents is not required.

For policies sourced online, crediting policies through an e-insurance account is mandatory, without any Sum assured limits.

Some insurance companies outsource the process of issue of Policy document to a third party Vendor. Under such circumstances, after Underwriting done by the Insurer, the files are sent to the Vendor for printing, stamping of document and despatch of Policy documents by Courier or Speed Post to the Policyholder.

FINANCIAL UNDERWRITING

Financial underwriting is the process of determining whether the insurance cover is justified with reference to a person's known source of income and needs. Otherwise, there could be a tendency to go for over-insurance and could result in adverse selection against the insurer. Every proposal for insurance should be financially

underwritten to ensure that the amount of insurance applied for will adequately compensate the beneficiary in the event of an untimely loss. This is best determined if the purpose of insurance is well established and the relationship with the beneficiary is logical.

Why Financial underwriting is conducted

The following objectives are sought to be achieved by conducting financial underwriting:

- (a) Ensure that the sum assured paid is proportionate to the expected financial loss on account death of the life assured – over insurance is avoided
- (b) Evaluating the Financial capacity of the Life assured to pay the premiums – avoiding potential lapse and early surrender of the Policies which could result in loss to the insurer
- (c) From anti-money laundering perspective, detect if a third party is funding the Policy by ensuring that the Policyholder has adequate income to pay the Premium from his own sources

Therefore, Financial underwriting aims at preventing the moral hazard of someone taking undue advantage under an insurance policy by overstating his capacity and means to pay the premium, thereby avoiding anti-selection against the insurer.

CONCEPT OF HUMAN LIFE VALUE AND INSURABLE INTEREST

Human life value determines the extent to which an insurance cover is needed by an individual. A person has unlimited insurable interest on his/her own life or that of his/her spouse. While one cannot place a finite value on a human life, in order to avoid moral hazard a scientific way of placing a limit of sum assured. From an underwriting point of view, it is prudent to qualify this aspect by clearly stating that the company retains the right to determine the amount of cover appropriate to the circumstances and needs of the parties to the contract. A Company has insurable interest on the life his/her key person to the extent of reduction in liability or profit resulting from the loss of special skills. This is also called key person insurance or key man insurance policy. Partners and co-directors in respect of any contractual liability to purchase the share of the business of a deceased partner or director.

The underwriter must carefully question the purpose of insurance when no obvious insurable interest exists. If the beneficiaries are neighbour, casual acquaintance, friend etc., a it requires some explanation. In these situations, it appears that there is lack of insurable interest on the part of the beneficiary towards the insured.

Insurance that covers non-existent financial loss also implies lack of insurable interest on the part of the beneficiary.

Amount of insurance cover can be arrived at by adopting any of the following three approaches:

(1) Needs analysis method

This method can be a part of a detailed financial planning program. This method attempts to arrive at a future financial need of the beneficiaries and then translates it in to the death benefit amount. It is based on the following assumptions:

- (a) It provides benefit in the period immediately following the death of the insured to offset additional expenses.
- (b) Supports the normal living expenses of the dependents.
- (c) Provides a long-term income for the retired surviving spouse.

(2) Human life value

The Need analysis method revolves round the concept of Human life value and is based on quantification of the estimated potential earnings of the life to be insured. This method attempts to arrive at a cover amount which is equal to the present value of the insured's future earnings. This is a more sophisticated method and also considers the following:

- (a) The actual after-tax-earnings.
- (b) Expected number of years the income will be earned.
- (c) Estimated increase in income.
- (d) Discount factor for future earnings.

In other words, the insurance cover (sum assured) under a Life insurance policy is an income replacement method – i.e. life insurance policy death benefit replaces the income earned by the Life assured which stops on account of his sudden death.

A simple example to understand the principle: Suppose a Person's current annual income is say, ₹50 lakhs per annum. Assuming that the average current market rate on investments (equity + debt) is say 9% p.a., the Capital which is required to earn ₹50 lakhs per annum as returns @ 9% would be $\frac{₹50,00,000}{9} \times 100$, which is around ₹5.55 Crores. In other words, on death of a Person whose current income is Rs.50 lakhs per annum, the amount which would be required by a Nominee (say a Housewife) upon death of the life assured would be ₹5.55 Crore. If ₹5.55 Crores is invested, it could on an average fetch a return of 8% p.a. which is around ₹50 lakhs. This would help the Nominee to maintain the same standard of living which the life assured can maintain when he is alive. The Income-to-Sum Assured multiple at the current interest rates works out to approximately 10.5 times.

The above example, in simpliciter explains a scientific way of arriving at Human Life value. It is to be noted that the above example assumes that the Sum assured required if the death of the Life assured happens at the current point of time. However, the death may happen any time in future as well. Moreover, the earning capacity may also increase in future and interest rates may also drop in future. There has to be assumptions on such factors to arrive the potential average loss of income on death of the life assured. This is because Life insurance policies cover the risk of dying over a longer period of time. Therefore, this method is further refined to include all the above scenarios and arrive at a scientific way of calculating the Sum assured under a Life insurance policy.

(3) Multiple of Salary

In this method, the maximum amount of cover is determined as a multiple of salary. This multiple will depend on the age of the life to be insured. This approach assumes that the life insured is the only breadwinner of the family. And the family can live adequately on some percentage of insured's income.

The following table gives a recommended income-multiplier for arriving at Sum assured

Age Income-multiple

18 to 35	15 to 20 times
36 to 50	10 to 15 times
51 to 60	10 to 12 times
>60	5 to 8 times

Longer the duration to retirement or income-stopping age, higher will be the multiple, as the probability of increase in future income is more and therefore higher sum assured

The above method is simple to understand and easy for especially the Sales persons to understand. However, the above method does not take into consideration the age of the surviving spouse, the number of dependents and how many years the income is needed, inflation etc.

Choice of method depends on the insurance company's Underwriting Policy.

Insurance on Housewives/Women with No earned income

In the above case, the need for life insurance will have to carefully looked into. It is difficult to arrive at the insurable value where the services of housewives are not compensated financially. There can be significant amount of adverse claims experience if due care is not taken while granting insurance to non-working women with little or no income

Generally, the sum assured granted on house wives not exceeding the sum assured granted to the husband.

INSURANCE ON MINOR LIVES

From a purely risk cover perspective, an insurance on the life o children does not make any financial sense. But still there is a market for this segment. Many parents apply for modest or large cover of their children for the purpose of savings, getting insurance at lower cost. The underwriter needs to keep in mind the existing insurance cover on the life of parent and siblings before considering grant of insurance cover on minor lives.

KEY PERSON (OR KEYMAN) INSURANCE

This is an insurance policy taken by a Company (or Partnership firm) on the life of a Key person who can be an employee or a director of the Company.

For example, let us assume that A is the founder and Promoter of XYZ Company Limited and has invested in the equity shares of the Company and is also the Chairman of the Board of the Company. But for him, the Company would not have turned profitable and his presence adds significant value to the Company.

Under the above scenario, on death of A, XYZ Company could be impacted financially. For example, his absence could create a vacuum in the form loss of potential income due to, say, some of the Clients of XYZ Company moving to other Companies since they were Clients in XYZ Company because of A. Or for that matter, there could be drop in the morale of the management and this could affect the Company's performance and therefore revenue and profitability.

In the above scenario, XYZ Company has an insurable interest on the life of A can, therefore, purchase a Keyman Insurance Policy from a Life insurance company, where under the Policyholder will be XYZ Company and the Life assured will be the Key man – A in the above example. XYZ has insurable interest on the life of A, as on death of A there is a loss to XYZ Company. Only Term insurance policy (where Sum assured is payable only on death of the Life assured) can be taken under Key man insurance cover.

Sum assured in such cases is calculated based on the contribution of the Keyman to the Company and potential loss to the Company if the sudden death of Keyman happens.

From an underwriting a Key man insurance policy it is first important to establish the need for insurance – i.e. whether the Life assured is indeed an indispensable person for the organisation. This could be subjective based on certain statements made by the organisations, but mostly it should translate into some visible benefit due to continuance or potential loss on death of the life to be covered. The following factors are considered while

considering the need for Key person insurance:

- (1) Age – generally the life assured is not too young or too old – too young because the person might not have significantly contributed to Company's success in such a young age, though there could be exceptions or too old that he or she might not have residual service to justify a minimum term of the Policy
- (2) Level of expertise – high level of technical expertise or management skills makes a person indispensable. Qualifications and experience in different fields is of significant importance
- (3) Successful track record - certain persons may not have high qualifications but could have a successful track record in the area of the person's expertise to qualify as a key person
- (4) Earning or profit-making track record of the Company – usually the key person's contribution translates into higher revenue or profitability over a period of time, especially when the person is in Sales or Marketing jobs or even Managing Directors or CEOs whose Key Performance Indicator is driving profitability. However, there could be other Functional heads like Chief Human Resources Officer who may not contribute directly to Profitability but builds a good work culture which motivates employees to stick on to the Company and contribute to the success. However, this needs to be demonstrated by the Company taking the Key person Policy

There is no limit to the number of Key persons in a Company. This depends on the needs of the Company.

Usually, the Sum assured under a Key person Policy is linked to the profitability of the Company and the amount of insurance cover granted could be say, minimum of the following 3 parameters:

- (1) 3 times the average gross profits of the Company for the last 3 years
- (2) 5 times the average net profit of the Company for the last 3 years
- (3) 10 times the total annual compensation package for the key man which includes salary, bonus and all other perquisites

If there are more than 1 key person in the Company, the overall limit will be governed by the same principle and the sum assured granted to the various key persons will not exceed the overall limit arrive at by the above method.

PARTNERSHIP INSURANCE

In a Partnership business, when a partner dies the legal heirs of the deceased partner may not be interested in continuing the partnership. The remaining partners will have the option to purchase the deceased partner's share on the terms and conditions spelt out in the partnership deed. This would require sufficient funds.

The need for partnership insurance is seldom realised until a partner dies and the money required to be paid out has to be found from the partnership funds. In the absence of partnership insurance, the surviving partners may be compelled to sell some of the assets or may have to close down the business. Hence it becomes advantageous to have a life insurance cover on the lives of all the partners. The proceeds of the insurance policy can be utilised for settling the account of the deceased partners without disturbing the working of the firm.

The amount of cover on each partner will depend on the amount of the purchase money required to be paid to the heirs in the event of the death. This can be determined by the contribution to the Share capital. Share of profit up to the withdrawal and the Goodwill of the individual partner. To minimise anti-selection (risk of taking insurance when there is no real need) it is advisable to consider partnership insurance on the lives of all the partners simultaneously.

EMPLOYER-EMPLOYEE INSURANCE

These are life insurance schemes taken by employers to retain employees for longer term in the Company. For example, an employer may take a Life insurance policy on the life of certain employees (who may or may not be Key man), whose long term retention is critical for success of the Company. Under such circumstances, Employer grant long term incentive plans to promote employee-loyalty. While there are various other ways of retaining employees like giving long term special bonus if the employee works for say, 5 years with the Company, alternatively, an employer can take life insurance policy on the life of the employee and pay the premiums on the condition that after the expiry of say, 3 or 5 years (as decided by the Employer), the Life insurance policy will be permanently transferred in the name of the Employee free of cost. After such transfer (assignment of the insurance policy), the employee becomes the Policyholder and gets the Policy with premiums paid till the date of assignment free to the employee. Thereafter, employee shall continue to pay the Premiums. Some employers take Policies with Premium payment terms ceasing on the date of assignment, so that there is no obligation to pay premium by the employee after the date of assignment.

If the employee leaves within the said period of 3 or 5 years, the Policy is surrendered and Surrender value paid to the employer and the Policy is closed.

If the employee dies during the said period of 3 or 5 years, the death benefit is paid to the employer who in turns passes on the benefit to the Nominee (e.g. Spouse of the deceased employee).

The main difference between Key man Insurance Policy and Employer-employee Policy is that the Employer is the beneficiary in the former whereas the Employee is beneficiary in the latter.

INSURANCE UNDER HINDU UNDIVIDED FAMILY ('HUF')

Historically, for generations India had a prevailing tradition of the Joint Hindu Family or undivided family. The system is an extended family arrangement prevalent throughout the Indian subcontinent, particularly in India, consisting of many generations living in the same home, all bound by the common relationship. A joint family consists of a husband and wife; their sons; their daughters, and so on up-to generations. Any number of these people may without impacting the legal existence of the family, be decreased.

The family is headed by a senior person called a 'Karta', usually the oldest male or female, who makes decisions on economic and social matters on behalf of the entire family. The patriarch's wife generally exerts control over the household and minor religious practices and often wields considerable influence in domestic matters. Family income flows into a common pool, from which resources are drawn to meet the needs of all members, which are regulated by the heads of the family. However, with urbanisation and economic development, India has witnessed a break up of traditional joint family into more nuclear-like families, and the traditional joint family in India accounted for a small number of Indian households.

A Hindu undivided family or HUF is a legal term related to the Hindu Marriage Act. The female members are also given the right of share to the property in the HUF. The term finds reference in the provisions of the Income Tax Act, but the expression is not defined in the Act. There are various aspects of Hindu law relevant for the purpose assessment of income of HUF with Hindu Succession Act 1956 and Income Tax Act 1961 and wealth in the status of HUF, as well as the impact of the provisions of Hindu Succession Act 1956 as amended by Hindu Succession (Amendment) Act 2005 relevant for the purpose of assessment of income and wealth in the status of HUF under the Income Tax Act 1961.

In the case of *Surjit Lal Chhabra* 101 ITR 776 SC, joint family and undivided family are synonymous: "A joint Hindu family consists of persons lineally descended from a common ancestor and includes their wives and unmarried daughters. The daughter, on marriage, ceases to be a member of her father's family and becomes a

member of her husband's family.”

In 2016, a judgment of the Delhi High Court ruled that the eldest female member of a Hindu Undivided Family can be its 'Karta' (manager).

Co-parceners:

Co-parceners are members of the Hindu undivided family who have a share in the rights to the property of the Family.

Till 2005, only male members were eligible to become co-parceners. However, by way of an amendment to Section 6 of the Hindu Succession Act, 1956, Female members were also recognised as Co-parceners with the following rights:

- Daughter shall have the same rights in the coparcenary property as she would have had she been a son;
- The daughter shall be subject to the same liability in the said coparcenary property as that of a son;
- The daughter shall be allotted the same share as is allotted to a son;
- The share of the per-deceased son or a per-deceased daughter shall be allotted to the surviving child of such per-deceased son or of such per-deceased daughter;
- The share of the per-deceased child of a per-deceased son or of a per-deceased daughter shall be allotted to the child of such per-deceased child of the per-deceased son or a per-deceased daughter.

Under the Income-tax laws, HUF is treated as a separate entity and policy finance through HUF gets tax benefits for HUF. Accordingly, an HUF is eligible for all the deductions and exemptions as described under the tax laws.

Life insurance can be taken by a HUF on the life of Karta or the Co-parceners. Policyholder will be the HUF and the Life assured will be the Karta or the Co-parcener. Premiums will be paid through HUF funds.

Generally, a multiple of 10 is applied on the income of HUF to arrive at total Sum Assured for all the Policies financed by HUF on the lives of Karta and all Co-parceners.

INSURANCE UNDER MARRIED WOMEN'S PROPERTY ACT ('MWP ACT')

A Nominee under a Life Insurance Policy can claim the proceeds upon death of the Life assured. However, where the Life assured has borrowed money and has indebtedness on his death, Creditors of the Husband can attach his Policy, for settlement of their dues, unless it is issued on the Life of a Judgment Debtor, i.e. any person against whom a decree has been passed or an order capable of execution has been made.

Therefore whatever asset (including house, car etc.) which a husband has hard-earned during his life time, may be taken away by his Creditors, in case the husband has huge debts. In these days, many businessmen borrow money and start a venture taking personal risk and responsibility. Banks and Financial Institutions insist on a Personal Guarantee of the Directors/Partners before they grant any loan. In case the husband (who is the owner of the business) dies, especially in the early days of his business, the debts outstanding may be very high and whatever assets left in the husband's estate (after his death) will be liable for attachment by his Creditors. Imagine the situation of his family at this juncture.

In other words, is there a way in which a husband can assure himself that he can create an asset in favour of his wife which cannot be touched by his Creditors after his death? Whether the Law gives any protection to the wife and children against such rival claims?

Policies taken under the Married Women's Property Act, 1874 (in short MWP Act), give an effective solution.

If a Life Insurance Policy is taken under Section 6 of the Married Women's Property Act, 1874, by a married man, with his wife and children as the beneficiaries, he can rest assured that the benefits will go only to his family members upon his death, irrespective of indebtedness on the date of death - Creditors cannot file a case for attachment of Death Benefits under the such a Life insurance Policy for settlement of their dues. Even Income-tax Officers cannot attach such a Policy for the dues from the husband. However, the important point to note is that this benefit is available only of the Policy is specifically issued under Section 6 of the Married Women's Property Act, 1874, by way of an endorsement on the Policy document itself.

Section 6 of the MWP Act states that the benefits under a Life Insurance Policy taken by a Married man, under MWP Act for the benefit of the married man's wife, or children or any of them, shall be payable only to the wife or children according to the ratio decided by the Life Assured. Further it states that the said Policy does not form part of the estate (property) of the deceased Husband. Hence the husband does not have any control over the Policy and is not his asset. Therefore the said Policy cannot be attached by the Creditors of other Legal Heirs of the deceased husband.

Thus, benefits payable under MWP Act Policies can neither be claimed by the Husband's Creditors. Even the husband cannot claim any benefit. *Therefore, an absolute estate is created in favour of the wife or children. This is a special privilege given by Law only to a Life Insurance Policy taken by a married man.*

The Policy shall be taken only by the Husband on his Own Life. The Nominees under the MWP Act Policy can be:

- Wife alone
- Child/Children alone (both natural and adopted)
- Wife and Children together or any of them

The Nominees under the Policy once declared cannot be changed at any time by the Policyholder. Trustees will have to be appointed under the Policy whose job will be to ensure that the Policy benefits reach the intended beneficiaries. Husband may revoke the Trustees and appoint new ones in their place.

Underwriting is done on the life of the Husband as per the usual underwriting procedures.

Generally, financial evidence is required for moderate to big sum assured depending on a Company's underwriting philosophy. It is advisable to request for evidence for 3 years so that the income trends can be reasonably established. When salary slips are requested, there should be at least 2 or 3 months' salary slips available to estimate a realistic income.

Basic Financial document requirements for all cases are as follows:

- Completely filled Proposal form
- Agent's Confidential Report
- Financial questionnaire duly signed by the Life assured (as per Company's internal requirements grid and format)

Apart from the above documents, for high sum assured cases, following are the financial requirements:

Standard income documents for Salaried applicants

- Salary certificates/Salary slips

- Form 16 issued by the employer
- Individual income tax returns in the name of life assured

Standard income documents for self-employed applicants/Professionals

- Individual income-tax returns in the name of the Life assured along with computation of income
- Audited Profit & loss account and Balance sheet of the Company/firm
- Shareholding pattern of the Company/Profit sharing pattern of the Partnership firm
- Form 16A issued by the organisations to Consultants/independent Professionals

In case the applied Sum assured is not justifiable on the basis of the above income documents, the following evidences can be used to arrive at the estimated annual income of the life assured. These can also be used to bridge the gap:

- Bank statements
- CA Certificates
- Agricultural receipts
- Mutual Fund statements
- Vehicle Registration papers with Vehicle insurance papers having Insured Declared Value
- Home Loan repayment records
- Rent receipts with copy of lease agreements

OCCUPATIONAL, AVOCATIONAL AND RESIDENTIAL RISKS

The occupation in which a Person is engaged, the avocations which the person undertakes and the place/country where a Person resides also determines the mortality risks. For example, a person working engaged in Para trooping activities, the risk on mortality increases due to the nature of the profession. Similarly, a person's avocation in say, Motor racing, could also increase the mortality risk. If the country or place of residence is prone to constant riots, terrorist activities, illegal activities etc., the risk increases.

Information about the occupation, avocation and residence is solicited as replies to questions in Proposal form (Application for life insurance). Besides, Life insurance companies can also do their own due diligence by searching Internet, Government database as well as Medical examiner's Report.

Basic risk factors for occupations

Major risk arises due to accident or when an individual has to work in hazardous environment. There are number of factors which assist to outline the risk associated with different occupations. They can be the following:

- Special skill required to perform the job.
- Environmental exposure (e.g. nuclear plant, mines etc.).
- Equipment(s) used (e.g. welding torch).
- Materials used (e.g. explosives, paper).
- Working conditions (e.g. working on heights for construction workers, electricians, building cleaners, factory workers).

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- Physical requirements (e.g. fitness required for aviation).
- Location (e.g. City or country).

Armed forces

Special risks associated with these forces are as follows:

- Bomb disposal.
- Arms and ammunition handling.
- Operation in areas of civil or political instability.

Aviation

The risk of flying is commonly appreciated. The aviation risks are becoming more complex due to variety of aircrafts (fixed wings, rotating wings) and increased usage of aircrafts for speedy transportation of people and commodities. There is an availability of good statistics concerning commercial aviation and is of good assistance to the underwriter. There are stringent medical requirements for those who are flying the aircraft and tight controls on safety standards for the aircraft imposed by the aviation authorities. Normally standard rates would be granted to passengers, flight and cabin crew who travel in a licensed airline.

Merchant Navy

These days instead of passenger ships, majority of vessels are associated with transporting cargoes and are categorised as containers, tankers, general cargo and ferries. Although there have been significant improvements over recent years, mortality and morbidity rates remain high amongst seamen. Apart from climatic hazards, there are risks involved with drug and alcohol abuse during shore leave, work hours and risks associated with moving large and dangerous cargoes. In addition to this, the risk also varies with different types of vessels.

Further on board ship, there is a very wide range of activities from seamen sailing the ship to captain, support function of doctors and catering staff. The risk varies with the activities performed.

Chemical Industry

Here the major risk arises from contact with dangerous chemicals, though there are laboratory procedures to minimise the risk exposure there is a risk of medical condition rather than accident. This is due to short or long term exposure to certain substances. These can be skin related or respiratory diseases. These can be acute and treatable or chronic with irreversible damage or can be a development of malignant disease.

Mining

Mines comprise of fuel mines, mines for metals, mines for extraction of non-metals, out of which coal mines, oil projects and metalliferous mines of different sizes employ over one million persons on a daily average basis.

A very relevant consideration is the mineral which is being mined and the location of the mine. Over the period, there have been great improvements in health and safety standards, but there are still significant risks of accidents, not only underground but also on the surface.

Nuclear power industry

Nuclear power is the major source of electricity in India after thermal, hydroelectric and renewable sources of electricity. The Indian nuclear power industry is expected to undergo a significant expansion in the coming

years. This is one of the newest occupational hazards to emerge following the acceptance of nuclear power as a significant means of generating electricity. Here there is a risk of possible exposure to small but constant doses of radiation. This can lead to an increase in testicular carcinomas, leukaemia, thyroid cancer and non-Hodgkin's lymphoma for the workers. The association of exposure to radioactive materials and malignant disease is well recognised. Therefore national and international bodies exist to ensure safety standards are maintained in handling uranium, in the creation of nuclear power and in the disposal of waste products.

Oil and Natural Gas Industry

Workers may be employed on onshore or offshore rigs. In spite of various control measures the major risk involved here is accidental. There is a vast range of activities undertaken in order to maintain a rig, ranging from support medical services, catering and technical functions through to manual work out on the platform. The most hazardous category consists of those who dive and maintain pipelines. Divers present what is believed to be the most hazardous activity in mortality terms in the world. Accident risks involve fire, explosion, helicopter travel, dangerous working conditions and crane failures. More general hazards include severe climatic risks, fatigue and stress due to working hours, conditions and isolation. The harsh climatic conditions give rise to health related problems such as respiratory and musculoskeletal problems and psychological problems associated with work conditions.

Basic risk factors for Avocation

- Age/health and physical requirement – many avocations require minimum fitness levels.
- Equipment requirements – Specialised equipments are required to safeguard the participant from avocation risks.
- Training requirements and level of expertise – some avocations required specialised training and certifications, in the absence of which it would be dangerous to practice and avocation.
- Frequency – frequent participation leads to higher risk of exposure.
- Location – e.g. mountaineering. It can lead to travel hazards and hazards of unavailability of immediate help.
- Participating in multiple avocations – some individuals participate in multiple avocations or engage in hazardous activities like car racing or identified with personalities who are “thrill seekers” and crave for excitement and danger. Such individuals pose accelerated risks rather than the sum of the independent risk factors.

Avocations having extra risk exposure

- Aviation
- Hand-gliding and Micro-lights
- Ballooning & Parachuting
- Scuba Diving
- Car racing
- Mountaineering

Residential risks

Every country has its own unique attributes and risks. The duration of the stay will determine the exposure of an individual to these risks. There are number of factors which affects the life expectancy of the residents residing in a particular country. Few of them (e.g. climate) are more or less permanent while some (e.g. political instability) are subject to changes. An underwriter needs to remain abreast of the changes. The ratings for these factors will from time to time, need to be adjusted accordingly. Following factors are considered from residential risks perspective:

- Climate
- Availability of standard health care and AIDS prevalence
- Political and Economic stability
- Infrastructure
- Ethnic/Tribal divisions, Religious fundamentalism
- Natural disasters

REINSURANCE

Reinsurance is a risk transfer mechanism whereunder an insurance company passes on the risk on an insurance policy to another entity called Reinsurer for a consideration under a Reinsurance treaty (contract).

Under reinsurance one direct insurance company (also called Ceding company) transfers (cedes) part of the risk to another insurance company (called Reinsurer). This helps in reducing the liability of the direct insurer to a large extent. If there is no reinsurance, it could result in a dent in the financial position of an insurance company, especially when a natural calamity happens.

Some of the global reinsurance companies who have opened reinsurance offices in India include Swiss Re., Munich Re., RGA, Hannover Re. etc. The Indian Reinsurer is GIC Re. (General Insurance Corporation of India).

Reinsurers have their teams which comprise of competent technical professionals who are experts in Actuarial, Claims, Underwriting etc.

Reinsurers take a proportion of the premium paid by the Policyholder and promises to pay the proportionate amount of any claims insured under the Policy.

Need for reinsurance

The actuary of the life insurance company prices the products and makes certain vital mortality assumptions, based on the medico-actuarial studies, mortality statistics, extensive research and his own expertise in this field. Generally, it is assumed that the actual mortality experience is in line with the mortality assumptions made by the actuaries. However, if there are variations and the actual experience is not favourable in terms of mortality experience, this could result in losses and thereby indemnifies the direct life insurance company from financial losses. This situation can be taken care of when the reinsurance arrangements are in place and the risk/liability is shared by the reinsurer in exchange for a proportionate pre-decided premium. Thus, reinsurance can be said to be “sharing or spreading of risks”. The reinsurance arrangements minimise the financial impact of death claims on a direct insurer. The quantum of liability which a direct insurance company (ceding company) takes on is known as the retention limit.

Retention limits

Retention limit is the risk retained by the Ceding company and any excess above the retention limit is passed on to the reinsurance companies. As per IRDAI Regulations, Retention limits of insurers depends on the age of the insurer as follows:

Sr. No.	Age of the insurer (years of existence)	Retention limit (Sum Assured ₹in lakhs)			
		Pure protection products like Term insurance and Personal Accident	All savings Products like Endowment & ULIPs	All kinds of Group	All kinds of health insurance products except Personal Accident
1.	0 to 3 years	5	10	5	1
2.	4 to 7 years	10	20	10	3
3.	8 to 11 years	15	30	15	3
4.	12 to 15 years	20	30	20	4
5.	Above 15 years	IRDAI to prescribe from time to time	IRDAI to prescribe from time to time	IRDAI to prescribe from time to time	IRDAI to prescribe from time to time

It may be noted from the above table that with the increase in age of the insurer, the Regulator progressively expects the Life insurance companies to retain more risk on Policies. Otherwise, Life insurance companies can be fronting the new business without assuming risk by having a reinsurance contract for passing on the risks to a third party.

If any Life insurer wants to retain less than the above limit, then they will have to write to IRDAI seeking their approval by submitting certain information. IRDAI approval is also required where the reinsurance premium exceeds 2% of the Total premium received for Savings products (Endowment, Money back Policies etc.) and 30% for Term and Protection products. This limit is based on Premium whereas the Retention limit given in the above Table is based on Sum assured.

TYPES OF REINSURANCE TREATIES

There are two basic methods of reinsurance:

1. **Facultative Reinsurance**, which is negotiated separately for each insurance policy that is reinsured. Facultative reinsurance is normally purchased by ceding companies for individual risks not covered, or insufficiently covered, by their reinsurance treaties, for amounts in excess of the monetary limits of their reinsurance treaties and for unusual risks. Underwriting expenses, and in particular personnel costs, are higher for such business because each risk is individually underwritten and administered. However, as they can separately evaluate each risk reinsured, the reinsurer's underwriter can price the contract more accurately to reflect the risks involved. Ultimately, a facultative certificate is issued by the reinsurance company to the ceding company reinsuring that one policy.
2. **Treaty Reinsurance** means that the ceding company and the reinsurer negotiate and execute

a reinsurance contract under which the reinsurer covers the specified share of all the insurance policies issued by the ceding company which come within the scope of that contract. The reinsurance contract may oblige the reinsurer to accept reinsurance of all contracts within the scope (known as “obligatory” reinsurance), or it may allow the insurer to choose which risks it wants to cede, with the reinsurer obliged to accept such risks (known as “facultative-obligatory” or “facoblig” reinsurance).

Types of Treaty Reinsurance

1. Quota Share
2. Surplus
3. Excess of Loss
4. Excess of Loss Ratio (Stop-Loss) and
5. Pools

1. Quota Share Treaty Reinsurance

This type of treaty requires the direct insurer to cede a predetermined proportion of all its business accepted in a certain class to the reinsurer(s), and the reinsurer(s) also agrees to accept that proportion in return for a corresponding proportion of the premium.

Example 1: Quota Share; arrangement: Direct Insurer: 10% and All Reinsurers: 90%. Risk assumed: ₹1,000,000. Therefore, risk distribution will be as follows:

Direct Insurer	10%	= ₹1,00,000
All Reinsurers	90%	= ₹9,00,000
	100%	= ₹10,00,000

Example-2: Quota share arrangement: Same as before. Risk assumed Rs.100,000 (same type of risk) Therefore, risk distribution will be:

Direct Insurer	10%	= ₹10,000
All Reinsurers	90%	= ₹90,000
	100%	= ₹1,00,000

It should be noticed from the above two examples that for a similar type of risk the amount falling onto the shoulder of the direct insurer is varying simply because of the term of the treaty, even though he could safely retain more.

May be in the 2nd example, the direct company could retain the full amount of ₹100,000 thereby earning the whole of the premium. But the contract is debarring him from doing so as he must cede as per predetermined percentage.

In spite of the above shortcomings, this type of arrangement is, however, particularly helpful for small offices or for a new office or for offices that are starting a new type of business. In the case of a loss, it will be borne by all in the same proportion.

2. Surplus Treaty Reinsurance

The important feature here is, this that the direct insurer agrees to reinsure only the surplus amount, after its retention, and the reinsurers agree to accept such cessions, usually up to a predetermined upper limit. Surplus treaties are usually arranged in lines, each fine being equal to insurer's own retention.

This means that the insurer can automatically make a gross acceptance of the risk to the extent of his own retention, plus, the amount of retention multiplied by the number of lines for which treaty has been made.

Example 1

Proposition : ABC Insurance Co. has received a proposal for Life insurance for an amount of Rs.1,00,00,000, The company's retention amount is Rs.10,00,000, A 9-line surplus treaty exists. The arrangement will be as follows:

ABC's Retention	= ₹10,00,000
Treaty consumes (9×10 lac)	= ₹90,00,000
Total	= ₹1,00,00,000

Example-2

Proposition: Same as Example 1, but the sum insured is \$7,000,000. Arrangement will be:

ABC's Retention:	= ₹1,000,000
Treaty receives:	= ₹6,000,000
Total	= ₹7,000,000

It may be noted that the treaty receives the balance only after Ceding Company's retention and even though the treaty has got a higher capacity, it is under placed because the sum-insured itself is lower than capacity and therefore they get the full balance of the sum insured.

Example-3

Proposition: Same as in Example – 1, but the sum insured is ₹1,50,00,000 and a treaty upper limit exists for ₹80,00,000. The arrangement will be:

ABC's Retention:	₹10,00,000
Treaty consumes: (upper limit applies)	₹80,00,000
Automatic cover:	₹90,00,000

It must be noted here that the principle of reinsurance is being violated by such an attempt. The excess retention of ₹60,00,000 will create an additional charge on the company's fund for which there is no provision and which attempt is bound to disturb the company's financial stability and profitability.

Merits

This method is the most accepted form of reinsurance nowadays. Whilst all the advantages of facultative and quota share system are prevalent, the disadvantages of these two types are also to be noted. Important advantages of the surplus treaty are

- Cover is automatic as opposed to the facultative system.

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- It is less expensive in comparison to facultative and little procedural formalities are involved.
- Unlike the quota system, the ceding company can retain whatever it likes and the balance only is ceded. Unnecessary cession of business and premium is not envisaged.
- This method is of particular advantage to established companies who are growing concerns and who have scope for gradually increasing their retention with the increase in financial strength.

Demerits

Demerits are very little and some of them are:

- For big liability insurances or for protection against losses of catastrophe nature, other methods like Excess of Loss or Stop Loss arrangements are better suited.
- Reinsurers cannot usually apply underwriting judgment for each and every individual case, even though they might have entries into ceding company's account at periodical intervals.
- This method is not suitable for new insurance companies.

3. Excess of Loss Treaty Reinsurance

The approach of the reinsurance arrangement is quite different here from those methods already discussed. Under this system, unlike facultative, quota or surplus, the sum insured does not form any basis and it is not expressed in terms of proportion or percentage of the sum insured. Here, the insurer first decides as to how much amount of loss he can bear on each and every loss under a particular class of business.

The arrangement is such that if a loss exceeds this predetermined amount then only reinsurers will bear the balance amount of loss. Nothing is payable by the reinsurers if the amount of loss falls below this selected amount.

There may usually be an upper limit of liability of the reinsurers beyond which they will not pay.

Example:

Proposition: Against all public liability insurances, the insurer decides to bear a loss up to Rs.1,00,000 in respect of each and every loss. The reinsurers agree to bear any balance amount beyond Rs.100,000. The actual loss is for ₹200,000. There is an upper limit of ₹80,000.

The recovery under the reinsurance arrangement will be as follows:

Loss: ₹200,000. Upper limit:	₹80,000
Insurer bears:	₹1,00,000
Reinsurer bears:	₹80,000
Insurer again bears the balance because of upper limit:	₹20,000
Therefore, Insurer bears	₹1,20,000
Reinsurer bears	₹80,000

It should be noted that if there would have been no upper limit, reinsurers would have borne ₹1,00,000.

This type of reinsurance arrangement is particularly helpful in cases of big liability insurances and for obtaining protection against catastrophe losses.

4. Excess of Loss Ratio Treaty Reinsurance

This type of arrangement is also known as STOP LOSS reinsurance and is a bit different from the Excess of Loss arrangement, even though both basically base on loss rather than sum-insured.

Here, a relationship is usually drawn in between the gross premium and the gross claim over a year in a particular class of business. The ceding company decides a gross loss ratio up to which it can sustain. The arrangement with the reinsurers is such that if at the year-end it is found that the total of all losses within the class has exceeded the predetermined loss ratio then the reinsurers will pay the balance loss so as to keep the loss ratio of the ceding company within the 'predetermined ratio'. The treaty may contain an upper limit also.

Example

Proposition: Company ABC has arranged an Excess of Loss Ratio Treaty with reinsurers whereby it will bear losses up to an amount not exceeding 70% of the gross premium of the class.

The reinsurers have agreed to bear any balance so that the ceding company's gross loss ratio is maintained at 70%, but not exceeding say 90% of the balance.

Ceding company's premium income is ₹1,00,00,000 and the total loss over the year is Rs.80,00,000.

The implication of loss distribution will be as follows Loss: ₹80,00,000.

This is 80% of the gross premium and therefore, reinsurers come into the picture to keep this 'loss ratio' down to predetermined 70%. Therefore;

Ceding Co. bears (70% of premium)	= ₹70,00,000
Reinsurer pays 90% of Rs.10,00,000	= ₹9,00,000
Ceding Co. again bears balance	= ₹1,00,000
Total	₹80,00,000
Therefore,	
Ceding Co. bears:	₹71,00,000
Reinsurers pay :	₹9,00,000
Total	₹80,00,000

It should be noted that had there been no upper limit the full balance of Rs.10,00,000 would have been paid by the reinsurers and the predetermined loss ratio of the ceding company would have been maintained. In this case, because of the upper limit, the predetermined loss ratio has been partly disturbed. This type of reinsurance is widely used for liability insurances and for catastrophe losses.

5. Pools Treaty Reinsurance

Pools are basically treaties, either quota share or surplus, in the sense that under these arrangements various member countries or member companies join their hands together beforehand for sharing each other's premium as well as claim. These pools usually operate in respect of especially hazardous classes of business or where the market as a whole is weak to absorb the risk. In such circumstances, such pools providing mutual support become very useful.

Examples of risks may be crop insurance, workmen's compensation insurance etc.

6. Catastrophe Reinsurance

This is also referred to as “Cat cover” and protects the insurance companies against catastrophes of large mortality claims coming at a single point of time.

For example, the 2004 Indian Ocean earthquake and Tsunami claimed the lives of more than 10,000 people mostly in Andaman & Nicobar Islands and Tamil Nadu. Also, the Kerala Floods in 2018 claimed the lives of over 400 people and damaged houses and cars of many people.

Under these circumstances, Insurance companies may face huge number of claims at a single point of time, which could create a dent in their Balance Sheet and may call for additional capital from shareholders of insurance companies to maintain their minimum solvency (Net worth) as per regulatory requirements. Thus, Catastrophe reinsurance protects the company against the short-term earnings impact of incurring multiple large claims at one time.

Advantages of reinsurance arrangements

The following are the advantages of the reinsurance arrangements:

- Reinsurance is a risk transfer mechanism and limits the Financial losses of insurance companies
- Reinsurers have a pool of talent and knowledge which help the direct insurance companies in knowledge upgradation and bringing in globally accepted and recognised best practices to their area of work, help in designing innovative products, which can help in revenue generation to the ceding insurers
- Insurance companies experience sudden spikes in volumes in certain times in a year and the reinsurers extend help in underwriting of cases received by the direct insurer through their registered offices
- Reinsurance treaty can be structure so that that the amount of reserves which must necessarily be held by a company can be reduced – which may be useful in coping with new business strain and other capital constraints
- Company’s overall performance can be measured in many ways including return on capital – if reinsurance can be used to reduce the capital required without impacting significantly on profits, the return on capital can be improved
- Tracking of global insurance applications by the same person – for example, a person who had applied earlier for insurance in US and was declined, applies now in India (for a high sum assured), such cases can be tracked by reinsurers due to their presence in multiple countries

Reinsurance treaty (Reinsurance contracts)

Reinsurance treaty denotes the legal agreement between the Ceding insurance company and the Reinsurance company signed by both the parties. It contains the obligations and responsibilities of both the parties, viz., the direct insurance company and the reinsurance company. Each treaty may be broken up into smaller units – into a number of provisions or sections, each pertaining to a separate point. The treaties may vary from each other and depend upon the type of the reinsurance arrangement and the purpose of the treaty. Reinsurance treaties also contain various points that are not directly concerned to underwriting.

Reinsurance treaties generally cover the following points:

- Provisions and conditions with reference to different types of reinsurance, e.g. Automatic, Facultative, retention limits etc.)

- Liabilities of reinsurers in cases of claims
- Details of the points from where the liability begins with reference to various types of Treaties
- Points pertaining to the Policy terminations, changes or increase in risk classification, reinstatements etc.
- Additional policy benefits, if any, like accidental death benefits and waiver of premium
- Claims related matters, viz., contestable claims, copies of proofs required for claims settlement etc.
- Errors & Omissions clause which details out the extent of errors that are of un-intentional and non-recurring in nature that will be accepted by the reinsurer and are very explicitly drafted
- Disputes resolution methodology, Arbitration methods
- Forms, manuals, guidelines, underwriting philosophy with its rules, procedures and processes etc.

Underwriting audit by Reinsurers

Audit of underwriting function by the reinsurers is an important activity in the life cycle of an insurance company and cannot be undermined. The reinsurers' audit of the underwriting department of an insurance company covers topics ranging from adherence of underwriting guidelines, to processes and procedures, to risk areas, the adherence of the underwriting philosophy, the risk assessment aspects etc. The procedures with reference to adherence of calling for additional requirements in the risk assessment process and managing risks within the agreed norms is also an important feature of the underwriting audit. The interface with the client through different modes of communication is also reviewed in greater detail during the course of the audit.

UNDERWRITING CONSIDERATIONS FOR CERTAIN SPECIFIC ILLNESSES AND DISORDERS

Underwriting denotes the acceptance of risk based on assessment during a medical examination or self-declaration of the status of health in a Proposal form. While there are no standard regulatory guidelines on what the Insurance companies need to do in the case of specific ailments and illnesses, mostly the Underwriters are guided by the provisions of Reinsurance contracts and guidelines. Reinsurers have prescribed guidelines on specified illnesses and their guidelines become the guiding principles for Insurance companies.

It will be possible only to give general pointers as the decision of Insurance companies may vary depending on the risk appetite of each insurer and the provisions of Reinsurance contracts.

In the following sections, only an attempt is made to generalise the approach followed generally by Insurance companies. The actual practices may vary from Company to Company. Also, only certain specified illnesses are covered to enable the Students to appreciate the Underwriting approach.

Blood disorders

Blood is the life maintaining fluid that circulates through Heart, Arteries, Veins and Capillaries. Blood performs various essential functions as it circulates through the body. It delivers oxygen and essential nutrients such as fats, sugars, minerals and vitamins to the body tissues. It carries carbon-dioxide to the lungs and other waste products like urea and creatinine to the kidneys for elimination from the body. It transports hormones to allow various parts of the body to communicate with each other. Blood also contains many other substances such as antibodies and anti-toxins

Any disorder of the blood has an impact from risk assessment perspective by an Underwriter as it could have impact on mortality risk. Therefore knowing the exact disorder and treatment taken is important from underwriting

perspective

Anemia

Anemia is a condition in which the number of red blood cells or the amount of hemoglobin is low. Red blood cells contain hemoglobin, a protein that enables them to carry oxygen from the lungs and deliver it to all parts of the body. When the number of red blood cells is reduced or the amount of hemoglobin in them is low, the blood cannot carry an adequate supply of oxygen. Inadequate supply of oxygen in the tissues produces symptoms of anemia

Anemia is caused due to excessive bleeding, inadequate protection of red blood cells and excessive destruction of red blood cells.

Underwriting of persons with Anemia depends on the type or cause and the severity of the hemoglobin and/or red cell deficiency. If it is clearly identified as anemia associated with chronic disease, then the rating is usually that of the underlying disorder. However, unexplained anemia is normally postponed pending investigation of the underlying cause.

Mild to moderate degrees of anemia can be regarded with less suspicion in pre-menopausal females than in males, as menstrual blood loss is a common and usually benign cause.

Polycythaemia

Polycythaemia is a blood disease in which the body makes too many red blood cells. The extra red blood cells make your blood thicker than normal. As a result, blood clots can form more easily. These clots can block blood flow through your arteries and veins which can cause a heart attack or stroke.

Leukemia

Leukemia is a cancer of the white blood cells. The various types of Leukemia are as follows:

- Acute lymphoblastic leukaemia – this is cancer of immature lymphocyte cells known as lymphoblasts. This is common type of leukemia in young children
- Acute myeloid leukemia – this is a cancer of the immature myeloid cells and mainly occurs in adults
- Chronic lymphocytic leukemia – this is a cancer of the lymphocyte cells and is the most common type of leukemia affecting adults and is very rare in children
- Chronic myeloid leukemia – this is a cancer of neutrophils cells. This is rare in children and mostly affects male than female adults

Lymphoma

Lymphoma is a cancer of certain types of white blood cells called lymphocytes. These cells circulate through the body in the blood stream and in the lymphatic system, which is part of the body's immune system. There are several different types of lymphocytes the major types being the B-lymphocyte and the T-lymphocyte.

Myeloma

Myeloma is the cancer that starts in Plasma cells, a type of white blood cell. It is most common type of plasma cell cancer. Plasma cells are white blood cells that make antibodies. Myeloma beings when a plasma cell becomes abnormal. The abnormal cell divides to make copies of itself. These abnormal plasma cells are called myeloma cells. In time, myeloma cells collect in the bone marrow. They may damage the solid part of the bone.

When myeloma cells collect in several of bones, the disease is called “multiple myeloma”. This disease may also harm other tissues and organs such as kidneys. Myeloma cells make antibodies called M proteins and other proteins. These proteins can collect in the blood, urine and organs.

Haemophilia

Haemophilia is a group of hereditary genetic disorders that impair the body’s ability to control blood clotting or coagulation which is used to stop bleeding when a blood vessel is broken. Haemophilia A is the most common form of the disorder and represents 80% of the haemophilia cases. Haemophilia B involves a lack of functional clotting Factor IX. It comprises approximately 20% of haemophilia cases. Haemophilia lowers blood plasma clotting factor levels of the coagulation factors needed for a normal clotting process. A haemophiliac does not bleed more intensely than a normal person but can bleed for a much longer time. In severe haemophiliacs, even a minor injury can result in blood loss lasting days or weeks or even never healing completely. IN areas such as the brain or inside joints, this can be fatal or permanently debilitating.

Life expectancy varies with severity and adequate treatment. People with severe haemophilia who do not receive adequate, modern treatment have greatly shortened lifespans. The primary leading cause of death of people with sever haemophilia has shifted from haemorrhage to HIV/AIDS acquired through treatment with contaminated blood products. The second leading cause of death related to severe haemophilia complications is intracranial haemorrhage which accounts for one third of all deaths of patients with haemophilia.

UNDERWRITING CONSIDERATIONS FOR BLOOD RELATED ILLNESSES

Generally, Proposals on persons with blood ailments such as Leukaemia are declined as there is a significant impact on mortality. However, in case where the severity is low, and the person is under treatment, consideration of the Proposals is postponed till complete recovery.

Nervous system

The nervous system comprises of 2 major systems:

- Central Nervous system -Brain and the Spinal cord
- Peripheral nervous system – network of spinal and cranial nerves linking the body to the brain and spinal cord. Peripheral nervous system is further broken into:
 - Automatic nervous system which control the involuntary actions of internal organs, blood vessels etc.
 - Somatic nervous system which controls the voluntary actions of the skins, bones etc.

Brain is typically divided into 4 parts:

- Cerebrum - it comprises of 2 hemispheres – right and left cerebral hemispheres which are interconnected by the corpus callosum. The 2 hemispheres are twins, each with centers for receiving sensory information and for initiating motor responses. The left side sends the received information to/from the right side of the body and vice versa. Various intellectual functions are concentrated either the left or right hemispheres. Main functions include thought/memory, vision, hearing, touch, speech, language, motor control and emotions
- Cerebellum – it sits below the cerebrum. It has an outer cortex of gray matter and has 2 hemispheres. IT receives/relays information via the brain stem. 3 major functions of cerebellum include balance/ equilibrium of the trunk, muscle tension, spinal nerve reflexes, posture and balance of the limbs and

motor control, eye movement.

- Thalamus & Hypothalamus – thalamus is a bilateral egg-shaped mass of gray matter serving as the main synaptic relay center while hypothalamus is a collection of ganglia associated with the pituitary gland
- Brain stem comprises of the medulla oblongata, pons and midbrain which are referred to collectively as the brain stem and control the most basic life functions like breathing/respiration, heart rate/action, blood pressure control etc.

Spinal cord lies within the spinal cavity, consisting of the vertebral column, the meninges, spinal nerves, spinal fluid and blood vessels. 31 pairs of nerves connect to the spinal cord. They are numbered according to the level of the spinal column from which they emerge. There are 7 cervical, 12 thoracic, 5 lumbar, 5 sacral and 1 coccygeal pairs of spinal nerves. The spinal cord has 2 general functions – it provides the 2-way conduction routes to/from the brain and serves as the reflex centre for all spinal reflexes

Automatic nervous system is that part which consists of motor neurons that control internal organs. The automatic system controls muscles in the heart, the smooth muscle in internal organs such as the intestine, bladder and uterus. It has 2 subsystems. The Sympathetic Nervous System is involved in the fight or flight response. For example, when you are scared the sympathetic system causes your heart to beat faster, the para-sympathetic system reverses this effect.

Somatic nervous system includes all nerves controlling the muscular system and external sensory receptors. External sense organs, including skin are receptors.

Cerebro-spinal fluid

This is a colourless liquid consisting of water, oxygen, sodium, potassium, calcium, magnesium, glucose and proteins which circulates around the brain and spinal cord. This fluid acts as a shock absorber to potential blows and sudden movements, allowing the brain to float in a cushioned space. IN addition to its protective cushioning effect, the cerebro-spinal fluid transports nutrients to the brain cells of the brain and carries waste products away.

General disorders of the Nervous system

Stroke

Stroke is a sudden death of a portion of the brain cells due to a lack of oxygen. A stroke occurs when blood flow to the brain is damaged resulting in abnormal function of the brain. It causes by blockage or rupture of an artery to the brain.

Epilepsy

It is a condition characterised by recurring seizures in an individual. Seizures are an abnormal over-activity of the cells of the brain. The classic appearance of physical convulsions in a patient is a common manifestation of seizures.

Brain Tumour

Brain tumour is an abnormal growth that involves the brain itself or its surrounding structures. Tumours vary in location as well as other characteristics such as their typical presenting symptoms, their speed of growth and aggressiveness (whether they are benign or malignant). Benign tumours arise from meninges or from the nerve

sheaths, the acoustic cranial nerve being the important example. They may cause pressure symptoms but can often be removed surgically with complete recovery.

A Malignant tumour is subdivided into several types according to the histological appearances. Such varieties include astrocytomas, ependymomas, oligodendrogliomas etc. More commonly, malignant brain tumours are due to metastatic deposits from a distance site, especially carcinoma of the bronchus.

Spine disease

Spinal disease is any pathology which affects the spinal column and/or the spinal cord and spinal nerves which are contained therein. Spinal diseases include degenerative spine disease like herniated disc and spinal stenosis, Spinal Tumours & Spinal Dysraphisms

Neuro-vascular diseases

These include Arteriovenous malformation (abnormal tuft of blood vessels that connect arteries), Brain Aneurysm (outpouchings of the walls of an artery that supplies the brain) and Cavernous malformation (malformation of blood vessels in the brain).

Multiple Sclerosis

This is a disease of central nervous system which leads to recurring attacks of neurological symptoms. Nerve fibres are covered with a substance called myelin, which acts as an insulator and allows impulses to travel down the nerves quickly and efficiently. In Multiple Sclerosis, the myelin becomes inflamed and scarred and is eventually destroyed. The nerve impulses become weaker as the myelin is less efficient and may eventually fail altogether.

Parkinson's Disease

This is a degenerative disease which leads to progressively worsening neurological symptoms, primarily related to movement, including tremor and rigidity.

Alzheimer's Disease

This is a degenerative process with loss of cells from different areas of brain. The cause is incompletely understood but involves inflammatory processes and the deposition of amyloid in the characteristic plaques along with reduced concentration of neuro transmitters.

Underwriting considerations

For underwriting insurance on persons with history of Stroke, following are considered:

- Time elapsed since the occurrence of the last event
- Cause/type of Stroke
- Severity of resulting permanent neurological impairment
- Presence of underlying risk factors and co-morbid conditions like Diabetes etc.
- Current status of activities of daily living
- Age at the occurrence of event

Sub-standard terms for isolated events without major risk factors or co-morbid conditions are usually possible.

However, cases with severe stroke or co-morbid conditions like Diabetes are usually declined.

In the case of Epilepsy, the effects of seizures will have to be considered. Effects of seizures depend on their location in the brain and their extent. The classic appearance of physical convulsions in a patient is a common manifestation of seizures but not all types of seizures include convulsions.

There are many causes of seizures. In general, any injury to the brain can lead to seizures, including trauma, tumours, vascular lesions, haemorrhage and developmental anomalies

To evaluate the risk associated with epilepsy, the following points are considered:

- Type of epilepsy
- Number of attacks
- Duration since last attack
- Nature and compliance of treatment
- History of status epilepticus
- Occupation
- Results of investigations

Sub-standard terms are usually available for most case of recently diagnosed epilepsy. Favourable terms are possible if the applicant has had no attacks for the last 2 to 4 years and there are no other complications. If there is an event of Status Epilepticus in recent past, this would carry a worse prognosis. Febrile epilepsy would not require additional rating once underlying cause is treated.

Diabetes Mellitus

Diabetes Mellitus is a disorder of nutrition which arises when pancreas fails to produce insulin sufficient quantity for metabolism of carbohydrates. Normally action of pancreas, thyroid and pituitary gland is so balanced that the amount of sugar in blood remains constant.

In diabetes either there is not enough insulin produced by pancreas or the body stops responding to insulin, leading to chronic elevation of blood sugar levels. This, in turn, results in abnormally high blood glucose levels.

Kidneys filter glucose (sugar) from the blood and excrete it in the urine once the blood glucose concentration exceeds a certain level. This can result in a chance finding of sugar in the urine (glycosuria) which may lead to detection of undiagnosed diabetic.

Types of Diabetes

Type 1 Diabetes – this is an auto-immune disease where the body's own immune system destroys the insulin-producing beta cells in the pancreas. This is also known as juvenile-onset diabetes as it very often begins abruptly in children or young adults. People with Type 1 Diabetes are insulin-dependent for their survival

Type 2 Diabetes – this is the most common form of diabetes. This is known as late-onset diabetes and is characterized by insulin resistance and relative insulin deficiency. It has strong genetic basis but lifestyle factors such as obesity, lack of exercise, high blood pressure and poor diet are major risk factors for its development. Indians are particularly predisposed to diabetes, tending to occur in younger adults as well as older age groups. Symptoms may not show for many years and by the time they appear, significant complications may have developed. Type 2 diabetes may be treated by dietary changes, exercise and/or tablets. Insulin injections may be required to establish control.

Risk factors impacting Type 2 Diabetes

The following are the risk factors which need to be kept in mind for assessing the impact on Type 2 Diabetes:

- Age
- Body Mass Index ('BMI')
- Central obesity
- Sedentary lifestyle
- Family history
- Insulin Resistant States
- Ethnicity (e.g. Indian)

In Type 2 Diabetes Mellitus, the cells of the body are less able to respond to the actions of insulin due to underlying “insulin resistance” (seen often in obese individuals) so that the amount of insulin required is greater than normal.

Gestational Diabetes Mellitus

This is diagnosed during pregnancy. Between 5 to 8% of pregnant women develop this state. Risk factors for this disorder include family history of diabetes, increasing maternal age and obesity. Often glucose intolerance returns to normalcy after birth. However, the mother runs the risk of becoming diabetic again, besides the infant is more likely to develop obesity and impaired glucose tolerance and/or diabetes later in life.

Impaired Fasting Glucose

Such individuals having Fasting glucose above the upper limit of normal but below the threshold for Diabetes Mellitus, can run the risk of developing Type 2 Diabetes Mellitus.

Impaired Glucose Tolerance

Individuals with impaired glucose tolerance have an abnormal response to the glucose tolerance test, but do not fulfil the criteria to be diagnosed as diabetic.

Underwriting criteria for Diabetes Mellitus

Blood test

The level of blood glucose levels tested while the person is Fasting (usually 12 hours) and Post-prandial (2 hours after taking meals) are given below:

Fasting Glucose levels	Post-prandial levels	Probable interpretation
< 100 mg/dl	< 140 mg/dl	Normal
>110 mg/dl < 126 mg/dl	Not applicable in IFG	Impaired Fasting Glucose ('IFG')
Not applicable in IGT	>140 mg/dl < 180 mg/dl	Impaired Glucose Tolerance ('IGT')
>126 mg/dl	> 180 mg/dl	Diabetes

The appearance of glucose in urine, by itself does not justify diabetes. Some individuals have a tendency to

pass glucose into the urine even when the levels in the blood are normal. This phenomenon is seen due to low renal threshold or renal glycosuria. It may be seen in normal people and has no pathological significance.

Other tests for Glucose (sugar) levels

- Oral Glucose Tolerance Test – this requires 4 to 5 samples of blood to be taken within 2 hours with fasting and 2 hours after taking a solution containing 75 grams of glucose and blood sample is taken every half an hour for the next 2 hours – a level of > 200 mg/dl or greater at 2 hours indicates Diabetes
- Glycosylated Haemoglobin – also called as HbA1c test measures the percentage of the glucose in haemoglobin in Red blood cells to the total circulating haemoglobin. Since red cells live for 8 to 12 weeks before they are replaced, this test gives average blood glucose levels over the last 8 to 12 weeks. HbA1c level of > 6.5% indicates Diabetes

Underwriting considerations for Diabetes

Long term mortality rates in insured lives have improved in modern times with advancement in medicine. However, Diabetes Mellitus remains a significant risk to life. Blood reports will have to carefully reviews to accurately assess the excess mortality risk in diabetic applicants.

Underwriting decision may include additional loading or decline depending on the following factors:

- Type of Diabetes
- Duration of Diabetes
- Treatment and control
- Complications
- Other Cardiac Risk Factor Profile

Thyroid Glands

Thyroid is a small gland shaped like a butterfly that is located in the lower part of our neck in front of the windpipe near the throat. The function of any gland is to secrete hormones. The main hormones released by the gland are thyroxine (T4) and Tri-iodothyronine (T3)

The normal action of thyroid hormones is to keep all bodily functions occurring at a correct rate. It therefore has actions on the heart rate, bowel activity, skin, muscle and other organs. The production of T4 is controlled by another hormone known as thyroid stimulating hormone which is produced by pituitary gland, a control centre in the brain.

Hypothyroidism

This refers to under activity of the thyroid gland. In this condition, the thyroid gland produces less thyroid hormone than normal. This may cause many bodily functions to slow down. Hypothyroidism is known as 'cretinism' when occurring in infants and children.

The reasons why thyroid gland fails to produce enough thyroid hormone are Hashimoto's Disease (an auto-immune disease), radioactive iodine treatment, thyroid operations, medications, sub-acute thyroiditis and congenital hypothyroidism.

Hyperthyroidism

This refers to the over activity of the thyroid gland. It is also known as “thyrotoxicosis”. In this condition, the thyroid gland produces too much thyroid hormone. This may cause many bodily functions to speed up.

Common causes include Graves’ Disease, Toxic Multinodular Goitre, Toxic Nodule and Excessive Iodine Ingestion.

Treatment for Hyperthyroidism includes RAI (small doses of radioactive iodine is administered to kill excessive thyroid cells over time), Anti-thyroid drugs (drugs which decrease thyroid hormone production) and Surgical removal of most of the thyroid gland.

Underwriting considerations

Unless treated, mortality risk is low. All those using anti-thyroid drugs usually achieve remission. Thyroid eye disease may cause serious impairment of vision.

Urinary system

Urinary system comprises of the following parts:

- Kidneys – large bean-shaped organ towards the back of the abdomen which help us to get rid of waste products by making urine and excreting it from the body. They regulate the amount of water in the body. They produce renin (a hormone important in regulating blood pressure) and erythropoietin (a hormone that helps produce red blood cells)
- Ureters – they carry urine to the bladder and are 25 to 30 cms. long tubes with smooth muscle. The muscular tissue helps force urine downwards.
- Bladder – is a reservoir for storing urine, until it is ready to be discharged from the body. Bladder can hold up to 500 ml. of urine
- Urethra – is a tube leading from the bladder to the outside opening of the body through which urine is discharged and the meatus is the external opening where urine comes out

Proteinuria & Albuminuria

Proteinuria means the appearance of excessive protein in the urine – greater than 20 mg/dl in the random sample. Out of the 20 mg. of protein in the random sample, less than 3 mg. is albumin. Albuminuria is presence of excessive albumin in the urine, greater than 3 mg/dl.

High levels of proteinuria are always important. However, proteinuria that is small in amount and come and goes is not as significant. Sometimes low levels of proteinuria (microalbuminuria) are early signs kidney abnormalities that can worsen with time.

Hematuria

It is blood in urine. Normally urine does not contain any blood. Gross hematuria means urine discoloured by blood, appearing in red or tea-coloured and could be an indicator of some other disorder.

Kidney Stones

This refers to presence of stones or calculi in the urinary system. Stones form in the kidneys and may be found anywhere in the urinary system. They vary in size. Some stones can cause great pain while others cause very little. The aim of the treatment is to remove stones, prevent infection and prevent recurrence. Both non-surgical

and surgical treatments are used.

Prognosis is good after removal of the stones, but recurrences are common if the cause is not found and treated. From an underwriting perspective, it should be ascertained whether there are any underlying disorders. Deaths occurring directly from calculi are relatively few, but the underlying metabolic or systemic disorder (if present) may have an increased risk of mortality.

Renal failure

This is a state where the kidneys are not able to regulate water and chemicals in the body or remove the waste products from your blood. Acute renal failure is the sudden onset of kidney failure. This condition can be caused by an accident that injures the kidneys, loss of lot of blood, or some drugs or poisons. IT may lead to permanent loss of kidney function. But if the kidneys are not seriously damaged, they may recover. Chronic kidney disease is the gradual reduction of kidney function that may lead to permanent kidney failure or end stage renal disease.

Prognosis of chronic kidney disease depends on the cause. However, chronic kidney disease is an independent cardiovascular risk factor and is associated with increased mortality rate. The condition can progress to end stage renal failure if there is associated hypertension, diabetes mellitus or a progressive primary kidney disorder such as glomerulonephritis or polycystic kidney disease.

The level of the glomerular filtration rate, the degree of proteinuria and the control of any associated cardiovascular risk factors are the major determinants of outcome. Substandard terms may be possible for early Chronic Kidney diseases. However, cases of advance Chronic Kidney disease with underlying diseases are usually declined.

Urinary Tract Infections

These are caused by bacteria in the urinary tract. Women get the infection more often than men. They are treated with antibiotics. It can happen anywhere in the urinary tract. N infection in the bladder is called cystitis. If the infection is in one or both kidneys, the infection is called pyelonephritis.

Generally, occasional history of Urinary Tract Infections which has been treated with antibiotics has no impact on mortality. Pyelonephritis can cause serious damage to the kidneys if it is not adequately treated.

Polycystic Kidney Disease

It is a kidney disorder passed down through families in which multiple cysts form on the kidneys, causing them to become enlarged. If one parent carries the gen, the children have a 50% chance of developing the disorder.

In the autosomal dominant form, the average age at death is age 50, without dialysis or transplantation. Highly sub-standard terms may be available for select cases.

Diabetic Nephropathy

It is kidney disease or damage that results as a complication of diabetes. Too much blood sugar can damage the nephron, causing it to thicken and become scarred. Slowly, over time, more and more blood vessels are destroyed. The kidney structure begins to leak and protein (albumin) begins to pass into the urine. If untreated it can result in renal failure.

Underwriting considerations are like Renal failure.

Glomerulonephritis

It is a type of kidney disease in which the part of the kidneys that helps filter waste and fluids from the blood is damaged. Glomerulonephritis may be caused by specific problems with the body's immune system. Often, the precise cause of disease is now known. Damage to the glomeruli causes blood and protein to be lost in urine.

Renal Cell Carcinoma

It is a type of kidney cancer in which the cancerous cells are found in the lining of very small tubes in the kidney. Renal cell carcinoma is the most common type of kidney cancer in adults. It occurs most often in men ages 50 to 70.

The outcome depends on how much the cancer has spread and how well it responds to the treatment. The survival rate is highest if the tumour is in the early stages and has not spread outside the kidney. If it has spread to the lymph nodes or to other organs, the survival rate is much lower.

Diagnosis of kidney disorders

Following tests are done for diagnosing kidney disorders:

- Urinalysis – can show blood, sugar, white blood cells and other findings.
- Serum Creatinine and Blood Urea Nitrogen Tests are known as primary Renal Function Tests.
- Ultrasound imaging tests of Kidney, Ureter and Bladder area and a plain film x-ray give an idea of the size, consistency and presence of any stones.
- Other tests include Renal biopsy, intravenous pyelogram, renal angiography and Cystoscopy.

Respiratory system

Every cell in the human body needs a constant supply of oxygen to produce energy to grow, repair or replace itself and maintain vital functions. The oxygen must be provided to the cells in a way that they can use. It must be brought into the body as air that is cleaned, cooled or heated, humidified and delivered in the right amounts. This is done by the Respiratory system in the human body.

The Upper respiratory Tract comprises of the Nose, Pharynx (cone-shaped passageway), Larynx (voice box), while the Lower Respiratory Tract comprises of Trachea (windpipe) and the Bronchial Tree.

Bronchi are formed as the lower part of the trachea divides into two tubes. The primary portion enters the lungs at a region called the hilus. The primary branch forms a secondary branch, which then branches into smaller tertiary bronchi.

Bronchioles are smaller tube divisions of the bronchi. Its walls contain smooth muscles and no cartilage. This allows contraction and relaxation, thereby regulating air flow to the alveoli.

Alveoli are tiny ends of the alveolar ducts. These tiny air sacs function to exchange oxygen and carbon-dioxide in the blood.

The two lungs are located in the thoracic cavity and are divided by the mediastinum. The left lung is divided into two lobes and the right lung into three lobes. Separating the thoracic cavity from the abdomen is an upwardly domed sheet of muscle and tendon called the diaphragm, the major muscle of respiration. Both lungs are covered by the pleura, a membrane made up of the parietal pleura, which covers the chest wall and the visceral pleura, which encases the lung. The two layers of pleura are in close contact but the space between them, the pleural cavity, contains fluid providing lubrication to allow movement without friction, during breathing.

Asthma

Asthma is a clinical syndrome characterised by reversible airway obstruction caused due to chronic inflammation of airways. Asthma causes narrowing of breathing airways which interferes with the normal movement of air in and out of lungs. It affects only the bronchial tubes (airways) and not the air sacs or the lung tissue.

In most cases, asthma starts in early childhood from 2 to 6 years of age. In this age group, cause of asthma is often linked to exposure to allergens, such as dust, mites smoke, respiratory infection. It is called as extrinsic or allergic type of asthma.

Asthma however can develop again in adulthood and is mostly non-allergic in nature, also called as intrinsic type of asthma.

Symptoms could be shortness of breath, wheezing, hissing or whistling sound, Coughing and chest tightness.

Asthma is clinically classified according to the frequency and severity of symptoms or attacks and the results of pulmonary (lung) function tests including forced expiratory volume in 1 second and peak expiratory flow rate.

Underwriting evaluation depends on medical history. Asthma/Respiratory Questionnaire needs to be usually filled in by the Proposer or by the treating Physician to include the following and help classify the severity of the condition:

- Frequency and severity of attacks
- Any trigger for symptoms
- Treatment (past and present)
- Hospitalisation
- Occupation
- Smoking habit
- Time off work
- Limitation of functional capacity or exercise tolerance

Also obtain any tests or investigations done in the past for the condition. Mild levels pose negligible mortality risk, while for moderate to severe condition, terms can vary from sub-standard loadings to declinature.

Bronchitis

It is a condition in which mucous membranes of the bronchial passages in the lungs become inflamed. The irritated membrane swells and grows thicker resulting in narrowing of and shutting of airways in the lungs, resulting in coughing spells and breathlessness.

Bronchitis can be acute – inflammation and irritation of bronchial tubes of acute nature. It is common among both children and adults.

Chronic bronchitis is a chronic cough and sputum production for at least 3 months a year for 2 consecutive years without an underlying disease to explain the cough.

The primary cause is heavy, long term cigarette smoking which irritates the bronchial tubes and causes them to produce excess mucus.

Respiratory questionnaire needs to be usually filled up by Life assured or treating physician which will include the following questions:

- Frequency and severity of attacks
- Any trigger for symptoms
- Treatment (past and present) and long-term therapy
- Hospitalisation
- Occupation
- Smoking habit
- Time-off work
- Limitation of functional capacity or exercise tolerance

Emphysema

It denotes progressive illness of the lungs in which there is permanent damage to air sacs or alveoli. It causes shortness of breath due to over inflation of the alveoli (air sacs in the lung). In people with emphysema, the lung tissue involved in exchange of gases (oxygen and carbon-dioxide) is impaired or destroyed.

Smoking is the most common cause of emphysema and co-exists with chronic bronchitis.

Respiratory questionnaire is usually filled up by the Life assured or the treating Physician and the underwriting approach is similar to Chronic bronchitis.

Tuberculosis

It is an infectious disease caused by a bacteria – Mycobacterium tuberculosis.

The predominant point of entry for tuberculosis infection is the lungs. The lungs are also the main site of most tuberculosis infections although the clinical form of the disease depends upon the immune response of infected individuals. Primary infection with tubercle bacilli is most often clinically silent and is identified only by a positive skin test which may be falsely negative in acute infection.

Extra pulmonary (non-pulmonary) tuberculosis can occur in nearly any site of the body. TB of the bones (e.g. vertebrae) and brain (meningeal) are common sites.

TB Questionnaire needs to be usually obtained duly filled by Life assured or treating physician which will usually include the following:

- Full details regarding diagnosis
- Treatment
- Any relapse or multi-drug resistance
- HIV antibody status

With the use of modern Anti-TB treatment regimes, pulmonary tuberculosis in an HIV negative individual has an excellent prognosis and once the treatment course is completed without complications, mortality risk is minimal. Extra-pulmonary TB like meningeal tuberculosis and vertebral tuberculosis may have a high morbidity due to complications.

Gastrointestinal/Digestive System

The digestive system or gastrointestinal system of Alimentary system is a group of organs which are responsible

for the process of digestion. It begins with the mouth where the food enters and ends with anus from where the solid waste material leaves the body.

The main functions of the digestive system include digestion, absorption and defecation.

Parts of the digestive system includes the following organs:

- Mouth and Pharynx – mouth comprises of lips, tongue and teeth. The teeth cut and grind the food by chewing. Chewed food is mixed with saliva and is moved around in the mouth by the tongue to form a bolus. The food bolus is then swallowed and passed into the pharynx.
- Esophagus – Food pipe which is muscular tube which extends from pharynx to stomach. The swallowed food is pushed down in Esophagus on to the stomach
- Stomach – it is a sac where food is stored, mixed and digested. Gastric juices are secreted which contain hydrochloric acid and digestive enzymes. The stomach thus liquefies the food and prepares it or the intestine.
- Small intestine – longest part of the digestive trace (20 feet) and comprises of:
 - Duodenum – it receives food from the stomach, bile from gall bladder and pancreatic enzymes from pancreas. These digestive juices mix the food to continue to the process of digestion
 - Jejunum and Ileum – these are the second and third compartments in the small intestine. There is a valve between ileum and large intestine called Ileo-caecal valve which prevents backflow of food back into the Ileum. Most of the digestion and absorption of the food happens in the small intestine
- Large intestine (Colon) – it extends from the end of the Ileum to the anus. It is called large because of its diameter (and not length). It consists of:
 - Caecum – it is a pouch on the right side of the body which connects to the ileum by the ileo-caecal valve
 - Appendix – this is a vestigial (non-functional) organ which is attached to the caecum. It can get inflamed and infected resulting into appendicitis (for which surgical intervention may be required)
 - Colon – ascending colon extends from the Caecum upwards and then bends horizontally under the liver to form transverse colon. This descends down the pelvis on the left side to form the descending colon. Sigmoid colon is an S shaped structure which lies at the distal end of the descending colon and leads into the rectum. The rectum terminates in the opening called anus.
- Salivary glands which secrete 3 types of salivary glands:
 - Parotid gland
 - Sub-mandibular gland
 - Sublingual gland
- Liver – Liver is a large glandular organ which lies in the right upper part of the abdomen. The liver functions include:
 - Carbohydrate/lipid and protein metabolism (breakdown)
 - Secretes bile which contains cholesterol, bile acids and several bile pigments, viz., bilirubin

- Removes/metabolism of harmful substances like alcohol and drugs
- Storage of important vitamins like Vitamins A, D, K etc.
- Gall bladder – this is a pear shaped organ near the liver. It receives bile by the hepatic duct from the liver. Bile is concentrated and stored in gall bladder and is released in response to meals. The bile is released into the duodenum via the common bile duct
- Pancreas – a spongy organ which stretches behind the stomach is an exocrine and endocrine organ. As an exocrine organ, it secretes enzymes like amylase and lipase etc. which are required for digestion. These are released into the duodenum through the pancreatic duct. As an endocrine gland, it secretes insulin hormone (released into the blood stream)

Gastro esophageal reflux (GERD)

It denotes reflux of stomach contents into esophagus due to incompetent valve or hiatus hernia (upper part of stomach protrudes upwards through the diaphragm). The incompetent valve allows the acid rich gastric contents to flow back into the esophagus, causing heartburn, indigestion etc. It results in esophagitis.

If the condition is chronic, it could lead to ulceration and scarring of the wall of the esophagus resulting in stricture (narrowing and obstruction).

From underwriting perspective, assessment of the esophagus usually required an endoscopy to be done. The frequency and severity of symptoms, complications, investigations and treatment done would help in risk assessment. For example, diagnosis of Hiatal hernia without complications on endoscopy is not associated with extra mortality, but presence of barrettes esophagus would be associated with increased mortality.

Gastritis

It denotes inflammation of the stomach lining. It can be acute or chronic depending on duration. Underwriting assessment would depend on the underlying cause treatment and any complications.

Peptic ulcer

It is a term used to describe an ulcer occurring in stomach or duodenum, as a result of exposure to gastric juices. It can be aggravated by use of medications like pain killers, steroids etc. or due to infection due to bacteria. It is diagnosed on endoscopy and can be treated with medications, though surgery may be required in some cases.

Risk assessment depends on whether the Peptic ulcer has been treated medically or needed surgery and if there were associated complications or current symptoms. Recent findings of Peptic ulcers, Doctor's Report which summarises the below should normally be called for:

- Details of duration of symptoms and current symptoms
- Investigations reports done and treatment taken
- Underlying cause
- Associated intake of alcohol or tobacco
- Complications

Ulcerative Colitis

It mainly involves the colon and rectum. Only the mucosa (inner lining) of the intestine is involved. There is continuous inflammation extending from the rectum.

Crohn's disease

It can involve any part of the Gastro-intestinal tract but predominantly involves the ileum, colon and rectum. It is associated with inflammation of all layers of intestinal wall and there is segmental involvement. Common symptoms include abdominal pain, diarrhoea, weight loss etc.

As these diseases are chronic, a treating physician's report commenting on the following would normally be required:

- Duration and severity of disease
- Date of last attack
- Details of investigations including colonoscopy and biopsy reports
- Any complications/hospitalisation required
- Treatment done including surgical and/or medical treatment
- Current medical status

Irritable bowel syndrome

It is a disorder which causes abdominal symptoms for which no apparent cause can be found. It is a clinical diagnosis. It can be precipitated for certain foods, stress.

For applicants with confirmed diagnosis of Irritable bowel syndrome and no other comorbid conditions, no ratings are usually applicable.

Carcinoma of the esophagus

Majority of the cancers of the esophagus are squamous cell cancers, predisposing factors include chronic gastritis or exposure to chronic irritants. It is detected by symptoms of dysphagia, weight loss, heartburn etc. and investigations like Barium Swallow or endoscopy.

Carcinoma of the Stomach

Most common types include adenocarcinoma, carcinoid and gastrointestinal stromal tumours etc.

Carcinoma Colon and rectum

These cancers usually are adenocarcinomas (adeno is a type of cell found in intestine). Risk factors include individuals > 50 years of age, family history of colon cancer or history of certain types of intestinal polyps or Irritable Bowel Syndrome.

Information needed to assess the risk for the above tumours include:

- Staging, grading and histopathology of the tumour
- Details of investigations and treatment done
- Residuals or recurrence
- Current medical condition

APS and Tumour questionnaire filled by the treating oncologist will be required.

Gall bladder disorders

Cholelithiasis (Gall Bladder Stones)

Gall stones may be seen in gall bladder or the bile duct. They may be asymptomatic and incidentally diagnosed or they may cause abdominal pain.

Cholecystitis (Gall bladder inflammation)

It may be acute or chronic and may recur multiple times. If recurrent especially in Diabetics, may need to undergo a surgery

The above Gall bladder disorders do not generally pose any additional mortality risks.

Hepatitis

Hepatitis indicates inflammation of liver. Common reasons include the following:

- Hepatitis virus A, B, C, D & E
- Alcohol
- Drugs
- Auto-immune

Most common symptoms include abdominal pain, jaundice, fever, tiredness, loss of appetite, nausea and vomiting.

Hepatitis A is a common type of viral hepatitis caused by a virus which spreads by ingestion of infected food and water. It is relatively mild and does not result in any chronic liver disease. Hepatitis E is also mild and does not cause any chronic liver disease.

Hepatitis B spreads through contact with infected blood, semen and other body fluids. It can spread through:

- Parentally (by blood, intravenous drug use, exposure to contaminated syringes or during surgery)
- Sexually through contact with infected person
- Perinatally (from infected mother to child)

Hepatitis C is caused by Hepatitis C Virus and it too spreads through contact with contaminated blood.

Cirrhosis of liver

Cirrhosis of liver is the outcomes of chronic liver disease characterised by degeneration of cells, inflammation and fibrous thickening of the tissues. As normal tissue is replaced by abnormal non-functional tissue, liver function begins to fail. Cirrhosis is caused by long term alcohol abuse, chronic hepatitis due to virus, autoimmune conditions etc. It results in edema, ascites, easy bruising and bleeding.

Cirrhosis is irreversible and generally proposals with medical history of Cirrhosis are declined.

Cardiovascular system

The cardio vascular system is comprised of the heart, lungs and blood vessels. The main role of this system is to transport oxygen and other vital nutrients to all tissues of the body and assist in removal of metabolic waste product through the blood. This continuous rotation of blood is called as circulation. The adult heart is the size

of a closed fist and is present in the thoracic cavity between the 2 lungs. The heart is designed as a pump with 4 chambers. It has valves which help control circulation and ensure flow of blood in one direction.

Normal investigations in Cardio-vascular system

- **Electrocardiogram ('ECG')** – this instrument records the electrical activity of the heart on a graph paper to assess the heart condition.
- **Echocardiogram/Echo Doppler** – it is the sonography of the heart and uses ultrasound techniques to image the heart. The echocardiogram also can assess the blood flow through the heart using continuous or pulsed wave Doppler ultrasound. It helps in assessing the size and shape of the heart, its pumping action and location and state of the heart.
- **Exercise Stress Test (Stress Test or Treadmill Test)** – this is done to assess the functional capacity of the heart and presence of obstruction to blood flow. With exercise, myocardial oxygen demand increases and any abnormality in coronary blood flow will be detected on the cardiac stress test. In this test, the person has to exercise on the treadmill or exercise bicycle while Blood pressure, heart rate and ECG are monitored under such stress conditions.
- **Coronary angiography** – this procedure is visualization of the coronary arteries after injection of contrast (dye). It is a gold standard test to identify coronary artery disease.
- **Nuclear cardiology** – this technique uses radioactive isotopes such as thallium to identify damages if any to heart muscles.
- **Cardiac CT** – this technique uses advanced CT technology with or without intravenous tests to visualize cardiac anatomy, including the coronary arteries and great arteries and veins.
- **Blood Pressure** – this is the pressure exerted by the blood on the wall of the blood vessels. It has 2 values – Systolic and Diastolic. Systolic reading indicates the pressure produced within the arterial system when the Left Ventricle (a chamber in the heart) contracts and pushes blood into the aorta (the biggest blood vessel in the heart). The blood pressure measured when the heart is at rest is called Diastolic blood pressure. Normal Blood pressure readings are 120 (Systolic) and 80 (Diastolic). Any increase in Blood pressure consistently for a longer period of time requires examination.

Hypertension

Any sustained blood pressure reading above the generally accepted normal maximal level is called Hypertension.

Normal range of Blood pressure for adults aged more than 18 years is 120 (Systolic) and 80 (Diastolic). Any blood pressure ranges above 120/80 for a persistent period of time could indicate Hypertensive state.

Hypertension if not controlled, could lead to other complications involving heart, kidneys and eyes and the brain.

From underwriting perspective, Hypertension questionnaire is called for asking for the details of the hypertension such as year from which the condition exists, medicines, if any, taken, Diagnosis reports, Past Blood pressure readings, Doctor prescriptions etc. to assess the risk. For persons with controlled blood pressure, with or without medication and who have no complications or associated risk factors, no additional loadings are applied. For applicants with moderately raised blood pressure or for those with associated risk factors, substandard terms are offered. For applicants with significantly raised blood pressure or with complications, detailed information is required before taking any decision.

Coronary Arterial Disease ('CAD')

This is the most common heart disease in the world. Coronary artery disease develops when coronary arteries become narrowed or occluded because of which there is inadequate blood supply to the heart muscle. It could be caused due to atherosclerosis (clogging of arteries). It is a chronic progressive disease in which plaques build up in the inner wall of the arteries. Plaques obstruct the blood flow by protruding into the artery or can cause sudden rupture. Main reasons could be deposits of cholesterol and other fatty substances along with fibrous tissues and blood components.

Modifiable risk factors for CAD includes Smoking, Hyperlipidaemia (high LDL, low HDL Cholesterols and High Triglycerides), Diabetes, Hypertension, Physical inactivity and Obesity

Non-modifiable risk factors include Family history, Gender (males are at a greater risk when compared to females) and Age (CAD is more common in advanced ages)

Treatment for CAD includes reducing the risk factors (like quitting smoking), medications, hospital treatments etc.

Risk assessment information should include the following:

- Type of CAD & severity
- Results of all investigations done in the past
- Details of angioplasty or any other hospital treatments done
- Current medical conditions
- Any other cardiovascular risk factors

Underwriting terms are likely to be possible for mild to moderate levels of CAD. However, for severe forms of CAD, the proposals are generally declined due to significant mortality risk. CAD coupled with Diabetes is almost always declined due to excessive mortality in such cases.

Prognosis of unoperated case is variable. Asymptomatic individuals with mild disease can remain stable for many years, whilst those with moderate and severe disease may have a worse prognosis. Unoperated, severe disease has significant excess mortality. Mortality is related to multiple factors ranging from severity of the valvular stenosis/regurgitation, to structural abnormality of the valve to co-morbid conditions and pre-operative LV function among other factors.

For operated cases, survival after valve replacement is variable and strongly related to long term complications and the heart's functional condition at the time of surgery. Long term complications include heart failure and arrhythmias.

Underwriting requirements include results of investigations like ECG, 2D Echocardiography, Pre-treatment and post-treatment hospital reports, indications of past or present symptoms and current follow up reports and cardiac status. Actual underwriting decision depends on an assessment of all the above factors.

Disorders of the Eyes, Ears and Nose

Eye is the organ of sight. The eye can be compared to a camera which gathers light and transforms into a picture. Parts of the eye include:

- Pupil – hole in the center of the eye through which light passes through
- Iris – circular band of muscles that control the size of the pupil

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- Cornea – transparent tissues covering the front of the eye
- Conjunctiva – mucous membrane which covers the sclera and the inside of the eyelids
- Sclera – also known as the white of the eye – it protects the inner parts
- Lens – highly elastic biconvex body which bends light passing through the eye
- Retina – layer of tissue at the back of the eye which contains photo receptors called rods and cones
- Vitreous humor is a clear gel which provides constant pressure to maintain the shape of the eye

Cataract

It is the formation of opacities in the lens of the eye which results in obstruction to passage of light, resulting in clouding of vision. Types of cataract include age related, congenital, traumatic or due to systemic diseases like Diabetes, prolonged corticosteroid treatment etc.

Age at onset of cataract formation, cause, degree of visual impairment and any residual complication after treatment should be looked for. For life benefit, no ratings are usually required.

Glaucoma

It is a disorder often associated with increased intraocular pressure of the eye. This can result in damage to the optic nerve which impairs vision.

Primary glaucoma – can be open angle and is seen in people above 50 years of age and Angle-closure glaucoma

Congenital Glaucoma is the abnormality since birth

Secondary glaucoma is caused secondary to other diseases, e.g. due to eye diseases

Treatment is aimed at treating the cause and medications to reduce the intraocular pressures.

From underwriting perspective, the degree of visual impairment, cause of glaucoma and effect on applicant's occupation would influence underwriting. Ratings are usually for the underlying cause, rather than glaucoma itself.

Retinopathy

It is a disorder of the retina due to various causes, resulting in unilateral or bilateral loss of vision., e.g. Diabetic and Hypertensive retinopathy – which brings about changes in retinal blood vessels leading to loss of vision and retinal detachment.

This condition can be of significant concern for life, Critical illness and Disability benefit and underwriting approach will depend on the extent of damage and underlying cause

Blindness

It is the inability to see – may be congenital or acquired. It may be partial or complete and bilateral or unilateral. Colour blindness is impairment of colour perception, usually congenital.

Underwriting will depend on usually the following factors:

- Cause of blindness
- Residual visual acuity and any impairment of functional capacity
- Occupation

- Whether Progressive
- Any systemic disorders

For life benefits, disorders of the eye do not usually attract ratings by itself, but ratings may be applicable for underlying cause. For critical illness benefit, special considerations need to be given as blindness is usually a covered condition under Critical illness policies.

Strabismus (Squint)

It denotes defective or weakness in nerve supply to the extraocular muscle which results in inability of the eyes to move together. It can be congenital or can be caused due to neurological disorders.

Underwriting will depend upon the cause of squint, the present visual acuity, any progression and the effect of this impairment on occupation of insured.

Ear related disorders

Otitis denotes inflammation of the ear.

Acute Otitis media

It denotes acute inflammation of the middle ear cavity. This infection can spread to mastoid (bone above the ear), inner ear (labyrinthitis) or to the brain (meningitis).

Chronic Otitis media

This causes permanent perforation of tympanic membrane (ear drum) and can spread like acute otitis media. It can result in conduction defects in the ear.

Deafness

Hearing loss may be unilateral or bilateral, total or partial. There are 2 types of hearing loss:

- Conduction deafness – sound impulses do not pass from external ear to inner ear. It can occur due to congenital conditions, due to trauma, impacted wax, ear drum perforation, Otosclerosis etc.
- Sensorineural Deafness – which occurs due to damage to sensory cells in inner ears or due to damage to the nerve transmitting impulses to brain.

Causes include congenital, trauma, infections like mumps or measles etc.

Underwriting considerations should include the following:

- Type and degree of hearing loss and whether it is progressive
- Cause – local or systemic
- Occupation
- Any associated complications

For life benefit, disorders of the ear do not usually attract ratings by itself, but ratings may be applicable for underlying cause. For critical illness benefit, special considerations need to be given as deafness is usually a covered condition under Critical illness Policies.

Nose related disorders

Nose is made up of bone and cartilage. It filters and moistens the air that is inhaled. It is also the organ of smell. The bones of the face around the nose contain hollow spaces called paranasal sinuses. The 2 nostrils are separated by the nasal septum.

Deviated Nasal Septum

Usually the nasal septum between the nose is straight. Occasionally since birth or due to trauma there is a deviation of the septum, resulting in one nostril been smaller than the other. Severe deviation can block one side of the nose and result in sinusitis. Deviated septum may require surgery.

No rating is required.

Sinusitis

It is the inflammation of the sinuses. In this condition, the membrane of the sinuses get inflamed and may progress to the sinus cavities becoming filled with infected material.

This is usually an acute condition and does not require any rating.

Nasal Polyp

These are fleshy outgrowths of the mucosa of the membrane of the nose. They may occur due to infections or due to allergies. If the nasal polyps produce significant symptoms, they may require excision with surgery.

Underwriters generally call for histopathology reports to rule out any malignancy if surgery has been done in the recent past.

LESSON ROUND-UP

- Insurance is transfer of risk and Insurance companies are in the business of accepting the risks
- Underwriting denotes acceptance of risk on a Proposal.
- Mortality denotes the death rate which is the risk of persons dying at each age. It is relevant for Term, Whole Life and Endowment Policies or any other life insurance policy where a Sum assured is payable on death.
- A Standard life is one which exposes to the insurer to a normal risk, i.e. the predictive mortality on the life does not deviate significantly when compared to the mortality indicated in the mortality table
- Factors considered while underwriting lives are Personal health history, Family history, Occupation history, Personal habits and life style, Financial status and capacity to pay, Country or Place risk
- If the Sum assured is greater than the routine non-medical limits of the insurer, then depending upon the level of sum assured, various forms of medical evidence are obtaining, e.g. existing or past health condition of the person whose life to be insured.
- Mortality risk of an individual is determined by personal information of an individual's past current and genetic health situation.
- Underwriting process denotes the steps involved in considering a risk on the Proposal. Insurance
- PAN is a mandatory if the Annualised premium payable on the Application exceeds Rs.50,000
- After verification of documents, data is entered in the Insurer's central Policy administration system

through user name and password access provided to the Branch employees

- Human life value determines the extent to which an insurance cover is needed by an individual.
- A person has unlimited insurable interest on his/her own life or that of his/her spouse.
- The need for partnership insurance is seldom realised until a partner dies and the money required to be paid out has to be found from the partnership funds. In the absence of partnership insurance, the surviving partners may be compelled to sell some of the assets or may have to close down the business
- A Hindu undivided family or HUF is a legal term related to the Hindu Marriage Act. The female members are also given the right of share to the property in the HUF. The term finds reference in the provisions of the Income Tax Act, but the expression is not defined in the Act.
- If a Life Insurance Policy is taken under Section 6 of the Married Women's Property Act, 1874, by a married man, with his wife and children as the beneficiaries, he can rest assured that the benefits will go only to his family members upon his death, irrespective of indebtedness on the date of death - Creditors cannot file a case for attachment of Death Benefits under the such a Life insurance Policy for settlement of their dues.
- The occupation in which a Person is engaged, the avocations which the person undertakes and the place/country where a Person resides also determines the mortality risks. For example, a person working engaged in Para trooping activities, the risk on mortality increases due to the nature of the profession.
- Reinsurance treaty denotes the legal agreement between the Ceding insurance company and the Reinsurance company signed by both the parties. It contains the obligations and responsibilities of both the parties, viz., the direct insurance company and the reinsurance company
- Audit of underwriting function by the reinsurers is an important activity in the life cycle of an insurance company and cannot be undermined. The reinsurers' audit of the underwriting department of an insurance company covers topics ranging from adherence of underwriting guidelines, to processes and procedures, to risk areas, the adherence of the underwriting philosophy, the risk assessment aspects etc.

GLOSSARY

Increasing extra risks: These types of risks may or may not be major risk sat the time of commencement of the policy, but as time goes by its effect is likely to become more significant, for example, high blood pressure or obesity.

Automated underwriting: Also called 'Jet underwriting', it is a process which is automated based on a rule engine built into the system.

Counter offer: Where after assessment of risk, a Life insurer proposes to offer terms which are different from the standard terms, then a "counter-offer" is sent to the Proposer for acceptance.

Financial underwriting: Financial underwriting is the process of determining whether the insurance cover is justified with reference to a person's known source of income and needs.

Key person (or Keyman) insurance: This is an insurance policy taken by a Company (or Partnership firm) on the life of a Key person who can be an employee or a director of the Company

Employer-employee insurance: These are life insurance schemes taken by employers to retain employees for longer term in the Company.

Co-parceners: Co-parceners are members of the Hindu undivided family who have a share in the rights to the property of the Family.

Facultative Reinsurance which is negotiated separately for each insurance policy that is reinsured.

Treaty Reinsurance means that the ceding company and the reinsurer negotiate and execute a reinsurance contract under which the reinsurer covers the specified share of all the insurance policies issued by the ceding company which come within the scope of that contract.

Glaucoma: It is a disorder often associated with increased intraocular pressure of the eye.

Cataract: It is the formation of opacities in the lens of the eye which results in obstruction to passage of light, resulting in clouding of vision.

Retinopathy: It is a disorder of the retina due to various causes, resulting in unilateral or bilateral loss of vision.

Blindness: It is the inability to see – may be congenital or acquired. It may be partial or complete and bilateral or unilateral. Colour blindness is impairment of colour perception, usually congenital.

Nasal Polyp: These are fleshy outgrowths of the mucosa of the membrane of the nose. They may occur due to infections or due to allergies.

SELF TEST QUESTIONS

1. Briefly write about the recent developments in life insurance underwriting?
2. Write about medical underwriting, life style underwriting and financial underwriting
3. What are the factors that influence the mortality of life insured?
4. Discuss the underwriting process under life insurance?
5. Discuss the Underwriting considerations for the following specific illnesses and disorders
 - (a) Blood disorders
 - (b) Haemophilia
 - (c) Leukaemia
6. Discuss the Underwriting considerations for Nervous system related illnesses.
7. Explain in detail the types of Treaty Reinsurance with examples.

FURTHER READINGS

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Lesson 5

Applications of Life Insurance

LESSON OUTLINE

- Introduction
- Financial Planning
- Components of Financial Planning
- Risk Management
- Personal Financial Statements & Ratios
- Investment planning
- Investment Products
- Retirement planning
- Tax planning
- Estate planning
- Risk Management & Insurance planning
- Risk Management process
- Risk Management Techniques
- Health Insurance Policies
- Pensions And Annuities
- Investment Avenue Options under PFRDA
- Pension Policies Of Life Insurance Companies
- Types of Annuity
- LESSON ROUND UP
- SELF TEST QUESTIONS

LEARNING OBJECTIVES

This unit focuses on the application of Life Insurance. After reading this unit, the students will be able to understand:

- What is the basic role of financial planning as a investor.
- What steps to be taken care of while doing the financial planning?
- What are the main components to be evaluated while doing financial planning?
- How risk is managed through personal financial statements & ratios?
- What is investment planning?
- Role of retirement planning.
- Importance of tax planning.
- Relevance of estate planning.
- Relationship between risk management and insurance planning.
- What is the risk management process?

INTRODUCTION

“Financial planning is the process of identifying a person’s financial goals, evaluating existing resources and designing the financial strategies that help the person to achieve those goals”.

“Financial Planning is the process of examining a client’s personal situation, financial resources, financial objectives and financial problems in a comprehensive manner, developing an impartial, integrated plan to utilise the resources to meet objectives and solve problems, taking the steps to implement that plan once approved by the client, and monitoring the plan performance to take corrective action as necessary to assure that results match the plan projections”.

“Financial planning is the process of meeting life goals through the proper management of finances”. Life goals can include buying a home, Children’s education or planning for retirement.

Benefits of Financial Planning

Financial planning provides direction and meaning to financial decisions:

Financial planning helps in understanding how each financial decision affects other areas of finances. For example, buying a house or renting the house; buying investment products to pay off mortgage faster or it might delay the retirement significantly

Financial planning helps to adopt the life changes more easily and feel more secure that their goals are in track

Financial planning can achieve the following for the clients:

- Organise their finances.
- Improve their Cash flow.
- Lower their personal income taxes.
- Plan for their retirement.
- Plan for their other life goals like Children’s Education.
- Improve their Investment performance and lower their investment risk.
- Optimum Insurance planning and Reduce their Insurance cost.
- Minimise their estate settlement costs.

And to achieve, the practitioner should be able to answer the following based on the current financial situation of the client:

- Clients current financial status.
- The client’s immediate and long-term needs.
- The gap between the client’s needs and the current financial situation.
- The most immediate concern of the client.
- The services or implementation that a practitioner can apply to the client’s needs.
- The estimated time frame to complete the plan and accomplish goals.
- The role of practitioner – Adviser, Distributor, Motivator.

Basic Steps In Financial Planning

The role of the Financial planner is just not to suggest the investment schemes that may make them rich. Rather, is to, Evaluate and study the client's needs; Gather and analyse data; and preparation and implementation of financial plan.

The Financial Planning Process includes:

Client agreements and Confidentiality Clause:

Letter of engagement that defines responsibilities of both the Practitioner and the Client. This prevents unnecessary litigation and disputes in the future

Confidentiality clause: That the practitioner shall not share financial and other personal information of the clients with anyone else. It is practitioner's obligation to maintain utmost confidentiality

Data Gathering and Goal Setting:

The Financial Planner / Practitioner should collect the required information that will facilitate him to design and implement a successful financial plan. The Information includes:

- (a) Understanding the client's current financial position. This includes gathering of both Quantitative data and Qualitative data. It would be easy for the client to give the data if it is available in the questionnaire format for each and every head.

Quantitative data is specific information that includes –

- General family profile that includes name of the Family Members and their Date of Birth; Address and Phone number of the client; Occupation, Marital status, Dependent
- Assets and Liabilities;
- Cash inflows and outflows;
- Employee benefit and pension plan information;
- Insurance policy information – both Life and non- Life;
- Current Investment details;
- Copies of Wills and Trusts; and
- Other relevant available financial data.

Qualitative Data: Client's and other Family Member's health status; Risk tolerance level, employment status, Interest and hobbies, Expectations in employment, anticipated changes in current / future lifestyle, other planning assumptions like retirement age, % increase in the annual salary.

- (b) Getting to know the client's financial goals, objectives and requirements: - Retirement lifestyle, Children educational aspiration, Dream car, Dream vacation destination, Dream House etc.

Develop Financial Goals:

Financial goals are the milestones that the client hopes to reach with the help of their financial resources. The practitioner while setting goals must educate the client the difference between Need and want.

By setting specific goals, the client and the practitioner will be able to:

- Define priorities

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- Establish decision
- Identify expected results
- Clarify expectations

The important life goals that the client may have are:

- Marriage / Child Birth
- Buying a new car / house / electronic
- Creating a corpus for retirement, Children's education
- Adequately insuring self and family
- Creating cash reserves for emergency usage etc.
- Repay the loan

The Financial Practitioner should ensure that the goals are Specific, Realistic, Measurable / quantifiable in money terms, Agreed and attainable, Time-bound.

The Financial Practitioner should help clients in prioritising the goal based on the current and expected future condition. Less important goals must be sacrificed or postponed to achieve the more important goals

Identification of Financial Problems

The practitioner should analyse all the information gathered to assess the current situation and determine what the client must do to meet their goals. This includes analysing the client's assets, liabilities and cash flow, current insurance coverage, investments and tax savings.

Identify and Develop appropriate strategies and alternate courses of action

The Financial planning prepared should offer recommendations that addresses the client's goals based on the information provided by the client. While preparing the Financial Plan, the practitioner needs to develop appropriate strategies for the client in the following areas:

Cash flow Management and Budgeting, Emergency Planning, Insurance Planning, Investment Planning, Retirement Planning, Income Tax Planning, Estate planning.

Evaluating alternatives and evaluating risk

The Practitioner need to perform an assessment to understand the client in the following:

- Risk Tolerance level – Testing clients risk appetite. According the Investment model portfolio is planned.
- Time horizon – The time period that the client willing to invest.
- Liquidity concerns – The number of days that the Client can live with income.
- Income tax consequences – The client's eligibility to avail the different classes of investment to avail the income tax benefits.

After evaluating, the practitioner duty is to educate the areas of investments which will be more suitable for him. This includes explaining the key concepts such as types of risk that the investors are exposed to, rate of return, and the risk/return trade-off present in investing.

The last step is to objectively determine the investment strategies for achieving financial goals. Practitioner

need to advise the client on the types of Investment vehicles to select - essentially have two options debt and equity. Base on the clients Risk profile and return expectations, the practitioner needs to advise the client about the percentage allocation to each class of investment.

Create & Implement the Financial plan

The Financial plan is the result of long process of probing, information collecting, interpretation and synthesis. Many a times, the recommendations need to be fine-tuned before the client fully agrees to implement the plan.

It is better to involve the client in each and every stage of preparing the plan. This makes client to take the ownership of the making the plan and also the commitment. Once the client agrees to the recommendations as recommended by the practitioner in the plan, a concise written proposal is prepared along with the various disclaimers, assumptions, and other relevant information which the client must know. This includes:



Monitoring the Financial plan

The final step in the financial planning process is periodic monitoring of the plan. Some events that may cause change in the financial goals of a client are:

- Changes in the marital status.
- Birth / Death.
- Disability or illness.
- Loss or changes of employment or changes in the income statement.

COMPONENTS OF FINANCIAL PLANNING

Cash flow Management and Budgeting

Cash flow Statement: It is the starting point of the planning process. Cash flow refers to the inflow and outflow of money. It is a record of income and expenses. This helps the client in knowing how his finances look like.

The purpose of cash flow planning is to ensure surplus. It is important to analyse each and every head of income and expenditure statement. Once the client has planned to maximise income and minimise spending, the surplus can be planned for their Insurance, Investment, and Education, Income Tax, Retirement and their estate.

Cash flow planning helps to match the expenses on life goals with the available income.

Having a Budget is an important part of managing money effectively. It is the most practical way to keep track of spending and more importantly, to keep grip on it. The steps in making the budget are:

List all the incomes, derived from different sources. Income not limited to Salary, Rent, Royalty and Dividend

List all the expenses. The expense head need to be divided into three heads – Fixed, Variable and Discretionary

After listing down the expenses - analyse each head and check for either reducing the cost or completely erase it from the list. Advise the client to get rid from the expenses which are completely not required. The saved money can be utilised either to pay off the debt or to plan a goal.

Budgeting

A budget is a plan for how you intend to spend your money during the coming month or year, based on details of your income statement and balance sheet for the past month or year.

Budget is working document and need to be revised every month. All the family members need to be involved while preparing the budget. Budgeting helps to get rid from unwanted spending. This increase the income that can be either invested or utilised for debt management

Budget and Financial Planning

Budgeting promotes discipline and keeps the client focused on maintaining the income stream. Budgeting keeps a tab on expense. Any investment program to be planned by the financial practitioner is directly dependent upon the surplus available after budgeting.

Ideally allocate

20% of income towards savings – goals, retirement and / or put towards payoff the debt

30% of income allocated towards housing

Remaining 50% should be allocated to spend on everything else

If the client's income is ₹50,000 a month. Then invest at least ₹10,000 to pay off debt and saving towards retirement and other goals; pay not more than ₹30,000 to pay EMI and/or rent; and spend no more that ₹25,000 on everything else.

RISK MANAGEMENT

Emergency Planning

Building Emergency fund is a financial priority. None of us have the ability to predict the hurdles which lie ahead of us. There can be various crisis like we become ill or disabled, loss of job, unexpected medical emergencies, major home repair. Without emergency fund we may be forced to take a loan or incur credit card debt which could take many years to pay off the debt. Interest cost will be more.

If two or more people are employed in the family: Money equivalent to 3 months of basic living expenses that should be invested in low risk fund like liquid fund or in saving bank account.

Single bread winner in the family / business people: Money equivalent to 6 months of basic living expenses should be invested in the low risk fund in liquid fund / savings bank account.

The expenses include for the purpose of calculating emergency fund is does not include any luxury spending

including vacation.

Insurance Planning

People buy Insurance to take care of various risks that can cause financial loss. Insurance mitigates risks by transferring risk from an individual to a larger group of people.

The specific reasons why people buy insurance are:

- To maintain their existing lifestyle after the death of a loved one (Life insurance)
- To ensure continuity of income (disability insurance)
- To pay medical bills (Medical Insurance)
- To replace or repair a tangible item (Home and Automobile)

The Practitioner should help the client in the identifying those risks and construct a plan of action to provide adequate insurance against the risks.

Insurable risks are:

Business Risks, Professional Liabilities, Legal Liabilities, Damage to Automobiles, Damage / theft of movable assets, Untimely Death, Disability, Poor Health, Damage to immovable property

PERSONAL FINANCIAL STATEMENTS AND RATIOS

Practitioners must be able to conduct appropriate analysis for clients to provide a best financial advice. Ratios help in evaluating Client's financial health. Ratios helps to determine credit rating. The most commonly used personal finance ratios are Liquidity, Debt, Risk Exposure, Tax Burden, Inflation Protection and Net Worth, Savings.

Each and every client's financials need not be analysed with all the ratios. It varies with individual's circumstances and positioning. Factors need to be considered when interpreting a client's Personal Finance Ratios are, 'life cycle, Family Status, Economic status and environment, Client's objectives and preference'.

Liquidity Ratio:

Imaging that the client lost his / her job and have no monthly regular income. Practitioner may perform an analysis using **liquidity ratio**. This ratio will tell you for how many months the clients may able to pay the monthly basic expenses with the liquid money, cash.

Liquid Ratio = Liquid Assets / Monthly expenses

Maintaining 6 months emergency is appropriate. Minimum target should be 4 months.

Basic monthly expenses are Living expenses, Interest expenses, Taxes like property, water, etc., Children's education fees.

Liquid assets – Savings / current account balance, Fixed Deposit, Investment in money market / liquid funds, cash on hand.

Expanded Liquid Ratio = (Liquid assets + 50% of (other financial assets))/Monthly expenses

Financial assets are equity investments, mutual fund investments, bonds and ETFs valued at market value at the time of calculating the ratio.

Debt Ratio:

Limit debt to 25% your income – Debt or Mortgage ratio

Client should spend less than 30% of total income to pay-off housing loan

$$\text{Debt to income ratio} = \frac{\text{Total Debt}}{\text{Total Realized increase in Networth}}$$

If the client's income is ₹1 lakh, this means the debt shouldn't be greater than ₹30,000.

$$\text{Liquid asset coverage ratio} = \frac{\text{Liquid assets}}{\text{Total Debt}}$$

$$\text{Solvency Ratio} = \frac{\text{Liquid and other assets}}{\text{Total Debt}}$$

(indicative range is 20%)

$$\text{Current ratio} = \frac{\text{Liquid asset}}{\text{Nonmortgaged Debt}}$$

(indicative range is 30 %. This is related to stage in life cycle. The mortgage loan is long term)

$$\text{Debt coverage ratio} = \frac{\text{Liquid assets}}{\text{Short term Debt} + 12 \text{ months payment on other debt}}$$

(Adequate range is anything over 1)

$$\text{Investment Leverage ratio} = \frac{\text{Investment liabilities}}{\text{Investment assets}}$$

Investment liabilities is margin account payable for purchase of investments

Investment assets are Other Financial Assets including Tangible assets + Equity Assets

(The lower the ratio the more solvent the client)

$$\text{Investment Leverage ratio} = \frac{\text{Personal Liabilities (Less Mortgage)}}{\text{Personal assets (Less Market Value of Home)}}$$

(This should be lower than investment leverage ratio since an investment should generate the cash to service its debt. And also the investments usually appreciate while personal assets depreciate.

$$\text{Financial Flexibility Ratio} = \frac{(\text{Short-term debt} + 12 \text{ month payment on other debt})}{\text{Total realised increases in net worth}}$$

Investments assets = other financial assets + tangible assets.

Higher the ratio, the tighter the client's budget

Net Worth of an individual

Net Worth = Assets - Liabilities

Assets = Both Physical and Financial Assets

Liabilities = Both Short term and Long term

If there is any negative net worth, Practitioner must check for sufficient insurance backup

$$\text{Saving to Income Ratio} = \frac{\text{Savings}}{\text{Income}}$$

Income (Indicative range is 20% and above)

Risk Exposure

This ratio measures how adequately are financial risks covered. Adequate property and liability protection, adequate life protection, Current cash flow derived from the salary.

$$\text{Wage Dependency Ratio} = \frac{\text{Salary bonuses of Principal wage earner}}{\text{Total Realised increases in net worth}}$$

If indicative range is one, the focus should be more on life and disability insurance programme.

$$\text{Life Insurance Coverage} = \frac{(\text{Net Worth} + \text{Death Benefit of Principal Wage Earner})}{\text{Salary of Principal Wage Earner}}$$

(Indicative range is 7 to 10). Liquidity of the assets varies with each and every individual.

$$\text{Personal Liability Ratio} = \frac{\text{Personal Liability Insurance}}{[(2 \times \text{Net Worth}) + (5 \times \text{Total realised increase in Net Worth})]}$$

Tax Burden

This helps practitioner to evaluate how effective tax planning have been. Tax planning is one of the most effective ways to enhance a client's Net Worth

$$\text{Effective Income Tax Ratio} = \frac{\text{Income Tax Liability}}{\text{Total Realised Increases in Net Worth}}$$

$$\text{Effective Total Tax Ratio} = \frac{\text{Total Tax Liability (Income, Property, etc.)}}{\text{Realised Increases in Net Worth}}$$

Inflation Protection

$$\text{Inflation Hedge Ratio} = \frac{\text{Equity, Tengible and Personal Assets}}{\text{Net Worth}}$$

$$\text{Balance Ratio} = \frac{(\text{Equity} + \text{Tangible Assets})}{[(\text{Liquid} + (\text{Other Financial Asset} - \text{Equity Asset}))]}$$

$$\text{Net Cash Flow} = \frac{(1 - \text{Realised Decreases in Net Worth})}{\text{Realised increases in Net Worth}}$$

Net Worth Growth Ratio

This ratio indicates the percentage growth of the Individual's Net Worth over a period of time

$$\text{Net worth Growth Ratio} = \frac{\text{Net increase in Net Worth}}{\text{Net worth at the beginning of the period}}$$

(Benchmark is inflation during the period More than inflation is positive. But inflation rate varies with person to person depending on their life style)

Time Value of Money concepts and Numericals

Fact that a rupee today is worth more than a rupee tomorrow.

Conceptually 'Time Value of Money' means that the value of money is different in different time periods.

Money received sooner rather than later allows one to utilise it either for investment purpose or consumption purpose. This is referred to as Time value of money.

This concept is used to choose among alternative investment proposals

The factors that determine the changes in value of money in different time periods are:

1. Risk of Uncertainty
2. Delay in Consumption and inflation
3. Opportunity Cost
4. Risk of Investment
5. Effect of tax

Financial Mathematics

The Interest Rate

Which would you prefer? ₹10,000 today or ₹10,000 after 5 years? Obviously, the reply is ₹10,000 today.

Types of Interest:

Simple Interest: Interest earned (paid) on the original amount, or principal

$$\frac{P \times R \times T}{100}$$

Where P is Principal, R is rate of interest and T is Time period

Compound Interest: Interest earned (paid) on any previous interest earned, as well as on the principal borrowed

Compound Interest = A – P

A is amount of accumulation and P is principal of Investment

Amount A = $P(1+R\%)^n$. Where R is rate of interest, n = time period

CI = A-P = $P((1+R\%)^n - 1)$

Illustration: ₹10000/- invest @10% p.a for 3 years

At the End of the year	Simple interest (₹)	Compound Interest (₹)
1	11,000	11,000
2	12,000	12,100
3	13,000	13,310
Difference	Additional ₹310 is earned in Compound interest	

Financial Universe Compound interest has more relevance than simple interest.

Power of Compounding

Power of compounding can make assets grow much faster.

Invention – Albert Einstein called it the 8th wonder. It can work for you or against you. When you invest it works for you. When you borrow it works against you.

Compounding is a mathematical phenomenon that basically means the longer you stay invested – and reinvest your earning – the faster your money will grow

Time value calculations

(One can either use financial calculator or excel sheet)

$$\text{Nominal Yield} = \frac{\text{Annual Interest}}{\text{Face Value of the bond}}$$

$$\text{Current Yield} = \frac{\text{Annual Interest}}{\text{Current Price of Security}}$$

$$\text{Real Return} = \frac{(1+r)}{[(1+i)]} - 1$$

where r = Rate of interest and i = Rate of Inflation

Accounting Rate of Return – Average Profit / Project Cost

Arithmetic Mean - Simple mean of returns

Geometric Mean = It is useful to determine average factors

CAGR = Compound annual growth rate is average annual growth rate of an investment over a specified period of time

$$\text{CAGR} = \left(\frac{\text{FV}}{\text{PV}} \right)^{1/n} - 1$$

Where FV is Future value of investment, PV is Present Value of Investment and n is number of years

$$\text{Effective Rate of Return} = (1 + r/m)^n - 1$$

Where r = interest rate, n = Time in year, m = compounding period in a year

Compounding Frequency	Calculation	Effective Yield
Annual Compounding	$100 \times (1+.1)^1 = 110$	10%
Semi – annual	$100 \times (1+.1/2)^1 \times 2 = 110.25$	10.25%
Monthly	$100 \times (1+.1/12)^1 \times 12 = 110.47$	10.47%
Weekly	$100 \times (1+.1/52)^1 \times 52 = 110.51$ 10.51%	
Daily	$100 \times (1+.1/365)^1 \times 365 = 110.515$	10.52%

Rule of 72

It is a rule of thumb that helps us to compute how long it will take to double the money at a given interest rate. It is approximation method.

$$\text{Year of Double} = \frac{2}{\text{InterestRate}}$$

Rule of 69

Payback Period

The length of time it takes to recover the initial cost of project. It does not consider time value of money and cash flow. Hence it will not give complete picture. However, in practice IRR (Internal Rate of Return) is used to arrive at a decision about the desired profitability

Payback Period = (Cost of Project / Investment)/Annual cash flow inflows

Dividend Yield = Annual Dividends per share / Price per share

Dividend yield is a way to measure how much cash flow an investor is getting for each rupee invested in an equity

EPS

Earnings per share. Total earning / no. of shares outstanding

Profit earnings Ratio (EPS) = Market Value per share / Earnings per Share (EPS)

Book Value = (Paid-up equity capital + Reserves and surplus)/Number of o/s equity shares

Risk – Risk refers to the chance that an investment's actual return may be different than expected. It includes the possibility of losing some or all of the original investment. Examples are Currency risk, inflation risk, principal risk, country risk, economic risk, mortgage risk, liquidity risk, market risk, opportunity risk, interest rate risk, credit risk, unsystematic risk, etc.

Return – Gain or loss of security in a particular period

Risk – Return Trade-off

Relationship between risk and return. The greater the amount of risk that an investor is willing to take, the greater the potential return.

Risk tolerance analysis plays a major role. The practitioner can advise the investment portfolio to the client based on their risk appetite

Risk-adjusted return

Alpha

Alpha is a coefficient which measure risk – adjusted performances. It factors in the risk due to the specific security, rather than the overall market. Positive alpha is the extra return awarded to the investor for taking additional risk rather than accepting the market risk.

Beta

Beta is the measure of an asset risk in relation to the market. A beta of 1 indicated that the security's price will move with the market. Less than one, security is less volatile than one and More than one, security is more volatile than the market

Sharpe Ratio

It is a risk-adjusted measure developed by William F. Sharpe.

$((R_p - R_f) / \text{SD of portfolio})$

R_p = Return of portfolio

R_f – Return on Risk free security

SD – Standard Deviation of the portfolio

Treynor Ratio

Developed by Jack Treynor that measures returns earned in excess of that which could have been earned on a riskless investment per each unit of market risk

$((\text{Average Return of the portfolio} - \text{Average return of the Risk free rate}) / \text{Beta of the portfolio})$

$(R_p - R_f) / \text{Beta}$

Duration

Duration means the change in the value of fixed income security that will result from a 1% change in interest rates. Duration is stated in years

Net Present Value – NPV

The NPV formula is a way of calculating the Net Present Value (NPV) of a series of cash flows based on a specified discount rate. The NPV formula can be very useful for financial analysis and financial modelling when determining the value of an investment (a company, a project, a cost-saving initiative, etc.). It is a difference between present value of cash inflows and the present value of cash out flows

Present value = $FV / (1+i)^n$

Where i = discount rate, n = number of years

$$NPV = \frac{F}{(1+i)^n}$$

Where,

PV = Present Value

F = Future payment (cash flow)

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i = Discount rate (or interest rate)

n = the number of periods in the future the cash flow is

Future Value of Single cash flow

$$FV_n = PV \times (1+r)^n$$

Where PV denotes Present Value of money

r denotes rate of return / interest rate

N denotes time period

FV_n denotes Future Value of money after a time period of 'n'

INVESTMENT PLANNING

The gap between the current financial situation and future financial goals is essentially bridged by effective investment planning. The following steps are applied in investment planning:

1. Risk Tolerance

Risk Profiling to know the Risk appetite of the client is important step in Financial planning. The investment suggestion will be based on the client's capacity to take the risk. There are few tools available to test the Risk profile of an individual. Ideally both husband and wife should take the test

2. Asset Allocation – Goal based and Risk based asset allocation

Strategic Asset Allocation – is a method used to fully diversify the investment portfolios by properly balancing asset classes of different correlation in order to maximise returns and minimise risk.

Hedging – is a strategy used to offset investment risk; the perfect hedge eliminates the possibility of future losses.

Tactical Asset Allocation justifies much higher allocations. Actively seeking out strategies that will enhance portfolio performance by shifting the asset mix in a portfolio in response to the changing patterns of return and risk.

3. Analyse the existing Investments

4. Identify new Investment avenues and schemes

5. Select specific investment products

INVESTMENT PRODUCTS

A. Mutual Funds

A mutual Fund is a trust that pools the saving of a number of investors who share a common financial objective. The money thus collected is then invested in capital market instruments such as shares, debentures and other securities.

There are open ended and closed ended mutual funds. Load and no load funds.

Classification of Mutual Fund Schemes

Equity Schemes, Debt Schemes, Balance Schemes, Sector Funds, Gilt Funds, Indexed Funds, MIPs, Money Market Funds

B. Post office Saving Schemes

C. Fixed Deposits

D. Insurance

E. Derivatives

F. Commodities Market

G. International Market Investments

H. Public Provident Fund (PPF)

I. Equity Market

This market is also known as share market or stock market and is the place where shares are purchased and sold. Share represents an ownership in the Company

Classification of Shares:

- (a) Ordinary shares or common stock
- (b) Preference shares

Factors that influence the price of a share:

- (1) Economy – GDP, Inflation, Interest rate, employment, industrial production etc. Favourable news indicates health economy and share price will increase
- (2) Sectoral Factors – certain conditions in the economy or Government Policy announcements might impact a particular sector or group of sectors
- (3) Company specific news
- (4) Business Life Cycle – Shares prices depend on whether the business is just a start-up or at growth stage or matured one or in decline phase.

J. Debt Market

Debt is an obligation by one party to pay a specific amount of money to another party at a future point of time. In simple language, Debt is borrowing. A person who borrows money is called 'Indebted' and person who lends is called 'Lender'. There are generally two parties to the contract, i.e., a Borrower and Issuer.

In the debt market, both Governments and Companies issue debt securities. Bonds, Debentures, Leases, Certificates, Bills of exchange, Promissory notes are the examples of debt instruments.

The duration of debt-instruments can be long term or short term

Long term Debt Market: When securities are issued for a tenure or maturity period of more than one year, we call them as long-term debt papers which are traded in long term debt market. Eg., Long term loans, Mortgages

Short term Debt Market: When securities are issued for a tenure or maturity periods that is less than one year. Eg. Credit card bills, treasury notes, commercial papers

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Elements involved in any borrowing/lending are:

- (1) The amount – called price of the Bond.
- (2) The time period for which the money is borrowed or lent – called Maturity Period or Bond Tenure or Tenor.
- (3) The amount that the borrower pays to lender. It varies depending on the terms and conditions.
 - (i) Agreement to pay the interest on specific time interval – called coupons payment or coupon.
 - (ii) Instead of paying coupon periodically, agrees to pay the interest accumulated along with the principal amount at the end of the tenor.
- (4) The lender always would be interested to know his return on investment. This depends upon the coupon, the price of the bond and the tenure. This is called 'Yield', important element in the bond market.

Two types of Yield

$$\text{Current Yield (\%)} = \frac{(\text{Annual Coupon}/\text{Current Market Price})}{\text{Current Market Price}} \times 100$$

$$\text{Yield to Maturity (YTM)} = \left[\frac{C + \{(M-P)/N\}}{(0.4M + 0.6M)} \right] \times 100$$

Where, C = Coupon in ₹

N = Residual Maturity (Balance period from now till maturity),

M = Maturity Price (generally face value),

P = Current Market Price.

Few Bond instruments are Treasury Bills, Certificate of Deposits, Commercial Papers, Discounted Bonds, Zero coupon bonds, Debentures, etc.

Risks involved in Debt Investments

- Default Risk
- Interest Rate Risk
- Reinvestment Rate Risk
- Price Risk
- Call Risk
- Liquidity Risk
- Inflation Risk

K. Real Estate

RETIREMENT PLANNING

Retirement is the point where a person stops employment completely.

Superannuation: It is a term synonymously used with retirement which is associated with attainment of a particular age after which it is assumed that the individual would not be able to discharge their regular duties. The retirement age in our country is 60 years.

Superannuation benefit

It is a type of voluntary benefit extended to employees of an organisation. When an employee retires, he no longer get a salary but the need for regular income continues. Retirement benefits like Provident Fund and Gratuity are paid in lumpsum at the time of retirement. Defined benefit plans and Defined Contribution plans.

Defined Benefit Plans: Benefits given to employee is clearly defined. This amount is normally determined based on the certain calculations like service tenure, terminal pay etc. Eg., Gratuity, Leave Encashment Salary, Employee Deposit Linked Insurance, Voluntary Retirement Scheme benefits

Defined Contribution Plans – Provident fund and superannuation fund

Phases of Retirement Planning

Accumulating Phase: It occurs in the age of 25 to 50 when one saves a part of his income consciously for creating the retirement corpus

Preservation Phase: This is normally from the age 45 to 60. Prepares oneself towards retirement

Distribution Phase – Dilution phase

Major risks which affect the Retirement income are:

- Longevity risk – living more than anticipated and outliving the nest egg.
- Inflation risk
- Asset Allocation risk
- Excessive withdrawal risk
- Medical Expenses risk
- Government regulations
- Practitioner must work on appropriate strategies to counter above risks.

TAX PLANNING

In the process of wealth creation, a person would be very keen on the return on investment. The 2 important and significant factors which erode the wealth are:

- (1) Inflation
- (2) Taxation.

Hence it is the important responsibility of practitioner is to advise the clients the inflation and tax efficient investment plan. In simple words, the real rate of return (after tax and after inflation) is what one should be ultimately bothered about.

Terms to know in personal taxation

Assessee: Who is liable to pay tax as per the Income Tax Act, 1961?

Year – Financial year is from April 1 of the year to March 31 of the following year. For eg., the current financial year is 1st April 2018 to 31st March 2019. All income earned in the financial year (Previous year) is subject to be taxed in the immediate following year (assessment year). The Assessment year of Financial year 2018-19 is 2019-20

Income

Gross Total Income:

The income of an individual computed under five major heads of income and they are:

- Income from Salaries
- Income from House Property
- Profits and Gains from Business or Profession
- Capital Gains
- Income from other sources

Exempted Income

Certain incomes earned are not subject to tax and are referred to as **Exempted Income** in the Income Tax Act, 1961. Examples are Interest on Public Provident fund, Receivables under Traditional Life insurance policy, Commuted pension, Agricultural income, House Rent Allowance, Conveyance Allowance, Leave Travel Allowance and some of the terminal benefits paid by the employer to employee like Gratuity, PF accumulation, VRS, etc.

Deductions

Deductions u/s 80C, 80D, health care expenses, Section 80E, Section 24 etc.

Net Taxable Income

The gross total income is reduced by the amount of the qualified deductions and the residual income after such deductions is the Net Taxable Income. This income is subject to tax based on the residential status of the assessee and subject to the tax rate applicable for the relevant assessment year.

Residential Status

The residential status of the assess is determined in respect of each previous year depending on the number of days the assessee was staying in India. Subject to certain provisions of I.T. Act, 1961, Assesseees are classified as Resident & Ordinarily Resident, Resident but not ordinarily Resident, and Non-Resident. Certain incomes are not taxable for some of the categories.

Tax Deducted at Source (TDS)

It is the tax that an assessee has to pay at the time of earning an income. It is different from the tax paid at the time of filing of return, since this is paid in the previous year itself.

Advance Tax

When the tax payable by any assessee for the previous year exceeds ₹10000 or more he is liable to pay the tax in advance as per the schedule given below without waiting for the year to end:

On or before 15th September	30% of estimated tax payable
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- On or before 15th December Additional 30% of estimated tax payable
- On or before 15th March Balance 40% of estimated tax payable

Tax Planning

It is an arrangement of financial activities in such a way that the maximum tax benefits as provided in the Income Tax Act, 1961 is availed of. It envisages use of certain exemptions, deductions and reliefs provided in the Income Tax Act. There is a huge scope for the financial practitioner to advice clients and help them in investing as per the latest applicable income tax laws and also for creation and distribution of wealth depending upon the life stage of the client

Useful Tax deductions to Save Tax

1. The maximum amount to be claimed as deduction u/s 80C, 80CCC and 80 CCD – ₹1.5 lakhs
2. The additional ₹50,000 is allowed for investment in NPS u/s sec 80CCCD
3. Deduction u/s 80 TTA for interest on Savings Account: up to ₹10,000
4. Interest on Home loan u/s 24 : Self occupied property = ₹2,00,000
5. Interest on home loan under section 24 for non-self-occupied property – no limits
6. Sec 80 CCG : Deduction of amount invested in Equity Saving scheme – 50% of the investment maximum of ₹25,000
7. Sec 80 D – Medical Insurance Premium and health checkup

Description	Medical insurance premium paid in respect of		Total deduction u/s 80D
	Self, spouse and dependent children	Parents whether dependent or not	
No one attained 60 years of age	25,000	25,000	50,000
Assessee and family less than 60 years and parents more than 60 years	25,000	30,000	55,000
All are above 60 years	30,000	30,000	60,000

8. Sec 80DD and Sec 80 U – Income Tax deduction for Disability:
 - Disability - with 40% or more disability: ₹75,000
 - Disability - with 80% or more disability: ₹1,25,000
9. Sec 80 DDB: for treatment of specified diseases: Actual paid or ₹40,000 whichever is higher
10. Sec 80E: Education loan for self, spouse and Children
11. Donations u/s 80G, 80GGA, 80GGB, 80GGC
12. Income Tax deduction for rent u/s GGA up to ₹60,000. Conditions apply

ESTATE PLANNING

The concept of estate planning can be defined as the process of making proper arrangements for the protection,

preservation and provision of person's total assets for the benefit of his or her family or loved ones. The definition of estate includes all the property and the property rights that a person owns including the rights from which no life time benefit will be received, eg., life insurance death claim proceeds.

Estate planning is a process of accumulating and disposing an estate to maximize the goals of the estate owner. The various goals of estate planning are:

- Making sure that the largest amount of estate passes to the estate owner's intended beneficiaries.
- Minimizing or avoiding probate court involvement.
- Paying least amount of taxes
- Providing for and designating guardians for minor children.
- Planning for incapacity.

Estate Planning Tools

1. Wills
2. Trusts
3. Power of Attorney
4. Family Settlement Deed
5. Deed of Assignment
6. Nominations
7. Business Succession or Continuation plan

Types of Will:

1. Individual Will
2. Joint Will
3. Reciprocal Will
4. Conditional or Contingent Will
5. Duplicate Will
6. Concurrent Will
7. Living Will
8. Holograph Will
9. Privileged or Oral Will

Conditions necessary for any valid Will

1. The testator making the Will should be of the age of majority
2. He should be sound mind and should not be suffering from any mental disorder
3. The will should clearly specify the details of the property regarding which is being made along with the person or persons who will be beneficiary of such a property

4. Such a Will should be made in presence of at least two witnesses who should also be of age of majority and if it is a written Will such a Will should be signed by the testator in the presence of this witnesses, who also sign it in the presence of the testator.
5. Such a Will should clearly mention the person who will be the executor
6. There is no prescribed format for a Will. A Will can be written in any language and no technical words needs to be necessarily used. However, the words used should be clear and unambiguous so that the intention of the testator is reflected in the Will

Writing the Plan

To maintain discipline and transparency, financial planning recommendation must be provided in writing.

Comprehensive Financial plan format:

Cover sheet, Forwarding letter, Table of contents, personal data, Executive summary

Statement of current situation:

- Current Net Worth now
- Statement of Income and Expenses

Summary of the Plan

- Client Goals and Objectives
- Analysis, Recommendations and Projections

Assumptions

All the assumptions on the basis of which the plan is prepared. Life expectancy, inflation, returns assumed from investment products, etc.

Risk Profile, Goal Base Risk Based Asset Allocation, Investments, Analysis of existing investment and insurance policies

Recommendations: Property and casualty insurance, Life Insurance, Medical Insurance, Liability Cover, Critical Illness

Taxes, Estate & Wills

Financial statements (Cash flows, Graphs and Statements)

- Action Plan
- Disclosure and Disclaimers

Presenting the Plan and Revision of the Plan

- Compliance
- A Financial Planner / practitioner / Investment Advisor must always adhere to SEBI Investment Advisor guidelines
- All practitioners should act fiduciary towards the client

RISK MANAGEMENT AND INSURANCE PLANNING

Risk is uncertainty regarding occurrence of loss, deviation from expected outcome. There are 2 types of risks – Objective and Subjective risks. Objective is a relative variation of actual loss from expected loss. As number of exposures increase, insurer can predict future loss experience more accurately relying on the law of large numbers and measuring the standard deviation. Subject risk, as the name suggest is uncertainty based on a state of mind or mental condition, as such difficult to measure.

Further, Risks can be classified into Personal risk, Property risk, Liability risk and Speculative risk. Personal risk is the risk to one's security and safety. For example, death, illness, disability. Property risk is the risk of damage to property such as fire, floods etc. Liability risk is the risk of someone suing claiming damages. In a Speculative risk, the outcome can be a loss or gain. For example, investment in equity stocks.

RISK MANAGEMENT PROCESS

The function of risk management is to reduce the risk of loss and minimise its effects through:

- (a) Identification of sources of Property, Income, Liability and Personal risks from which losses may arise
- (b) Evaluation of the financial risk involved in each exposure in terms of expected frequency, severity and impact
- (c) Treatment of risks by:
 - (i) Elimination or avoidance of risk
 - (ii) Reduction or control
 - (iii) Transfer to others
 - (iv) Funding
- (d) Monitoring of results continuously and systematically

Identifying Exposure to Loss

Identifying exposures is an important first step in risk management. Knowing all possible losses is important to develop realistic, cost-effective strategy for dealing with them. It is not easy to recognise hundreds of perils that can lead to an unexpected loss. For example, unless one has seen fire, he may not realise how extensive fire losses can be. Apart from damage to the building and its contents, one should think of Smoke and Water damage, Damage to employees' personal property and to others' property left on the premises, the amount of business one will lose during the time it takes to return business to normal and potential permanent loss of customers to competitors. In order to identify the exposure to loss, the types of risks a person may be exposed to, is classified into:

- (a) Personal risk
- (b) Property risk
- (c) Liability risk

Personal risks

Personal risks include events that involve the Client, his/her Spouse, Family or a Business Partner. It includes Personal injury, Disability and Death.

The following questions become relevant while assessing the Personal risk:

- (a) Number of dependents on the income generated by the client and the extent to which they will be impacted in the case of death or disability of the client
- (b) How much are the borrowings of the client and how will such borrowings be paid
- (c) How much money is required to be paid to the Dependents?
- (d) How are these people affected if the client is able to generate income?
- (e) If the client is a businessman, how will the business continue after his/her death?
- (f) Can the client afford to hire a person to help during recovery period?
- (g) Can the client afford to buy out the share of the Partner (if he is business with another Partner)?

In particular, the following questions are directly relevant from Financial Planning perspective for managing the Personal risks in the Planning process:

- If there is a personal injury to the person or his family members, due to accident whether the person can continue to earn the same income which he/she was earning before such injury ?
- If the person or his family member is hospitalised for any reason, will he or she be able to pay the hospital bills and does he have sufficient assets built to take care of these contingencies? If not, how to manage to risk of sudden hospitalisation?
- If the breadwinner suddenly dies, will the Family be able to sustain with the same income and standard of living, which they were enjoying before death?

Property risks

Property risks are the possibility of property being damaged or destroyed. The first step is to identify the property at risk against different perils which might damage it.

Losses from Property can be divided into 3 categories:

- (a) Direct Loss
- (b) Indirect Loss
- (c) Contingent Loss

A Direct Loss is the loss that is experienced by the owner of property when it is damaged by a peril. Property damage can be caused by fire, windstorm, lightning and vandalism. Losses may include damage to raw materials and finished goods, Loss of valuable accounting records making it difficult to bill or collect from customers, Vital machinery or equipment becoming inoperable and if replacements cannot be found and installed immediately, the business may even be forced to temporarily be shut down.

Indirect losses are losses which occur when, as a result of damage to property, income is reduced or additional expenses are incurred other than for the repair or replacement of damaged property. For example, in case a restaurant catches fire and is damaged, it is not in a position to open for normal business for a period of one month. Loss of business during this one month period is an indirect loss to the business owner.

Contingent loss is a loss that may be suffered by a party who is dependent upon the activities of another party owning or operating the property that is damaged. For example, if a major supplier's facility is damaged, individual may lose income or incur additional expenses as a result of the storm.

Liability risk

Liability risk arises because of losses caused by injuries to persons or liability for injuries to persons or damage to property of others. Workers Compensation, General liability, Auto and similar losses are considered casualty losses inviting liability of the person responsible.

Liability losses: Every individual or business faces exposure to liability losses. A business may become legally liable for bodily injury suffered by another person or persons or for damage to or destruction of the property of others. This liability may be the result of a Court decision in a lawsuit or Statutory provisions.

Public Liability: An individual or a business may be held liable for injuries or other losses suffered by a member of the general public as a result of the Company's employee negligence or fault. Examples include a Customer in business premises falling on a broken step and injures himself or a defective product causing injury to its user or improper installation of a product that causes injury to a customer.

Liability to Employees: Under the Workmen's Compensation Act, 1923, an employer is liable for partial and total disablements or death of employees arising out of or during the course of employment

Evaluation of risks

Every risk is measured is measured based on two parameters:

- (a) Frequency of the risk
- (b) Severity (impact) of the risk if it happens

Frequency: Frequency is how often a particular type of loss occurs or will occur. Generally, what we experience in our life is that smaller losses occur more frequently and larger losses less frequently and this is true in all spheres. Thus each risk has to be measured and a probable frequency must be anticipated to decide the risk management

If a finer and sharper analysis of Risk is required, the likelihood can be measured in a 5 point scale as under:

Risk likelihood	Likelihood description	Level
Rare	May occur rarely only in exceptional circumstances	1
Unlikely	Unlikely to occur, but could occur at some point of time	2
Possible	Fairly likely occur at sometime or in some circumstances	3
Likely	Will probably occur at some time or in most circumstances	4
Almost certain	Is expected to occur in most circumstances	5

Severity of risk

When considering the degree of risk involved, we must also consider severity, the amount of loss that is to be sustained (impact). To predict future losses, prior occurrences should be reviewed to determine how often losses of a certain type have taken place and the range in cost of those losses. Various factors are applied to recognise such things as inflation, changes in laws, delay in reporting claims, increased activity etc.

Risk measurement

Therefore a Risk is measured based on both Frequency and Severity of the risk.

Consider the example of the Risk of Earthquakes in Indonesian region. Since Indonesia is located in a high seismic risk zone, the frequency (probability of occurrence) is very high. At the same time, an Earth quake if it happens in Indonesia is accompanied mostly by Tsunami and creates huge destruction to Property & lives.

Therefore, the Risk arising out of Earthquakes in Indonesia is “Very high”.

All risks can be classified based on an analysis of the above two factors and accordingly a 2 x 2 matrix can be created and all risks can be classified in the appropriate quadrant given below, depending on the assessment of the risks.

Frequency/Impact	Low impact	High impact
Low Frequency	Low risk	High risk
High Frequency	High risk	Very High risk

RISK MANAGEMENT TECHNIQUES

Risk control

There are many strategies to deal with the risk. The particular risk control program that works best for an individual will depend on the circumstances:

Avoidance of risk: This is the simplest of the risk control techniques. Do not get into something which has a risk. It is possible to avoid certain types of risk altogether. That is, remove the possibility of losses associated with a given risk by not exposing to that risk. In generally, this strategy is appropriate for certain risks that are of both high frequency and high severity. For example, if some one is engaged in the sports of hang-gliding for adventure sports, the frequency and severity of accidents that occur are high. Thus, the best course of action to ensure that one does not die or suffer injury while hang gliding is to avoid hang gliding completely.

Though it is simplest form of risk control, it is not an appropriate strategy for dealing with most of the risks that an individual face. For example, if an individual wants to ensure that he will never suffer financial loss from a car accident. He can avoid the risk by never driving a Car. While this certainly would eliminate the possibility of a loss, it is clearly not a viable option for those who must drive in order to function on a daily basis. That is why most of us take a Motor insurance to combat the financial risks associated with driving rather than leaving driving.

Loss control: Loss control refers to minimising the severity of losses if they occur. This could mean simply relocating valuables from home to a safe deposit locker at a bank to minimise any losses that could result in home from fire or theft. The person may still suffer from financial loss if the home burns down or if thieves burgle the house, particularly if the person does not have home owners’ insurance, but those losses will be less severe that if he had not moved some of the valuable belongings.

Risk financing

Risk financing is paying for losses that risk control techniques do not entirely stop from happening. These sources of funds or risk financing techniques can be classified into 2 large groups, viz., retention (the funds for paying losses originate within the organisation) and transfer (the funds originate from a source outside the organisation). While this distinction between retention and transfer is useful in analysing and planning to meet an organisation’s risk financing needs, some risk financing arrangements may involve elements of both retention and transfer.

Retention: Some risks are just retained or are not addressed. This strategy is generally appropriate for risks that occur frequently but are of low severity. Such risks are usually not covered by insurance because of the high cost of handling frequent claims. Even if one gets an insurance coverage for ay high frequency, low-severity losses, it would result in high cost of insurance coverage than the cost of paying out-of-pocket for the losses.

For example, consider the risk of Car tyres getting punctured while driving. This is something that happens to everyone but it usually does not produce big financial losses when it occurs. Neither insurance companies will cover the risk of tyres getting punctured nor will the Car-owner be willing to pay the extra premium to cover this risk as it may not be worth it. Under such circumstances, it is better to 'live with the risk'. Such risks are called retained risks.

Non-insurance risk-transfers

For example, if you are buying a new LED TV costing say ₹75,000, the risk of TV not working properly during the first year of purchased is covered through a Warranty.

Similarly if some one is taking an apartment on lease, there may be clause in the agreement to cover the risk of material damages to the premises by the Tenant, by having an indemnity clause.

The above two are non-insurance based risk transfers.

Monitoring the Risk Management Program

All risk management programs need to be monitored to achieve the expected results and to adjust the program for changes in loss exposures and the availability and/or costs of alternative risk management techniques. The monitoring and adjusting process requires each of the elements of the general management function.

Insurance as a risk management tool

The most common method of transferring of risk is insurance. By insuring a home and a car, one can transfer risk of loss, to the insurance company. The Policyholder pays consideration in the form of premium to protect himself of a much larger financial loss. In business insurance, the owner can decide which exposures he must insure against. Some decisions, however, must be taken, as they are statutory.

For example, for buying a Motor Car or Motor Cycle, Third Party Liability insurance cover is mandatory. Sometimes, Lenders of Home loan may insist on insuring the property mortgaged for the loan, against fire.

When a person buys insurance from an insurance company, he enters into a contract with that company. The person pays premiums and in return the Company agrees to indemnify or cover for specified losses. The basis of the insurance contract is the principle of risk transfer. By purchasing insurance, a person gets protection against risks that he would probably not be able to cope up with. But insurance is not a solution to all kind of risks. It is generally not the appropriate strategy for many kinds of high frequency, low-severity risks or losses. The greater the probability of loss, the higher the average loss per insured and the higher each Policyholder's premium will be. If a risk produces minimal losses each time it occurs, it may be cheaper and better to pay for it from own pocket than to buy an expensive insurance policy. Insurance is advisable for low frequency, high-severity risks or losses such as death and terminal illness. Because the likelihood of the covered event occurring is so low, the cost of insurance is correspondingly low. At the same time, the potential benefit is great and generally exceeds the protection that any other risk management strategy could provide for these kinds of losses.

Selection of the right policy and right amount of coverage for the risks is critical to a robust Financial Planning process. For example in Property insurance, it is important to decide what property items to be covered (e.g. jewellery and antiques) and what perils to be covered (e.g. fire, floods, theft etc.). In life insurance the Sum Assured for a Term Policy, for example, is important.

Let us specifically look into Life insurance as a part of Financial Planning in the following sections.

Determination of need for life insurance cover

Needs depend on the life-stage of an individual. Following are different considerations while arriving at the life insurance needs of an individual:

Unmarried individual having dependents

- (a) **Loss of income:** If an individual becomes disabled and cannot work, he will lose on salary payments and thus needs to replace salary with other income. If the employer may provide some disability insurance coverage, but then again, the individual must assess his income need in such a situation, which may or may not arise and accordingly get himself the needed disability coverage to bridge the gap in income. Disability insurance policies provide payment of lump sum or weekly benefit based on capital sum insured and terms of the policy. It is to be made sure that the amount of coverage is enough for the needs. If it is not, then individual must purchase additional disability coverage.
- (b) **Health:** It is important that an individual has health care coverage that allows him to see the best doctors and provides access to any medial treatment that might be needed. It is advisable to have basic health coverage, either through a health insurance policy administered by many hospitals of their own or through a health insurance policy issued by insurance companies in various forms and under various names that provide coverage for hospitalisation and payment of critical illness benefits. Cancer care, Major surgical benefits etc.
- (c) **Dependents:** if the earning member has number of dependents like father, mother, sister, brother and any other relative, the need arises from the fact that how will the dependant's need be met in case of any mis-happening. One way to do this is to buy life insurance and to designate the people who are dependent as the beneficiaries of the policy. In case of mis-happening, the policy would pay the beneficiaries in one lump sum or in the form of an annuity, which would provide income over a period of time.
- (d) **Repayment of debt:** In case an individual has mortgage loan or any other form of debt, there are prime responsibilities of the breadwinner of the family and life insurance can repay these commitments even after the individual dies. Need for the insurance arises to repay the debt in the absence of the individual so that the family and dependants are not disturbed. Thus, one must be sure to purchase enough insurance coverage to repay the current balance on loans.
- (e) **Final expenses:** Death is a natural part of life. Though the emotional loss cannot be met, if there are provisions for meeting these expenses after death, which are viewed as customary in our society and can become an expensive affair, the family can find financial support to stand up during these times of grief. One must consider owning enough life insurance to ease the burden during what will be a difficult time for those who care about you the most.

Married person with kids

The following are some of the expenses for a married person with kids

- (a) Living expenses for children
- (b) Activities – e.g. sports, music classes etc. for kids
- (c) Healthcare for kids – this can be included in health insurance policy
- (d) Education for kids

- (e) Family events, transportation expenses and household support – includes vacations, weddings, other celebrations, daily household expenses etc.

Determining the right amount of life insurance coverage (Sum assured or Sum insured)

- (a) Rule of Thumb approach
- (b) Human life value approach
- (c) Family need approach

Rule of Thumb approach

A simple rule of thumb would be that the Sum assured should be 6 to 8 times the gross annual income of the breadwinner. For example, if some one is earning a gross salary of ₹12 lakhs per annum, the Sum assured must be somewhere between ₹72 lakhs and ₹96 lakhs.

A variant of the above thumb rule would be gross annual income along with cash needs at death and any special funding needs, such as private school or college tuition. Under this rule, the insurance requirement is 5 times the gross income plus the total of any mortgage, personal debt, final expenses and special funding needs, such as college funding.

Another thumb rule is Premium as a percentage of income. Under this rule, the amount to be spent on premiums instead of the amount of life insurance coverage. Under this rule, 6% of the earning member's gross income plus an additional 1% for each dependent should be spent on life insurance premiums. Once the Premium is arrived at, the Sum Assured which can be purchased for such arrived Premium, is calculated.

Human Life Value (Income replacement approach)

The income replacement approach or the Human Life Value or the Capital Needs Analysis is a method to determine an estimation of a person's human life value. Important points in consideration are:

- (a) The amount of life insurance needed is calculated in multiples of current earning income
- (b) The income replacement calculation is based on the theory that the purpose of insurance is to replace the loss of earning when a person dies
- (c) It works on the assumption that individuals have dependents and the level of earned income provides a satisfactory standard of living that will remain constant, but
- (d) It fails to consider special circumstances or financial needs

The human life value concept deals with human capital. Human capital is a person's income potential. Every individual has a human life value and insuring human life value is the primary purpose of life insurance. This method is widely used by most insurance agents and financial planners.

Briefly stated, it can be said that an individual's net worth is the present value of that person's future income stream that will be allocated to fulfil the lifestyle needs of people dependent on him.

Human life value projects the income that the insured would earn between current age and retirement age and discounts these inflows. It calculates the net contribution of the insured to the family's living standard by subtracting the insured's present value of future tax payments and living expenses from his or her present earnings. Using this method, it is required to:

- (a) Estimate the individual's average annual income from the person's present age to the age of retirement

- (b) Deduct the amount that is not allocated to others. Money spent for income taxes, self-life and health insurance premiums and all other self-maintenance expenses should be deducted
- © Using a reasonable rate of interest, determine the present value of the amounts allocated to others for the working period used in step (a).

Example 1

Mr. X aged 35, earning a gross income of ₹2 lakhs today, will retire at the age of 65. His personal expenses is estimated at ₹56,000. Current interest rate in the economy is 8%. Calculate the human life value of Mr.X.

Answer:

Age of the Person:	35
Age of Retirement:	65
Years to Retirement:	30
Annual Gross Income:	₹2 lakhs
Personal Expenses + Tax:	₹56,000
Net disposable income:	₹1.44 lakhs
Rate of discounting:	8%
Net Present Value:	₹16.21 lakhs

If Mr. X does not return home today, his family will lose his earnings, whereas if they have ₹16.21 lakhs deposited earning 8% interest, then the family will be able to withdraw ₹1.44 lakhs every year for the next 30 years, at the end of which this amount will become NIL. Therefore, Mr. X's Human Life value is ₹16.21 lakhs.

The above example ignores inflation. If the cost of living is expected to increase, say, 6% every year, the Net Present Value in the above example will be ₹32.76 lakhs.

Even though the above method is a scientific way of calculating the amount of insurance cover needed, it suffers from the following disadvantages:

- This method will generate larger amount of life insurance if the family sets a high surplus available for survivors
- It does not take into account what the beneficiary's actual needs will be in future
- It does not integrate with pension plans or other sources of income
- This method only factors in the replacement of income and does not take into account any lump sum needs at death

Family needs approach

The family needs approach or needs analysis is a method of determining the amount of life insurance an individual should carry. It assumes that the goal of life insurance is to cover the surviving family members' immediate expenses after the insured member's death as well as the ongoing expenses of family members in future. In contrast to the income replacement approach, it focuses on the financial needs of surviving family members rather than expected earnings of the insured. It involves determining the amount necessary to allow the family to meet its various expenses in the event that the insured family members should die. Under this method, family's needs are divided into 2 main categories:

- (a) Immediate needs at death (cash needs) – Final medical treatment, Funeral & burial costs, Estate settlement costs, costs of settling credit cards, mortgage and other debts, emergency fund for unexpected costs and establishment of college education expenses fund
- (b) Ongoing family needs (net income needs) – the ongoing family needs may be classified into needs under 4 periods, viz., Readjustment period, Child dependency period, Blackout period and Surviving spouse retirement period.

Readjustment period is generally 1 or 2 year period in which the family adjusts to the new living conditions after death of the breadwinner.

Child dependency period is the period starting after readjustment period and running until the youngest child in the family reaches the age of 18 years.

Blackout period refers to surviving spouse income needs after the child dependency period and up to retirement.

Surviving spouse retirement period refers to the need during retirement period.

Adding immediate needs and net ongoing needs gives the total requirement of the family and from this subtract the family's other available assets that could be used to meet up some of the expenses. For example Bank Accounts, Savings bonds, Real estate etc.

Thus Life insurance to meet family needs = Immediate needs at death + Present value of ongoing family needs – expected available assets.

HEALTH INSURANCE POLICIES

Health Policies cover the risk of high expenses associated with hospitalisation and associated treatment costs which can erode one's wealth if not properly planned for. It will be very difficult to estimate the exact amount of hospitalisation and create a fund by oneself. The fund may or may not be adequate to meet the expenses.

Instead, covering the above risk through an Insurance Policy which takes care of the above expenses would be ideal. There are 2 types Insurance Policies covering the risk of expenses relating to hospitalisation:

- (a) Indemnity based insurance policies issued by General insurance companies and Stand-alone Health insurance companies. Under indemnity based policies, the exact amount incurred by the Policyholder is reimbursed/paid by the Insurance company within the Sum assured limit, subject to Policy terms and conditions.
- (b) Fixed benefit based products issued by Life insurance companies, popularly called as Critical illness riders which specifically cover special illnesses like Cancer, Heart ailments etc. These Life insurance policies pay Fixed sum assured upon happening of the events, i.e. upon life assured contracting illness and hospitalisation.

While considering health insurance, both indemnity based policies and Critical illness covers complement each other and both would be required to complete the health insurance coverage requirements.

Health insurance is available as individual policies which can be purchased by any individual directly for himself and family. Alternatively, if the individual is working in say a Company which purchases a Group Medclaim Policy covering all its employees and dependents, benefits can be availed under such Group Insurance Policy as well.

Under Individual health insurance policy, hospitalisation expenses of an individual are covered. A health insurance policy is a contract between an insurance company and an individual in which the insurance company

agrees to provide health insurance cover at a premium pre-fixed by the insurance company on the basis of age and medical conditions of the individual.

Coverage is provided for the expenses incurred by the insured for hospitalisation for illness/diseases or injury sustained (domiciliary hospitalisation also payable). These include hospital charges (room, boarding & operation theatre), fees for surgeon, An aesthetist Nursing, Specialist etc., Diagnostic tests, cost of medicines, blood, oxygen etc., cost of appliances like pacemaker, artificial limbs etc. Illness/ disease, accidental injury sustained leading to one or more class of expenses listed above is normally covered.

Following are the category of benefits payable under an indemnity based hospitalisation expenses policy (medi-claim policies):

- (a) Actual hospitalisation expenses of various types as covered by the policy up to a maximum sum assured chosen at the inception of the policy
- (b) Actual domiciliary hospitalisation expenses limited up to a specified amount depending upon the amount chosen at inception
- (c) Cost of health check-up reimbursable usually at the end of 4 continuous claim free underwriting years limited to 1% of average sum incurred in the 4 claim free years
- (d) Sum insured may be increased by 5% cumulative bonus for every claim free year. If there is a claim in a policy with cumulative bonus 10% of the sum insured will be reduced from the earned bonus.

Family floater health insurance

Family floater health insurance policy is a policy wherein entire family is covered under single Sum Insured. The Policy covers reimbursement of hospitalisation expenses for illness/diseases contracted or injury sustained by the insured person. In the event of any claim becoming admissible under the policy, the Company either pay directly to the insured if TPA service is not availed by the insured or pay to the hospital/nursing home through TPA the amount of such expenses subject to limits as would fall under different heads. There are limits applicable for Room& Boarding expenses, Surgeon, Anaesthetist, Medical Practitioner Fees, Nursing Expenses etc.

Exclusions

Exclusions under Medical insurance policies are scenarios when the Benefits are not payable.

Usually all injuries/diseases which are pre-existing on the date of purchasing the policy are not covered. However, there are exceptions under Group Mediclaim policies where, upon payment of extra premiums, pre-existing illnesses may be covered. Otherwise, under individual health policies, in order to rule out the moral hazard, usually after 3 continuous renewals of the Policies, pre-existing illnesses are covered.

IRDAI have provided a standard list of definitions for various illnesses which shall be used by all insurance companies in their Policy contracts. They have also given the exclusions which can be imposed by insurance companies.

For example, in the case of liver failure, Liver failure secondary to alcohol or drug abuse can be excluded. Similarly loss of limbs due to self-inflicted injury is excluded.

IRDAI have also published list of medical conditions for which optional covers may be provided, such as Hair removal cream, Baby charges, cost of spectacles etc.

Hospital cash

The Policy comes in handy when the family goes through the trauma of a loved one being hospitalised as well as an increased financial burden. There are hospitalisation expenses, doctors' fees and various tests to be carried out. Meanwhile, the patient loses out on his earning for being away from work and a dismayed and worried family beings to feel the anxiety of the financial implications. It provides cash benefits for each and every completed ay of hospitalisation. Day for this purpose shall be every completed 24 hours of hospitalisation. However, period less than 24 hours shall be considered as a day if it is a period of 12 hours but includes 0300 hours.

Critical illness

Critical illness plan offers insurance against the risk of serious illness in much the same way as one insurers a car and a house. It gives the same security of knowing that a guaranteed cash sum will be paid if the unexpected event happens and the individual is diagnosed with a critical illness.

A critical illness insurance policy covers some of the critical illnesses like Cancer, Coronary Artery bypass surgery, First heart attack, Kidney failure, Multiple Sclerosis, Major organ transplant, Stroke etc.

Usually a survival period of 30 days is imposed

Travel & Overseas Medical insurance

This is a policy which covers insurance need of a person going abroad on a holiday, business tour or for education. The basic coverage is accidental and medical risk apart from other features. The other coverages available include Medical cover, daily allowance in case of hospitalisation, dental treatment , repatriation of remains, checked baggage loss, checked baggage delay, Personal accident, Personal liability, Financial emergency assistance, Hijack Distress Allowance, Trip cancellation and interruption, Missed connecting flights, Trip delays etc.

Disability insurance

Individual disability income insurance pays the benefits if an individual cannot work because of sickness or injury. Individual policies specify how much will be paid, how soon the disability benefits will begin and when benefits will end. The length of time for which an individual may receive benefits can depend on whether the accident or illness caused the disability. Monthly benefits are payable for a fixed period set forth in the Policy document.

Disability insurance is aimed to support the Policyholder when he faces stoppage of income due to sudden disabilities. Under such circumstances, the family requires income for minimum sustenance such as monthly expenses, payment of EMIs etc. Thus, Disability insurance becomes handy under such circumstances.

Personal accident & Disability insurance

Personal accident and disability insurance replaces income an individual loses if he has a long-term illness or injury and cannot work. It compensates individual against death, loss of limbs, loss of eyesight and permanent total disablement, permanent partial disablement and temporary total disablement. This is an important type of coverage for working-age people to consider. Disability insurance does not cover the cost of rehabilitation if one is injured.

Accident means any sudden, unintended and fortuitous external and visible event, which might cause bodily injury or which leads to a physical disability or death.

Dismemberment means loss of or loss of use of specified members of the body resulting from accidental bodily injury.

Permanent partial disability is a condition of doctor-certified total and continuous loss or impairment of a bodily part or sensory organ specified.

Permanent total disability is a Doctor-certified disablement which entirely prevents an individual from engaging in usual occupation or employment or any other occupation or employment for which he/she is suited by reason of education, training, experience or skill or it not employed, from engaging in any every occupation for the remainder of their life.

Temporary total disablement is a Doctor-certified inability to engage in usual occupation or employment for specified period of time.

The coverage is usually offered on a world-wide basis.

PENSIONS AND ANNUITIES

The word pension always makes us remember of a post-retirement income. Our Parents and Grand-parents used to get pensions for their service in the Government for their life-time. Pension is a benefit provided by usually the Government-employers as a gesture of the good services provided by the employees during their active employment.

However, with the establishment of Pension Funds Development Regulatory and Development Authority, the need and awareness of creating Pension fund for Private sector employees and self-occupied persons also has assumed importance.

With the advent of researches and remedies for almost all illnesses, expectancy of life has increased dramatically over the last 25 to 30 years. Super Specialty hospitals in India have the best medical facilities which were available only in developed countries like US

With the increase in longevity, two important responsibilities are cast on the Government:

- An inflation adjusted income which helps an old person to survive
- Provisions for health expenses of the old age

Since only Government employees get an index linked pension, a need to save and provide for post-retirement income and insurance against hospitalisation expenses are 2 critical imperatives for an average Indian citizen. Owing to declining birth rates and longer expectancy, India's elderly are growing annually at a rate of 3.8% as against the annual average growth rate of 1.8% of the total population. Current formal pension system caters only to 12% of India's workforce, according to a study done by FICCI-KPMG. As per above study, pension reforms held the prospect of enlarging the pension market size from ₹56,100 Crores in 2002 to about ₹4,06,400 Crores by 2025. Further, as per the study, the existing Government administered pension schemes are inefficient as it caters only to a small percentage of the workforce and the pension provided under such schemes are inadequate to cover financial needs of the retirees. The need for constructing a portfolio with some exposure to equities and international markets was stressed for low risk and high returns. For a successful regulatory regime, the three corner stones of product, processes and distribution were stressed. With only LIC and few other life insurance companies active currently in the pension segment there is a huge potential for life insurance companies to expand in this segment. Even PFRDA is regulating only the pension fund management and ultimately will have to transfer the corpus to a life insurance company to provide annuities, there is a great demand for annuity service providers. Pension funds, being long term in nature, support infrastructure

investments in a big way

Challenges of an average citizen

- Low awareness – Awareness of an average Indian on the need to save for retirement is low. Need to save for post-retirement is not a priority. Money is spent on day to day expenses, fun and leisure, luxury are more. Fundamentals like the need to invest early and the power of compounding are not understood
- Aversion to Long term – Average Indian is averse to saving over a longer period. Generally not convinced of a term beyond 5 years
- Lured by high return products – Since there is a need to protect the savings for long term, a reasonable proportion of investments will have to be made in guaranteed products like debt instruments. However, the urge to earn more through equity linked investments make an average investor to put their entire money in high risk instruments for their post retirement savings – preference to save through high risk instruments than a mixture of low, medium and high risk instruments
- Undisciplined approach towards investments - an average Indian does not go to a Financial Planner and prefers to go to an agent or broker – the average financial literacy levels are low
- Absence of separate incentives - Current deduction of ₹1 lakh is for Section 80C, 80CCC and 80CCD put together. Mostly, the ₹1 lakh is exhausted by employee's contribution to PF, Principal repayment towards housing loan etc. and hardly any amount is available to encourage savings in Life insurance products.

Therefore, Pensions and annuities are two common sources of retirement. However, they are quite different with their own advantages and disadvantages. Which one is better for you will depend on your individual circumstances. For example, some people may choose a pension because they already have good retirement savings and just want the steady pay. Other people may prefer the flexibility that comes with annuities.

What Is a Pension?

A Pension is creation of a Fund for savings for your post-retirement needs by regularly and systematically contributing to the Fund during your active service. The Fund is utilised to purchase annuities for providing the post-retirement income.

An Annuity is a Life insurance policy which provides periodic, usually uniform, pay-out to the Annuitant (one who purchases the Policy) for his life-time.

With the establishment of PFRDA, any one including private company employees, self-employed persons etc. can participate in the PFRDA schemes and invest their money with the Pension Service Providers registered with PFRDA to manage your funds and grow the corpus. Upon attaining the age of superannuation, the individual can decide to commute (draw in lumpsum, if required).

Under the New Pension Scheme, individual savings are pooled into a pension fund which is invested by PFRDA regulated professional fund managers as per the approved investment guidelines of PFRDA into the diversified portfolios comprising of Government bonds, bills, corporate debentures and shares. These contributions would grow and accumulate over the years, depending on the returns earned on the investment made.

At the time of exit from New Pension Scheme upon the attainment of age of Superannuation, the subscribers may use the accumulated pension wealth under the scheme to purchase a life annuity from a PFRDA empanelled life insurance company apart from withdrawing a part of the accumulated pension wealth as lump-sum, if they

wish to.

Opening an account with New Pension Scheme provides a Permanent Retirement Account Number (PRAN) which is a unique number and it remains with the subscriber throughout his lifetime. The Scheme is structured into 2 tiers:

Tier-I account: This is a non-withdrawable permanent retirement account into which the accumulations are deposited and invested as per the option of the subscriber.

Tier-II account: This is a voluntary withdrawable account which is allowed only when there is an active Tier-I account in the name of the Subscriber. Withdrawals are permitted from this account as per the needs of the Subscriber as and when claimed.

Salient features of the New Pension Scheme

Age group

New Pension Scheme is available to all Indian citizens aged 18 to 65 years

Benefits of New Pension Scheme ('NPS')

- (a) **Low Cost** - NPS is considered to be the world's lowest cost pension scheme. Administrative charges and fund management fee are also lowest.
- (b) **Simple** - All applicant has to do is to open an account with any one of the POPs or through eNPS and get a Permanent Retirement Account Number (PRAN)
- (c) **Flexible** - Applicant can choose his/her own investment option and Pension Fund or select Auto choice to get better returns.
- (d) **Portable** - Applicant can operate an account from anywhere in the country and can pay contributions through any of the POP-SPs irrespective of the POP-SP branch with whom the applicant is registered, even if he/she changes his/her city, job etc and also make contribution through eNPS. The account can be shifted to any other sector like Government Sector, Corporate Model in case the subscriber gets the employment
- (e) **Prudentially Regulated**— Transparent investment norms, regular monitoring and performance review of funds by NPS Trust.
- (f) **Tax benefit to employees:**
- (g) Individuals who are employed and contributing to NPS would enjoy tax benefits on their own contributions as well as their employer's contribution as under: -
 - (a) **Employee's own contribution**- Eligible for tax deduction up to 10% of Salary (Basic + DA) under Section 80 CCD(1) within the overall ceiling of ₹ 1.50 lacs under Sec 80 CCE.
 - (b) **Employer's contribution** – The employee is eligible for tax deduction up to 10% of Salary (Basic + DA) contributed by employer under Sec 80 CCD(2) over and above the limit of ₹ 1.50 lacs provided under Sec 80 CCE.
- (i) **Tax benefit for self-employed:**
- (j) Eligible for tax deduction up to 10 % of gross income under Sec 80 CCD (1) with in the overall ceiling of ₹1.50 lacs under Sec 80 CCE.
- (k) Subscriber is allowed deduction in addition to the deduction allowed under Sec. 80CCD(1) for additional

contribution in his NPS account subject to maximum investment of ₹50,000/-under sec. 80CCD 1(B)

Two types of account

Tier-I account: The applicant shall contribute his/her savings for retirement into this restricted withdrawable account. This is the retirement account and applicant can claim tax benefits against the contributions made subject to the Income Tax rules in force. Minimum initial and subsequent contributions is ₹500. However, minimum contribution in a year shall not be ₹1,000 excluding charges and taxes. If the contribution is less than ₹1,000, account access may be restricted and can be reactivated by making the minimum contribution of ₹500. If the account value falls to zero, the account shall be closed.

Tier-II account: This is a voluntary savings facility. The applicant will be free to withdraw his/her savings from this account whenever he/she wishes. This is not a retirement account and applicant cannot claim any tax benefits against contributions to this account. Minimum contribution at the time of opening is ₹1,000 and all subsequent transactions ₹250. No yearly minimum contributions unlike Tier-I account.

Investment avenue options under PFRDA

Active choice

Under this choice, Subscriber will have the option to actively decide as to how his/her NPS pension wealth is to be invested in the following three options:

- Asset Class E - Investments in predominantly equity market instruments.
- Asset Class C- investments in fixed income instruments other than Government securities.
- Asset Class G - investments in Government securities.
- Asset class A: Investment in Alternative Investment Schemes including instrument like CMBS, MBS, REITS, AIFs etc.

Subscriber can choose to invest his/her entire pension wealth in C or G asset classes and up to a maximum of 50% in equity (Asset class E) and up to a maximum of 5% in asset class "A". Subscriber can also distribute his/her pension wealth across E, C, G and A asset classes, subject to such conditions as may be prescribed by PFRDA.

Auto-choice (Default choice, Life-cycle Fund)

NPS offers an easy option for those participants who do not have the required knowledge to manage their NPS investments. In case subscribers are unable/unwilling to exercise any choice as regards asset allocation, their funds will be invested in accordance with the Auto Choice option.

In this option, the investments will be made in a life-cycle fund. Here, the proportion of funds invested across three asset classes will be determined by a pre-defined portfolio (which would change as per age of subscriber), with the investment in E decreasing and in C & G increasing with the age of the subscriber.

Three Life Cycle funds are available under this Auto Choice:

- (i) LC75 – Aggressive Life Cycle Fund: In this Life Cycle Fund, the exposure in Equity Investments starts with 75% till age 35 and gradually reduces as per the age of the subscriber.
- (ii) LC50- Moderate Life Cycle Fund: In this Life Cycle Fund, the exposure in Equity Investments starts with 50% till age 35 and gradually reduces as per the age of the subscriber.

- (iii) LC 25- Conservative life cycle fund: In this Life Cycle Fund, the exposure in Equity Investments starts with 25% till age 35 and gradually reduces as per the age of the subscriber.

The default auto choice if the subscriber is not choosing any of the above option is Moderate life Cycle Fund.

Withdrawal/Exit options

A. Upon attainment of the age of 60 years:

At least 40% of the accumulated pension wealth of the subscriber needs to be utilised for purchase of annuity providing for monthly pension to the subscriber and balance is paid as lump sum payment to the subscriber. In case the total accumulated corpus is less than ₹2 Lacs, the subscriber may opt for 100% lump sum withdrawal.

However, the subscriber has the option to defer the lump sum withdrawal till the age of 70 years. Subscriber has also got the option to continue contributing up to the age of 70 years. This option is required to be exercised up to 15 days prior to completion of 60 years.

B. At any time before attaining the age of 60 years:

The subscriber may exit from NPS before attaining the age of 60 years, only if he has completed 10 years in NPS. At least 80% of the accumulated pension wealth of the subscriber needs to be utilized for purchase of annuity providing for monthly pension to the subscriber and the balance is paid as a lump sum payment to the subscriber.

In case the total accumulated corpus is less than ₹1 Lac, the subscriber may opt for 100% lumpsum withdrawal

C. Death of the subscriber:

In such an unfortunate event, option will be available to the nominee to receive 100% of the NPS pension wealth in lump sum. However, if the nominee wishes to continue with the NPS, he/she shall have to subscribe to NPS individually after following due KYC procedure

Under National Pension System, PFRDA has entrusted the responsibility of receiving, processing and settlement of all withdrawal claims made to Central Recordkeeping Agency (CRA) and CRA has created a special NPS claim processing cell (NPSCPC) for this purpose for handling all types of withdrawal claims. The CRA will monitor the performance of NPSCPC on the withdrawal processing as per the instructions provided by PFRDA in this regard. At present the NPSCPC is fully functional.

Charges under NPS

NPS offers Indian citizens a low cost option for planning their retirement. NPS perhaps is the world's lowest cost retirement savings product. Following are the charges under NPS:

Intermediary	Charge Head	Service Charge			Method of Deduction
POP	Initial Subscriber Registration	₹200			To be Collected Upfront
	Initial Contribution	0.25% of the contribution Min:			
	All Subsequent Contribution	₹20 & Max : ₹25,000			
	All Non-Financial Transaction.	₹20			
	Persistency Charges(per annum per associated account where minimum contribution of ₹1000/- received in the account)	₹50			Through cancellation of units
CRA		NCRA(NSDL)		K C R A (Karvy)	Through cancellation of units
		Existing	From 01.04.2017	Existing	
	Account Opening Charge	₹50	₹40	₹39.36	
	Annual Maintenance Charges	₹190	₹95	₹57.63	
	Per Transaction (Financial/ Non- Financial)	₹4	₹3.75	₹3.36	
Custodian	Asset maintenance (Per Annum)	0.0032% of AUM			Through adjustment in NAV
PF	Investment Management (Per Annum)	0.01% of AUM			
NPS Trust	Reimbursement of Expenses	0.01% of AUM			Through adjustment in NAV
Trustee Bank	Trustee Bank charges	No charges levied by Trustee Bank			

Service tax and other levies, as applicable, will be levied as per the existing tax laws. There are no additional CRA charges for the maintenance of Tier –II account. Also, please note that the fee structure may change from

time to time as may be decided by PFRDA.

Retirement Corpus (Accumulated Pension) under PFRDA = Contributions + Investment growth - Charges

PENSION POLICIES OF LIFE INSURANCE COMPANIES

As an alternative to PFRDA, individuals can also purchase individual Pension Policies from Life insurance companies under which the Policyholder will have to pay premiums during his/her active service and upon attainment of the age of superannuation, up to 1/3 of the corpus can be commuted (withdrawn as lump sum) and the balance is utilised to invest in a Single Premium Annuity Policy with the same insurer who has sold the Pension Policy.

Annuity Policies

Both PFRDA and Life insurance companies will have to utilise their corpus to purchase Annuity Policy only from a Life insurance company.

While building up a corpus is accumulation phase and is pure fund management and can be done by PFRDA or by a Life insurance company, Annuity service can be provided only by a Life insurance company as the benefit under Annuity Policy is payable subject to survival which is a contingency linked to human life.

Annuity is a Life insurance Policy which covers the risk of living longer as against a pure Term Policy which covers the risk of dying early.

Like Term Policy, mortality tables (which include survival rates for each age) is utilised to calculate the premiums payable under an Annuity Policy.

Further, Annuity Policy also takes care of investment risk by guaranteeing monthly annuity amounts for longer periods.

Thus Annuity Policy takes care of 2 risks: (a) Risk of living longer (Longevity risk) and (b) Risk of fall in interest rates (Investment risk)

Thus under an Annuity Policy, in consideration of a lump sum, the Life insurer undertakes to pay a periodic usually fixed and monthly amounts, to the Annuitant till he/she is alive.

TYPES OF ANNUITY

Fixed rate Annuity

A fixed rate annuity is an annuity in which the insurance company agrees to pay a guaranteed amount of annuity based on the investment for life.

A Variable Annuity means that the monthly income provided by the Policy may vary according to the actual investment experience of the insurer. Variable annuities are much like an investment in mutual funds because the variable annuities offer a collection of securities. The customer can decide how the investment will be allocated among the various choices.

Equity indexed Annuity is an annuity that earns interest that is linked to a stock or other equity index. An equity-indexed annuity is different from other fixed annuities because of the way it credits interest. Equity-linked annuities credit interest using a formula based on changes in the index to which the annuity is linked. The formula decides who the additional interest, if any, is calculated and credited.

Settlement options (Payment terms) under an Annuity Policy

Life Annuity

This is the most popular form of Annuity and under this option, the Annuitant receives a specified amount of income for his or her life, whether the period of the annuitant's life is 1 year or many years. Once the annuitant dies, there are no more payments to the state or family

Annuity Certain

Annuity Certain provides a specified amount of monthly income for a specified period of years, without consideration of any life contingency. IF an individual buys an annuity certain for 10 years, he is sure to get the annuity payments for 10 years if he is alive or if he dies during the period of 10 years, his beneficiary will receive the annuity for the residual period.

Joint Life Annuity

Joint Life Annuity is issued on 2 individuals under which payments continue in whole or in part until both individuals die. It is also called Joint Life Last Survivor Annuity.

Annuity with Return of Purchase Price

These are annuities which pay back the purchase price of the annuity after a certain period or on death as per the terms of the Policy

Increasing Annuity

Annuity increases at the rate of 1% or 2% or 3% per annum as the case may be and payable during the life of the annuitant. This is intended to take care of the increased cost of living.

Tax benefits

A Pension Policy taken from a Life insurance Company will enjoy tax benefits under Section 80CCC for the premiums paid. However, the limit is ₹1 lakh, including the deductions under Section 80C, 80CCC and 80CCD put together.

If the Pension Policy for which deduction under Section 80CCC was taken is surrendered, the Surrender value is taxable in the hands of the Policyholder.

Commuted value of Pension is tax free to the extent it is allowed to be commuted under the Policy terms and conditions (usually 1/3 of corpus is allowed to commute, i.e. taken as lump sum)

Annuity as an when received is taxable in the hands of Annuitant.

Pension works under 'EET' principle – Exempt (investment stage), Exempt (accumulation stage), Tax (Exit stage).

Takaful Insurance

Takaful insurance is specific to Islamic community. Takaful is a type of Islamic insurance, where members contribute money into a pool system in order to guarantee each other against loss or damage. Takaful-branded insurance is based on sharia, Islamic religious law, and explains how it is the responsibility of individuals to cooperate and protect each other.

The Takaful-compliant model under the Shari'ah Laws does not allow the following 3 things in insurance/ investment activities:

- (a) Uncertainty and speculation ('Gharar');
- (b) Gambling ('Maysir')
- (c) In the case of investment or fund management, interest or usury ('Riba')

In view of the above 3 reasons, conventional insurance plans are considered as against the principles laid down in Shari'ah laws.

Maisir (gambling) is regarded as the excessive side of Gharar. Whilst the participants (insured) may have an insurable interest in the subject matter, if the risk transfer (risk sharing in Takaful) contains any speculative element, it is prohibited under the Islamic Insurance concept.

Riba (interest or usury) is totally prohibited under the Shari'ah law and under a Takaful arrangement. To avoid Riba, Takaful treats participants' contribution to the risk sharing scheme not as a premium in the way conventional insurance does. In Takaful terms it is treated as being a contribution in the form of a donation with the condition of compensation. The funds secured from the participants' contributions or donations, must be managed and invested in accordance with the Shari'ah Law.

In Islam it is not the risk in human life that needs to be eliminated since this is a natural phenomenon in human life. It is the selling or exchange of risk or risk transfer to third parties using sales/exchange contracts that is not allowed. Helping each other in any situation including in the event of misfortune is highly encouraged in Islamic teaching as mentioned in the Holy Qur'an.

Models of Takaful insurance

There are several models (and several variations) of how takaful can be implemented:

- Mudharabahmodel (profit-sharing): the manager (shareholders) are sharing Profit and Losses with the policyholders; used initially in Far East
- Tabarru`-based: "donations" (Tabarru`) i.e. premiums are accumulated into a fund to meet members' losses. Members are not allowed to take back any contributions or profits from investments.
- A combination of Tabarru` and Mudharabah: Bahrain, UAE and Middle East countries;
- Wakalamodel: agency fee, received up front from the contributions and transferred to shareholders fund.
- Al Waqf-based model: Waqf is a distinct entity and legal person. According to one critic, "except for names and terms, the essence" of both Al Waqf takaful and conventional insurance is the same, and as a consequence this structure "has come under a lot of criticism from Shari'ah scholars". This model is mainly used in Pakistan and South Africa

Mudharabah model

Basically, Mudharabah is defined as a profit sharing principle applied normally to a business or commercial contract between the party that provides the fund or capital and the party that manages the business.

For takaful this would mean the contract of profit sharing between the takaful participants and the operator from the profit, if any, of the takaful business. Under this arrangement, a profit sharing contract is signed between the operator, as the entrepreneur or termed "Mudharib" entrusted with managing the takaful business and

the participant(s) as the provider of capital, called “sahibul-mal” who is obliged to pay the takaful contribution as the capital or “ra’sul-mal”. The contract will define profit of the takaful business and the ratio to be shared between the two parties such as 50:50, 60:40 or 70:30 between the participant and operator respectively. In essence, profit in takaful is defined as returns on the investment and surplus from the underwriting in respect of the takaful funds only. Therefore this does not include profit posted by the Shareholders’ Fund. For the family business it includes the mortality surplus to be allocated to the eligible participant as declared by the actuarial valuation at the end of every financial year. However, unlike the Mudharabah contract for Islamic banking product, profit sharing in takaful will be undertaken only after all the obligations of takaful have been accounted for: the biggest factor is claim. In the event of a loss or deficit of the takaful fund, the loss will be borne wholly by the participant(s) as provider of capital.

Notwithstanding the above, it is the responsibility of the operator to safeguard the interest of the participants in order to ensure the business will not be seriously affected by the loss that might jeopardise the credibility and confidence of takaful as a whole. For this reason proper governance, prudence and professionalism in managing the business on the part of the operator is imperative. In the event of such loss, it is incumbent upon the operator to make good the loss by “qard” or loan by the shareholders. An important feature to note is that under the Mudharabah model, management expenditure is not charge on the takaful fund instead it is borne by the shareholders’ fund. Revenue of the latter is its portion from the profit sharing of the takaful funds with the participants, and all returns on the investment of the shareholders fund itself.

Tabarru model

Tabarru’ is an Arabic word that means donation or gifts and this contract of Tabarru’ is introduced as the basis of takaful system whereby the participant will agree to donate certain proportion of the takaful contribution that he agrees or undertakes to pay, thus enabling him to fulfil his obligation of mutual help and joint guarantee should any of his fellow participants suffer a defined loss. The concept of Tabarru’ is selected as a fundamental contract in running insurance activities and transactions from the Islamic point of view. Without this concept of donation, the transaction will be similar to the insurance practise which required any exchange or returns as buying and selling contract. In Insurance the contract is only considered completed when the buyer hands over the money (product price) and the seller hands over the product to be sold, if not the contract is considered as illegal.

Islam provides the solution to Insurance system implementation which is following the Shariah principle. The contract of Tabarru’ is introduced as it is practical and safer. Each participant in a Takaful system allocates some or all of his contributions to be donated for the purpose of helping other participants facing calamities. It should be emphasised here that the advantages of this concept is not specifically for Muslims only but it also provides benefits to all participants regardless of their religious belief, ranks or status and it is focused on profit sharing and charity. Tabarru’ is categorised as a unilateral contract which does not require any exchange or returns that existed in exchange contract like buy and sell contract; which determine the existence of exchange between two parties involved in a contract. A person who gives donation only needs to hand over the things to be donated to the relevant parties and his contract is considered completed. In fact, there is no such thing as money loss in this situation as misinterpreted by some parties because it is the donation money. In takaful application, if there is no claims made towards what have been protected, the Tabarru’ contribution plays the role as alms that are highly regarded in Islam.

The implementation of Tabarru’ that is combined with the principle of Takaful (mutual help) created a helping each other situation. In a simple analogy, Participant A gives donation to help Participant B, while Participant B provides donation to help Participant A. This mutual help situation is called “Takaful” in which participants mutually help each other and not between participants and the provider as what happens in conventional insurance

system. Based on Tabarru' principles, the contribution made cannot be returned back to the participants. If a participant cancelled his participation in takaful, the portion channelled to Risk Fund will not be returned. However, the participant has the right to get back his balance in Personal Risk Investment Account ('PRIA').

For instance, under Takaful Ikhlas Model, each participant has promised to provide monthly contribution (al Iltizam bi al Tabarru') into the Risk Fund. In this model, participants' contribution will be placed in an account such as Personal Risk Investment Account (PRIA) which is owned by the participants. Participants have promised to provide the donation, allowed Takaful Ikhlas to take certain amount from PRIA which is the amount needed to help participants facing calamity to be dripped each month into the Risk Fund. Each participant will mutually help each other when some of them are burdened by calamity.

Tabarru' is one of the pious acts which are really urged by Islam. Besides the obligatory alms known as charity, the practice of giving out voluntary alms is highly regarded in Islam and the practice of giving out alms is guaranteed with enormous rewards by Allah. The practice of tabarru' in Takaful system is considered as a first class tabarru' because it is done sincerely, such that a person's left hand does not know what his right hand has given and it was based on spirit of thinking brotherhood. The participants will enjoy both world and the hereafter rewards simultaneously and these are among the benefits and beauty of takaful system which the conventional insurance system lacked.

Wakala model

The term *wakalah* in Arabic means agency. Therefore under the structure, an agency relationship is agreed between two parties to conduct a certain business undertaking. Based on this premise, the model describes an agency agreement between the operators, acting as the agent or "*wakil*" to the participant as the principal to manage the participation of the latter in a variety of takaful products provided by the operator. In return for rendering the agency services, the operator is permitted to charge a fee under the agreement. The fee is payable from the takaful contribution paid by the participant. In this sense under the above model, management expenditure can be charged to the takaful fund as upfront charges. By this model, the operator earns its revenue from the agency fee described in the aforementioned as well as returns on the investment of its shareholders' fund. However, there are also operators practising the above model who charged performance fees on its roles and services of managing the investment of the takaful fund. In the event of a cancellation or surrender, the participant will be refunded of the net balance of his contribution, if any, after deducting all the upfront charges such the *wakalah* fees and other management expenses from the takaful fund.

AI-Wakf based model

The term *waqf* referred for this model explains the contract of takaful that underlines the agreement or consent of the participant that the takaful contribution paid in return for participating in the takaful product to be credited by the operator into the takaful fund in accordance with the principle of *waqf* or endowment. To begin with, a waqf account has to be established by the operator within the takaful fund. To this effect the operator is required to relinquish some kind of "seed" money as *waqf* to generate the said *waqf* account. This *waqf* account of the takaful fund will be invested similar to the three business models hereinbefore. The *Waqf* fund shall work to achieve the following objectives:

- (a) To extend financial assistance to its members in the event of losses
- (b) To extend benefits to its members strictly in accordance with the Waqf Deed.

All the expenses related to the underwriting and operational cost of takaful shall be charged to the *Waqf* fund. As manager, the takaful operator will perform all functions necessary for the operations of the *Waqf* against a

Wakala fee to be deducted from the contribution paid by the participants. As *Mudarib*, the operator will manage the investment of the takaful fund including its *Waqf* account in *Shariah*-compliant investment avenues and will share its returns on the investment at an agreed ratio similar to the profit sharing structure under the *Mudarabah* contract.

It is important to note the different principles of *Sharia* used in the takaful contract to express the consent of the participants for their contributions to be credited into the takaful fund for the purpose of undertaking the concept of joint guarantee as encapsulated in the term takaful. In contrast to the *Waqf* model, the other three models applied the principle of *tabarru* to the contract.

It is a basic feature of the model below that the *Waqf* Fund will lay down the rules for distribution of its proceeds to the beneficiaries and will determine how much compensation be paid out to a participant. In addition, the *Waqf* will be the owner of the contributions and has the right to act as a legal entity and dealing with its surplus. The operator, whilst managing the *Waqf* Fund, will assume two different functions at the same time – manager and *Mudarib* or entrepreneur.

LESSON ROUND UP

- Financial planning is the process of identifying a person’s financial goals, evaluating existing resources and designing the financial strategies that help the person to achieve those goals.
- Financial planning can achieve the following for the clients: Organise their finances, Improve their Cash flow, Lower their personal income taxes, Plan for their retirement, Plan for their other life goals like Children’s Education, Improve their Investment performance and lower their investment risk, Optimum Insurance planning and Reduce their Insurance cost, Minimise their estate settlement costs
- The role of the Financial planner is just not to suggest the investment schemes that may make them rich. Rather, is to, Evaluate and study the client’s needs; Gather and analyse data; and preparation and implementation of financial plan.
- Financial goals are the milestones that the client hopes to reach with the help of their financial resources. The practitioner while setting goals must educate the client the difference between Need and want.
- The Financial plan is the result of long process of probing, information collecting, interpretation and synthesis. Many a times, the recommendations need to be fine-tuned before the client fully agrees to implement the plan.
- The final step in the financial planning process is periodic monitoring of the plan. Some events that may cause change in the financial goals of a client are: Changes in the marital status, Birth / Death, Disability or illness, Loss or changes of employment or changes in the income statement
- Budget is working document and need to be revised every month. All the family members need to be involved while preparing the budget. Budgeting helps to get rid from unwanted spending. This increase the income that can be either invested or utilised for debt management
- Building Emergency fund is a financial priority. None of us have the ability to predict the hurdles which lie ahead of us. There can be various crisis like we become ill or disabled, loss of job, unexpected medical emergencies, major home repair. Without emergency fund we may be forced to take a loan or incur credit card debt which could take many years to pay off the debt. Interest cost will be more.
- Practitioners must be able to conduct appropriate analysis for clients to provide a best financial

advice. Ratios helps in evaluating Client's financial health. Ratios helps to determine credit rating. The most commonly used personal finance ratios are Liquidity, Debt, Risk Exposure, Tax Burden, Inflation Protection and Net Worth, Savings.

- Sharpe Ratio is a risk-adjusted measure developed by William F. Sharpe. $((R_p - R_f) / SD \text{ of portfolio})$ where, R_p = Return of portfolio, R_f – Return on Risk free security, SD – Standard Deviation of the portfolio
- In the process of wealth creation, a person would be very keen on the return on investment. The 2 important and significant factors which erode the wealth are Inflation and Taxation.
- The residential status of the assess is determined in respect of each previous year depending on the number of days the assessee was staying in India. Subject to certain provisions of I.T. Act, 1961, Assesseees are classified as Resident & Ordinarily Resident, Resident but not ordinarily Resident, and Non-Resident. Certain incomes are not taxable for some of the categories.
- Risk is uncertainty regarding occurrence of loss, deviation from expected outcome. There are 2 types of risks – Objective and Subjective risks
- Contingent loss is a loss that may be suffered by a party who is dependent upon the activities of another party owning or operating the property that is damaged. For example, if a major supplier's facility is damaged, individual may lose income or incur additional expenses as a result of the storm.
- Liability risk arises because of losses caused by injuries to persons or liability for injuries to persons or damage to property of others. Workers Compensation, General liability, Auto and similar losses are considered casualty losses inviting liability of the person responsible.
- NPS offers an easy option for those participants who do not have the required knowledge to manage their NPS investments. In case subscribers are unable/unwilling to exercise any choice as regards asset allocation, their funds will be invested in accordance with the Auto Choice option.
- Takaful insurance is specific to Islamic community. Takaful is a type of Islamic insurance, where members contribute money into a pool system in order to guarantee each other against loss or damage. Takaful-branded insurance is based on sharia, Islamic religious law, and explains how it is the responsibility of individuals to cooperate and protect each other.

GLOSSARY

CashFlow: Cashflow refers to the inflow and outflow of money. It is a record of income and expenses

Financial Planning: "Financial planning is the process of meeting life goals through the proper management of finances". Life goals can include buying a home, Children's education or planning for retirement.

Risk Tolerance level: Testing clients risk appetite.

Time horizon: The time period that the client willing to invest

Liquidity concerns: The number of days that the Client can live with income

Income tax consequences: The client's eligibility to avail the different classes of investment to avail the income tax benefits

Budget : A budget is a plan for how you intend to spend your money during the coming month or year, based on details of your income statement and balance sheet for the past month or year.

Risk Exposure: This ratio measures how adequately are financial risks covered. Adequate property and liability protection, Adequate life protection, Current cash flow derived from the salary.

Net Worth Growth Ratio: This ratio indicates the percentage growth of the Individual's Net Worth over a period of time.

Payback Period: The length of time it takes to recover the initial cost of project.

Dividend Yield: Dividend yield is a way to measure how much cash flow an investor is getting for each rupee invested in an equity.

Alpha: Alpha is a coefficient which measure risk – adjusted performances

Beta: Beta is the measure of an asset risk in relation to the market.

Duration: Duration means the change in the value of fixed income security that will result from a 1% change in interest rates

Investment Planning: The gap between the current financial situation and future financial goals is essentially bridged by effective investment planning.

Hedging: It is a strategy used to offset investment risk; the perfect hedge eliminates the possibility of future losses.

Estate planning: The concept of estate planning can be defined as the process of making proper arrangements for the protection, preservation and provision of person's total assets for the benefit of his or her family or loved ones.

Pension: A Pension is creation of a Fund for savings for your post-retirement needs by regularly and systematically contributing to the Fund during your active service.

SELF TEST QUESTIONS

These are meant for re-capitulation only. Answers to these questions are not to be submitted for evaluation.

1. Insurance plays as an important role in financial planning as a tool for asset protection and also for tax efficient investment. Explain
2. As a client manager explain the investment process and risk-return analysis to your client in detail.
3. As a financial planner, how will you do the retirement planning of your client. Explain in detail.
4. What are the various goals of estate planning? Who needs an estate plan? Explain the tools of Estate planning.
5. What do you mean by Takaful Insurance? Explain the different models of Takaful Insurance.
6. What are the components of financial planning
7. How the risk is managed during insurance planning?
8. Explain the risk management process?

FURTHER READINGS:

1. K.S.N. Murthy, K.V.S. Sarma, 2013, Modern Law Of Insurance In India, Fifth Edition, Published By Lexis Nexis

Lesson 6

Life Insurance – Finance

LESSON OUTLINE

- Introduction
- Financial Statements and Compliance with Accounting Standard
- Filling of Financial Statements with IRDAI
- Accounting Disclosure Requirements
- Final Accounts/Financial Statements of Life Insurance Co.
- Final Accounts/Financial Statements of Non-Life Insurance Co.
- Investments by Insurance Co.
- Guidelines for preparation of Financial Statements
- Guidelines for Recognition of Claims
- Expenses of Management for Life Insurance Co.
- Guidelines on Prudential Norms for Income Recognition, Asset Classification, Provisioning and Other Matters
- Additional Disclosures in Financial Statements
- Taxation Aspects of Life Insurance Companies
- Goods & Services Tax
- Anti-Money Laundering Guidelines and PML Act
- Compliance with IFRS
- LESSON ROUND UP
- SELF TEST QUESTIONS

LEARNING OBJECTIVES

Section 129 of the Indian Companies Act, 2013 requires every Company to prepare Financial statements which give a true and fair view of the financial position of the Company in accordance with the Accounting Standards and in accordance with Schedule III to the said Act. However, by virtue of the second Proviso to Section 129(1), Financial statements of Insurance companies are governed by the Regulations passed by IRDAI under the powers with it vested Insurance Act, 1938. Special formats of Financial statements for Life insurance companies. Section 40 of the Insurance Act, 1938 empowers IRDAI to frame Regulations on Expenses of Management for Insurance companies. Life Insurers shall prepare Financial Statements as per specified Forms such as Revenue Account (Form A-RA), Profit and Loss Account (Form A-PL) and Balance Sheet (Form A-BS) as per Part V in Schedule A of Regulation III. The said financial statements will be prepared in accordance with General Instructions for preparations as per Part III. The said financial statements shall be supported by disclosures forming part of financial statements and the comments of management report as per Part II and Part IV respectively, of the Schedule A.

INTRODUCTION

Section 129 of the Indian Companies Act, 2013 requires every Company to prepare Financial Statements which give a true and fair view of the financial position of the Company in accordance with the Accounting Standards and in accordance with Schedule III to the said Act. However, by virtue of the second Proviso to Section 129(1), Financial Statements of Insurance companies are governed by the Regulations passed by IRDAI under the powers with it vested Insurance Act, 1938.

Section 11(1A) of the Insurance Act, 1938, requires every Insurance company to prepare a Revenue Account, Profit and loss account, a Balance Sheet and Receipts & Payments account on a Financial year basis, as per Regulations to be framed by IRDAI from time to time.

Accordingly, IRDAI have provided for special formats for Financial Statements and governing rules thereunder, in the form of IRDAI (Preparation of Financial Statements and Auditors Report of Insurance Companies) Regulations, 2002, as amended from time to time.

Special formats of Financial Statements for Life insurance companies.

Every life insurance company shall comply with Schedule A to the IRDAI (Preparation of Financial Statements and Auditors Report of Insurance Companies) Regulations, 2002, as amended from time to time

Financial Statements and Compliance with Accounting Standards

As per Section 129 of the Companies Act, the Financial Statements of any Company shall give a true and fair view and shall comply with the Accounting Standards as notified under Section 133 of the Companies Act, 2013. Under Section 133 of the said Act, the Central Government have prescribed the Accounting Standards of the Institute of Chartered Accountants of India for compliance with Accounting Standards as specified in Section 129.

IRDAI have also made the Accounting Standards as mentioned above as applicable to Life insurance business, except that:

- (i) Cash flow statement (under AS-3) shall be prepared only as per Direct method
- (ii) Segmental Reporting (under AS-17) shall be applicable to all Life insurance companies irrespective of the Turnover or listing requirements as mentioned in the Accounting standard
- (iii) Accounting Standard 13-Accounting for Investment shall not be applicable

Section 2C of the Regulation provides that all words and expressions used herein and not defined in the Insurance Act, 1938 or in the IRDA Act, 1999 or in the Companies Act, 2013 shall have the meanings respectively assigned to those Acts. However, regulatory provisions prescribed by the IRDA and the specific and relevant Accounting Standards promulgated by the Institute of Chartered Accountants of India are being separately discussed in detail in subsequent units.

Financial Statements of insurance companies comprise the following as stated earlier:

- Balance Sheet,
- Revenue Accounts,
- Profit and Loss Account, and
- Receipts and Payments Account.

Besides the Financial Statements, the annual reports of an insurance company also contain the following

statutory documents for the review and analysis of the various interested groups including shareholders, policyholders, regulators, reinsurers, employees, co-insurers, etc.

1. Report of the board of directors
2. Management report
3. Auditors report
4. Segment reporting
5. Significant accounting policies
6. Notes and disclosures forming part of accounts

Let us now discuss the above Financial Statements and reports with reference to legal requirements, accepted principles and practices with a few examples and exercises. Certain examples with hypothetical data are also given in Annexure for clarity of understanding of students in respect of Financial Statements

Directors' Report: legal Requirement as Regards Directors' Report (Companies Act 2013)

As per provisions of the Companies Act, 2013 there shall be attached to every balance sheet laid before a company general meeting a report by its Board of Directors with respect to following particulars:

- The state of affairs of the company.
- The amounts, if any, which it proposes to carry to any reserve in balance sheet.
- The amount, if any, which it recommends, should be paid by way of dividend.
- The material changes and commitments, if any, affecting the financial position of the company, which have occurred between the end of the financial year of the company to which the balance relates and the date of the report.
- The technology absorption, foreign exchange earnings and outgo and the manners thereof.
- The material changes, if occurred during the financial year in respect of the nature and class of business of the company or its subsidiary.
- The statement showing the name of every employee of the company who, if employed throughout the financial year, was in receipt of remuneration for that year, which in the aggregate was not less than ₹24,00,000 per annum or if employed for a part of the financial year was not less than ₹2,00,000 per month. Such state shall also indicate that whether any such employee is a relative of any director or manager of the company.
- The Directors' Responsibility Statement must mention that
 - (a) In the preparation of the annual accounts, the applicable accounting standards have been followed along with proper explanations relating to material departure,
 - (b) The directors had selected such accounting policies and applied them consistently,
 - (c) The results and estimates are reasonable and prudent so as to give a true and fair view of the state of affairs of the company at the end of the financial year and of the profit or loss of the company for that period,
 - (d) That the directors had taken proper and sufficient care for the maintenance of adequate accounting records in accordance with the provisions of the Companies Act, 1956 for safeguarding the assets

of the company and for preventing and detecting frauds and other irregularities and that the directors had prepared the annual accounts on a going concern basis.

- The reasons for the failure, if any, to complete the buy back within the time specified in Section 77 A of the Act.
- The fullest and explanations on every reservation, qualification or adverse remarks contained in the auditors' report.

Common Disclosures in Directors' Report Contained in the Annual Report of a General Insurance Company

Director report of an insurance company generally furnishes the following information specifically as per the above requirements of the Companies Act, 2013:

1. Comparative Performance Analysis (Class-wise Underwriting Performance) for the financial year under report with reference to previous year) as appended in Annexure A.2 showing performance analysis of XYZ General Insurance Co. Ltd. in respect of the following performance review for FY.
 - Gross direct premium and percentage of growth over previous year
 - Reinsurance premium ceded
 - Reinsurance accepted
 - Net premium and percentage of growth over previous year
 - Increase in unexpired risks reserve and percentage to net premium
 - Net premium earned
 - Net incurred claims and percentage to net premium
 - Others
2. Review of accounts as an annexure to accounts.
3. Profit before tax and after tax.
4. Proposed dividend.
5. General reserves and current year transfer of profit to that reserve.
6. Total assets and the contribution of increase of fair value change account.
7. Total investments, its composition/portfolio, its increase over the last year.
8. Solvency margin and its change over the previous year.
9. Compliance with Section 40C in regard to prescribed % of expenses.

Filing of Audited Financial Statements with IRDAI

With a view to facilitate the process of review of the audited accounts and statements of the insurers referred to under section 11 or section 13(5) of Insurance Act, 1938 and the Regulations, insurers have been directed to file the Financial Statements together with the Auditors Report within 15 days from the date of adoption of accounts by the Board. Further, it is preferable that the returns prescribed are filed in the normal course within a period of thirty days of the adoption by the shareholders and in any case within six months from the end of the period to which they refer, whichever is earlier.

Expenses of Management for Life insurance companies

Section 40 of the Insurance Act, 1938 empowers IRDAI to frame Regulations on Expenses of Management for Insurance companies.

Under these provisions, Insurance companies are required to contain their expenses of running insurance business within certain ceilings which are calculated as a percentage to the Premium income generated by the Insurance company.

It is like restricting one's spend as a percentage to what one earns as income – a method to rationalise spending by insurance companies, as over spending is not in the best interests of Policyholders as well as Shareholders.

IRDAI have notified Regulations named IRDAI (Expenses of Management for insurers transacting Life Insurance Business) Regulations 2016 ('EOM Regulations'). Primarily these Regulations prescribe calculation of maximum expenses of management as a percentage of premium as follows, depending on the type of business and year of receipt of premium.

Typically for longer term policies, the allowances are more. In respect of Life insurance companies which have are more than 10 years of age from inception, Policies which carry terms exceeding 10 premium paying years get the maximum ceiling of 80% of First year's premium and 15% of Renewal premiums (premiums payable from second year onwards). Higher ceilings are applicable for Companies up to 10 years of age from inception. Different ceilings are applicable for Group insurance companies.

For the first 10 years of operations, Life insurance companies which are not compliant with the ceilings may be given forbearance (excused from compliance), based on a representation made to IRDAI by the Life insurance company, based on the recommendations of Life Insurance Council (the industry body which represents the interests of Life insurance companies). However beyond 10 years, the insurance companies shall charge the amount spent in excess of the ceilings in Shareholders' Account instead of Policyholders' account. Further, beyond 10 years, Life insurance companies may also face regulatory action for non-compliance.

Further, the compliance with the ceilings on expenses of management will have to be ensured on a segmental basis. Segments are lines of business for a life insurance company, which are as follows:

- (a) Linked Policies:
 - (i) Life
 - (ii) General Annuity & Pension
 - (iii) Health
 - (iv) Variable Life insurance products
- (b) Non-linked Policies:
 - (i) Non-participating Policies:
 - I. Life
 - II. General Annuity & Pension
 - III. Health
 - IV. Variable Life insurance products
 - (ii) Participating Policies:

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- I. IFE
- II. General Annuity & Pension
- III. Health
- IV. Variable Life insurance products

Variable Life insurance shall further be segregated into Life, General Annuity & Pension and Health, if the Variable Life insurance segment contributes more than 10% or more of the total Premium income of the Life Insurance Company

Under each of the above segment, compliance with the ceilings on expenses will have to be demonstrated, in addition to the compliance with the ceilings at the Company level.

For the purpose of allocating Expenses of management amongst various lines of business, the Board of Directors of the Life Insurance Company shall frame a Policy on allocation of Expenses of management amongst various lines of businesses mentioned above. All expenses shall be allocated as per such Board-approved-Policy only. It is the responsibility of Chief Financial Officer and Appointed Actuary of the Life Insurance Company to ensure compliance with allocation of expenses to various lines of business in line with the Board-approved Policy.

Every insurer transacting life insurance business in India shall furnish to the Authority, the Return on Expenses of Management as prescribed under Schedule II to the EOM Regulations, duly signed by the Chief Executive Officer, Chief Financial Officer and Chief Compliance Officer of the Company. Further, the Statutory Auditors of the Company shall also confirm, as per the format prescribed in Schedule III to the EOM Regulations, that the allocation of expenses amongst various lines of business have been carried out in accordance with the Board approved Policy on Expenses of Management and that the expenses of management have been computed in the Return under Schedule II in accordance with the EOM Regulations.

The above Returns shall be filed along with the Financial Statements within a period of 6 months from the end of each Financial year.

A status report on compliance with Corporate Governance Guidelines issued by the Authority shall be filed in the prescribed form at within 90 days of the end of the financial year or within 15 days of adoption of account by the Board of Directors, whichever is earlier. A certificate from Compliance Officer that insurer has complied with the guidelines must also be filed with the Annual Report.

Further the format of the summary of the financial statement for the last five years and the standardised analytical ratios are required to be furnished by life insurance companies.

A Management Report shall be attached to the Annual Financial Statements, duly authenticated by the management. The report shall contain all the confirmations/certifications/declarations as stipulated in Part IV of Schedule A of the IRDA(Preparation of Financial Statements and Auditors' Report of Insurance Companies), 2002.

ACCOUNTING AND DISCLOSURE REQUIREMENTS

Segment Reporting

As per the Regulations, separate Financial Statements –Revenue Account and Balance Sheet, are required to be prepared for participating and non-participating policies, and linked and non-linked business. Further, for non-linked business, separate statements are required for ordinary life, general annuity, pension and health insurance. A separate segment for Variable Insurance Products (VIPs) shall also be included under the Non-

Unit-Linked category.

IRDAI requires the segments to be reported on the basis of line of business, and on the basis of business within and outside India. While providing the segment details, previous year’s figures should also be given for all the segments.

Insurers can lay down Accounting Policies in line with the Accounting Standard-17 and the Regulations issued by the Authority in this regard, and consistently follow the Policies.

Separate Balance Sheets need to be prepared for each business segment

Cash Flow Statement

All insurers are required to furnish the cash flow statement as per the Direct Method as specified in the Regulations.

Value of investments as at the Balance Sheet Date

Attention is drawn to Clause 6(c), Part I, Schedule A of the Regulations, which provides that listed equity securities and derivative instruments that are traded in the active markets shall be measured at fair value on the balance sheet date. Measurement for the purpose of calculation of fair value shall be the closing price on the last business day of the year on the Primary Exchange. The Investment Committee of the Life insurance company shall select from NSE and BSE as the Primary and Secondary Exchange, and the valuation shall be made at the closing price of the Primary Exchange as selected. If a security is not listed or traded on the Primary Exchange, the insurance company shall use the closing price on the Secondary Exchange.

Financial Statements for life Insurers

Life Insurers shall prepare Financial Statements as per specified Forms such as Revenue Account (Form A-RA), Profit and Loss Account (Form A-PL) and Balance Sheet (Form A-BS) as per Part V in Schedule A of Regulation III. The said Financial Statements will be prepared in accordance with General Instructions for preparations as per Part III. The said Financial Statements shall be supported by disclosures forming part of Financial Statements and the comments of management report as per Part II and Part IV respectively, of the Schedule A. The specified forms of Financial Statements are given hereinafter as ready reference.

Form A-BS

Balance Sheet of Life Insurance Company

Particulars	Schedule No.	Current Year	Previous Year
SOURCES OF FUNDS			
Shareholders’ Funds:			
Share capital			
Reserves and surplus			
Credit/debit fair value change account			
Sub-total			
Borrowings			
Policyholders’ Funds:			
Credit/debit fair value change account			
Policy liabilities			

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Insurance reserves			
Provision for linked liabilities			
Sub-total			
Funds for Future Appropriations			
Total (Sources of Funds)			
APPLICATION OF FUNDS			
Investments			
Shareholders'			
Policyholders'			
Assets Held to Cover linked liabilities			
loans			
Fixed Assets			
Current Assets			
Cash & bank balances			
Advances and other assets			
Sub-total(A)			
Current liabilities			
Provisions			
Sub-total(B)			
Net Current Assets (C) = (A-B)			
Miscellaneous Expenditure(not written off)			
Debit BalanceinProfit & loss Account			
(Shareholders' account)			
Total (application of funds)			

Form A-RA

Revenue Account of Life Insurance Company

Policyholder's Account

Particulars	Schedule No.	Current Year	Previous Year
Premiums Earned-(Net)			
(a) Premium	1		
(b) Reinsurance ceded			
(c) Reinsurance accepted			
Income from Investments			
(a) Interest, dividends & rent-(Gross)			
(b) Profit on sale/redemption of investments			
(c) Loss on sale/redemption of investments			

(d) Transfer/Gain on revaluation/change in fair value*			
Other Income (to be Specified)			
TOTAL (A)			
Commission	2		
Operating Expenses Related to Insurance Business	3		
Provision for Doubt full Debts			
Bad debts written off			
Provision for Tax			
Provisions (other than taxation)			
(a) For diminution in the value of Investment (Net)			
(b) Others (to be specified)			
TOTAL (B)			
Benefits Paid (Net)	4		
Interim Bonuses Paid			
Change in Valuation of liability in Respect of life Policies			
(a) Gross			
(b) Amount ceded in reinsurance			
(c) Amount accepted in reinsurance			
TOTAL (C)			
Surplus/Deficit (D) = (A)-(B)-(C)			
APPROPRIATIONS			
Transfer to Shareholders' Account			
Transfer to Other Reserves (to be Specified)			
Balance Being Funds for Future Appropriations			
TOTAL (D)			

The above Financial Statements are to be prepared in accordance with applicable accounting standard issued by ICAI .These Financial Statements will be supported by specified schedules giving the required details as per regulations.

Disclosures forming part of Financial Statements (Life Insurer) Part II

A. The following shall be disclosed by way of notes to the balance sheet:

1. Contingent liabilities:
 - Partly-paid up investments

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- Underwriting commitments outstanding
 - Claims, other than those under policies, not acknowledged as debts
 - Guarantees given by or on behalf of the company
 - Statutory demands/liabilities in dispute, not provided for
 - Reinsurance Obligations to the extent not provided for ill accounts
 - Others (to be specified).
2. Actuarial assumptions for valuation of liabilities for life policies in force.
 3. Encumbrances to assets of the company in and outside India.
 4. Commitments made and outstanding for Loans, Investments and Fixed Assets.
 5. Basis of amortization of debt securities.
 6. Claims registered and remaining unpaid for a period of more than six months as on the balance sheet date.
 7. Value of contracts in relation to investments, for:
 - Purchases where deliveries are pending;
 - Sales where payments are overdue.
 8. Operating expenses relating to insurance business: basis of allocation of expenditure to various segments of business.
 9. Computation of managerial remuneration.
 10. Historical costs of those investments valued on fair value basis.
 11. Basis of revaluation of investment property.

B. Following accounting policies shall form an integral part of the Financial Statements:

1. All significant accounting policies in terms of the accounting standards issued by the ICAI, and significant principles and policies given in Part I of Accounting Principles. Any other accounting policies, followed by the insurer, shall be stated in the manner required under Accounting Standard AS 1 issued by the ICAL.
2. Any departure from the accounting policies shall be separately disclosed with reasons for such departure.

C. The following information shall also be disclosed:

1. Investments made in accordance with any statutory requirement together with its amount, nature, security and any special rights in and outside India;
2. Segregation into performing/non performing investments for income recognition.

Assets to the extent required to be deposited under local laws Percentage of business sector-wise;

A summary of Financial Statements for the last five years, in the manner as may be prescribed by the Authority;

Bases of allocation of investments and income thereon between Policyholders' Account and Shareholders' Account;

Accounting Ratios as may be prescribed by the Authority.

Example

Financial Statements for non-life Insurance

Non-life Insurers shall prepare Financial Statements as per specified Forms such as Revenue Account (Form A-RA), Profit and Loss Account (Form A-PL) and Balance Sheet (Form A-BS) as per Part V in Schedule B of Regulation 3. The said Financial Statements will be prepared in accordance with General Instructions for preparations as per Part III. The said Financial Statements shall be supported by disclosures forming part of Financial Statements and the comments of management report as per Part II and Part IV respectively, of the Schedule B.

The specified forms of Financial Statements are given hereinafter as ready reference for the purpose of necessary discussion and analytical study for financial management based on insurance accounting.

Form B-BS

Balance Sheet: Non-Life Insurer

Particulars		Schedule No.	Current Year	Previous Year
SOURCES OF FUNDS				
Share capital		5		
Reserves and surplus		6		
Fair value change account				
Borrowings		7		
	TOTAL			
APPLICATION OF FUNDS				
Investments		8		
Loans		9		
Fixed assets		10		
Current Assets				
Cash and bank balances		11		
Advances and other assets		12		
	Sub-total (A)			
Current Liabilities		13		
Provisions		14		
	Sub-total (B)			
Net Current Assets (C) = (A - B)				
Miscellaneous Expenditure (not written off)		15		
Debit Balance in pal Account				
	TOTAL			

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The above Financial Statements are to be prepared according to the general instruction for preparation of Financial Statements as specified in Part III of the IRDA Regulation. Again said Financial Statements will be supported by specific disclosure forming part of Financial Statements as specified by Part II and comments of management report specified by Part IV of Schedule B of the Regulation. It should also mention about the contingent liability in respect of the following items:

- Party paid-up investments.
- Underwriting commitments outstanding.
- Claims, other than those under policies, not acknowledged as debts.
- Guarantees given by or on behalf of the company.
- Statutory demands/liabilities in dispute not provided for.
- Reinsurance obligations to the extent not provided for in accounts.
- Others (to be specified).

Form B-RA

Non-life Revenue Account

Particulars	Schedule No.	Current Year	Previous Year
1. Premium earned (Net)	1		
2. Profit/loss on sale/redemption of investments			
3. Others (to be specified)			
4. Interest, dividend & rent (Gross)			
TOTAL (A)			
1. Claims incurred (Net)	2		
2. Commission	3		
3. Operating expenses related to insurance business	4		
TOTAL (B)			
Operating profit/loss from Fire/Marine/Misc.			
Business C = (A - B)			
APPROPRIATIONS			
Transfer to Shareholders' Account			
Transfer to Catastrophe Reserve			
Transfer to Other Reserves (to be specified)			
TOTAL (C)			

Form B-PL

Profit and Loss A/c of a General Insurance Company

Particulars	Schedule No.	Current Year	Previous Year
1. Operating profits/loss (a) Fire insurance (b) Marine insurance I (c) Miscellaneous insurance 2. Income from investments (a) Interest, dividends & rents (Gross) (b) Profit on sale of investments 3. Other income (to be specified)			
TOTAL (A)			
4. Provisions (other than taxation) (a) For diminution in value of investment (b) For doubtful debts (c) Others (to be specified) 5. Other expenses (a) Expenses other than those related to Ins. Business (b) Bad debts written off (c) Others (to be Specified)			
TOTAL (B)			
Profit before tax Provisions for taxation Appropriations (a) Interim dividend paid during the year (b) Proposed final dividend (c) Dividend distribution tax (d) Transfer to any reserve or other account Balance of Profit/loss Brought Forward from Last yr. Balance Carried Forward to Balance Sheet			

IRDAI defers the effective date for implementation of Ind AS in the Insurance Sector to 1 April 2020

The Insurance Regulatory Development Authority of India (IRDAI) through its order dated 17 November 2015 stated that the insurance sector in India would converge with International Financial Reporting Standards (IFRS) after the issuance of the revised standard on insurance contracts by the International Accounting Standards Board (IASB).

Subsequently, the Ministry of Corporate Affairs (MCA) on 30 March 2016 notified the road map for implementation of Ind AS for Scheduled Commercial Banks, insurance companies and Non-Banking Financial Companies (NBFCs) from 1 April 2018 onwards.

The IRDAI also constituted an Implementation Group (IG) on 17 November 2015 to facilitate Ind AS convergence for the Indian insurance sector. On 29 December 2016, the IG submitted its report to the IRDAI, highlighting the potential Ind AS implementation issues for insurers in India along with its recommendations to ease out the implementation process. Additionally, the insurance companies were directed to submit proforma Ind AS financial statements from the quarter ended 31 December 2016 in the specified formats (IRDAI circular no. IRDA/F&A/CIR/ACTS/262/12/2016 dated 30 December 2016).

On 18 May 2017, the IASB issued the much awaited comprehensive international standard on insurance i.e. IFRS 17, Insurance Contracts. IFRS 17 replaces IFRS 4, Insurance Contracts¹ which was in the nature of an interim standard pending the completion of the project on insurance contracts by the IASB. The release of IFRS 17 standard led to IRDAI to review its position in the matter of implementation of Ind AS in the insurance sector.

The Board of IRDAI in its meeting dated 31 May 2017 noted the peculiarities of the insurance sector in India, specifically the fact that India does not have a standard equivalent to International Accounting Standard (IAS) 39, Financial Instrument: Recognition and Measurement. The IRDAI concluded that implementation of Ind AS in the present form is expected to lead to a position where assets would be valued on fair value/market value basis and liabilities would continue to be valued as per the existing formula based approach. This would lead to mismatch in the asset and liability valuation and would also cause volatility in the financial statements of the insurance companies.

Additionally, IRDAI observed that the compliance costs would have to be incurred twice – once immediately on implementation of Ind AS and second when IFRS 17 would be implemented in India.

After considering the given facts, IRDAI through its circular no. IRDA/F&A/CIR/ACTS/146/06/2017 dated 28 June 2017 deferred the implementation of Ind AS in the insurance sector in India for a period of two years. Accordingly, Ind AS for Indian insurance companies would be applicable from 1 April 2020 (instead of 1 April 2018).

However, insurance companies would still be required to submit the proforma Ind AS financial statements to IRDAI on a quarterly basis effective from 31 December 2016. Therefore, the requirement to submit proforma Ind AS financial statements on a quarterly basis has not been deferred.

Ratio Analysis

Importantly, the users of Financial Statements cannot form any opinion on any of the trends for their economic decisions with the company only on the basis of Financial Statements unless they use various ratio analysis and trend analysis with comparative and classified accounting or financial statement. In using the financial statement including balance sheet, and income statements along with required disclosure and management report and computing percentage change, trend change, component percentages, and ratios as exemplified

in annexure, the finance manager and analyst constantly search for some standard of comparison to establish whether the information and relationship they have found are favourable or adverse for their future economic decisions. Generally two standards of comparison used by financial analysts are (i) the past performance of the company, and (ii) the position of the company with respect to industry performance in the country and overseas. The insurance business is carried on with international process, principle and perspective because of its very nature of international character. So its trend analysis or trend percentage needs to be compared with industry data and international standard to judge the company's position in respect of growth, profitability, liquidity, solvency, etc. In the following table, certain performance analysis has been done with some hypothetical figures just to show accounting information are used for trend analysis.

INVESTMENTS BY INSURANCE COMPANIES

Insurance companies generally function on two dimensional landscapes which include (a) underwriting activity which is mainly centered on collecting premiums and honouring claim, and (b) investment activity which is meant to dispense assets into various investments to earn additional revenues in the form of interests, dividends and realised capital gains. Under underwriting activity, insurance companies collect premiums from people and form an insurance fund. The insurance fund should not be held ticking over until claims being lodged. It should be invested through creating a float.

Investment management is a backbreaking area of operation in any insurance company, which has to put aside certain sum for claim that might arise over a period of time keeping in view the changing nature of risk, regulations and variety of investment objectives implicit in mind of policyholders and shareholders. Investment earnings made by insurance firms constitute a significant proportion of their operating results; thereby improving their competitiveness. Investment results are increasingly key determinants of both adequacy and volatility of insurance companies' financial well being and considered in calculation of premium rate and for declaration of bonus by insurers.

Insurance investment activities diversify firm's capital base and enhance its ability to settle claims when they occur. Insurance capital and reserves are paramount hotspot of money finances of the economy. Insurance industry particularly in emerging markets like India is playing an important role in the advancement of capital markets, providing finance to companies and governments and bringing forward the mechanisms for corporate control and risk management. Insurance companies additionally decrease dependence on the banking system and acting as a shock absorber now and again for budgetary trouble. Toward the same time, the consistent streams of premium considerably in period of business sector downturn empowers insurers to be a hotspot of liquidity and to purchase all the holdings that are undervalued throughout the downturn when a significant number of market players sell. Therefore, insurers have a counter-cyclical and settling impact on the economy. On account of large scale protection arrangements and predictable long haul liabilities, insurers could put resources into long haul and illiquid assets. Insurers should have sound, systematic and objective process of determining investment pattern to maximise the value of shareholder as well preserve the value of policyholders.

The Indian insurance sector reforms build a new competitive environment lead to better customer services, competitiveness, innovative products and rapid development of technology which in turn increased complexity of insurance investment management. The intensification of globalisation, the emergence of new financial instruments, rapid development of technology as well as opening of private participation set in motion a race of supremacy among players which have increased complexities in investment management. Therefore, investment strategies and risk management are becoming more important. In pre liberalization period, Indian insurance sector emulated a specific investment pattern being an aftermath of legislature arrangements and priorities. There was a public sector life insurance company and one public sector non life insurance company

with their four subsidiaries, which were generally invest fund in the furtherance of social development programme and for government expenditure financing sake. They hardly had any freedom to utilize their fund according to their discretion. Most of investment might have been in fixed income securities particularly in government securities.

Fund management is now a challenge for insurance sector and calls for high degree of sophistication in market prediction, asset allocation and strategy formulation. Insurers require multifarious skills for assessing liabilities, aspiration of policyholders and other factors which can influence the investment policy. Insurers should be dexterous in identifying appropriate assets, devising relevant asset allocation strategies and putting strong organisation in place for efficient management of funds. Insurance companies' investment operations are influence by up and down in internal as well as external factors. The changing market and regulatory environment stimulate insurance companies to invest not only in the government securities and money market instruments but also in stocks which make them vulnerable to the high risks emanates elsewhere and sweeps in the stock market. Therefore, insurers should have robust risk and investment management framework to deliver superior risk adjusted returns to customers.

Most of the problems confronted by an insurer in managing a portfolio of life insurance policies are based on investment risk (due to interest rates) and insurance risk (due to mortality) and on their interaction. The main investment risks to technical provisions and solvency are market risk (fluctuations in stocks, bonds and exchange rates), credit risk (counterparty collapse), liquidity risk (incapability to unwind a position at or near market price), operational risk (system/internal control negligence), and legal risk. Therefore, there is an apparent need of discerning investment risks, their regular screening and quantitative assessment. Insurance companies may turn to derivatives instruments to manage risk and increase their income.

Life insurance companies can invest their fund in short term and long-term financial instruments viz. instruments of money market and capital market. The investment portfolio is generally dominated by long-term assets, but one part of funds is invested in short-term assets for securitization of liquidity. The procedure of designing a portfolio must be in accordance with obligations of life insurance companies, expected profit and price policy. Every portfolio should be rebalanced from time to time i.e. its composition should be re-assessed in order to minimize the risk and earn the highest possible rate of return for a predetermined level of risk. Insurers should determine investment portfolio by using a robust optimisation framework and diversifying investment portfolio into higher income generating strategies with insurance specific constraints to increase overall efficiency and risk generating return.

Investment portfolio of insurance companies encompasses an extensive range of securities. These are government and municipal securities, debenture, preference and ordinary shares of companies operating in various industries, freehold and leasehold properties, and mortgages and loans. Investment instruments are accessible for varying duration ranging from money at call to perpetual securities. The terms upon which these investments can be secured i.e. their market prices are dictated in the long run by the laws of supply and demand as between borrowers and lenders. Insurers need assets that match the maturity of their liabilities, which requires introduction of some new products and development from a few existing ones, such as credit enhancement and credit derivatives. They can also fund businesses through securitisations, direct lending to small and medium enterprises investments in infrastructure, mortgages, real estate, private equity, derivatives, mutual funds and venture capital. While investment in these alternative asset classes currently makes up a small proportion of insurers' portfolios.

Life insurance companies' investment are categorised as linked investments, non-linked investments and shareholders' investments. The unit linked policies are issued with a condition to repurchase such unit at net asset values as on the date of repurchase. As the liability under these contracts is to be settled at fair

market value, the investments representing such liability are valued on mark-to-market basis as per regulation. Conventional policies imply commitments to pay the sum assured including bonus, if any, to the policyholder after occurrence of the event or upon expiry of period of the contract. The assets/investments representing discharge of this obligation should equal to the liability by end of period of the contract. Hence, the regulations prescribe a combination of measuring investment at market value and amortized cost.

The Insurance industry in India is subjected to a comprehensive set of rules and regulations. The regulations strictly specify forms of security in which insurers may invest and limit their share in the total amount. Insurance companies are required to invest minimum amounts of their invested assets in government securities; and restrictions are likewise placed on the amount to be invested in approved investments and other investments, as per a detailed list that includes specific equities and corporate bonds as well as bank deposits. Approved investments are in companies that have a strong, multi-year dividend payment record. Investments that do not fit these criteria are called Other Investments. The objectives behind such comprehensive set of regulations are the preservation of the real value of funds in the coeval circumstances of an unstable investment setting as well as support the insurers in satisfying their commitment towards policyholders at any given time.

Apart from this, insurance investment professionals should be familiar with economic, accounting and regulatory frameworks in the management of a company's investment portfolio. In some cases, conflict among these measures leads to suboptimal economic investment decisions. Therefore, investment policy should set reasonable investment goals for the fund that would comply with the broad objectives of the fund. The investment policy should define the strategic asset allocation strategy for the fund, performance objectives and method for screening and when necessary modifying allocations in the light of evolving liabilities and market conditions. It should likewise cover broad decisions pertaining to tactical asset allocation, security selection and trade execution. There should be procedures by which the governing authority periodically reviews the investment policy and figures out if there is a need to transform the policy, its implementation procedures, the decision-making structure as well as those responsibilities connected to its design, implementation and review. A fund manager must invest only in assets whose risks it can legitimately identify, measure, monitor, manage, control and report. Investment portfolio must balance the objectives of security, quality, liquidity and profitability as a whole commensurate with the predetermined policy objectives. However, insurance companies especially in most emerging market economies like India are facing several constraints in their investment management due to lack of long-term fixed-income instruments, paucity of derivatives (such as interest rate swaps, caps, floors, and currency swaps) and relative illiquidity in bond and equity markets.

GUIDELINES FOR PREPARATION OF FINANCIAL STATEMENTS

Provisioning for diminution in the value of equity:

Clause 6(c), Part I, Schedule A, of the Regulations requires that the insurer shall assess on each balance sheet date whether any impairment of listed equity securities/derivative instruments has occurred. Impairment denotes possible depletion in the value of investments that has already occurred.

An impairment loss (other than temporary diminution in value) shall be recognised as an expense in the Revenue/Profit and Loss A/c to the extent of the difference between there-measured fair value of the security/investment and its acquisition cost as reduced by any previous impairment loss recognised as expense in the Revenue/Profit and Loss Account. Any reversal of impairment loss, earlier recognised in Revenue/Profit and loss Account, shall be recognised in the Revenue/Profit and Loss Account.

Insurers shall disclose their policy on recognition of impairment losses in the notes to accounts.

Provision for free-look period

The insurers are required to evolve principles for provisioning for free-look period based on assumptions and experience. Free-look period is a period of 15 days from the date of receipt of Policy document by a Policyholder (30 days if the Policies are sold through distance marketing mode) to review the Policy document and in case there is any disagreement by the Policyholder on the terms and conditions mentioned in the Policy document, the Policyholder has the right to return the Policy document and seek refund of premiums paid, subject to deduction of cost of medical examination, stamp duty and cost of insurance cover for the period till cancellation. Such basis or assumptions are required to be certified by the Appointed Actuary and shall be disclosed as part of Notes to Accounts in the Financial Statements.

Unallocated Premium

Unallocated premium refers to premium which has been received but not allocated to any of the risks and shall be shown separately under "Current Liabilities" in the Balance Sheet. Till such time amount received from the Policyholder is not allocated towards premium, it is required to be treated as a liability. Once it is allocated, it becomes an income and moved out of Current liabilities. Since the amounts are expected to be allocated within a short period, they are treated as current liabilities.

Premium Received in Advance

Premium received in advance is the premium received prior to the commencement of the risk, where the period of cover sought falls clearly outside the accounting period and is shown under current liabilities. Moreover, a Customer may wish to pay Premiums in advance of the premium due dates. Such premiums are also treated as Premiums received in advance. As per IRDAI guidelines, Premiums can be collected in advance of the due dates, if the Policyholders opts to pay in advance for any personal reason, but within the same financial year. However, for April May and June in a year, premiums are allowed to be collected 3 months in advance.

Guidelines for recognition of claims

The date for recognition of claims shall be the date of intimation of death or date of intimation of surrender by the policy holder. The date of recognition of claims in case of maturity, survival benefits, annuity, etc. Shall be as per the terms and conditions of the policies. Due date of maturity, survival benefits and annuity policies as per Policy document determine the liability booking in the Balance sheet.

Accounting of policies 'in force'

As per the term under which life insurance policies are issued, the policy holder has a grace period within which the premium is to be deposited as per the terms of the policy. Grace period is generally 30 days for Yearly, Half-yearly and Quarterly modes of premium payment and 15 days for Monthly mode. This policy is followed through out the accounting period, as also at the year end. Thus, premium on any policy which is in force as on 31st March of any Financial year, would be accrued if due and also within the specified grace period. For linked business, the due date for payment may be taken as the date when the associated units are created.

Further, Section 13 of the Insurance Act, 1938 lays down the requirement for preparation of Actuarial Report and Abstract. The Regulations on Assets, Liabilities and Solvency Margin further provide for valuation of liabilities as on the valuation date, i.e., 31st March of every Financial year.

In view of the above, and as matter of regulatory prudence, Life insurers shall finalise the financial statement for the Financial year to which they pertain, taking into account the policies which are in force as on 31st March to ensure compliance with the requirements of the Act and the Regulations framed there under.

Recognition of Surplus arising in non-participating funds as profit in the Profit & Loss Account:

Under Non-participating segment, the Policyholders are not entitled for participation in the Surplus. The entire Surplus, if any, is required to be transferred to Shareholders' account. Therefore, Surplus arising in non-participating funds may be recognised as profit in the Profit and Loss account on quarterly basis provided that

- (a) Financial Statements are audited on quarterly basis.
- (b) The surplus to be transferred to Profit and Loss account must be certified and recommended by the Appointed Actuary of the company.
- (c) A disclosure to this effect should be made in the Financial Statements.
- (d) In any case, the amount transferred must not exceed the yearly profit. The difference, if any must be adjusted in the 4th quarter. In case the variation in the surplus is in excess of 10% or Rs. 5 crore, whichever is higher, then the company shall submit to the Authority an explanation stating reasons for variation alongwith the annual financial statement. The explanation of variations so submitted shall be approved by the Board of Directors.

Accounting treatment of Enhanced Provision of Gratuity

The maximum limit for Gratuity under "Payment of Gratuity Act 1972" from Rs.10 Lakhs to Rs. 20 Lakhs and liability towards Gratuity towards employees will have to be booked accordingly. As per Accounting Standards, liability towards Gratuity and Leave Encashment will have to be provided based on an actuarial valuation of the liability.

Investments of Policy holders and Shareholders

All insurers are required to maintain separate investment accounts for the shareholders and the policy holders and the income/losses accrued/capital gains/losses on the investments is to be credited/debited to the Revenue Account/Profit & Loss Account, as the case may be. Revenue account is for the Policyholders and Profit & Loss Account is for the Shareholders.

Declaration of Bonus

Policyholders who take Life insurance policies which are eligible for participating in the surplus arising out of the Participating business are eligible for bonus, if and when declared by the Life Insurance Company. These Policies which are eligible for bonus are also called "With Profits" Policies or "Participating" Policies. Policyholders' Bonus is not guaranteed and is subject to availability of surplus arising in the Participating segment of the Life insurance business. However, given the competition in the Life insurance industry, a Life insurance company which is in deficit in Participating segment (Expenditure more than Income), cannot afford to avoid declaring bonus, as otherwise Policyholders can move other Life insurance companies who declare bonuses. Therefore, Life insurance companies which are in deficit are also allowed to declare bonus to Policyholders subject to some conditions as can be seen in the succeeding paragraph.

Section 49 of the Insurance Act, 1938 inter alia, provides that no insurer shall declare bonus to the policy holders except out of a surplus shown in the valuation Balance Sheet which may arise as a result of actuarial valuation of the assets and liabilities of the insurer nor shall he increase such surplus by contributions out of any reserve fund or otherwise unless such contributions have been brought in as revenue through the Revenue account on or before the valuation date.

Therefore where the Participating segment is in surplus, a Bonus can be declared, provided the contribution

towards the deficit and the cost of bonus is transferred from Shareholders.

Conditions to be met for declaration of bonus to the policyholders when the Participating fund is in deficit

An insurer intending to declare bonus, where the Participating Life Fund is in deficit, should strictly satisfy the conditions, as laid down by the Authority, here under:

- (i) The Insurer shall make good the accumulated deficit in the Policyholders' A/c and also transfer adequate assets to cover the cost of bonus, prior to declaration of bonus to the participating policyholders. Such transfer from the Shareholders' A/c can be out of the Profit & Loss A/c balance or reserves in the Shareholders A/c, and/or by drawing upon the paid-up capital of the Insurer. By implication, there shall be no deficit in the Policyholders' A/c in case of the insurer opting for declaration of bonus under these circumstances.
- (ii) Any transfer as aforesaid, shall be by a debit to the Profit & Loss (Shareholders') Account and a credit to the Revenue (Policyholders') Account.
- (iii) The funds so transferred to the Policyholders' A/c shall be irreversible in nature, i.e., at no point of time can they be recouped to the Shareholders' Fund.
- (iv) The transfer to the Policyholders' A/c must be fully backed by transfer of assets/ investments to the Policyholder' Funds and should be adequate to meet the policyholders' liabilities, including the cost of bonus.
- (v) The proposed rates of bonus should be capable of being sustained over the future.
- (vi) The transfer of funds to the Policyholders' A/c shall be supported by a special resolution of the shareholders at the general meeting of the insurer. Further, the Insurer shall appropriately increase the paid-up equity capital, within a period of six months from the date of transfer of funds, or such longer period as may be approved by the Authority, with a view to aligning the paid-up equity capital, such as to makeup the deficiency (including the cost of bonus) in the life fund as aforesaid, and is backed up and represented by Policy holders' assets/investments.

The above provisions, for the purposes of meeting the requirement of declaration of bonus are available to the insurers only during the first twelve financial years commencing from the year in which the life insurance business operations were started, thereafter, it is expected that declaration of bonus will be supported by surplus within the life fund without recourse to contribution from the shareholders.

Disclosures in the Notes to Accounts

Further, the insurer shall make a disclosure in the Notes to the Accounts, to the effect that the contributions made by the shareholders to the Policy holders' A/c are irreversible in nature and shall not be recouped to the shareholders at any point of time in future.

The Notes shall also refer to the general meeting of the insurer at which such prior approval of the shareholders has been obtained.

Social Sector business

Point C(4) of Part II of the Regulations requires the percentage of business sector-wise to be given. Along with the total business and rural business, the social sector business under written by the insurer should also be furnished, indicating the gross premium under written, number of policies issued and number of lives covered

(both actuals and percentages).

Accounting for Transfer of Assets between Funds

The treatment of transfer of assets (Investments) must be as under:

Transfer from shareholder's account to the policy holder's account:

Transfer of investments pursuant to transfer of funds from the Shareholder's account to the policy holders' account to meet the deficit in the policy holders' account in a given financial year should be at the cost price or market price, whichever is lower. In case of debt securities, all transfers are to be carried out at the lower of the market price and net amortised cost. On transfer, the accounting treatment of the debt securities shall be based on the same accounting principles as provided for in the IRDA (Preparation of Financial Statements) Regulations, 2002.

Transfer between policy holder's funds:

No transfer of assets (investments) between different policy holders' funds shall be allowed.

Purchase/ Sale transactions between Unit-Linked Funds

The sale/purchase of investments when Insurers consider sale/purchase transactions between unit linked funds would be based on the market price of the investments, which are being shifted between unit-linked schemes.

Funds of Non-linked business

No sale/purchase is permitted between the various Policy holders' funds under the non-linked business.

Small sized fund

In the initial stages of the new insurance companies, funds are likely to build up gradually, and insurers may face problems with regard to purchase of securities because of stipulations of minimum market lot. To tide over such difficulties, in the initial years, security sale at market price is permitted from the shareholders' assets, that to only in the "approved category", to meet the needs of investments of policy holders' funds.

Such transactions shall be permitted only where a policy holders' fund size is small, i.e., up to Rs. 50 crores.

Life Insurer's funds shall be categorised under the following heads:

- (a) Life Fund
- (b) Pension and General Annuity Fund
- (c) Group Schemes excluding Group Pension / Annuity
- (d) Linked Life Insurance Fund.

And the ceiling of ₹50 crores as mentioned above would apply to each of the Fund as listed above and not to individual funds within each of the above funds.

With a view to ensuring an audit trail on such transaction, it is mandatory that such transactions be subject to compliance of the following:

- (a) Authorisation of the Investment Committee giving the reason for such sale transaction to the Policy holders' funds.
- (b) Disclosure in the financial statements/returns.

- (c) Audit by the Statutory auditors.

Disclosure on Ageing on claims

While the section on "Contents of Management Report" requires disclosure of "Ageing of claims indicating the trends in average claim settlement time during the preceding five years. The required details are to be furnished in the following format:

Claims registered and not settled (separately for Linked and Non-Linked business):

(Rs. in lakhs)

Period	No. of Claims	Amount Involved
30 days;		
30 days to 6months;		
6 months to 1 year;		
1 year to 5 years		
5 years and above		

Details of payments to individuals, firms, companies and organisations in which directors are interested required to be disclosed as part of Management Report to be furnished in the following format:

Sl. No.	Name of the Director	Entity in which he is interested	Interested as	Amount of payment during the financial year (Rs. In lakhs)

As part of the disclosure requirement under

"Notes to Accounts" on the Previous year's figures being regrouped, insurers shall disclose the line in the final accounts which have been re-grouped and reasons for the same.

It is observed that insurance companies are incurring various expenses which may be below threshold limit for disclosure as a separate line item. As such, at times the following heads of account are getting clubbed under, "Others" or included under some other sub-head under the schedule for Operating Expenses. The expenses incurred under the following heads may be disclosed as part of 'Notes to Accounts':

- (a) Outsourcing Expenses
- (b) Business Development
- (c) Marketing Support

Information on Penal Action taken on an insurer

Details of various penal actions taken by various Government Authorities, Nil report in case of "No" penalties, duly certified by the Statutory Auditor of the Insurer, shall be disclosed as part of the Annual Report of the Insurer.

The amount of penalty levied by the Authority shall be charged to the Shareholders' Account.

Disclosures relating to Discontinued Policies

In Unit linked insurance Policies, if the premiums are not paid, the fund value under these Policies are moved from the active ULIP fund to a Discontinuance Fund. The Discontinuance Fund comprises of investments which earn a lower return as the investments are generally guaranteed investments giving an assured return. The Policyholder is given a 2 year period to reinstate the Policies by paying the arrears of premium, at which point in time the funds are re-transferred from the Discontinuance fund to the active ULIP fund. The Policies in respect of which funds are lying in Discontinuance fund are called Discontinued Policies under ULIPs.

The Funds arising from the discontinuance of policies shall be shown under a separate head in the Balance Sheet under ‘Policy holders’ Funds’ alongside Policy Liabilities in the following manner:

Funds for discontinued Policies:

- (i) Discontinued on account of non-payment of premiums
- (ii) Others

The Amount refunded to the policy holders and amount transferred to the “Funds for Discontinued Policies” during the financial year shall be shown under a separate head. In addition, the details of number of policies discontinued, the percentage of discontinued policies, charge imposed on discontinued policies and charges readjusted on account of revival of such discontinued policies shall also be shown.

Expenses of Management for Life insurance companies

In Insurance Business, historically there has always been Rules which intends to ensure that an Insurer does not overspend by fixing limits upto which an insurer can spend as expenses of management in any Financial year. Such ceilings are fixed as a % of the Premium income earned by the Insurer. The ultimate objective is to ensure that the insurer is prudent in spending money while running an insurance business by fixing a ceiling which is linked to the Premium income earned by the insurer.

Section 40B of the Insurance Act, 1938 states that no insurer shall spend as expenses of management in excess of the limits prescribed by IRDAI by way of Regulations passed in this regard.

Accordingly, IRDAI have notified IRDAI (Expenses of management for insurers transacting Life insurance business) Regulations, 2016 which provides the ceilings.

The ceilings, as stated earlier, are calculated as a percentage of premiums received by a Life insurer as follows:

Sr. No.	Premium payment term on in-force policies	Allowance % of premiums received	
		Beyond 10 years of Life insurer’s business operations	Up to 10 years of Life insurer’s business operations
1	Regular Premium Policies (I) Regular Premium Pure Risk Policies For Premium payment of 10 years & above		

(a) First year's premium	100	100
(b) Renewal premium	25	25
For Premium payment term of less than 10 years		
(a) First year's premium (100 -(PPT*7.5))		
(II) Regular premium (other than Pure Risk)		
5 to 7 years (both inclusive)		
(a) First Year's premium	60	70
(b) Renewal premium	15	18
8 and 9 years (both inclusive)		
(a) First Year's Premium	70	80
(b) Renewal Premium	15	19
10 years and above		
(a) First year's premium	80	90
(b) Renewal Premium	15	20
2 Single Premium Policies:		
(I) Individual		
(a) Single Premium other than Annuity & Pure Risk	5	
(b) Single Premium Immediate and Deferred Annuity Policies	5	Same as previous column
(c) Single Premium Pure Risk	10	
(II) Group		
(a) Group Pure Risk Policies	10	
(b) Group One year Renewable Policies (other than fund based Policies)	15	Not applicable
(c) Group Fund based Policies (based on average AUM)		
(i) For AUM upto Rs.10,000 crores	1	
(ii) In excess of Rs.10,000 crores	0.8	

3	Regular premium Deferred Annuity Policies		
	(a) First year's premium	10	Same as previous column
	(b) Renewal premium	4	
4	Allowance on Annuities paid	0.50	
5	On paid up policies - on average of the sum assured at the beginning and at the end of the year	0.05	
6	On lapsed policies - on total sum assured of lapsed policies within revival period, at the beginning of the year	0.01	
	TOTAL		

The ceilings calculated by applying the above percentages on the premiums received during a Financial year under each of the above categories constitute the total amount which can be spent by a Life insurance company. The actual expenses of management will have to be within the above ceiling.

During the first 10 years of operations of Life insurance business, if a Life insurer fails to keep the actual expenses of management within the above ceiling, such Life insurer can apply to IRDAI for seeking their forbearance for the non-compliance with the ceilings. Such requests for forbearance shall be sent to IRDAI through Life Insurance Council (an industry body formed under the Insurance Act, 1938 which represents the interests of all Life insurers) along with the Council's recommendations for acceptance of the Forbearance. IRDAI may consider the request for Forbearance based on the recommendations of the Council.

Beyond 10 years of Life insurance business if a Life insurer fails to keep the actual expenses of management within the above ceilings, IRDAI may direct the Life insurer to charge the amount excess spent to Shareholders' account. Besides, IRDAI may take regulatory action for non-compliance beyond 10 years, which, depending on the severity and intensity of non-compliance may include restriction on approvals for opening of new offices by the Life insurer, imposition of a Penalty for non-compliance, constriction of the remuneration of Key management personnel including Managing Director & CEO and shutting down even a line of business.

An yearly Return on status of compliance with the ceilings on expenses of management is required to be filed with IRDAI by all Life insurers, duly certified by the CEO, CFO and the Chief Compliance Officer. Further, the Statutory Auditors of the Life insurer will also have to be filed with IRDAI.

OTHER DISCLOSURES IN FINANCIAL STATEMENTS

Allocation of Expenses

All expenses should be allocated between the Segment Revenue/Profit & Loss Account on a rational basis to be followed consistently and the basis of allocation should be disclosed along with the details of apportioned expenses as a part of notes to accounts.

GUIDELINES ON PRUDENTIAL NORMS FOR INCOME RECOGNITION, ASSET CLASSIFICATION, PROVISIONING AND OTHER RELATED MATTERS IN RESPECT OF DEBT PORTFOLIO

The guidelines are based on the RBI guidelines issued in this regard, duly modifying, keeping in view the industry specific requirements. Any item not covered below will be governed by the provisions as mandated by the RBI for banks.

Asset Classification

Adequate provision shall be made for estimated loss arising on account from/under recovery of loans and advances (other than loans and advances granted against insurance policies issued by the insurer) outstanding at the balance sheet date. Insurers shall classify their loans/advances into four categories, viz., (i) standard assets, (ii) sub-standard assets, (iii) doubtful assets and (iv) loss assets. Classification of assets into these categories shall be done taking into accountability of the borrower to repay and the extent of value and realizability of security.

Standard Assets

Standard asset is one which does not disclose any problem and which does not carry more than normal risk attached to the business. Such an asset is not an NPA. The insurer should make a general provision on Standard Assets of a minimum of 0.40 percent of the value of the asset.

In respect of loans extended directly by insurers to sick units taken over by borrowers falling under the "standard" classification, the facilities of the transferee and merged units may continue to be classified separately, for a period not exceeding 24 months from the date of the take over of the sick unit, after which the performance of the loans sanctioned to the borrower as a whole should determine their classification. In cases of reverse merger (i.e., take-over of a healthy unit by a sick unit) as well, the facilities of both the units may continue to be classified separately for a period of 24 months after which the combined performance may be taken for asset classification.

Sub-standard assets

Sub-standard asset is one which has been classified as NPA for a period not exceeding 12 months, e.g., an asset which has been treated as an NPA on 1st April, 2004, would be treated as a sub-standard asset only up to 31st March 2005.

In case of time over run for completion of project directly financed by insurers, the Boards of Insurers should decide based on valid grounds, whether the advance should be treated as standard asset.

An asset where the terms of the loan agreement regarding interest and principal have been renegotiated or rescheduled after commencement of production, should be classified as sub-standard and should remain in this category for at least two years of continually satisfactory performance under the revised terms. The classification of an asset should not be upgraded merely as a result of rescheduling, unless there is satisfactory compliance of the above condition.

Doubtful assets

A doubtful asset is one which has remained as NPA for a period exceeding 12 months, e.g., a loan facility to a borrower which is treated as NPA on 1st April, 2004 would be treated as 'doubtful' from 1st April, 2005.

A loan classified as doubtful has besides the weakness inherent in that classified as sub-standard, with the continuing default makes the recovery in full, to be improbable. Here too, as in the case of sub-standard assets,

rescheduling does not lead upgradation of the category of the asset automatically. Similarly a doubtful asset which is subject to rehabilitation and where the asset has been subsequently continually satisfactorily serviced for one years hall be graduated to a standard asset.

Loss assets

A loss asset is one where loss has been identified by the insurer or its internal or statutory auditors or by IRDA, but the amount has not been written off wholly. In other words, such an asset is considered un-collectible and as such its continuance as a bankable asset is not warranted although there may be some salvage or recovery value.

Overdue Amounts Interest/Principal

An amount, whether interest or principal, is said to be overdue if it is not paid to the insurer on the specified date. An asset is classified as an NPA if the interest and/or installment of principal remain overdue for more than 90 days.

Provisioning for Loans and Advances

Taking into account the time lag between an account becoming doubtful of recovery, its recognition as such, the realisation of the security and the erosion in the value of security charged to the insurers, it is necessary that insurers make adequate provisions against sub-standard assets, doubtful assets and loss assets, as per the procedure outlined below:

Loss assets treatment

The entire asset should be written off. If the assets are to remain in the books for any reason, 100 per cent of the outstanding should be provided for.

Doubtful assets treatment

- (a) 100 percent provision of the extent to which the asset is not covered by the realisable value of the security to which the insurer has a valid recourse and the realisable value is estimated on a realistic basis.
- (b) Over and above item (a) above, depending upon the period for which the asset has remained doubtful, 20% to 100% provision of the secured portion (i.e., estimated realisable value of the outstandings) should be made on the following basis :

Period for which the asset has been considered as doubtful %of provision

Up to one year	20%
One to three years	30%
More than three years	100%

Sub-standard assets treatment:

- (i) A general provision of 10% of total value outstanding remaining substandard is required to be made including loans granted by the Central/State government.
- (ii) Loans granted under rehabilitation packages
- (iii) In case of nursing finance granted by an insurer, the additional loan facilities sanctioned under the

rehabilitation programme may be treated as a separate account and the performance assessed separately. Asset classification and provisioning in respect of such loan facilities as per the prescribed guidelines may be made only if the interest/principal payments remain due beyond one quarter.

It is clarified that the proviso has been included to take care of the existing portfolio of the insurers.

Defaults in repayment of principal

On account of various reasons, such as delays in project implementation, getting adequate working capital facilities, etc., repayment of principal may be delayed beyond the stipulated one quarter. The asset may continue to be considered as standard if the instalments of the principal amount are rescheduled with the approval of the Board of the concerned insurer. This is subject to the condition that there can be only a one time re-schedulement and that the interest continues to be paid regularly.

Time overrun

In case of time over run for completion of project directly financed by insurers, the Boards of Insurers should decide based on valid grounds, whether the advance should be treated as standard asset.

One Time Settlement (OTS)

- (a) In respect of loan facilities extended to sick units (under nursing programmes or otherwise) taken over by borrowers falling under the "standard" classification, the facilities of the transferee and the merged units may continue to be classified separately for a period not exceeding 2 years from the date of takeover of the sick unit, after which the performance of the loan facility sanctioned to the borrower as a whole should determine their classification.
- (b) Sometimes insurers enter into one time settlement (OTS) of their dues with a new owner. In cases where a sick unit has been merged with a healthy and strong unit and where payments are being made as per the OTS scheme, the asset in respect of the merged unit may be considered as standard without waiting for a period of 2 years for upgradation from sub-standard to standard asset. However, such cases should be approved by the Board of the concerned insurer.

Units Enjoying More than One Loan Facility

In case of borrowers who have been granted more than one loan facility by the insurer, all the dues from them will have to be treated as NPAs if 50 percent of its total interest and/or principal dues from all loans extended to it remain overdue for more than one quarter.

Government Guaranteed Loans

Loans or other credit facilities backed by Central/State Government guarantees should be treated on par with other assets for income recognition and provisioning. However, in respect of loans backed by Central Government guarantee, such loans shall be treated as NPA only when the Government repudiates its guarantee when invoked.

Income Recognition

Income in respect of any asset classified as NPA shall not be recognized unless realized. However, any adjustment towards overdue interest against any fresh/additional loan shall not be considered as realized.

ADDITIONAL DISCLOSURES IN FINANCIAL STATEMENTS

Controlled Fund

The details of the Controlled Fund shall be furnished as part of the annual Financial Statements of life insurance companies.

Disclosures under Section 31B (2) of the Insurance Act, 1938

Attention is drawn to section 31B(2) of the Insurance Act, 1938 by virtue of which “Every insurer shall before the close of the month following every year, submit to the Authority [a statement, in the form specified by the Regulations made by the Authority,] showing the remuneration paid, whether by way of commission or otherwise, to any person in cases where such remuneration exceeds (such sum as may be specified by the regulations made by the Authority.)” Accordingly, insurers are advised to submit details of remuneration paid whether by way of commission or otherwise to any person, in cases where such remuneration exceeds Rs.5 lakhs per annum to the Authority in the format prescribed.

The said details for financial year ending 31st March may be furnished by 30th April of every year. However, Employee remuneration details which are being furnished as part of the Directors’ Report as required under Section 217(2A)(a) of the Companies Act, 1956 read with the Companies (Particulars of Employees) Rules, 1975 may continue to be provided along with Directors’ Report.

Further, Insurers shall also confirm the presence of effective internal controls/systems towards compliance with section 40A of the Insurance Act, 1938. The same shall be strengthened with Proper IT backed systems and appropriate internal reporting mechanism. These systems shall, at the minimum, comply with the following:

- (i) Internal controls/systems shall be subject to half yearly internal audit.
- (ii) Reports of the internal auditors shall be placed before the Audit Committee.
- (iii) Exception reports, if any, alongwith corrective steps taken shall be placed before the Board.

A Compliance Certificate duly signed by the Chief Executive Officer/Managing Director (by whatever name called) shall be filed with the Authority along with the details furnished under section 31B(2) of the Insurance Act, 1938 as per the format prescribed.

Disclosures for ULIP business

- (a) To ensure transparency and consistency in the disclosures across the industry the format of reporting under the Regulations, 2002 has been modified to include the following, i.e., Segregation of the Unit Linked Revenue A/c in to two components, viz., (i) Non–Unit Funds and (ii) Unit Fund (which form Addendum to the Form A-RA);
- (b) Format of reporting of the segregated funds – Revenue A/c, Balance Sheet and the underlying Schedules
- (c) Additional disclosures to form part of the Annual Report

Clarifications on the above disclosures

- i. The Investment portion of premium shall be disclosed in the Unit segment and the non-investment portion in the non-unit segment;
- ii. Income on investment shall be disclosed under unit and non-unit portion in consonance with (i) above;

- iii. Fees and charges shall be shown as “Income” in the non-unit segment and as “Expenses” in the unit segment.
- iv. All operating expenses and Commission shall be disclosed in non-unit segment.
- v. Claims arising from cancellation of units alone shall be shown against linked segment and other items like mortality, morbidity and value of guaranteed benefits shall be disclosed under non-unit segment

Application of Indian Accounting Standards to Life insurance

Indian Accounting Standard(also known as Ind-AS) is the Accounting standard adopted by companies in India and is issued under the supervision of Accounting Standards Board (ASB) which was constituted as a body in the year 1977. ASB is a committee under Institute of Chartered Accountants of India (ICAI) which consists of representatives from government department, academicians, other professional bodies viz. ICAI, representatives from ASSOCHAM, CII, FICCI, etc.

The Ind-AS are named and numbered in the same way as the International Financial Reporting Standards (IFRS). National Advisory Committee on Accounting Standards(NACAS) recommend these standards to the Ministry of Corporate Affairs(MCA). MCA has to spell out the accounting standards applicable for companies in India. As on date MCA has notified 41 Ind-AS. This shall be applied to the companies of financial year 2015-16 voluntarily and from 2016-17 on a mandatory basis.

Based on the international consensus, the regulators will separately notify the date of implementation of Ind-AS for the banks, insurance companies etc. standards for the computation of Tax has been notified as ICDS in February 2015.

For the insurance sector, in their Press release dated 18 January 2016, Ministry of Corporate Affairs had notified and laid down the roadmap for implementation of IND-AS 104 for Insurance sector from 01 April 2018 onwards with one year comparatives. Rule 4 of the Indian Accounting Standards (Amendment) Rules 2016, states that Banking and Insurance companies shall apply IND-AS as notified by Reserve Bank of India and IRDAI, respectively.

In the meanwhile the International Accounting Standards Board, on 18 May 2017, released IFRS-17 on Insurance Contracts which replaced the interim standard IFRS-4. Further, International Accounting Standards board also released IAS-39 on Recognition and Measurement of Financial instruments. However, there are no corresponding standards to IAS-39 which has been drafted in India. In such a scenario, there was a need for synchronising the Indian Accounting Standards with that of the International Accounting Standards as far as Insurance is concerned.

The development around IFRS-17 and IAS-39 has led IRDAI to review the IND-AS applicable to Insurance contracts in India. Therefore, exercising its regulatory override powers, IRDAI have deferred implementation of IND-AS for Insurance sector till the Financial year 2020-21. However, in order to prepare the Insurers for the ultimate preparation of Financial Statements as per IND-AS, IRDAI have asked proforma Financial Statements to be prepared every quarter as per IND-AS notified by the Ministry of Corporate affairs.

In the meantime, IRDAI had constituted a Working Group to examine the IND-AS for insurance sector and provide its recommendations to IRDAI.

IFRS-17 – INSURANCE CONTRACTS

IFRS 17 establishes the principles for the recognition, measurement, presentation and disclosure of insurance contracts within the scope of the standard. The objective of IFRS 17 is to ensure that an entity provides relevant

information that faithfully represents those contracts. This Standard was published on 18 May 2017, effective for the Annual period on or after 01 January 2021.

IFRS-17 is applicable to 3 types of insurance contracts:

- Insurance contracts, including inward reinsurance contracts accepted
- Reinsurance contracts ceded
- Investment contracts with discretionary participation features, by an entity which issues insurance contracts as well

SOME KEY DEFINITIONS IN IFRS-17

Insurance contract

A contract under which one party (the issuer) accepts significant insurance risk from another party (the policyholder) by agreeing to compensate the policyholder if a specified uncertain future event (the insured event) adversely affects the policyholder.

Portfolio of insurance contracts

Insurance contracts subject to similar risks and managed together.

Contractual service margin

A component of the carrying amount of the asset or liability for a group of insurance contracts representing the unearned profit the entity will recognise as it provides services under the insurance contracts in the group.

Insurance risk

Risk, other than financial risk, transferred from the holders of a contract to the issuer.

Fulfilment cash flows

An explicit, unbiased and probability-weighted estimate (i.e. expected value) of the present value of the future cash outflows less the present value of the future cash inflows that will arise as the entity fulfils insurance contracts, including a risk adjustment for non-financial risk.

Risk adjustment for non-financial risk

The compensation an entity requires for bearing the uncertainty about the amount and timing of the cash flows arising from non-financial risk as the entity fulfils insurance contracts.

Separating components from an insurance contract

An insurance contract may contain one or more components that would be within the scope of another standard if they were separate contracts. For example, an insurance contract may include an investment component or a service component (or both). Unit Linked Life insurance policies, for example, have an insurance component and investment component. It is a contract bundled with insurance element and investment element and is like Term insurance + Mutual fund. In such cases this principle applies.

The standard provides the criteria to determine when a non-insurance component is distinct from the host insurance contract.

Investment component to be separated from a host insurance contract only if that investment component is distinct. The entity shall then apply IFRS 9 to account for the separated investment component.

After performing the above steps, separate any promises to transfer distinct non-insurance goods or services. Such promises are accounted under IFRS 15 'Revenue from Contracts with Customers'

Level of aggregation

IFRS 17 requires entities to identify portfolios of insurance contracts, which comprises contracts that are subject to similar risks and managed together. Contracts within a product line would be expected to have similar risks and hence would be expected to be in the same portfolio if they are managed together. [IFRS 17:14]

Each portfolio of insurance contracts issues shall be divided into a minimum of: [IFRS 17:16]

- A group of contracts that are onerous at initial recognition, if any;
- A group of contracts that at initial recognition have no significant possibility of becoming onerous subsequently, if any; and
- A group of the remaining contracts in the portfolio, if any.

An entity is not permitted to include contracts issued more than one year apart in the same group.

If contracts within a portfolio would fall into different groups only because law or regulation specifically constrains the entity's practical ability to set a different price or level of benefits for policyholders with different characteristics, the entity may include those contracts in the same group.

Recognition

An entity shall recognise a group of insurance contracts it issues from the earliest of the following:

- (a) the beginning of the coverage period of the group of contracts;
- (b) the date when the first payment from a policyholder in the group becomes due; and
- (c) for a group of onerous contracts, when the group becomes onerous.

Measurement

On initial recognition, an entity shall measure a group of insurance contracts at the total of:

- (a) the fulfilment cash flows ("FCF"), which comprise:
 - (i) estimates of future cash flows;
 - (ii) an adjustment to reflect the time value of money ("TVM") and the financial risks associated with the future cash flows; and
 - (iii) a risk adjustment for non-financial risk.
- (b) the contractual service margin ("CSM").

An entity shall include all the future cash flows within the boundary of each contract in the group. The entity may estimate the future cash flows at a higher level of aggregation and then allocate the resulting fulfilment cash flows to individual groups of contracts.

The estimates of future cash flows shall be current, explicit, unbiased, and reflect all the information available to the entity without undue cost and effort about the amount, timing and uncertainty of those future cash flows.

They should reflect the perspective of the entity, provided that the estimates of any relevant market variables are consistent with observable market prices. [IFRS 17:33]

Discount rates

The discount rates applied to the estimate of cash flows shall:

- (a) reflect the time value of money (TVM), the characteristics of the cash flows and the liquidity characteristics of the insurance contracts;
- (b) be consistent with observable current market prices (if any) of those financial instruments whose cash flow characteristics are consistent with those of the insurance contracts; and
- (c) exclude the effect of factors that influence such observable market prices but do not affect the future cash flows of the insurance contracts.

Risk adjustment for non-financial risk

The estimate of the present value of the future cash flows is adjusted to reflect the compensation that the entity requires for bearing the uncertainty about the amount and timing of future cash flows that arises from non-financial risk.

Contractual service margin

The CSM represents the unearned profit of the group of insurance contracts that the entity will recognise as it provides services in the future. This is measured on initial recognition of a group of insurance contracts at an amount that, unless the group of contracts is onerous, results in no income or expenses arising from:

- (a) the initial recognition of an amount for the FCF;
- (b) the derecognition at that date of any asset or liability recognised for insurance acquisition cash flows; and
- (c) any cash flows arising from the contracts in the group at that date.

Subsequent measurement

On subsequent measurement, the carrying amount of a group of insurance contracts at the end of each reporting period shall be the sum of:

- (a) the liability for remaining coverage comprising:
 - (i) the FCF related to future services and;
 - (ii) the CSM of the group at that date;
- (b) the liability for incurred claims, comprising the FCF related to past service allocated to the group at that date.

Onerous contracts

An insurance contract is onerous at initial recognition if the total of the FCF, any previously recognised acquisition cash flows and any cash flows arising from the contract at that date is a net outflow. An entity shall recognise a loss in profit or loss for the net outflow, resulting in the carrying amount of the liability for the group being equal to the FCF and the CSM of the group being zero.

On subsequent measurement, if a group of insurance contracts become onerous (or more onerous), that excess shall be recognised in profit or loss. Additionally, the CSM cannot increase and no revenue can be recognised, until the onerous amount previously recognised has been reversed in profit or loss as part of a service expense.

Premium allocation approach

An entity may simplify the measurement of the liability for remaining coverage of a group of insurance contracts using the Premium Allocation Approach (PAA) on the condition that, at the inception of the group:

- (a) the entity reasonably expects that this will be a reasonable approximation of the general model, or
- (b) the coverage period of each contract in the group is one year or less.

Where, at the inception of the group, an entity expects significant variances in the FCF during the period before a claim is incurred, such contracts are not eligible to apply the PAA.

Using the PAA, the liability for remaining coverage shall be initially recognised as the premiums, if any, received at initial recognition, minus any insurance acquisition cash flows. Subsequently the carrying amount of the liability is the carrying amount at the start of the reporting period plus the premiums received in the period, minus insurance acquisition cash flows, plus amortisation of acquisition cash flows, minus the amount recognised as insurance revenue for coverage provided in that period, and minus any investment component paid or transferred to the liability for incurred claims. [IFRS 17:55]

Practical expedients available under the PAA

If insurance contracts in the group have a significant financing component, the liability for remaining coverage needs to be discounted, however, this is not required if, at initial recognition, the entity expects that the time between providing each part of the coverage and the due date of the related premium is no more than a year.

In applying PAA, an entity may choose to recognise any insurance acquisition cash flows as an expense when it incurs those costs, provided that the coverage period at initial recognition is no more than a year.

The simplifications arising from the PAA do not apply to the measurement of the group's liability for incurred claims, measured under the general model. However, there is no need to discount those cash flows if the balance is expected to be paid or received in one year or less from the date the claims are incurred.

Investment contracts with a DPF

An investment contract with a DPF is a financial instrument and it does not include a transfer of significant insurance risk. It is in the scope of the standard only if the issuer also issues insurance contracts. The requirements of the Standard are modified for such investment contracts.

Reinsurance contracts held

The requirements of the standard are modified for reinsurance contracts held.

In estimating the present value of future expected cash flows for reinsurance contracts, entities use assumptions consistent with those used for related direct insurance contracts. Additionally, estimates include the risk of reinsurer's non-performance.

The risk adjustment for non-financial risk is estimated to represent the transfer of risk from the holder of the reinsurance contract to the reinsurer.

On initial recognition, the CSM is determined similarly to that of direct insurance contracts issued, except that

the CSM represents net gain or loss on purchasing reinsurance. On initial recognition, this net gain or loss is deferred, unless the net loss relates to events that occurred before purchasing a reinsurance contract (in which case it is expensed immediately).

Subsequently, reinsurance contracts held are accounted similarly to insurance contracts under the general model. Changes in reinsurer's risk of non-performance are reflected in profit or loss, and do not adjust the CSM.

MODIFICATION AND DERECOGNITION

Modification of an insurance contract

If the terms of an insurance contract are modified, an entity shall derecognise the original contract and recognise the modified contract as a new contract if there is a substantive modification, based on meeting any of the specified criteria.

The modification is substantive if any of the following conditions are satisfied:

- (a) if, had the modified terms been included at contract's inception, this would have led to:
 - (i) exclusion from the Standard's scope;
 - (ii) unbundling of different embedded derivatives;
 - (iii) redefinition of the contract boundary; or
 - (iv) the reallocation to a different group of contracts; or
- (b) if the original contract met the definition of a direct par insurance contracts, but the modified contract no longer meets that definition, or vice versa; or
- (c) the entity originally applied the PAA, but the contract's modifications made it no longer eligible for it.

Derecognition

An entity shall derecognise an insurance contract when it is extinguished, or if any of the conditions of a substantive modification of an insurance contract are met.

Presentation in the statement of financial position

An entity shall present separately in the statement of financial position the carrying amount of groups of:

- (a) insurance contracts issued that are assets;
- (b) insurance contracts issued that are liabilities;
- (c) reinsurance contracts held that are assets; and
- (d) reinsurance contracts held that are liabilities.

Recognition and presentation in the statement(s) of financial performance

An entity shall disaggregate the amounts recognised in the statement(s) of financial performance into:

- (a) an insurance service result, comprising insurance revenue and insurance service expenses; and
- (b) insurance finance income or expenses.

Income or expenses from reinsurance contracts held shall be presented separately from the expenses or income from insurance contracts issued.

Insurance service result

An entity shall present in profit or loss revenue arising from the groups of insurance contracts issued, and insurance service expenses arising from a group of insurance contracts it issues, comprising incurred claims and other incurred insurance service expenses. Revenue and insurance service expenses shall exclude any investment components. An entity shall not present premiums in the profit or loss, if that information is inconsistent with revenue presented.

Insurance finance income or expenses

Insurance finance income or expenses comprises the change in the carrying amount of the group of insurance contracts arising from:

- (a) the effect of the time value of money and changes in the time value of money; and
- (b) the effect of changes in assumptions that relate to financial risk; but
- (c) excluding any such changes for groups of insurance contracts with direct participating insurance contracts that would instead adjust the CSM.

An entity has an accounting policy choice between including all of insurance finance income or expense for the period in profit or loss, or disaggregating it between an amount presented in profit or loss and an amount presented in other comprehensive income (“OCI”).

Under the general model, disaggregating means presenting in profit or loss an amount determined by a systematic allocation of the expected total insurance finance income or expenses over the duration of the group of contracts. On derecognition of the groups amounts remaining in OCI are reclassified to profit or loss.

Under the VFA, for direct par insurance contracts, only where the entity holds the underlying items, disaggregating means presenting in profit or loss as insurance finance income or expenses an amount that eliminates the accounting mismatches with the finance income or expenses arising on the underlying items. On derecognition of the groups, the amounts previously recognised in OCI remain there.

Disclosures

An entity shall disclose qualitative and quantitative information about:

- (a) the amounts recognised in its Financial Statements that arise from insurance contracts;
- (b) the significant judgements, and changes in those judgements, made when applying IFRS 17; and
- (c) the nature and extent of the risks that arise from insurance contracts.

Effective date

IFRS 17 is effective for annual reporting periods beginning on or after 1 January 2021. Earlier application is permitted if both IFRS 15 Revenue from Contracts with Customers and IFRS 9 Financial Instruments have also been applied.

Transition

An entity shall apply the standard retrospectively unless impracticable, in which case entities have the option of using either the modified retrospective approach or the fair value approach.

Under the modified retrospective approach, an entity shall utilise reasonable and supportable information and

maximise the use of information that would have been used to apply a full retrospective approach but need only use information available without undue cost or effort. Under this approach the use of hindsight is permitted, if that is the only practical source of information for the restatement of prior periods.

Under the fair value approach, an entity determines the CSM at the transition date as the difference between the fair value of a group of insurance contracts at that date and the FCF measured at that date. Using this approach, on transition there is no need for annual groups.

At the date of initial application of the Standard, those entities already applying IFRS 9 may retrospectively re-designate and reclassify financial assets held in respect of activities connected with contracts within the scope of the Standard.

Entities can choose not to restate IFRS 9 comparatives with any difference between the previous carrying amount of those financial assets and the carrying amount at the date of initial application recognised in the opening equity at the date of initial application. Any restatements of prior periods must reflect all the requirements of IFRS 9.

TAXATION ASPECTS OF LIFE INSURANCE COMPANIES

Income-tax Act, 1961 governs the provisions relating to taxation of income arising out of Life insurance business.

Section 44 read with First Schedule of the Income-tax Act 1961 provides that the Profits and Gains of Life insurance business shall be calculated at the rate of 12.5% plus applicable surcharge on the amount arrived as follows (as mentioned in the First Schedule):

The profits and gains of life insurance business shall be taken to be the annual average of the surplus arrived at by adjusting the surplus or deficit disclosed by the actuarial valuation made in accordance with the Insurance Act, 1938 (4 of 1938), in respect of the last inter-valuation period ending before the commencement of the assessment year, so as to exclude from it any surplus or deficit included therein which was made in any earlier inter-valuation period.

Sections 28 to 43 of the Income-tax Act relating to various deductions are not applicable to Life insurance business.

Taxation benefits for a Life insurance Policy taken by a Policyholder (Customer)

A Policyholder who takes a Life insurance Policy is entitled to certain tax benefits as follows:

Tax benefits on the Premiums paid by the Policyholder

Section 80C of Income-tax Act, 1961

Under Section 80C of the Income-tax Act, 1961, any premiums paid for a Life Insurance Policy on the life of the person, his/her spouse or children is eligible for a deduction from the Gross Total income a person. However, such a deduction is subject to the following conditions:

- (a) The premiums paid in any year by the Policyholder is allowed as a deduction up to a maximum amount not exceeding 10% (15% in the case of certain persons with specified illnesses or ailments) of the Actual Capital Sum Assured under the Policy. Any amount in excess of the said 10%/15% will not qualify for deduction. This condition is not applicable to Deferred annuity Policies. Actual Capital Sum Assured is the amount guaranteed to be paid by the Life insurance company on the happening of the events insured under the Policy. However, such Actual Capital Sum Assured shall not include premiums agreed to be returned and Bonuses declared from time to time.

- (b) If the Policyholder (other than annuity policy) discontinues the Policy within two Policy years, no benefit is available in the second Policy year. Besides the deduction given in the first Policy year will be treated as an income in the second Policy year.
- (c) Deduction is allowed for the policies taken on the life of an individual, his wife/husband and children.
- (d) Life Insurance policies including deferred annuity Policies are eligible. But Pension policies are treated separately under Section 80CCC and hence are not eligible under Section 80C.
- (e) Under Section 80C, many tax saving instruments are eligible for deduction and Life insurance policies is one among them.
- (f) The maximum amount which can be claimed as a deduction under Section 80C, 80CCC (Deduction for Pension Policies) and 80CCD (Contributions under the New Pension Scheme) cannot exceed ₹1,50,000

Section 80CCC (Pension Policies)

Under Section 80CCC, the premiums paid for a Pension Policy issued by a Life insurance company is eligible for a deduction. Any amount received under a Pension Policy on account of surrender of the Policy or as Pension (annuity payments) are taxable on receipt. The limit is ₹1,50,000 which is subject to overall limit of deductions under all the 3 sections 80C, 80CCC and 80CCD put together, as mentioned above

Section 80CCD (Contributions under the Pension Schemes notified by Central Government)

Central Government have notified contributions made under the New Pension Scheme administered by the Pension Funds Regulatory and Development Authority ('PFRDA') as eligible for deduction under Section 80CCD. PFRDA collects contribution from subscribers and invests them as per fund options with some limited flexibilities, which can be selected by the Subscribers. PFRDA invests the funds of subscribers like a Mutual fund and manages them. Employees of Public, Private Sector as well as Self employed persons can join the New Pension Scheme and subscribe to the Scheme.

Upon attaining the age of Superannuation, at least 40% of the corpus must be utilised to purchase an annuity Policy from empanelled Life insurance company, who will then pay monthly annuity to the subscriber depending on the annuity option chosen. Up to 60% of the corpus can be withdrawn as commuted value at the time of superannuation.

While the basic contributions under Section 80CCD(1) is subject to the overall deduction under Section 80C, 80CCC and 80CCD put together, Section 80CCD(1B) provides additional Rs.50,000 deduction only for the contributions to the Pension Schemes notified under the Section by Central Government, i.e. PFRDA's New Pension Scheme. The amount of contribution from employee is limited to 10% of salary.

Section 80DD (Premiums paid for Life insurance Policies taken for the benefit of dependents who are persons with disabilities)

A Life insurance Policy taken by an individual who has a dependent with some specified disabilities under the Section, will be eligible for a deduction up to ₹75,000 per year for taking the Life insurance policy for such dependents. The deduction increases to ₹1,25,000 per year where such dependents have serious disabilities.

Such Policies are taken by the Caretaker of such dependent (who must be a relative having insurable interest) on his own life and the dependent shall be the nominee who will get the benefits under the Policy upon death of the Caretaker. If the dependent predeceases the Caretaker, the amount allowed as deduction shall be deemed

to be an income in the year in which such amount is received by the Caretaker and shall be taxed accordingly.

Section 10(10D) (Treatment of benefits received under a Life insurance policy)

Any benefits paid under a Life insurance Policy is tax-free provided the premiums paid in any year does not exceed 10% of the actual capital sum assured (15% in the cases persons with certain specified illnesses or ailments). However, any paid upon death of the life assured is completely and unconditionally tax-free.

Any sum paid under Key man insurance policies are taxable in the hands of the Company (beneficiary under Key man insurance policies). Similarly any benefits received under Policies issued under sub-section (3) of Section 80DD are taxable in the hands of beneficiaries.

Annuities received under Pension policies for which a deduction has been claimed under Section 80CCC will be taxable on receipt. Commuted value received under a Pension policies at the time of superannuation is tax-free.

Goods & Services Tax

Goods and Service Tax (GST) is one of the most significant tax reforms introduced in the history of the Indian fiscal evolution. With a singular impact on the economic growth of the country and the way business is done in India, it is expected to achieve the following:

- Convert India into one market by seamless flow of tax credits – today some taxes are not creditable when goods move outside an Indian State, service tax credit is not available to a trader or a services unit cannot claim credit of Value Added Tax (VAT) paid on goods.
- Multiple taxes to be replaced by singular tax making compliance easier.
- Number of tax rates to be reduced substantially making life easier and disputes lesser.
- Compliance process to become uniform due to singular IT portal where business and government agencies interact – this can also reduce human interaction and bring transparency in operations.
- Business decisions may not be driven by tax considerations as most of the taxes will be creditable, bringing in overall efficiency in business operations spurring economic growth.
- Electronic filing and online credit matching would substantially reduce non-compliance and tax frauds – this may provide significant boost to honest businesses.

Dual GST structure

The central and state governments will levy GST simultaneously, on a common taxable value, on the supply of goods and services.

IGST - an Indian innovation

However, in the case of imports and inter- State supplies, an Integrated IGST (GST) shall be levied by the central government, proceeds of which will be shared by the central and the recipient state government. IGST is an Indian innovation which would help tax move along with goods/services, across states and therefore reduce refund situations at state borders.

Destination based tax

GST, is expected to bring a significant shift from origin-based taxation to a destination-based tax structure. This is likely to impact not only the operating business models but also the revenues of the centre/states. It has the potential to impact cash flow, pricing, working capital, supply chain and IT systems and hence provides an

opportunity to transform your business.

Goods and services will be taxed by both the governments

Unlike the previous regime of Service Tax, when services are taxed by the central government, sale of goods is taxed by the states while the manufacturer is taxed only by the central government, GST will allow equal opportunity to the centre and the state to tax all supplies of goods and services. In this respect, it establishes the truly federal character of Indian fiscal system.

GST on Insurance services

The GST rate on insurance services is 18%. The value of taxable services for insurance on which the 18% rate is applied is as follows:

- For ULIPs (other than Single premium annuity): Where policy has dual benefits of risk coverage and investment – Taxable value is gross premium charged less amount allocated for investments or savings if such allocation is intimated to the policy holder at the time of collection of premium.
- For Single Premium ULIPs (Annuity): Single premium annuity policy where allocation for investments and savings is not intimated to the policy holder – taxable value is ten percent of the single premium charged from the policy holder.
- Pure risk cover Policies: Where insurance policy has benefit of risk coverage only, then taxable value is entire premium charged from the policy holder.
- Other Policies (Endowment Policies etc.) - Twenty five percent of premium charged from the policy holder in the first year and twelve and a half percent of premium charged for subsequent years.

ANTI-MONEY LAUNDERING GUIDELINES

Background

Money constitutes the blood of the financial system. Banks and Financial institutions which are dealing in public money by providing a variety of services to the customers are more vulnerable to money laundering activities. Lack of any kind of preventive and detective mechanism will lead to a loss of reputational risk which is valuable to any organisation.

As per Financial Action Task Force (FATF) the aggregate size of money laundering in the world could be somewhere between two and five percent of the world's Economic output or anywhere between \$590 billion to \$1.5 trillion.

Why is it called Money Laundering?

The word 'Money Laundering' is apt since it describes perfectly the mechanism of introducing 'Illegal' or 'Dirty Money' in the system and is put through a cycle of transactions so that it comes out washed at the other end and is called 'Legal' or 'Clean' Money. Criminal enterprises generate funds in a myriad of different ways. But, the primary stages of money laundering remain the same for all crimes:

- (1) placement of the criminal proceeds into the financial or other transfer system;
- (2) layering the funds so as to conceal their original source; and
- (3) integration into the legitimate financial markets such as banks, companies, real estate and many others

Macro-economic consequences of Money Laundering

World governments are making strenuous efforts to combat money laundering and terrorist financing. Some of macro-economic consequences of Money Laundering are as follows:

- It can pose risks to the soundness of financial institutions and financial systems.
- It contaminates legal financial transactions.
- It can increase the volatility of international capital flows and exchange rates due to huge unanticipated cross border transfers.

Global Attention

Following are some of the key reasons why the issue of Money Laundering is gaining global attention:

1. The 9/11 plane crash that brought down the World Trade Centre, New York that killed many people including the hijackers and the passengers as the World watched helplessly.
2. The terrorist activities in Jammu & Kashmir and the 26/11 Mumbai carnage created by terrorists.
3. Eruption of terrorist activities in many pockets all around the World.

Regulatory Framework

The Prevention of Money Laundering Act, 2002 brought into force with effect from 1 July 2005, is applicable to all the financial institutions which include insurance institutions mandate all financial institutions to report Cash Transaction Reports (CTR), Suspicious Transaction Reports (STR) & Counterfeit Currency Reports (CCR)

IMPORTANT ASPECTS IN CURBING MONEY LAUNDERING

5 Ticks that are considered important in an Effective AML Regime

- ✓ Know your Customer at inception as well as on an Ongoing basis & validation of the documents
- ✓ Risk Profiling of the Customer
- ✓ Imparting training to staff
- ✓ Account Monitoring and Reporting of transactions
- ✓ Effective System Controls including internal audit

Let us go through all the above aspects one by one in detail:

1. Know Your Customer at inception as well as on an Ongoing basis & Validation of the documents

If we do not know who our customers are, how do we reach them?

Hence identifying customers is very important. Also, the AML checks carried out at account opening stage are very closely linked to anti-fraud measures and are one of the primary controls for preventing criminals opening accounts or obtaining services from financial institutions. Hence, Companies should have an effective strong control at this stage akin to a 'Strong Gatekeeper'. The following lists down the various stages where the Customer identification procedure takes place:

- (a) Collection and verification of KYC & re-KYC at regular intervals – The word 'Customer' refers to the policy owner/beneficiary & assignee -It is very important for the insurance company to determine the

true identity of the all the customers who enter in to a contract either as beneficial owner or otherwise.

Aadhaar & PAN have been mandated as the 2 basic KYC documents as per the Central Government Gazette notification dated 01 July 2017 which amended the existing Prevention of Money Laundering Act. Brief summary of the requirements as per the said Gazette notification are as follows:

- Aadhaar & PAN are the only 2 basic KYC documents to be obtained
- If Aadhaar not available, Application for obtaining Aadhaar to be obtained along with an 'Officially valid document' (Passport or Driving licence or Voter's identity card or Job card issued by NREGA)
- If PAN not available, Form 60 to be obtained (Declaration giving reasons for not possessing the PAN)
- For Corporate Customers, deed of constitution like Memorandum and Articles of Association, Board resolution authorising signatories and Aadhaar and PAN card of the authorised signatory as per the Board resolution to be obtained
- Aadhaar to be validated by the Insurer with UIDAI database and confirmed. Only then KYC is confirmed. This means the identity and address provided by the Customer will have to be matched with the identity and address as per UIDAI records
- Existing Customers who have not submitted Aadhaar or PAN will also have to submit Aadhaar and PAN and Aadhaar validated by Insurer, so that these two numbers are tagged with every application form for insurance
- New Customers who are not able to provide Aadhaar or PAN may be given 6 months' time from the date of taking the Insurance Policy to submit these documents failing which their Policy will be made inoperative
- Existing customers were given time till 31 March 2018 to provide Aadhaar and PAN, if not already provided. However, by virtue of Hon'ble Supreme Court case which has been filed against insisting Aadhaar as a mandatory document for any transaction, the enforcement of this compliance has been deferred by IRDAI till the judgement of the Hon'ble Supreme Court.

It is equally important to get the KYC authenticated by an authorised person of the insurer (other than Aadhaar which is directly authenticated with the UIDAI). In case, the premium payor and proposer are different, KYC of both the person needs to be obtained. Not only collection of the aforesaid documents is essential but it is equally important to validate/authenticate the collected documents against the original by an authorised person of the Insurer.

- (b) Screening customer names against negative/black lists – Insurers need to have a robust system which prohibits the company from entering into a contract with a negative listed/barred entity. Hence, the screening of customer names against the aforesaid lists assumes importance. This screening can be a part of the scrutiny points for a branch official before the proposal is receipted or can be done centrally before the decision of accepting the proposal is arrived at. It is also important to screen the existing customer database against the negative lists on a semi-annual/annual basis to ascertain whether the existing customer's name appears in the negative lists.
- (c) Extensive/Enhanced due diligence for high risk customers – As Customer identification, equally important is the risk categorisation of the customers. A customer who is categorised as a 'high risk' person needs enhanced due diligence which should not be limited to obtaining income proofs and source of funds. A credible database can be consulted or the Insurer may choose to conduct independent enquiries.

Insurance Companies also have a grid in place depending on certain thresholds the proposals should be backed with select documentary evidences e.g. till a lower threshold for example ₹1 lakh should be backed by an acceptable latest income proof (not more than 6 months old). The documents thus obtained should be such that the same can be retrieved at a later date and evidencing the fact that the insurer has conducted adequate due diligence before issuance of contract. It is also advised to review the risk rating of a customer on an ongoing basis (say annual)

- (d) Compliance alerts for suspicious clients/unusual transactions – The Company depending on its risk monitoring framework should have a suspicious activity monitoring program that focuses on unusual patterns of transactions also to include unusually large amounts. The alert monitoring framework and process should necessarily include the attempted transactions. Illustration of an attempted transaction is where a customer has submitted a proposal however when a further requirement was raised on submitting the income related documents, the customer withdrew the policy. Such attempted transaction also needs to be reported to Financial Intelligence Unit ('FIU').

2. Risk Profiling of the Customer

It is essential to categorise the customer into High, Medium & Low risk on the basis of risk parameters e.g. on the basis of occupation of the customer or the type of product he opts for or the geographical area that the customer belongs to. Some businesses are legitimately cash based, including large parts of the retail sector and so there will often be a high level of cash deposits associated with some accounts. The risk is in failing to identify such businesses where the level of cash activity is higher than the underlying business would justify, thus providing grounds for looking more closely at whether the account is being used for money laundering or terrorist financing. Equally important is the activity of PEP profiling. The risk profiling is never a one time activity and should be revisited again for the existing clients on a semi-annual basis depending on the total policies owned by the client/change in the occupation/geographical area that the customer belongs to.

3. Imparting training to Staff

AML guidelines mandate training to all employees and agents of the Insurance Companies. It is suggested that customised trainings to be imparted to Staff on the basis of the roles & responsibilities that they carry. For example a staff who is in front line and interacts with the customer is an important defence in combating money laundering whereas for new employees, basics and background of money laundering can be imparted thus they can highlight any unusual or suspicious transactions. It is to be noted that refresher and ongoing trainings are also mandatory. Awareness about AML and reporting unusual transactions to the AML Compliance team needs to be made part of the in-house training of employees.

4. Account Monitoring and Reporting of transactions

The insurance Company should have effective alert generation process by which preliminary details of a transaction which appears to be unusual/suspicious are analysed further to determine whether it is actually suspicious or not. Alert generation sources can be branches, Risk control unit team during their investigations if they find anything suspicious, AML compliance team during their routine monitoring work, any query about the customer from Law Enforcement Agencies etc. Once it is ascertained that the transaction is suspicious, the Principal Compliance Officer needs to analyse and decide on the reporting of the transaction to Financial Intelligence Unit – India (FIU-IND). There is also a need to put a Process of Ongoing Account Monitoring and White labeling of accounts in place. It may be noted that arriving at a decision that an alert is suspicious or not cannot be just based on few considerations. It is the result of a wholistic analysis of the case and requires application of mind and judgement on the part of the Principal Compliance Officer. It is equally important to have

the AML Compliance team at a Centralized level. The centralisation of the responsibility and decision making is required to de-risk the AML monitoring process from 'Tipping off' of the information instead of having the team in regions or delegation of responsibility. It is also recommended that the process of alert generation can be more effective if it is automated to the maximum possible extent.

5. Effective System Controls including internal audit

'Internal Audit' is one of the important aspects of an AML regime that provides for comments on the robustness of the internal policies, procedures and controls related to money laundering. There should be an audit of AML systems, processes on an ongoing basis (at least semi-annually/annually). Any deviations/exceptions found should be placed before the Board. The menace of Money Laundering cannot be curbed unless the System & Controls built in it are effective. At every step of curbing money laundering and implementing processes the insurance company needs the systems and controls. For example, if there is a cash acceptance policy, we cannot check the adherence till the system control is built to check the allowable amount per customer at a pre-defined frequency. Screening of the customer names against the black listed names is not effective unless it is system driven, because the Company needs to screen the customer names against the names & also known as (alias) names of the black listed individuals. The controls can be a mix of systems plus manual review. The controls in the system should also be tested on an ongoing basis. There should be an AML policy which lists down the 'Roles & Responsibilities' of each department in the AML regime, controls in place etc. This needs to be approved by the Board and reviewed every year. The Board needs to be apprised on a quarterly/semi-annual basis a summary of trainings imparted, transactions reported etc.

Preservation of records

As per the IRDA AML guidelines, the insurers/agents/corporate agents are required to maintain the records of type of transactions mentioned in Rule 3 of the Prevention of Money Laundering Rules 2005 as well as those relating to verification of identity of clients for a period of 5 years. Sharing of information on customers may be permitted between different organisations such as banks, insurance companies, Income tax authorities, local government authorities on request. Records can also be maintained in electronic form.

Reporting of Transactions to Financial Intelligence Unit ('FIU')

Cash Transaction Reporting

Payment of any amount in cash to an Insurance company for an amount exceeding Rs.10 lakhs is reportable as Cash Transaction Report to FIU

Suspicious Transaction Reporting

A Suspicious transaction is one which lacks economic rationale and raises a doubt in the minds of the insurer on the genuineness of the transaction. Such transactions are also reportable to FIU.

For example, if a Policyholder is paying premium in multiple demand drafts, say 5 demand drafts for a Premium of Rs.2 lakhs, it is possible that cash would have been used to purchase a Demand draft and since Banks restrict issuance of Demand draft across counter unless a person has a Bank account, multiple demand drafts would have been necessitated. This is a reportable Suspicious Transaction. The following are the minimum pre-requisites that should be in place as a starting point to institutionalise the AML Compliance Framework in any Insurance Company:

- (a) Robust KYC and enhanced KYC verification process
- (b) In depth training of the front line and back office employees

- (c) System of generation of alerts to enable the Principal Compliance Officer to analyse and prepare Suspicious and Cash Transaction Reports
- (d) Effective internal audit as an independent overseeing mechanism and who conducts audits on an ongoing basis
- (e) Board governance for monitoring the AML compliance framework
- (f) Control over acceptance of Cash
- (g) Screening of names of Sanctioned parties before issuance of a policy
- (h) Trained & Vigilant AML team to monitor transactions
- (i) Adherence to the AML guidelines by individual/corporate agents

It is the responsibility of the Principal Compliance Officer to ensure that the AML compliance framework is in place and ensure that the processes are running effectively and efficiently.

IRDAI defers the effective date for implementation of Ind AS in the insurance sector to 1 April 2020

The Insurance Regulatory Development Authority of India (IRDAI) through its order dated 17 November 2015 stated that the insurance sector in India would converge with International Financial Reporting Standards (IFRS) after the issuance of the revised standard on insurance contracts by the International Accounting Standards Board (IASB).

Subsequently, the Ministry of Corporate Affairs (MCA) on 30 March 2016 notified the road map for implementation of Ind AS for Scheduled Commercial Banks, insurance companies and Non-Banking Financial Companies (NBFCs) from 1 April 2018 onwards.

The IRDAI also constituted an Implementation Group (IG) on 17 November 2015 to facilitate Ind AS convergence for the Indian insurance sector. On 29 December 2016, the IG submitted its report to the IRDAI, highlighting the potential Ind AS implementation issues for insurers in India along with its recommendations to ease out the implementation process. Additionally, the insurance companies were directed to submit proforma Ind AS financial statements from the quarter ended 31 December 2016 in the specified formats (IRDAI circular no. IRDA/F&A/CIR/ACTS/262/12/2016 dated 30 December 2016).

On 18 May 2017, the IASB issued the much awaited comprehensive international standard on insurance i.e. IFRS 17, Insurance Contracts. IFRS 17 replaces IFRS 4, Insurance Contracts which was in the nature of an interim standard pending the completion of the project on insurance contracts by the IASB. The release of IFRS 17 standard led to IRDAI to review its position in the matter of implementation of Ind AS in the insurance sector.

The Board of IRDAI in its meeting dated 31 May 2017 noted the peculiarities of the insurance sector in India, specifically the fact that India does not have a standard equivalent to International Accounting Standard (IAS) 39, Financial Instrument: Recognition and Measurement. The IRDAI concluded that implementation of Ind AS in the present form is expected to lead to a position where assets would be valued on fair value/market value basis and liabilities would continue to be valued as per the existing formula based approach. This would lead to mismatch in the asset and liability valuation and would also cause volatility in the financial statements of the insurance companies.

Additionally, IRDAI observed that the compliance costs would have to be incurred twice – once immediately on implementation of Ind AS and second when IFRS 17 would be implemented in India.

After considering the given facts, IRDAI through its circular no. IRDA/F&A/CIR/ACTS/146/ 06/2017 dated 28 June 2017 deferred the implementation of Ind AS in the insurance sector in India for a period of two years. Accordingly, Ind AS for Indian insurance companies would be applicable from 1 April 2020 (instead of 1 April 2018).

However, insurance companies would still be required to submit the proforma Ind AS financial statements to IRDAI on a quarterly basis effective from 31 December 2016. Therefore, the requirement to submit proforma Ind AS financial statements on a quarterly basis has not been deferred.

LESSON ROUND UP

- Section 129 of the Indian Companies Act, 2013 requires every Company to prepare Financial statements which give a true and fair view of the financial position of the Company in accordance with the Accounting Standards and in accordance with Schedule III to the said Act.
- Special formats of Financial statements for Life insurance companies.
- Life Insurers shall prepare Financial Statements as per specified Forms such as Revenue Account (Form A-RA), Profit and Loss Account (Form A-PL) and Balance Sheet (Form A-BS) as per Part V in Schedule A of Regulation III. The said financial statements will be prepared in accordance with General Instructions for preparations as per Part III. The said financial statements shall be supported by disclosures forming part of financial statements and the comments of management report as per Part II and Part IV respectively, of the Schedule A
- Section 40 of the Insurance Act, 1938 empowers IRDAI to frame Regulations on Expenses of Management for Insurance companies. Under these provisions, Insurance companies are required to contain their expenses of running insurance business within certain ceilings which are calculated as a percentage to the Premium income generated by the Insurance company.
- Insurance companies generally function on two dimensional landscapes which include (a) underwriting activity which is mainly centered on collecting premiums and honouring claim, and (b) investment activity which is meant to dispense assets into various investments to earn additional revenues in the form of interests, dividends and realised capital gains.
- Policyholders who take Life insurance policies which are eligible for participating in the surplus arising out of the Participating business are eligible for bonus, if and when declared by the Life insurance company
- IRDAI defers the effective date for implementation of Ind AS in the insurance sector to 1 April 2020
- Income-tax Act, 1961 governs the provisions relating to taxation of income arising out of Life insurance business. Section 44 read with First Schedule of the Income-tax Act 1961 provides that the Profits and Gains of Life insurance business shall be calculated at the rate of 12.5% plus applicable surcharge on the amount arrived.
- Under Section 80C of the Income-tax Act, 1961, any premiums paid for a Life Insurance Policy on the life of the person, his/her spouse or children is eligible for a deduction from the Gross Total income a person.
- Under Section 80CCC, the premiums paid for a Pension Policy issued by a Life insurance company is eligible for a deduction. Any amount received under a Pension Policy on account of surrender of the Policy or as Pension (annuity payments) are taxable on receipt. The limit is `1,50,000 which is subject

to overall limit of deductions under all the 3 sections 80C, 80CCC and 80CCD put together.

- Central Government have notified contributions made under the New Pension Scheme administered by the Pension Funds Regulatory and Development Authority ('PFRDA') as eligible for deduction under Section 80CCD.
- A Life insurance Policy taken by an individual who has a dependent with some specified disabilities under the Section, will be eligible for a deduction up to `75,000 per year for taking the Life insurance policy for such dependents. The deduction increases to `1,25,000 per year where such dependents have serious disabilities.
- Any benefits paid under a Life insurance Policy is tax-free provided the premiums paid in any year does not exceed 10% of the actual capital sum assured (15% in the cases persons with certain specified illnesses or ailments). However, any paid upon death of the life assured is completely and unconditionally tax-free.
- The GST rate on insurance services is 18%.
- The Prevention of Money Laundering Act, 2002 brought into force with effect from 1 July 2005, is applicable to all the financial institutions which include insurance institutions mandate all financial institutions to report Cash Transaction Reports (CTR), Suspicious Transaction Reports (STR) & Counterfeit Currency Reports (CCR).

GLOSSARY

IRDAI: Insurance Regulatory and Development Authority of India.

AS: Accounting Standards

VIP: Variable Insurance Products

CFS: Cash Flow Statement

FS: *Financial Statements*

IFRS: International Financial Reporting Standards

IASB : International Accounting Standards Board

MCA : Ministry of Corporate Affairs

IG: Implementation Group

NBFC: Non-Banking Financial Companies

TVM: Time Value Of Money

PAA: Premium Allocation Approach

OCI: Other Comprehensive Income

SELF TEST QUESTIONS

These are meant for re-capitulation only. Answers to these questions are not to be submitted for evaluation.

1. What is represented by the Bill of lading?
2. What is multi modal transportation?

Lesson 7

Health Insurance

LESSON OUTLINE

- Health Insurance in India
- Categorization of Health Insurance Plans
- Health Financing Models and Health Financing in India
- Government Sponsored Health Insurance Schemes
- Health Insurance Underwriting Policy
- Health Insurance Policy Forms And Clauses
- Legal Framework of Health Insurance
- Health Insurance Regulation
- Duties, Power and Functions of Insurance Regulatory and Development Authority
- Regulating Third Party Administrators
- Claims
- Portability of Health Insurance Policies
- Non-Life and Health Package Products
- Health Insurance Fraud
- Reinsurance
- LESSON ROUND UP
- SELF-TEST QUESTIONS

LEARNING OBJECTIVES

Health insurance is insurance that covers the whole or a part of the risk of a person incurring medical expenses, spreading the risk over a large number of persons. A health insurance policy is a contract between an insurance provider (e.g. an insurance company or a government) and an individual or his/her sponsor (e.g. an employer or a community organization).

It has been seen that in recent years there has been a greater focus on health in recent years resulting in larger allocation to the sector especially in the context of the National Rural Health Mission.

It is the decision of the insurer to accept or reject or postpone or make a counter-offer after assessment of the risk on the Proposal for insurance cover submitted by a customer. Portability is the right accorded to the Policyholder to transfer the credit gained for pre-existing conditions and time-bound exclusions from one insurer to another insurer or from one plan to another plan of the same insurer.

In Health Insurance Fraud, false or misleading information is provided to a health insurance company in an attempt to have them pay unauthorized benefits to the policy holder, another party, or the entity providing services.

This chapter will tell about how the insurance evolved over time. It will also explain what healthcare is, level of healthcare and type of healthcare. The students will also learn about the healthcare system in India and factors affecting it.

INTRODUCTION

Health insurance is insurance that covers the whole or a part of the risk of a person incurring medical expenses, spreading the risk over a large number of persons. By estimating the overall risk of health care and health system expenses over the risk pool, an insurer can develop a routine finance structure, such as a monthly premium or payroll tax, to provide the money to pay for the health care benefits specified in the insurance agreement. The benefit is administered by a central organization such as a government agency, private business, or not-for-profit entity.

A health insurance policy is a contract between an insurance provider (e.g. an insurance company or a government) and an individual or his/her sponsor (e.g. an employer or a community organization). The contract can be renewable (e.g. annually, monthly) or lifelong in the case of private insurance, or be mandatory for all citizens in the case of national plans. The type and amount of health care costs that will be covered by the health insurance provider are specified in writing, in a member contract or “Evidence of Coverage” booklet for private insurance, or in a national health policy for public insurance.

The individual insured person’s obligations may take several forms:

- **Premium:** The amount the policy-holder or their sponsor (e.g. an employer) pays to the health plan to purchase health coverage.
- **Deductible:** The amount that the insured must payout-of-pocket before the health insurer pays its share. For example, policy-holders might have to pay a ₹500 deductible per year, before any of their health care is covered by the health insurer. It may take several doctor’s visits or prescription refills before the insured person reaches the deductible and the insurance company starts to pay for care. Furthermore, most policies do not apply co-pays for doctor’s visits or prescriptions against your deductible.
- **Co-payment:** The amount that the insured person must pay out of pocket before the health insurer pays for a particular visit or service. For example, an insured person might pay a ₹45 co-payment for a doctor’s visit, or to obtain a prescription. A co-payment must be paid each time a particular service is obtained.
- **Coinsurance:** Instead of, or in addition to, paying a fixed amount up front (a co-payment), the co-insurance is a percentage of the total cost that insured person may also pay. For example, the member might have to pay 20% of the cost of a surgery over and above a co-payment, while the insurance company pays the other 80%. If there is an upper limit on coinsurance, the policy-holder could end up owing very little, or a great deal, depending on the actual costs of the services they obtain.
- **Exclusions:** Not all services are covered. Billed items like use-and-throw, taxes, etc are excluded from admissible claim. The insured are generally expected to pay the full cost of non-covered services out of their own pockets.
- **Coverage limits:** Some health insurance policies only pay for health care up to a certain dollar amount. The insured person may be expected to pay any charges in excess of the health plan’s maximum payment for a specific service. In addition, some insurance company schemes have annual or lifetime coverage maxima. In these cases, the health plan will stop payment when they reach the benefit maximum, and the policy-holder must pay all remaining costs.
- **Out-of-pocket maxima:** Similar to coverage limits, except that in this case, the insured person’s payment obligation ends when they reach the out-of-pocket maximum, and health insurance pays all further covered costs. Out-of-pocket maxima can be limited to a specific benefit category (such as

prescription drugs) or can apply to all coverage provided during a specific benefit year.

- **Capitation:** An amount paid by an insurer to a health care provider, for which the provider agrees to treat all members of the insurer.
- **In-Network Provider:** A health care provider on a list of providers pre-selected by the insurer. The insurer will offer discounted coinsurance or co-payments, or additional benefits, to a plan member to see an in-network provider. Generally, providers in network are providers who have a contract with the insurer to accept rates further discounted from the “usual and customary” charges the insurer pays to out-of-network providers.
- **Prior Authorization:** A certification or authorization that an insurer provides prior to medical service occurring. Obtaining an authorization means that the insurer is obligated to pay for the service, assuming it matches what was authorized. Many smaller, routine services do not require authorization.
- **Explanation of Benefits:** A document that may be sent by an insurer to a patient explaining what was covered for a medical service, and how payment amount and patient responsibility amount were determined.

HEALTH INSURANCE IN INDIA

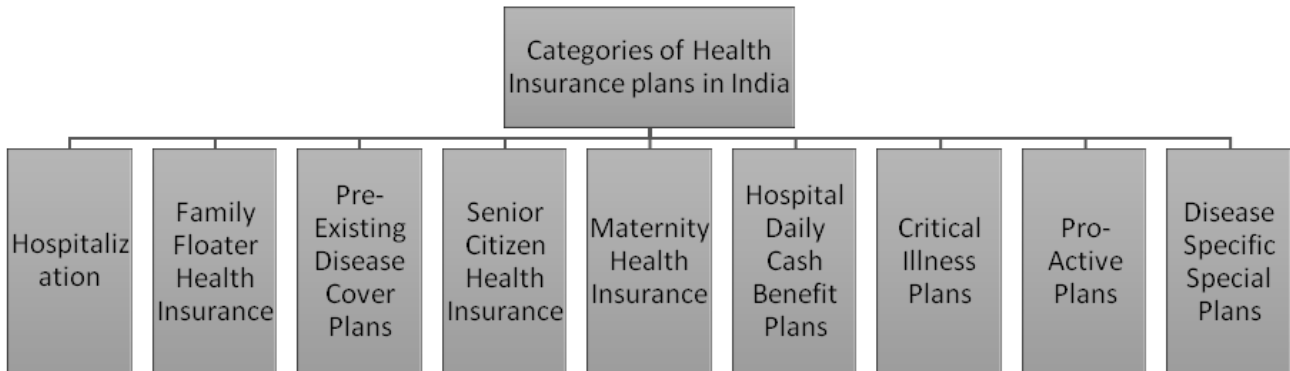
Health Insurance in India is a growing segment of India's economy. In 2011, 3.9% of India's gross domestic product was spent in the health sector. According to the World Health Organisation (WHO), this is among the lowest of the BRICS (Brazil, Russia, India, China, South Africa) economies. Policies are available that offer both individual and family cover. Out of this 3.9%, health insurance accounts for 5-10% of expenditure, employers account for around 9% while personal expenditure amounts to an astounding 82%. In the year 2016, the NSSO released the report “Key Indicators of Social Consumption in India: Health” based on its 71st round of surveys. The survey carried out in the year 2014 found out that, more than 80% of Indians are not covered under any health insurance plan, and only 18% (government funded 12%) of the urban population and 14% (government funded 13%) of the rural population was covered under any form of health insurance.

Launched in 1986, the health insurance industry has grown significantly mainly due to liberalization of economy and general awareness. According to the World Bank, by 2010, more than 25% of India's population had access to some form of health insurance. There are standalone health insurers along with government sponsored health insurance providers. Until recently, to improve the awareness and reduce the procrastination for buying health insurance, the General Insurance Corporation of India and the Insurance Regulatory and Development Authority (IRDA) had launched an awareness campaign for all segments of the population.

Health insurance in India typically pays for only inpatient hospitalization and for treatment at hospitals in India. Outpatient services were not payable under health policies in India. The first health policies in India were Mediclaim Policies. In Year 2000, Government of India liberalized insurance and allowed private players into the insurance sector. The advent of private insurers in India saw the introduction of many innovative products like family floater plans, top-up plans, critical illness plans, hospital cash and top up policies.

The health insurance sector hovers around 10% in density calculations. One of the main reasons for the low penetration and coverage of health insurance is the lack of competition in the sector. IRDA which is responsible for insurance policies in India can create health circles, similar to telecom circles to promote competition.

Health insurance plans in India today can be broadly classified into these categories:



Hospitalization

Hospitalization plans are indemnity plans that pay cost of hospitalization and medical costs of the insured subject to the sum insured. The sum insured can be applied on a per member basis in case of individual health policies or on a floater basis in case of family floater policies. In case of floater policies the sum insured can be utilized by any of the members insured under the plan. These policies do not normally pay any cash benefit. In addition to hospitalization benefits, specific policies may offer a number of additional benefits like maternity and newborn coverage, day care procedures for specific procedures, pre- and post-hospitalization care, domiciliary benefits where patients cannot be moved to a hospital, daily cash, and convalescence.

There is another type of hospitalization policy called atop-up policy. Top up policies have a high deductible typically set a level of existing cover. This policy is targeted at people who have some amount of insurance from their employer. If the employer provided cover is not enough people can supplement their cover with the top-up policy. However, this is subject to deduction on every claim reported for every member on the final amount payable.

Family Floater Health Insurance

Family health insurance plan covers entire family in one health insurance plan. It works under assumption that not all member of a family will suffer from illness in one time. It covers hospital expense which can be pre and post. Most of health insurance companies in India offering family insurance have good network of hospitals to benefit the insurer in time of emergency.

Pre-Existing Disease Cover Plans

It offers covers against disease that policyholder had before buying health policy. Pre-Existing Disease Cover Plans offers cover against pre-existing disease e.g diabetes, kidney failure and many more. After Waiting period of 2 to 4 years it gives all covers to insurer.

Senior Citizen Health Insurance

As name suggests these kinds of health insurance plans are for older people in the family. It provides covers and protection from health issues during old age. According to IRDA guidelines, each insurer should provide cover up to the age of 65 years.

Maternity Health Insurance

Maternity health insurance ensures coverage for maternity and other additional expenses. It takes care of both pre and post natal care, baby delivery (either normal or caesarean). Like Other Insurance, The maternity insurance provider has wide range of network hospitals and takes care of ambulance expense.

Hospital Daily Cash Benefit Plans

Daily cash benefits are a defined benefit policy that pays a defined sum of money for every day of hospitalization. The payments for a defined number of days in the policy year and may be subject to a deductible of few days.

Critical Illness Plans

These are benefit based policies which pay a lump-sum (fixed) benefit amount on diagnosis of covered critical illness and medical procedures. These illnesses are generally specific and high severity and low frequency in nature that cost high when compared to day to day medical / treatment need. e.g. heart attack, cancer, stroke etc. Now some insurers have come up with option of staggered payment of claims in combination to upfront lump-sum payment.

Pro Active Plans

Some companies like Cigna TTK offer Pro-active living programs. These are designed keeping in mind the Indian market and provide assistance based on medical, behavioural and lifestyle factors associated with chronic conditions. These services aim to help customers understand and manage their health better.

Disease Specific Special Plans

Some companies offer specially designed disease specific plans like Dengue Care. These are designed keeping in mind the growing occurrence of viral diseases like Dengue in India which has become a cause of concern and thus provide assistance based on medical needs, behavioural and lifestyle factors associated with such conditions. These plans aim to help customers manage their unexpected health expenses better and at a very minimal cost.

Healthcare has become one of India's largest sectors - both in terms of revenue and employment. Healthcare comprises hospitals, medical devices, clinical trials, outsourcing, telemedicine, medical tourism, health insurance and medical equipment. The Indian healthcare sector is growing at a brisk pace due to its strengthening coverage, services and increasing expenditure by public as well private players.

Indian healthcare delivery system is categorised into two major components - public and private. The Government, i.e. public healthcare system comprises limited secondary and tertiary care institutions in key cities and focuses on providing basic healthcare facilities in the form of primary healthcare centres (PHCs) in rural areas. The private sector provides majority of secondary, tertiary and quaternary care institutions with a major concentration in metros, tier I and tier II cities. India's competitive advantage lies in its large pool of well-trained medical professionals. India is also cost competitive compared to its peers in Asia and Western countries. The cost of surgery in India is about one-tenth of that in the US or Western Europe.

Market Size

The healthcare market can increase three-fold to ₹8.6 trillion (US\$ 133.44 billion) by 2022. India is experiencing 22-25 per cent growth in medical tourism and the industry is expected to double its size from US\$ 3 billion in April 2017 to US\$ 6 billion by 2018. Medical tourist arrivals in India increased to 1.07 million in January 2018 from 0.98 million in January 2017.

There is a significant scope for enhancing healthcare services considering that healthcare spending as a

percentage of Gross Domestic Product (GDP) is rising. Rural India, which accounts for over 70 per cent of the population, is set to emerge as a potential demand source. In 2017, the Government of India has provided grant-in-aid for setting up of AYUSH educational institutions in States and Union Territories.

Investment

The hospital and diagnostic centers attracted Foreign Direct Investment (FDI) worth US\$ 4.99 billion between April 2000 and December 2017, according to data released by the Department of Industrial Policy and Promotion (DIPP). Some of the recent investments in the Indian healthcare industry are as follows:

- India and Cuba have signed a Memorandum of Understanding (MoU) to increase cooperation in the areas of health and medicine, according to Ministry of Health and Family Welfare, Government of India.
- Fortis Healthcare has approved the de-merger of its hospital business with Manipal Hospital Enterprises. TPG and Dr. Ranjan Pal could invest Rs. 3,900 crore (US\$ 602.41 million) in Manipal Hospital Enterprise.

Government Initiatives

Some of the major initiatives taken by the Government of India to promote Indian healthcare industry are as follows:

- India's first ever 'Air Dispensary', which is based in a helicopter, will be launched in the Northeast and the Ministry of Development of Northeast Region (DONER) has already contributed Rs 25 crore (US\$ 3.82 million) for its funding.
- The Intensified Mission Indra dhanush (IMI) has been launched by the Government of India with the aim of improving coverage of immunisation in the country and reaches every child under two years of age and all the pregnant women who have not been part of the routine immunisation programme.
- The Union Cabinet approved setting up of National Nutrition Mission (NNM) with a three year budget of Rs 9,046.17 crore (US\$ 1.40 billion) to monitor, supervise, fix targets and guide the nutrition related interventions across the Ministries.
- The Government of India aims to increase the total health expenditure to 2.5 per cent of Gross Domestic Product (GDP) by 2025 from the current 1.15 per cent.
- Mr. J P Nadda, Union Minister of Health and Family Welfare, Government of India, launched initiatives such as LaQshya, for Labour Room Quality Improvement, a mobile application for safe delivery, and operational guidelines for obstetric high dependency units (HDUs) and intensive care units (ICUs).
- In March 2018, the Union Cabinet of India approved the continuation of National Health Mission with a budget of Rs 85,217 crore (US\$ 13.16 billion) from 1st April 2017 to 31st March 2020.
- In April 2018, the Government of India approved to sign Memorandum of Understanding (MoU) with the medical agencies of BRICS countries for cooperation in the field of medical products.
- In April 2018, the Government of India apprised the signing of Memorandum of Agreement (MoA) between India and World Health Organisation to facilitate in improving public health in India.
- In May 2018, the Government of India approved financial outlay of ₹14,832 crores (US\$ 2.30 billion) for FY2017-18 to FY2019-20.
- In May 2018, the Government of India approved ₹1,103 crore (US\$ 170.14 million) for setting up All India Institute of Medical Sciences (AIIMS) in Deoghar, Jharkhand.

- In June 2018, the Ministry of Health and Family Welfare signed an Memorandum of Understanding (MoU) with the Norwegian Ministry of Foreign Affairs through the Norway India Partnership Initiative (NIPI) from 2018-2020, the cooperation is aligned with National Health Policy 2017.

Road Ahead

India is a land full of opportunities for players in the medical devices industry. India's healthcare industry is one of the fastest growing sectors and in the coming 10 years it is expected to reach \$275 billion. The country has also become one of the leading destinations for high-end diagnostic services with tremendous capital investment for advanced diagnostic facilities, thus catering to a greater proportion of population. Besides, Indian medical service consumers have become more conscious towards their healthcare upkeep.

Indian healthcare sector is much diversified and is full of opportunities in every segment which includes providers, payers and medical technology. With the increase in the competition, businesses are looking to explore for the latest dynamics and trends which will have positive impact on their business.

India's competitive advantage also lies in the increased success rate of Indian companies in getting Abbreviated New Drug Application (ANDA) approvals. India also offers vast opportunities in R&D as well as medical tourism. To sum up, there are vast opportunities for investment in healthcare infrastructure in both urban and rural India.

HEALTH FINANCING MODELS AND HEALTH FINANCING IN INDIA

It has been seen that in recent years there has been a greater focus on health in recent years resulting in larger allocation to the sector especially in the context of the National Rural Health Mission. The provision of flexible funds to State governments under NRHM Flexi-Pool has provided an opportunity for States to develop and implement innovative programmes. Other NRHM financing strategies such as untied funds to institutions, financing of NGO sector for public health goals and risk pooling where money follows patient, has the potential to strengthen and widen the reach of public health care services. Key concerns with regard to financing of the public sector include:

1. Budget formulation by and large continues to be incremental and normative, even though current policy favors outcome budgeting and need based allocation, Mechanisms for using decentralized planning as tool for identifying local requirements and involving communities in developing need based programmes as envisaged under NRHM are yet to be institutionalized.
2. Budget documents are complex and not user friendly. They are technical documents and it is difficult for the average person to identify key fiscal trends or expenditure priorities. Complexity of budget on account of multiplicity of central and state schemes and multiple provisions to the same entity arises from a complex budget classification system that is followed in the government. While, the 19 digit classification system currently followed by the government meets the needs of legislative sanction and oversight, it is quite dysfunctional when it comes to the requirements of the administrator as the budget is prepared neither by function nor by the provider. A particular function is provided under many providers as also a provider serves many functions. As a result, if one wants to get an idea of budget by a function or provider, it will have to be obtained by going through the entire budget, a task that is complex and confusing even for trained finance specialist.
3. NRHM is often seen as an entirely new programme bringing with it fresh allocation of funds. However, NRHM funds also subsume existing allocation for RCH and other disease control programmes. There is need for better clarity on the resource envelope for NRHM, pooling of resources and the process of budgeting under NRHM.
4. Funds flow to the district from the state budget which also comprises of central funds for national programmes and through off-budget mechanisms under NRHM and NACP. Funds under NRHM are provided under

different programmes through different mechanisms at the level of district and below. The variety of funds flow mechanisms makes lower level budgets confusing. There is need for greater clarity regarding allocation for districts and who provides for it.

5. There is need to systematically track and study flow of funds from the centre to state and then to district and below, right up to the level of the beneficiary. In the absence of which, an assessment of impact and efficiency of health spending cannot be done. In the context of NRHM it would be particularly useful to have an idea of the impact of NRHM financing strategies such as provision of flexible funds.

6. The central government is committed to increasing budget allocation by about 30% annually in moving towards the National Health Policy goal of increasing public spending on health to around 2-3% of the GDP. However, there is lack of an evidence based resource envelope for health. A key constraint has been the lack of data on financial costs. The National Commission of Macroeconomics and Health has made a key contribution in providing estimates of unit costs of facilities and costing of programmes at the national level. However, there is requirement for more disaggregate data on financial costs for managing diseases and conditions and prevalence rates at district level for arriving at a more meaningful resource envelope. There is a need to develop methodologies for collecting such financial data on a regular basis.

7. While working towards developing methodologies for collecting disaggregate data on financial costs, it would be useful to study data that is currently available. Costing studies have been carried out in the country and sharing of reports on a website could be a good option for pooling of such data. Care should be taken to see that the data is used properly, including acknowledgement of data source.

8. Most states have not been able to satisfactorily utilize funds allocated under NRHM. Given the available evidence to justify significant allocation of public funds to the health sector, the inability to spend allocated funds is a matter of deep concern especially for the poorly performing states.

9. Weak absorption capacity in the public sector is linked to systemic and institutional issues as well as poor designing of expenditure items. Lack of stability and flexibility in the budgetary processes has been a major reason for the government to adopt the society mode of funding the health sector, as in the case of NRHM. Potential areas which could have an impact on under spending of NRHM funds and requires studying were identified by the group. They include:

- NRHM financing is linked to strategies such as decentralized planning and implementation; integration of health programmes with the general health services; inter-sectoral convergence; central role of Panchayati Raj Institutions (PRIs) in planning, managing and monitoring public health services; and promotion of nonprofit sector in health service delivery. Efforts towards operationalizing these strategies are still in rudimentary stages in many States.
- Capacity for planning and programme management has been generally weak in the health services. Further, the NRHM framework requires development of capacities in health departments for effectively managing coordination within the health services, collaboration with departments having complementary functions and building partnerships.
- Lack of clear guidelines in managing flexible funds. While flexible funds are meant for use as per local requirements, key personnel and oversight committees are not yet empowered with capacities to prioritize and plan for requirements.
- Weak financial capabilities within health services. Capacity in budgeting and accounting functions is deficient not only in numbers but also in quality. At the State level, financial management is generally vested with few officers and support staff. In the district offices the accounts are being maintained

mostly by junior assistants and senior assistants who do not have relevant educational qualification or formal training in maintaining accounts. In health facilities, the departmental personnel manage the finance functions as drawing & disbursing officers (DDOs) and are often vested with accounting functions also. They are in many instances medical officers with no training in management of financial systems.

- Use of information technology in maintenance of accounts and monitoring of spending is generally weak

GOVERNMENT SPONSORED HEALTH INSURANCE SCHEMES

Rashtriya Swasthya Bima Yojana ('RSBY')

This is a Health insurance scheme launched by the Ministry of Labour and Employment, Government of India for Below the Poverty Line ('BPL') families. The beneficiary under this Scheme is any Family included as BPL family in the District BPL List prepared by State Governments. Such BPL family needs to enrol by identifying before the authorised official

Benefits (insurance coverage)

Under this Scheme, hospitalisation expenses up to ₹30,000 for a family comprising of up to 5 members is provided on a floater basis. Under a floater cover any one or more of the members is eligible to claim the hospitalisation expenses. In addition, cost of Transportation up to ₹100 per visit with a ceiling of ₹1,000 is also reimbursed. No age limits have been prescribed for the Members to get enrolled into this Scheme. Hospitalisation means admission to hospital for 24 hours or more. RSBY applies to such hospitalisation, including maternity related treatments. However, it includes such day care treatments entailing less than 24 hours for certain treatments specified in the Scheme. All pre-existing illnesses on the date of admission to the Scheme are also covered.

Premium payable

The Premium payable for RSBY is different for different districts. State Governments select insurance companies through a bidding process and technically qualified lowest bidder is selected.

Who pays the Premium

Total premium is funded by the Central and State Governments, with Central Government bearing 75% of the Premium payable (90% in the case of J&K State) and the balance is borne by the respective State Government. Beneficiaries will have to pay only an Enrolment fee of ₹30.

Policy coverage period

The Policy is issued by the concerned Insurance Company for a maximum period of 1 year and usually ends on 30 April and can be renewed for further periods of 1 year. An active Smart Card is issued to the Beneficiary to claim the benefits. Over 3.50 Crore beneficiaries have been issued Smart Cards and over 1.40 Crores beneficiaries have availed benefits as of 31 March 2017 under this Scheme.

Employees State Insurance

Employees State Insurance Act, 1948 is the governing Act in this regard. Under Section 2(12) the Act is applicable to non-seasonal factories employing 10 or more persons.

Under Section 1(5) of the Act, the Scheme has been extended to shops, hotels, restaurants, cinemas including

preview theatres, road-motor transport undertakings and newspaper establishments employing 10 or more persons.

Further under section 1(5) of the Act, the Scheme has been extended to Private Medical and Educational institutions employing 10 or more persons in certain States/Union Territories.

What is ESI Scheme?

Employees' State Insurance Scheme of India is a multi-dimensional Social Security Scheme tailored to provide Socio-economic protection to the 'employees' in the organised sector against the events of sickness, maternity, disablement and death due to employment injury and to provide medical care to the insured employees and their families.

How does the scheme help the employees?

The scheme provides full medical care to the employee registered under the ESI Act, 1948 during the period of his incapacity, restoration of his health and working capacity. It provides financial assistance to compensate the loss of his/ her wages during the period of his abstinence from work due to sickness, maternity and employment injury. The scheme provides medical care to his/her family members also.

Who administers the ESI Scheme?

The ESI Scheme is administered by a statutory corporate body called the Employees' State Insurance Corporation (ESIC), which has members representing Employers, Employees, the Central Government, State Government, Medical Profession and the Hon'ble Members of Parliament. Director General is the Chief Executive Officer of the Corporation and is also an ex-officio member of the Corporation.

The ESI scheme is a self financing scheme. The ESI funds are primarily built out of contribution from employers and employees payable monthly at a fixed percentage of wages paid. The State Governments also bear 1/8th share of the cost of Medical Benefit.

What is registration of Factory/ Establishment?

Registration is the process, by which every factory/ establishment, to which the Act applies, gets itself registered online for compliance. Otherwise when a factory/ establishment is identified by ESIC, it is asked to get itself registered under the Act. It is the statutory responsibility of the employer under Section 2A of the Act read with Regulation 10-B, to register their Factory/ Establishment under the ESI Act within 15 days from the date of its applicability to them.

If the wages of an employee exceeds ₹21,000 in a month, he continues to be an employee till the end of that contribution period and the contribution is to be deducted and paid on the total wages earned by him.

What is the benefit admissible to the family members?

Following are the benefits admissible to family members under the ESI Scheme

- (i) Family members are also entitled to full medical care as and when needed.
- (ii) The Family members are also entitled to artificial limbs, artificial appliances as a part of Medical treatment.
- (iii) The medical benefit is also admissible to the family during the period the insured person is in receipt of unemployment allowance. In case he/she dies during the period, his/her family continues to receive the medical benefit till receipt of unemployment allowance.

- (iv) In case of the death of the insured employee due to employment injury, the widow, widowed mother and children are entitled to Dependents' benefit.
- (v) The Funeral Expenses up to ₹10000/- are defrayed to any family member or person who actually incurs the above expenditure on funeral.

An Insured person who superannuates or retires under a voluntary Retirement Scheme or takes premature retirement, after being an insured person for not less than 5 years, shall be eligible to receive medical benefit for himself and his spouse subject to production of proof thereof, and payment of a nominal contribution of rupees one hundred and twenty for one year. In case the insured person expires his spouse shall continue to receive medical benefit under Rule 61 on payment of contribution as mentioned above.

Varishta Mediclaim Policy (Senior Citizens Health Insurance Scheme)

Varishta Mediclaim policy by government is made specifically for the senior citizens between the age of 60 and 80 years to meet the requirements of a senior citizen health insurance scheme. The policy period is only of a year but the renewal of the plan can be made up to the age of 90 years. One lakh of sum assured is provided for hospitalisation and up to 2 lakhs for critical illnesses coverage.

Other features of the plan are mentioned below:

- Cost of medicines, drugs, blood, oxygen, diagnosis charges etc. is covered by half of the sum assured.
- Upto 1000 rupees for emergency ambulance charges.
- Treatment of critical medical problems like benign prostate hyperplasia, cataract and organ transplant etc. are covered but only up to a pre-specified amount.
- A fourth of the total sum assured is for fees of surgeons, consultants, specialists, medical practitioners etc.
- Coverage for illnesses like cancer, multiple sclerosis, stroke etc. is provided even without hospitalization.
- No waiting period for preexisting conditions like Diabetes and hypertension, if an additional premium is paid.
- Post hospitalization charges are covered for the age up to 60 years.
- Under section 80D of Income Tax Act, the premiums of up to ₹15,000 are allowed as deductions.

Central Government Employees and Pensioners Health Insurance Scheme

This scheme is especially for the employees of central government, both newly recruited and the retired one. The sum cover provided under this plan is of 5 lakhs with a minimal premium.

Pre-existing conditions, pre and post hospitalization and maternity benefits are the coverage provided.

Besides all the traditional benefits, this plan has some of its exclusive benefits that are not available with a lot of plans in the market like zero initial waiting period for coverage initialization and the preexisting conditions and even for the major critical illnesses like cataract, diabetes, hernia etc. while most plans carry a waiting period of up to 4 years for the preexisting conditions and 30 days for the inception of coverage of the insured under the plan.

The term of coverage is for the lifetime until the survival of the insured.

Following are other benefits of the plan:

- Reimbursement for the cost of medical apparatus like artificial parts, hearing aids etc.
- Free Specialist and medical practitioner visits at government hospitals.
- OPD treatment and medicinal cost
- Medication and consultation at Siddha, Ayurveda, Unani systems of medicines and homeopathy.
- Reimbursement for emergency treatment both at government and private hospitals.
- Cashless treatment for the insured and the beneficiaries at diagnostic centers and certain authorized hospitals.
- Additional members can be covered under the plan if a fixed additional is paid per member.
- Policy period is for lifetime even for the beneficiaries.

Prime Minister's Aayushman Bharath Health Scheme

Prime Minister Narendra Modi rolled out the Pradhan Mantri Jan Arogya Yojana-Ayushman Bharat Health Scheme in September 2018. Termed as a “game-changer initiative to serve the poor“, the Scheme is also termed as ‘Modicare’ aimed at providing health care to the deprived.

“PMJAY-Ayushman Bharat is the biggest government-sponsored healthcare scheme in the world. The number of beneficiaries is almost equal to the population of Canada, Mexico and the US taken together.

The magnitude of the scheme could be gauged from the fact that more than 1,300 ailments are covered under it, including heart diseases, kidney and liver disorders and diabetes.

No one needs to register for the initiative. A health card would be provided to the beneficiaries for availing of the benefits. A toll-free number will be made available to the people for finding out more about the scheme.

2,500 modern hospitals would come up in tier-II and tier-III cities and would generate employment opportunities. A total of 13,000 hospitals have become a part of the Ayushman Bharat scheme.

Billed as the world's largest government healthcare programme, it will be funded with 60 per cent contribution coming from the Centre and remaining from the states.

As of September 2018, 15,686 applications for hospital empanelment have been received by the Government and over 8,735 hospitals, both public and private, have already been empanelled for the scheme, and as many as 31 states and union territories have signed MoUs with the Centre and will implement the programme. Telangana, Odisha, Delhi, Kerala and Punjab are not among the states which have opted for the scheme.

According to Health ministry officials, the 71st round of National Sample Survey Organisation (NSSO) revealed that 85.90% of rural households and 82% of urban households have no access to health care insurance. More than 24% of the households in rural India and 18% population in urban area have met their health care expenses through some sort of borrowing.

Who are the beneficiaries?

The scheme will target poor, deprived rural families and identified occupational category of urban workers' families, 8.03 crore in rural and 2.33 crore in urban areas, as per the latest Socio-Economic Caste Census (SECC) data. It will cover around 50 crore people and there is no cap on family size and age in the scheme ensuring that nobody is left out.

Who contributes to the Scheme?

60% of the contribution comes from the Centre and remaining from States. The burden on the Centre is likely to be around Rs.3,500 Crores in the fiscal year 2018-19 on account Centre's contribution to this Scheme.

Health Insurance Coverage

₹5 lakh cover per year is provided under this Scheme. 1,354 ailments are covered. Treatment for coronary bypass, knee replacements and stenting, among others, would be provided at 15 to 20% cheaper rates than Central Government Health Schemes

Where can the treatment be availed

Benefits can be availed in Government hospitals as well as listed Private hospitals.

Who can avail and how?

The entitlement is decided on the basis of deprivation criteria in the SECC database. The beneficiaries are identified based on deprivation categories (D1, D2, D3, D4, D5 and D7). For urban areas, 11 occupational criteria will determine entitlement. Rashtriya Swasthya Bima Yojana beneficiaries in States where it is active, are also included. There is no cap on family size and age in the Scheme. Aadhaar card is not mandatory. Even election identity card or ration card can be used to establish identity. NHPS will subsume the ongoing centrally sponsored schemes such as Rashtriya Swasthya Bima Yojana (RSBY) and the Senior Citizen Health Insurance Scheme.

Cashless Hospitalisation

In the case of hospitalisation, members of the beneficiary families do not need to pay anything under the Scheme, provided one goes to a government or an empanelled private hospital. Each empanelled hospital will have an Ayushman Mitra help desk where a prospective beneficiary can check documents to verify the eligibility and enrolment to the Scheme. Other points to note:

- Pre-existing diseases covered from Day 1 of enrolment of the scheme
- Portable across India at all empanelled healthcare Providers
- Fixed Transportation Allowance payable from place of residence to hospital
- AYUSH (Alternative Medicine Systems other than Allopathic) covered

Privately Administered Health Insurance Schemes

Besides there are many privately administered Health insurance schemes administered by General Insurance companies or Stand-alone Health insurance companies which are regulated by IRDAI. Besides Critical illness covers are provided by Life insurance companies.

Any individual can purchase health insurance cover directly by purchasing a Health insurance policy from any of the above insurance companies.

Employer Sponsored Health Insurance Schemes

Besides the above, many employers provide health insurance cover to their employees under a Group Mediciam Policy purchased from any of the insurance companies under which premiums are either paid only by employer or only by employee or partly by employer and partly by employee. This would depend on Company's HR Policy on providing employee benefits.

Health Insurance Regulations Applicable To Insurance Companies

IRDAI (Health Insurance) Regulations 2016 provides the governing framework for health insurance policies. Let us study the regulatory framework applicable to Health insurance policies in the following paragraphs

Definition of Health Insurance

It is important to first know the components of Health insurance policies. Section 2(6C) of the Insurance Act, 1938, defines Health insurance business to include Policies providing the following benefits:

- (a) Sickness benefits, medical benefits, hospital benefits, surgical benefits (both in-patient as well as out-patient benefits)
- (b) Travel insurance
- (c) Personal accident cover

Two types of Medical insurance policies

- (a) Policies providing indemnity benefits – under indemnity contracts only the actual amount of loss is reimbursed
- (b) Policies providing fixed medical benefits

As per the general principles of insurance contracts, while a general insurance is a contract of indemnity, a Life insurance is not a contract of indemnity. Therefore only general insurance companies and Standalone health insurance companies can provide indemnity based health insurance covers.

Life insurance companies can provide fixed health insurance benefit cover, under which a defined certain amount (Sum insured) can be paid upon hospitalisation without considering into the actual amount spent by the Policyholder. For example, Critical illness covers are offered by Life insurance companies fall under this category. These are fixed amounts paid by the Life insurance companies upon the Life assured contracting any of the illnesses covered under the Policy contract. Life insurance companies cannot offer Travel insurance or Personal accident cover. However, Accident death benefit can be provided as a rider by Life insurance companies, i.e. upon death due to accident, an additional sum assured is paid to the Nominee. Under Personal accident cover by General insurance companies, upon accident any cost incurred by the Policyholder including stoppage of income, disablement benefits etc. are offered.

Note: A General insurance company can insure anything from pin to plane, other than human life, including health insurance products, whereas a Standalone health insurance company is a Specialised General insurance company allowed to sell only Health insurance products.

Policy Term (coverage period) of Health Insurance Policies

- (a) Individual Policies – under individual health insurance policies, General insurance companies and Standalone health insurance companies can provide insurance cover for a minimum period of 1 year and maximum period of 3 years. However, Life insurance companies can provide only for a minimum Policy term of 5 years. This is because Life insurance contracts, by nature, are long-term contracts
- (b) Premium guarantee – No premium can be changed during the Policy period. However, for a Life insurer, premiums cannot be changed for a minimum period of 3 years
- (c) Group Policies – these are one year renewable Policies, except for Group Health policies under lender-borrower groups (Group credit linked products), where the term can be extended up to 5 years. A

minimum group size of 7 has been prescribed for issuing the Group policies.

- (d) Personal accident and Travel covers – may be offered for a term of less than 1 year as well.

HEALTH INSURANCE UNDERWRITING POLICY

Underwriting in insurance means acceptance of risk on a Proposal for insurance cover. It is the decision of the insurer to accept or reject or postpone or make a counter-offer after assessment of the risk on the Proposal for insurance cover submitted by a Customer.

An insurance company selling health insurance products shall have a Board approved Health insurance Underwriting Policy which shall provide the broad framework for underwriting of health insurance proposals. Among other things, the Policy shall include the parameters for risk categorisation and approach towards disposing of Proposals from Standard and Sub-standard lives. A Standard Life denotes a Customer whose risk parameters are normal and who can be offered normal premium rates and terms and conditions, whereas, a Sub-standard Life denotes a Customer whose risk parameters are adverse and therefore will have to be offered special premium rates and terms and conditions, subject to further assessment of risk based on Medical examination. In extreme cases, a Proposal for insurance cover may be denied by the insurer and in such cases, the reasons shall be communicated by the Insurer to the Customer.

Wellness and Preventive Benefits

In insurance, offering of any rebates or discounts or concessions or any form of inducement to a Customer for taking out an insurance policy or for continuing an insurance policy is strictly prohibited under Section 41 of the Insurance Act, 1938, unless offering of a discount or rebates or concessions are part of the product specifications as approved by IRDAI under “File and use” for an insurance product. No discount on any other third party service or merchandise is allowed.

Insurers are allowed to offer reward customers on early entry or continued renewals of health insurance policies or favourable claims experience or preventive or wellness habits, provided such benefits are approved by IRDAI for the product as specified above and such benefits are disclosed in the Prospectus and Policy documents issued by the Insurer.

For example, offering a discount in premium if the Customer has the regular habit of running or walking and he keeps track of his running or walking habits through a Fitness watch. An insurer may offer discounts in premiums (if approved by IRDAI for the Product), if the Customer is able to demonstrate his healthy lifestyle to the insurer.

The following wellness benefits, in the form of discounts by tie-ups with Network Providers, viz., Hospitals or Diagnostic Centres empanelled by the Insurer, can be offered under Health insurance products:

- (a) Outpatient consultations or treatments
- (b) Pharmaceuticals
- (c) Preventive health check ups

The above benefits in the form of discounts on cost of medicines, diagnosis or consultation offered by a Network Provider is also allowed if such offers are approved by IRDAI. Network Provider means the hospital or health care provider with whom insurer and/or Third Party Administrator ('TPA') have a tie-up for providing health services either on cash basis or cashless basis.

A TPA is an intermediary registered with IRDAI, who facilitates claims settlement under health insurance policies

for an insurer (with whom TPA has tied up) both under cashless basis as well cash basis, as per terms and conditions of the Health insurance policy issued by the insurer. However, a TPA cannot decide any claim – only an insurer can decide to accept or part-accept or reject any health insurance claim. Such TPAs also handle Personal Accident and Travel insurance claims. Further, TPAs are also allowed to conduct medical examination of Customers who take insurance policies. Cash basis means that Customers first pays for the insured event covered under the Policy and then seeks reimbursement from the insurer. Cashless basis means the Customer does not pay from his pocket first to the extent of the claim covered under the Policy and instead the Insurer, through the TPA arranges for direct payment of the claim amount to the Hospital or Diagnostic Center to the extent of allowable amount within the Sum assured and as per Terms and conditions of the Policy document. Any balance amount which is uncovered only is paid by the Customer.

Pricing and other product level considerations for a Health insurance policy (other than Personal Accident and Travel insurance covers)

Term of Health Insurance Cover

No revisions to an health insurance product, once approved by IRDAI, will be considered till the expiry of an initial period of 3 years. After the revision, further revisions may be considered only after a minimum gap of 1 year.

General and Health insurance companies generally offer 1 year health insurance cover, which can be renewed at the end of each year. Premiums under Health insurance policies issued by such Companies can be changed only at the end of the year, subject to claims experience.

In the case of Life insurance policies, premiums can be changed only after a minimum period of 3 years.

Under Group Health insurance policies, premiums can be changed at the end of the term of the Policy as per the Group insurance policy contract. Normally, Group Health insurance policies are issued for a period of 1 year.

Entry and Exit Age

All health insurance policies shall cover persons who are taking health insurance policies for the first time, up to an age of 65.

Renewal of Health Insurance Policies

A renewal of Health insurance policy cannot be denied by an insurer on the following grounds:

- (a) High incidence of claims by the Customer, except in the case of benefit-based health insurance policies issued by Life insurance companies, where the Policy itself comes to an end upon payment of say, a Critical illness claim, as per terms and conditions of the Policy.
- (b) On the grounds of age, if the Customer has renewed the Policy without any break.

However, renewal of Health insurance policy can be denied by the insurer, if fraud or misrepresentation on the part of the Customer during the previous Policy period or non-cooperation by the Customer.

A period of 30 days from the due date of renewal is allowed, within which the renewal premium may be paid and the Policy cover continued, failing which the Insurer may reject renewal. However, during such period, no insurance cover will be granted by the insurer. The 30 day period shall not be reckoned as a break in insurance cover.

Loadings upon renewals

Under individual policies, where the Policy is renewed by the Customer, extra premiums cannot be charged only based on the unfavourable claims experience in the said Policy and, instead, shall be based on increase or decrease in premium for the entire portfolio.

No fresh medical examination can be called by the Insurer at the time of renewals, provided the Customer has renewed the Policy without any break. However, if there is any favourable factor for the Customer, viz., reduction in the risk profile of the Customer, loadings in premiums shall be considered for reduction by the Insurer.

Freelook Cancellation

A freelook is the right of the Customer to review the Policy terms and conditions and return the Policy to insurer seeking return of premiums, if the Customer disagrees with any of the terms and conditions. However, such a right shall be exercised within 15 days from the date of receipt of Policy document. Upon cancellation, the Insurer shall return the Premiums subject to deduction of (a) proportionate risk premium to the extent of risk which has already commenced and covered under the policy till the date of cancellation (b) medical examination charges (c) Stamp duty on Policy (d) repurchase price in the case of Unit linked health insurance policy.

In the case of unit linked health insurance policies, since part of the premiums are invested in market linked instruments by the Insurer, repurchase price denotes the sale value of units on the date of cancellation to facilitate refund of premiums to the Customer. Upward or downward movement in the value of units is borne by the Customer.

Upon Freelook cancellation, full cost of medical examination shall be borne by the Customer and recovered from Premiums as mentioned above, in the case of freelook cancellation. However, where the Policies are issued either full cost of Medical examination is borne by the Insurer or upto 50% of the cost under Health insurance products of term of 1 year or less can be passed on to the Customer and the and balance borne by the Insurer, provided the portion borne by the Customer is not charged to the Premium which the Customer has to pay the insurer.

Cumulative Bonus

Any cumulative bonus offered by Insurers shall be explicitly stated in the Prospectus for the Product. If any claim has been made, the cumulative bonus may be proportionately reduced at the same rate at which it was accrued.

Special provisions for Senior Citizens

As already mentioned, maximum age at entry (first time insurance cover) shall be age 65, which means all Senior Citizens up to age 65 can start getting insurance coverage.

Secondly, once the insurance coverage is taken up to age 65 for the first time, further renewals cannot be denied on the grounds of age, provided there is no break in insurance cover in between. This provision ensures that health insurance coverage can be continued as long as the Senior citizen is alive.

A separate channel to address the claims and complaints of Senior citizens shall be formed by Insurance companies.

HEALTH INSURANCE POLICY FORMS AND CLAUSES

The standardised clauses of Health Insurance Policy (commonly known as “Policy Wordings”) are as under:

TITLE	DESCRIPTION	REFER TO POLICY CLAUSE NUMBER
Product Name	Optima Restore	
What am I covered for	<p>a) In-Patient Treatment – Covers Hospitalisation Expenses For Period More Than 24 Hrs.</p> <p>b) Pre-Hospitalisation – Medical Expenses Incurred In 60 Days Before The Hospitalisation.</p> <p>c) Post-Hospitalisation – Medical Expenses Incurred In 180 Days After The Hospitalisation.</p> <p>d) Day-Care Procedures – Medical Expenses For Day Care Procedures.</p> <p>e) Domicillary Treatment – Medical Expenses Incurred For Availing Medical Treatment At Home Which Would Otherwise Have Required Hospitalisation.</p> <p>f) Organ Donor – Medical Expenses On Harvesting The Organ From The Donor For Organ Transplantation.</p> <p>g) Ambulance Cover – Upto Rs. 2,000 per hospitalisation for utilizing ambulance service for transporting insured person to hospital in case of an emergency.</p> <p>h) Daily Cash for choosing shared accommodation – Daily cash amount if hospitalized in shared accommodation in network hospital and hospitalisation exceeds 48 hrs.</p> <p>i) E-Opinion in respect of a critical Illness – Second opinion by a Medical Practitioner from our panel for a Critical Illness suffered during the policy period.</p> <p>j) Emergency Air Ambulance Cover – Covers expenses for ambulance transportation in an airplane or helicopter for emergency life threatening health conditions.</p> <p>k) Restore Benefit – Instant addition of 100% Basic Sum insured on complete or partial utilization of your existing Policy Sum insured and Multiplier Benefit if applicable, during the Policy Year. The Restore Sum insured can be used for all claims under inpatient Benefit if the Restore Sum Insured is not utilized in a Policy Year, it will expire.</p>	<p>Section [1(a)]</p> <p>Section [1(b)]</p> <p>Section [1(c)]</p> <p>Section [1(d)]</p> <p>Section [1(e)]</p> <p>Section [1(f)]</p> <p>Section [1(g)]</p> <p>Section [1(h)]</p> <p>Section [1(i)]</p> <p>Section [1(j)]</p> <p>Section [1(k)]</p>

<p>What are the major exclusions in the policy</p>	<p>Following is a partial list of the policy exclusions. Please refer to the policy wording for the complete list of exclusions.</p> <p>War or any act of war nuclear, chemical and biological weapons, radiation of any kind, breach of law with criminal intent, intentional or attempted suicide, participation or involvement in naval, military or air force operation, racing, diving, aviation, scuba diving, parachuting, hang gliding, rock or mountain climbing, abuse of intoxicants or hallucinogenic substances such as intoxicating drugs and alcohol treatment of obesity and any weight control program, Psychiatric, mental disorders, congenital external disease or anomalies, sleep apneas expenses arising from HIV or AIDs and related diseases, sterility treatment to effect or to treat infertility or any fertility, sub-fertility, surrogate or vicarious pregnancy, birth control or circumscions, treatment for correction of refractive error, plastic surgery or cosmetic surgery, unless required due to an Accident, Cancer or Burns, any non-allopathic treatment.</p>	<p>Section V(c)</p>
<p>Waiting period</p>	<ul style="list-style-type: none"> ● 30 days for all illness (except accident) in the first year and is not applicable in subsequent renewals. ● 24 months for specific illness and treatments in the first two years and is not applicable in subsequent renewals. ● Pre-existing Diseases will be covered after a waiting period of 36 months. 	<p>Section (VAi)</p> <p>Section(VA ii)</p> <p>Section (VAiii)</p>
<p>Payout Basis</p>	<p>Payout on indemnity payment basis</p>	<p>Section I</p>
<p>Cost Sharing</p>	<p>Not Applicable</p>	
<p>Renewal Conditions</p>	<ul style="list-style-type: none"> ● Policy is ordinarily life-long renewal subject to application for renewal and the renewal premium in full has been received by the due dates and the realisation of premium. ● Grace period of 30 days for renewing the policy is provided. To avoid any confusion any claim incurred during break-in period will not be payable under this policy. 	<p>Section (VI n)</p>

Renewal benefits	<p>Multiplier Benefits- 50% increase in your basic sum insured for every claim free year, subject to a maximum of 100% in case a claim is made during a policy year, the limit under this benefit would be reduced by 50% of the sum insured in the following year. However this reduction will not reduce the basic Sum Insured of the policy.</p> <p>Preventive Health Check-up – We will reimburse up to the stated amount towards cost incurred in the preventive health check-up.</p> <p>Stay Active – Upto 8% discount on renewal premium subject to insured member achieving the average number of steps in each time interval prescribed in the grid by either walking or running regularly to keep fit. The discount will be accrued by the customer at defined time intervals and cumulative at the end of the policy period and offered as a discount on renewal premium.</p>	Section IV Section III
Cancellation	This policy will be cancelled on the grounds of misrepresentation, fraud, non-disclosure of material facts or non-cooperation by any Insured Person, upon giving 30 days notice.	Section VI
How to Claim	Please contact us at least 7 days prior to an event which might give rise to a claim. For any emergency situations kindly contact us within 24 hours of the event. For any claim related query, information or assistance you can also contact our toll free line at 1800-102-0333 or visit our website www.apollomunichinsurance.com or e-mail us at customerservice@apollomunichinsurance.com .	Section VIII

Note:

For Pre-Policy Check-up at our network may be required based upon the age and Basic Sum Insured. We will reimburse 100% of the expenses incurred on the acceptance of the proposal. The medical reports are valid for a period of 90 days from the date of Pre-Policy Check-up.

In order to be eligible for portability benefits you may apply 45 days in advance of the policy renewal date.

The standardised contents in the Application Form ("Proposal Form") are as under:

1. Proposer Details: Name, Date of Birth, Address, etc of Proposer of the policy
2. Plan Details: The details of plan opted
3. Proposed Insured(S) Details: Name, Date of Birth, Address, Photo etc of Insured of the policy
4. Nominee Details: Name, Address, etc of the nominee and Relationship with insured
5. Existing/Previous Insurance Details: Details of existing policy with the proposed insurance company as well as other Insurance company
6. Medical And Life Style Information: All past medical history and complete questionnaire
7. Payment Details: Details of payment of insurance premium
8. General Exclusions (Under The Policy) For More Details Please Refer To The Policy Wordings
9. Declaration & Warranty On Behalf Of All Persons Proposed To Be Insured
10. Agent's Declaration

11. Checklist
12. Neft Details attendance

LEGAL FRAMEWORK OF HEALTH INSURANCE

Governments, particularly in countries where public health systems are considered inadequate, look upon private health insurers, as partners in achieving health policy goals. Private health insurance is an alternative source of health financing, offered in the voluntary market and geared towards providing health coverage with customized benefits to a large portion of the population. While private health insurance is a potent tool to increase the capacity of a country's health system, government intervention is necessary to prevent market failures.

RATIONALE FOR PRIVATE HEALTH INSURANCE REGULATION

In order for private health insurance to achieve its objectives and fulfill its functions, effective regulation and supervision of both the carriers of risks (insurers) and the providers of health care are imperative for reasons of public safety and because health care services have aspects of public goods. This requirement is particularly critical in India, as private health insurance is emerging as an important source of health care financing. A Discussion Paper published by the WHO offers a comprehensive rationale for, . and the objectives of private health insurance regulation in developing countries, as summarized below:

1. Health insurance is more complex than other types of insurance. The exposures to health risks and the consequential costs of covering those risks are very difficult to assess due to the following factors:

- Health risks are not static; they change over a period of time and, in the long term, everyone requires health services.
- An individual has more control of his/her health risks compared to other types of insurance risks.
- The definition, nature and extent of insurable health risks keep changing due to medical advances.

2. Health insurance markets are particularly subject to a number of market failures, preventing or hindering their effective functioning. Some of these failures stem from information asymmetry about health risks and costs. These lead to moral hazard and anti-selection on the part of insured, adverse risk selection on the part of the insurers and potentially poor choice of health care providers for both.

To be effective, regulation and supervision of health insurance must encompass the following objectives:

- Establishing requisite procedures for intervention that safeguard the solvency and financial soundness of health insurers, so that they are in a position to fulfill the promises they made to the insured.
- Providing an environment to allow health insurers to continuously offer health insurance products and carry health risks on sustainable bases.
- Establishing and promoting a level playing field among the carriers of health risk so as to encourage participation of an optimal number of health insurers.
- Ensuring order in the market through the promulgation and enforcement of laws and regulations that address issues such as, the type or types of health policies or covers that insurers can sell.
- Establishing the manner and methodology of arriving at equitable product pricing, the prompt and orderly payment of claims, the contract terms and conditions including the specification of standardized definition of certain policy terms, mandatory minimum policy stipulations and setting market standards

for transacting the business of health insurance.

- Establishing similar safeguards and/or standards for the orderly functioning and financial soundness of other programs that assume health expenditure risks, such as subscription plans, health plans of mutual benefit associations, cooperatives, and other community plans.
- Prescribing appropriate authorization (registration) and oversight of entities that carry and manage these plans in order that public policy objectives of health insurance are realized and specific market failures are corrected. It is noteworthy that these entities operate in the same market as duly registered and thus regulated health insurers.

REGULATION OF HEALTH INSURANCE

Reforms in the Indian financial sector led to the enactment of the Insurance Regulatory and Development Act (IRDA) in 1999. The Act established the Insurance Development and Regulatory Authority (IRDA) and constituted it as the executive entity to “protect the interests of holders of insurance policies and to regulate, promote and ensure orderly growth of the insurance industry.

THE INSURANCE REGULATORY AND DEVELOPMENT ACT (IRDA) 1999 :

The Act allows for the entry of private sector entities in the Indian insurance sector, including health insurance. There is an entry requirement of a minimum capital of Rs 100 crore. The Insurance Act does not allow the insurers to undertake additional business that is not directly linked to insurance. The Act specifies a Code of Conduct for the insurance agents and also allows for a Tariff Advisory Committee to oversee premium rates, insurance plans and to prevent discrimination. However, there is no specific clause for the consumer.

The Act specifies the areas where regulations can be made. For instance, where the Act grants power to the Insurance Regulatory and Development Authority to make regulations on licensing of agents, such regulations would describe the qualifications and practical training required for an agent and specifies the corresponding fee etc. for a license to be granted. No Regulation may override the provisions of the Act.

Rules and Regulations are made, usually after discussions/consultations with various groups, who are likely to be most affected. They come into effect after their notification in the Official Gazette with the additional requirement, that they are presented (tabled) before the Parliament following their due notification. Rules and Regulations are referred to as ‘secondary legislation’. They are dynamic, and can be modified, revised or supplemented as exigencies arise through time and are therefore pro-active, as they fill in the details of primary legislations. Rules and Regulations are most used and effective in providing quick ‘ help and guidance to the public. For this reason, secondary legislation is a favored route to regulation because bringing in primary legislation is not only time consuming but also a tedious process. Parenthetically, legislative reforms are taking place internationally, granting more powers, including quasi-judicial (adjudicatory), to the executive branch of government. Additionally, Insurance Regulatory and Development Authority has also the power to issue directions in the public interest or to prevent the affairs of any insurer, from being conducted in a manner detrimental to the interest of policy holders or, in general, to secure proper management of any insurer and, in which case, insurers, or insurer as the case may be, shall be bound to comply with such directions

DUTIES, POWER AND FUNCTIONS OF INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY:

Section 14 of Insurance Regulatory and Development Act 1999 lays down the duties, powers and functions of Insurance Regulatory and Development Authority.

1. Subject to the provisions of this Act and any other law for the time being in force, the Authority shall have the duty to regulate, promote and ensure orderly growth of the insurance business and re-insurance business .

2. Without prejudice to the generality of the provisions contained in subsection (1), the powers and functions of the Authority shall include,

- Issue to the applicant a certificate of registration , renew, modify, withdraw, suspend or cancel such registration;
- Protection of the interests of the policy holders in matters concerning assigning of policy, nomination by policy holders, insurable interest, settlement of insurance claim, surrender value of policy and other terms and conditions of contracts of insurance;
- Specifying requisite qualifications, code of conduct and practical training for intermediary or insurance intermediaries and agents;
- Code of conduct for surveyors and loss assessors;
- Promoting efficiency in the conduct of insurance business;
- Promoting and regulating professional organizations, connected with the insurance and re-insurance business;
- Levying fees and other charges for carrying out the purposes of this Act;
- Calling for information from, undertaking inspection of, conducting enquiries and investigations including audit of the insurers, intermediaries, insurance intermediaries and other organizations connected with the insurance business;
- Control and regulation of the rates, advantages, terms and conditions that may be offered by insurers in respect of general insurance business not so controlled and regulated by the Tariff Advisory Committee of the Insurance Act, 1938.
- Specifying the form and manner in which books of account shall be maintained and statement of accounts shall be rendered by insurers and other insurance intermediaries;
- Regulating investment of funds by insurance companies;
- Regulating maintenance of margin of solvency;
- Adjudication of disputes between insurers and intermediaries or insurance intermediaries;
- Supervising the functioning of the Tariff Advisory Committee;
- Specifying the percentage of premium income of the insurer to finance schemes for promoting and regulating professional organizations referred to in clause;
- Specifying the percentage of life insurance business and general insurance business to be undertaken by the insurer in the rural or social sector;
- Exercising such other powers as may be prescribed;
- The Insurance Regulatory and Development Authority facilitate the organization and staffing of its health insurance department and implement continuing training of its staff to achieve higher level of institutional expertise in health insurance;
- The Insurance Regulatory and Development Authority promote and encourage development of

health insurance technical expertise in the industry by institutions such as the Institute of Actuaries of India, Insurance Institute of India, and Insurance Educational Institutions to adopt and implement contemporary health insurance curricula as well as organizations that offer studies and certification programs for health insurance professional; and

- The Insurance Regulatory and Development Authority lead in establishing contemporary healthcare financing models that provide accessible basic and primary health insurance products for the elderly and the “vulnerable” who are unable to obtain coverage in the normal channels. This can be achieved by creating risk pooling facilities among all health insurers, preferably with government participation, for basic and primary covers which could be supplemented with private health insurance obtained voluntarily.

REGULATING THIRD PARTY ADMINISTRATORS

The Insurance Regulatory and Development Authority set up a working committee in 2000 to suggest regulations for this new type of intermediary dealing with the administration of health insurance. The Committee was made up of representatives of the existing Third Party Administrators, several public and private sector insurance companies (non-life) and members of the Insurance Regulatory and Development Authority. The committee deliberated on a white paper that was circulated by Insurance Regulatory and Development Authority and the result of these deliberations, over a period of one year, was a set of regulations notified as The Insurance Regulatory and Development Authority (Third Party Administrators - Health Services) Regulations 2001, on September 17, 2001. The regulations stipulated the eligibility, scope of services, capital requirements, solvency margins, operating guidelines and code of conduct for Third Party Administrators. The ~ regulations also maintained that TPAs were indeed intermediaries as per the scope of the Insurance Regulatory and Development Authority Act, 1999, and therefore were fully under the jurisdiction of the Insurance Regulatory and Development Authority.

To date, this is the only Insurance Regulatory and Development Authority regulation specific to health insurance. This regulation established Third Party Administrators (TPA), and the rules for their licensing as intermediaries in rendering healthcare for insured beneficiaries and promoting a “cashless system” with easier access to and faster settlement of covered benefits of medical expense covers. The regulation prescribes high educational and practice standards of individuals, operating and managing a Third Party Administrator and requires adherence to a prescribed Code of Conducts. The salient features are as follows:

- Only an organization registered under the Companies Act 1956 with a share capital of at least Rs.1 0 million in equity shares can set up a Third Party Administrator in health services.
- Third Party Administrator will be required to start with a minimum working capital of Rs1 0 million at any point of functioning.
- Foreign equity in Third Party Administrator is limited to 26 per cent. In case of any share transfer, exceeding 5 per cent of paidup capital, IRDA has to be informed within 15 days of such transfer.
- The primary object of the company should be to carryon business in India as a Third Party Administrator in health services. It should not engage itself in any other business.
- At least one of the directors shall be a qualified medical doctor registered with the Medical Council of India.
- The CEO or CAO of the Third Party Administrator should have successfully undergone a course in hospital management from an institution recognized by Insurance Regulatory and Development

Authority and have passed the licentiate examination conducted by the Insurance Institute of India, Mumbai. Apart from this, he should have undergone practical training of at least three months in the field of health management.

- TPAs should have access to competent medical professionals to advise insurance companies and clients on various matters.
- TPAs should obtain license from Insurance Regulatory and Development Authority to function. The application fee is Rs. 20,000 and once the application is approved, another Rs. 30,000 has to be paid as licensing fee. The license will be renewed every third year by Insurance Regulatory and Development Authority. If the application is rejected, Third Party Administrator is not entitled to apply again within two years. The Third Party Administrator should furnish all documents including the agreement with the insurance company while applying for license. This agreement should contain details of the remuneration that may be payable to the Third Party Administrator by the insurance company.
- The Third Party Administrator will be allowed to enter into an agreement with more than one insurer, and similarly insurance companies can engage more than one Third Party Administrators.
- The Third Party Administrator has to spell out the scope of services that it will deliver, while entering into an agreement with a insurance company.
- Third Party Administrators shall not charge any fee from the clients.
- Insurance Regulatory and Development Authority guidelines do not permit marketing of health insurance policies by the Third Party Administrator.
- Third Party Administrators would also have to maintain and report to Insurance Regulatory and Development Authority on transactions carried out on behalf of the insurer. The Authority expects Third Party Administrators to maintain all records properly and maintain professional confidentiality between the parties. The authority holds the power to monitor and check the performance of Third Party Administrators from time to time. Third Party Administrator are expected to furnish to the insurance company and the 'authority an annual report and any other return as may be required by the Authority.
- The Insurance Regulatory and Development Authority has drawn up a code of conduct for the Third Party Administrators, refraining them from trading in information, submitting wrong information to insurers, and making advertisements without prior approval of the insurer, among other things. Their license will be revoked under such instances.

While this regulation has prompted expanded consumer interest and confidence in medical expenses insurance, many believe that the regulation needs to be revisited and updated considering the changes occurring in the industry and the imperatives to provide quality healthcare. Moreover, there is growing evidence that the Third Party Administrator System has not been effective in promoting quality of healthcare and in containing healthcare costs. Third Party Administrator business practices are quite often cited as one of the causes of the very high loss ratios in the current health insurance business.

Insurance Regulatory and Development Authority regulations place stringent conditions for licensing Third Party Administrators. Current regulation requires Third Party Administrators to meet a minimum equity capital of ₹10 million. The capital requirements for entering into this sector are not stringent. As a result, there may be a proliferation of players, not all of the best quality. A large number of players will mean pressure on margins. Besides this, Third Party Administrators need to set up infrastructure which would involve large investments, the payback period of which is likely to be long. Third Party Administrators face high operating risk of obtaining economies of scale necessary to break even. Volumes are critical because the revenue generation of Third

Party Administrators is linked to the number of policies, they undertake to administer.

The Authority publishes a list of approved TPAs from time to time, which is the final IRDAI approved list. Its advisable for all insurers, corporate clients and other health insurance enabling services, such as networked hospitals and diagnostic clinics, to review the same to ensure that they deal with approved and regulated TPAs. These entities, as well as all other regulated intermediaries, have their licensing requirements reviewed periodically at regular intervals, and if found lacking do not have their licenses renewed by IRDAI insurance.

Judicial Branch

The judiciary interprets the law, both primary and secondary legislation. It hears and decides disputes between insurers and the policyholders, protects the insuring public by imposing civil fines or criminal penalties for violation of the insurance laws and protects insurers, their agents and intermediaries by overturning arbitrary or unconstitutional legislation, rules, regulations or orders promulgated by the insurance regulator. The Supreme Court is the highest court in India, and its judgment is final in all respects.

Each geographic region is represented by a specific court. To facilitate dispute resolution, India has also Consumer Courts, Insurance Ombudsmen, Lok Adalats, etc., that address consumer grievances in summary proceedings. Policyholder complaints against insurers are mostly dealt with at the Insurance Ombudsmen and Consumer Courts. There are also various tribunals dealing generally with industrial or sector-specific matters as appellate authorities exercising specific adjudicatory powers. While these entities do not fall under the judiciary branch, they are considered a part of the court system.

Regulations are effective tools to promote access to private health insurance, improve consumer confidence and orderly growth of the health insurance industry. In addition, regulations provide definitive directions to health insurers and other industry stakeholders that would prime robust development and growth of private health insurance. A common recommendation of the subgroups/committees of the Insurance Regulatory and Development Authority Health Insurance Working Group is the need for regulations specific to health insurance.

To conclude, the legal and regulatory framework for private health insurance, because it operates in the voluntary market, should continually balance competing goals of access, affordability and quality of healthcare and providing health covers to a larger fraction of the population with varying risk characteristics and ability to pay. Regulations, aside from being solely aimed at providing protection of health insurance policyholders and beneficiaries, can be potent tools to promote access to healthcare control pricing of health covers *vis-a-vis* healthcare providers and enhance the quality of healthcare.

CLAIMS

Insurance claims are subject to waiting period and exclusions clauses included in Policy contracts, as per approval under product specifications ("File & use") by IRDAI.

A waiting period is the period which starts after issue of the Health insurance policy, during which the risk cover is not available. A clause on waiting period is generally imposed as a counter measure to adverse selection in health insurance policies. For example, if a Customer whose is expecting himself to be hospitalised shortly may take a Health insurance policy to seek reimbursement of hospitalisation expenses. This is an example of anti-selection. Insurers cannot run health insurance business if anti-selection is high.

Waiting period can be defined, as say, 6 months for the entire policy during which no insurance cover will be available or could be specific only to certain illnesses during the waiting period. Another category.

Similarly pre-existing illnesses may or may not be covered under health insurance policy for a specific period.

A pre-existing illness is a condition where the Customer taking the Policy has already contracted an illness. Depending on the terms of the Policy, a pre-existing illness may or may not be covered or may not be covered only for a specific period.

An exclusion is a policy condition which provides for circumstances under which a Claim is not payable. For example, in the case of persons engaged in hazardous occupations or persons engaged in war – any claim under such circumstances is excluded. These are time-bound exclusions, meaning claims are not paid only if they arise under the above circumstances.

An exclusion may also be event-specific without any limitation of time. For example, cosmetic dental surgeries or cosmetic surgeries may be excluded as treatments which are not covered at all. Any claim for these treatments are exclusions and are not payable.

Where the Customer holds multiple health insurance policies with different insurers, settlement of claims will be as per the following conditions:

- (a) Where the Customer holds multiple fixed benefit health insurance policies issued by the Life insurers, all Life insurers shall pay the benefit to the Customer as per the terms and conditions of their respective Policies
- (b) Where the Customer holds multiple indemnity-based health insurance policies issued by different General insurance or Health insurance companies, the Customer can seek settlement of claim only once from any of such insurers of his choice. Indemnity cannot be more than once. However, where the claim settled by one such insurer is insufficient to indemnify the Customer in toto, the balance amount(s) can be claimed from other insurers. Selection of such insurer for the purpose of claims settlement is the choice of the Customer.

In the case of cashless claims, a Pre-authorisation to the Network Providers shall be issued by the TPA or the Insurer for commencement of treatment in the Network Hospital where the life covered wants to undergo the medical treatment. All lives covered under the Health insurance policy, which may include the Family members of the Customer, shall be issued an identity card (Smart card with Quick Response, Magnetic reader facilities) giving the details of the life covered, date of birth and other necessary details for the purpose of availing the cashless facility.

A health insurance claim shall be decided within a period of 30 days of receipt of all necessary documents from the Customer, except in cases where frauds and misrepresentations on the part of the Customer.

Normal documents required for settlement of a health insurance claim shall be mentioned in the Policy document issued to the Customer. However, if there are any further documents required by the Insurer at the time of claim, such documents shall be called for together and not on piecemeal basis.

Insurers shall specify a period with which the Customer shall file the claim documents. However, where there is a delay the Insurer shall not reject the claim if there are valid reasons for the delay. No claim can be closed in the books of the insurer.

For delays in settlement of claims, insurers shall pay penal interest at the rate of Bank rate + 2% p.a.

Every insurer shall enter into an agreement with the TPA for the purpose of claims settlement and shall also publish detailed claims guidelines to enable TPAs to properly service the Customers. Payment of claims shall be made by Insurer either directly or through the TPAs.

Claims shall be decided only by the Insurer and not the TPAs. Acceptance or rejection or part acceptance of the claim shall be communicated only by the Insurer to the Customer.

Disclosures to Customers

Every Customer taking a Health insurance policy shall be provided with a Customer information sheet by the Insurer

Website disclosures

Website of the Insurer shall disclose the following information:

- (a) Product-wise and Geography-wise location of TPAs
- (b) Product-wise cashless services offered

In Policy document, the following details shall be disclosed:

- (c) Portability clauses (in Policy documents as well as brochures, pamphlets)
- (d) Procedure for Claims submission and timelines
- (e) Sub-limits for any of the insurance covers
- (f) Penal interest provisions
- (g) TPA details

In respect of Pilot products (Products which are launched on a test basis by an Insurer with the approval of IRDAI for a limited period), the product brochures, leaflets, pamphlets etc. shall specifically disclose the period up to which the Product will be available for sale and option to migrate to another product upon discontinuance of Pilot product

PORTABILITY OF HEALTH INSURANCE POLICIES

Portability is the right accorded to the Policyholder to transfer the credit gained for pre-existing conditions and time-bound exclusions from one insurer to another insurer or from one plan to another plan of the same insurer.

In simple words, it is the right conferred on a Policyholder who decides to move from one General or Health insurer to another or to another plan of the same General or Health insurer. Portability is not applicable to fixed benefits payable under Health insurance policies issued by a Life insurer. The advantage of portability is the carry forward of the credits accrued on account of having a Policy with the previous Insurer.

Request for portability should be given by filling up a Portability form to the existing insurer, earlier than 45 days but not before 60 days from the date of expiry of insurance cover under the existing health insurance policy. At the request of the Policyholder, the old insurer can extend the insurance cover for period of 30 days, pending receipt of confirmation from the new insurer upon charging premiums for the extended period. If a claim is made by the Policyholder during the extended period, portability is not possible, and the Policyholder shall continue the Policy for another period of 12 months from the date of expiry of insurance cover with the existing insurer. Insurer shall not cancel the existing Policy till receipt of the new Policy from the new Insurer or till receipt of a Customer request.

Portability form shall be submitted to the old insurer who shall send it through a portal to the new Insurer. New insurer may request the claims history and other details from the previous insurer who shall submit the required details within a period of 7 days from the date of receipt of request.

An insurer may reject the request for portability if the Policyholder approaches 60 days before or within 45 days of the date of expiry of the insurance policy. However, an insurer may at their option consider the request for renewal even outside the above period.

New insurer is under obligation to accept or reject within a period of 15 days from the date of receipt of the Portability form. If the New insurer does not convey any decision within the aforesaid 15 days, the New insurer is deemed to have accepted the request for portability. No charges for portability can be levied either by the Previous insurer or the New insurer.

No commission shall be paid to any Agent or Intermediary for the policy which is ported from one insurer to another insurer.

PRODUCT MANAGEMENT COMMITTEE (APPLICABLE TO GENERAL AND STANDALONE HEALTH INSURANCE COMPANIES)

A Product Management Committee shall be formed by both the above category of Insurers and the Terms of Reference of the Committee are as follows;

- (a) Reviewing Products to avoid duplication of Products within an insurance company
- (b) Annual Plan for filing of new Products and modification of existing Products
- (c) Launching products cleared under “File and use” or “Use and file” under applicable Guidelines of IRDAI
- (d) Designing and filing of ‘Pilot products’ – these are innovative products which an insurer wants to launch on a test basis
- (e) Product Performance and review

Non-Life and Health Package Products

General or Stand alone Health insurers can offer a combination of Health, including Personal Accident and/or Travel Insurance covers with other Non-life insurance products, with Health insurance being the predominant coverage.

Specialized Insurance Covers

Till recently, health insurance did not cover mental illnesses, but that is set to change, with the Insurance Regulatory and Development Authority of India (IRDAI) mandating coverage of mental illness by insurance companies. The circular is a step in the right direction as it increases the scope of health insurance coverage for a large number of population. As per the National Mental Health Survey of India for FY16 conducted by the National Institute of Mental Health and Neuro Sciences, nearly 15% of Indian adults are in need of active intervention for one or more mental health issues.

IRDAI, in its circular, said that insurers will have to make provisions to insure mental illness, according to the rules laid down by the Mental Healthcare Act, 2017. According to Section 21(4) of the Act, every insurer needs to make provisions for medical insurance for treatment of mental illness on the same basis as is available for treatment of physical illness. The circular stated that insurers will need to comply with these provisions with immediate effect.

Mental illness and health insurance

As per the Mental Healthcare Act, mental illness means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgement, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life. It also includes mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person. The Act further states that every person with mental illness will be treated as equal to persons with

physical illness when it comes to healthcare, including health insurance.

Irdai has taken cognisance of the law, and asked insurance companies to implement its provisions. One of the rationales of the Act is to not discriminate between mental illness and physical illness in coverage. Now, if an alcohol-induced physical illness leading to hospitalisation like in the case of cirrhosis is not covered, in a similar manner alcohol-induced mental illness too will also not be covered. A point to be remembered, is the circular only states that there should be no discrimination between the two illnesses, mental and physical. That doesn't change anything for the insurers in terms of their underwriting decision.

Even now, the insurer can altogether deny health insurance to a person suffering from a physical illness, say cancer or heart disease, as per its underwriting norms. The same underwriting criteria should apply to individuals with a pre-existing mental illness. However, if the insurer agrees to insure them, then after the waiting period on pre-existing ailment, these conditions would need to be covered.

What will health insurance pay for?

A typical health insurance policy pays for in-patient hospitalisation and not out-patient treatment. In other words, the consultation with the doctor or medicines that is purchased will not be payable. But treatment during hospitalization on account of a mental illness, is covered. A majority of people with mental conditions need out-patient care like consultations or may be medication which health insurance policies in their current form don't cover.

For instance, most health plans typically don't cover cosmetic surgery, treatments related to obesity or AIDS and fertility related treatments, among several others. Similarly, insurers can come out with exclusions with regard to mental illnesses as well.

This will limit the scope of health insurance in covering mental illness. "The insurance market in India is under-developed when it comes to out-patient treatment. There are fewer policies that cover OPD and the coverage is not very high and that's because the healthcare sector is not regulated,."

HEALTH INSURANCE FRAUD

In this type of fraud, false or misleading information is provided to a health insurance company in an attempt to have them pay unauthorized benefits to the policy holder, another party, or the entity providing services. The offense can be committed by the insured individual or the provider of health services. An individual subscriber can commit health insurance fraud by allowing someone else to use his or her identity and insurance information to obtain health care services or using benefits to pay for prescriptions that were not prescribed by his or her doctor.

Health care providers can commit fraudulent acts by:

- billing for services, procedures and/or supplies that were never rendered
- charging for more expensive services than those actually provided
- performing unnecessary services for the purpose of financial gain
- misrepresenting non-covered treatments as a medical necessity
- falsifying a patient's diagnosis to justify tests, surgeries, or other procedures
- billing each step of a single procedure as if it were a separate procedure
- charging a patient more than the co-pay agreed to under the insurer's terms

- paying “kickbacks” for referral of motor vehicle accident victims for treatment

REINSURANCE

Every insurer is required to maintain a retention, which is commensurate with its financial strength and volume of business. The Authority may require an insurer to justify its retention policy and may give directions to ensure that the Indian insurer is not merely fronting for a foreign insurer. Every insurer should cede such percentage of the sum assured on each policy for different classes of insurance written in India to the Indian re-insurer as may be specified by the Authority in accordance with the provisions the Insurance Act.

Every insurer is required to submit its reinsurance programme to the Authority for the forthcoming year within forth-five days before the commencement of the financial year. Additionally, the insurer should also file with the Authority a photocopy of every reinsurance treaty slip and excess of loss cover note in respect of that year together with a list of re-insurers and their shares in the reinsurance arrangement.

Insurers are permitted to place their reinsurance business outside India with only those re-insurers who have over a period of the past five years counting from the year preceding for which the business has to be placed, enjoyed a rating of at least BBB (with Standard and Poor) or equivalent rating of any other international rating agency. It is obligatory for all insurers to offer an opportunity to other Indian insurers including the Indian re-insurer to participate in its facultative and treaty surpluses before placement of such cessions outside India.

Any surplus over and above the domestic reinsurance arrangements class wise may be placed by the insurer independently with any of the re-insurers, subject to a limit of ten per cent of the total reinsurance premium ceded outside India being placed with any one re-insurer. In the even that the insurer would like to cede a share exceeding such limit to any particular re-insurer, in respect of specialized insurance, the insurer should seek the specific approval of the Authority in this regard.

Every insurer should also make an outstanding claims provision for every reinsurance arrangement accepted on the basis of loss information adv ices received from brokers/cedants and in cases where such advices are not received, on an actuarial estimation basis. In addition, every insurer should also make an appropriate provision for IBNR claims on its reinsurance accepted portfolio on actuarial estimation basis.

The Indian re-insurer is required to organize domestic pools for reinsurance surpluses in fire, marine hull and other classes in consultation with all insurers and should also assist in maintaining the retention of business within India. Such arrangements are required to be submitted to the Authority for approval. Further, the Indian re-insurer is required to retrocede at least fifty per cent of the obligatory cessions received by it to the ceding insurers after protecting the portfolio by suitable excess of loss covers.

Every insurer wanting to write inward reinsurance business should have an underwriting policy for underwriting reinsurance business, which should be filed with the Authority stating the classes of business, geographical scope, underwriting limits and profit objective.

LESSON ROUND UP

- Health insurance is insurance that covers the whole or a part of the risk of a person incurring medical expenses, spreading the risk over a large number of persons
- A health insurance policy is a contract between an insurance provider (e.g. an insurance company or a government) and an individual or his/her sponsor (e.g. an employer or a community organization).
- Healthcare has become one of India's largest sectors - both in terms of revenue and employment. Healthcare comprises hospitals, medical devices, clinical trials, outsourcing, telemedicine, medical

tourism, health insurance and medical equipment.

- Rashtriya Swasthya Bima Yojana is a Health insurance scheme launched by the Ministry of Labour and Employment, Government of India for Below the Poverty Line ('BPL') families.
- Employees' State Insurance Scheme of India is a multi-dimensional Social Security Scheme tailored to provide Socio-economic protection to the 'employees' in the organised sector against the events of sickness, maternity, disablement and death due to employment injury and to provide medical care to the insured employees and their families.
- Varishta Medclaim policy by government is made specifically for the senior citizens between the age of 60 and 80 years to meet the requirements of a senior citizen health insurance scheme.
- Underwriting in insurance means acceptance of risk on a Proposal for insurance cover. It is the decision of the insurer to accept or reject or postpone or make a counter-offer after assessment of the risk on the Proposal for insurance cover submitted by a Customer.
- Insurance claims are subject to waiting period and exclusions clauses included in Policy contracts, as per approval under product specifications ("File & use") by IRDAI.
- Every Customer taking a Health insurance policy shall be provided with a Customer information sheet by the Insurer.
- Portability is the right accorded to the Policyholder to transfer the credit gained for pre-existing conditions and time-bound exclusions from one insurer to another insurer or from one plan to another plan of the same insurer.
- In Health Insurance Fraud, false or misleading information is provided to a health insurance company in an attempt to have them pay unauthorized benefits to the policy holder, another party, or the entity providing services.
- Every insurer should cede such percentage of the sum assured on each policy for different classes of insurance written in India to the Indian re-insurer as may be specified by the Authority in accordance with the provisions the Insurance Act.

GLOSSARY

Health Insurance: Health Insurance covers the whole or a part of the risk of a person incurring medical expenses, spreading the risk over a large number of persons.

Premium: The amount the policy-holder or their sponsor (e.g. an employer) pays to the health plan to purchase health coverage.

Deductible: The amount that the insured must payout-of-pocket before the health insurer pays its share

Co-payment: The amount that the insured person must pay out of pocket before the health insurer pays for a particular visit or service

Coinsurance: Instead of, or in addition to, paying a fixed amount up front (a co-payment), the co-insurance is a percentage of the total cost that insured person may also pay

Exclusions: Not all services are covered. Billed items like use-and-throw, taxes, etc are excluded from admissible claim

Coverage limits: Some health insurance policies only pay for health care up to a certain amount.

Rashtriya Swasthya Bima Yojana: It is a Health insurance scheme launched by the Ministry of Labour and Employment, Government of India for Below the Poverty Line ('BPL') families.

Employees' State Insurance Scheme: It is a multi-dimensional Social Security Scheme tailored to provide Socio-economic protection to the 'employees' in the organised sector against the events of sickness, maternity, disablement and death due to employment injury and to provide medical care to the insured employees and their families.

Varishta Mediclaim policy: It is made specifically by government for the senior citizens between the age of 60 and 80 years to meet the requirements of a senior citizen health insurance scheme.

Cashless hospitalization: In the case of hospitalisation, members of the beneficiary families do not need to pay anything under the Scheme, provided one goes to a government or an empanelled private hospital.

Underwriting in insurance: It means acceptance of risk on a Proposal for insurance cover. It is the decision of the insurer to accept or reject or postpone or make a counter-offer after assessment of the risk on the Proposal for insurance cover submitted by a Customer.

Free look Cancellation: A freelook is the right of the Customer to review the Policy terms and conditions and return the Policy to insurer seeking return of premiums, if the Customer disagrees with any of the terms and conditions.

Portability: Portability is the right accorded to the Policyholder to transfer the credit gained for pre-existing conditions and time-bound exclusions from one insurer to another insurer or from one plan to another plan of the same insurer.

Reinsurance: Every insurer should cede such percentage of the sum assured on each policy for different classes of insurance written in India to the Indian re-insurer as may be specified by the Authority in accordance with the provisions the Insurance Act.

SELF TEST QUESTIONS

1. Briefly discuss the different categories of Health Insurances plans ?
2. What are government initiatives to promote Health Insurance in India?
3. Briefly discuss Health Financing models in India?
4. Briefly discuss the measures taken by government for Health Financing in India?
5. Explain the underwriting of Health Insurance Policy?
6. What are the clauses in Health Insurance Policy?
7. What are the contents in Proposal Form of Health Insurance?
8. What are the powers and functions of IRDA administrating Health Insurance?
9. Who are Third Party Administrators?
10. What is claim process of Health Insurance?
11. Discuss briefly about Portability of Health insurance policies?
12. Discuss briefly about Health Insurance Fraud?
13. Discuss briefly about Reinsurance?

Lesson 8

General Insurance –Practices and Procedures

LESSON OUTLINE

- Introduction to General Insurance
- Insurance Policy Contract
- Insurance Documentation
- Documentation
- Underwriting
- Claims settlement
- LESSON ROUND UP
- SELF TEST QUESTIONS

LEARNING OBJECTIVES

General Insurance refers to all insurance covers available for securing against loss exposures to property and liability loss exposures, against natural as well as man-made calamities. Since insurance is an intangible service, an insurance policy provides an evidence of the contractual obligation between the insurance company and the insured. Hence, policy documentation is an integral part of the insurance business which requires experience and judgement in assessing, underwriting, rating and pricing risk in order to enable the company ensure a profitable book of business.

After reading this lesson, a student will be able to

1. Understand the importance of all documents in the business of insurance
2. Understand and interpret the insurance policy
3. Appreciate the need and importance of underwriting Explain the claims settlement process in general insurance

“There is nothing certain in this world except the death and the Tax; yet the Death and Tax are uncertain as no body knows when will he die or when the tax will change”

– Benjamin Franklin

INTRODUCTION

A popular or generally accepted idea is that all insurance other than life is non - life or general insurance. General Insurance comprises of insurance of property against fire, burglary and natural calamities like floods and earthquakes etc., personal insurance such as Accident and Health Insurance, and liability insurance which covers legal liabilities. There are also other covers such as Errors and Omissions insurance for professionals, credit insurance, agricultural insurance, etc. Non-life insurance companies have products that cover property against fire and allied perils, flood storm and inundation, earthquake and so on.

The non-life insurers offer policies covering machinery against breakdown, there are policies that cover the hull of ships and so on. A marine cargo policy covers goods in transit including by sea, air and road. Further, insurance of motor vehicles against damages and theft forms a major chunk of non-life insurance business. In respect of insurance of property, it is important that the cover is taken for the actual value of the property to avoid being imposed a penalty should there be a claim.

Personal insurance covers include policies for Accident, Health etc. Products offering Personal Accident cover are benefit policies. Health insurance covers offered by non-life insurers are mainly hospitalization covers either on reimbursement or cashless basis. The cashless service is offered through Third Party Administrators who have arrangements with various service providers, i.e., hospitals. The Third Party Administrators also provide service for reimbursement claims. Sometimes the insurers themselves process reimbursement claims.

Accident and health insurance policies are available for individuals as well as groups. A group could be a group of employees of an organization or holders of credit cards or deposit holders in a bank etc. Normally when a group is covered, insurers offer group discounts.

Liability insurance covers such as Motor Third Party Liability Insurance, Workmen's Compensation Policy, etc., offer cover against legal liabilities that may arise under the respective statutes— Motor Vehicles Act, The Workmen's Compensation Act, etc. Some of the covers such as the foregoing (Motor Third Party and Workmen's Compensation Policy) are compulsory by statute. Liability Insurance not compulsory by statute is also gaining popularity these days. Many industries insure against Public liability. There are liability covers available for Products as well.

There are general insurance products that are in the nature of package policies offering a combination of the covers mentioned above. For instance, there are package policies available for householders, shop keepers and also for professionals such as doctors, chartered accountants etc. Apart from offering standard covers, insurers also offer customized or tailor-made ones. Industries also need to protect themselves by obtaining insurance covers to protect their building, machinery, stocks, etc. and need to cover their liabilities as well. Financiers insist on insurance of property which they finance through loans. So, most industries or businesses that are financed by banks and other institutions do obtain covers.

Most general insurance covers are annual contracts. However, there are few products that are long-term.

It is important for proposers to read and understand the terms and conditions of a policy before they enter into an insurance contract. The proposal form needs be filled correctly and completely, as this is the offer and first step of the insurance contract; it is always filled by a proposer to ensure that the cover is adequate and the right one. Unlike Life insurance, General insurance contracts are based on indemnity of the loss incurred by the insured. Therefore, the losses will have to be measured accurately. The Surveyor and Loss Assessor, as we saw in one of the earlier Chapters, play a crucial role in assessing the extent of damages to arrive at the compensation. While assessing the loss on account of fire accident to a Car could be relatively simple, it becomes complex in certain cases for example, Public Liability insurance. Therefore, it is important for the

reader to appreciate how the framework around determination of liability in General insurance operates in India.

Insurance business is one of the most highly regulated businesses globally for reasons of equity and efficiency. It has a well-defined regulatory and legislative framework to operate. Insurance law by itself is both unique and comprehensive because it operates within the limitations of all the other governing legislations and ensures the legal provisions by incorporating the same in its various policies. The transactions of general insurance business in India are governed by two main statutes, namely:

- The Insurance Act, 1938
- General Insurance Business (Nationalisation) Act, 1972

The Insurance Act was passed in 1938 and was brought into force from 1st July, 1939. This act applies to the GIC and the four subsidiaries. The act was amended several times in the years 1950, 1968, 1988, 1999. This Act specifies the restrictions and limitations applicable as specified by the Central Government under powers conferred by section 35 of the General Insurance Business (Nationalization) Act, 1972. The important provisions of the Act relate to:

Registration: Every insurer is required to obtain a Certificate of Registration from the Controller of Insurance, by making the payment of requisite fees. Registration should be renewed annually.

Accounts and audit: An insurer is required to maintain separate accounts of the receipts and payments in each class of insurance viz. Fire. Marine and Miscellaneous Insurance.

Apart from the regular financial statements, the companies are required to maintain the following documents in respect of each class of insurance:

- Record of Cover notes specifying the details of the risk covered
- Record of policies
- Record of premiums
- Record of endorsements
- Record of Bank guarantees
- Record of claims
- Register of agency force and business procured by each with details of commission
- Register of employees
- Cash Books
- Reinsurance details
- Claims register

Investments: Investments of insurance company are usually made in approved investments under the provisions of the Act. The guidelines and limitations are issued by the Central Government from time to time.

Limitation on management expenses: The Act prescribes the maximum limits of expenses of management including commission that may be incurred by an insurer. The percentages are prescribed in relation to the total gross direct business written by the insurer in India.

Prohibition of Rebates: The Act prohibits any person from offering any rebate of commission or a rebate of premium to any person to take insurance.

INSURANCE POLICY CONTRACT

An insurance policy is like any contract, a legal document and enforceable in a court; the provisions of the Indian Contracts Act, 1872 are applicable to insurance contracts as well.

The essential elements of a valid contract of insurance would be-

- i. Offer and acceptance
- ii. Capacity to contract
- iii. Consideration
- iv. Legality of object

An offer, intended to create legal relations, must be communicated to the offeree either by words or by conduct.

The phrase 'insurance is the subject matter of solicitation' is very commonly seen and heard -what this indicates is that insurance is to be sought by the person who wants to buy it from the insurer. It is advisory in nature. It should not be forced. Customer must not be threatened or coerced to buy insurance. It is to be solicited or purchased by the consumer. It must be remembered that "Customer's participation in availing the insurance products and services are purely on voluntary basis.

This means that the insurance company is providing you insurance against a risk on your request/solicitation, i.e. the company has agreed to sell you its insurance policy after you solicited or asked for such a sale. In legal terms, insurance is a product that should not be pushed or sold by a seller, but should be pulled or bought by a buyer.

The proposal is made by the insured and accepted by the insurer.

1. **Agreement between the Parties** – The acceptance of the proposal by the insurer together with the premium is expressed in the form of a contract – the insurance policy; together with the clauses is the basis of the agreement between the parties.
2. There must be Evidence of the Intention of the parties to enter into a contractual relation. This may be provided by the formal procedure of making the promise under seal, or it may be by the existence of consideration.
3. **Consideration** –The premium paid by the insured for the contract is the consideration
4. The parties must be recognized by the law as having the Capacity to Contract. All aspects regarding the capacity to contract, age, mental capacity and understanding etc. as defined in the Indian Contracts Act, 1872 is applicable.
5. The consent of the parties **MUST BE REAL**; that is to say, the parties must not have been threatened, unduly influenced, deceived or misled in a manner which would nullify their agreement.
6. The subject-matter of the contract must be Legal and Possible.

If one of these essentials is missing, the contract is void, voidable or unenforceable, depending upon the circumstances. A void "contract" is a contradiction in terms for it never can be a contract. A voidable contract is valid but, at the option of one of the parties.

An insurance policy is also governed by the principles of insurance as discussed in the earlier chapters.

To refresh ourselves, let's take a quick look again

1. Utmost Good faith
2. Principle of Insurable Interest,
3. Principle of Indemnity – with corollaries
 - i. Principle of Contribution,
 - ii. Principle of Subrogation,
4. Principle of Loss Minimization, and
5. Principle of Causa Proxima (Nearest Cause).

In the chapter on risk management, we noted that insurance is a method of risk transfer, where many share the losses of a few. The whole concept of insurance is spreading the risk. The principle of indemnity is the basis of the existence and spread of insurance- the fact that a person, who has suffered losses, needs to be placed in the pre-loss position where he was prior to the loss or as if the loss had in fact not happened.

The main point to be noted here is that the loss should be fortuitous, or accidental, the loss should not be intentional and inevitable.

–Principle of Uberrimae fi

The insurance contract is evidenced by a policy, however, the offer having come from the proposer in the form of a proposal. The proposal form elicits certain information about the proposer/insured, the subject matter of insurance and the experience or claims history, on the basis of which the terms and conditions of the contract would be decided and policy issued.

As the insured would like to avail of insurance for matter that he wants to have insured, it is necessary that he discloses all material facts about the same and his disclosures must be genuine and not misrepresented.

Policy Structure or key elements

Heading – The name of the insurer and other particulars regarding the issuing office- the name of the policy etc.

Preamble – This contains relevant information regarding the subject matter of insurance, the locations, identity, value, and period of insurance required etc.

Signature – The signature of an authorized official empower to accept the offer of the proposer and issue a policy.

Operative or insuring clause - States the peril(s) which are to be insured against. v. Exclusions – States the various conditions under which the policy will not pay.

Rules of Interpretation of a Policy

Like any other contract, disputes do arise regarding liability, quantum, extent and duration of cover, especially in cases where the insurer may have earlier repudiated the claim. It follows therefore, that interpretation of the policy document, is of paramount importance even at the time of inception and during the currency of the policy and not only in a court of law.

The policy document being a standard document, drafted by the insurer, the benefit of doubt is always in favour of the insured, as a principle of natural justice. This is as per the *contra preferentum* rule which states that where

the contractual language is capable of alternative interpretations, it will be construed or translated in favour of the insured, who accepts the standard contract.

Briefly, the following rules are applied-

- Printed and written portion of the policy is to be construed together as far as possible.
- In case of contradiction, the written portion over-rides the printed portion.
- The policy is to be interpreted as a whole.
- The words in the policy are to be given their plain, ordinary and popular meaning.
- Technical words are to be given their strict technical meaning.
- The ordinary rules of grammar shall apply.

Other Important features of a policy document

1. Conditions – These describe the various conditions which must be followed or eschewed by the insured and may be quite detailed, depending on the nature of the risk and the extent and duration of cover required.

The conditions mention under what circumstances the policy would pay and the precautions safeguards to be taken by the insured, eg duty of assured condition prescribes that the insured must take all those steps necessary to mitigate the loss, as if he was not in fact insured. Other terms and conditions would related to arbitration, duty to disclose material facts including any amendment/alteration in the risk or subject matter of insurance. There are certain clauses such as cancellation, arbitration, jurisdiction etc. which are recommended in every contract.

Implied/express conditions:

Generally express conditions are those that require the insured to do something – eg. in cargo insurance transit by road during monsoon. There are two types of express conditions,

- (i) Conditions, which are applicable to all policies of that class and are therefore, printed on the policy document.
- (ii) Special conditions, which are applicable only to that specific policy. The special conditions are thus handwritten or typed or rubber-stamped on the policy. (e.g. type of packing, compulsory excess, unloading survey, etc.)

Implied are those, which are so basic and material that their existence forms the very basis of the policy and cannot be ignored. In the absence of express conditions, the insurance contract is subject to implied conditions, which relate to

- (i) Good faith
- (ii) Insurable interest
- (iii) Subject matter of insurance
- (iv) Identification of the subject matter

Implied conditions can be expressed in a policy explicitly, or can be modified or excluded by the express conditions.

All conditions whether expressed or implied are the operative clauses of a policy. They are recited as conditions to be fulfilled by the insured for assuming the right to recover under the policy.

Conditions Precedent / subsequent to the contract

Conditions precedent refer to those conditions which are there prior to entering into a contract, which may be material to the contract being executed by either party. Whereas, conditions subsequent are due to the occurrence of a material event which may require the insurer to avoid the contract- condition subsequent to policy inception, like discovery of a fraud or gross misrepresentation which alters the basic circumstances under which the contract was accepted.

Conditions subsequent to liability

A condition subsequent presupposes an absolute obligation under the policy and provides that the policy will become void, or its operation defeated or suspended, or the insurer relieved wholly or partially from liability, upon the happening of some event or the doing or omission of some act. For example, upon an loss event happening, it is a condition that the insured has to notify the loss to the insurer immediately within 24 hours. On the contrary, if the intimation notice is violated, then the insurer may not be responsible for the compensation under the claim.

INSURANCE DOCUMENTATION

1. Proposals

As has been mentioned earlier, insurance is the subject matter of solicitation, i.e the offer or proposal for insurance has to come from the insured. It is also said that a proposal is the basis of insurance. In other words, the facts mentioned in the proposal form becomes the basis for the insurance policy cover. The proposal forms for most products have been designed, over the years, to conveniently and comprehensively, obtain information from the insured which would be material to underwriting the policy.

The basic principle of utmost good faith comes into operation here. The insured should at the start of the contract divulge all material information about the subject matter; this would enable the insurer to decide the terms of cover and the rating and help avoid any disputes in the future in the event of a claim.

The owner's pecuniary interest in the subject matter of insurance establishes that the loss if any would adversely affect him financially; this serves to prove the insurable interest that the proposer has in the property to be insured.

The policy of insurance is a personal contract, and thus if the insured wants to transfer the interest in the policy, he can only do so with the consent of the insurer. The transfer of rights can be made through assignment of the policy. Assignment means transfer of the rights to another person usually made through a written document.

When the property on which insurance has been obtained, is sold the existing policy might be transferred to the buyer of the policy, with the permission of the insurer. However, marine cargo policies are freely assignable as together with the invoice and contract of affreightment i.e – B/L, AWB. GCM or RR they form negotiable instruments that can be discounted at banks.

The proposal form is therefore the foundation of the insurance contract. It contains all the relevant information about-

1. Generic details about the insured/proposer – name, address etc. Important not only for incorporating on the policy form but also checking KYC diligences under the anti money laundering laws and for checking moral hazards etc.
2. Specific details about the subject matter to be insured-this may be a line or two, if a single machinery,

or a single shipment of goods by road; it may run into pages in case it contains details about projects which are to be insured-eg.hydro electric project, oil rigging platform etc.

3. Details regarding the value to be sum insured; duration of insurance covered required.

Almost all general insurance policies are for 1 year; specific voyage policies can be shorter for the transit duration only. Project polices can be longer than 1 year – till the project is commissioned and operative.

2. Policy Schedule

The policy schedule is the document which together with various clauses, warranties and conditions forms the contract.

Naturally, this would include such details as name address, nature of business, policy number etc. Other more particular information detailed in the policy schedule would be

1. Full details and description of the subject matter to be insured.
2. Sum insured based on value of the sum insured. The basis of valuation and the adequacy of the sum insured is to be measured and specified clearly to avoid dispute in future in the event of a claim.
3. Period of insurance.
4. Premium
5. The terms and conditions which details the actual cover eg. in marine cargo policies whether the cover is under ICC (A) or ICC (B) or ICC (C) etc.
6. The various clauses which attach to the policy schedule and which are applicable to the contract would be listed on the policy schedule as well to clearly specify the nature and extent of the cover which is being issued.

It is advisable to discuss with the insured, especially in case of insurance of high value risks , the exact words and clauses which attach to the policy and that define the cover. Eg , in case of project policies etc- it may be necessary to clarify what is testing period. It may be necessary to advise that when the plan becomes operational, post testing period, project insurance cover should be replaced by operational cover like fire policy.

3. Certificates of insurance

These are usually given in marine transit insurance under open policies and also for motor insurance. In motor insurance they are mandatory as it confirms that there is insurance cover existing for the vehicle plying on public roads. They are less detailed than a policy and not stamped, but essentially give the same information regarding insurance

4. Cover note

These are documents that are issued immediately to prove that insurance cover is existing and valid for 60 days from the date of issue. Mostly used in motor insurance and transit insurance, particularly for import covers by sea. The cover note in marine insurance would be valid for duration of transit. The cover note is valid for a maximum period of 60 days.

5. Endorsements

There may be instances, when during the currency of the policy, certain changes may be advised by the customer. Eg. Change in location, correction of name or other details of subject matter insured. There may be

instances of increase in the value to be insured, inclusion of extra covers or deletion of covers etc.

In such cases, the insurer would, on being so solicited by the insured customer, issue an endorsement which would reflect the changes or amendments and would thereafter form part of the policy document. This is particularly relevant, in the event of a claim, as the damaged property may have been the subject matter of the endorsement- which details would not be available in the original policy.

Generally endorsements are issued for such alterations as

1. Change in insurable interest
2. Cancellation of insurance
3. Change in the value at risk
4. Change in the location or situation of risk
5. Reduction or addition to the risk
6. Change of the insured as when a transfer of interest or assignment of interest is made.

Sometimes an endorsement is also issued to correct a typographical error in the policy already issued.

Renewal Notice

While it is not obligatory to issue renewal notices reminding insured that the policy is due for renewal, it is recommendatory as an excellent customer service initiative.

It is well known that getting a new customer is much more difficult and time consuming than retaining an old one. With much less effort one can cash in on their loyalty and ensure that policies are renewed year after year.

Warranties

Warranties are an extension of the terms and conditions contained in the clauses which attach to the policy schedule. As explained, the insured proposes insurance of a particular property and completes a proposal. Based on the same and customary trade conditions and practices, as well as underwriting experience the insurer would stipulate certain warranties or conditions, which help the minimize chances of loss.

Warranty is a statement by which the insured undertakes to do/not do a particular thing or fulfil a condition, or whereby he affirms or negates the existence of a particular state of facts which affect the incidence of a claim.

Warranties can either relate to facts existing at the time of the contract or relate to the future. It is an undertaking given by the insured either voluntarily or at the instance of the insurer about something that will determine the insurability of the risk.

For example, in a Marine Cargo policy, a warranty may read “Warranted that the consignments are transported in closed trucks covered by tarpaulins” – in case goods are being moved during monsoons.

Main Objectives of Underwriting

1. To reduce the possibility of adverse selection against the insurer.
2. Prudent underwriting reduces the chances of Physical, Moral, and Morale hazards.
3. Underwriting helps in determining the expected loss potential of the proposed insured and selecting a price in line with this expected loss.
4. To ensure a profitable book of business for the insurer.

Underwriting Process

Underwriting is defined as assumption of liability. It is a continuous process of risk selection and risk classification. The underwriting process follows a series of stages, at the end of which the status of a risk is decided. It is only after the risk has been weighed and all possible alternatives evaluated that the final underwriting is done. When a proposal for insurance is received, the underwriter has four possible courses of action:

- Accept the risk at standard rates
- Charge extra premium depending on the risk factor
- Impose special conditions
- Reject the risk.

There are different types of hazard which can influence his decision to accept or reject a risk —

1. Physical hazards

These are hazards that affect the physical characteristics of whatever is being insured. For example a building made of wood represents a higher level of physical hazard than one made of brick.

2. Moral hazards

These hazards refer to the defects that exist in a person's character that may increase the frequency or the severity of loss. Such a character may tend to increase the loss for the company e.g taking a policy of insurance with an intention to cheat or commit fraud.

3. Financial hazards

If the value of the risk is beyond the capacity of the insurer he may reject the risk, or share the same.

4. Morale hazard

This hazard refers to the attitude of the insured which is reflected through his behaviour because of existence of insurance towards his belongings. For example, an insured may not take minimum precaution of safety because he knows he has insurance policy. For example, leaving the house unlocked, leaving the keys in the car, reflects carelessness or indifference to loss due to existence of insurance policy.

Therefore the Underwriter has the following choices:

The underwriter can accept a proposal, reject it or accept it with certain modifications. Some of the modifications that can be made are:

- Hazard incidence can be reduced: For loss prevention and minimisation, underwriters can recommend certain changes that will safeguard against physical hazards. For example, installing sprinkler systems and better fire-fighting equipment in offices will reduce damages in case of fire.
- Changing rating plans and policy terms: Sometimes a proposal that seems unacceptable at one rate may become a desirable business under another rating plan or with Special Conditions such as 'compulsory excess'.

Facultative reinsurance can be used: When the business is not covered by the insurer's reinsurance treaty or the amount of insurance needed exceeds the net treaty capacity, the underwriter can transfer that excess to a facultative reinsurer

Disclosure - Terms And Conditions

Proper disclosures of terms and conditions are very important for the Insurance contracts. An insurer should make utmost efforts to ensure that all important terms and conditions are disclosed properly. Insurance Companies should also ensure that the customer is made aware about the important clauses of the insurance agreement. The policy schedule usually gives the most relevant information and summarizes information pertaining to risk, value, period of insurance, premium and cover details. The clauses which attach and form part of the policy are many and varied and would be attached to the policy schedule, depending on the type of policy. Most property policies such as fire and engineering policies are on an indemnity basis- which means that the compensation would seek to put the insured in the same place, financially, as prior to the loss.

1. Average Clause

It has been described before, that the insured knows best about the property which he would like to insure. Hence, in his own best interest, while completing the proposal form, he must declare the full value of the property. In the event of a partial loss, the value to the extent it is underinsured would have to be borne by the insured. He would be his own insurer for that portion of the property damaged, which has not been insured because of inadequacy in value insured.

Fixing of adequate sum insured is also important from the point of view of the banks or financial institutions that may have advanced money on the security of the insured property. It is sometimes found that the banks or financial institutions do not concern themselves with the adequacy of the sum insured so long as it is sufficient to cover the money advanced by them or at best the full value of the property on which they have advanced money. Invariably in such cases they find the problem only after happening of a loss when the claim amount is suitably adjusted for underinsurance and the full indemnity is not available due to the inadequacy of the sum insured.

Average clause enumerates - If the property hereby insured shall at the breaking out of any insured peril be collectively of greater than the sum insured thereon, then the insured shall be considered as being his own insurer for the difference, and shall bear a rateable proportion of the loss accordingly. Every item, if more than one, of the policy shall be separately subject to the condition.

Since the purpose of the insurance is to place the insured in the same financial position in which he was at the time of loss, it is necessary that there should be no under-insurance and the sum insured be adequate.

Points to be noted

- The sum insured is always fixed by the proposer.
- It is the limit of Insurer's liability under a policy.
- It is the amount on which the rate is applied to determine the premium payable for the insurance.
- The sum insured should represent the actual value of the property to be insured. Insuring for higher value than the actual value gives no advantage to the insured as payment of claim, if any, is subject to the principle of indemnity, which means payment is only for actual loss.
- Insuring for value lesser than the actual value makes the insured self-insurer for the difference and claim, if any, is subjected to 'average' clause whereby he is penalized for under-insurance.
- In case of joint ownership of any property, the insured can get the claim only in respect of his share. He could, however, insure full value of the property on behalf of other co-owners as well which case the claim, if any, is paid to each co-owner to the extent of their insurable interest.

Market Value

This is determined by the amount at which property of the same age and condition can be bought and sold. This value takes into account both depreciation due to age and appreciation due to inflation. For determining the sum insured for buildings, apart from excluding the value of land and plinth, the present cost of construction of similar building should be taken and then the depreciation for age and usage deducted.

Reinstatement Value

In fire insurance the principle of indemnity can be modified in the case of building, machinery and other fixed assets where, subject to the sum insured representing the value of similar new property, it can be insured under 'Reinstatement Value' clause.

In case of reinstatement value policy, the basis of loss settlement is the value of new property without taking any depreciation into account. In other words, it means it is replacement of old with new. This type of insurance enables the owner to replace his property without any financial strain on his own resources and is quite commonly taken by industrialists and building owners.

Duty of Assured Clause

All policies have a duty of assured clause- this spells out that the duty of the assured is, to behave as if he was not insured. Hence, in the event of a peril operating, he or his agent have to take all necessary steps to avert losses/ mitigate the damages caused due to peril.

Duration of Cover Clause

Particularly in transit insurance, where insured requires that warehouse to warehouse cover be issued - the duration of cover is defined as the from the time the goods leave the place of storage, and continue through transshipment till the goods reach final destination, or on the expiry of a certain period of time after the goods are discharged – 60/15/7 days depending on whether transit is by sea/air or road.

It is often a point of contention whether loading risks are covered, as damages often take place on loading. Peculiarly, only in Inland Transit (C), which is an extremely limited cover, are loading risks insured. In other policies, it is expected that additional premium be charged and the cover specifically mentioned-“loading risks covered’ on the policy schedule.

Transshipment – in the ordinary and customary course of transit is covered. The emphasis is that it should be in the ordinary and customary course of transit. Any other deviation or detour should be informed, prior to such instance, to the insurer. This is because the underwriting conditions have altered and the new risk environment should be evaluated in terms of risk acceptability and premium to be charged.

Deductibles

A deductible is that portion of the amount of an insured loss, which the insured agrees to pay. It is common in almost all types of insurance policies to stipulate a definite amount of money, which is to be borne by the insured. The insurer becomes liable for any amount beyond the deductible amount stated in the contract.

It is a provision by which a specific amount is subtracted from the total loss payment and are usually found in auto, property and health insurance. Deductibles are not used in life insurance because the death of an insured is always a total loss. It is also not used in personal liability insurance because even for a small claim, the insurer must provide a legal defence.

Deductibles may be either compulsory or voluntary. Voluntary deductibles will fetch a discount in the premium.

(also known as 'excess').

Excluded Losses

Most insurance policies differentiate between direct and indirect losses; they do not cover indirect losses arising out of the peril, even though the peril itself is covered under the policy. Like, for example in case of loss due to fire, losses arising as a result of fire fighting, viz. breaking windows, making holes on the roof, are also considered as direct loss. But loss of income due to interruption in business as a result of the fire is considered as indirect loss. If the assured wants to be covered against the indirect losses, he must obtain separate policy for the same, or on payment of additional payment of premium as an add-on covers, the insured can get the indirect losses also covered.

Proximate cause should be established for any claim to become liable and the insurer to accept liability, in case the proximate cause which refers to the most dominant cause is an insured peril. In case the policy is a named perils policy the onus would lie on the insured to prove that the insurer is liable by virtue of the fact that the loss happened because of operation of one of the named perils.

Obviously, as a commercial contract the elements of a legal contract are contained in the insurance policy; again in an idealistic world, the policy terms and conditions, as accepted at the time of purchasing the contract would later not be negated. However, this is not practically what happens. Therefore, it is of the utmost importance that both the parties to the contract should be of one mind- or consensus ad idem should be established at the start.

Coinsurance

Where the amount of insurance on large industrial complexes is substantial, it is advisable for the insured to seek cover from different insurers in the risk for varying proportions of acceptance, so that the total is covered. The practice is for each insurer to issue a policy with a specification or schedule giving a description of the property insured, with the "co-insurance clause" included therein.

Survey of the risk, rating, collection of premium and preparation of the specification is carried out by the "leading office", that is the office carrying the largest share in the business.

All co-insurances are agreed upon prior to the issue of the original policy.

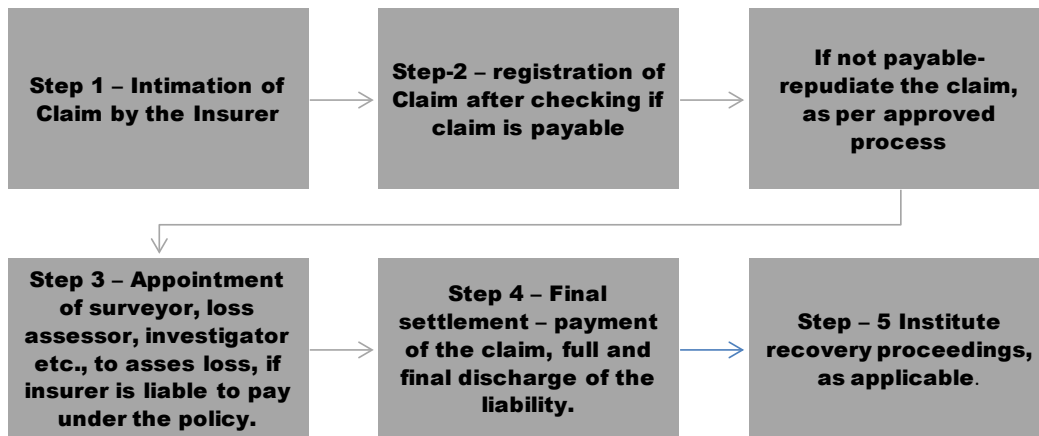
In the event of a claim all policies would contribute equally. In case, in rare instances where two policies are extant for a same risk, both would contribute in proportion of their interest in the sum insured at the time of claim. Notably, the policies would contribute in a manner to ensure that the insured is indemnified and not benefited from the loss. This means that all the policies should collectively compensate for actual loss.

The main postulate in underwriting all general insurance products is presence of mind and application of basic common sense. At every instance, a brief scan of one's surroundings would showcase an opportunity to provide protection and evaluation of the surrounding circumstances and environment reveal the conditions which affect the property (potential risk) and the possibility of loss (potential risk/peril.)

CLAIMS IN GENERAL INSURANCE

General Procedure for Claim Settlement

The general procedure for seeking claim settlement is same in most forms of General Insurance. The graphical presentation of claim settlement is as given below:



Step 1 – Intimation/Submission of the Claim by the Insured

The insured would intimate the insurance company of the occurrence of a peril or risk which has caused loss of or damage to the insured property

Step 2 – Evaluation/Registration of Claim

The insurer would briefly initiate process check –

- (i) Whether the policy has been issued by the insurer
- (ii) Whether the policy is in existence
- (iii) Whether correct premium has been received by the insurer
- (iv) Whether the peril causing loss/damage is an insured peril

If the insurer is not satisfied and the necessary elements of insurance are not present, it may repudiate the insurance claim and intimate the insured about the repudiation. In some cases, the insurer may ask for some other inputs about the insurance claim which he thinks necessary for processing the claim further. If on receipt of the additional input, the insurer is not satisfied, he may repudiate the claim and intimate the insured about the repudiation of claim. Only after getting satisfied about the claim, the insurer initiates the next step for claim processing.

Step 3 – Appointment of surveyor/loss assessor/investigator etc.

The insurer would immediately arrange for surveyor to be appointed who would look into the circumstances of the loss, assess the actual loss suffered in money terms and that which can be indemnified in terms of the contract, advise the insurer regarding compliance of the various terms conditions and warranties under the contract etc.

The loss assessor has also to advise the client on various aspects of loss mitigation, limitation, salvage. Loss investigation including forensic investigation and analysis may also come under the purview of a professional investigator.

Acid tests applied by the surveyor of the various principles – insurable interest, utmost good faith, proximate cause and of course contribution, help in deciding ultimately, if a claim is payable as well as quantum payable.

If the claim is not paid within the same financial year in which it occurred, then the surveyor's assessment would enable the adequate provisioning for the claim in its financials.

Step 4 – Settlement of claims

The insurer would ensure claims are settled on the receipt of the final report from the surveyor, generally within the TAT (Turn around time) stipulated by various regulations and committed by the insurance company.

Step 5 – Recovery

The next step for the insurance company, in certain cases is initiating process for recovery from the third person who is party – eg in marine cargo transit claims – recovery proceedings, as per applicable statutes are initiated against carriers. In motor third party liability claims – awards are settled with victims of any motor accident and action instituted against the owner of the vehicle for recovery.

Claim Procedure for Motor Insurance**(a) Vehicle Accident Claims**

After the insured submit his claim form and the relevant documents, the insurer appoints a surveyor to inspect the vehicle and submit his/her report to the insurance company. Insured also get the details of the surveyor's report. In case of major damage to the vehicle, the insurer arranges for a spot survey at the site of accident.

The insured can undertake repairs only on completion of the survey. Once the vehicle is repaired, the insured should submit duly signed bills/cash memos to the insurance company. In some cases, companies have the surveyor re-inspect the vehicle after repairs. In such a scenario, the insured should pay the workshop/garage and obtain a proof of release document (this is an authenticated document signed by you to release the vehicle from the garage after it is checked and repaired).

Once the vehicle has been released, insured should submit the original bill, proof of release, and cash receipt from the garage to the surveyor. The surveyor sends the claim file to the insurance company for settlement along with all the documents and Finally, the insurance company reimburses the insured.

In case of an accident, the insurance company pays for the replacement of the damaged parts and the labor fees.

The costs that the insured has to bear include:

- A. The amount of depreciation as per the rate prescribed
- B. Reasonable value of salvage
- C. Voluntary deductions under the policy, if the insured have opted for any
- D. Compulsory excesses levied by the insurer

If the insured uses the cashless repair facility, the claim money is paid directly to the workshop or garage. Otherwise, the amount of claim is paid to the insured.

(b) Third Party Insurance Claim

In the event of a third party claim, the insured should notify the insurance company in writing along with a copy of the notice and the insurance certificate. The insured should not offer to make an out-of-court settlement or promise payment to any party without the written consent of the insurance company. The insurance company has a right to refuse liabilities arising out of such promises.

The insurance company will issue a claim form that has to be filled and submitted along with:

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- (a) Copy of the Registration Certificate.
- (b) Driving license
- (c) First information report (FIR)

After verification, the insurance company will appoint a lawyer in the defense of insurer and the insurer should cooperate with the insurance company, providing evidence during court proceedings. If the court orders compensation, the insurance company will then do it directly.

(C) Vehicle Theft Claims

In the event of theft of vehicle, the insured should lodge the First Information Report (FIR) with a police station immediately, inform the insurance company and provide them with a copy of the FIR. He should also submit the Final Police Report to the insurance company as soon as it is received and extend full cooperation to the surveyor or investigator appointed by the company. After the claim is approved, the Registration Certificate of the stolen vehicle has to be transferred in the name of the company and the insured needs to submit the duplicate keys of the vehicle along with a letter of subrogation and an indemnity on stamp paper (duly notarized) to the insurance company.

If there is a dispute regarding the claim settlement between the insured and the insurer, how is the dispute resolved?

The most common form of dispute that arises between the insured and the insurer is about admission of liability or the size of the claim. Disputes regarding claim amounts, where the insurer has agreed to cover the claim under the policy, are referred to an arbitrator. If the decision of the arbitrator is disputed by either party, the Consumer Forum or the Civil Court could be approached. There is a special designated court namely Motor Accident Claims Tribunal (MACT) which settles all disputes related to Third Party Liability cases.

Claim Settling Process (Fire and Marine Insurance)

(1) Intimation to Insurance Company: The insured must give immediate intimation to the insurance company regarding the loss. The necessary details like the day, date, time and causes of fire and in case of marine insurance, ship and voyage taken should be mentioned.

(2) Assessment of the loss: The insured makes an assessment of the actual loss. Such assessment is required to fill the claim forms correctly in respect of the loss of goods or property.

(3) Submission of the claim form: the insured must fill all possible details in the claim form. He must lodge the claim form within 15 days of the fire to claim compensation. In case of marine insurance, the insured should lodge a claim with the following documents:

1. Original Insurance Policy
2. Copy of Bill of Lading
3. A copy of commercial Invoice
4. A copy of packing list
5. Survey report
6. Claim Bill

Delay in submission of claim form may result in non-acceptance of the claim.

(4) Evidence of Claim: Along with the claim form, the insured must send certain proof of fire and other records, if available and if necessary. The evidence should enable the insurance company to determine the amount of loss.

(5) Verification of Form: The claim form along with the supporting evidence is verified by the insurance company. The insurance company then appoints the surveyors to conduct an assessment of the actual loss.

(6) Survey: After the receipt of the form, and necessary verification, the insurance company appoints the surveyors to assess the actual loss. The surveyors conduct the necessary investigations. They investigate into the cause of fire, the actual amount of property lost and other relevant details. The surveyors then make the report of their findings and assessment of the loss.

(7) Landing Remarks: In case of marine insurance, the insured should obtain landing remarks, from the port authorities, if survey report is not obtained.

(8) Appointment of the arbitrator: There may be a dispute regarding the amount of claim. In such a case, an arbitrator is appointed, acceptable to both the parties, to settle the amount of the loss.

(9) Settlement of Claims: If there is no dispute between the two parties, as to the amount of loss, the insurance company then makes necessary payment to the insured. In case of marine insurance, the amount of money is paid to India Exporter in Indian rupees. If the claimant is not a resident of India, payment maybe made in foreign currency.

Health Insurance Claim Settlement Procedure

In Health insurance mainly two types of claims are raised

1. Claims pertaining to cash less
2. Reimbursement of medical expenses

Claim Procedure for Cashless Health Insurance

1. For availing the cashless facility, first the insured visit the hospitals which are covered in the network of insurance Company.
2. Hospital obtains details from the customer and verifies the details along with the insurance details and send the intimation to the insurance company
3. On receiving the intimation from the hospital, the insurance company approve the claim and authorise the hospital to carry out the treatment under cash less scheme. In some cases, the insurance company may ask for some additional information and even deny for the claim.
4. After getting the necessary authority from the insurance company, the hospital carry out the treatment without any deposit and get the settlement of bills from the insurance bills. Here it is pertinent to mention that the liability of insurance company is limited only the amount insured and if the bill for treatment is more than the amount insured, the balance needs to be recovered from the customer

Claim for Reimbursement of medical expenses

In the cases where the customer does not use the cashless health insurance, he raises the claim for reimbursement of medical expenses incurred.

SETTLEMENT OF INSURANCE CLAIMS

(a) Repair & replacement

The insurer has the option of repairing and/or replacing the damaged or destroyed property. Only conditions would be that the cost of repair/replacement will not exceed the sum insured; repair or replacement may not be exact. It may be partial repair and partial replacement.

(b) Replacement

Usually in total or constructive total loss cases.

Total loss of machinery insured under Fire policy due to fire accident. The subject matter is totally destroyed and the insurer, subject to applicable terms and conditions (depreciation, average clause, applicable liability) agrees to replace the same.

Constructive Total Loss occurs where the entire subject matter of insurance e.g. entire consignment of goods in transit, are effectively lost, by virtue of the fact that they are inaccessible to insured and the cost of recovery and/or salvage would be more than the cost of the goods itself.

(c) Repair

The compensation by the insurer would be in the form of cost of repairs to the subject matter damaged by the insured peril, subject to the maximum level of indemnity (sum insured) under the policy.

In property policies, for eg. Fire or engineering policy this is usually done usually after surveyor assesses the loss and submits his report indicating the net liability of the insured towards the cost of repairs.

In marine policies, where, goods need to be repaired or loss minimized in transit – repairs would include costs of segregation, conditioning etc. as part of the efforts of insured or his agent in minimizing losses.

(d) Reinstatement

One method of settlement is reinstatement of the insured to the position he was in prior to the loss occurrence. In many property claims, however, what sounds like an anomaly – ‘new for old’ is practiced. Here new items are replaced in place of damaged ones even if the original items were not new.

CLAIMS MANAGEMENT IN GENERAL INSURANCE

1. Underwriting and claims settlement are the two most important aspect of the functioning of an insurance company. Out of any insurance contract, the customer has the following expectations:
 - (i) Adequate insurance coverage, which does not leave him high and dry in time of need, with right pricing.
 - (ii) Timely delivery of defect free policy documents with relevant endorsements/warranties/conditions/ guidelines.
 - (iii) Should a claim happen, quick settlement to his satisfaction?
2. Unlike life insurance, where all policies necessarily result in claims – either maturity or death – in general insurance not all policies result in claim. Approximately around 15% policies in general insurance result in claim. The claim settlement in general insurance thus has their own peculiarities and therefore need proper handling. Also how 15% policy holders are attended is of great importance. The services being rendered will determine the attitude of the customers. How the services being rendered are perceived

by the customer? That also needs to be kept in mind.

3. In the present liberalized scenario, with cut-throat competition being the order of the day, the insurance companies have to go much beyond the handling of claims. The following aspect needs to be kept in mind.
4. General insurance being a market driven service industry, the customer has to be kept satisfied. With so many options available, a customer once lost is most likely a loss forever.

Claim settlement can be used as a marketing tool. Bringing in a new customer is much more costly than retaining the existing ones.

5. In a de-tariffed market, pricing will be the key factor. Proper claims management - quick settlement at optimal cost will help keep the price competitive.
6. A dissatisfied customer is a bad publicity. It has all the potential to damage the reputation of the company. It is an accepted fact that most of the customers complaint relate to claims. It should be the endeavour of any insurance company to ensure that such complaints do not occur in the first place and in some cases if they do occur it is attended promptly, efficiently and transparently.
7. IRDA guidelines on 'protection of policyholders' interest' stipulate certain obligation on the part of insurance company including time limit for claim settlement. This is a regulatory requirement and insurance company personnel at every level must understand its implication.
8. Delayed claim settlement generally result in higher claims cost. Claims cost is a very important factor vis-à-vis profitability. The delay in submission of survey reports is a very important reason for delay in claim settlement. The surveyors are duty bound as per IRDA regulations to submit report within a stipulated time. The insurance company should analyze about take necessary steps and put the systems in place for ensuring the timely settlement of insurance claims.
9. Claims files must be monitored as they progress. A little time spent thinking clearly right from the beginning will avoid lot of unnecessary and time consuming patch-ups and straightening out later on. Unpleasant decisions conveyed timely with proper justification of the decision is better than procrastination which is bound to create more problems and unpleasant situations.
10. Proper underwriting (u/w) is essential as defective u/w results in complication at the time of settlement of claims. Defective U/w may saddle the companies with unwanted claims. Various court judgments and consumers forum awards bear testimony to the same. Any defect / ambiguity in the documents issued invariably goes against insurance companies. It is therefore of utmost importance that the client is made aware in very clear terms about what exactly is covered and what is not. There should be a strong system of audit for examining the documents being issued.
11. Lot of time / energy / money is spent when claim cases go to Ombudsman / Consumer Forum/ Court. Besides, adverse comment bring bad name, when the insurance companies are held liable. Insurance companies are invariably at the receiving end. The "watch and wait" attitude must change. There is a need to find out why so many cases go to consumer forum or the ombudsman and what should be done about it.
12. Claims-settlement have social service angle which must be met. In times of natural calamity lot of bad publicity comes to insurance company for delay in settlement of claims. This is in spite of the fact that in such situation insurance companies goes out of their way to settle claims. In any case claims relating to the assets of weaker section needs to be attended on priority. So do the health / medical related claims.

In view of the above, it is necessary that

1. Insurance companies have a corporate claims management philosophy. Managing claims involves not only claims processing but goes on to cover the entire gamut of claims management – strategic role, cost monitoring role, service aspect as also the role of people handling the claim.
2. Out of the total outgo on account of claims it is estimated that around 10 to 15 % is because of leakages, frauds and inflated claims. In absolute terms this will be a quite substantial amount. If this can be effectively checked, the benefit can be passed on to the customer by way of reduced premium rates.
3. Claims reserving is also an important part of the overall claim management process. Adequacy of claims reserving is important for any insurance company to meet its claim obligation. In fact in a study in USA of the insurance companies going “bust” 34% (highest) was on account of insufficient reserve / premium. The analysis of reserve and the process that goes into making the same and its comparison with past experience can help address such important concerns as
 - Company’s likely future obligations on account of claims and its ability to meet them.
 - Solvency aspect and assessing the true picture of the financial health.
 - Analysis of claims trend can help to timely initiate remedial action. e.g. restricting a particular class of business.
 - Effectiveness of loss control measure.
 - Average time being taken for the settlement of a claim and the claim settlement ratio and how it compares with other operators in the market.

Underinsurance

A situation wherein the owner of a property or the person suffering a health condition does not have enough insurance to cover the value of the item or the health care costs may be termed as underinsurance. An uninsured individual knows that he lacks the security of insurance. An underinsured individual finds out about his lack of insurance coverage only after he files a claim.

For example, Mr. A believes that the health insurance cover provided by his workplace is more than adequate. Then, one day, he falls seriously ill. His family rushes him to hospital only to learn that the employer-provided medical insurance comes with a high deductible, limited annual benefits and exemptions on specific treatments. Thus, an underinsured person has insurance, but not enough.

Causes of Underinsurance

Underinsurance may be caused by many factors depending upon the nature and type of insurance. It ranges from a failure to update a policy in a timely manner to an underestimate of reconstruction or replacement value. Failure to report new construction or additions to the property or a decision not to purchase sufficient insurance due to cost could also lead to underinsurance problems. Relying on the health insurance problem by the employer may also be a reason of underinsurance. Even in many cases, cost cutting measure also a reason of underinsurance.

Consequences of Underinsurance

The dangers of underinsurance are just too high. If your business and personal assets are not adequately

covered or if you have high deductibles and exemptions on your health insurance, footing out-of-pocket expenses can become a huge hurdle. If you have inadequate life insurance, your family would suffer the financial consequences when you are no more. Remember, being underinsured is as bad as being uninsured is—this is a lesson that we all must learn.

Condition of Average in Insurance Policy

The doctrine of average – or average clause is always applied in indemnity policies – primarily in property claims – fire and engineering. At the time of taking the policy the insured has to consider the value of the risk or subject matter of insurance-sum insured. He must ensure that the adequate value has been declared and insured. If, at the time of loss, it is found that the sum insured is less than the actual value of the subject matter, then the proportionate or rateable portion of the claims would be payable. The insured would therefore be his own insurer for the difference.

Fixing of adequate sum insured is also important from the point of view of the banks or financial institutions who may have advanced money on the security of the insured property. It is sometimes found that the banks or financial institutions do not concern themselves with the adequacy of the sum insured so long as it is sufficient to cover the money advanced by them or at best the full value of the property on which they have advanced money. Invariably in such cases they find the problem only after happening of a loss when the claim amount is suitably adjusted for underinsurance and the full indemnity is not available due to the inadequacy of the sum insured.

Eg. If the value of stocks which have been insured are actually Rs. 10 lac, but insurance premium has been paid on a sum insured of Rs.5 lac only- underinsurance is 50%. Hence the loss amount indemnified would be reduced by 50%.

Under average clause, the claim is calculated as

Claim amount = Actual Loss x Stock insured/Total Loss, where Actual Loss = Total Loss - Stock salvaged or stock saved

Recovery in Insurance Contracts

Subrogation refers to the the right of recovery of the insurer after having compensated to the insured. Under subrogation, the insurer is subrogated to the rights and remedies that the insured enjoys against third parties who are responsible for the loss. The insured, who under the duty of the assured clause, is required to protect right of recovery against persons responsible for the loss, surrenders the same on being compensated; again the principle of indemnity restricts him from benefiting and making a profit, by recovering from the third party as well.

All transits are usually done under a contract of affreightment – bill of lading air way bill, goods consignment note, railway receipt post parcel receipt etc. These are negotiable and freely assignable, together with the invoice and insurance policy they can be assigned and usually are used for discounting with banks etc. A number of statutes come into play, particularly in cargo insurance- Marine Insurance Act, Carriage of Goods by Sea Act, Carriers Act, Railways Act, Port Trusts Act, Bailees Act. etc.

Each statute specifies action to be taken, and the time limit/jurisdiction etc under which action can be taken by the parties to the contract of affreightment.

Insurable interest in cargo insurance, is of utmost importance at the time of claim occurring, as the consignee who is in possession of the negotiable documents is the owner of the goods and would institute action under

the appropriate statute, for recovery against the transporter.

Primarily in Marine insurance (cargo), the insurer pursues the rights of recovery, on being subrogated post claim settlement. The insurer initiates action by way of negotiating or filing a suit for recovery of compensation in civil courts, against the transporter. Therefore, the current owner of the goods, at the time of loss, should initiate action for recovery on being intimated the same by the transporter. Especially in case of transit by sea, intimation may come weeks after the loss has occurred, eg. When the ship has sunk or been captured by pirates.

Pay & Recover

Pay and recover is the parlance used, generally in motor accident compensation cases, where award is pronounced by the Motor Accident Claims Tribunal (MACT). After payment of the claim to the injured party or his legal heirs etc. The insurer can initiate action against the erring party- eg. the owner of the insured vehicle.

Modes of Recovery

1. Excess/deductible – That portion of the claim which is to be borne by the insured is called an excess or deductible.
2. Subrogation – Rights and remedies preferred against the third party.
3. Contribution – This occurs when the insured property is insured by more than one insurer- in such cases recovery would be made by the lead insurer from the co insurer.
4. Reinsurance – Reinsurance is the most common method of risk transfer – where the risk is re- insured with reinsurers and after the claim the same is recovered from them after payment to insured.

Salvage in Insurance Contracts

Salvage is also a form of recovery in any claim. In most property claims, including transit insurance claims, damaged property can be disposed off for either lower or scrap value, this is done to reduce the financial impact of claims. Hence, most insurers advise the surveyors to complete the net assessment by valuing the salvaged value of the damaged property as well. Especially in total loss cases, the insured may abandon the wreck or damaged property in favour of the insurer who would thereafter sell the same and credit the sale proceeds to claims account.

LESSON ROUND UP

- General Insurance comprises of insurance of property against fire, burglary and natural calamities like floods and earthquakes etc., personal insurance such as Accident and Health Insurance, and liability insurance which covers legal liabilities.
- Most general insurance covers are annual contracts and indemnity in nature, and governed under the provisions of contract act.
- Proposal is the basis of insurance. The proposal form needs be filled correctly and completely, as this is the offer and first step of the insurance contract.
- Insurance business is one of the most highly regulated businesses globally for reasons of equity and efficiency.
- An insurance policy is like any contract, a legal document and enforceable in a court; the provisions of

the Indian Contracts Act, 1872 are applicable to insurance contracts as well.

- An insurance policy is also governed by the principles of insurance.
- The insurance contract is evidenced by a policy, however, the offer having come from the proposer in the form of a proposal
- A policy structure comprises of
 - Heading
 - Preamble
 - Signature
 - Operative or insuring clause
- The policy schedule is the document which together with various clauses, warranties and conditions forms the contract.
- Certificates of insurance are less detailed than a policy and not stamped, but essentially give the same information regarding insurance
- Cover note is a document that is issued immediately to prove that insurance cover is existing and valid for 60 days from the date of issue.
- Endorsements would reflect the changes or amendments and would thereafter form part of the policy document. Generally endorsements are issued for such alterations as
 - Change in insurable interest
 - Cancellation of insurance
 - Change in the value at risk
 - Change in the location or situation of risk
 - Reduction or addition to the risk
 - Change of the insured as when a transfer of interest or assignment of interest is made.
- Underwriting is defined as assumption of liability. It is a continuous process of risk selection and risk classification and includes
 - Accept the risk at standard rates
 - Charge extra premium depending on the risk factor
 - Impose special conditions
 - Reject the risk.
- Claims settlement is one of the challenging functions of the insurer where in the insured would intimate the insurance company of the occurrence of a peril or risk which has caused loss of or damage to the insured property.
- General insurance being a market driven service industry, the customer has to be kept satisfied.
- Claim settlement can be used as a marketing tool. Bringing in a new customer is much more costly than retaining the existing ones.

- Claims reserving is also an important part of the overall claim management process.
- Adequacy of claims reserving is important for any insurance company to meet its claim obligation.
- Underinsurance may be caused by many factors depending upon the nature and type of insurance. It ranges from a failure to update a policy in a timely manner to an underestimate of reconstruction or replacement value.
- Salvage is also a form of recovery in any claim, wherein the damaged property can be disposed off for either lower or scrap value, to reduce the financial impact of claims.

GLOSSARY

IA: Insurance Act, 1938

TAT: Turn Around Time

FIR: First Information Report

MACT: Motor Accident Claims Tribunal

IRDA : Insurance Regulatory and Development Authority

U/w: Underwriting

SELF TEST QUESTIONS

1. Why is it said that “proposal is the basis of Insurance”?
2. Discuss the salient features of an Insurance Policy with all important components.
3. Define the following:
 - i. Reinstatement value
 - ii. Cover note
 - iii. Certificate of insurance
 - iv. Endorsement
 - v. Underinsurance
 - vi. Underwriting
 - vii. Salvage
4. Discuss the steps followed in the General Insurance claims settlement process.
5. What is meant by recovery? Discuss the various modes of recovery followed in a general insurance claims settlement process.

Lesson 9

Fire & Consequential Loss Insurance

LESSON OUTLINE

- Basic Principles of the Fire Policy
- Add on Covers and Special Policies
- Fire Hazards and Fire Prevention
- Erstwhile Tariff – Rules and Rating Documents
- Underwriting Claims – Legal & Procedural Aspects
- Consequential Loss Insurance
- Specialized Policies and Overseas Practice
- LESSON ROUND UP
- SELF TEST QUESTIONS

LEARNING OBJECTIVES

Under section 2(6A) Insurance Act 1938, the fire insurance business is defined as follows:-
“Fire insurance business means the business of effecting, otherwise than independently to some other class of business, contracts of insurance against loss by or incidental to fire or other occurrence customarily included among the risks insured against in fire insurance policies”.

Insurance of property means insurance of buildings, machinery, stocks etc against Fire and Allied Perils, Burglary Risks and so on. Goods in transit via Sea, Air, Railways, Roads and Courier can be insured under Marine Cargo Insurance. Hulls of ship and boats can be insured under Marine Hull Insurance.

Further, there are specialized policies available such as Aviation Insurance Policy for insurance of planes and helicopters. Thus Property Insurance is a very vast category of General Insurance and the type of cover that you need depends upon the type of property you are seeking to cover.

The purpose of this chapter is to enable the students to understand –

- Features of Fire Insurance
- Add on Covers and Special Policies
- Consequential Loss Insurance
- General Exclusions of Fire Insurance
- Fire Hazards and Fire Prevention
- Underwriting Process
- Claim Process
- Specialized Policies and Overseas Practice
- New Trends in Insurance Sector

INTRODUCTION

The term fire in a fire insurance is interpreted in the literal and popular sense. There is a fire when something burns. In other words fire means visible flames or actual ignition. Simmering/ smoldering is not considered fire in Fire Insurance. Fire produces heat and light but either of them alone is not fire. Lightening is not a fire but if it ignites something, the damage may be due to fire.

Under section 2(6A) Insurance Act 1938, the fire insurance business is defined as follows: "Fire insurance business means the business of effecting, otherwise than independently to some other class of business, contracts of insurance against loss by or incidental to fire or other occurrence customarily included among the risks insured against in fire insurance policies".

Fire Insurance is applicable to stationary assets, such as buildings, Plant and machinery, stocks etc. The items which are in normal course of work kept in one premises for purpose of manufacturing or production .

Example

The following are the items which can be burnt/ damaged through fire:

- Buildings
- Electrical installation in buildings
- Contents of buildings such as machinery, plant and equipment, accessories, etc.
- Goods (raw materials, in-process, semi-finished, finished, packing materials, etc.) in factories, godown etc.
- Goods in the open
- Furniture, fixture and fittings
- Pipelines (including contents) located inside or outside the compound, etc.

The owner of abovementioned properties can insure against fire damage through fire insurance policy which provides financial protection for property against loss or damage by fire.

Insurance of property means insurance of buildings, machinery, stocks etc against Fire and Allied Perils, Burglary Risks and so on. Goods in transit via Sea, Air, Railways, Roads and Courier can be insured under Marine Cargo Insurance. Hulls of ship and boats can be insured under Marine Hull Insurance. Further, there are specialized policies available such as Aviation Insurance Policy for insurance of planes and helicopters. Thus Property Insurance is a very vast category of General Insurance and the type of cover that you need depends upon the type of property you are seeking to cover.

FEATURES OF FIRE INSURANCE

(1) **Offer & Acceptance:** It is a prerequisite to any contract. Similarly, the property will be insured under fire insurance policy after the offer is accepted by the insurance company. Example: A proposal submitted to the insurance company along with premium on 1/1/2011 but the insurance company accepted the proposal on 15/1/2011. The risk is covered from 15/1/2011 and any loss prior to this date will not be covered under fire insurance.

(2) **Payment of Premium:** An owner must ensure that the premium is paid well in advance so that the risk can be covered. If the payment is made through cheque and it is dishonored then the coverage of risk will not exist. It is as per section 64VB of Insurance Act 1938.

(3) **Contract of Indemnity:** Fire insurance is a contract of indemnity wherein the insurance company promises to put the insured party in same financial condition as he was immediately prior to accident, which resulted in damage/loss of asset -- If there is no loss, there is no liability even if there is fire. Example: If the property is insured for Rs 20 lakhs under fire insurance and it is damaged by fire to the extent of Rs. 10 lakhs, then the insurance company will not pay more than Rs. 10 lakhs.

(4) **Utmost Good Faith:** The property owner must disclose all the relevant information to the insurance company while insuring their property. The fire policy shall be voidable in the event of misrepresentation, mis-description or non-disclosure of any material information.

Material information means the information and facts about the subject matter proposed for insurance and which has bearing on decision making of insurance company about the premium to be charged or risk to be accepted and terms and conditions for acceptance of such risk under the insurance cover.

Example

The use of building must be disclosed i.e whether the building is used for residential use or manufacturing use, as in both the cases the premium rate will vary.

(5) **Insurable Interest :** The fire insurance will be valid only if the person who is insuring the property is owner or having insurable interest in that property. Such interest must exist at all times during the validity of the insurance cover. It is well known that insurable interest exists not only with the ownership but also as a tenant or bailee or financier. Banks can also have the insurable interest. Example: Mr. A is the owner of the building. He insured that building and later on sold the building to Mr. B and the fire took place in the building. Mr. B will not get the compensation from the insurance company because he has not taken the insurance policy being a owner of the property. After selling to Mr. B, Mr. A has no insurable interest in the property.

(6) **Contribution:** If a person insured his property with two insurance companies, then in case of fire loss both the insurance companies will contribute to pay the loss to the owner proportionately. Example: A property worth Rs. 50 lakhs was insured with two Insurance companies A and B. In case of loss, both insurance companies will contribute equally.

(7) **Period of fire Insurance:** The period of insurance is to be defined in the policy. Generally the period of fire insurance policy is twelve months(365 days). The period can be less than one year but not more than one year. The only exception being the residential houses which can be insured for the period exceeding one year also.

(8) **Deliberate Act:** If a property is damaged or loss occurs due to fire because of deliberate act of the owner, then that damage or loss will not be covered under the policy.

Add on Covers and Special Policies

In India, under fire insurance policy, in addition to fire, other perils are also included and the policy is known as "Standard Fire and Allied Perils Policy".

The most popular property insurance is the standard fire insurance policy. The fire insurance policy offers protection against any unforeseen loss or damage to/destruction of property due to fire or other perils covered under the policy. The different types of property that could be covered under a fire insurance policy are dwellings, offices, shops, hospitals, places of worship and their contents industrial/manufacturing risks and contents such as machinery, plants, equipment and accessories; goods including raw material, material in process, semi-finished goods, finished goods, packing materials etc in factories, godowns and in the open; utilities located outside industrial/manufacturing risks; storage risks outside the compound of industrial risks; tank farms/gas holders located outside the compound of industrial risks etc.

The perils specified in the fire policy are:-

- A. **Fire:** Fire caused by any means such as short circuit, human negligence e.g. lighted cigarette being thrown in premises, overheating of moving parts, accidental falling or spilling of chemicals resulting in flames and fire.

It however excludes destruction or damage to property by :-

- i. its own fermentation, natural heating or spontaneous combustion
 - ii. its undergoing any heating or drying process, and
 - iii. burning of property insured by order of any Public authority.
- B. **Lightning:** Any lightning due to cloud burst may damage the property and the same will be covered under the fire policy.
- C. **Explosion / Implosion:** Sudden change in the temperature or pressure in any plant & machinery or exposure to atmospheric pressure may result into loss and the same will be covered under fire policy. However the policy excludes the explosion/implosion in Industrial boilers from coverage. It also excludes explosion/implosion due to generation of centrifugal force in such apparatus.
Only domestic boilers and gas holders are therefore covered under this peril under the policy.
- D. **Aircraft Damage:** Any damage to the property due to any dropping of any articles from aerial devices /aircraft or by itself falling will also be covered under the fire policy.
- E. **Riot, Strike and Malicious Damage (RSMD):** Any damage to the property due to rioters or by striking employees or malicious damage (intentional damage) by any person will be covered under this policy.
- F. **Storm, Cyclone, Typhoon, Tempest, Hurricane, Tornado, Flood and Inundation (STFI):** The property damage due to any of these storms and flood will also be covered under this policy. The meaning of these perils lies in different intensity of the storms. Flood not only means the leakage of water through river but also accumulation of water due to heavy rains in the premises. Any waterbody/ water carrying channel when breaches its boundaries and affects insured assets is called flood. Damage.
- G. **Impact Damage:** Damage to the property due to impact by any Rail / Road vehicle or animal by direct contact, but not belonging to or owned by the Insured or any occupier of the premises or their employees while acting in the course of their employment.
- H. **Subsidence and Landslide including Rock Slide:** Destruction or damage caused by Subsidence of part of the site on which the property stands or Land slide / Rock slide.
- I. **Bursting and/or overflowing of Water Tanks, Apparatus and Pipes:** If due to bursting or overflowing of water from the water tanks installed in the premises of the policyholder any damage or loss to the property of the policyholder is caused, it will be covered under this policy.
- J. **Missile Testing Operations:** Any loss or damage due to missile testing by the Govt. or otherwise will be covered under this policy.
- K. **Leakage from Automatic Sprinkler Installations:** In most of the organizations as a fire protection measure, automatic sprinkler system is installed. If due to non-usage of the sprinkler system or otherwise it starts leaking and damages the property, then it will be covered under the fire insurance policy.
- L. **Bush Fire:** It means fire spread from the bushes (small fire) but will not include forest fire.

TYPES OF FIRE INSURANCE POLICIES

I. Floater Policy: This policy is issued only for the stocks, not for plant & machineries. Sometime the stock is kept at various locations and it is very difficult to provide the value of stock at each location. Therefore to cover the risks of stocks at various locations under one sum insured an additional load of 10% on premium is to be paid. Example: A person is having two godowns at Delhi and the value of stock is Rs 50 lakhs and he is not having the value at each location then he can insure the stock under floating policy by paying an additional premium.

II. Declaration Policies: This type of policy is useful where there is frequent fluctuations in stocks / stock values and to avoid the under insurance (insurance of lower value) of the stock,

Declaration Policy(ies) can be granted subject to the following conditions:

- (a) The minimum sum insured shall be ₹ 1 crore.
- (b) Monthly declarations based on the average of the highest value at risk on each day or highest value on any day of the month shall be submitted by the Insured latest by the last day of the succeeding month. If declarations are not received within the specified period, the full sum insured under the policy shall be deemed to have been declared.
- (c) Reduction in sum insured shall not be allowed under any circumstances.
- (d) Refund of premium on adjustment based on the declarations / cancellations shall not exceed 50% of the total premium.
- (e) The basis of value for declaration shall be the Market Value unless otherwise agreed to between insurer and insured.
- (f) It is not permissible to issue declaration policy in respect of
 - i) Insurance required for a short period
 - ii) Stocks under going process
 - iii) Stocks at Railway sidings

III. Floater Declaration Policy: It is combination of the above mentioned policies i.e. stock lying at different locations and the value of stock fluctuating. In this type of policies adjustment of policy is done at the end of the policy period based on actual average stock held by the insured during the year. The excess premium is refunded if the average stock during the year was lower than declared for the policy in the beginning of the year. A minimum of 80% of premium collected is however retained irrespective of average of stock values declared during the year.

CONSEQUENTIAL LOSS INSURANCE

Generally insurance policies cover only physical damage to property by insured perils. This, at best, covers the expenses incurred for repairing or replacing the damaged property. But what about the financial loss suffered due to interruption of business operations whilst the damaged property is being repaired or replaced? Consequential Loss (Fire) Insurance offers a solution by covering profit lost due to reduction in turnover arising from interruption of business following damage to the property insured. This Policy can be taken only in conjunction with a Standard Fire and Special Perils Policy. This Policy is also known as Business Interruption Policy or Loss of Profit Policy.

The most significant benefit of this Policy is that it protects your balance sheet from an adverse consequence

arising out of an interruption to your business from a peril covered under your Fire (Material Damage) Policy. You may extend your policy by paying additional premium. Major optional extensions available are:

- Wages-dual basis or pro rata basis
- Layoffs and retrenchment compensation and notice wage liability
- Auditor's fees
- Extension to cover supplier's premises
- Extension to cover customer's premises
- Insured's property stored at other situations
- Extension to cover loss due to accidental failure or public electricity/gas/water supply
- Molten material damage
- Spoilage consequential loss

Consequential Loss may arise due to:

- loss of gross profit due to reduction in turnover/output;
- increase in cost of working - This is the additional expenditure that has to be incurred in order to avoid or diminish the reduction in turnover following a loss payable under the Fire (Material Damage) Policy.

Gross profit – It is the sum of net profit & standing charges.

Net profit – It is the net trading profit excluding capital receipts, accretions and outlay chargeable to capital after making provisions for all standing charges.

Standing charges – It means all expenses which do not reduce proportionately with a reduction in turnover.

Package or Umbrella policies – There are package or umbrella covers available which give, under a single document, a combination of covers. For instance there are covers such as Householders Policy, Shopkeepers Policy, Office Package policy etc that, under one policy, seek to cover various physical assets including buildings,, contents, etc. These policies have various sections but predominant section is Fire Insurance. Such policies, apart from seeking to cover property against Fire and Burglary policy perils may also include certain personal lines or liability covers. Make sure you understand the complete details of cover and exclusions contained in the policy you are considering. Package or Umbrella covers could have common terms and conditions for all sections as also specific terms for specific sections of the policy.

GENERAL EXCLUSIONS OF FIRE INSURANCE

- (i) The policy has standard excess clause. The amount which is deducted from each and every loss. The amount is dependent on the Sum Insured under the policy. The clause reads as under:-
- Policies having Sum Insured upto Rs.10 Crores : 5% of claim amount subject to minimum of Rs.10000/- for each and every claim.
 - policies having sum insured from Rs.10 Crores to Rs.100 Crores : 5% of claim amount subject to minimum of Rs.25000/- each and every claim.
 - policies having sum insured from Rs.100 crs to Rs.1500 crs.:5% of claim amount subject to minimum of Rs.500000/- each and every claim.

- policies having sum insured from Rs.1500 crores to Rs.2500 crores: 5% of claim amount subject to minimum of Rs.2500000/- each and every claim.
 - policies having sum insured above Rs.2500 crores: 5% of claim amount subject to minimum of Rs.50 lakhs each and every claim.
- (ii) Loss, destruction or damage caused by war, and kindred perils.
 - (iii) Loss, destruction or damage directly or indirectly caused to the insured property by nuclear peril.
 - (iv) Loss, destruction or damage caused to the insured property by pollution or contamination.
 - (v) Loss, destruction or damage to any electrical and / or electronic machine, apparatus, fixture or fitting (excluding fans and electrical wiring in dwellings) arising from or occasioned by over-running, excessive pressure, short circuiting, arcing, self-heating or leakage of electricity, from whatever cause (lightning included). However damage to other assets by spread of such fire is covered under the policy.
 - (vi) Loss of earnings, loss by delay, loss of market or other consequential or indirect loss or damage of any kind or disruption whatsoever.
 - (vii) Earthquake: It is not covered under the fire policy but by paying additional premium, the earthquake can be covered.

FIRE HAZARDS AND FIRE PREVENTION

Fire Hazard

Factors, which may influence the outcome, are referred to as hazards. These hazards are not themselves the cause of the loss, but they can increase or decrease the effect should a peril operate. The consideration of hazard is important when an insurance company is deciding whether or not it should insure some risk and what premium to charge. So a hazard is a condition that creates or increases the chance of loss. Physical hazard relates to the physical characteristics of the risk, such as the nature of construction of a building, security protection at a shop or factory, or the proximity of houses to a riverbank. Therefore a physical hazard is a physical condition that increases the chances of loss. Thus, if a person owns an older building with defective wiring, the defective wiring is a physical hazard that increases the chance of a fire. Another example of physical hazard is a slippery road after the rains. If a motorist loses control of his car on a slippery road and collides with another motorist, the slippery road is a physical hazard while collision is the peril, or cause of loss. Following are the hazards in the fire insurance:

Nature of the construction material:

Here the physical hazards are the material used in construction. The nature of the material, whether they are combustible or non-combustible plays an important role here.

The lighting and the heating system in the premises:

The system of the lighting and the heating in the premises can be a physical hazard. The wire and the cable material of the building can cause a fire. It is essential that these elements are in good shape and are not worn-out.

Housekeeping

Fire can spread easily if there is rubbish scattered everywhere. Such rubbishes can be of a hazardous nature as far as the fire insurance is considered.

Smoking cigarette in the premises:

Smoking is the enemy of the inflammable materials. Especially in factories, where there is combustible material present, indiscriminate smoking becomes a physical hazard.

Nature of business occupation:

Any business involved in the usage of petroleum, kerosene or chemicals, the probability of the hazard increases. Such materials are considered as physical hazards in fire insurance.

Nature of the adjoining premises:

A fire can spread quickly from the adjoining premises to the premises of the insured. Hence the nature, construction, and the occupation of such adjoining premises are considered as the physical hazard.

Fire Prevention

A fire needs three elements - heat, oxygen and fuel. Without heat, oxygen and fuel a fire will not start or spread. A key strategy to prevent fire is to remove one or more of these elements -heat, oxygen or fuel. The risk assessment should include detail on all three elements to minimise the risk of a fire starting/ spreading.

Heat Safeguards

- Ensure employees are aware of their responsibility to report dangers
- Control sources of ignition
- Have chimneys inspected and cleaned regularly
- Treat independent building uses, such as an office over a shop as separate purpose groups and therefore compartmentalized from each other
- Ensure cooking food is always attended
- Use the Electricity Supply Board's Safety webpage
- Have regard to relevant Authority Safety Alerts, e.g. Mobile Phone "Expert XP-Ex-1", Filling LPG Cylinders
- Use the Code of Practice For Avoiding Danger From Underground Services

Oxygen Safeguards

- Ensure employees are aware of their responsibility to report dangers
- See safeguards in the Code of Practice for Working in Confined Spaces
- Oxygen should never be used to "sweeten" the air in a confined space
- Where oxygen is used,
 - follow safety advice from the supplier
 - follow the safeguards on the safety data sheet
 - keep the safety data sheet readily available
- Be aware of the dangers of oxygen if in doubt, ask
- Prevent oxygen enrichment by ensuring that equipment is leak-tight and in good working order

- Check that ventilation is adequate
- Always use oxygen cylinders and equipment carefully and correctly
- Always open oxygen cylinder valves slowly
- Do not smoke where oxygen is being used
- Never use replacement parts which have not been specifically approved for oxygen service
- Never use oxygen equipment above the pressures certified by the manufacturer
- Never use oil or grease to lubricate oxygen equipment
- Never use oxygen in equipment which is not designed for oxygen service

Fuel Safeguards

- Ensure employees are aware of their responsibility to report dangers
- Follow the Authority's advice on LPG
- Follow the Authority's advice on explosive
- Use the Code of Practice For Avoiding Danger From Underground Services
- Use Bord Gáis Networks safety webpage including Dial Before You Dig
- Ensure furnishings and fittings in places of assembly comply with the Code of Practice for Fire Safety of Furnishings and Fittings in Places of Assembly
- Permit no timber lining on ceiling, corridor walls/ ceilings or stairways (only exception is Class 0 MDF)
- Take care if placing notice boards in escape corridors/ routes as any paper on the board could be fuel in the event of a fire
- Where there is a possibility of the presence of flammable gas/ vapour, conduct a full risk assessment and consider the need for gas detection equipment
- Where gas detection equipment is needed, ensure it is properly installed, maintained and serviced

Underwriting Process

The underwriting in fire insurance relates to understanding and rating the assets for arriving at the premium to be charged to cover the same against the Fire and allied perils. This exercise involves C.O.P.E. (CONSTRUCTION, OCCUPATION, PROTECTION AND EXPOSURES) analysis of the assets.

Description of the property

This would include:

- (i) Construction of external walls and roof, number of storeies.
- (ii) Occupation of each portion of the building.
- (iii) Presence of hazardous goods.
- (iv) Process of manufacture.
- (v) The sums proposed for insurance.

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- (vi) The period of insurance.
- (vii) History of previous losses.
- (viii) Insurance history - whether previously other insurers had declined the risk, etc.

Inspection of the property: In case of property of any business organization, whether manufacturing or other type of organization, a risk inspection report is submitted by the insurer's engineers. The engineers submit in their report the nature of risk involved in the factory/ manufacturing unit.

Payment of Premium: Based on the proposal form and the inspection report of the engineers, the insurance company will submit the premium rates to the property owner and if these rates are acceptable to him then he should pay the amount to the insurance company. It is also a legal requirement under section 64VB of Insurance Act 1938 that the premium is paid in advance in full to the insurance company.

Claim Process

A) If there are any damage or loss arising due to fire or other perils covered under the policy then the policy holder should immediately inform the insurance company in writing and with estimated amount of loss.

B) **Survey Report:** If the amount of loss is small (i.e. up to `50000/-/-), the insurance company may depute an officer to survey the loss and decide on the settlement of the loss on the basis of the claim form and the officer's report. However, in large losses, an independent surveyor duly licensed by the IRDA is appointed to give a report on the loss.

The survey report would generally deal with the following matters:

- (i) Cause of loss.
- (ii) Extent of loss.
- (iii) Under-Insurance, if any.
- (iv) Details and value of salvage, and how it has been disposed of or proposed to be disposed of.
- (v) Details of expenses (e.g. fire brigade expenses).
- (vi) Compliance with policy conditions and warranties.
- (vii) Details of other insurance policies on the same property, and the apportionment of the loss and expenses among co-insurers.

C) **Claim form:** The policy holder will submit the claim form with the following information:

- (i) Name and address of the Insured.
- (ii) Date of loss, time and place from where the fire started.
- (iii) Cause of fire.
- (iv) Details of the property damaged such as description, etc.
- (v) Value at the time of fire, value of salvage and the amount of loss.
- (vi) Details of other policies on the same property giving the name of the insurer, policy number and sum insured.
- (vii) Fire Brigade report details.

(viii) F.I.R. at the nearest police station regarding third party liability, if any.

D) **Settlement of claim:** On the basis of the claim form and the survey report, decision is taken about the settlement or otherwise of the loss.

Business Interruption Insurance

Commercial coverage that reimburses a business owner for lost profits and continuing fixed expenses during the time that a business must stay closed while the premises are being restored because of physical damage from a covered peril, such as a fire. Business interruption insurance also may cover financial losses that may occur if civil authorities limit access to an area after a disaster and their actions prevent customers from reaching the business premises. Depending on the policy, civil authorities' coverage may start after a waiting period and last for two or more weeks.

Business interruption coverage is a tightly constructed part of broader commercial insurance policies. This coverage is most commonly found in commercial property insurance policies and business owner's policies (a package policy for small businesses, often referred to as a "BOP").

There are four critical elements to business interruption insurance:

- (1) It is only triggered in three limited circumstances:
 - There is physical damage to the premises of such magnitude that the business must suspend its operations.
 - There is physical damage to other property caused by a loss that would be covered under the company's insurance policy, and that damage totally or partially prevents customers or employees from gaining access to the business.
 - The government shuts down an area due to property damage caused by a peril covered by the company's insurance policy that prevents customers or employees from gaining access to the premises.
- (2) Even after a covered event, most policies have a waiting period of several days before business interruption coverage comes into play. Once it is in play, the coverage is not retroactive to the day of the event.
- (3) Coverage is limited. Specifically, after the waiting period expires, coverage is provided for lost net income, temporary relocation expenses (designed to reduce overall costs), and ongoing expenses such as payroll that enables businesses to continue paying employees rather than laying them off.
- (4) Coverage is not open-ended. Coverage is available only for as long as it is necessary to get the business running again, and usually not longer than 12 months. In addition, the business is required to prove all business interruption losses to its insurer.

LESSON ROUNDUP

- The fire policy does not cover only the loss/damage of fire but also due to other perils like lightning, storms, strike, aircraft damage etc. Therefore the fire policy in India, is known as
- Standard Fire and Special Perils Policy. Though these risks are covered yet exceptions are always there. For the growth of the Indian economy every business organization should insure its assets.

- If the value of stocks is fluctuating substantially during the year then the same should be insured under declaration fire insurance policy. To protect the interest of the financial institutes the agreed bank clause may be included.
- In India, the fire insurance premium contributes 30% to 40% of every insurance company.

SELF TEST QUESTIONS

These are meant for re-capitulation only. Answers to these questions are not to be submitted for evaluation.

- (1) Explain the features of the fire insurance policy.
- (2) Discuss the fire insurance policy in India.
- (3) Explain the various types of fire insurance policies.
- (4) Write short notes on
 - a. Reinstatement Value
 - b. Agreed Bank Clause
 - c. Local Authorities Clause
- (5) What are allied perils in Fire insurance policy?
- (6) What is utmost good faith?
- (7) What is period of insurance?

FURTHER READINGS

1. M. N. Srinivasan : Principles of Insurance Law, Wadhwa & Co.
2. Rajiv Jain : Insurance Law and Practice, Vidhi Publication Private Limited
3. Taxmann : Insurance Manual, Taxmann Publication Private Limited
4. Bharat : Manual of insurance Laws, Bharat Publication Private limited
5. Dr. Avtar Singh : Law of Insurance, Universal Publication Pvt. Limited

Lesson 10

Marine Insurance

LESSON OUTLINE

- Meaning of Marine Insurance
- Operation of Marine Insurance
- Role of Banker's In Marine Insurance
- Procedure to Insure Under Marine Insurance
- Types of Marine Insurance
- Procedure of Claim Settlement
- Risk Coverage
- Marine Recoveries
- Reinsurance
- Maritime Fraud
- Underwriting
- Loss Prevention

LEARNING OBJECTIVES

A contract of marine insurance is an agreement whereby the insurer undertakes to indemnify the insured, in the manner and to the extent thereby agreed, against transit losses, that is to say losses incidental to transit. Marine insurance plays an important role in domestic trade as well as in international trade. Most contracts of sale require that the goods must be covered, either by the seller or the buyer, against loss or damage. The normal practice in export /import trade is for the exporter to ask the importer to open a letter of credit with a bank in favour of the exporter. The broad purpose of reinsurance is for the direct insurer to be covered in respect of his liability under an original insurance policy, pursuant to which the original insured is entitled to recover from him. Maritime fraud has many guises and its methods are open to infinite variations.

INTRODUCTION

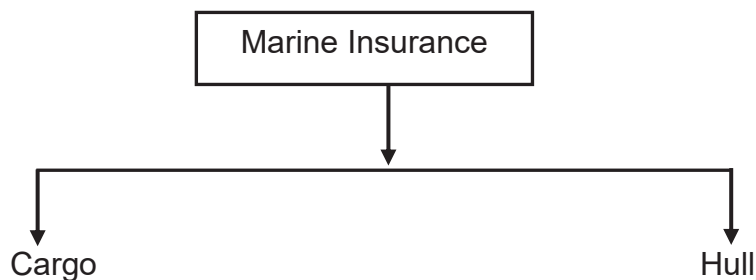
This is the oldest branch of Insurance and is closely linked to the practice of Bottomry which has been referred to in the ancient records of Babylonians and the code of Hammurabi way back in B.C.2250. Manufacturers of goods advanced their material to traders who gave them receipts for the materials and a rate of interest was agreed upon. If the trader was robbed during the journey, he would be freed from the debt but if he came back, he would pay both the value of the materials and the interest.

The first known Marine Insurance agreement was executed in Genoa on 13/10/1347 and marine Insurance was legally regulated in 1369 there.

Meaning of Marine Insurance

A contract of marine insurance is an agreement whereby the insurer undertakes to indemnify the insured, in the manner and to the extent thereby agreed, against transit losses, that is to say losses incidental to transit.

A contract of marine insurance may by its express terms or by usage of trade be extended so as to protect the insured against losses on inland waters or any land risk which may be incidental to any sea voyage.



A. Cargo insurance which provides insurance cover in respect of loss of or damage to goods during transit by rail, road, sea or air.

Thus cargo insurance concerns the following:

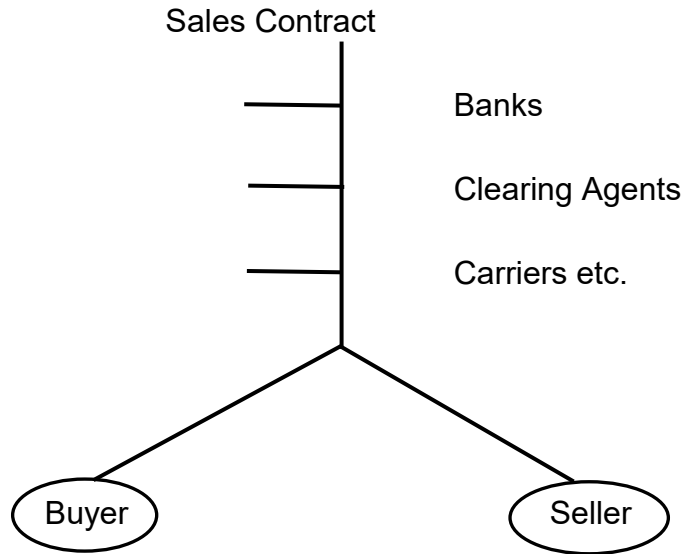
- (i) Export and import shipments by ocean-going vessels of all types,
- (ii) Coastal shipments by steamers, sailing vessels, mechanized boats, etc.,
- (iii) Shipments by inland vessels or country craft, and
- (iv) Consignments by rail, road, or air and articles sent by post.

B. Hull insurance which is concerned with the insurance of ships (hull, machinery, etc.). This is a highly technical subject and is not dealt in this module.

Operation of Marine Insurance

Marine insurance plays an important role in domestic trade as well as in international trade. Most contracts of sale require that the goods must be covered, either by the seller or the buyer, against loss or damage.

Who is responsible for affecting insurance on the goods, which are the subject of sale? It depends on the terms of the sale contract. A contract of sale involves mainly a seller and a buyer, apart from other associated parties like carriers, banks, clearing agents, etc.



The principal types of sale contracts, so far as Marine insurance is directly concerned, are as follows:

Type of Contract	Responsibility for Insurance
Free on Board (F.O.B. Contract)	The seller is responsible till the goods are placed on board the steamer. The buyer is responsible thereafter. He can get the insurance done wherever he likes.
Free on Rail (F.O.R. Contract)	The provisions are the same as in above. This is mainly relevant to internal transactions.
Cost and Freight (C&F Contract)	Here also, the buyer's responsibility normally attaches once the goods are placed on board. He has to take care of the insurance from that point onwards.
Cost, Insurance & Freight (C.I.F. Contract)	In this case, the seller is responsible for arranging the insurance upto destination. He includes the premium charge as part of the cost of goods in the sale invoice.

Types of Marine Insurance

(a) Special Declaration Policy

This is a form of floating policy issued to clients whose annual estimated dispatches (i.e. turnover) by rail / road / inland waterways exceed Rs 2 crores.

Declaration of dispatches shall be made at periodical intervals and premium is adjusted on expiry of the policy based on the total declared amount.

When the policy is issued sum insured should be based on previous year's turnover or in case of fresh proposals, on a fair estimate of annual dispatches.

A discount in the rates of premium based on turnover amount (e.g. exceeding Rs.5 crores etc.) on a slab basis and loss ratio is applicable.

(b) Special Storage Risks Insurance

This insurance is granted in conjunction with an open policy or a special declaration policy.

The purpose of this policy is to cover goods lying at the Railway premises or carrier's godowns after termination of transit cover under open or special declaration policies but pending clearance by the consignees. The cover terminates when delivery is taken by the consignee or payment is received by the consignor, whichever is earlier.

(c) Annual Policy

This policy, issued for 12 months, covers goods belonging to the insured, which are not under contract of sale, and which are in transit by rail / road from specified depots / processing units to other specified depots / processing units.

(d) "Duty" Insurance

Cargo imported into India is subject to payment of Customs Duty, as per the Customs Act. This duty can be included in the value of the cargo insured under a Marine Cargo Policy, or a separate policy can be issued in which case the Duty Insurance Clause is incorporated in the policy. Warranty provides that the claim under the Duty Policy would be payable only if the claim under the cargo policy is payable.

(e) "Increased Value" Insurance

Insurance may be 'goods at destination port' on the date of landing if it is higher than the CIF and Duty value of the cargo.

Role of Banker's In Marine Insurance

The normal practice in export /import trade is for the exporter to ask the importer to open a letter of credit with a bank in favour of the exporter. As and when the goods are ready for shipment by the exporter, he hands over the documents of title to the bank and gets the bill of exchange drawn by him on the importer, discounted with the bank. In this process, the goods which are the subject of the sale are considered by the bank as physical security against the monies advanced by it to the exporter. A further security by way of an insurance policy is also required by the bank to protect its interests in the event of the goods suffering loss or damage in transit, in which case the importer may not make the payment. The terms and conditions of insurance are specified in the letter of credit.

For export/import policies, the-Institute Cargo Clauses (I.C.C.) are used. These clauses are drafted by the Institute of London Underwriters (ILU) and are used by insurance companies in a majority of countries including India.

Procedure to Insure Under Marine Insurance

- (A) Submission of form
- (B) Quotation from the Insurance Company
- (C) Payment of Premium
- (D) Issue of cover note/Policy

(A) Submission of form

- (a) The form will have the following information:

- (1) Name of the shipper or consignor (the insured).
- (2) Full description of goods to be insured: The nature of the commodity to be insured is important for rating and underwriting. Different types of commodities are susceptible for different types of damage during transit- sugar, cement, etc are easily damaged by sea water; cotton is liable to catch fire; liquid cargoes are susceptible to the risk of leakage and crockery, glassware to breakage; electronic items are exposed to the risk of theft, and so on.
- (3) Method and type of packing: The possibility of loss or damage depends on this factor. Generally, goods are packed in bales or bags, cases or bundles, crates, drums or barrels, loose packing, paper or cardboard cartons, or in bulk etc.
- (4) Voyage and Mode of Transit: Information will be required on the following points:
 - i. the name of the place from where transit will commence and the name of the place where it is to terminate.
 - ii. mode of conveyance to be used in transporting goods, (i.e.) whether by rail, lorry, air, etc., or a combination of two or more of these. The name of the vessel is to be given when an overseas voyage is involved. In land transit by rail, lorry or air, the number of the consignment note and the date thereof should be furnished. The postal receipt number and date thereof is required in case of goods sent by registered post.
 - iii. If a voyage is likely to involve a trans-shipment it enhances the risk. This fact should be informed while seeking insurance. Trans-shipment means the change of carrier during the voyage.
- (e) Risk Cover required: The risks against which insurance cover is required should be stated. The details of risks are discussed subsequently in this chapter.

(B) Quotation by insurance company

Based on the information provided as above the insurance company will quote the premium rate. In nutshell, the rates of premium depends upon:

- (a) Nature of commodity.
- (b) Method of packing.
- (c) The Vessel.
- (d) Type of insurance policy.

(C) Payment of premium:

On accepting the premium rates, the concerned person will make the payment to the insurance company. The payment can be made on the consignment basis.

(D) Issue of cover note /Policy document:

(i) Cover Note

A cover note is a document granting cover provisionally pending the issue of a regular policy. It happens frequently that all the details required for the purpose of issuing a policy are not available. For instance, the name of the steamer, the number and date of the railway receipt, the number of packages involved in transit, etc., may not be known.

(ii) Marine Policy

This is a document which is an evidence of the contract of marine insurance. It contains the individual details such as name of the insured, details of goods etc. These have been identified earlier. The policy makes specific reference to the risks covered. A policy covering a single shipment or consignment is known as specific policy.

(iii) Open Policy

An open policy is also known as 'floating policy'. It is worded in general terms and is issued to take care of all "shipments" coming within its scope. It is issued for a substantial amount to cover shipments or sending during a particular period of time. Declarations are made under the open policy and these go to reduce the sum insured.

Open policies are normally issued for a year. If they are fully declared before that time, a fresh policy may be issued, or an endorsement placed on the original policy for the additional amount. On the other hand, if the policy has run its normal period and is cancelled, a proportionate premium on the un-utilised balance is refunded to the insured if full premium had been earlier collected.

On receipt of each declaration, a separate certificate of insurance is issued. An open policy is a stamped document, and, therefore, certificates of insurance issued thereunder need not be stamped.

Open policies are generally issued to cover inland consignments.

There are certain advantages of an open policy compared to specific policies. These are:

- (a) Automatic and continuous insurance protection.
- (b) Clerical labour is considerably reduced.
- (c) Some saving in stamp duty. This may be substantial, particularly in the case of inland sendings.

(iv) Open Cover

An open cover is particularly useful for large export and import firms-making numerous regular shipments who would otherwise find it very inconvenient to obtain insurance cover separately for each and every shipment.

It is also possible that through an oversight on the part of the insured a particular shipment may remain uncovered and should a loss arises in respect of such shipment; it would fall on the insured themselves to be borne by them.

In order to overcome such a disadvantage, a permanent form of insurance protection by means of an open cover is taken by big firms having regular shipments.

An open cover describes the cargo, voyage and covers in general terms and takes care automatically of all shipments which fall within its scope. It is usually issued for a period of 12 months and is renewable annually. It is subject to cancellation on either side, i.e., the insurer or the insured, by giving due notice.

Since no stamps are affixed to the open cover, specific policies or certificates of insurance are issued against declaration and they are required to be stamped according to the Stamp Act.

There is no limit to the total number or value of shipments that can be declared under the open cover. The following are the important features of an open policy/ open cover.

- (a) Limit per bottom or per conveyance**

The limit per bottom means that the value of a single shipment declared under the open cover should not exceed the stipulated amount.

(b) Basis of Valuation

The 'Basis' normally adopted is the prime cost of the goods, freight and other charges incidental to shipment, cost of insurance, plus 10% to cover profits, (the percentage to cover profits may be sometimes higher by prior agreement with the clients).

(c) Location Clause

While the limit per bottom mentioned under (a) above is helpful in restricting the commitment of insurers on any one vessel, it may happen in actual practice that a number of different shipments falling under the scope of the open cover may accumulate at the port of shipment. The location clause limits the liability of the insurers at any one time or place before shipment. Generally, this is the same limit as the limit per bottom or conveyance specified in the cover, but sometimes it may be agreed at an amount, say, upto 200% thereof.

(d) Rate

A schedule of agreed rates is attached to each open cover.

(e) Terms

There may be different terms applying to different commodities covered under the open cover, and they are clearly stipulated.

(f) Declaration Clause

The insured is made responsible to declare each and every shipment coming within the scope of the open cover. An unscrupulous insured may omit a few declarations to save premium, especially when he knows that shipment has arrived safely. Hence the clause.

(g) Cancellation Clause

This clause provides for cancellation of the contract with a certain period of notice, e.g., a month's notice on either side. In case of War & S.R.C.C. risks, the period of notice is much shorter.

Distinction between "Open policy" and "Open cover"

The open policy differs from an open cover in certain important respects. They are:

- (a) The open policy is a stamped document and is, therefore, legally enforceable in itself, whereas an open cover is unstamped and has no legal validity unless backed by a stamped policy/certificate of insurance.
 - (b) An open policy is issued for a fixed sum insured, whereas there is no such limit of amount under any open cover. As and when shipments are made under the open policy, they have to be declared to the insurers and the sum insured under the open policy reduces by the amount of such declarations. When the total of the declarations amounts to the sum insured under the open policy, the open policy stands exhausted and has to be replaced by a fresh one.
- (h) Certificate of Insurance**

A certificate of insurance is issued to satisfy the requirements of the insured or the banks in

respect of each declaration made under an open cover and / or open policy. The certificate, which is substituted for specific policy, is a simple document containing particulars of the shipment or sending. The number of open contract under which it is issued is mentioned, and occasionally, terms and conditions of the original cover are also mentioned.

Certificates need not be stamped when the original policy has been duly stamped.

Procedure of Claim Settlement

As the risk coverages are different for import/export and inland (with in India) consignments, the procedure of claim settlement is explained separately.

For Import/Export consignments

Claims Documents

Claims under marine policies have to be supported by certain documents which vary according to the type of loss as also the circumstances of the claim and the mode of carriage.

The documents required for any claim are as under:

- (a) **Intimation to the Insurance Company:** As soon as the loss is discovered then it is the duty of the policyholder to inform the Insurance Company to enable it to assess the loss.
- (b) **Policy:** The original policy or certificate of insurance is to be submitted to the company. This document establishes the claimant's title and also serves as an evidence of the subject matter being actually insured.
- (c) **Bill of Lading:** Bill of Lading is a document which serves as evidence that the goods were actually shipped. It also gives the particulars of cargo.
- (d) **Invoice:** An invoice evidences the terms of sale. It also contains complete description of the goods, prices, etc. The invoice enables the insurers to see that the insured value of the cargo is not unreasonably in excess of its cost, and that there is no gross over valuation. The original invoice (or a copy thereof) is required in support of claim.
- (e) **Survey Report:** Survey report shows the cause and extent of loss, and is absolutely necessary for the settlement of claim. The findings of the surveyors relate to the nature and extent of loss or damage, particulars of the sound values and damaged values, etc. It is normally issued with the remarks "without prejudice," i.e. without prejudice to the question of liability under the policy.
- (f) **Debit Note:** The claimant is expected to send a debit note showing the amount claimed by him in respect of the loss or damage. This is sometimes referred to as a claim bill.
- (g) **Copy of Protest:** If the loss or damage to cargo has been caused by a peril of the sea, the master of the vessel usually makes a protest on arrival at destination before a Notary Public. Through this protest, he informs that he is not responsible for the loss or damage. Insurers sometimes are required to see the copy of the protest to satisfy themselves about the actual cause of the loss.
- (h) **Letter of Subrogation:** This is a legal document (supplied by insurers) which transfers the rights of the claimant against a third party to the insurers. On payment of claim, the insurers may wish to pursue recovery from a carrier or other third party who, in their opinion, is responsible for the loss. The authority to do so is derived from this document. It is required to be duly stamped.

Some of the other documents required in support of particular average claims are Ship survey report lost

overboard certificate if cargo is lost during loading and unloading operation, short landing certificate etc.

(i) Bill of entry: The other important document is bill of entry issued by the customs authorities showing therein the amount of duty paid, the date of arrival of the steamer, etc., account sales showing the proceeds of the sale of the goods if they have been disposed of; repairs or replacements bills in case of damages or breakage; and copies of correspondence exchanged between the carriers and the claimants for compensation in case of liability resting on the carriers.

Inland Transit Claims (Rail / Road)

In regard to claims relating to inland transit, the documents required to be submitted to the insurers in support of the claim are:

- (a) Original policy or certificate of insurance duly endorsed.
- (b) Invoice, in original, or copy thereof.
- (c) Certificate of loss or damage (original) issued by carriers.
- (d) If goods are totally lost or not delivered, the original railway receipt and / or non-delivery certificate / consignment note.
- (e) Copy of the claim lodged against the railways / road carriers (By Regd. A.D.)
- (f) Letter of Subrogation, duly stamped.
- (g) Special Power of Attorney duly stamped. (Railway Claims).
- (h) Letter of Authority addressed to the railway authorities signed by the consignors in favour of consignees whenever loss is claimed by consignees.
- (i) Letter of Authority addressed to the railway authorities signed by the consignors in favour of the insurers
- (j) Letter of Undertaking from the claimant in case of non-delivery of consignment.
- (k) Claim Bill, after adjusting salvage value proposed.

Risk Coverage

(A) For export/import policies

The-Institute Cargo Clauses (I.C.C.) is used. These clauses are drafted by the Institute of London Underwriters (ILU) and are used by insurance companies in a majority of countries including India.

Exclusions

All three sets of clauses contain general exclusions. The important exclusions are:

- i. Loss caused by willful misconduct of the insured.
- ii. Ordinary leakage, ordinary loss in weight or volume or ordinary wear and tear. These are normal 'trade' losses which are inevitable and not accidental in nature.
- iii. Loss caused by 'inherent vice' or nature of the subject matter. For example, perishable commodities like fruits, vegetables, etc. may deteriorate without any 'accidental cause'. This is known as 'inherent vice'.
- iv. Loss caused by delay, even though the delay is caused by an insured risk.
- v. Deliberate damage by the wrongful act of any person. This is called 'malicious damage' and can be

covered at extra premium, under (B) and (C) clauses. Under 'A' clause, the risk is automatically covered.

- vi. Loss arising from insolvency or financial default of owners, operators, etc. of the vessel. Many ship owners, especially tramp vessel owners, fail to perform the voyage due to financial troubles with consequent loss or damage to cargo. This is not an accidental loss. The insured has to be cautious in selecting the vessel for shipment.
- vii. Loss or damage due to inadequate packing.
- viii. War and kindred perils. These can be covered on payment of extra premium.
- ix. Strikes, riots, lock-out; civil commotions and terrorism (SRCC) can be covered on payment of extra premium.

(B) Inland Consignments.

Exclusions

All three sets of clauses have the same exclusions as are found in ICC Clauses.

Marine Recoveries

Total Loss

Goods may be totally lost by the operation of the marine peril. The measure of indemnity in the event of total loss of the goods is the full insured value. The insurers are entitled to take over the salvage, if any. An actual total loss takes place where the subject matter is entirely destroyed or damaged to such an extent that it is no longer a thing of the kind insured. As against actual total loss, a constructive total loss, which is a commercial total loss, takes place where the subject matter insured is abandoned on account of the actual total loss being inevitable, or where the expenditure to be incurred for repairs or recovery would exceed the value of the subject-matter after the repairs or recovery.

Salvage Loss

When the goods insured are damaged during transit, and the nature of the goods is such that they would deteriorate further and would be worthless by the time the vessel arrives at destination, it would be a prudent and sensible way of dealing with the situation by disposing off the same at an intermediate port for the best price obtained. The term 'salvage loss' refers to the amount payable which is the difference between the insured value and the net proceeds of the sale. This is a practical method of settlement.

Recovery from Carriers

As stated earlier, in many marine claims, there are possibilities of recovery from the carriers, i.e., road carriers, railways, steamer companies, etc. After payment of claim, the insurers are subrogated the rights and remedies available to the insured against the carriers or third parties responsible for the loss.

Reinsurance

In insurance, the matching of exposure and protection to assure both solvency and profitability is absolutely fundamental. Reinsurance – of whatever type – is a principal means to this end. The broad purpose of reinsurance is for the direct insurer to be covered in respect of his liability under an original insurance policy, pursuant to which the original insured is entitled to recover from him. The direct insurer gives protection to

individuals and businesses against the uncertain risks associated with life and commerce. The reinsurer takes a share of those risks (and a share of the premium), thus spreading the consequences of the losses should a risk event take place. Furthermore, an insurer cannot predict with certainty which part of the business that it writes will result in profits and which part in losses each year, and reinsurance enables the insurer to smooth the peaks and troughs of his business results.

The functions of reinsurance, however, are not only protective – there are significant business advantages to be gained by an insurer that can obtain reinsurance. Primarily reinsurance provides capacity to an insurer, thereby enabling the insurer to insure a volume, type or size of risk that it would not be able to cover in the absence of reinsurance. In effect, the reinsurer enlarges the direct insurer's underwriting capacity by accepting a share of the risks and by providing part of the necessary reserves for losses. Reinsurance also increases the capital available to the direct insurer which would otherwise be earmarked to cover potential losses. Regulatory authorities will frequently have minimum margins or ratios below which they will not allow insurers to operate. Reinsurance, therefore, can strengthen the solvency ratio of the direct insurer.

Maritime fraud

Maritime fraud has many guises and its methods are open to infinite variations. Majority of these crimes can be classified into four categories as under:

- Scuttling of ships
- Documentary frauds
- Cargo Thefts
- Fraud related to the chartering of vessels

Scuttling of Ships

Also known as 'rust bucket' frauds, this involves deliberate sinking of vessels in pursuance of fraud against both cargo and hull interests. With occasional exceptions, these crimes are committed by ship-owners in a situation where a vessel is approaching or has the end of its economic life, taking into account the age of the vessel, its condition and the prevailing freight market. The crime can be aimed at hull insurers alone or against both hull and cargo interests.

Documentary Frauds

This type of fraud involves the sale and purchase of goods on documentary credit terms and some or all of the documents specified by the buyer to be presented by the seller to the bank in order to receive payment, are forged. Bankers pay against documents. The forged documents attempt to cover up the fact that the goods actually do not exist or that they are not of the quality ordered by the buyer. When the unfortunate purchaser of the goods belatedly realizes that no goods are arriving, he starts checking, only to find that the alleged carrying vessels either does not exist or was loading at some other port at the relevant time.

Cargo Thefts

There are several variations in the modus operandi of cargo thefts. In a typical example, the vessel, having loaded a cargo, deviates from its route and puts it into a port of convenience. The cargo may be discharged and stowed on the quayside or in a more sophisticated manner. Such an act is often accompanied by a change of the vessel's name or a subsequent scuttling in order to hide the evidence of theft. The whole process of investigation is proved difficult as by the time the loss is known the cargo disappears and the actual recovery of goods is unlikely. The owners of these ships are "paper companies" set up a few days prior to the operation.

Fraud related to Chartering of vessels

This is also known as Charter-part fraud". Establishing a chartering company required a modest initial financial commitment and is usually subject to little regulation. In depressed conditions of shipping market, there is no have demand on tonnage and owners anxious to avoid laying up their vessels are tempted to charter them to unknown companies without demanding any substantial financial guarantee for the performance of the charter contract.

LESSON ROUND UP

Marine insurance deals with goods when these are being moved from one place to another by approved mode of transportation. The goods can be moved within the country and outside the country. The risks are involved in any type of transportation and to cover these risks marine (transit) insurance is developed. The risk coverage depends upon the nature of goods and packing and to cover the risks the price is to be paid which is known as premium. The consignment can be single or multiple and accordingly the marine insurance policy i.e single transit or open cover or open policy is issued by the insurance company. The risk coverage is defined by Institute of London Underwriters under the various clause ICC (A), (B), (C) and the same is acceptable to all throughout the world. Similarly the clauses for inland transit have been defined as ITC (A),(B), (C).

GLOSSARY

- Marine Insurance: A contract of marine insurance is an agreement whereby the insurer undertakes to indemnify the insured, in the manner and to the extent thereby agreed, against transit losses, that is to say losses incidental to transit.
- Free on Board (F.O.B. Contract): The seller is responsible till the goods are placed on board the steamer. The buyer is responsible thereafter. He can get the insurance done wherever he likes.
- Free on Rail (F.O.R. Contract): The provisions are the same as in above. This is mainly relevant to internal transactions.
- Cost and Freight (C&F Contract): Here also, the buyer's responsibility normally attaches once the goods are placed on board. He has to take care of the insurance from that point onwards.
- Cost, Insurance & Freight (C.I.F. Contract): In this case, the seller is responsible for arranging the insurance upto destination. He includes the premium charge as part of the cost of goods in the sale invoice.
- Cover Note: A cover note is a document granting cover provisionally pending the issue of a regular policy. It happens frequently that all the details required for the purpose of issuing a policy are not available.
- Marine Policy: This is a document which is an evidence of the contract of marine insurance
- Open Policy: An open policy is also known as 'floating policy'. It is worded in general terms and is issued to take care of all "shipments" coming within its scope.
- Open Cover: An open cover is particularly useful for large export and import firms-making numerous regular shipments who would otherwise find it very inconvenient to obtain insurance cover separately for each and every shipment.
- Bill of Lading: Bill of Lading is a document which serves as evidence that the goods were actually shipped. It also gives the particulars of cargo.

Lesson 11

Agricultural Insurance

LESSON OUTLINE

- Introduction to Indian Agriculture
- Risk in Agriculture
- Miscellaneous Agriculture Insurance Schemes
- Agriculture Reinsurance
- State Livestock Insurance Scheme
- LESSON ROUND UP
- SELF TEST QUESTIONS

LEARNING OBJECTIVES

On perusing this chapter, it is expected that the reader would get acquainted with basic concept of agricultural & livestock insurance, the challenges faced by the agricultural community and the initiatives introduced by the Government at various levels to alleviate the ills plaguing the agricultural sectors.

One of the objectives is to acquaint the reader with unique and atypical underwriting insurance factors and to provide an eye opener into the fact that agriculture insurance recently has burst on the insurance landscape as a means to provide insurance cover, while at the same time earning substantial revenues for the carriers.

AGRICULTURE AND RURAL INSURANCE

The history of Agriculture in India dates back to Indus Valley Civilization Era and The history of Agriculture in India dates back to Indus Valley Civilization Era and even before that in some parts of Southern India. Today, India ranks second worldwide in farm output. Agriculture and allied sectors like forestry and fisheries accounted for 13.7% of the GDP (gross domestic product) in 2013, [2]about 50% of the work force. The economic contribution of agriculture to India's GDP is steadily declining with the country's broad-based economic growth. Still, agriculture is demographically the broadest economic sector and plays a significant role in the overall socio-economic fabric of India.

In the years since its independence, India has made immense progress towards food security. Indian population has tripled, and food-grain production more than quadrupled. There has been a substantial increase in available food-grain per capita.

India has shown a steady average nationwide annual increase in the kilograms produced per hectare for some agricultural items, over the last 60 years. These gains have come mainly from India's green revolution, improving road and power generation infrastructure, knowledge of gains and reforms. Despite these recent accomplishments, agriculture has the potential for major productivity and total output gains, because crop yields in India are still just 30% to 60% of the best sustainable crop yields achievable in the farms of developed and other developing countries. Additionally, losses due to poor monsoons, flooding, other natural calamities, continue to afflict the Indian farmer, coupled with the burden of compounding legacy of debt.

Agricultural insurance is an effective mechanism for reducing the losses farmers suffer due to natural calamities such as floods, droughts, and outbreaks of pests and diseases. There are a number of schemes initiated by the Government to promote and protect interests of the agricultural sector-

- Pradhan Mantri Fasal Bima Yojana
- Crop Insurance
- Livestock Insurance
- Weather Based Crop Insurance
- Unified Package Insurance Scheme (UPIS).

I. PRADHAN MANTRI FASAL BIMA YOJANA

Objectives

1. To provide insurance coverage and financial support to the farmers in the event of failure of any of the notified crop as a result of natural calamities, pests & diseases.
2. To stabilise the income of farmers to ensure their continuance in farming.
3. To encourage farmers to adopt innovative and modern agricultural practices.
4. To ensure flow of credit to the agriculture sector.

Highlights of the scheme

- There will be a uniform premium of only 2% to be paid by farmers for all Kharif crops and 1.5% for all Rabi crops. In case of annual commercial and horticultural crops, the premium to be paid by farmers will be only 5%. The premium rates to be paid by farmers are very low and balance premium will be paid by

the Government to provide full insured amount to the farmers against crop loss on account of natural calamities.

- There is no upper limit on Government subsidy. Even if balance premium is 90%, it will be borne by the Government.
- Earlier, there was a provision of capping the premium rate which resulted in low claims being paid to farmers. This capping was done to limit Government outgo on the premium subsidy. This capping has now been removed and farmers will get claim against full sum insured without any reduction.
- The use of technology will be encouraged to a great extent. Smart phones will be used to capture and upload data of crop cutting to reduce the delays in claim payment to farmers. Remote sensing will be used to reduce the number of crop cutting experiments.
- PMFBY is a replacement scheme of NAIS / MNAIS, there will be exemption from Service Tax liability of all the services involved in the implementation of the scheme. It is estimated that the new scheme will ensure about 75-80 per cent of subsidy for the farmers in insurance premium.

Farmers to be covered

All farmers growing notified crops in a notified area during the season who have insurable interest in the crop are eligible.

Compulsory coverage: The enrolment under the scheme, subject to possession of insurable interest on the cultivation of the notified crop in the notified area, shall be compulsory for following categories of farmers:

- Farmers in the notified area who possess a Crop Loan account/KCC account (called as Loanee Farmers) to whom credit limit is sanctioned/renewed for the notified crop during the crop season. and
- Such other farmers whom the Government may decide to include from time to time.

Voluntary coverage: Voluntary coverage may be obtained by all farmers not covered above, including Crop KCC/Crop Loan Account holders whose credit limit is not renewed.

Unit of Insurance

The Scheme shall be implemented on an 'Area Approach basis' i.e., Defined Areas for each notified crop for widespread calamities with the assumption that all the insured farmers, in a Unit of Insurance, to be defined as "Notified Area" for a crop, face similar risk exposures, incur to a large extent, identical cost of production per hectare, earn comparable farm income per hectare, and experience similar extent of crop loss due to the operation of an insured peril, in the notified area. Defined Area (i.e., unit area of insurance) is Village/Village Panchayat level by whatsoever name these areas may be called for major crops and for other crops it may be a unit of size above the level of Village/Village Panchayat. In due course of time, the Unit of Insurance can be a Geo-Fenced/Geo-mapped region having homogenous Risk Profile for the notified crop.

For Risks of Localized calamities and Post-Harvest losses on account of defined peril, the Unit of Insurance for loss assessment shall be the affected insured field of the individual farmer.

Coverage of Crops

Food crops (Cereals, Millets and Pulses), Oilseeds, Annual Commercial / Annual Horticultural crops.

Sum Insured per hectare for both loanee and non-loanee farmers will be same and equal to the Scale of Finance as decided by the District Level Technical Committee, and would be pre-declared by SLCCCI and

notified. No other calculation of Scale of Finance will be applicable. Sum Insured for individual farmer is equal to the Scale of Finance per hectare multiplied by area of the notified crop proposed by the farmer for insurance. 'Area under cultivation' shall always be expressed in 'hectare'.

2. Sum insured for irrigated and un-irrigated areas may be separate.

Risks covered under the scheme

A. Shortfall in Yield Losses (standing crops, on notified area basis). Comprehensive risk insurance is provided to cover shortfall in yield losses due to non-preventable risks, such as :-

- i. Natural Fire and Lightning,
- ii. Storm, Hailstorm, Cyclone, Typhoon, Tempest, Hurricane, Tornado.
- iii. Flood, Inundation and Landslide,
- iv. Drought, Dry spells,
- v. Pests/ Diseases other than controllable pests and diseases.

B. Loss incurred due to insured farmers being prevented from carrying out sowing and planting activity due to deficit rainfall or adverse seasonal conditions The insured farmers shall be eligible for indemnity claims upto a maximum of 25 per cent of the sum-insured provided that :-

- i. the insured farmer has every intention to sow/plant; and
- ii. the insured farmer has incurred expenditure for the planting/sowing activity.

Once such claim is preferred and becomes admissible, the coverage for such farmers whose claim is admitted by the insurer, terminates for future losses.

C. Loss or damage to the insured crop due to cyclone post harvest subject to the following conditions are covered:-

- i. the cyclone affected area is a coastal area
- ii. crops post harvest are lying in the field for drying purpose in "cut& spread" condition.

In such post-harvest losses, coverage will be available up to a maximum period of 14 days from harvesting. The assessment of damage would be on individual basis..

D. For certain localized problems, Loss / damage resulting from occurrence of identified localized risks like hailstorm, landslide, and Inundation affecting isolated farms in the notified area would also be covered.

Major Contributors for Successful Implementation

1. Increase in Public & Private partnership, 2. Adoption of technology with continues improvement, 3. Use of Smart Phones, 4. Geo Coding of experimental fields, 5. OTP for verification, confirmation & identification, 6. Instant photo & video uploading to data repository, 7. Central portal for all data sets, 8. Weekly Video Conference for status updates at all levels, 9. Incentive to field level staff, 10 Direct monitoring at PMO level, 11 Appointment of CEO for PMFBY, 12. Adoption of technology leads to transparency & improvement in services

Based on Actuarial Premium Rate (APR), the rate of insurance paid by the farmer is governed by a slab mentioned in PMFBY guidelines which is mentioned below. Rest of premium the premium us shared between state and central Govt. on 50 : 50 basis as subsidy

Season Crop Maximum Insurance charges payable by farmer (% of Sum Insured) Kharif All food grain and

oil seeds (all cereals, millets, pulses and oil seeds crop) 2% of Sum Insured or Actuarial rate, whichever is less Rabi All food grain and oil seeds (all cereals, millets, pulses and oil seeds crop) 1.5% of Sum Insured or Actuarial rate, whichever is less Kharif and Rabi Annual Commercial and horticulture crops 5% of Sum Insured or Actuarial rate, whichever is less.

Need of Pricing Discipline in Agriculture Insurance Rainfall is the major risk factor in Indian Agriculture, especially for yield index insurance. About 35% (Approximate) of the gross crop area is irrigated There are several aspects of rainfall-uncertainty. Other than the variation in the total rainfall during a given period of time, there are significant temporal and spatial variations. While the annual all-India total rainfall has a coefficient of variation of about 11%, the coefficient of variation of the annual southwest monsoon rainfall ranges from 44% to 10% for each of the meteorological divisions. The pattern of rainfall across time is also important since crops require appropriate rainfall during critical periods in the crop cycle. The variability of rainfall over short time horizons is significantly greater than over longer time horizons. There are three levels of indemnity — 90%/80%/70%, corresponding to low/medium/ high risk areas for all crops, which is high in comparison to indemnity offered in other countries.

Weather Based Crop Insurance Scheme (WBICS)

Weather Based Crop Insurance Scheme aims to mitigate the hardship of the insured farmers against the likelihood of financial loss on account of anticipated crop loss resulting from incidence of adverse conditions of weather parameters like rainfall, temperature, frost, humidity etc.

Crops covered

- Major Food crops (Cereals, Millets & Pulses) & Oilseeds
- Commercial / Horticultural crops

Farmers covered

All farmers including sharecroppers and tenant farmers growing the notified crops in the notified areas are eligible for coverage. However, farmers should have insurable interest on the insured crop. The non-loanee farmers are required to submit necessary documentary evidence of land records and / or applicable contract/ agreements details (in case of sharecroppers / tenant farmers).

All farmers availing Seasonal Agricultural Operations (SAO) loans from Financial Institutions (i.e. loanee farmers) for the crop(s) notified are covered on compulsory basis. The Scheme is optional for the non-loanee farmers. They can choose between WBCIS and PMFBY, and also the insurance company.

Perils covered

Following major weather perils, which are deemed to cause “Adverse Weather Incidence”, leading to crop loss, shall be covered under the scheme.

- Rainfall – Deficit Rainfall, Excess rainfall, Unseasonal Rainfall, Rainy days, Dry-spell, Dry days
- Relative Humidity
- Temperature – High temperature (heat), Low temperature
- Wind Speed
- A combination of the above
- Hailstorms, cloud-burst may also be covered as Add-on/Index-Plus products for those farmers who have already taken normal coverage under WBCIS.

The perils listed above are only indicative and not exhaustive, any addition deletion may be considered by insurance companies based on availability of relevant data.

Risk period (i.e. Insurance Period)

Risk period would ideally be from sowing period to maturity of the crop. Risk period depending on the duration of the crop and weather parameters chosen, could vary with individual crop and reference unit area and would be notified by SLCCCI before the commencement of risk period.

Premium Rates

The revised premium rates payable by the cultivator for different crops are as follows:

S. No.	CROPS	Maximum Insurance charges payable by farmer (% of Sum Insured)
(i)	Season - Kharif - Food & Oilseeds crops (all cereals, millets, & oilseeds, pulses)	2.0% of SI or Actuarial rate, whichever is less
(ii)	Season - Rabi - Food & Oilseeds crops (all cereals, millets, & oilseeds, pulses)	1.5% of SI or Actuarial rate, whichever is less
(iii)	Season - Rabi and Kharif - Annual Commercial / Annual Horticultural crops	5% of SI or Actuarial rate, whichever is less

The 'net premium payable in case of the insured loanee cultivator is financed by the Lending Bank.

Insurance companies participating in WBCIS

The public sector and private sector General Insurance Companies empanelled by the Department of Agriculture & Cooperation (DAC) and Farmers Welfare, Government of India and selected by concerned State Government / Union Territory (UT) implement WBCIS.

Unified Package Insurance Scheme (UPIS)

The **UPIS** aims at providing financial protection to citizens associated in agriculture sector, thereby ensuring food security, crop diversification and enhancing growth and competitiveness of agriculture sector besides protecting farmers from financial risks. The UPIS will be implemented in 45 selected districts on Pilot basis from Kharif 2016 season.

The cover will be for one full year except for Crop Insurance (which will be bi-annual separately for Kharif and Rabi seasons) renewable from year to year. The Loanee farmers will be covered through Banks/Financial Institutions whereas non loanee farmer shall be covered through banks and/or insurance intermediaries.

Suitability

This policy is designed to take care of the insurance needs of farmers associated with agriculture activities. This policy provides yield based crop insurance to the farmer based on his ownership rights of land and sown crop. It covers both the personal assets of the farmer like the dwelling & its contents (Fire), the other assets which help him in earning his livelihood such as Agricultural Pump Sets, and Agriculture Tractor owned by farmer.

The policy also provides protection to farmer and his/her family members in case of the Accidental Death / Disablement, accidental insurance protection of farmer's school/college going children and provisioning of education fee to the students in case of death of parent.

Life insurance protection to the farmer and his/her family members and is issued for a period up to 1 year.

Salient Features and Benefits

The farmer's package policy will be underwritten by the General Insurance Companies empanelled by Department of Agriculture, Cooperation and Farmers Welfare under crop insurance programmes and/or designated by this Department or through General Insurance Companies having tie-up with concerned Financial Institution/Banks for non-crop sections of the policy.

Crop Insurance is mandatory. However, farmers have to choose at least two other sections also to avail the applicable subsidy under crop insurance section. In case of crop insurance, applicable Farmer's share of premium ranging between 1.5% to 5% based on their insured crops is payable by farmer & in case Actuarial premium is more, the Government will provide subsidy equivalent to the difference between Actuarial premium and premium paid by farmer. The crop insurance is based on area approach whereas all other sections are on individual basis.

If the farmers already availed any insurance policy of similar nature and sum insured not less than as mentioned in the policy than they would be exempted from taking such section(s). However details of such policy would be provided in their proposal form.

The rates above are indicative & subject to the concurrence of the insurers. Sum Insured and premium rates are provisionally taken and may change according to the risk(s). The above premium rates are without GST which is likely to be exempted

General Insurance Companies empanelled under Crop Insurance Schemes

List of insurance companies empanelled under crop insurance schemes:

- Agriculture Insurance Company
- Cholamandalam MS General Insurance Company
- Reliance General Insurance Co. Ltd.
- Bajaj Allianz
- Future Generali India Insurance Co. Ltd.
- HDFC ERGO General Insurance Co. Ltd.
- IFFCO Tokio General Insurance Co. Ltd.
- Universal Sompo General Insurance Company
- ICICI Lombard General Insurance Co. Ltd.
- Tata AIG General Insurance Co. Ltd.
- SBI General Insurance
- United India Insurance Co. Ltd.

Livestock Insurance Scheme

This is a centrally sponsored scheme, implemented on a pilot basis during 2005-06 and 2006-07 of the 10th Five Year Plan and 2007-08 of the 11th Five Year Plan in 100 selected districts. The scheme was later implemented on a regular basis from 2008-09 in 100 newly selected districts of the country. The scheme was later subsumed as a component titled Risk Management and Insurance under the sub-mission on livestock development of National Livestock Mission.

The component aims at management of risk and uncertainties by providing protection mechanism to the farmers against any eventual loss of their animals due to death and to demonstrate the benefit of the insurance of livestock to the people.

Coverage

The scheme is implemented in all the districts of the Country from 21.05.2014.

Animals covered

The indigenous / crossbred milch animals, pack animals (Horses, Donkey, Mules, Camels, Ponies and Cattle/ Buffalo Male), and Other Livestock (Goat, Sheep, Pigs, Rabbit, Yak and Mithun etc.) are covered under the purview of this component.

Government Assistance

Benefit of subsidy is to be restricted to 5 animals per beneficiary per household for all animals except sheep, goat, pig and rabbit. In case of sheep, goat, pig and rabbit the benefit of subsidy is to be restricted based on "Cattle Unit" and one cattle unit is equal to 10 animals i.e a total of 50 animals. If a beneficiary has less than 5 animals / 1 Cattle Unit, can also avail the benefit of subsidy.

Process

An animal will be insured for its current market price. The market price of the animal to be insured will be assessed jointly by the beneficiary and the insurance company preferably in the presence of the Veterinary officer or the Block Development Officer (BDO).

The market price of pack animals (Horses, Donkey, Mules, Camels, Ponies and Cattle/ Buff. Male) and Other livestock (Goat, Sheep, Pigs, Rabbit, Yak and Mithun) are to be assessed by negotiation jointly by owner of animal and by insurance company in the presence of veterinarians Doctor. In case of dispute the price fixation would be settled by the Gram Panchayat / BDO.

The animal insured will have to be properly and uniquely identified at the time of insurance claim. The ear tagging should, therefore, be fool-proof as far as possible. The traditional method of ear tagging or the recent technology of fixing microchips could be used at the time of taking the policy. The cost of fixing the identification mark will be borne by the Insurance Companies and responsibility of its maintenance will lie on the concerned beneficiaries.

Agriculture Reinsurance

This covers the production and financial risks of farmers and related shortfall risks of interconnected stakeholders, such as input suppliers or grain processors. The reinsurance function provides capacity to clients on a worldwide basis, focusing on cedants (insurers who transfer risk to reinsurers) with a market leading knowledge of the original risk. Our key criteria include multi-peril crop, hail and named peril insurance covering both yield and revenue fluctuations from catastrophic events. Our ability to offer these products enables us to support our key clients across both their property agriculture programmes. additional treaty reinsurance, proportional and aggregate stop loss for primary insurance companies writing multiple peril, hail and named peril covers, as well as custom risk transfer mechanisms for agricultural-dependent industries with exposure to yield or price.

Underwriting appetite

The major part of the portfolio consists of programmes protecting crop insurance.

Coverage

- Aggregate cover stop loss
- Crop catastrophe excess of loss.
- Broad range of agricultural risk transfer solutions for all stakeholders in the agricultural production chain and insurance business, such as multi-peril crop insurance or index insurance products.

LESSON ROUNDUP

- Agriculture insurance is an effective mechanism for reducing the losses of farmers due to natural calamities such as floods, drought, outbreak of pests/diseases etc.
- There are a number of schemes initiated by the Government to promote and protect interests of the agricultural sector –
 - Pradhan Mantri Fasal Bima Yojana - Objectives:
 - To provide insurance coverage and financial support to the farmers in the event of failure of any of the notified crop as a result of natural calamities, pests & diseases.
 - To stabilise the income of farmers to ensure their continuance in farming.
 - To encourage farmers to adopt innovative and modern agricultural practices.
 - To ensure flow of credit to the agriculture sector.
 - Weather Based Crop Insurance
 - (WBICS) aims to mitigate the hardship of the insured farmers against the likelihood of financial loss on account of anticipated crop loss resulting from incidence of adverse conditions of weather parameters like rainfall, temperature, frost, humidity etc.
 - Livestock Insurance
 - Aims at management of risk and uncertainties by providing protection mechanism to the farmers against any eventual loss of their animals due to death and to demonstrate the benefit of the insurance of livestock to the people.
 - Unified Package Insurance Scheme (UPIS).
 - The UPIS aims at providing financial protection to citizens associated in agriculture sector, thereby ensuring food security, crop diversification and enhancing growth and competitiveness of agriculture sector besides protecting farmers from financial risks.

SELF TEST QUESTIONS

These are meant for re-capitulation only. Answers to these questions are not to be submitted for evaluation.

1. Multiple Choice Questions:

- (a) Workforce engaged in agriculture and allied sectors in India are around % of population
(i) 10% (ii) 70% (iii) 50%
- (b) Crop Insurance is offered in India by: (i) Life Insurance Companies (ii) General Insurance Companies (iii) Health Insurance Companies

Lesson 12

Motor Insurance

LESSON OUTLINE

- Introduction to Motor Insurance
- Type of motor vehicles
- Types of Motor Insurance Policy
- Underwriting in Motor Insurance; Motor Insurance Claims;
- Motor Vehicles Act, 1988
- Motor Vehicle (Amendment) Bill, 2016
- LESSON ROUND UP
- SELF TEST QUESTIONS

LEARNING OBJECTIVES

On perusing this chapter, it is expected that the reader would understand the need and rationale of Motor Liability Insurance, an introduction to latest amendments proposed in the Motor Vehicles Amendment Act, 2018.

Tortious liability and 'no fault' liability concepts are introduced, as well as a brief introduction on amendments to the M V Act, 1988, 2016, 2017 which would impact Act Only (third party liability) insurance.

The reader is expected to understand the basic principles governing motor vehicle insurance underwriting and claim considerations .

MOTOR INSURANCE

In Motor Insurance First party is the owner of property(Motor Vehicle), Second party is the Insurer and the Third party is everyone else, say person on street. Normally in insurance loss or damage to the property of insured is covered. If your car gets damaged, its repair and replacement is covered. This is commonly called First party insurance or own damage section of Insurance policy.

Third-party insurance is compulsory for all vehicle-owners as per the Motor Vehicles Act. It covers only your legal liability for the damage you may cause to a third party - bodily injury, death and damage to third party property - while using your vehicle on public spaces. Recently, pursuant to the Supreme Court decision, IRDAI has mandated all General Insurance Companies, to make it compulsory to provide long term third-party motor covers for new vehicles to curb the number of uninsured vehicles plying on the road.

The top court, in a July 20, 2018 order, said that in the case of new vehicles third party insurance i.e, cars should at least be covered for three years and two-wheelers for five years, either as a separate insurance policy or as part of the comprehensive cover. The order will be effective from September 1,2018. The court also asked the regulator to work with the police and online channels to push sale and renewal of the third party accident cover.

The decision came after a Supreme Court-appointed committee on road safety found that only one in every three vehicles—among 18 crore plying on Indian roads—is insured. This leads to accident victims or their kin not getting any compensation.

On the same lines, IRDAI has now recently mandated Insurance Companies to enhance the Compulsory Accident Cover from the existing ₹ 1,00,000 to at least not less than ₹ 15,00,000/- for owner of the vehicle with the purpose of adding solace to the victims of road accidents, who are the owners of the vehicles.

Definition

Motor insurance policy is a contract between the insured and the insurer in which the insurer promises to indemnify the financial liability in event of loss to the insured. This loss to insured can arise out of:-

- i. Loss to insured motor vehicle due to accidental damage arising out of various perils covered under the policy.
- ii. His incurring financial liability towards third parties due to accident of motor vehicle resulting in injury/disability or death of the third party or damage or loss of third party property
- iii. Personal Accident Injury to owner arising out of insured vehicle meeting with an accident

Where as Section I – Own damage to vehicle is voluntary section which one may insure or not, the Section II- Third Party Liability and Section -III Personal Accident injury to owner Driver are compulsory cover as per Motor Vehicle Act 1988.

Motor third-party insurance or third-party liability cover, which is sometimes also referred to as the 'act only' cover, is a statutory requirement under the Motor Vehicles Act. It is referred to as a 'third-party' cover since the beneficiary of the policy is someone other than the two parties involved in the contract i.e. the insured and the insurance company. The policy does not provide any benefit to the insured; however it covers the insured's legal liability for death/disability of third party or damage to third party property.

WE will make an endeavor to explain relevance of third party insurance.? What is third party insurance? Who is a third party? Why third party insurance is compulsory for all vehicles under the Motor Vehicles Act, 1988? What are the salient features of third party insurance? These aspects of the third party insurance have been explained with the help of various case laws.

What is Third Party Insurance?

There are two quite different kinds of insurance involved in the damages system. One is Third Party liability insurance, which is just called liability insurance by insurance companies and the other one is first party insurance.

A third party insurance policy is a policy under which the insurance company agrees to indemnify the insured person, if he is sued or held legally liable for injuries or damage done to a third party. The insured is one party, the insurance company is the second party, and the person you (the insured) injure who claims damages against you is the third party.

Section 145(g) "third party" includes the Government. *National Insurance Co. Ltd. v. Fakir Chand*, "third party" should include everyone (other than the contracting parties to the insurance policy), be it a person traveling in another vehicle, one walking on the road or a passenger in the vehicle itself which is the subject matter of insurance policy.

According to Section 24 of Motor Vehicles Act, "No person shall use or allow any other person to use a motor vehicle in a public place, unless the vehicle is covered by a policy of Insurance." Here the term insurance is to be referred as "Third Party Insurance."

Classification of Motor Vehicles

As per the Motor Vehicles Act for the purpose of insurance the vehicles are classified into three broad categories such as:

Private cars

- (a) Private Cars - vehicles used only for social, domestic and pleasure purposes.
- (b) Private vehicles - Two wheeled.
 - 1. Motorcycle/Scooters
 - 2. Auto cycles
 - 3. Mechanically assisted pedal cycles
- (c) Commercial vehicles
 - 1. Goods carrying vehicles
 - 2. Passengers carrying vehicles
 - 3. Miscellaneous & Special types of vehicles

The risks under motor insurance are of two types:

- 1. Legal liability due to bodily injury, death or damage caused to the property of others.
- 2. Loss or damage to one's own vehicle\ injury to or death of self and other occupants of the vehicle.

IRDAI has set up a panel to look into pricing of auto insurance covers as well as classification of the various types of vehicles.

BASIC PRINCIPLES OF MOTOR INSURANCE

Motor insurance being a contract like any other contract has to fulfill the requirements of a valid contract as laid down in the Indian Contract Act 1872.

In addition it has certain special features common to other insurance contracts.

They are:

- Utmost good faith
- Insurable interest
- Indemnity
- Subrogation and contribution
- Proximate cause

All of these principles have already been discussed in detail in earlier chapters. But for the student's convenience, we will be discussing these here again:

Utmost good faith

The principle of Utmost good faith casts an obligation on the insured to disclose all the material facts. These material facts must be disclosed to the insurer at the time of entering into the contract. All the information given in the proposal form should be true and complete. E.g. the driving history, physical health of the driver, type of vehicle etc. If any of the mentioned material facts declared by the insured in the proposal form are found inappropriate by the insurer at the time of claim it may result in the claim being repudiated.

Insurable Interest

In a valid insurance contract it is necessary on the part of the insured to have an insurable interest in the subject matter of insurance. The presence of insurable interest in the subject matter of insurance gives the person the right to insure. The interest should be pecuniary and must be present at inception and throughout the term of the policy. Thus the insured must be either benefited by the safety of the property or must suffer a loss on account of damage to it.

Indemnity

Insurance contracts are contracts of indemnity. Indemnity means making good of the loss by reimbursing the exact monetary loss. It aims at keeping the insured in the same position he was before the loss occurred and thus prevent him from making profit from insurance policy.

Subrogation and Contribution

Subrogation refers to transfer of insured's right of action against a third party who caused the loss to the insurer. Thus, the insurer who pays the loss can take up the assureds' place and sue the party that caused the loss in order to minimise his loss for which he has already indemnified the assured.

Subrogation comes in the picture only in case of damage or loss due to a third party. The insurer derives this right only after the payment of damages to the insured. Contribution ensures that the indemnity provided is proportionately borne by other insurers in case of double insurance. Another such instance is the Insurer paying claims in case of "Lost Vehicle" and subsequently the vehicle is recovered. In such cases, due to subrogation rights, the Insurer becomes the owner of such vehicle and steps in the shoes of the Insured.

TYPES OF MOTOR INSURANCE POLICIES

The All India Motor Tariff governs motor insurance business in India. According to the Tariff all classes of vehicles can use two types of policy forms. They are form A and form B. Form A which is known as Act Policy is

a compulsory requirement of the Motor Vehicle Act. Use of motor vehicle in public place without such insurance is a penal offence..

1. **Liability only policy** – This covers third party liability and/or death and property damage. Compulsory personal accident covers for the owner in respect of owner driven vehicles is also included.

Types of Car Insurance Coverage

As per All India Motor Tariff there are two types of Policies:-

- a) **Liability only policy:** This covers Third party liability for bodily injury and/or death and Property damage . Personal Accident cover for owner driver is also included as part of this policy.

(i) Liability Coverage : When involved in an accident and if it is concluded that accident took place because of fault/negligence, the liability coverage will be of use. The following benefits are offered by the liability insurance plan:

- Covers the repair/replacement cost of the damaged property (of third-party)
- Covers the medical bills of the third party due to hospitalization or medical treatment
- Vehicle owners should buy minimum liability insurance as per the legal obligation and the insurance policy will cover the same.
- The liability coverage will include the third-party injury, death or damage to the third party property.

Liability coverage is mandatory as per the motor vehicle Act 1988.

(ii) Personal Injury Coverage

In addition to the mandatory liability insurance, you can include certain coverage to overcome various risk factors.

Personal injury protection will cover all the costs associated with the accident.

The medical bills of the driver and other passengers will be covered by the personal injury protection.

Regardless of whose fault, the insurance company will pay the medical bills.

- b) **Comprehensive Package policy :** This covers loss or damage to the vehicle insured in addition to (a) above.

The tariff provides for restricting the coverage under package policy in respect of cover for loss or damage to the vehicle insured. It is however not allowed to reduce or increase the scope of the Liability policy coverage(third party liability) which is provided in the policy to take care of the Motor Vehicle Act 1988 regulations relating to protection of third parties from usage of motor vehicles in public places.

Form B which is also known as Comprehensive Policy is an optional cover.

A comprehensive insurance coverage will include all kinds of risk factors that are associated with your vehicle, driver, passengers, third-party vehicle, third-party driver, third-party vehicle passengers and third-party property.

The insurance policy will also cover the following risk factors:

- Weather damage

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- Floods
- Fire
- Theft

By installing anti-theft devices and other security-enhancement gadgets, one decrease the insurance premium quoted by the insurance carrier.

Add-on Insurance Cover for the Vehicle

The following add-ons can be included as per need to get optimum protection:-

- **Roadside Assistance** - If a vehicle stops in the middle of the road, the insurance company will come to the rescue. Assistance so that the vehicle can be moved to the nearest service station very easily is provided.
- **Engine Replacement** - The damage of the engine due to various reasons will be replaced when this 'engine replacement' coverage is taken.
- **Nil Depreciation Cover** - Nil depreciation cover or zero depreciation cover will help one get maximum compensation for car. The vehicle will be insured to the invoice price so that there will be no loss.
- **Replacement of the windshield** - If the windshield is damaged due to the accident, the replacement will be done with the compensation paid by the insurance company.
- Damage to the car due to the entry of flood waters into the engine and other parts of the vehicle
- Damage to the car and accessories due to fire.
- Damage due to natural disasters such as a windstorm or earthquake.
- Damage to the vehicle by hitting an animal.
- Damage due to strike, vandalism, riots.
- Damage to the third-party.
- Consumeable material coverage
- Tyre protection cover

Are There Exclusions with the Comprehensive Cover?

Comprehensive auto insurance will offer maximum coverage. However, there are certain exclusions. You should be aware of these exclusions so that there will not be unpleasant surprises while claiming the policy.

- Normal wear and tear of the vehicle.
- Aging of the vehicle.
- Breakdown of electrical or mechanical parts.
- Damage to tires and tubes of the vehicle.
- Damage to the vehicle driven by an unlicensed driver.
- Damage to the vehicle driven by a person under the influence of drugs or alcohol.
- Damage due to war or nuclear attack.

Transfer of Ownership

In case of any sale of vehicle involving transfer of policy, the insured should apply to the insurer for consent to such transfer. The transfer is allowed, if within 15 days of receipt of application, the insurer does not reject the plea. The transferee shall apply within fourteen days from the date of transfer in writing to the insurer who has insured the vehicle, with the details of the registration of the vehicle, the date of transfer of the vehicle, the previous owner of the vehicle and the number and date of the insurance policy so that the insurer may make the necessary changes in his record and issue fresh Certificate of Insurance.

Insurer's Duty to Third Party

It is obligatory on the part of the insurer to pay the third party since, the insurer has no rights to avoid or reject the payment of liability to a third party. The duties of the insurer towards a third party are provided in section 96(1). The Motor Accident Claims Tribunal (MACT)/Court determine the third party liability and accordingly compensation is paid. The liability is unlimited.

Cancellation of Insurance

The insurer may cancel a policy by sending to the insured seven days notice of cancellation by recorded delivery to the insured's last known address and the insurer will refund to the insured the pro-rata premium for the balance period of the policy. A policy may be cancelled at the option of the insured with seven days notice of cancellation and the insurer will be entitled to retain premium on short period scale of rates for the period for which the cover has been in existence prior to the cancellation of the policy. The balance premium, if any, will be refundable to the insured.

Double Insurance

When two policies are in existence on the same vehicle with identical cover, one of the policies may be cancelled. Where one of the policies commences at a date later than the other policy, the policy commencing later is to be cancelled by the insurer concerned. If a vehicle is insured at any time with two different offices of the same insurer, 100% refund of premium of one policy may be allowed by canceling the later of the two policies. However, if the two policies are issued by two different insurers, the policy commencing later is to be cancelled by the insurer concerned and pro-rata refund of premium thereon is to be allowed.

Calculation of Premiums

In the case of Comprehensive Insurance Cover, for the purpose of premium vehicles are categorized as follows:

Private Car

This is used for personal purposes. Private cars are lesser exposed than taxis, as the latter is used extensively for maximum revenue. The premium is computed on the following basis

1. Geographical area of use: Large cities have higher average claim costs followed by suburban areas, smaller cities, and small towns or rural areas. In India, the geographical areas have been classified into Group A and Group B.
2. Cubic capacity: The more the cubic capacity, the higher the premium rate.
3. Value of the vehicle: The premium rate is applied on the value of the vehicle. Owner has to declare the correct value of the vehicle to the insurer. This value is known as the Insured's Estimated Value (IEV) in motor insurance and represents the sum insured.

Two-wheeler

It is used for personal purpose only. Premium is calculated on cubic capacity and value of vehicle. Theft of accessories is not covered, unless the vehicle is stolen at the same time.

Commercial Vehicle

This is the vehicle used for hire. For goods carrying commercial vehicle, premium is calculated on the basis of carrying capacity i.e. gross vehicle weight and value of the vehicle. For passenger carrying commercial vehicles, premium is calculated on the basis of again carrying capacity i.e. number of passengers and value of the vehicle. Accessories extra, as specified. Heavier vehicles are more exposed to accidents since the resultant damages they incur are more. Similarly, vehicles with higher carrying capacity expose more passengers to risk. Therefore heavier vehicles attract higher premium rate.

Innovative trends in Auto Insurance

Recent trends promote, Usage-Based Insurance (UBI) also known as Pay As You Drive (PAYD) and Pay How You Drive (PHYD) and mile-based auto insurance is a type of vehicle insurance whereby the costs are dependent upon type of vehicle used, measured against time, distance, behavior and place.

This differs from traditional insurance, which attempts to differentiate and reward “safe” drivers, giving them lower premiums and/or a no-claims bonus.

The general concept of pay as you drive includes any scheme where the insurance costs may depend not just on how much you drive but how, where, and when one drives.

Pay As You Drive (PAYD) means that the insurance premium is calculated dynamically, typically according to the amount driven. There are three types of usage-based insurance:

1. Coverage is based on the odometer reading of the vehicle.
2. Coverage is based on mileage aggregated from GPS data, or the number of minutes the vehicle is being used as recorded by a vehicle-independent module transmitting data via cellphone or RF technology.
3. Coverage is based on other data collected from the vehicle, including speed and time-of-day information, historic riskiness of the road, driving actions in addition to distance or time travelled.

Compulsory Personal accident insurance

Effective January 1, 2019, IRDAI has unbundled the Compulsory Personal Accident (CPA) cover and permitted the issuance of a stand-alone policies. This move can reduce the cost of ownership of a vehicle. Here’s how this can happen.

As a policyholder, the premium of Rs. 750 per annum for annual CPA cover for both cars and two-wheelers was to be paid. Now, effectively, this is the amount of savings if one already has a stand alone personal accident cover.

Buying standalone cover

Effective January 1, on expiry of a bundled CPA cover, it may be replaced with a stand-alone CPA cover and the same may be taken from any registered general insurer. Since a general personal accident cover also includes cover against motor accidents, if an owner-driver already has a 24 hour personal accident cover against death and permanent disability (total and partial) for CSI of at least Rs.15 lakh, there is no need for a separate CPA cover, as part of the liability only policy or the package policy as it exists today, one can continue to do so. In

the event the policyholder chooses to take a stand-alone CPA policy, the CPA cover offered as part of liability only or package policy shall be deleted.

IRDAI, in its statement, said it had received from various quarters wherein it has been pointed out that many owner-drivers already have existing general Personal Accident covers which ought to be taken cognizance of.

Also, the fact that owner-drivers may own more than one vehicle needs to be taken into consideration in a more rational manner so that the owner-driver does not have to take different policies for different vehicles that one owns. Coverage under the stand-alone CPA will now be valid when the owner-driver drives any of the vehicles one owns.

IRDAI has made it mandatory for all General Insurance Companies to issue a three year third party insurance cover for new cars and five year third party insurance cover for new two wheelers as a separate product or as part of a comprehensive insurance product. IRDA should issue instructions accordingly to all General Insurance Companies.

ii) The GIC and IRDA should ensure that the legacy insurance data is also shared with MoRTH as soon as possible for its integration with Vahan data.

iii) IRDA should ensure that all General Insurers follow its directions dated 01.01.2018 advising them to make available the third party insurance cover to all proposers on online channels; liaise with police authorities to facilitate issue and renewal of third party insurance cover and ensure its easy availability.”

In light of the above, it is expected the Authority will issue necessary guidance on the commission, remuneration and rewards that shall be paid for long term policies.

Currently in the motor segment there are two types of policies namely: a) Stand-alone Motor TP policy and b) Motor Package Insurance policy for 2-wheelers and Private Cars.

Rationale for proposed commission, remuneration, rewards and distribution fees for Long Term Motor Insurance Policies

Following discussions with the General Insurance Council and based on the Report of the Internal Group to examine framework for Long term products in General Insurance the following new motor insurance products are permitted in the general insurance market in the country:

- i) 5 years Long term Stand-Alone motor Third Party Insurance Policy for new 2 – wheelers
- ii) 3 years Long term Stand-Alone motor Third Party Insurance Policy for new Private Cars
- iii) 5 years Long term Motor Package Insurance Policy for new 2 – wheelers
- iv) 3 years Long term Motor Package Insurance Policy for new Private Cars
- v) Bundled cover with one year term for own damage and 5 years motor third party insurance policy for new 2 – wheelers
- vi) Bundled cover with one year term for own damage and 3 years motor third party insurance policy for new private cars

Claim Settlement-Motor Insurance

Claim arise when:

- (1) The insured’s vehicle is damaged or any loss incurred.

- (2) Any legal liability is incurred for death of or bodily injury.
- (3) Or damage to the third party's property.

The claim settlement in India is done by opting for any of the following by the insurance company:

- (a) Replacement or reinstatement of vehicle.
- (b) Payment of repair charges.

In case, the motor vehicle is damaged due to accident it can be repaired and brought back to working condition. If the repair is beyond repair then the insured can claim for total loss or for a new vehicle. It is based on the market value of the vehicle at the time of loss. Motor insurance claims are settled in three stages. In the first stage the insured will inform the insurer about loss. The loss is registered in claim register. In the second stage, the automobile surveyor will assess the causes of loss and extent of loss. He will submit the claim report showing the cost of repairs and replacement charges etc. In the third stage, the claim is examined based on the report submitted by the surveyor and his recommendations. The insurance company may then authorize the repairs. After the vehicle is repaired, insurance company pays the charges directly to the repairer, in case of cashless claims or to the insured if he had paid the repair charges. Section 110 of Motor Vehicle Act, 1939 empowers the State Government in establishing motor claim tribunals. These tribunals will help in settling the third party claims for the minimum amount.

CLAIM PROCEDURE FOR MOTOR INSURANCE

(a) Vehicle Accident Claims

After the insured submit his claim form and the relevant documents, the insurer appoints a surveyor to inspect the vehicle and submit his/her report to the insurance company. Insured also get the details of the surveyor's report. In case of major damage to the vehicle, the insurer arranges for a spot survey at the site of accident.

The insured can undertake repairs only on completion of the survey. Once the vehicle is repaired, the insured should submit duly signed bills/cash memos to the insurance company. In some cases, companies have the surveyor re-inspect the vehicle after repairs. In such a scenario, the insured should pay the workshop/garage and obtain a proof of release document (this is an authenticated document signed by owner to release the vehicle from the garage after it is checked and repaired).

Once the vehicle has been released, insured should submit the original bill, proof of release, and cash receipt from the garage to the surveyor. The surveyor sends the claim file to the insurance company for settlement along with all the documents and finally, the insurance company reimburses the insured.

In case of an accident, the insurance company pays for the replacement of the damaged parts and the labor fees.

The costs that the insured has to bear include:

- A. The amount of depreciation as per the rate prescribed
- B. Reasonable value of salvage (to be discussed separately)
- C. Voluntary deductions under the policy, if the insured have opted for any
- D. Compulsory excesses levied by the insurer

In the insured uses the cashless repair facility, the claim money is paid directly to the workshop or garage. Otherwise, the amount of claim is paid to the insured.

(b) Third Party Insurance Claim

In the event of a third party claim, the insured should notify the insurance company in writing along with a copy of the notice and the insurance certificate. The insured should not offer to make an out-of-court settlement or promise payment to any party without the written consent of the insurance company. The insurance company has a right to refuse liabilities arising out of such promises.

The insurance company will issue a claim form that has to be filled and submitted along with:

- (a) Copy of the Registration Certificate
- (b) Driving license
- (c) First information report (FIR)

After verification, the insurance company will appoint a lawyer in the defense of insurer and the insured should cooperate with the insurance company, providing evidence during court proceedings. If the court orders compensation, the insurance company will then do it directly.

Motor Accident Claims Tribunal and Lok Adalats

MACT and Lok Adalats are playing an important role in Third party liability claims and almost 90% of third party motor accident claims are being settled through MACT courts or through Lok Adalats organized for settlement of these claims. These platforms provide for a good opportunity for negotiated settlement of the third party claims and timely help to accident victims without waiting for years together to get compensation from the insurance companies.

(c) Vehicle Theft Claims

In the event of theft of vehicle, the insured should lodge the First Information Report (FIR) with a police station immediately, inform the insurance company and provide them with a copy of the FIR. He should also submit the Final Police Report to the insurance company as soon as it is received and extend full cooperation to the surveyor or investigator appointed by the company. After the claim is approved, the Registration Certificate of the stolen vehicle has to be transferred in the name of the company and the insured needs to submit the duplicate keys of the vehicle along with a letter of subrogation and an indemnity on stamp paper (duly notarized) to the insurance company.

If there is a dispute regarding the claim settlement between the insured and the insurer, how is the dispute resolved?

The most common form of dispute that arises between the insured and the insurer is about admission of liability or the size of the claim. Disputes regarding claim amounts, where the insurer has agreed to cover the claim under the policy, are referred to an arbitrator. If the decision of the arbitrator is disputed by either party, the Consumer Forum or the Civil Court could be approached.

Motor Vehicles Act, 1988

The Motor Vehicles Act, 1988 is an Act of the Parliament of India which regulates all aspects of road transport vehicles. The Act came into force from 1 July 1989. It replaced the Motor Vehicles Act, 1938 which earlier replaced the first such enactment Motor Vehicles Act, 1914. The Act provides in detail the legislative provisions regarding licensing of drivers and conductors, registration of motor vehicles, control of motor vehicles through permits, special provisions relating to state transport undertakings, traffic regulations, insurance, liability, offences and penalties etc. Further, in order to exercise the legislative provisions of the Act, the Government

of India made the Central Motor Vehicles Rules, 1989. On 22 May 2018, the Central Government issued a notification by which the scale of compensation for third party fatal accidents and injury claims under the Second Schedule of the Motor Vehicles Act 1988 (MV Act) was amended. These claims for compensation are considered on a 'no-fault liability' basis as envisaged under §163A of the MV Act. In other words, the claimant is not required to prove or plead that death or permanent disablement was due to 'any wrongful act or neglect or default of the owner of the vehicle.'

Section 140 of Motor Vehicles Act, 1988 deals with the liability without fault. The claimant involved in a motor vehicle accident is not required to prove wrongful act, neglect, or default on the part of the owner of the vehicle or by any other person.

The claim under these provisions is neither defeated or affected in any way, by any wrongful act, neglect or default on the part of the claimant; nor can be of the claimant's share of responsibility for the accident. In other words, the legal defense of 'contributory negligence' is not available to the motorist and his insurer.

These provisions apply in cases where the claimant suffers death or permanent disablement, as defined in the Act. The amounts of compensation are fixed as follows:

- Death ₹ 200000
- Permanent Disablement /Grievous Injury ₹ 50000

The object behind no-fault principle is to give minimum statutory relief expeditiously to the victim of the road accident or his legal representative. To that extent, these provisions constitute a measure of social justice.

Where no-fault liability is concerned, there is clearly a departure from the usual common law principle that a claimant should establish negligence on the part of the owner or driver of the motor vehicle before claiming any compensation for death or permanent disablement arising out of a motor vehicle accident.

The right to claim compensation under section 140 in respect of death or permanent disablement of any person shall be in addition to any other right to claim compensation in respect thereof under any other provision of this Act or of any other law for the time being in force.

Thus the claims for death or permanent disablement can also be pursued under other provisions of the Act on the basis of negligence. The motorist i.e. the owner of the vehicle or driver of the vehicle is liable to pay compensation on the basis of 'no fault' as well as on the basis of 'fault' or negligence he has to pay first the compensation on 'no fault' basis i.e. ₹ 200000 or ₹ 50000 as the case may be, for death or permanent disablement.

If such compensation paid is less than the compensation awarded on the principle of 'fault' or negligence, the motorist is liable to pay the balance. For example, if ₹ 30,000/- is awarded for permanent disablement on the basis of negligence, the claimant is entitled to receive only ₹ 5,000/- being the excess over the no-fault compensation settled first. In any claim for compensation under this section, the claimant shall not be required to plead or establish that the death or permanent disablement in respect of which the claim has been made, was due to any wrongful act or neglect or default of the owner/s of the vehicle/s concerned or any other person.

Section 143 of the Act will also apply in relation to any claim for compensation in respect of death or permanent disablement of any person under the Workmen's Compensation Act, 1923, resulting from a motor accident. Time limit for depositing compensation under this section is one month.

The erstwhile Second Schedule of the Motor Vehicle Act provided for compensation on a 'structured formula basis' which was indicated in a tabular form. Broadly, compensation was formulated on the basis of the victim's age and income and suffered from several defects and inconsistencies as observed by the Supreme Court in

Sarla Verma v. Delhi Transport Corporation [(2009) 6 SCC 121]. Further, the Court noted in *Sarla Verma* that different tribunals were utilising different calculation mechanisms on similar factual scenarios which was leading to a lack of uniformity and consistency in awarding compensation under such claims.

In addition, the Supreme Court in *Puttamma v. K L Narayan Reddy* [(2013) 15 SCC 45] observed that the Second Schedule of the MV Act was in need of an urgent amendment, as it was based on the prevailing cost index of 1994.

Motor Vehicle (Amendment) Bill 2016 - Salient features

The Union Cabinet has given its approval for Motor Vehicle (Amendment) Bill 2016. The new Bill provides for hefty penalties for violation of road safety rules. The Bill makes it easier to get a learner's driving licence and ease the provisions on vehicle permits, to help growth of public transport. The Bill also promotes automation and computerization.

The present Motor Vehicle Act has 223 sections out of which the Bill aims to amend 68 sections whereas Chapters 10 has been deleted and a Chapter 11 is being replaced with new provisions to simplify third party insurance claims and settlement process.

Some of the important features of the Bill are:

- **Offences by juveniles** – The Bill proposes that in the case of offences committed by juveniles, the guardian/owner shall be deemed guilty. The juvenile would be tried under Juvenile Justice Act. Registration of the motor vehicle will also be cancelled.
- **Enhancement of compensation in Hit and Run cases** – The compensation payable for victims in 'hit and run' out of the scheme fund under section 161 has been enhanced to ₹ 2 lakhs in case of death, and ₹ 50,000/- in case of bodily injury, from ₹ 25,000/- and ₹ 12,500/- respectively.
- **Motor Vehicle Accident Fund** – The Bill seeks to introduce a Motor Vehicle Accident Fund under section 164B, which is to be augmented by a special tax or cess. The Fund is to be utilized for giving immediate relief to victims of motor accidents, and also hit and run cases. The compensation paid out of the fund shall be deductible from the compensation which the victim may get in future from the Tribunal.
- **Community Service as punishment** – The Act defines "Community Service" as unpaid work which a person is required to perform as a punishment for an offence committed under this Act. For causing motor accidents, punishment in the form of 'Community Service' can be imposed.
- **Protection of Good Samaritans** – The Act defines "good Samaritan" as a person, who in good faith, voluntarily and without expectation of any reward or compensation renders emergency medical or non-medical care or assistance at the scene of an accident to the victim or transporting such victim to the hospital. The Act makes provision for protection of Good Samaritans from unnecessary trouble or harassment from civil or criminal proceedings and empowers Central Government to frame Rules for their protections.
- **Registration process for new vehicles** – There is also a proposal to improve the registration process for new vehicles. Registration at the end of the dealer is being enabled and restrictions have been imposed on temporary registration, under the new Bill.
- **National Register for Driving Licence and National Register for Vehicle registration** – To bring harmony of the registration and licensing process, government proposes to create National Register for Driving Licence and National Register for Vehicle registration through "Vahan" & "Sarathi" platforms.

This will facilitate uniformity of the process across the country, says the government.

- **Multiplier** – The Bill proposes that the State Government can specify a multiplier, not less than one and not greater than ten, to be applied to each fine under this Act and such modified fine.
- **Increase in penalties** – With an aim to enhance road safety, the bill proposes to increase penalties, that it hopes will act as deterrent against traffic violations. Stricter provisions are being proposed with respect to offences like driving without licence, over-speeding, juvenile driving, drunken driving, dangerous driving, overloading etc.

The notification of May 2018 has now amended the Second Schedule and removes the formula system that had existed without amendment since 1994.

As per the substituted Second Schedule, compensation will now payable be as follows:

- For accidents resulting in minor injury: fixed compensation of ₹ 20,000.
- For accidents resulting in permanent disability: compensation payable will be calculated based on the 'disability percentage' specified in Schedule I of the Employee's Compensation Act 1923, where the minimum compensation payable shall be not less than ₹ 50,000 and the maximum compensation payable shall be ₹ 5 lakhs.
- For fatal accidents: fixed compensation of ₹ 5 lakhs.

The notification further provides that the amounts payable in case of death, permanent disability and minor injury will be increased at the rate of 5% annually, effective from 1 January 2019.

It is pertinent to note that additional compensation for various conventional heads, such as funeral expenses, loss of estate and consortium are no longer expressly provided for in the amended Second Schedule. It is unclear if these amounts will now be considered to be encompassed within the compensation amounts prescribed.

While the amendment reflects a much required update of the structured formula system that had been in existence since 1994, the actual impact of this notification is yet to be tested, particularly in the case of larger claims.

The new Bill takes into account taxi aggregators, third party insurance, computerisation of licensing authorities, and so on. It also provides for a National Road Safety Board.

Removal of Intermediaries

Anyone visiting their local Road Transport Authority will understand how difficult it is to obtain a driving licence without the help of touts. The Motor Vehicles (Amendment) Bill seeks to redress this by taking the process online. Tests for driving licences will be automated, and learner's licences will be issued online.

Third-Party Insurance

The 2016 version of the Bill had capped the payments to be made under third-party insurance. The 2017 Bill has removed that cap.

Solatium Fund

The 1988 Act already has a Solatium Fund for victims of hit-and-run accidents, but the new Bill has also provided for another Fund. Earlier, the Bill said that the Fund would be credited with a cess or a tax, but that provision has now been removed, and instead the money will come either from the government, or from a grant or loan.

LESSON ROUNDUP

- Parties to Motor Insurance are (i) Owner of the Vehicle (b) Insurance Company and (c) Third party on the street
- Under the Motor Vehicles Act, Third Party Cover is mandatory for all vehicles
- Third Party Policy is a policy under which the insurance company agrees to indemnify the insured person if he is sued or held legally liable for injuries or damage done to third party
- At the time of issuance of motor vehicle policy, third party cover should be for a minimum period of 3 years for cars and 5 years for two wheelers
- At the time of issuance of policy, Compulsory Accident Cover for the owner driven Vehicle is Rs.15 lacs
- As per the Motor Vehicles Act, Vehicles are classified as (a) Private Car and (b) Commercial Vehicles
- Motor Insurance is a Contract and has to fulfil the requirements of a valid contract as laid in the Indian Contract Act of 1872.
- Principles of Insurance Contract are:
 - Utmost good faith
 - Insurable Insurance
 - Indemnity
 - Subrogation and contribution
 - Proximate cause
- Types of Policy Coverage:
 - Liability only Policy (Third party Liability)
 - Comprehensive Cover Policy-This is an optional cover and includes all kinds of risk –weather damage, floods, fire, theft etc.
 - The premium for cover depends on the nature of cover i.e, Third Party or Comprehensive and the extend of cover.
- Types of Claims:
 - Vehicle accident claims
 - Third party claims
 - Theft claims

SELF TEST QUESTIONS

These are meant for re-capitulation only. Answers to these questions are not to be submitted for evaluation.

1. Multiple Choice Questions:
 - (1) Long term third party cover is:
 - (a) Voluntary

- (b) Mandatory
 - (c) Depends on the nature of Vehicle
- (2) Minimum insurance cover for Compulsory Accident Cover is:
- (a) ₹ 1 lac
 - (b) ₹ 10 lacs
 - (c) ₹ 15 lacs
- (3) Insurance Contract is governed by:
- (a) Companies Act 2013
 - (b) Indian Contract Act 1872
 - (c) Partnership Act
2. State whether the following are true or false:
- (a) There are 5 parties involved in a Motor Insurance Contract
 - (b) Long term Third Party Cover for a new motor car is for a minimum period of 5 years
 - (c) Long term Third Party Cover for a new two wheeler is for a minimum period of 3 years.
3. Write short notes on:
- (a) Subrogation rights
 - (b) Third Party Claims
 - (c) Principles of Insurance Contract

FURTHER READINGS

- 1. <https://www.bloomberqint.com/business/2018/07/25/supreme-court-makes-multi-year-motor-insurance-plans-compulsory>
- 2. <https://www.IRDAR.gov.in>

Lesson 13

Liability Insurance

LESSON OUTLINE

- Introduction
- Legal Background
- General Public Liability (Industrial/Non-industrial Risks)
- Products Liability Insurance Act, 1991
- Professional Indemnity Insurance
- Commercial General Liability Policy
- Reinsurance.
- LESSON ROUND UP
- SELF TEST QUESTIONS

LEARNING OBJECTIVES

In this chapter, we would like to introduce the concept of liability which in insurance parlance refers to a duty, responsibility or an obligation under the law and the impact it has on all transactions of an organizational entity or an individual, whether such impact is financial or otherwise.

Liability can be tortuous or contractual liability, and a method of risk treatment is through transferring such risks through insurance of liability. Tortuous liability may arise on account of breach of duty independently, of the personal obligation undertaken by contract. Breach of contract occurs where that which is complained of is a breach of duty arising out of the obligation undertaken by the contract. Mandatory insurance, to some extent address injury arising out of tort

The reader would have a fair idea of –

- i. Meaning and features of different types of Liability insurance
- ii. Mandatory & optional liability insurance
- iii. General insurance practices relating to liability insurance, and
- iv. Reinsurance of such liability insurance

INTRODUCTION

Insurance is primarily concerned with risks that have a financially measurable outcome and impact. But no tall risks are capable of measurement in financial terms. However, this is a good point to stress how innovative some insurers are in that they are always looking for ways to provide new covers, which the customers want. The difficult part is to be innovative and still make a profit.

Insurance is a valuable risk-financing tool. Few organizations have the reserves or funds necessary to take on the risk themselves and pay the total costs following a loss. Purchasing insurance, however, is not risk management. A thorough and thoughtful risk management plan is the commitment to prevent harm. Risk management also addresses many risks that are not insurable, including brand integrity, potential loss of tax-exempt status for volunteer groups, public goodwill and continuing donor support.

It is important to distinguish between pure and speculative risks; as through the use of commercial, personal, and liability insurance policies, insurance companies in the private sector generally insure only pure risks the outcome of which is either a loss or no loss situation. Speculative risks are not considered insurable, with some exceptions.

Risk transfer is another technique for handling risk. Risks can be transferred by several methods, among which are the following:

- (a) Transfer of risk by contracts;
- (b) Hedging price risks; and
- (c) Conversion to Public Limited Company.

Liability insurance covers such as Motor Third Party Liability Insurance, Workmen's Compensation Policy, etc., offer cover against legal liabilities that may arise under the respective statutes — Motor Vehicles Act, The Workmen's Compensation Act, etc. Some of the covers such as the foregoing (Motor Third Party and Workmen's Compensation Policy) are compulsory by statute. Liability Insurance not compulsory by statute is also gaining popularity these days. Many industries insure against Public liability, which means the liability of the industry for any loss caused to the general public due to the operations of the industry. There are liability covers available for Products as well.

General insurance contracts are based on indemnity of the loss incurred by the insured. Therefore, the losses will have to be measured accurately. The Surveyor and Loss Assessor, as we saw in one of the earlier Chapters, play a crucial role in assessing the extent of damages to arrive at the compensation. While assessing the loss on account of fire accident to a Car could be relative simple, it becomes complex in certain cases for example, Public Liability insurance. Therefore, it is important for the reader to appreciate how the framework around determination of liability in General insurance operates in India.

IMPORTANT LEGISLATIONS GOVERNING GENERAL INSURANCE BUSINESS IN INDIA

Motor Vehicles Amendment Act, 2019

The Motor Vehicles Amendment Act, 2019 is an Act of the Parliament of India which regulates all aspects of road transport vehicles. The Act came into force from 9 August, 2019. It replaced the Motor Vehicles Act, 1988 which earlier replaced the Motor Vehicles Act, 1938. The Act provides in detail the legislative provisions regarding licensing of drivers and conductors, registration of motor vehicles, control of motor vehicles through permits, special provisions relating to state transport undertakings, traffic regulations, insurance, liability, offences and penalties etc.

Necessity for insurance against third party risk

Section 146 of the above Act states that no person shall use, other than as a passenger or allow to use a motor vehicle in a public place unless a policy of insurance which covers the liability to third party on account of death or bodily injury to such third party or damage to any property of a third party arising out of the use of the vehicle in a public place. Therefore, it is mandatory for the owner of any motor vehicle to obtain, at the minimum, a policy from any General insurance company holding a valid licence from IRDA, which covers the risk of death or bodily injury to a third party arising out of usage of the vehicle in a public place.

The liabilities which require compulsory insurance are as follows:

- (a) Death or bodily injury of any person including the owner of the goods or his authorised representative carried in the carriage
- (b) Damage to any property of a third party
- (c) Death or bodily injury of any passenger of a public service vehicle
- (d) Liability arising under the Workmen's Compensation Act, 1923 in respect of death or bodily injury of the paid driver of the vehicle, conductor or ticket examiner (public service vehicles) and workers carried in a goods vehicle
- (e) The limit of liability to damage of third party property under MVA 1988 is currently Rs. 6000.
- (f) However, the government has amended the compensation amount payable for third-party fatal accidents and injury claims. According to the amendment made in Motor Vehicle Act, 1988 through notification dated May 22, 2018, the amount of compensation payable in case of death will be Rs five lakh. The amount payable as compensation has been decided keeping in view costs of living said the notification. The notification also states that if the accident results in permanent disability, compensation will be payable based on this formula:

$$\text{Compensation amount} = ₹ 5 \text{ lakh} \times \text{percentage disability as per schedule I of the Employee's Compensation Act, 1923.}$$

The minimum compensation in case of permanent disability of any kind shall not be less than ₹50,000. However, for accidents resulting in minor injuries, the compensation amount is fixed at ₹25,000.

The changes have come into effect from May 22, 2018. Therefore, any third-party claims filed on and from May 22, 2018 will be paid as per the amount mentioned above. This means that from January 1, 2019, the amount of compensation payable in the event of death will increase by 5 percent to ₹5,25,000. Similarly, compensation in case of minor accidents will increase from ₹25,000 to ₹26,250. "As per the earlier law, the minimum amount payable as compensation in case of death was ₹50,000 and for permanent disability was ₹25,000. However, these cases used to go to court and the compensation amounts were decided by the courts to settle these claims. Now it stands at Rs 5 lakh for death and ₹50,000 for permanent disabilities.

No Fault liability

Section 140 of the Motor Vehicles Act, 1988, provides for liability of the owner of the Motor Vehicles to pay compensation in certain cases, on the principle of no fault. The amount of compensation so payable is ₹50,000 for death and ₹25,000 for permanent disablement of any person resulting from an accident arising out of the use of the motor vehicles. The principle of "no fault" means that the claimant need not prove negligence on the

part of the motorist. Liability is automatic in such cases. Further, under Section 141(1) of the said Act, claims for death or permanent disablement can also be pursued under other provisions of the Act on the basis of negligence (fault liability).

Duty of insurers to satisfy judgements and awards against persons insured in respect of third party risks

Where a judgement or an award has been given against a insured person in respect of a third party liability covered under the insurance policy, then, notwithstanding the rights or the insurer to avoid or cancel the insurance policy, the insurer shall be liable to pay to the person entitled to the benefit of decree (third party), as if the insurer were the judgement debtor, together with any amount payable in respect of costs and any sum payable along with interest.

However, no sum as above shall be payable by an insurer if notice of the bringing of any such proceedings in which the judgement or award is given, is given to insurer and the insurer can defend the action on the ground of breach of any of the policy conditions.

PUBLIC LIABILITY INSURANCE ACT, 1991

Very often we can notice members of the public are affected because of major accidents in establishments.

This Act provides for mandatory public liability insurance for installations handling hazardous substances to provide minimum relief to victims of accidents, other than employees. For example, the Bhopal Gas Tragedy, which arose on account of leakage of the methylisocyanate gas from the Union Carbide plant in Bhopal on 2 & 3 December 1984, resulting in to a liability of US\$ 470 million for Union Carbide. In a way, this incident led to the enactment of Public Liability Insurance Act in 1991.

The Act imposes no fault liability, i.e. irrespective of any wrongful act, neglect or default on the owner to pay relief in the event of (a) death of or injury to any person (other than workman) or (b) damage to property of any person arising out of accident while handling any hazardous substance. No fault liability means that the claimant is not required to prove that the death, injury or damage was due to any wrongful act, neglect or default of any person.

Amount of relief

The amount of relief payable under Section 3 is as per the schedule incorporated in the Act as follows:

Fatal accident	: 25,000 per person
Permanent total disability	: 25,000 per person
Permanent partial disability	: The amount of relief on the basis of percentage of Disablement as certified by an authorised physician
Temporary partial disability	: Fixed monthly relief not exceeding ₹1,000 p.m. Upto a maximum of 3 months (provided the victim has been hospitalized for a period exceeding 3 days and is above 16 years of age)
Actual medical expenses	: Upto a maximum of ₹12,500 in each case mentioned above
Actual damage to property	: Upto ₹6,000

Compulsory Insurance

The liability has to be compulsorily insured under a contract of insurance for an amount of the paid up capital of the undertaking handling any hazardous substance. The maximum aggregate liability of the insurer to pay relief under an award to the several claimants arising out of an accident shall not exceed rupees five crores and in case of more than one accident during the currency of the policy or one year, whichever is less, shall not exceed rupees fifteen crores in the aggregate. Every owner, in addition to premium, has to pay to the insurer an equivalent amount to be credited to the Environment Relief Fund established under the act. The contribution received by the insurer shall be remitted as per the Scheme made by the Government.

Policy exclusions

The policy does not cover the following liabilities:

- (a) Arising out of wilful or intentional non-compliance of any statutory provisions
- (b) In respect of fines, penalties, punitive and/or exemplary damages
- (c) In respect of damage to property owned, leased etc., by the insured or in his custody. This is not deemed to be third party property. The insured can avail of a separate Material Damage Policy.

Industrial Risks and Non-industrial Risks

There are two types of Public Liability insurance policies – Industrial and Non-Industrial Risks.

Industrial Risk Policies cover the risks arising in manufacturing premises including godown, warehouses etc., forming part there of.

Non-Industrial Risks comprise of risks arising out of the following establishments:

- (a) Hotels, Motels, Club Houses, Restaurants etc.
- (b) Cinema Halls, Auditoriums and similar public places
- (c) Residential premises
- (d) Office or administrative premises, medical establishments, airport premises etc.
- (e) Schools, Educational Institutions, Libraries
- (f) Exhibitions, fairs, stadia
- (g) Amusement parks
- (h) Film studios
- (i) Depots, Warehouses, Godowns, Shops, Tank farms and similar other non industrial risks

Coverage

The coverage under the policy includes the following indemnities:

- (a) Legal liabilities
- (b) Other than liabilities under the Public Liability Insurance Act or any other statute
- (c) Compensation including claimant's costs, fees and expenses

Products Liability Policy

The demand for products liability insurance has arisen because of the wide variety of products, e.g. canned food

stuff, aerated waters, medicines, injections etc., manufactured and sold to the public in the modern industrial society which products, if defective, may cause death, bodily injury or illness or even damage to property. Apart from the goods, the containers too can cause injury or damage. These liabilities are covered under a Products Liability Policy.

Lift (Third party) Insurance

The policy is designed for owners of passenger lifts in building to cover third party liabilities for personal injuries or property damage arising out of the use and operation of lifts. The coverage applies to:

- (a) Death or bodily injury of any person (not being a member of the insured's family or an employee of the insured)
- (b) Loss of or damage to property (not being the property of the insured or of his family members or of his employees)
- (c) Direct damage to personal effects of any person (not being a member of the insured's family or an employee of the insured)

Professional Indemnity Policies

Professional indemnities are designed to provide insurance protection to professional people against their legal liability to pay damages arising out of negligence in the performance of their professional duties.

Such policies are available to Doctors, Medical establishments, Engineers, Architects and Interior decorators, Chartered Accountants, Financial Consultants including Insurance Agents and Brokers, Management Consultants, and Lawyers etc.

Professional risks fall into the following two broad groups:

- (a) Where professional negligence may result in bodily injuries (fatal or otherwise). Doctors, Dentists etc., fall into this group
- (b) Where professional negligence may result in financial loss. Chartered Accountants, Lawyers etc. fall into this group.

Employer's Liability Policy

New policies have been developed to cover any liability that might be imposed on an employer if an employee is injured in the course of his or her employment. In those countries where such insurance is not compulsory, smaller organizations risk insolvency when faced by employee claims not covered by insurance.

This is also known as the Workmen's Compensation Insurance. The policy protects the employers against their legal liability for payment of compensation arising as a result of death or disablement of the employees arising out of and in the course of employment. The policy provides indemnity against legal liability under the Workmen's Compensation Act, Fatal Accidents Act and Common Law.

The policy does not specify any sum insured because the amounts of compensation stipulated in the Act(s) or awarded by a Court of Law determine the limits of liability of the insurers.

The total earnings of the employees cannot be accurately computed at the commencement of the policy. An estimate of the total earnings is made and a deposit premium is charged. The premium is finally adjusted after the expiry of the policy, on the basis of the actual total earnings of the employees during the period.

Directors and Officers Liability Policy

This is a specialised insurance policy introduced to cover the liabilities of Directors or Officers of a Company. Since they hold positions of trust and responsibility, they may become liable to pay damages, due to acts of omission or commission.

It is a type of liability insurance which covers the directors and officers against the claims made by-

- Employees
- Suppliers
- Competitors
- Regulators
- Customers
- Shareholders
- Other stakeholders

For wrongful acts committed by them in the supervision and management of the affairs of the Company. Besides the Company itself may be liable. The policy is designed to provide protection to the Company as well as its Directors and Officers against their personal civil liability.

Commercial General Liability Policy

Comprehensive General Liability provides comprehensive protection against:

- Bodily injury and Property Damage
- Personal and Advertising injury
- Medical Expenses
- Supplementary Payment

Covered Exposures:

- Premises Liability
- Operations Liability
- Products Liability
- Completed Operations Liability
- Duty to Defend Form
- Coverage for defense costs apart from damages

Key Exclusions:

- Product defects
- Expected or intended injury
- Workers' Compensation and Similar Laws
- War & Terrorism

Cyber risk insurance Policy

A cyber insurance policy is designed to help an organization or business to cover against the liability and property losses arising due to any cyber related activity that the business engages in. This policy helps to offset the risk involved with recovery, after a cyber-related security breach.

Commercial crime insurance Policy

A Commercial Crime Insurance policy offers to protect the businesses against the losses due to third-party fraud or employee fidelity. It protects the business against:

- Employee dishonesty
- Theft of money
- Burglary
- Robbery
- Forgery
- Computer fraud

Carrier legal liability insurance Policy

Carrier legal liability insurance covers the insured for the physical loss or damage to goods or merchandise directly caused by fire or/and accident to the vehicle while such goods or merchandise are in transit. It covers for the losses of the goods or merchandise when they are in the custody of the insured.

Product liability insurance Policy

- A product liability insurance covers the business against the claims arising with respect to its products and services. The claims may arise due to personal injury or property damage caused due to the products or services of the business.
- Trade credit insurance:
- This insurance helps the business owners to protect their accounts receivable from loss due to credit risks such as protracted default, insolvency or bankruptcy.

REINSURANCE

Re-insurance and reinsurance are both forms of financial protection which are used to guard against the risk of losses. Losses are guarded against by transferring the risk to another party through the payment of an insurance premium, as an incentive for bearing the risk. Insurance and reinsurance are similar in concept even though they are quite different to each other in terms of how they are used. While insurance is for individual and businesses to transfer their risk exposures, reinsurance is a risk transfer mechanism for insurance companies to transfer their risk exposures. Reinsurance, also known as insurance for insurers or stop-loss insurance, is the practice of insurers transferring portions of risk portfolios to other parties by some form of agreement to reduce the likelihood of paying a large obligation resulting from an insurance claim.

Because reinsurance covers them against unusually large losses, this keeps a cap on the claims the insurer has to pay. This is important when a country is vulnerable to natural disasters and an insurer is heavily committed in that country. Insurance may be reinsured to spread the risk outside the country. Reinsurance

is important for insurance companies because an insurance company can reduce its risks from policies it has underwritten by spreading some of that risk to other insurers. For example, ABC Life Insurance Co. has written a \$10 million policy on the life of Joe. If Joe were to suddenly die, ABC would have to pay \$10 million to Joe's beneficiaries, which would have a significant effect on ABC. So ABC decides to cede part of its business. It can buy \$5 million worth of coverage for Joe's life from another company, DEF Life Insurance Co. Now if Joe suddenly dies, ABC will not be liable for entire \$10 million. DEF will cover its \$5 million obligation. As long as the policy is in effect, both companies share its premiums and profits. ABC is the ceding party in this exchange; DEF is known as the reinsurer. Thus, Reinsurance enables insurers to spread risk and function more effectively. They can take on more business without substantially increasing their exposure or obligations.

LESSON ROUND UP

- SUMMARY Insurance is primarily concerned with risks that have a financially measurable outcome and impact.
- Risk management addresses risks that are not insurable, including brand integrity, potential loss of tax-exempt status for volunteer groups, public goodwill and continuing donor support.
- Liability insurance covers such as Motor Third Party Liability Insurance, Workmen's Compensation Policy, etc., offer cover against legal liabilities that may arise under the respective statutes.
- General insurance contracts are based on indemnity of the loss incurred by the insured.
- MV Act mandates that no person shall use, other than as a passenger or allow to use a motor vehicle in a public place unless a policy of insurance which covers the liability to third party.
- No –Faulty liability provides protection to the liability of the owner of the Motor Vehicles to pay compensation in certain cases, on the principle of no fault.
- Public liability Act provides for mandatory public liability insurance for installations handling hazardous substances to provide minimum relief to victims of accidents, other than employees.
- Product liability provides protection to companies engaged in manufactured and sold to the public in the modern industrial society which products, if defective, may cause death, bodily injury or illness or even damage to property.
- Professional indemnities are designed to provide insurance protection to professional people against their legal liability to pay damages arising out of negligence in the performance of their professional duties.
- Director and Officers Liability is a specialised insurance policy introduced to cover the liabilities of Directors or Officers of a Company.
- A cyber insurance policy is designed to help an organization or business to cover against the liability and property losses arising due to any cyber related activity that the business engages in.
- Reinsurance is the practice of insurers transferring portions of risk portfolios to other parties by some form of agreement to reduce the likelihood of paying a large obligation resulting from an insurance claim.

Lesson 14

Aviation Insurance

LESSON OUTLINE

- Introduction
- Benefits of Aviation Insurance Policy
- Aviation Insurance Policy Covers
- Aviation Insurance Policy Claim Process
- LESSON ROUND UP
- SELF TEST QUESTIONS

LEARNING OBJECTIVES

This chapter attempts to introduce a highly complex and fairly recent subject of aviation insurance.

On reading through this chapter the reader would get an idea types of aviation insurance covers and the names of aviation laws etc The underwriting approach is briefly touched upon

- Understand the necessary processes for obtaining insurance cover
- Identify the factors that an aircraft operator should take into consideration when purchasing insurance cover
- Comprehending the special features of claim settlement
- Analyze the critical components of the different insurance contracts available to aircraft operators
- Gain an understanding of the main conventions and protocols
- Gain an understanding of how hull and liability risks are insured

AVIATION INSURANCE

The modern airports, low cost carriers, FDI, Liberalization, Privatization and Globalization are few of the many factor that have ushered in the growth of Aviation Industry. India is the ninth largest Civil Aviation Industry in the world.

The aviation industry is susceptible to a series of risks and threats, especially with respect to technical operations of an aircraft, and the consequent dangers. Aviation insurance is a specialised insurance which has been formulated to provide coverage to the specific operations of an aircraft and other possible risks in aviation. This type of insurance is quite different from other types of transportation insurance. The clauses, terms, limits in aviation insurance are quite unique.

Aviation insurance is the insurance that covers the risks involved in the Civil Aviation. The policies regarding aviation are very peculiar in nature and require separate specialization unlike other insurance matters; this is primarily because of the jargon used in the Aviation Policy. Since India does not possess a separate Space Law, it is interpreted under the Civil Aviation Law in India. It is sometimes also called as 'Aerospace Insurance'. Micro-satellites and commercial space launchers are all governed under this policy.

The first Aviation insurance policy was written in London, in 1911. But, it only became popular and a matter of law in 1924. The infamous Warsaw Convention was signed in 1929 which was an agreement to establish terms, conditions and limitations of liability for Civil Aviation. The International Union of Aviation Insurers (IUAL) was created in 1933 to establish a specialist Industry sector in Civil Aviation.

Though advancements in sectors of law and insurance have been made, no single insurer possesses the resources to handle the risk, the size of a major airline company. Also, since the nature of cataclysms occurring in the Civil Aviation Industry are usually devastating in nature, losses being measured in lives and sometimes property, it is impossible for an insurer to sufficiently insure a person. As a result, most airlines create 'fleet policies' to cover their losses.

Different aviation insurance policies provide a series of options tailor-made to suit the varied needs of each customer. The types of coverage provided are extremely specific to each plan, and it is of utmost importance to understand these nuances before choosing which plan to buy.

The concept of aviation insurance has gained momentum only of late. A series of aircraft disasters (especially the mysterious disappearance of Malaysia Airlines with over 200 passengers on board) have not only prompted more and more people to buy aviation insurance, but it has also increased the number of claims by a huge margin.

Benefits of Aviation Insurance Policy

In this age when all of us are hard-pressed for time, and are required to travel (for business or for leisure) taking a flight has become an indispensable part of our lives. Though flying comes with a huge amount of life risks, it is unavoidable. Be it turbulent weather, terrorist activities leading to hijacks, mysterious disappearance of flights, auto/technical failure, or a plane crash; taking a flight is never devoid of these life threatening dangers. As they say, better safe than sorry; a comprehensive aviation insurance policy covers you against the aforementioned dangers.

- In flight insurance provides coverage against damages that can happen to the aircraft while it is mid-air (in motion). Though this is expensive, it is worth it as most accidents happen when a plane is mid-air.
- You are protected from a series of natural weather turbulences and also man-made calamities.
- You are duly compensated for any damages sustained which can happen after you have boarded a flight.

Aviation Insurance Policy Covers

Aviation insurance offers protection against a wide array of perils, dangers, risks and damages to policyholders. Given that aircrafts are extremely prone to technical failures, accidents, terrorist activities, and such like, aviation insurance is extremely crucial. In the current scene, there are a number of aviation policies that are making their presence felt with interesting features, feasible cover plans, and a lot more. Take a look at the various kinds of aviation policies that are reckoning in India.

1. Aircraft Policy related to Flight and Ground Risk

This policy cover is taken to replace or repair accidental loss or damage caused to an aircraft; along with other things, it covers the standard parts that were temporarily detached during the flight of the aircraft. This policy also covers third parties and the legal liability of passengers.

2. Aircraft Hull Policy Comprehensive

This policy is aimed at covering the loss or damage caused to an aircraft while its in-flight or taxing on the ground. It also covers the liability to third parties and passengers.

3. Aircraft Hull War Risks Policy

This policy covers indemnity for loss or damage to the aircraft caused due to war or any other act of foreign enemies and strikes, riots, or worker disturbances. The policy also provides cover for the accidental or deliberate losses incurred due to political or terrorist acts; as well as any acts of sabotage.

4. Aviation Personal Accident Policy (Crew)

This is basically a group personal accident insurance policy that is provided to operators in the airline industry for offering benefits to crew members in case of any injury caused due to accident.

5. Breach of Warranty Insurance

Due to the breach of any policy's warranty, or in case the claim is not granted to the insured, the outstanding loan amount at that time will be reimbursed to the financier. This is somewhat similar to the Agreed Bank Clause of property insurance.

6. Confiscation Endorsement

This aviation insurance policy is aimed at covering the loss or damage caused to an aircraft as a result of confiscation, seizure, nationalization, and so on. These events have to be as per the order of the government, public authorities, or local authorities.

7. Hijacking Endorsement

This insurance is aimed at covering up any loss or damage caused to the aircraft as a result of hijacking, illegal seizure, or unfair exercise of the crew or any individual on board the aircraft during flight

8. Loss of License Insurance

The crew members operating in the aircraft are required to possess a valid professional license issued by the government that allows their work. The license can be suspended both permanently as well as temporarily on the basis of laid-down medical grounds. The resulting financial loss is covered up by this policy.

9. Product Legal liability Insurance Policy

This policy is affected by a manufacturer of aircraft parts, or a repairer that takes care of the risk resulting due to faulty design or imperfect repairing. The maker or the repairer is indemnified with all the sums that he might have to pay because of defective manufacturing.

10. Random Indemnity Cover

This insurance includes indemnity to the insured up to 60% of compensation that he might have to pay as a result of threats to the insured aircraft. The remaining 40% stays uninsured at the insurer's risk.

Companies Providing Aviation Insurance:

The following companies offer aviation insurance to customers :-

- New India Assurance Co. Limited
- Alliance Insurance Brokers
- AON Global India
- Far sight India Wealth Management
- Emed life

Aviation Insurance Policy Claim Process

Aviation insurance policies are distinctly different from those for other areas of transportation and tend to incorporate aviation terminology, limits and clauses specific to aviation insurance. The aviation claim process involves the following steps:

Initial Process:

Once contact has been established with the adjustor, you will normally be asked to complete a company loss report and document several items including aircraft registration, airworthiness certificate, and applicable information from the aircraft and/or engine logbook(s) to include confirmation of a current annual inspection. You will also be required to fully document pilot credentials, including logged hours, specific confirmation of any required training and/or checkout requirements and verification of a current FAA medical certificate and flight review. The adjustor may or may not physically inspect the aircraft, depending on the degree of damage. Often you will be asked to provide photographs of the damage, including a complete photo of the aircraft to document the registration number.

Once the insurance company is reasonably satisfied the claim is covered under the policy, they typically request estimates to repair the damage. Often more than one estimate is required and this may be difficult, depending on the circumstances of the loss. The aircraft owner is ultimately responsible for authorizing any work order, however the adjustor will want to have an opportunity to review the estimates and discuss the repairs with you before you commission the work.

Engine Inspections due to Prop Strike, FOD, etc:

If it becomes necessary to disassemble your engine as a result of the occurrence, some insurance companies routinely reimburse for the cost to remove, disassemble, inspect and reassemble the engine. Other companies may not necessarily cover the disassembly if no applicable damage is discovered, depending on the circumstances of the claim. Any components damaged as a result of the occurrence are covered. Sometimes

however, parts may be discovered that are unairworthy for reasons of wear and tear or causes unrelated to the occurrence. The insurance company cannot reimburse the cost of repairing or replacing such parts therefore they become the owner's responsibility.

Windshield damage claims often result in the use of independent laboratory testing to ascertain whether the damage arose out of an occurrence or over time due to wear and tear. These lab reports are typically ordered and paid for by the insurance company.

Betterment - Depreciation of Propellers and Time Life Components:

In many cases when propellers and limited-life components are damaged and repaired or replaced, they are returned in a "zero-time" condition. Since manufacturers routinely recommend a time limit between overhauls on these items, insurance companies calculate prorated depreciation based on an estimated flat rate overhaul cost of the propeller or component part had it not been damaged. For example, a \$1,000 propeller damaged at "mid-time" would result in \$500 reimbursement, if replaced.

Occasionally during the repair process, other repairs are elected, equipment upgraded or appearance enhanced. In these cases, obviously only the repairs associated with the damage will be reimbursed by the insurance company. For example, a damaged component may require painting to match but not warrant an entire painting of the aircraft. If a complete painting is desired, the cost will be prorated.

Forwarding Repair Invoices:

When corresponding with the insurance company, always reference the Named Insured, the date of the occurrence along with the claim number assigned by the company, if available. Please request your repair facility to exclude non-damage work on the repair invoice. Any work unrelated to the damage repairs should be performed on a separate work order. Insurance companies prefer not to receive faxed invoices. Please send itemized originals or copies that are readable to avoid unnecessary delays.

If your repair facility sends components such as engines to others for repair, the insurance company will typically need an itemized repair invoice and condition report, if applicable, from the subcontractor to be included with the primary contractor's invoices. If your repair includes several invoices from different repair facilities and associated expenses, please include a note describing what is being sent.

Claims for other expenses should be submitted in a logical format that completely describes what type of reimbursement is being presented for consideration. Keep in mind there are some expenses an insurance policy will not cover such as your time in working through the claims process.

Payment of Your Claim:

Most insurance companies require a properly executed Proof of Loss form (signed and notarized) in their office prior to claim payment. Claim drafts are typically made payable to the Policyholder and other documented parties and must be endorsed by signature prior to presenting for payment (company stamps are not accepted). If you have a lienholder or owner/lessor listed on your policy as a loss payee, their name will appear on any claim draft/check issued for a physical damage (hull) loss. Arrangements should be made with these interested third parties for their endorsement of the draft/check.

During the process of handling the loss, insurance companies frequently will order a title report from FAA records. If the Named Insured and the registered owner of the aircraft are not the same, be prepared to provide the insurance company with acceptable proof that the Named Insured has an insurable interest in the aircraft.

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The claims documents would relate to various entities involved in operation which would include:

FROM THE PILOT/PILOT'S Copies of:

- A full copy of the pilot's licence which reflects his or her name, ID number, and expiry dates.
- Current medical certificate.
- The last three pages of the pilot's logbook and summary of total time and experience on type.
- Completed SACAA PILOT Questionnaire (The pilot has to send this to the SACAA in any event)

FOR THE AIRCRAFT Copies of:

- Certificate of Registration
- Certificate of Airworthiness
- Maintenance Release
- Last CA43-02 form (from the maintenance organisation)
- Completed SACAA Owners Questionnaire (The owner has to send this to the SACAA in any event) available on our website www.aviationinsuranceindia.com

FOR THE OPERATION - If it was a charter flight copies of:

- Cargo and passenger manifest
- Load sheet
- AOC
- Copies of the passenger tickets or Airway Bills
- If it was a training flight
- Copies of Authorisation Sheet
- ATO Certificate 29
- Depending on the nature of the claim insurance company might insist on reviewing the student pilot's training file OR lease agreement between the rental pilot and the Insured.
- Weight & balance sheet + flight planning sheet if it was a cross country flight or rental flight.

DGCA Investigation and the Report

Report from Insurance Company Independent Surveyor.

LESSON ROUND UP

- Aviation insurance is a specialised insurance which has been formulated to provide coverage to the specific operations of an aircraft and other possible risks in aviation.
- The types of coverage provided are extremely specific to each plan, and it is of utmost importance to understand these nuances before choosing which plan to buy.
- Aviation Insurance Policy Covers:
 - In-flight coverage
 - Hull all risk

Lesson 15

Risk Management

LESSON OUTLINE

- Introduction
- Probability Theory and Statistics
- Risk Management And Internal Controls
- Reinsurance And Other Forms Of Risk Transfer
- Enterprise Risk Management For Solvency Purposes
- Risk Management
- Role of Insurance In Risk Management
- Risk Management Process
- Risk Analysis
- Risk Planning And Control
- Risk Avoidance
- Risk Transfer
- Insurance And Reinsurance As A Risk Transfer Techniques
- Recovery Planning
- Risk Management Checklists
- Reserving
- LESSON ROUND UP
- SELF TEST QUESTIONS

LEARNING OBJECTIVES

We live in a risky world. Forces that threaten our financial well being constantly surround us and are largely outside our control. Some people experience the premature and tragic death of a beloved family member, loss or destruction of their property from both man-made and natural disasters. There is other group of people where there is no accident but are exposed to the traumatic effects of a liability law suit.

The purpose of this chapter is to enable the students to understand –

- Meaning and classification of different types of risk
- Meaning of Perils and Hazards,
- The meaning of Risk Management
- Risk Management process and its different steps
- Mechanism of handling risk.
- Insurance and reinsurance as a risk transfer tool

INTRODUCTION

Businesses face decisions about risk nearly every day. From equipment purchases to new hires to acquisitions and closures, each business decision carries an element of risk. The key aspect of making the right business decisions comes from determining the balance between risk and reward. Companies that expose themselves to high risks with minimal rewards can gamble themselves right out of business. At the other extreme, firms that play it too safe can miss out on growth opportunities they need to survive and thrive in a competitive marketplace.

Risk is inherent or a facet of every human endeavour or aspect of life. From the moment we get up in the morning, drive or take public transportation to get to school or to work until we get back into our beds (and perhaps even afterwards), we are exposed to risks of different degrees. What makes the study of risk fascinating is that while some of this-risk bearing may not be completely voluntary, we seek out some risks on our own (speeding on the highways or gambling, for instance) and enjoy them. While some of these risks may seem trivial, others make a significant difference in the way we live our lives. On a loftier note, it can be argued that every major advance in human civilization, from the caveman's invention of tools to gene therapy, has been made possible because someone was willing to take a risk and challenge the status quo.

Risk is the potential of loss (an undesirable outcome, however not necessarily so) resulting from a given action, activity and/or inaction. The notion implies that a choice having an influence on the outcome sometimes exists (or existed). Potential losses themselves may also be called "risks". Any human endeavor carries some risk, but some are much riskier than others.

Risk can be defined in seven different ways –

- The probability of something happening multiplied by the resulting cost or benefit if it does.
- The probability or threat of quantifiable damage, injury, liability, loss, or any other negative occurrence that is caused by external or internal vulnerabilities, and that may be avoided through pre-emptive action.

PROBABILITY THEORY AND STATISTICS

Probability theory, a branch of mathematics, is a means of predicting random events by analysing large quantities of previous similar events. Probabilities in statistics are the mathematical odds that an event will occur. To obtain a probability ratio, the number of favorable results in a set is divided by the total number of possible results in the set. The probability ratio expresses the likelihood that the event will take place. This ratio is significant to insurance providers.

Uncertainty

Uncertainty is at the very core of the concept of risk itself. It is uncertainty about the outcome in a given situation. Uncertainty does not exist in the natural order of things though there are a number of outcomes, which are uncertain. For example: the weather for the test match; the possibility of being made redundant; the risk of having an accident. There is surely uncertainty surrounding all of these events.

In 1921, Frank Knight summarized the difference between risk and uncertainty thus: "... Uncertainty must be taken in a sense radically distinct from the familiar notion of Risk, from which it has never been properly separated. ... The essential fact is that "risk" means in some cases a quantity susceptible of measurement, while at other times it is something distinctly not of this character; and there are far-reaching and crucial differences in the bearings of the phenomena depending on which of the two is really present and operating. It will appear that

a measurable uncertainty, or “risk” proper, as we shall use the term, is so far different from an un-measurable one that it is not in effect an uncertainty at all.”

Risk is incorporated into so many different disciplines from insurance to engineering to portfolio theory that it should come as no surprise that it is defined in different ways by each one. It is worth looking at some of the distinctions:

- **Risk versus Probability:** While some definitions of risk focus only on the probability of an event occurring, more comprehensive definitions incorporate both the probability of the event occurring and the consequences of the event. Thus, the probability of a severe earthquake may be very small but the consequences are so catastrophic that it would be categorized as a high-risk event.
- **Risk versus Threat:** In some disciplines, a contrast is drawn between risk and a threat. A threat is a low probability event with very large negative consequences, where analysts may be unable to assess the probability. A risk, on the other hand, is defined to be a higher probability event, where there is enough information to make assessments of both the probability and the consequences.
- **All outcomes versus Negative outcomes:** Some definitions of risk tend to focus only on the downside scenarios, whereas others are more expansive and consider all variability as risk. The engineering definition of risk is defined as the product of the probability of an event occurring, that is viewed as undesirable, and an assessment of the expected harm from the event occurring.

Risk = Probability of an accident × Consequence in lost money/deaths

In contrast, risk in finance is defined in terms of variability of actual returns on an investment around an expected return, even when those returns represent positive outcomes. Building on the last distinction, we should consider broader definitions of risk that capture both the positive and negative outcomes

Sources of Risk

Risk as we have seen is all about losses. In the absence of possibility of loss there would be no risk thus it is important to know about the factors, which cause or contribute towards the occurrence of loss or extent of loss. There are two such factors and these are “Perils” and “Hazards”. The terms “peril” and “hazard” should not be confused with the concept of risk discussed earlier. Let us first consider the meaning of peril.

Peril

Perils cause the deviation in events from those that we expect. They are the immediate cause of loss. Their very existence ensures that we are surrounded by risk for example flood, death, sickness, theft, terrorism etc. and these are discussed below:

Natural Perils

Our very existence on the planet earth ensures that we live with risk as the almighty in all his wisdom has although gifted nature with many sources of energy unbalance or disturbances beyond limits take the form of risk called perils, which can lead to unexpected losses. There are unexpected natural phenomena, which year in and year out cause untold misery, loss of life and property. The most recent example in the Indian context being the Gujarat Earthquake on Jan 26th 2001, which caused widespread devastation. Nearly 20,000 lives were lost, numerous villages and localities were razed to the ground and lakh were rendered homeless. There is no stopping the fury of nature and the havoc that it plays with mankind. Volcanic eruptions, fire due to lightning, landslides, cyclones, hurricanes, storms, floods, the vagaries of weather, unseasonal rainfall and prolonged dry spells, hailstorms are some other examples of natural risks that can cause losses. These perils

are also called Act of God perils, and there is little that mankind can do to stop them, he can only learn to live with them and devise means to lessen the negative impact.

A global survey of losses for the year 2006 conducted by Sigma estimated the insured losses due to natural calamities at 14.8 billion dollars and out of this 12.6 billion dollars was on account of floods alone (while looking at these figures we have to bear in mind that these are only for insured losses, the actual figure may be actually much more). 40% of the lives lost during the year in catastrophes were on account of natural disasters with a major contribution being the lives lost due to floods in India & Bangladesh in and Southern Africa in February'2000 and Tsunami in 2005-06.

Man Made Perils:

Then there are the manmade perils, which cause loss, these are an outcome of our society and are the violent actions and unethical practices of people, which result in deviation from the expected. There are many of these but only a few are being discussed to illustrate their significance.

- (a) **Theft:** - Page – 3 of your daily newspaper provides a fair idea about this rampant malady in our society. The entire page is full of incidents of thefts of motorcycles, daylight robberies and burglaries loss to human life by accident, terrorism, enmity, adulteration murder etc. The figure for the exact extent of losses due to such incidents is not available for India but a study done by the FBI in USA way back in 1974 estimated that such losses in material terms alone exceeded \$3 billion that year. Not only outsiders but insiders also steal. Employees steal tools, equipments and goods from their employers worth millions every year.
- (b) **Riots, Strikes and Malicious Damage:** - These are perils, which every property owner faces. During Riots miscreants' damage, Public and Private property, loot stores, inflict injury or death to innocent people and the police personnel and bring business to a standstill causing untold damage. Similarly strikes sometimes turn violent resulting in damage to life and property. Strikes also result in loss of production causing huge monetary losses, which may even result in bankruptcy. Vandals target unoccupied houses when the proprietors are on vacation and damage the property, in some cases setting it on fire. Cars parked in the street are also often vandalized.
- (c) **Accidents:** - Accidents are caused by people and they cause injury to themselves or to others and also damage to property. Automobile accidents alone contribute the maximum share of losses due to this peril. As per WHO study each year "Road Traffics" take the lives of 1.2 million men, women & children around the world and seriously injure millions more. In addition to automobile accidents, accidents due to carelessness of humans result in huge losses to property and life. A carelessly dropped cigarette can lead to fire resulting in heavy losses to property and even life. Thousands of workers lose their lives and limbs every year in industrial accidents caused by human error or carelessness.

In one of the reports by Sigma for the year 2006 puts the global figure of man made insured losses at 5 billion dollars with 50% being attributed to Industrial fires. 11700 people lost their lives and out of these 65% were killed in transport related disasters (which appreciating the extent of losses. We must remember that Sigmas report is only a study of major disasters and only 350 events during the year have been evaluated / studied. The figures therefore just give an idea whereas the ground reality may be even more alarming).

Economic Perils:

The third category of Perils or cause of Risk is economic in nature and the examples of this type of Risk are Depression, Inflation, Local fluctuations and the instability of Industrial firms.

Depression in the market leads to low production levels and an increase in unemployment. Low production results in reduced profits or losses for business houses whereas unemployment stops the income of individuals causing mental and physical suffering. When Inflation is there in the economy the buying power of money declines and the real value of savings and income is reduced. People whose livelihood is based on fixed income such as pensioners (Retired persons) during such periods are the hardest hit and may find it impossible to make both ends meet.

This fluctuation in the general economy can cause unfavourable deviation from the expectations and create risks for both Industries firms as well as individuals. Sometimes it so happens that even though the general economic condition in the country is stable there are some areas, which may experience recession. These are known as local fluctuations and can effect the Individuals or the business houses in the same manner as the general fluctuation in economy i.e. Depression & Inflation. When particular area is effected the value of investments made in the area declines and jobs are also lost. At time it is the individual firms which are to blame. The owners lose part or whole of their investment and workers lose their jobs. There are many towns and communities, which are dependent on one single Industry for their well being and when this Industry fails or decides to shift operation the entire town or community is exposed to risk.

Hazard

Factors, which may influence the outcome, are referred to as hazards. These hazards are not themselves the cause of the loss, but they can increase or decrease the effect should a peril operate. The consideration of hazard is important when an insurance company is deciding whether or not it should insure some risk and what premium to charge. So a hazard is a condition that creates or increases the chance of loss. There are three major types of hazards: Hazard can be physical or moral or Morale.

Physical hazard

Physical hazard relates to the physical characteristics of the risk, such as the nature of construction of a building, security protection at a shop or factory, or the proximity of houses to a riverbank. Therefore a physical hazard is a physical condition that increases the chances of loss. Thus, if a person owns an older building with defective wiring, the defective wiring is a physical hazard that increases the chance of a fire. Another example of physical hazard is a slippery road after the rains. If a motorist loses control of his car on a slippery road and collides with another motorist, the slippery road is a physical hazard while collision is the peril, or cause of loss.

Morale hazard

This usually refers to the attitude of the insured person. Morale hazard is defined as carelessness or indifference to a loss because of the existence of insurance. The very presence of insurance causes some insurers to be careless about protecting their property, and the chance of loss is thereby increased. For example, many motorists know their cars are insured and, consequently, they are not too concerned about the possibility of loss through theft. Their lack of concern will often lead them to leave their cars unlocked. The chance of a loss by theft is thereby increased because of the existence of insurance.

Morale hazard should not be confused with moral hazard. Morale hazard refers to an Insured who is simply careless about protecting his property because the property is insured against loss.

Moral hazard is more serious since it involves unethical or immoral behaviour by insurers who seek their own financial gain at the expense of insurers and other policy owners. Insurers attempt to control both moral and morale hazards by careful underwriting and by various policy provisions, such as compulsory excess, waiting periods, exclusions, and exceptions.

When used in conjunction with peril and hazard we find that risk means the likelihood that the hazard will indeed cause the peril to operate and cause the loss. For example, if the hazard is old electrical wiring prone to shorting and causing sparks, and the peril is fire, then the risk, is the likelihood that the wiring will indeed be a cause of fire.

Basic Categories of Risk

With regards insurability, there are basically two categories of risks;

- Speculative or dynamic risk; and
- Pure or static risk

Speculative or Dynamic Risk

Speculative (dynamic) risk is a situation in which either profit OR loss is possible. Examples of speculative risks are betting on a horse race, investing in stocks/bonds and real estate. In the business level, in the daily conduct of its affairs, every business establishment faces decisions that entail an element of risk. The decision to venture into a new market, purchase new equipment, diversify on the existing product line, expand or contract areas of operations, commit more to advertising, borrow additional capital, etc., carry risks inherent to the business. The outcome of such speculative risk is either beneficial (profitable) or loss. Speculative risk is uninsurable.

Pure or Static Risk

The second category of risk is known as pure or static risk. Pure (static) risk is a situation in which there are only the possibilities of loss or no loss, as oppose to loss or profit with speculative risk. The only outcome of pure risks are adverse (in a loss) or neutral (with no loss), never beneficial. Examples of pure risks include premature death, occupational disability, catastrophic medical expenses, and damage to property due to fire, lightning, or flood.

It is important to distinguish between pure and speculative risks for three reasons. First, through the use of commercial, personal, and liability insurance policies, insurance companies in the private sector generally insure only pure risks. Speculative risks are not considered insurable, with some exceptions.

Second, the law of large numbers can be applied more easily to pure risks than to speculative risks. The law of large numbers is important in insurance because it enables insurers to predict loss figures in advance. It is generally more difficult to apply the law of large numbers to speculative risks in order to predict future losses. One of the exceptions is the speculative risk of gambling, where casinos can apply the law of large numbers in a very efficient manner.

Finally, society as a whole may benefit from a speculative risk even though a loss occurs, but it is harmed if a pure risk is present and a loss occurs. For instance, a computer manufacturer's competitor develops a new technology to produce faster computer processors more cheaply. As a result, it forces the computer manufacturer into bankruptcy. Despite the bankruptcy, society as a whole benefits since the competitor's computers work faster and are sold at a lower price. On the other hand, society would not benefit when most pure risks, such as an earthquake, occur.

Other Risks

Besides insurability, there are other classifications of Risks. Few of them are discussed below:

Fundamental Risks and Particular Risks

Fundamental risks affect the entire economy or large numbers of people or groups within the economy. Examples of fundamental risks are high inflation, unemployment, war, and natural disasters such as earthquakes, hurricanes, tornadoes, and floods.

Particular risks are risks that affect only individuals and not the entire community. Examples of particular risks are burglary, theft, auto accident, dwelling fires. With particular risks, only individuals experience losses, and the rest of the community are left unaffected.

The distinction between a fundamental and a particular risk is important, since government assistance may be necessary in order to insure fundamental risk. Social insurance, government insurance programs, and government guarantees and subsidies are used to meet certain fundamental risks in our country. For example, the risk of unemployment is generally not insurable by private insurance companies but can be insured publicly by federal or state agencies. In addition, flood insurance is only available through and/or subsidized by the federal government.

Subjective Risk

Subjective risk is defined as uncertainty based on a person's mental condition or state of mind. For example, assume that an individual is drinking heavily in a bar and attempts to drive home after the bar closes. The driver may be uncertain whether he or she will arrive home safely without being arrested by the police for drunken driving. This mental uncertainty is called subjective risk.

Objective Risk

Objective risk is defined as the relative variation of actual loss from expected loss. For example, assume that a fire insurer has 5000 houses insured over a long period and, on an average, 1 percent, or 50 houses are destroyed by fire each year. However, it would be rare for exactly 50 houses to burn each year and in some years, as few as 45 houses may burn. Thus, there is a variation of 5 houses from the expected number of 50, or a variation of 10 percent. This relative variation of actual loss from expected loss is known as objective risk.

Objective risk declines as the number of exposures increases. More specifically, objective risk varies inversely with the square root of the number of cases under observation. Now assume that 5 lacs instead 5000 houses are insured. The expected number of houses that will burn is now 5000, but the variation of actual loss from expected loss is only 50. Objective risk is now $50/5000$, or 1 percent.

Objective risk can be statistically measured by some measure of dispersion, such as the standard deviation or coefficient of variation. Since objective risk can be measured, it is an extremely useful concept for an insurance company or a corporate risk manager.

As the number of exposures increases, the insurance company can predict its future loss experience more accurately because it can rely on the "Law of large numbers." The law of large numbers states that as the number of exposure unit's increase, the more closely will the actual loss experience approach the probable loss experience. For example, as the number of homes under observation increases, the greater is the degree of accuracy in predicting the proportion of homes that will burn.

Static Risks

Static risks are risks connected with losses caused by the irregular action of nature or by the mistakes and misdeeds of human beings. Static risks are the same as pure risks and would, by definition, be present in an unchanging economy.

Dynamic Risk

Dynamic risks are risks associated with a changing economy. Important examples of dynamic risks include the changing tastes of consumers, technological change, new methods of production, and investments in capital goods that are used to produce new and untried products.

Static and dynamic risks have several important differences –

- Most static risks are pure risks, but dynamic risks are always speculative risks where both profit and loss are possible.
- Static risks would still be present in an unchanging economy, but dynamic risks are always associated with a changing economy.
- Dynamic risks usually affect more individuals and have a wider impact on society than do static risks.
- Dynamic risks may be beneficial to society but static risks are always harmful.

Financial and Non-financial Risks

A financial risk is one where the outcome can be measured in monetary terms.

This is easy to see in the case of material damage to property, theft of property or lost business profit following a fire. In cases of personal injury, it can also be possible to measure financial loss in terms of a court award of damages, or as a result of negotiations between lawyers and insurers. In any of these cases, the outcome of the risky situation can be measured financially.

There are other situations where this kind of measurement is not possible. Take the case of the choice of a new car, or the selection of an item from a restaurant menu. These could be construed as risky situations, not because the outcome will cause financial loss, but because the outcome could be uncomfortable or disliked in some other way. We could even go as far as to say that the great social decisions of life are examples of non-financial risks: the selection of a career, the choice of a marriage partner, having children. There may or may not be financial implications, but in the main the outcome is not measurable financially but by other, more human, criteria.

Insurance is primarily concerned with risks that have a financially measurable outcome. But not all risks are capable of measurement in financial terms. One example of a risk that is difficult to measure financially is the effect of bad publicity on a company - consequently this risk is very difficult to insure.

However, this is a good point to stress how innovative some insurers are in that they are always looking for ways to provide new covers, which the customers want. The difficult part is to be innovative and still make a profit.

Enterprise Risk Management for Solvency Purposes: The supervisor establishes enterprise risk management requirements for solvency purposes that require insurers to address all relevant and material risks.

RISK MANAGEMENT AND INTERNAL CONTROLS

The supervisor requires an insurer to have, as part of its overall corporate governance framework, effective systems of risk management and internal controls, including effective functions for risk management, compliance, actuarial matters and internal audit. The supervisor requires the insurer to establish, and operate within, effective systems of risk management and internal controls. Further, the supervisor requires the insurer to have effective control functions with the necessary authority, independence and resources.

The supervisor requires the insurer to have effective control functions with the necessary authority, independence

and resources. The control functions are those which do not involve in the core business activities, such as Chief Risk Officer, Chief Finance Officer, and Appointed Actuary etc. these functions are conscience keeping functions, which do not have core business operational responsibilities and are independent of such core business functions. In order to remove any conflict of interest, the same person does not hold responsibility both for core business function and the control function at the same time.

Each control function should have the authority and independence necessary to be effective in fulfilling its duties and attaining its goals. The Board should set or approve the authority and responsibilities of each control function. The authority and responsibilities of each control function should be set out in writing and made part of or referred to in the governance documentation of the insurer. The head of each control function should periodically review such document and submit suggestions for any changes to Senior Management and the Board for approval.

Notwithstanding the possibility for insurers to combine certain control functions, a control function's independence from Senior Management and from other functions should be sufficient to allow its staff to:

- serve as a further component of the insurer's checks and balances;
- provide an objective perspective on strategies, issues, and potential violations related to their areas of responsibility; and
- implement or oversee the implementation of corrective measures where necessary.

Each control function should avoid conflicts of interest. Where any conflicts remain and cannot be resolved with Senior Management, these should be brought to the attention of the Board for resolution. Each control function should have the authority to communicate on its own initiative with any employee and to have unrestricted access to such information as it needs to carry out its responsibilities. In addition, control functions should have appropriate access to Senior Management.

Board

The Board should grant the head of each control function the authority and responsibility to report periodically to it or one of its committees. The Board should determine the frequency and depth of such reporting so as to permit timely and meaningful communication and discussion of material matters. The reporting should include, among other things:

- information as to the function's strategy and longer term goals and the progress in achieving these;
- annual or other periodic operational plans describing shorter term goals and the progress in achieving these; and
- resources (such as personnel, budget, etc.), including an analysis on the adequacy of these resources.

In addition to periodic reporting, the head of each control function should have the opportunity to communicate directly and to meet periodically (without the presence of management) with the chair of any relevant Board committee (e.g. Audit or Risk Committee) and/or with the Chair of the full Board.

The Board should periodically assess the performance of each control function. This may be done by the full Board, by the Chair of the Board, by the committee of the Board to which the head of the control function reports, or by the Chair of such committee.

REINSURANCE AND OTHER FORMS OF RISK TRANSFER

Reinsurance is a mechanism through which insurance companies transfer the risks they assume on insurance

policies to another insurer, called Reinsurer. Accordingly a Reinsurance contract is entered into with the Reinsurer by the primary insurer.

The supervisor sets standards for the use of reinsurance and other forms of risk transfer, ensuring that insurers adequately control and transparently report their risk transfer programmes. The supervisor takes into account the nature of reinsurance business when supervising reinsurers based in its jurisdiction.

The supervisory focus should be on expectations of the Board and Senior Management of the cedant (insurer which is ceding the risks with the reinsurer), discussions with them about their approach and an assessment of that approach and how it is executed. This focus does not preclude other activities which supervisors should undertake, both as part of the initial licensing process (where applicable) and as part of ongoing supervision.

The assessment of reinsurance arrangements by the supervisor should be based on a number of factors, which need to be reviewed on a case-by-case basis, including:

- the relative financial strength and claims payment record of the reinsurers in question (both in normal and stressed conditions);
- the soundness of the risk and capital management strategy;
- the appropriateness of the reinsurance strategy given the underlying insurance portfolios;
- the structure of the programme including any alternative risk transfer mechanisms;
- the extent to which relevant functions are outsourced, either externally or within the same group of companies;
- the levels of aggregate exposure to a single reinsurer or different reinsurers being part of the same group;
- the proportion of business ceded so that the net risks retained commensurate with the cedant's financial resources;
- the level of effective risk transfer;
- the resilience of the reinsurance programme in stressed claims situations;

The supervisor requires that cedants have reinsurance and risk transfer strategies appropriate to the nature, scale and complexity of their business, and which are part of their wider underwriting and risk and capital management strategies. The supervisor also requires that cedants have systems and procedures for ensuring that such strategies are implemented and complied with, and that cedants have in place appropriate systems and controls over their risk transfer transactions

ENTERPRISE RISK MANAGEMENT FOR SOLVENCY PURPOSES

The supervisor establishes enterprise risk management requirements for solvency purposes that require insurers to address all relevant and material risks.

The supervisor requires the insurer's enterprise risk management framework to provide for the identification and quantification of risk under a sufficiently wide range of outcomes using techniques which are appropriate to the nature, scale and complexity of the risks the insurer bears and adequate for risk and capital management and for solvency purposes.

Enterprise risk management framework - documentation

The supervisor requires the insurer's measurement of risk to be supported by accurate documentation providing

appropriately detailed descriptions and explanations of the risks covered, the measurement approaches used and the key assumptions made.

Enterprise risk management framework - risk management policy

The supervisor requires the insurer to have a risk management policy which outlines how all relevant and material categories of risk are managed, both in the insurer's business strategy and its day-to-day operations.

The supervisor requires the insurer to have a risk management policy which describes the relationship between the insurer's tolerance limits, regulatory capital requirements, economic capital and the processes and methods for monitoring risk.

The supervisor requires the insurer to have a risk management policy which includes an explicit asset-liability management (ALM) policy which clearly specifies the nature, role and extent of ALM activities and their relationship with product development, pricing functions and investment management.

The supervisor requires the insurer to have a risk management policy which is reflected in an explicit investment policy which:

- specifies the nature, role and extent of the insurer's investment activities and how the insurer complies with the regulatory investment requirements established by the supervisor; and
- establishes explicit risk management procedures within its investment policy with regard to more complex and less transparent classes of asset and investment in markets or instruments that are subject to less governance or regulation.

The supervisor requires the insurer to perform its own risk and solvency assessment (ORSA) regularly to assess the adequacy of its risk management and current, and likely future, solvency position

The supervisor requires the insurer's Board and Senior Management to be responsible for the ORSA

RISK MANAGEMENT

'Risk, in insurance terms, is the possibility of a loss or other adverse event that has the potential to interfere with an organization's ability to fulfill its mandate, and for which an insurance claim may be submitted'.

What is risk management?

Risk management ensures that an organization identifies and understands the risks to which it is exposed. Risk management also guarantees that the organization creates and implements an effective plan to prevent losses or reduce the impact if a loss occurs.

A risk management plan includes strategies and techniques for recognizing and confronting these threats. Good risk management doesn't have to be expensive or time consuming; it may be as uncomplicated as answering these three questions:

- What can go wrong?
- What will we do, both to prevent the harm from occurring and in response to the harm or loss?
- If something happens, how will we pay for it?

Benefits to managing risk

Risk management provides a clear and structured approach to identifying risks. Having a clear understanding of all risks allows an organization to measure and prioritize them and take the appropriate actions to reduce

losses. Risk management has other benefits for an organization, including:

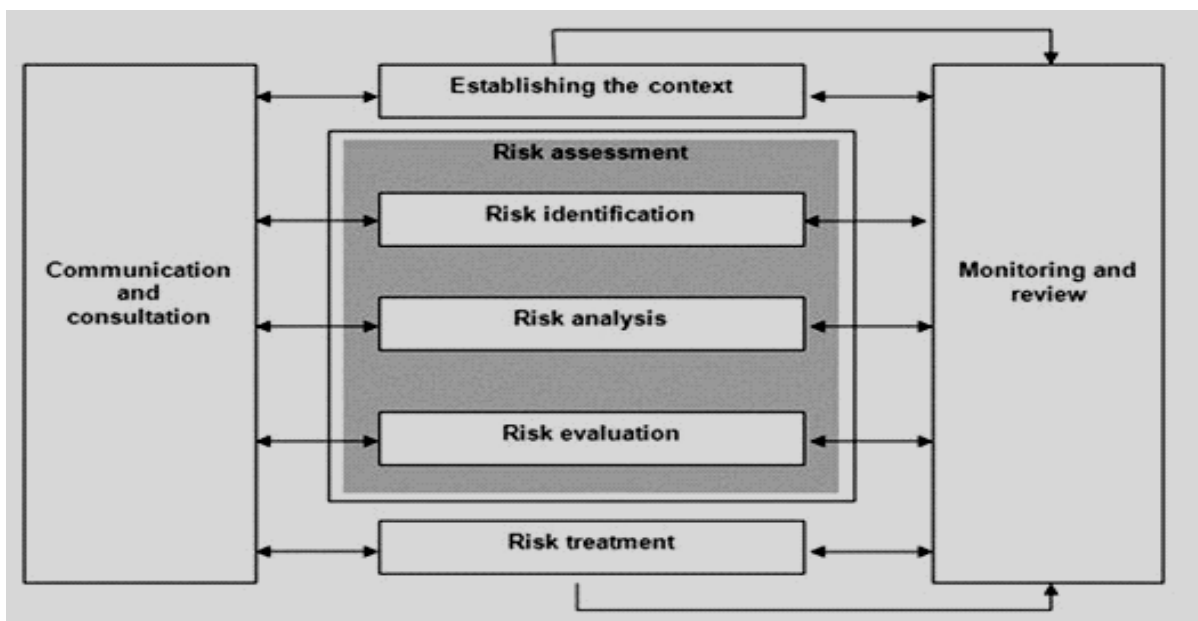
- Saving resources: Time, assets, income, property and people are all valuable resources that can be saved if fewer claims occur.
- Protecting the reputation and public image of the organization.
- Preventing or reducing legal liability and increasing the stability of operations.
- Protecting people from harm.
- Protecting the environment.
- Enhancing the ability to prepare for various circumstances.
- Reducing liabilities.
- Assisting in clearly defining insurance needs.

An effective risk management practice does not eliminate risks. However, having an effective and operational risk management practice shows an insurer that your organization is committed to loss reduction or prevention. It makes your organization a better risk to insure.

ROLE OF INSURANCE IN RISK MANAGEMENT

Insurance is a valuable risk-financing tool. Few organizations have the reserves or funds necessary to take on the risk themselves and pay the total costs following a loss. Purchasing insurance, however, is not risk management. A thorough and thoughtful risk management plan is the commitment to prevent harm. Risk management also addresses many risks that are not insurable, including brand integrity, potential loss of tax-exempt status for volunteer groups, public goodwill and continuing donor support.

RISK MANAGEMENT PROCESS



Risk Management Comprises of mainly three steps:

- Risk Analysis

- Risk Identification
- Risk Assessment
- Risk Planning
- Risk Controlling

RISK ANALYSIS

Risk Analysis is the process of identifying, analyzing and communicating the major risks. Once risks have been identified, they must then be assessed as to their potential severity of impact (generally a negative impact, such as damage or loss) and to the probability of occurrence. These quantities can be either simple to measure, in the case of the value of a lost building, or impossible to know for sure in the case of the probability of an unlikely event occurring. This process is known as risk analysis. In the assessment process it is critical to make the best educated decisions in order to properly prioritize the implementation of the risk management plan.

RISK PLANNING AND CONTROL

Once risk and identified and analyzed, it is important to plan and adopt a suitable strategy for controlling the risk. Risk planning and controlling is the stage which comes after the risk analysis process is over.

There are five major methods of handling and controlling risk.

- Risk avoidance;
- Risk retention;
- Risk transfer;
- Loss control; and
- Insurance.

RISK AVOIDANCE

Risk avoidance is one method of handling risk. For example, you can avoid the risk of being pick pocketed in Metropolitan cities by staying out of them; you can avoid the risk of divorce by not marrying; a career employee who is frequently transferred can avoid the risk of selling a house in a depressed real estate market by renting instead of owning; and a business firm can avoid the risk of being sued for a defective product by not producing the product.

But as a practical matter, not all risks can or even should be avoided. For example, you can avoid the risk of death or disability in a plane crash by refusing to fly. But is this practical and desirable? The alternatives are not appealing. You can drive or take a bus or train, all of which take considerable time and often involve great fatigue. Although the risk of a plane crash is present, the safety record of commercial airlines is excellent, and flying is a reasonable risk to assume. Or one may wish to avoid the risk of business failure by refusing to go into business for oneself. But a person may have the necessary skills and capital to be successful in business, and risk avoidance may not be the best approach for him to follow in this case.

Risk Retention

Risk retention is a second method of handling risk. An individual or a business firm may retain all or part of a given risk. Risk retention can be either active or passive.

Active Risk Retention

Active risk retention means that an individual is consciously aware of the risk and deliberately plans to retain all or part of it. For example, a motorist may wish to retain the risk of a small collision loss by purchasing an own damage insurance policy with a `2,000 voluntary excess. A homeowner may retain a small part of the risk of damage to the house by purchasing a Householders policy with substantial voluntary excess. A business firm may deliberately retain the risk of petty thefts by employees, shoplifting, or the spoilage of perishable goods. Or a business firm may use risk retention in a self-insurance program, which is a special application of risk retention. In these cases, the individual or business firm makes a conscious decision to retain part or all of a given risk. Active risk retention is used for two major reasons. First, risk retention can save money. Insurance may not be purchased at all, or it may be purchased with voluntary excesses; either way, there is often a substantial saving in the cost of insurance. Second, the risk may be deliberately retained because commercial insurance is either unavailable or can be obtained only by the payment of prohibitive premiums. Some physicians, for example, practice medicine without professional liability insurance because they perceive the premiums to be inordinately high.

Passive Risk Retention

Risk can also be retained passively. Certain risks may be unknowingly retained because of ignorance, indifference, or laziness. This is often dangerous if a risk that is retained has the potential for destroying a person financially. For example, many persons with earned incomes are not insured against the risk of long-term disability under either an individual or group disability income plan. However, the adverse financial consequences of a long-term disability generally are more severe than premature death. Thus, people who are not insured against the risk of long-term disability are using the technique of risk retention in a most dangerous and inappropriate manner.

In summary, risk retention can be an extremely useful technique for handling risk, especially in a modern corporate risk management program. Risk retention, however, is appropriate primarily for high frequency, low severity risks where potential losses are relatively small. Except under unusual circumstances, an individual should not use the technique of risk retention to retain low frequency, high severity risks, such as the risk of catastrophic losses like earthquake and floods.

RISK TRANSFER

Risk transfer is another technique for handling risk. Risks can be transferred by several methods, among which are the following:

- Transfer of risk by contracts;
- Hedging price risks; and
- Conversion to Public Limited Company.

Transfer of risk by contracts

Unwanted risks can be transferred by contracts. For example, the risk of a defective television or stereo set can be transferred to the retailer by purchasing a service contract, which makes the retailer responsible for all repairs after the warranty expires. The risk of a substantial increase in rent can be transferred to the landlord by a long-term lease. The risk of a substantial price increase in construction costs can be transferred to the builder by having a firm price in the contract rather than a cost-plus contract.

Hedging price risks

Hedging price risks is another example of risk transfer. Hedging is a technique for transferring the risk of unfavourable price fluctuations to a speculator by purchasing and selling futures contracts on an organized exchange, such as NSE.

In recent years, institutional investors have sold stock index futures contracts to hedge against adverse price declines in the stock market. This technique is often called portfolio insurance. However, it is not formal insurance but is a risk transfer technique that provides considerable protection against a decline in stock prices.

Conversion to Public Limited Company

Incorporation is another example of risk transfer. If a firm is a sole proprietorship, creditors for satisfaction of debts can attach the owner's personal assets, as well as the assets of the firm. If a firm incorporates, however, creditors for payment of the firm's debts cannot attach the personal assets of the stockholders. In essence, by incorporation, the liability of the stockholders is limited, and the risk of the firm having insufficient assets to pay business debts is shifted to the creditors.

Loss Control

Loss control is another important method for handling risk. Loss control consists of certain activities undertaken to reduce both the frequency and severity of losses.

Thus, loss control has two major objectives:

- Loss prevention.
- Loss reduction.

Loss Prevention

Loss prevention aims at reducing the probability of loss so that the frequency of losses is reduced. Several examples of personal loss prevention can be given. Automobile accidents can be reduced if motorists pass a safe driving course and drive defensively. Dropping out of college can be prevented by intensive study on a regular basis. The number of heart attacks can be reduced if individuals watch their weight, give up smoking, and follow good health habits.

Loss prevention is also important for business firms. For example, a boiler explosion can be prevented by periodic inspections by a safety engineer; occupational accidents can be reduced by the elimination of unsafe working conditions and by strong enforcement of safety rules; and fire can be prevented by forbidding workers to smoke in an area where highly flammable materials are being used. In short, the goal of loss prevention is to prevent the loss from occurring.

Loss Reduction

Although stringent loss prevention efforts can reduce the frequency of losses, some losses will inevitably occur. Thus, the second objective of loss control is to reduce the severity of a loss after it occurs. For example, a warehouse can install a sprinkler system so that a fire is promptly extinguished, thereby reducing the loss; highly flammable materials can be stored in a separate area to confine a possible fire to that area; a plant can be constructed with fire resistant materials to minimize a loss; and fire doors and fire walls can be used to prevent a fire from spreading.

Loss Control-Ideal Method For Handling Risk

From the viewpoint of society, loss control is the ideal method for handling risk. This is true for two reasons. First, the indirect costs of losses may be large, and in some instances, they can easily exceed the direct costs. For example, a worker may be injured on the job. In addition to being responsible for the worker's medical expenses and a certain percentage of earnings (direct costs), the firm may also incur sizeable indirect costs: a machine may be damaged and must be repaired; the assembly line may have to be shut down; costs are incurred in training a new worker to replace the injured worker; and a contract may be cancelled because goods are not shipped on time. By preventing the loss from occurring, both indirect costs and direct costs are reduced.

Second, the social costs of losses must also be considered. For example, assume that the worker in the preceding example dies from the accident. Substantial social costs are incurred because of the death. Society is deprived forever of the goods and services that the deceased worker could have produced. The worker's family loses its share of the worker's earnings and may experience considerable grief and financial insecurity. And the worker may personally experience great pain and suffering before he or she finally dies. In short, these social costs can be reduced through an effective loss control programme.

INSURANCE AND REINSURANCE AS A RISK TRANSFER TECHNIQUES

Insurance and reinsurance are both forms of financial protection which are used to guard against the risk of losses. Losses are guarded against by transferring the risk to another party through the payment of an insurance premium, as an incentive for bearing the risk. Insurance and reinsurance are similar in concept even though they are quite different to each other in terms of how they are used.

Insurance

Insurance is a more commonly known concept that describes the act of guarding against risk. An insured is the party who will seek to obtain an insurance policy while the insurer is the party that shares the risk for a paid price called an insurance premium. The insured can easily obtain an insurance policy for a number of risks. The most common types of insurance policy taken out is a vehicle/auto insurance policy as this is mandated by law in many countries. Other policies include home owner's insurance, renter's insurance, medical insurance, life insurance, liability insurance, etc.

The insured who takes out a vehicle insurance will specify the losses against which he wishes to be insured. This may include repairs to the vehicle in case of an accident, damages to the party who is injured, payment for a rented vehicle until such time the insured's vehicle is fixed, etc. The insurance premium paid will depend upon a number of factors such as the insured's driving record, driver's age, any medical complications of the driver, etc. If the driver has had a reckless driving record he may be charged a higher premium as the probability of loss is higher. On the other hand, if the driver has had no previous accidents then the premium will be lower since the probability of loss is relatively low.

Reinsurance

Re insurance is when an insurance company will guard themselves against the risk of loss. Reinsurance in simpler terms is the insurance that is taken out by an insurance company. Since insurance companies provide protection against the risk of loss, insurance is a very risky business, and it is important that an insurance company has its own protection in place to avoid bankruptcy.

Through a reinsurance scheme, an insurance company is able to bring together or 'pool' its insurance policies and then divide up the risk among a number of insurance providers so that in the event that a large loss occurs

this will be divided up throughout a number of firms, thereby saving the one insurance company from large losses.

Insurance vs Reinsurance

Insurance and reinsurance are similar in concept in that they are both tools that guard against large losses. Insurance, on the one hand, is a protection for the individual, whereas reinsurance is the protection taken out by a large insurance firm to ensure that they survive large losses. The premium that is paid by an individual will be received by the company that provides the insurance whereas the insurance premium paid for reinsurance will be divided among all the insurance companies in the pool that bear the risk of loss.

RECOVERY PLANNING

An organization's disaster recovery plan should identify the people in the organization responsible for recovering data, provide a strategy for how data will be recovered, and document acceptable recovery point and recovery time objectives. It should also include the steps to take in recovering data. A disaster recovery plan (DRP) is a documented process or set of procedures to recover and protect a business IT infrastructure in the event of a disaster. Such a plan, ordinarily documented in written form, specifies procedures an organization is to follow in the event of a disaster.

Disaster recovery and business continuity planning are processes that help organizations prepare for disruptive events – whether an event might be a hurricane or simply a power outage caused by a backhoe in the parking lot. Management's involvement in this process can range from overseeing the plan, to providing input and support, to putting the plan into action during an emergency.

All BC/DR plans need to encompass how employees will communicate, where they will go and how they will keep doing their jobs. The details can vary greatly, depending on the size and scope of a company and the way it does business. For some businesses, issues such as supply chain logistics are most crucial and are the focus on the plan. For others, information technology may play a more pivotal role, and the BC/DR plan may have more of a focus on systems recovery. For example, the plan at one global manufacturing company would restore critical mainframes with vital data at a backup site within four to six days of a disruptive event, obtain a mobile PBX unit with 3,000 telephones within two days, recover the company's 1,000-plus LANs in order of business need, and set up a temporary call center for 100 agents at a nearby training facility.

Risk and Loss Exposure

The four types of loss exposures that small businesses face are: 1) liability loss exposures 2) income loss exposures 3) people loss exposures 4) property loss exposures.

RISK MANAGEMENT CHECKLISTS

Comprehensive risk management refers to a self-control type of risk management based on a comparison of a financial institution's financial strength (capital) and all risks faced by the institution, including risks not counted in the calculation of the capital adequacy ratios (credit concentration risk, interest rate risk in the banking book, etc.) and assessed on a category-by-category basis (credit risk, market risk, operational risk, etc.). The "integrated risk management" is a type of comprehensive risk management based on a comparison of a financial institution's financial strength (capital) and the aggregate of various risks measured with uniform yardsticks such as VaR (value at risk).

On the other hand, a comprehensive risk management method not using this universal-yardstick approach may conduct risk management by, for example, comparing a financial institution's financial strength (capital) and

the overall risk level evaluated as a result of qualitative and quantitative assessments of the risks conducted with various methods according to the risk type. - The development and establishment of the risk management system for a financial institution in its entirety is one of the key elements for ensuring the soundness and appropriateness of the institution's business. The institution's management is charged with and responsible for taking the initiative in the development and establishment of this system by deciding basic corporate management policies (business policies), determining strategic objectives based on these policies and developing an organizational framework for securing the effectiveness of the function of managing risks for the whole of the institution in a comprehensive manner.

RESERVING

The financial condition of an insurance company cannot be adequately assessed without sound loss reserve estimates sufficient to meet any outstanding liabilities at any point of time. The estimation process involves not only complex technical tasks but considerable judgment as well. It is important for the insurance company to understand the data before embarking on the task of estimating loss reserve which has a significant impact on the financial strength and stability of the company.

The general insurance companies apart from the general reserves maintain a number of technical reserves which can be divided into following six categories, namely, unearned premium reserves (UPR), unexpired risk reserve (URR), unexpired risk reserve (URR), outstanding claims reserve (OCR), incurred but not reported reserves (IBNR), catastrophe reserves, and claims equalization reserves. A brief explanation of each of these reserves along with their significance has been given as follows;

A. Unearned premium reserves (UPR)

Unearned premium reserves is the proportion of premiums received which relates to the future period. It is assumed that the risk is uniform over the duration of the policy and the liability arising out of the risk can be met by reserving a pro rata amount of the balance of the premium after deducting initial expenses. In the circumstances of high inflation, changes in expenses and widely fluctuating claims ratio; the expected claims liability under the unexpired risks can differ significantly from the UPR provision. If the UPR is regarded as inadequate, an additional reserve is necessary. The insurer therefore needs to create extra reserve to offset the shortfalls in the UPR by creating an additional unexpired risk reserve (or AURR).

B. Unexpired risk reserve (URR)

Unexpired risk reserve is created by the insurer to manage the risk arising out of the non receipt of future premiums. It is estimated by multiplying with the unearned premiums the ratio of the claims incurred in the year to the premiums earned in the same year. The unearned premiums also allows for inflation and changes in experience in the various risk groups and their relative proportion of the total premium. Over and above, a prudent fluctuation margin may be added to the above to minimize the impact of errors associated with the estimation process.

C. Outstanding claims reserve (OCR)

OCR is maintained by the general insurance companies to meet the outstanding liability for claims which have already been reported and not settled. The commonly used method to estimate OCR is to obtain estimates in respect of all outstanding claims on an accounting date after taking into consideration the following:

- i. The certainty of the claim;
- ii. The likely time needed to complete settlements;

- iii. The rate of inflation on claims costs between the accounting date and the date of settlements; and
- iv. The judicial trends in claims settlements.

D. Incurred but not reported reserves (IBNR)

The IBNR reserve is the estimated liabilities for the unknown claims arising out of incidents occurred prior to the year end but have not been notified to the company during the accounting period. In practice, the provision for future development on known claims, which is called as incurred but not enough reserved (IBNER) is included in IBNR. The average cost of an IBNR claim often differs from that of currently reported claims. The insurance companies hence develop the ratio of average cost of an IBNR claim to average cost of reported claims, for different classes of business on the basis of historical data in order to measure the effectiveness of the IBNR reserves.

E. Catastrophe reserves

The catastrophe reserves are created to meet any unprecedented and/or uncontrollable risk factor affecting the insurer. These reserves are created out of taxed income after taking into account the operating position and the effect of provision upon the presentation of its results. Catastrophe reserve in the long run equates the accumulated catastrophe loadings in premiums without impacting the financial stability of the insurer.

F. Claims equalization reserves

Claims equalization reserves are made to smooth out the effects of year to year fluctuations in the incidence of larger claims such as the unusual floods in Mumbai in 2005 and in Surat in 2006. The provision is created based on past experience of the frequency of claims and the 'probability density function' of this risk. Claims equalization reserve is not created to meet an inevitable liability.

Reserving provisions and IRDA

The IRDA emphasizes on uniformity in method of reserve estimations wherever sufficient data is available. Besides, standard reporting formats have been devised to analyze current year's transactions and to build up cumulative data for the amounts and number of claims settled. IRDA further emphasizes on collecting all relevant information for each class of business from all insurers so that the consolidated industry data can be used for reserving purposes for those classes where availability of data is insufficient.

LESSON ROUND-UP

- The study was developed to identify the risks to which the insured and the insurer are subject to, especially in India and the mechanism through which these risk complexions are effectively managed. The study reveals that both the insured and the insurer in India generally face risks ranging from financial to non financial in nature. The financial risks for both of them are classified as capital risk, asset/liability management risk, insurance risk and credit risk, whereas the non financial risk include enterprise risk and operational risk. The capital risk includes capital structure risk and capital (in) adequacy risk. Whereas the asset liability management risk includes exchange risk, interest rate risk and investment risk. Similarly the insurance risk includes underwriting risk, catastrophe risk, reserve risk, claims management risk and the credit risk includes reinsurance risk, policy holders and broker's risks, claims recovery risk and other debtor's risk. In the same manner the enterprise risk includes reputation risk, parent risk, competitors risk and the operational risk includes regulatory

risk, business continuity risk, IT obsolescence risk, process risk, regulatory compliance risk and outsourcing risk. The risk management mechanism found prevalent in the general insurance industry for the insured are in the form of enterprise risk management comprising of planning, risk tracking and reporting, implementation, tools and risk management. Whereas for the insurer it is in the form of risk based capital management and reserving, with the former consisting of management role, capital and solvency margins, and risk based capital and the later consisting of unearned premium reserves, unexpired risk reserves, outstanding claim reserves, incurred but not reported reserves, catastrophe reserves and claims equalization reserve.

GLOSSARY

- **CRO:** Chief Risk Officer
- **CFO:** Chief Finance Officer
- **CEO:** Chief Executive Officer
- **AA:** Appointed Actuary
- **AC:** Audit Committee
- **RC:** Risk Committee
- **ALM:** Asset-Liability Management
- **ORSA:** Own Risk & Solvency Assessment
- **UPR:** Unearned Premium Reserves
- **URR:** Unexpired Risk Reserve
- **URR:** Unexpired Risk Reserve
- **OCR:** Outstanding Claims Reserve
- **IBNR:** Incurred But Not Reported Reserves
- **AURR:** Additional Unexpired Risk Reserve

SELF TEST QUESTIONS

1. Define risk.
2. What are the different types of perils?
3. Distinguish between Moral and Morale hazard.
4. What are various sources of risk?
5. Distinguish between Pure Risks & Speculative risks.
6. Explain various risk assumption.

Further Readings

1. Principles of Risk Management and Insurance by George E. Rejda (Published by Pearson Education Asia)

Lesson 16

Corporate Governance for Insurance Companies

LESSON OUTLINE

- Principles of Corporate Governance
- Constitution of Board of Directors
- Broad tasks of Board of Directors
- Control Functions to be exercised by board
- Formation of different mandatory committee and their function
- Disclosures requirement
- Outsourcing policy guideline
- Relationship with stakeholders
- Reporting to IRDAI for compliance
- LESSON ROUND UP
- SELF TEST QUESTIONS

LEARNING OBJECTIVES

Corporate Governance is understood as a system of financial and other controls in a corporate entity and broadly defines the relationship between the Board of Directors, senior management and shareholders. In case of the financial sector, where the entities accept public liabilities for fulfillment of certain contracts, the relationship is fiduciary with enhanced responsibility to protect the interests of all stakeholders. The Corporate Governance framework should clearly define the roles and responsibilities and accountability within an organization with built-in checks and balances.

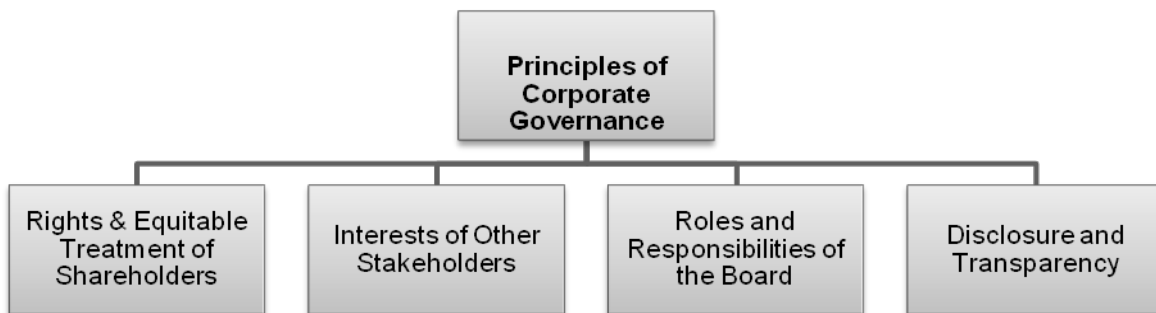
The importance of Corporate Governance has received emphasis in recent times since poor governance and weak internal controls have been associated with major corporate failures. It has also been appreciated that the financial sector needs to have a more intensive governance structure in view of its role in the economic development and since the safety and financial strength of the institutions are critical for the overall strength of the financial sector on which the economic growth is built upon.

In this chapter we will study about corporate governance and ethical practices in insurance companies.

INTRODUCTION

Corporate Governance may be defined as a set of systems, processes and principles which, while enabling conduct of business within the applicable regulatory norms, ensure that a company is governed in the best interest of all stakeholders. It is the system by which companies are directed and controlled. It is about promoting corporate fairness, transparency and accountability. Corporate Governance involves regulatory and market mechanisms and the roles and relationships between a company's management, its board, its shareholders and other stakeholders and the goals for which the Company is governed.

PRINCIPLES OF CORPORATE GOVERNANCE



- (a) **Rights and equitable treatment of shareholders** – Companies must encourage values and systems that respect rights of shareholders and help shareholders exercise those rights. Communicating the rights and encouraging shareholders to participate in meetings is very important
- (b) **Interests of other stakeholders** – Other stakeholders include Customers, Employees, Investors, Creditors, Distributors, Suppliers, Regulators, Communities, Policy makers etc. The Governance must ensure that the Company grows after taking care of the interests of the stakeholders
- (c) **Roles and responsibilities of the Board** – The Board needs to be segregated from the management and the roles and responsibilities of the members of the management team including the CEO must be clearly defined. Management must be required to be accountable to the Board who must monitor their performance. While management runs the Company, the Board oversees it. The Board must have qualified and competent persons to evaluate the management performance
- (d) **Disclosure and transparency** – this is a cardinal principle of Corporate governance and includes public disclosures as appropriate, internal communications, other external communications etc. Such a disclosure mechanism must enable all stakeholders to take an informed decision

Provisions promoting Corporate Governance under the Companies Act, 2013

Let us discuss the provisions regarding Corporate Governance enshrined in the Companies Act, 2013:

Provisions relating to Directors

[Independent Directors (Section 149(4))]

An independent director is defined as a person who does not have any pecuniary relationship with the Company or is not related to the promoters or managerial persons and has not been an executive of the Company during the preceding 3 financial years or is not a partner or executive during the preceding 3 years with any statutory or audit firm or a legal and consulting firm which renders services to the Company or is not a material supplier

or a person holding equity shares of 2% or more in the company. Independence of the Board promotes good corporate governance. The Companies Act, 2013 has included another qualification criteria – the independent director should not have been a CEO or Director of a non-profit organisation which derives at least 25% of its income from the Company or CEO or Director of a non-profit organisation holding more than 2% in the Company in which the director acts as an independent director. An independent director shall hold office for a period of 5 years and is eligible for being appointed for one more term of 5 years, after which a cooling off period of 3 years has been prescribed.

Section 149 mandates that at least 1/3rd of the Directors of listed public companies to be independent directors. As per SEBI's Listing and Disclosure Obligations Regulations (applicable for companies listed in any Stock Exchange), where Chairman of the Board is non-executive, at least 1/3rd of the Board shall comprise of independent directors, and at least ½ where the Chairman of the Board is an Executive Director.

Independent Directors remove conflicts and bias in decision making, since they are not related to Promoters or do not have any material interest in the Company. Schedule IV of the Companies Act, 2013 lays down the Code of conduct for Independent Directors, including guidelines for professional conduct, their roles, functions, duties and responsibilities.

Directors representing small shareholders (Section 151)

In order to promote the interests of small shareholders, listed companies may have one Director on the Board appointed by shareholders holding share not valued more than Rs.20,000 or such sum as may be prescribed. This step promotes interests of smaller stakeholders.

Restrictions on number of directorships (Section 165)

Number of Companies in which a person can act as Directors not to exceed 20, out of which not more than 10 can be Public companies. As per section 25(1) of the SEBI (Listing Obligations and Disclosure Requirements) Regulations, a person shall not serve as an independent director in more than seven listed entities. However, any person who is serving as a whole-time director in any listed entity shall serve as an independent director in not more than three listed entities.

Disclosures of interests by Directors (Section 184)

The section requires Directors to disclose their interests in any contract or arrangement which the Company proposes to enter into. Further the Director is required to stay away from the discussions happening in the Board meetings and cannot participate in any voting which happens in the meetings on such matters. This has to be specifically recorded in the Minutes. A Director is deemed to be interested in an entity with whom the Company enters into an arrangement or a Contract, if such Director or groups of directors hold not less than 2% equity in such an entity. Register of Contracts in which Directors are interested to be kept open during Annual General meeting for inspection by the Shareholders. Non disclosure of interest by Directors does not render the contract void. It renders the contract voidable at the instance of the company and makes the director accountable for any secret profit which he has made (*Hely Hutchinson vs. Brayhead Limited* (1968) 1 Comp L J 263).

Loans to Directors (Section 185)

Companies are prohibited in granting loans to Directors directly or indirectly to any person in whom the director is interested. Even providing guarantees for loans taken by Directors is prohibited. However granting of Loans to Whole-time Directors as per Scheme applicable to all employees or after getting approval from Shareholders is allowed. Similarly, granting of loan to its Director which is engaged in the business of giving loans to any

Customer is allowed and the interest charged is not less than the Bank rate. This is aimed at promoting financial discipline.

Related party transactions (Section 188)

All related party transactions, including appointment of related parties of Directors to any office or place or profit in the Company) require the approval of Audit Committee under section 177. However, where the related party transactions are not in the ordinary course of business or not at arms' length, approval of Board of Directors is also required. In certain cases, Shareholders approval also required (shareholders who are interested in the related party transaction not to participate in the discussion or voting).

Register of Contracts in which directors are interested (Section 189) and Contract of employment with Whole time or Managing Director (Section 190) required to be kept open for inspection by the Shareholders– This promotes greater transparency in the appointment of the key managerial person. The Shareholders may question where the terms of appointment as per the Contract are different from the terms approved by the Shareholders in their resolution.

Restrictions on non-cash transactions involving directors (Section 192)

Where any transaction is proposed to be entered into with a Director of the Company or Director of the Holding Company or Director of the Subsidiary Company for purchase of assets or sale of assets for consideration other than cash, approval of the shareholders of the Company as well as the concerned Holding or Subsidiary company shall be obtained.

Prohibition in Insider trading (Section 195) and forward dealings in securities by Directors or Key management personnel (Section 194) – The Companies Act 2013 has also introduced provisions restricting Insider Trading by Directors and Employee of the Company who are privy to price sensitive insider information and dealing in shares and securities of the Company based on such information. Further, in order to prohibit unhealthy forward trading in shares by insiders, Directors and key management personnel are prohibited from engaging in forward contracts to buy or sell the securities of the Company, as such transactions could also be based price sensitive insider information.

Provisions relating to appointment and remuneration of Whole-time and Managing Director (Section 196)

Companies Act 2013 contains provisions for qualifications, appointment, remuneration, removal etc. of the Managing Director and Whole-time Directors. Approval of Shareholders required in certain cases. This promotes transparency in the appointment and remuneration of the key managerial person. Ceiling on managerial remuneration is calculated as a percentage of the company's profits.

Prevention of Oppression and mismanagement (Section 241)

On the basis of complaint by a shareholder of the Company that the affairs of a Company are carried on in a manner prejudicial or oppressive to interests of shareholders, the National Company Law Tribunal may investigate and take appropriate action as it deems fit. The Companies Act 2013 also recognises Class action by Shareholders or Depositors of the Company if the Company's acts are prejudicial to their interests. The petition for class action before the Tribunal can seek for restraining the company from committing any act which is *ultra vires* the company or desist the company from taking any action based on a resolution which was based on irregular facts. This is another step towards promoting corporate democracy.

Provisions Concerning Holding of Meetings

Procedure for adjournment of meetings (Section 103 read with Clause 49 of Table F- Articles of Association) – One of the pillars of Corporate democracy is proper conduct of meetings and rules relating thereto. Detailed procedures laid down for adjournment of meetings.

In respect of Shareholders' meetings and Board meetings, if a quorum (minimum number of members required to be present) is not present within half an hour of the scheduled time for commencement, the meeting stands adjourned to the same time the following week at the same place or at such other place the Board may decide. In the adjourned shareholders' meeting, if the quorum is not present, the members present shall be the quorum. In adjourned Board meetings also if there is no quorum, the Board meeting shall decide the dates of further adjourned Board meeting(s).

Chairperson may also adjourn a meeting after it is convened if the time was insufficient to complete the agenda items. However, no business shall be transacted at any adjourned meeting other than the business left unfinished at the meeting from which the adjournment took place. When a meeting is adjourned for thirty days or more, notice of the adjourned meeting shall be given as in the case of an original meeting.

Procedures for assessing the sense of the meeting (Sections 107 to 110)

Details procedures laid down for voting by show of hands, polls etc. with the role of Chairman to ensure that the decisions are taken properly at the Shareholders' meetings. Persons holding share capital representing not less than 1/10th of the total voting power on which an aggregate sum of Rs.5 lakhs has been paid, can demand a poll

Maintenance of records of proceedings of Shareholders meetings, Boards and the Board Committees (Section 118)

The Act requires drawing up of Minutes of meetings of Shareholders, Board of Directors and the Board Committees to be drawn within 30 days, signed by the Chairman and preserved for future reference. The Minutes of Shareholders meetings are open for inspection by any Shareholder.

Detailed financial statements to form part of the Agenda papers for the Annual General meeting (Sections 129 & 134)

The Financial statement of accounts with Schedules forms part of the Agenda for the Annual General meeting. Extensive disclosures are required to be made. Details of employees drawing remuneration in excess of the percentages specified, the Company's spend towards conservation of energy, foreign exchange outflow, technological absorption etc. need to be disclosed along with Directors' Annual Report. The said Report shall contain a Directors' Responsibility Statement on the true and fair representation of the financial position of the Company.

Corporate Social Responsibility (Section 135)

Companies Act 2013 has mandated constitution of a Corporate Social Responsibility ('CSR') Committee of Directors by Companies having a Net profit of Rs.5 Crore or a Networth of Rs.500 Crores or a Turnover of `1,000 Crores in a financial year. This Committee will decide on the expenditure of Companies for CSR activities (not less than 2% of average net profits for preceding 3 financial years) and monitor the implementation of the CSR programme. This initiative is aimed at making business "sustainable and responsible" and looking beyond profits as the sole purpose of business.

Internal Audit and Statutory Audit & Audit Committee

Requirement of internal audit (Section 138) for certain classes of companies, appointment of Internal Auditor has been mandated.

Requirement of Statutory audit (Section 139)

This section prescribes requirement for mandatory Statutory audit of all Companies once a year, provisions relating to appointment, qualifications and disqualifications of auditors, provisions relating to tenure and rotation of Auditors etc. In order to remove conflict, no audit firm having a common partner or partners to the other audit firm, whose tenure has expired in a company immediately preceding the financial year, shall be appointed as auditor of the same company for a period of five years. Further the Act also prohibits the statutory auditors from having any other pecuniary relationship with the Company of which they are acting as statutory auditors. IRDAI have framed separate guidelines for appointment of statutory auditors for Insurance companies.

Audit Committee and Nomination and Remuneration Committee (Section 177& 178)

Every listed company and such other companies as may be prescribed shall have an audit committee comprising of minimum three directors with independent directors forming a majority of the Committee. Audit Committee to oversee appointment of statutory and internal auditors, review of financial statements, evaluation of financial controls and risk management systems and monitoring end use of funds. Further, section 178 of the Companies Act 2013 also requires constitution of Nomination and Remuneration Committee to recommend appointment of Directors and Key Managerial Personnel and their remuneration to Board of Directors for their approval.

Miscellaneous rights of Shareholders

Rights to inspect Register of Members (Shareholders) and Register of Directors (Section 94) with their shareholdings and taking copies thereof.

Right to call for Extraordinary General meeting (Section 100) on the requisition of members holding atleast 1/10th of the voting rights.

Agenda for Shareholders meeting to contain disclosure of interests of Directors (Section 102)

key management personnel and their relatives in matters to be moved in the General meeting and the entities with which the Company proposes to enter into a contract and in which entity any of the directors or their key management personnel hold not less than 2% equity stake.

Corporate Governance in Insurance

IRDA's Corporate Governance guidelines are applicable to Insurance companies in addition to the applicable provisions of the Companies Act, 2013 and norms as applicable to a listed company. Wherever there is a conflict, the provisions as per IRDAI's Corporate Governance guidelines shall prevail. Some of the important requirements under Corporate Governance guidelines are summarised below.

In order to promote diversity and inclusion, section 149, read with the Companies (Appointment & Qualification of Directors) Rules 2014, requires Board of Directors of every Company listed Company as well as Public Companies with a Capital of at least Rs.100 Crores or Turnover of at least Rs.300 Crores, to have at least 1 Woman Director. Since, as per Insurance Act, 1938, all Insurance companies are required to be Public Limited Companies with a minimum paid up Share capital of Rs.100 Crores, this requirement becomes mandatory for all Insurance Companies.

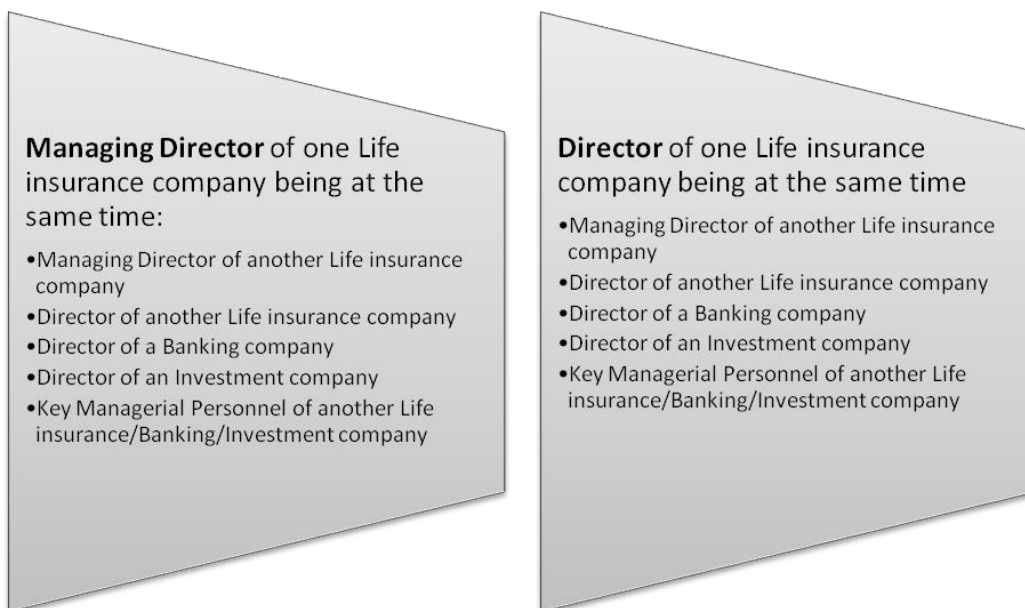
Conflicts of Interest

Auditors, Directors, Actuaries and other key managerial personnel are prohibited from holding positions which are conflicting with each other. This is to ensure that the business decisions are taken without any bias. For example, the Appointed Actuary cannot take responsibilities of Claims function, since Appointed Actuary is required to evaluate the impact of the variance between with actual and expected claims and the impact on the Company. Similarly the Statutory auditors of the Company cannot have any other contract with pecuniary interest in the Company, as this could conflict with rendering the audit services.

Section 48A of Insurance Act, 1938, prohibits interlocking directorships between an insurance company and Insurance intermediary, without prior approval of IRDAI. The word Insurance intermediary includes Distributors in Insurance such as Corporate Agents, Insurance Brokers, Web Aggregators, Insurance Marketing Firms etc. Similarly Insurance Agents are prohibited from becoming directors of insurance companies without prior approval of IRDAI. Approval may be granted by IRDAI, subject to such conditions IRDAI may impose to avoid conflicts of interest or to protect interests of Policyholders. For example, if the Director of the Insurance company is only an Independent director on the Board of the insurance company or on the Board of the Insurance intermediary, approval may be granted, as the chances of conflicts of interest is low in such cases.

Section 48B provides that a Director of a Life insurance company shall not be a Director of another life insurance company.

Further under the provisions of section 32A of Insurance Act, 1938 the following common directorships are prohibited:



The exception to the above Rule is where IRDAI permits the above interlocking directorships in the context of amalgamations or transfer of one life insurance business to another.

However, there are no such prohibitions for non-life or standalone Health insurance or Reinsurance companies.

Independence of the Board

While the Guidelines expect the board to be broad-based and have independent directors in line with Clause 49 of the Listing Agreement, till such time the insurance companies are listed, a minimum of 3 independent directors

have been advised, except for the first 5 years of operations of an insurer during which period 2 independent directors may be appointed. Chief Executive Officer shall be a member of the Board if the Chairman of the Board is non-executive, i.e. is not an employee of the Company.

In addition, the composition of the Board and conduct of the meetings be in compliance with provisions of IRDAI Guidelines on Indian Owned and Controlled.

Board of Directors

The Board has been given the responsibility of giving overall direction for the business of insurer, addressing conflicts of interests, ensuring overall compliance, fair treatment of policyholders and employees and developing a corporate culture.

Fit & Proper criteria and Deed of Covenants to be signed by Directors

While Insurance Act prohibits common directorships between Insurance companies and Insurance Intermediaries, the guidelines also expect the incumbent to have a clean track record and a declaration is required to be taken from the Director before his appointment. This declaration has to be renewed on an yearly basis. In order to ensure that there are no gaps in understanding the roles and responsibilities, the Guidelines also requires every Director to sign a Deed of Covenant with the company.

Constitution of Committees

The following Committees of Directors are mandatory for an insurance company:

- (a) Investment Committee (formed under the Investment Regulations)
- (b) Audit Committee
- (c) Risk Management Committee
- (d) Policyholders Protection Committee
- (e) Nomination and Remuneration Committee
- (f) Corporate Social Responsibility Committee (as per provisions of Companies Act, 2013 and Rules thereunder)
- (g) 'With Profits Committee' for Life insurance companies

The non-mandatory Committees (optional) are Asset Liability Management Committee and Ethics Committee

Investment Committee shall comprise of a minimum of 2 non-executive directors, Chief Investment Officer, Chief Financial Officer, Chief Risk Officer and Appointed Actuary to oversee the performance of the Investment function of the Company. The Committee shall be responsible for laying down an overall investment policy and operational framework for the investment operations of the insurer. The investment policy and operational framework is recommended by the Committee to the Board for approval and is also responsible for a period review of the investment policy in line with the market changes. The Committee shall be responsible to recommend investment policy and lay down the operational framework for the investment operations of the insurer, including Stewardship Code in accordance with the guidelines issued by IRDAI. The policy should focus on a prudential Asset Liability Management (ALM) supported by robust internal control systems.

The investment policy and operational framework should, inter alia, encompass aspects concerning liquidity for smooth operations, compliance with prudential regulatory norms on investments, risk management / mitigation strategies to ensure commensurate yield on investments and above all protection of policyholders' funds.

Members of the Committee are expected to familiarise themselves and be conversant with the various Acts, Rules, Regulations, Guidelines, Circulars, etc., issued by the Authority as amended from time to time.

For assessment of credit risk and market risk, the members of the Committee should not be influenced only by the credit rating. The committee should independently review their investment decisions and ensure that support by the internal due diligence process is an input in making appropriate investment decisions.

The Committee shall formulate an effective reporting system to ensure compliance with the Policy set out by it apart from Internal /Concurrent Audit mechanisms for a sustained and ongoing monitoring of Investment Operations.

The Committee shall meet at least once in a quarter to review investment operations and submit a report to the Board on the performance of the investment portfolio with regard to its safety and soundness.

Audit Committee is primarily responsible for periodic review of financial statements, atleast once in a quarter. Further the Committee is also responsible for overseeing the process controls. The Committee also oversees the performance of the internal audit function. Further the terms of appointment and remuneration of any Statutory auditors and Concurrent auditors are reviewed by this Committee and recommended to the Board for approval. The Chairman of Audit Committee may be a Chartered Accountant or a person with strong financial background and shall be financially literate and an Independent Director. CEO shall not be a member of this Committee. Majority of members of the Audit Committee shall comprise of Independent directors. Any other work allocated to statutory auditor shall be specifically approved by the Audit committee subject to provisions of section 144 of Companies Act, 2013.

Risk Management Committee oversees the overall risk management function of the Company. The Chief Risk Officer of the Company shall be responsible for risk management and attends the meetings of the Committee. This Committee reviews risk registers prepared by the concerned functions with the help of CRO and the status of action plans to mitigate the risks. In particular, following are the specific deliverables of the Risk Management Committee:

- Establish effective Risk Management framework and recommend to the Board the Risk Management policy and processes for the organization.
- Set the risk tolerance limits and assess the cost and benefits associated with risk exposure.
- Review the Company's risk-reward performance to align with overall policy objectives.
- Discuss and consider best practices in risk management in the market and advise the Respective functions.
- Assist the Board in effective operation of the risk management system by performing Specialised analyses and quality reviews.
- Maintain an aggregated view on the risk profile of the Company for all categories of risk. Including insurance risk, market risk, credit risk, liquidity risk, operational risk, compliance risk, legal risk, reputation risk, etc.
- Advise the Board with regard to risk management decisions in relation to strategic and operational matters such as corporate strategy, mergers and acquisitions and related matters.
- Report to the Board, details on the risk exposures and the actions taken to manage the

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- Exposures; review, monitor and challenge where necessary, risks undertaken by the Company.
- Review the solvency position of the Company on a regular basis.
- Monitor and review regular updates on business continuity.
- Formulation of a Fraud monitoring policy and framework for approval by the Board.
- Monitor implementation of Anti-fraud policy for effective deterrence, prevention, detection and mitigation of frauds.
- Review compliance with the IRDAI guidelines on Insurance Fraud Monitoring Framework for insurance companies.

Policyholders Protection Committee is responsible for overseeing the interests of Policyholders of the Company. Such Committee shall be headed by a Non-Executive Director and shall include an expert/representative of customers as an invitee to enable insurers to formulate policies and assess compliance thereof. The general agenda items include review of Customer complaints, claims performance of the Company, review of Unclaimed amounts, Review of Awards passed by Insurance Ombudsmen, Review of other Policyholder Servicing payouts like maturity benefit, loans, surrender processing etc. The Committee is expected to adopt standard operating procedures for treating the customer fairly and establish an effective mechanism to address customer grievances. Further, any Ombudsmen award not implemented by the insurer for more than 3 months by the Company shall specifically be reviewed.

Asset Liability Management ('ALM') Committee (optional) is responsible for reviewing the asset liability management position and strategy of the Company and advise the company appropriately. Since this is an optional committee, some insurance companies have included this item in Board Investment Committee or Risk management Committee. Asset Liability Management is an ongoing process of formulating, implementing, monitoring and revising strategies related to assets and liabilities to achieve an organisation's financial objectives, given the organisation's risk appetite, risk tolerances and business profile. ALM lays down the framework to ensure that the insurer invests in a manner which would enable it to meet its cash flow needs and capital requirements at a future date to mitigate liquidity risk and solvency stipulations.

The functions of the ALM Committee (wherever constituted) shall include:

- Setting the insurer's risk/reward objectives and assessing policyholder expectations;
- Quantifying the level of risk exposure (eg. market, credit and liquidity) and assessing the expected rewards and costs associated with the risk exposure;
- Formulating and implementing optimal ALM strategies and meeting risk-reward objectives at both product and enterprise level;
- Ensuring that liabilities are backed by appropriate assets and manage mismatches between assets and liabilities to ensure they remain within acceptable monitored tolerances for liquidity, solvency and the risk profile of the entity;
- Monitoring risk exposures at periodic intervals and revising ALM strategies where required;
- Reviewing, approving and monitoring systems, controls and reporting used to manage balance sheet risks including any mitigation strategies;
- Regular review and monitoring of mismatch between assets and liabilities and the acceptable tolerance limits for mismatch, if any;

- Ensuring that management and valuation of all assets and liabilities comply with standards, prevailing legislation and internal and external reporting requirements;
- Submitting the ALM information before the Board at periodic intervals. Annual review of strategic asset allocation;
- Reviewing key methodologies and assumptions including actuarial assumptions, used to value assets and liabilities;
- Managing capital requirements at the company level using the regulatory solvency Requirements; and
- Reviewing, approving and monitoring capital plans and related decisions over capital transactions (e.g. dividend payments, acquisitions, disposals, etc).

Where an insurer does not constitute the Asset Liability Management (ALM) Committee, the functions of ALM shall form part of the Risk Management Committee.

Nomination and Remuneration Committee shall comprise of at least 3 Non-executive Directors, with at least 50% as independent directors. Chairman of the Nomination and Remuneration Committee shall be an Independent Director. Nomination and Remuneration Committee is responsible for evaluation of the candidates for the post of Chief Executive Officer or Managing director and certain other key position.

A 'fit and proper' declaration is required to be taken from all candidates proposed to be appointed as a Director and a due diligence is conducted to determine their suitability for appointment as Director. Further, due diligence is also conducted for Key Managerial Personnel and members of the core management team of the Company. The appointment of Managing Director & CEO is made by Board of Directors, subject to approval by IRDAI under section 34A of Insurance Act, 1938. Approval from Central Government or adherence to Schedule on limits to managerial remuneration under Companies Act, 2013 are not applicable for remuneration for Managing Director & CEO or Insurance companies, which is subject to approval of IRDAI under section 34A. Therefore, Nomination and Remuneration committee is responsible for recommending the remuneration for Chief Executive Officer or Managing Director for approval by the Board, subject to approval of IRDAI. Every Director who is appointed by the Board is required to execute a 'Deed of Covenants' with the Insurance company. This Deed gives the duties, responsibilities, and obligations etc. of the Director of an Insurance company. Evaluation of Directors is required to be conducted as per Schedule IV of Companies Act, 2013 and the results shall be reviewed by the Nomination and Remuneration Committee.

The responsibility of Ethics Committee includes monitoring compliance programs of the company, acting as a channel for whistleblower complaints, advising the effectiveness of the compliance structure etc. The functions and responsibilities of the Ethics Committee shall include:

- Monitoring the compliance function and the insurance company's risk profile in respect of compliance with external laws and regulations and internal policies, including its code of ethics or conduct.
- Receiving reports on the above and on proactive compliance activities aimed at increasing the insurance company's ability to meet its legal and ethical obligations, on identified weaknesses, lapses, breaches or violations and the controls and other measures in place to help detect and address them.
- Supervising and monitoring matters reported using the insurer's whistle blowing or other
- confidential mechanisms for employees and others to report ethical and compliance concerns or potential breaches or violations.
- Advising the board on the effect of the above on the insurer's conduct of business and helping the board set the

correct “tone at the top” by communicating, or supporting the communication, at all levels of the insurer of the importance of ethics and compliance.

- Approving compliance programmes, reviewing their effectiveness on a regular basis and signing off on any material compliance issues or matters.

Corporate Social Responsibility Committee is mandated as per section 135 of the Companies Act, 2013. The roles and responsibilities of the Committee are prescribed in the said section. IRDAI have clarified that this Committee is required to be constituted only by Insurers who are earning profits.

‘With Profits’ Committee is unique to Life insurance companies. Under Participating line of business for Life insurance companies, Policyholders are entitled to a Bonus which may be declared depending on the surplus that emerges from this line of business. Out of the surplus, not less than 90% shall be distributed to Policyholders as bonus and the balance 10% goes to Shareholders. In order to ensure transparency and governance over the distribution of surplus, Regulation 45(d) of IRDAI (Non-linked Products) Regulations, 2013 have prescribed constitution of a ‘With Profits’ Committee comprising of the following members:

- CEO
- Appointed actuary
- 1 Independent Director
- 1 Independent Actuary

The Committee is responsible for the following:

- Examining detailed working of the asset share (share of assets for participating business) at the Policy level
- Expenses allocated to Participating business
- Investment income earned in Participating business

Since the surplus emerging in Participating business (out of which at least 90% goes to Policyholders) is dependent upon correct allocation of expenses and correct booking of investment income, this Committee is responsible for overseeing this process.

All mandatory committees shall meet 4 times in a year and not more than 4 months shall elapse between two meetings.

Role of Appointed Actuary

The Guidelines also lay down the role of an Appointed Actuary. He shall also fulfill the ‘fit and proper’ criteria and accordingly confirm that he is ‘fit and proper’ in writing to the insurer before he is appointed. He has the responsibility of informing the Board of any non-compliance or a likely non-compliance within his knowledge. In case he feels the Board does not take any action, he has to inform IRDA. The Appointed Actuary is expected to provide expert or technical advice to the management on matters such as solvency margin requirements, financial condition testing, identification of material risks and management etc.

Statutory auditors

The firm of statutory auditors of insurance companies will have to possess a track record of at least 15 years. One of the partners must have a qualification on Systems Audit. A cooling off period of 3 years is given between 2 audit tenures with the same insurer. Further one statutory auditor cannot work with more than 2 insurance companies at a time.

Disclosure requirements

The following disclosure requirements have been prescribed along with annual financial statements:

- (a) Quantitative and qualitative information on the insurer's financial and operating ratios, namely, incurred claim, commission and expenses ratios
- (b) Actual solvency margin details vis-à-vis the required margin
- (c) Policy lapse ratio for life insurers
- (d) Financial performance including growth rate and current financial position of the insurer
- (e) Description of the risk management architecture
- (f) Details of number of claims intimated, disposed of and pending with details of duration
- (g) All pecuniary relationships or transactions of the Non-Executive Directors vis-à-vis the insurer
- (h) Details of the board composition
- (i) Number of meetings of the Board and committees held during the year and the details of directors who attended
- (j) Details of remuneration paid to Independent directors
- (k) Any other matters, which have material impact on the insurer's financial position.

Extensive guidelines on Disclosure norms in websites of insurance companies and Outsourcing by insurance companies have been released by IRDA.

Whistleblower Policy

The guidelines also require insurers to have a Whistleblower policy in place. This is intended to act as a mechanism to promote voluntary reporting of possible frauds and non-compliances. The whistleblower can remain anonymous, if he wishes to.

Key Management Persons Guidelines

The definition of Key Management Persons ('KMP') under these Guidelines are different from the definition of Key Managerial Personnel under Companies Act, 2013. While under Companies Act, 2013, Managing Director, Chief Financial Officer and Company Secretary are defined as Key Managerial Personnel, IRDAI guidelines define KMPs are as follows:

Key Management Person" means members of the core management team of an insurer including all whole-time directors/ Managing Directors/ CEO and the functional heads one level below the MD/CEO, including the CFO, Appointed Actuary, Chief Investment Officer, Chief Risk Officer, Chief Compliance Officer and the Company Secretary.

Explanation: The nomenclature or designations used in the above definition are only illustrative and shall be appropriately mapped to the respective functions of the Insurers while reporting information under these guidelines, wherever, necessary.

With regard to the appointment and in order to ensure that all positions of "Key Management Persons" are adequately and totally manned, the Guidelines provide further as follows:

- Appointment of MD/CEO/Whole-time Director and Appointed Actuary shall be governed by the

provisions of the Insurance Act, 1938 and Regulations made thereunder.

- Appointment or termination of all such key management persons shall be made with the approval of Board of Directors on recommendation of the Nomination and Remuneration Committee. Before appointment of a person as a KMP, the Board or Committee thereof shall carry out due diligence to ensure that the appointee is “fit and proper” for the proposed position. Insurers shall obtain declaration in Form KMP-1 prescribed under these guidelines from the proposed KMP prior to their consideration for appointment.
- Insurers shall ensure that no single individual is simultaneously holding more than one position of Key Management Person that may have potential conflict of interest. Where a person is going to have two or more positions of Key Management Person simultaneously, insurer shall furnish a note highlighting the reasons for such appointment, to the Authority prior to such dual/ multiple appointments.
- All insurers are required to obtain and maintain the particulars of their respective ‘Key Management Persons’ in the format ‘Form - KMP–1’, separately for each key person, as and when there is an appointment/ change in the individual person holding the position of Key management Person. Intimation of appointment/reappointment/ change of any KMP shall be filed with the Authority within 30 days from the date of new person taking over the position of ‘Key Management Person’.
- Insurers shall within a period of 30 days notify the Authority in the event of any position of ‘key Management person’ falling vacant, with the details of the person who will officiate in that position.
- In the event of vacancy in the office of any Key Management Person, insurers shall initiate action for filling up of such vacant positions on a priority basis. At no point of time the position of any ‘Key Management Person’ shall remain vacant for a continuous period of more than 180 days.
- Names and designations of all the ‘Key Management Persons’ shall be disclosed on their respective websites by all Insurers.
- Chief Compliance Officer shall be the designated Compliance Officer for submitting returns, reports and applications for approvals to the Authority.
- Notwithstanding the above provisions, in order to develop the accountable organisational reporting structures, it shall be ensured that any information that is called for by the Authority, shall be submitted only by the concerned ‘Key Management Person’. The Board of the Insurer or Committee thereof may also delegate the powers to any of the ‘Key Management Person’ for submitting such information to the Authority.
- Every Insurer shall submit an annual compliance certificate or declaration as a part of the Corporate Governance Check-list, to the Authority.

Appointment of Statutory Auditors by Insurers

Section 12 of Insurance Act, 1938 prescribes that all insurers must be audited annually by the Auditors. The following are the Guidelines of IRDAI on appointment of Statutory Auditors. These provisions are in addition to and not in lieu of the provisions of Companies Act, 2013. However, in case there is any inconsistency between the provisions under the IRDAI Guidelines and Companies Act provisions, the IRDAI Guidelines shall prevail.

On recommendation of the Audit Committee, the Board shall appoint the statutory auditors, subject to the shareholders’ approval at the general meeting of an Indian insurance company. The remuneration of the auditors shall also be approved by the shareholders in the General meeting.

The eligibility, qualifications and other requirements of the auditors are detailed below:

- Statutory Auditor of an insurer shall be a firm, including a Limited Liability Firm, constituted under the LLP Act, 2008
- Firm should have been established and in continuous practice for at least 15 Years
- Statutory Auditor should have:
 - (a) a minimum of 5 full-time partners, of whom,
 - (i) at least 2 should have been in full-time practice as partners exclusively associated with the firm for a continuous period of minimum of 10 years, and
 - (ii) at least 2 other partners should have been in continuous association with the audit firm either as partner or as employee for a minimum period of 5 years, and
 - (iii) one partner in full-time practice with the firm as a partner for a minimum period of 1 year, and
 - (iv) out of the total partners of the firm, at least two should be FCA and be in practice for a minimum period of 5 years as FCA.

OR (Alternatively)

- (a) a minimum of 7 Chartered Accountants,
 - (i) of which not less than 2 are partners in full-time practice exclusively associated with the firm for a continuous period of a minimum of 10 years, and
 - (ii) at least 3 other Chartered Accountants in continuous association with the audit firm as partner or employee for a minimum period of 5 years, and
 - (iii) at least 2 Chartered Accountants should be FCA and be in practice for a minimum period of 5 years as FCA
- At least one partner or employee of the audit firm should possess the DISA/ CISA or equivalent qualification as may be recognized by the IRDAI from time to time and such partner or employee must be involved in the audit of the insurer.
- Audit firm should have a minimum experience of 5 years in audit assignments of entities in the financial sector. At least one of the joint statutory auditors of an insurer must have experience in insurance company audits of at least two years.
- For the above purposes, a full-time partner shall not include a person who is –
- A partner in other CA firm(s) or (b) employed full time/ part time elsewhere, practicing in own name, or engaged in practice otherwise or engaged in other activity which would be deemed to be in practice under section 2(2) of the Chartered Accountants Act, 1949.
- Insurers should verify to their satisfaction that the proposed auditors meet the eligibility criteria before considering / approving their appointment. A declaration in the prescribed format (Form A1) shall be obtained by insurers at the time of appointment of auditors.
- Any change in the constitution of the Audit firm/information submitted/certifications submitted which affects the eligibility criteria indicated in these guidelines, should be duly informed by the Audit firm to the Insurers within 7 working days of such change. In such cases, the insurer must ensure compliance with the guidelines within six months from date of such intimation.

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- IRDAI must be informed about appointment of auditors within 7 working days thereof with a certification to the effect that the above eligibility stipulations have been met, as per the prescribed format (Form A2).
- Insurers are required to file a Return on an annual basis as per the prescribed (Form A3) giving details of Chartered Accountant firms engaged in various capacities like Statutory Auditors, Internal Auditors, Concurrent Auditors, and Tax Auditors etc.
- An insurer shall not remove its statutory auditor without the prior approval of the Authority.

Maximum Number of Statutory Audits of Insurers that can be accepted by an audit firm at a time:

- An Audit firm shall be entitled to carry out Statutory Audits of not more than three Insurers (Life/Non life/Health/Reinsurer) at a time. Provided that an audit firm shall not have the audit assignments of more than 2 insurers in one line of business (i.e. life insurance, general insurance, health insurance and reinsurance) at a time.

Explanation: An audit firm shall include its associate/ affiliate firms which are under the same network or other firm(s) whose name or trade mark or brand is used by the audit firm or any of its partners

Joint Statutory Audit and Rotation of Joint Auditors

- Each insurer shall have a minimum of two auditors as joint auditors. A joint auditor of an insurer shall not include other associate/ affiliate firms which are under the same network or whose name or trade mark or brand is used by the firm or any of the partners of the other joint auditor
- However, the requirement of joint auditors would not be applicable in case of new insurers during their first year of operations. The requirement shall be mandatory from the financial year succeeding the year in which the Certificate of Registration is granted by the Authority
- Rotation of Statutory auditors:
 - An audit firm which completes the tenure of five years at the first instance in respect of an insurer may be reappointed as statutory auditors of that Insurer for another term of five years
 - Thus, an audit firm may be appointed as statutory auditors by an insurer for a continuous period of up to ten years.
 - Thereafter there shall be a cooling-off period of five years. The incoming auditor during the cooling-off period shall not include other associate/ affiliate firm(s) which are under the same network or whose name or trademark or brand is used by the firm or any of the partners of the retiring auditor. The retiring/outgoing statutory auditor or its associate/ affiliate as explained above, shall not undertake the investment risk management, or concurrent audit of the insurer during cooling-off period.

Statutory Auditors taking up other assignments

Statutory auditor may take up other assignments with the insurer subject to compliance of the following:

- Any additional work other than statutory audit that is entrusted to the auditor or other firms under the same network/ associate/ affiliate firms whose name or trademark or brand is used by the audit firm or any of its partners shall be specifically approved by the Board or Audit Committee thereof.
- Board or its committee while approving the assignment shall ensure the independence and integrity of the audit relationship.
- Aggregate of the fees for the additional work in a financial year shall not exceed the Statutory Audit Fees

for the said financial year. It is clarified that the fees for the quarterly and half yearly audit/ review may be excluded for the purpose of calculating the aggregate fees for other assignments of the statutory auditors. All fees/ remuneration for such other work entrusted to the auditor or other firms whose name or trade mark or brand is used by the firm or any of its partners shall be specifically disclosed in the Notes to Accounts forming part of the annual accounts of the insurer.

- Compliance with section 144 of the Companies Act 2013 and Chartered Accountants Act, 1949 and Regulations issued thereunder, and the applicable guidelines of ICAI issued from time to time in this regard, shall be ensured before considering provision of any additional work to Statutory auditors.

LESSON ROUND UP

- IRDA's Corporate Governance guidelines are applicable to Insurance companies in addition to the applicable provisions of the Companies Act, 1956.
- The Committees mandatory for an insurance company are Investment Committee (formed under the Investment Regulations), Audit Committee, Risk Management Committee, Nomination & Remuneration
- Committee, Corporate Social Responsibility Committee (CSR Committee), With Profit Committee and Policyholders Protection Committee.
- The non-mandatory Committees (optional) are Asset Liability Management Committee, Ethics Committee,
- The Appointed Actuary is expected to provide expert or technical advice to the management on matters such as solvency margin requirements, financial condition testing, identification of material risks and management etc.
- The Financial statement of an Insurance Company are prepared in accordance with the
- The Insurance Regulatory and Development Authority (Preparation of Financial Statements and Auditor's
- Report of Insurance Companies) Regulations, 2002.
- Insurance industry is capital intensive and claims sensitive. Adequacy of capital for a successful insurance operation is a must. IRDA have provided 'Insurance Regulatory and Development Authority (Protection of Policyholders' Interests) Regulations, 2002' provide for protection of the interest of policyholders.
- The Treating Customers Fairly (TCF) principle aims to raise standards in the way financial institutions carry on their business by introducing changes that will benefit consumers and increase their confidence in the financial services industry.
- One of the methods to promote fairness in dealings with customers is appropriate disclosures to customers about an insurance company's key operational parameters.
- An actuary is an expert who applies mathematical and statistical methods for assessment of financial and other risks relating to various contingent events and for scientific valuation of financial products in the fields of insurance, retirement and other benefits, investments etc.
- Insurance Surveyors and Loss Assessors (Licencing, Professional Requirements and Code of Conduct) Regulations, 2000 provides rules for Insurance Surveyors and Loss Assessors in India.

GLOSSARY

- **CG:** Corporate Governance
- **BOD:** Board of Directors
- **KMP:** Key management personnel
- **WTMD:** Whole-time and Managing Director
- **AOA:** Articles of Association

SELF TEST QUESTIONS

1. What are the definition, objectives and fundamentals of Corporate Governance?
2. Describe briefly various provisions under the Companies Act, 2013 and IRDAI Regulations designed to create effective Corporate Governance framework.
3. Who are the different stakeholders and how the provisions of the Companies Act, 2013 and IRDAI Regulations ensures protection of their interest.
4. Explain the provisions of Indian Owned and Controlled Regulations of IRDAI.
5. Which are mandatory and non-mandatory committees that the Company should have as per IRDAI Corporate Governance Guidelines and what are its main role and responsibilities?
6. Explain provisions under Companies Act and IRDAI Regulations for control of Conflict of Interest of the Directors and employees.

Further Readings:

- www.irdai.org.in

**PROFESSIONAL PROGRAMME
INSURANCE – LAW & PRACTICE**

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WARNING

It is brought to the notice of all students that use of any malpractice in Examination is misconduct as provided in the explanation to Regulation 27 and accordingly the registration of such students is liable to be cancelled or terminated. The text of regulation 27 is reproduced below for information:

“27. Suspension and cancellation of examination results or registration.

In the event of any misconduct by a registered student or a candidate enrolled for any examination conducted by the Institute, the Council or any Committee formed by the Council in this regard, may suo motu or on receipt of a complaint, if it is satisfied that, the misconduct is proved after such investigation as it may deem necessary and after giving such student or candidate an opportunity of being heard, suspend or debar him from appearing in any one or more examinations, cancel his examination result, or registration as student, or debar him from re-registration as a student, or take such action as may be deemed fit.

PROFESSIONAL PROGRAMME
INSURANCE – LAW & PRACTICE
TEST PAPER

(This test paper is for practice and self study only and not to be sent to the Institute)

Time allowed: 3 hours

Maximum Mark: 100

1. Mr. R, aged 30 years, was employed as a supervisor in a bank. On 4th June, 2014, he took two life endowment insurance policies on his life for ₹50,000 each from Prudent Life Insurance Co. Ltd. Each policy had a different maturity term and period. Both the policies had accident claim benefit of an equivalent amount, viz. in the case of death of the insured due to an accident, the amount payable by the insurer would be twice the amount of the sum assured. Mr. R made his wife Mrs. R as his nominee under the policies and also the legal assignee, since the couple had no issues then.

On 31st May, 2016, Mr. R while going to his office on his two-wheeler was involved in a head-on collision with a motor car coming from the opposite direction and was severely injured. He was admitted to a hospital, but succumbed to the injuries and died in the hospital on the morning of 2nd June, 2016.

Mrs. R filed a claim under the policies with the insurer for payment of the sum assured together with the accident benefits. The company, after processing the claim, informed her on 15th July, 2016 that they were rejecting the claim on the ground that Mr. R, while taking the policies, had suppressed material facts.

The insurer indicated that Mr. R did not mention in the proposal form, the fact of an earlier ailment of having suffered from para-typhoid in June – July, 2012 and having been away from his employer on medical leave between 6th June, 2012 and 5th July, 2012.

The nominee filed a complaint on 18th August, 2016 with the District Consumer Forum stating that the repudiation of the claim was not justified. The insurer reiterated its argument that the on-mention of the previous ailment to it was a suppression of material facts and affected the fundamental nature of the contract. The District Consumer Forum on consideration of the arguments before it held in favour of the insurer agreeing with it that the deceased had suppressed material facts at the time of the proposal.

Mrs. R, not accepting the decision of the District Consumer Forum, filed an appeal with the State Forum. Her counsel contended before the Forum that even if the deceased had suffered from para-typhoid less than two years prior to obtaining the policies and did not give the necessary information in the proposal form, it did not amount to a material suppression of facts. His main argument was that the cause of death was the accident with the motor vehicle and the cause had no nexus whatsoever with the alleged ailment. Thus, there was no suppression of facts.

The State Forum after hearing the arguments of both the parties, allowed Mrs. R's appeal and held that the cause of death was accident and not illness. The non-mention of the fact of illness and hospitalisation did not amount to any non-disclosure of material facts. The Forum granted the relief asked for and directed the insurance company to pay Mrs. R ₹2,00,000 under the policies. The decision taken on 6th January, 2017 also entitled the nominee with interest at 9% per annum from the date of filing the claim, viz. 18th August, 2016.

From the information given above, answer the following questions —

- (a) Was the State Forum justified in its conclusion in terms of the conditions of life policies issued by Indian insurance companies? Give reasons for your answer. Cite relevant case law, if any.

(10 marks)

- (b) If Mr. R had died on account of an illness, and not in an accident, will the decision of the State Forum be different? Give reasons. (10 marks)
- (c) What are the provisions of the Insurance Act, 1938 regarding the time-limit beyond which the terms of a life insurance policy cannot be questioned? (10 marks)
- (d) What do you mean by 'guaranteed surrender value' in a life policy? (10 marks)
- (e) Can a discontinued life insurance policy be revived by the insured and if so under what circumstances and on what terms? (10 marks)
2. (a) Ravi, an individual, has taken with New Insurance Co. Ltd, a fire policy against his residential property, for a sum assured of ₹6,00,000. The cover lasts till the end of September, 2016. On 20th May, 2016, an accidental fire takes place and the entire building is gutted and damaged. Ravi prefers a claim with the insurance company. The claim is rejected on the ground of negligence on Ravi's part. Representations made by Ravi to the insurer against such a rejection were not successful. What options are left to Ravi to proceed further in this regard? Discuss. (10 marks)
- (b) Explain the maxim caveat emptor. Does this apply to insurance contracts? (10 Marks)
- (c) What do you understand by condition of 'average' in a fire insurance contract? How does this operate? Explain. (10 Marks)

OR

- 2A. (a) On 1st February, 2015 there was the fire in the factory of ABC Co Ltd. due which 80% of the factory got damaged. The factory was insured worth ₹10,00,000/- from The New India Assurance Co. Ltd. The owner of the factory went to the Insurance Company indicating the Peril he has suffered. The Insurance Company asked the applicant to submit certain information and documents to start the claim process. All the information was provided by the applicant and the claim process started. The company deputed the surveyor for assessing the loss of the factory. The surveyor visited the factory and gone through the detailed investigation. After conducting the survey, the surveyor on 25th February, 2016 he submitted his report to the company indicating that claim should not be passed as the fire was caused due to negligence. Was the decision taken by the surveyor right? Justify your answer. (10 marks)
- (b) Southern Ltd. carries a large volume of stock. It has secured fire policies to cover the stocks from three general insurers, the details of which are as under:
- | Insurer | Sum Assured |
|------------------------|-------------|
| A Insurance Co. Ltd. — | ₹90,00,000 |
| B Insurance Co. Ltd. — | ₹60,00,000 |
| C Insurance Co. Ltd. — | ₹30,00,000 |
- On 31st January, 2016, when a fire took place the value of the actual stocks in the godown, on the basis of the company's accounts was ₹1,80,00,000. Salvage gained was ₹1,60,000 which the company recovered and realised by way of sales. Determine the individual liability of each of the insurers on the premise that the claim was admitted by the companies. (10 marks)
- (c) Which section of the Motor Vehicles Act, 1988 talks about 'hit and run accident'? What is the payment of compensation provided under this section? (10 marks)
3. What are the definition, objectives and fundamentals of Corporate Governance? (5 marks)

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4. Discuss the contents of Proposal Form 4 with respect to life insurance. *(5 marks)*
5. Write a note on Pradhan Mantri Fasal Bhima Yojna (PMFSBY). *(5 marks)*
6. Give a brief note on each of the following:
 - (a) Doctrine of contra proferentem.
 - (b) Doctrine of good faith and fair dealing. *(2.5 marks each)*

