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irdai

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Awareness & Development in Insurance

– Holistic Growth

भारतीय बीमा विनियामक और विकास प्राधिकरण

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From the Publisher

The 25 years of liberalization trajectory placed India as a key global player in the financial markets. This has also offered a wide array of opportunities, fuelling the rising aspirations of the generation next. The economy is more resilient now and India is the fastest growing economy with a growth rate of 7.6% during 2015-16 surpassing all other countries of the world including China.

While the insurance sector was opened for private participation with enactment of IRDA Act, 1999 and formation of IRDAI in 2000, the year 2015 marked another milestone for insurance sector in India when many changes to the existing Laws and consequent changes to Regulations came into effect. Some more changes to the existing Regulations and new proposals are underway. For example, IRDAI has recently issued a Discussion Paper on Listing of Insurance Companies proposing mandatory listing of insurers after a specified time limit. The Guidelines which govern insurers upon Listing have already come into effect. Further, IRDAI has also come up with revised Corporate Governance Guidelines and the Guidelines streamlining remuneration to top management of private insurance companies. All these measures have been initiated as second generation reforms in insurance sector and are aimed at bringing in more transparency. With these measures taking effect in the days to come which will see many insurance companies hitting the stock markets, I am sure, the sector would have tremendous growth opportunities.

However, the real growth of insurance sector lies in increasing insurance penetration and bringing uninsured into the fold of insurance. The motto of IRDAI is to ensure such high penetration combined with a transparent and policyholder friendly environment. Many steps have been initiated in the recent past towards this end, some of which are:

(i) The revised Health Insurance Regulations, the Guidelines on Standardization and the Guidelines on Product Filings in Health Insurance have come into effect in July 2016.

(ii) With the notification of Regulations on Issuance of e-Insurance Policies and the proposed e-commerce Regulations, a fillip is being given to efficient use of technology thereby resulting in a reduction of costs and an increased scope for lower insurance premium.

(iii) The training and examination requirements of various channels of intermediaries have been rationalised and simplified in July 2016.

(iv) Sale of simple insurance products through CSCs and Point of Sale centres is being encouraged and efforts are being made to widen the product range that can be sold through these channels.

It is also heartening to note that subsequent to the changes to Insurance Act and the corresponding Regulatory environment, an amount exceeding Rs.17,100 crore has already come into the country as Foreign Investment in Insurance Sector. Some more proposals of foreign investment as well as proposals of mergers and amalgamations are under active consideration of the Authority.

In a nutshell, the insurance sector is marching towards a stable and transparent phase and IRDAI would put in place an appropriate enabling regulatory environment aimed towards achieving the objective of protection of interests of insurance policyholders.

T.S. Vijayan

प्रकाशक का संदेश

उदारीकरण के 25 वर्ष के दौर ने भारत को वित्तीय बाज़ारों में एक मुख्य वैश्विक खिलाडी के रूप में खड़ा कर दिया है। इसने अगली पीढ़ी की बढ़ती आकांक्षाओं को प्रोत्साहित करते हुए अवसरों का एक व्यापक श्रृंखला भी प्रदान किया है। आघात को सहने में अर्थव्यवस्ता अब अधिक सक्षम है तथा भारत सबसे अधिक तीव्र गति से वृद्धि करनेवाली अर्थव्यवस्था है जिसकी संवृद्धि दर 2015-16 के दौरान 7.6% रहा है और यह चीन सहित विश्व के अन्य सभी देशों से बढ़कर है।

जबकि आईआरडीए अधिनियम, 1999 के अधिनियमन और 2000 में आईआरडीएआई की स्थापना के साथ बीमा क्षेत्र निजी सहभागिता के लिए खोला गया था, वर्ष 2015 भारत में बीमा क्षेत्र के लिए एक और मील का पत्थर साबित हुआ जब मौजूदा कानूनों में कई बदलाव हुए और परिणामस्वरूप विनियमों में भी परिवर्तन लागू हो गये। वर्तमान विनियमों में कुछ और परिवर्तन एवम् नये प्रस्ताव प्रक्रिया में है। उदाहरण के लिए आईआरडीएआई ने हाल ही में एक विनिर्दिष्ट समय-सीमा के बाद बीमाकर्ताओं की अनिवार्य सूचीबद्धता का प्रस्ताव करते हुए बीमा कंपनियों की सूचीबद्धता पर एक चर्चा पत्र जारी किया है। सूचीबद्धता होने पर बीमाकर्ताओं को नियंत्रित करने वाले दिशानिर्देश पहले ही लागू हो चुके है। इसके अलावा, आईआरडीएआई संशोधित कॉरपोरेट अभिशासन संबंधी दिशानिर्देश तथा निजी बीमा कंपनियो के शीर्ष प्रबंध के लिए पारिश्रमिक को सुव्यवस्थित करने वाले दिशानिर्देश भी लाया है। ये सभी उपाय बीमा क्षेत्र में दूसरी पीढ़ी के सुधारों के रूप में प्रारंभ किये गये हैं तथा इनका उद्देश्य इस क्षेत्र में अधिक पारदर्शिता लाना है। आने वाले दिनों में इन उपायों के प्रभावी होने के साथ ही, अनेक बीमा कंपनियाँ शेयर बाजारों में प्रवेश करेगी और मुझे आशा है कि इस क्षेत्र में वृद्धि के जबरदस्त अवसर उपलब्ध होंगे।

फिर भी, बीमा क्षेत्र की वास्तविक वृद्धि बीमा व्यापन को बढ़ाने में और बीमारहित व्यक्तियों को बीमे के दायरे में लाने में निहित है। आईआरडीएआई का सिद्धांत एक पारदर्शी और पॉलिसीधारक हितैषी परिवेश के साथ ऐसे उच्च व्यापन को सुनिश्चित करना है। इस उद्देश्य को पूरा करने के लिए हाल ही में कई उपाय प्रारंभ किये गये है, जिनमें से कुछ है:

i) संशोधित स्वास्थ्य बीमा विनियम, मानकीकरण, संबंधी दिशानिर्देश तथा स्वास्थ्य बीमा में उत्पाद फाइलिंगों संबंधी दिशानिर्देश जुलाई 2016 में लागू हो गये हैं।

ii) ई-बीमा पॉलिसियों के निर्गम संबंधी दिशानिर्देशों की अधिसूचना और प्रस्तावित ई-कॉमर्स विनियमों के साथ प्रौद्योगिकी के कुशलतापूर्वक उपयोग को प्रोत्साहन दिया जा रहा है तथा इसके द्वारा लागतों में कमी होगी और इस प्रकार से कम बीमा प्रीमियम के लिए गुंजाइश बनेगी।

iii) विभिन्न माध्यमों के मध्यवर्तियों की प्रशिक्षण और परीक्षा संबंधी अपेक्षाओं को जुलाई 2016 में युक्तिसंगत और सरल बनाया गया है।

iv) सामान्य सेवा केन्द्रों (सीएससी) और बिक्री केन्द्रों के माध्यम से सरल बीमा उतपदों के विक्रय को प्रोत्साहित किया जा रहा है तथा ऐसे उत्पादों के दायरे को व्यापक बनाने के लिए प्रयास किये जा रहे है जिनका विक्रय इन माध्यसमों के द्वारा किया जा सकता है।

यह जानकारी भी उत्साहवर्धक है कि बीमा अधिनियम और तदनुरूप विनियामक परिवेश में परिवर्तन किये जाने के बाद 17,100 करोड़ रुपये से भी अधिक राशि विदेशी निवेश के रूप में देश में आ चुकी है । विलयनों और एकीकरण में विदेशी निवेश के कुछ और प्रस्तावत प्राधिकरण के विचाराधीन है।

संक्षेप में, बीमा क्षेत्र एक स्थिर और पारदर्शी चरण की दिशा में अग्रसर है तथा आईआरडीएआई बीमा पॉलिसीधारकों के हितों के संरक्षण के लक्ष्य को प्राप्त करने के प्रयोजन के लिए अनुकूल एक उपयुक्त समर्थकारी विनियमाक परिवेश का निर्माण करेगा।

टी.एस. विजयन

टी.एस. विजयन
अध्यक्ष

I N S I D E

SPECIAL FEATURE

PERSPECTIVE

ISSUE FOCUS

FROM THE EDITOR

Financial reforms which engendered the opening of the insurance sector marked a huge paradigm shift in economic thinking and charted out a course that has remained steady for first 15 years of the liberalized insurance sector. During these years, the demographic profile of the world has changed rapidly, with India being no exception. In his address on the occasion of Insurance Awareness Day on 19th April, 2016, Dr. Y V Reddy, Ex-Governor of RBI, who graced the occasion as Chief Guest opened his address by an emphatic shot on the financial literacy. He said that, insurance awareness serves both the objectives of the IRDAI, viz., protecting the interests of the holders of the insurance policies through financial literacy, and promoting orderly growth of insurance industry and thereby paving way for financial inclusion.

There is a rise in the aspirations of the people and with increase in the income levels and growing consumerism, expectations are high with regard to services provided by various institutions, and insurance is no exception. Insurance awareness is the focused feature of this issue. In the article, titled 'Awareness for Life Insurance', Mr. R. Venugopal, stresses on the importance of insurance awareness for enhancing the penetration of life insurance across India. According to him, once the policy contract is issued, the settlement of claims occupies a place of prominence. Mr. Ashok Kumar & Dr. Syed Asif Hussain, in their joint article titled 'Claim Management Efficiency in Life insurance' focus on efficient claims handling process, and state that the biggest concern for a life insurance company is that they should not end up paying a claim that is not valid. They also suggested that an effective claims handling process should take care of educating customers about how to prevent death claims getting declined.

With the passage of amended Insurance Act, there is change in the dynamics of the framework and it is slowly, but steadily moving towards minimum supervision and maximum governance, thereby, bringing more confidence and trust among various stakeholders. Mr. DVS Ramesh, in his article titled "Manoeuvring the Monitoring", discusses the evolution of regulatory framework and stresses on the importance of self regulation, in enforcing the discipline amongst the players towards establishing matured market.

In a country like India, where needs of people vary from one to another, there cannot be any single perfect solution or product. Under the feature 'Perspective'- CEOs Corner,Mr. Antony Jocob, exhorts the importance of Innovation and states that innovative thinking will help to reach out to the newer segments. We also have the quarterly business figures of Life and Non-life insurers as at the end of the first quarter. There is new feature viz.'IQ Time' introducing Cross Word and Jumble.

We are at the thirtieth anniversary of Mediclaim, the first national policy for health insurance and at the fifteenth for TPA Regulations and the tenth since the beginning of the first standalone Health Insurer.We have excerpts on health insurance from Mr. K K Srinivasan through his contribution titled 'Health care and sustainable health care delivery'. Given the fact that the Heart attack is one of the major critical illnesses covered under health insurance portfolio, the second largest segment of general insurance sector, Dr. Amit Vora explains the medical reasons for heart attack in his article titled 'Solving the intricacies of Heart failure'. It is followed by an article titled 'Fixing of health insurance's health' by Mr. MunishDaga which discusses the role of technology and automation in managing health care costs.

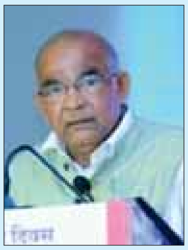
While insurers have the responsibility to make the holder of the policy understand the nuances of the coverage at the point of sale, they have to be ever ready to fulfill the promise of payment of claims as per insurance contract, as their reputation is at stake as well. Management of claims and maintaining steady flow of revenue through balancing between assets and liabilities have always been a tricky affair for the insurer and these are to be handled with the highest care. The insurance industry has to gear up to meet the challenges posed by the implementation of changes in the sphere of IAS (Ind. ASs) which would come in force shortly.

The focus of next quarterly issue would be Claims Management, the changing dynamics of Indian Accounting Standards, and Asset Liability Management of insurers along with other topical issues.

K.G.P.L. Rama Devi

SPECIAL FEATURE

Speech of Dr Yaga Venugopal Reddy, Chief Guest on the occasion of Insurance Awareness Day 2016



Chairman, Mr. Vijayan, distinguished members of IRDAI, former members, officers, staff and friends,

At the outset, I would like to compliment the IRDAI for taking initiative for celebrating the IRDAI Formation Day, as Insurance Awareness Day. I made enquiries about the initiatives taken by IRDAI. They seem to be in the forefront on several fronts; grievous redressel; dispute resolution; consumer awareness, financial literacy and out-reach. I must compliment the Chairman Mr. Vijayan, and his team for their pioneering efforts.

Mr. Vijayan, the first person to move from being the Chairman of a regulated entity to becoming Chairman of regulatory body of insurance industry is credited with heralding a new paradigm in customer service in the industry. I believe it was called SAMPARK offices concept.

I must congratulate all prize winners for their excellence. I am delighted to have released the reading material, especially in Telugu.

My personal contact with insurance was in 1966, fifty years ago. A friend of mine was a LIC agent and so he persuaded me to take insurance for Rs.25,000/, which I did. A few years later, after I was married and had two children, I wanted to insure for additional sums, but I was told that I was unfit to be insured. I was insulin dependent diabetic. Only my car could be insured. I believe that things have improved a lot – both for diabetics and the insurers!

My official contact with insurance was in my days in the Ministry of Finance in early 1990s, about 25 years ago. As Joint Secretary, I had to write a note on Reform of Insurance Sector. At that time, insurance was the monopoly of public sector. I requested non-life insurance companies for information about the mandatory insurance as distinguished from voluntary insurance. For example, if somebody took a loan from IDBI for establishing an industry, insurance was compulsory. Similarly, every car owner had to have some insurance. We found out that about 98% of the total insurance was mandatory insurance only. In other words, almost nobody was buying insurance unless he or she was compelled either as per law or as per condition of financial transaction. It was a small input that went into appointment of Malhotra Committee headed by former Governor, RBI, on reforms in insurance sector in 1993. The Committee felt that insurance industry should be opened up to competition in order to improve the customer services and increase the coverage of the insurance industry.

In the case of insurance, unlike banking, a new regulatory institution had to be set up and so IRDAI came into existence. I am happy to see that you have come a long way in building this institution. I am also happy that the regulatory authority has been taking initiatives to create awareness of insurance. In fact, insurance awareness serves both the objectives of the IRDAI, viz., protecting the interests of the holders of the insurance policies through financial literacy, and promoting orderly growth of insurance industry through financial inclusion.

Why do we require financial literacy? We do not have literacy program for buying vegetables, we do not have such programs for buying clothing or even housing. Obviously, there is something special about the financial sector.

When people go to buy vegetables for Rs.200/-, they ensure that it is weighed carefully, look at quality, feel their texture with palms, etc. There is lot of bargaining. Why is it that people do not spend as much time when they are putting thousands of rupees while depositing in a bank or while buying insurance?

I believe that the distinguishing feature of financial sector is the special relationship between trust and the financial sector. Trust is a universal value, but trust is critical in finance. There is no exchange of goods and services which you can feel instantly. You are only exchanging money which will give the claim for goods and services in future. You buy insurance now, and under some conditions, you will get money in future. You put a bank deposit now, and you get back the money with interest sometime in future. However, there is nothing tangible like feeling a vegetable.

Exchange of money and financial instruments involves movement of claims. Claims move over space, i.e., I give money to somebody in Hyderabad and they go and spend it in Vijayawada. I give money today, and it can be used sometime in future. I may give money taking some risk to a friend, and that friend may be using this money to take more risk than I would have taken. This makes the dealings in financial sector, what I may call, less tangible.

Whenever we, as common persons, deal with a financial institution like a bank or an insurance company, we give lot of information about ourselves. In the process, the banker or the insurance company knows a lot about us, but we have very little information about the institutions. When we buy health insurance, the insurance company knows a lot about my health condition, but I know very little about the financial health of the insurance company!

Most of the financial intermediaries are limited liability entities. The liability of owners or share holders is limited to their capital put in. Therefore, there is always a temptation on the part of the owners or the managers to leverage excessively and take excessive risks. They gain when there is profit, but when they lose, they can declare insolvency. In financial sector, we common persons, are dealing with financial intermediaries, who have limited liability and who know more about us than what we know about them.

Experience has shown that some of the characteristics of modern financial sector attract many intelligent people to this sector. It is mainly due to the potential for making enormous amount of money within a short period by dealing in other people's savings. It also means that financial sector will be especially attractive to those who are both intelligent and crooked.

In brief, therefore, financial sector is special and it requires appropriate regulation. However, it is also important that the customers are on their guard and take informed risks and informed decisions, rather than being uninformed. Hence the regulator has to protect the customer and that too without interfering in the competition amongst the insurance providers.

Let me share with you my experience in dealing with the subject of Financial Inclusion, financial literacy, financial counseling, etc. during my tenure as Governor. I felt strongly that the financial sector should focus on financial services as much as financial markets. I was always uncomfortable when people talked of labour markets, as if people are commodities. Finance is not just financial markets, but is something lot more important for security and day-to-day living of common persons.

People asked me when I was Governor, why is it that I was always emphasizing the common person. I explained that I am a selfish person. I was retiring very soon. Once I retire, I become a common person. So, I am trying to serve myself.

Anyway, in my tenure, I concentrated on matters like zero balance account, credit for consumption smoothening, expanding ATMs, making drawl of cash from all ATMs free, etc. I also emphasised the use of technology for disbursement from the Government as a service to common person. Experimentation was made in Mahboobnagar District here. As far as the credit was concerned, I encouraged micro-finance institutions mainly on the ground that they were non-profit making institutions and, therefore, worthy of support. I also wanted the banks to deliver what they promised in terms of standards of service. The Banking Codes and Services Board as an industry and association, modelled on UK, was part of that initiative.

As in case of most other initiatives, there were some failures in our efforts, some successes and some mixed successes, but financial inclusion propounded by us in Reserve Bank of India was accepted as a policy objective by Government of India also.

Global Financial Crisis brought the whole subject of Financial Inclusion to the forefront and brought it on global agenda for reform of financial sector. The Global Financial Crisis compelled many countries to spend huge amounts of money to bail out large financial institutions. This had to be done by Governments and central bankers in both advanced economies and developing countries. The financial sector was viewed as a villain by many and, yet they were bailed out at great expense to the exchequer. So the policy-makers at a global level had felt the need to demonstrate that they were equally concerned with people as much as with finance. So, in bailing out the large financial institutions at great expense, the policy makers wanted to convince the people at large that they were creating a direct stake to larger segments of population in the financial sector that they were intending to build in future. We must appreciate the importance given to Financial Inclusion and financial awareness etc. at global level in the broader political context.

The limits to spread of Financial Inclusion may be set by economic or social disadvantages of segments of population. Program of Financial Inclusion may do many things to facilitate financial transactions, financial sector coverage, penetration and efficiency of financial sector but the temptation to treat it as a panacea must be resisted. It can at best facilitate but cannot deliver employment, development, equity or environmental friendliness. The most important lessons of Global Financial Crisis must not be forgotten. Financialisation in excess doses can be injurious to health. Housing "bubble", is a classic example of danger of excessive Financial Inclusion. There is a need for continuous rebalancing between Regulation and Development.

Financial Inclusion is an important policy that gives human face to the tasks of financial sector. However, its role in the policy depends on how broad or how narrow the scope of Financial Inclusion is set in a given country. It is useful to demarcate what Government should do, what Central Banks and regulators could and how they relate to each other in pursuit of a national policy for Financial Inclusion.

In conclusion, what are my thoughts today, keeping in view my experience and subsequent developments? Financial literacy is useful only upto a point. Many people simply are not inclined to apply their mind to finance merely for study and use in taking financial decisions in future. At the same time, we should find means of explaining matters relating to finance when a common person wants to know something specific or relevant at a point of time.

I am delighted to find that IRDAI has call centres for customer care. It has Grievance Call centres. I suggest a slight extension of the Customer Care Centre; let it be a 'query' centre. This query centre is a sort of centre for purposive financial literacy on demand. Let me explain. It may be difficult to convince all people to get financial literacy in general. However, we can help people to get literacy that is appropriate for specific transactions, for example, say buying life insurance or health insurance when they are contemplating. Currently, we get functional financial literacy only from marketing by the sellers. The Query Centre that I am suggesting deals with explaining or informing, and not marketing or with grievance redressal.

The query centre could give information or literacy, when required, and as appropriate. The Query Centre can have a 24x7 Call Centre in English, Hindi, and regional languages to which one can call. For example, when my assistant wants to take a health insurance, he will call the Query Centre on what he should be informed about. That Centre may be authorized to explain or to read out from the published material that IRDAI has already prepared, or send it as a text message on his mobile or by email. IRDAI could have an "on demand service, for insurance literacy and awareness" called Query Centre. Query Centres responding to mobiles in the language required will be functional, purposeful, tailored to individual needs, time-saving and available when needed.

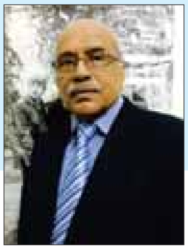
In conclusion, the Integrated Grievance Management System for grievance redressel, Ombudsman system for inexpensive and speedy settlement of disputes, a dedicated consumer education website for imparting financial literacy with content for all ages, have together placed IRDAI as one of unique insurance regulators in the world. Take one more step: make your consumer education interactive, in a query 'mode'.

Thank you all, ladies and gentlemen. Happy birthday to IRDAI.

The preceeding is the full length speech delivered by Dr. Y.V. Reddy, former chairman of RBI and Chairman of the 14th Finance Commission on the Insurance Awareness Day 2016. The views expressed are his own.

GUEST COLUMN

Inaugural Talk of K.K.Srinivasan, Former Member, IRDAI
Health Care Summit
"Sustainable Health Care delivery" Bangalore 28/6/2016



Introduction:

"In this talk Mr. K.K. Srinivasan, Former member, IRDAI, explains the current scenario of Health Insurance in India and its potential for growth and goes on to press upon the need for Health care delivery to be sustainable in terms of its viability and adaptability".

When we talk of health care sector we talk of a variety of services encompassing hospitals, medical services, diagnostic services, ambulance services, drugs, clinical trials, medical equipments, medical tourism, health insurance and similar things.

Constitutionally speaking, the health care sector in India is a complicated maze. Public Health, sanitation, hospitals and dispensaries fall under the State List (item 6). Medical professionals and Drugs (Pharma) fall under Concurrent List (item 26 & 19). Insurance falls under the Union List (item 47).

As regards licensing, medical professionals (Doctors) are licensed by MCI in the States while the Nursing council licenses the Nurses. Private Hospitals and clinics are by and large licensed by municipalities under Shops & Establishment Act. Drugs and medicines are regulated by the Central Drugs Standard Control Organization (CDSCO) under the Ministry of Health and Family welfare. Health Insurance is regulated by IRDAI. Road ambulances are licensed by RTAs and Air Ambulances by DGCA. Only very recently has the Government notified rules for Air Ambulance (or Air Medical Transport)as a part of the new Aviation Policy.

Despite this maze, health care has emerged as one of India's largest sectors – both in terms of revenue and employment. Experts have estimated the current overall Indian health care market (apart from Drugs) at $100 billion and expect it to grow to $ 280 billion by 2020 (Compounded Annual Rate of Growth of 23%). The current medical tourism industry is estimated at $ 3 billion per annum with an estimated medical tourist population of 230000.

Hospitals and Diagnostic centers attracted FDI worth $ 3.4 billion between April 2000 and December 2015 as per reports quoting Department of Industrial Promotion & Policy (DIPP).

Can health insurance be left behind? It is the 2nd largest line of business (motor is the first) of non-life insurers. For FY 2015 Health Insurance contributed around 24% for private insurers and 32% for public insurers. This was 17% and 24% in 2010. The four public sector insurers still have a dominant share of 64%, the private NL companies 22% and the stand-alone health companies (all in the private sector 14%).

"The Gross health insurance premium underwritten which was Rs 2221 crore in the year 2005-06 has increased to Rs. 20,096 crore by 2014-15. The number of lives covered under Health insurance policies during FY 2014-15 was 28.80 crore. As per the Census of India 2011, the population of India was 121.02 crore. As such, assuming that only one policy has been issued to one person, it may be estimated that approximately 24 per cent of India's total population has been covered under any of the health insurance policies during the FY 2014-15" says the IRDAI Annual Report of 2014-15.

IRDA data also indicates that while the share of individual health premium has gone up from 35% in 2010-11 to 44% in 2014-15, the share of premium from Government sponsored schemes has come from 20% to 12%. The share of group health premium has stayed stable at around 45%. One hypothesis is that this could be because the corporate groups and the Government have more bargaining powers than individuals. Another could be that some State Governments have gone for the direct payment / reimbursement route rather than the insurance route. However this aspect needs study rather than a heuristic comment. There is also a perception that the profitable individual business is cross subsiding the loss making group business. Recently IRDAI has come out with some kind of diktat against undercutting corporate premium rates by insurers.

Acknowledging the importance of health insurance, the Insurance law Amendment Act 2015 recognizes health insurance as a separate class of business .The six specialist health insurance companies – Star Health, Apollo Munich, Max Bupa, Religare Health & Cigna TTK, now stand truly as stand-alone health insurers. They were hitherto licensed as a part of non-life insurance companies.

Revised and Comprehensive Health Insurance Regulations and Health Insurance Product filing Guidelines are expected to be brought out soon by IRDAI.

Health Insurance policy is of limited value if the services for claims are not offered cash-less. Recognising this, in the early stages of liberalization (that is in 2000) itself IRDA notified the IRDA Third Party Administrators – Health Services regulations enabling the licesing and operation of TPAs. The draft of the new comprehensive regulations for TPAs are also under discussion. There are as many as 30 TPAs in existence now. The capital for a TPA company was kept at a relatively low level of Rs. 1 crore. However, the draft of the new TPA regulations proposes a four fold increase in the capital requirement. There is perhaps a realization that TPAs will require advanced infrastructute, particularly IT infrastructure to deliver services and that does not come cheap. This may inturn mean that there could be exits and consolidations of TPA entities in the near future. It is interesting to note the general perception that the top 4 or 5 TPAs control a bulk of the TPA business now. Another interesting perception is that while the PSU insurers are depending on TPAs the most, private insurers do health claims servicing in-house. The recent setting up of HITPA – the dedicated TPA company promoted by the PSU insurers - is yet another interesting development.

The sub-title of this summit , "sustainable health care delivery", needs some focused discussion. There are two facets of sustenance. One is viability, that is, the delivery systems must earn adequately. A delivery system that is not viable cannot sustain for long. The second one is that the system must be robust enough to scale itself to higher levels of volumes and absorb higher levels and newer methods and technologies.

That this summit is taking place in Bengaluru, the silicon valley of India and a major bio-medical research and manufacturing hub is not lost on me. I am from Bengaluru but I am not an expert on technology or bio-sciences. However, I will not hesitate to take the common sense stance of that innocent child in Hans Christian Anderson's "Emperor's New Clothes" , where the child exclaimed "why the emperor is not wearing any clothes ?", while the adults were silently watching the emperor's so-called 'invisible clothes'!

One of the developments in technologies is 'disruptive technologies'. They are so termed because they disrupt the present status and modes of functioning and this might lead to a possible disconnect in the health care system.

Health care system involves heavy entrepreneurial investments. This ranges from huge capitation fees for becoming a doctor to heavy investments in hospital infrastructure including expensive equipments, diagnostic and other tools. The pressure on medical professionals to recover this investment is understandable from a business angle. The fact that this can result in commercial practices like excessive expensive investigations, prolonged but expensive stays in the relatively costlier ICUs, than ordinary wards, is also understandable from a commercial angle.

However, the commercial angle can lead to totally unwanted consequences of projecting medical services as a commercial business rather than a human welfare activity. Some practices like prolonged stays in ICUs can also lead to incurable and often fatal infections like the often heard serious lung infections.

However, I do believe that advancements in the realm of medical sciences come from the hard work of scientists and biologists and compared to the past, scientific and technological innovations are taking place at a rapid pace and any tendency that shuts out progress is not good.

However, a more serious possible retrogade fall-out of the commercial angle that requires all out efforts to recover existing investments, is the reluctance to move to new methods and new technologies that will require further investments. For example if scientists and biologists come out with new non-surgical and non-interventionist treatment for heart ailments, it will seriously disturb the economics of present model and hence the new treatment modes may be given a go by.

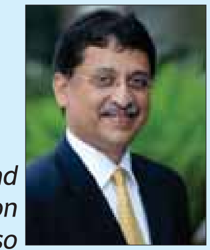
I do not have an answer to these issues. However, I do believe that advancements in the realm of medical sciences come from the hard work of scientists and biologists and compared to the past, scientific and technological innovations are taking place at a rapid pace and any tendency that shuts out progress is not good.

I am sure the experts and the participants in today's summit will debate these and other issues and suggest solutions.

The preceeding is the full length talk delivered by K.K. Srinivasan, former member (Non-Life of IRDAI) at Health Care Summit, Bengeluru 2016. The views expressed are his own.

PERSPECTIVE

Innovation should transcend boundaries to reach the masses



In this article Mr. Antony Jacob, briefly talks about the development of technology and how it can be put to effective use in the health care sector. He also presses on the need on part of the insurers to quickly accomodate to the rapid changes in health care sector, so that both can achieve great success.

- Antony Jacob

While growing up in the 1980s and 1990s, people could only imagine technology consuming their lives as a far-fetched notion. Computers, laptops, mobile phones were the 'in thing'. Today technology has pushed the limits of the boundaries we thought existed even farther. We shall soon have driverless cars and robots to do all our work, not to mention the possibilities that 3D printing throws up for everyone.

Until today, innovation has largely been related to products, as they are the most tangible. To transform services is a challenge that every company should strive for in order to effect change in consumers' lives. Healthcare is one such industry that has truly moved boundaries over the past decades and is expected to have an exponential explosion in the coming years.

Healthcare has already advanced in technological terms from what it was a decade ago. With the proliferation of technology, robotics and scientific research, robots have started to perform surgeries on people while being controlled by medical professionals.

Until today, innovation has largely been related to products, as they are the most tangible. To transform services is a challenge that every company should strive for in order to effect change in consumers' lives. Healthcare is one such industry that has truly moved boundaries over the past decades and is expected to have an exponential explosion in the coming years.

Wearable technology has also entered the healthcare space and is being recommended as a part of prevention and wellness protocols. Today this technology helps people monitor their heart rate, brain activity, blood pressure and also tracks one's fitness regimes. The future wearable may offer an unbeatable combination of biosensors and history of wearer to indicate factors of concern such as stress levels, irregular heartbeats, low insulin levels that can aid in quick treatment. Wearables today are largely devices that are worn around one's hands. In the future they might be insoles that can be placed in one's shoes, or technologically advanced contact lenses, or even smart pills.

Diagnosis of ailments in some western countries is being done through devices that would just require a person to breathe into an apparatus. This would certainly chase the 'needle' phobia away for the rest of one's life. Hence diagnosis of ailments would be faster and help garner quicker treatment protocols. Such use of technology will also banish away the need for paper in the healthcare environment. As more and more data will be electronically controlled, physical paper will soon be a thing of the past. Current and past records, treatment protocols, diagnoses, medical test results will all be available in an electronic format that can be shared across healthcare specialists anywhere in the world, to allow a consumer immediate access to the best quality healthcare.

The medical professional in the future will also benefit immensely from such technology as he or she would have immediate access to medical data, research and protocols that would aid in rapid diagnosis and treatment. Spending hours pouring over medical books shall be a thing of the past - 1980s and 1990s.

A bane for most people is the anxiety of visiting a hospital, clinic or a doctor and hence we do not enjoy the experience. This has been a large concern for everyone involved in the healthcare process. The key to the future success of all parties would be to determine how the system can reduce the time involved in the pre and post hospitalization phase that a customer undergoes. Technology will move healthcare into small bits that can be carried in one's pocket. People will soon carry diagnostic test reports, X-rays, past files, etc. in a stored card that fits into his or her pocket.

Technology will move healthcare into small bits that can be carried in one's pocket. People will soon carry diagnostic test reports, X-rays, past files, etc. in a stored card that fits into his or her pocket.

If healthcare is poised to change in such an advanced manner, then it is high time that health insurance companies also move quickly to accommodate the rapid change in technology. The very nature of health insurance will enable the segment to be a partner with the healthcare industry in transforming customer experiences. By helping to mitigate medical expenses, health insurance can provide more and more people with access to such technological advancements.

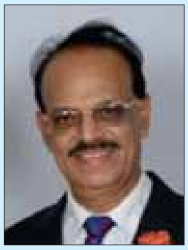
Innovative thinking will help us all lead our companies to reach out to newer segments all the time. With more and more people taking interest in insurance, we should all continue to work hard to foster innovative behaviour. Innovation is what led private insurers to gain market share. We must move from simple to electronic/online payment gateways and the data gathering tools. We must be able to offer customized health insurance policies based on diagnosis and life style trends in rapid real time. By using wearable technology, would we be able to decrease the premium levied on customers on renewal? Can preventive healthcare and wellness channels be implemented in order to reduce the costs for all parties concerned?

Health insurance providers are natural and essential partners to the healthcare industry and a rapid technological adoption model will aid both parties in achieving great successes in the near future.

***By Antony Jacob**, Chief Executive Officer, Apollo Munich Health Insurance, E-mail: Antony.Jacob@apollomunichinsurance.com*

ISSUE FOCUS

Awareness of Life Insurance



In this article, Mr. Venugopal sheds some light on the status (quo) of the life insurance sector in the Indian context. The article elaborates on factors affecting the sector ranging from inadequate awareness to entrenched superstions. Besides, he elaborates upon the multitude of Insurance products and various ways to bring them to the population to their own benefit and the benefit of the country.

- R. Venugopal

As per the IRDA data, the number of policies serviced by the life insurance companies including the Public Sector Behemoth- the Life Insurance Corporation of India- is around 30 crores. If multiple policies- one individual holding more than one policy- is taken into account, this number may come down to less than 25 crores. The penetration of life insurance is about 2.6 % of the GDP as per the Annual report of IRDAI for the financial year 2014-15, showing the extent to which we have to still cover in India. This is the position of life insurance, despite the Privatization of life insurance brought in from 1999/ 2000.

With our total population exceeding 110 crores, it is crystal clear that the penetration and awareness of life insurance among our countrymen is quite meager.

Reasons for this low penetration

One of the main reasons for this low spread of life insurance is the lack of awareness among the people regarding life insurance.

Still people in the rural areas look at life insurance as a 'death fund' and are some times reluctant to invest in it due to superstitious beliefs.

People living below poverty line, who need life insurance the most, are unable to take or sustain the policy taken, due to their poor and irregular income and the people whose polices lapsed, become the bitter critics of life insurance.

Apart from protection, life insurance is a financial provision that functions as an instrument of sustenance, recognizing the value of human life.

The salaried class persons view life insurance as a tax saving device, that too only in the month of March every year-and the moment these incentives are withdrawn, this class may lose interest in life insurance.

The rich class, who does not need life insurance as such (since there will be no loss of regular income), takes life insurance mostly as a wealth-building measure.

The fourth Need

After the three primary needs- food, clothing and shelter- life insurance comes as the fourth need for most of the persons in India.

This protection is offered by the life insurance companies, when there is a loss of human life either by natural cause or accident or suicide. (Suicide clause operates for one year after taking the policy, where no claim is payable.)

Apart from this protection, life insurance is a financial provision that functions as an instrument of sustenance, recognizing the value of human life.

Human Life Value

There is not only a need for life insurance for every one but also the right amount of insurance.

This is very important because the very purpose of taking life insurance itself is to make sure that the family's needs are taken care of even in the absence of the bread-winner.

Every life has got some monetary value depending up on the present earnings of the bread winner and also his/her future earning capacity.

This concept is called the Human Life Value.

HLV is normally calculated on the following bases:

- The age of the bread winner
- The ages of the dependents
- The current expenses of the family per month
- The future expected needs of the family like the education and marriage of the child/children, home loan etc
- The present outgo like the EMI for housing loan, educational loan and their duration, the medical expenses in the family etc
- The ages of the head of the family and other earners will help us to project their living years and their earning capacities.
- The total figure arrived in the above manner is the amount of life insurance a person requires.

> The rising costs of medicines and the hospitalization have led to the economic doom of many a family in this country. Many families above poverty line have slipped in to below poverty line as their economic condition has been ruined by the illnesses faced in the family.

Life insurance is superior because, unlike the other modes of savings, it gives full protection against the risk of death.

In case of natural death, sum assured is payable.

In case of death due to accident, double the sum assured or triple the sum assured, depending up on the features of the insurance plan, are payable.

In case of permanent disability due to accident, one sum assured is generally payable in installments and the second one is generally paid at the end of the stipulated term.

In the case of partial disability too due to accident, there are certain benefits structured to be payable.

Under Educational Annuity Plan, if the policyholder unfortunately dies, the sum assured is generally payable in installments- not in lump sum so that it is not frittered away- and the aim of education of the child is fulfilled.

Similarly under the Marriage Endowment Plan, the sum assured is generally payable only at the end of the stipulated term, even if the policyholder dies in between, so that the intended goal of the wedding of the offspring takes place.

The rule that a minimum period of 3 years' premiums are to be paid to get the monies remitted back adds to the compulsory nature of the life insurance savings, whereas in other saving modes, this compulsion may not be there and the people may withdraw from the savings at regular intervals and erode the savings.

Again this compulsory nature of savings also helps in keeping the life insurance policy in the full force position, offering the life protection which is the sole aim of taking the policy.

Health Insurance

Not only life insurance is needed for each person, health insurance too has become a necessity, since living long is not enough, but also living with a good health.

The rising costs of medicines and the hospitalization have led to the economic doom of many a family in this country. Many families above poverty line have slipped in to below poverty line as their economic condition has been ruined by the illnesses faced in the family.

Term Insurance

The concept of term insurance is catching up because this is very cheap and also the need of the hour.

By paying a small to moderate premium, one can obtain a huge life cover through this term insurance, where there is no saving element but only risk cover.

This has assumed great importance, since the family in the absence of the bread winner or stoppage of monthly income due to incapacity to earn in view of disability due to accidents, has to face considerable outgo due to EMIs for housing loan, vehicle loan, educational loan and what not.

Hence it is a must that every young earning member of the family should have adequate term life insurance.

Group Insurance

There are Laws in this country making life insurance protection compulsory for all the employees contributing to Employees' Provident fund in the early stages of career.

The employer can do this either through Regional Provident Fund Commissioner or through a life insurance company's group insurance scheme, if it provides for a greater death benefit.

Similarly wherever there are ten or more employees in a Concern, payment of Gratuity by the employer is compulsory.

Provision for Gratuity can be made by the Employer company through a Private Trust approved by the Income tax Commissioner or a Group Gratuity cum Life Insurance Policy through a life insurance company. Under this scheme, not only the accumulated gratuity on the death of the employee in service is paid but also the future gratuity eligible for the deceased employee had he/she normally superannuated is payable under a life insurance scheme.

Micro Insurance

Micro insurance is a boon for the poor and the unorganized sections of the society.

For a small premium, a good life cover is given to the members of the BPL Families.

There are even schemes under which not only life protection is given but also hospitalization costs are taken care of. There is a provision for pension too after the age 60.

IRDAI has made it compulsory for every life insurance company to bring out micro-insurance products and also to insure a minimum number of people under this umbrella.

Awareness among the people

It is not sufficient that these schemes are brought in to operation, but also the people should be educated about them.

There should be awareness campaigns through the Press and the TV media by regular advertisements.

School children should be made aware by bringing the life insurance subject in the higher school curriculum, as per the dictum- Catch them Young.

This will spread the knowledge of life insurance to the parents through the children.

Some Universities are having life insurance as one of their subjects under their B Com Degree course.

Some Universities have MBA degrees in Life insurance.

These courses not only increase the job opportunities for the youth in the sunrise insurance sector but also bring about a metamorphosis in the thinking of the people about the life insurance.

Let us hope that day is not far off.

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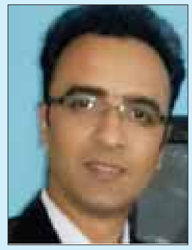
ISSUE FOCUS

Claims Handling Efficiency (Life Insurance)

This article talks about the need to have in place an effective claims management system by the insurers so as to reaffirm the confidence of common man in the risk management tool called Life Insurance

- Ashok Kumar, Syed Aisf Hussain

Uncertainties are a part of our life but the ability to manage the risks arising of those uncertainties is what determines the quality of life we and our loved ones are able to live. While there are a plethora of risks which we have to manage, it is the loss of life of the breadwinner leading to uncertainty which is the most dilapidating one from a family's perspective. Life insurance is a tool for risk management, a process for dealing with the risk of loss of life. Life Insurance substitutes certainty for uncertainty by indemnifying through claim benefits, and hence claims management is a core process in a life insurance company. The purpose of a sound claims management is to protect the interests of various stakeholders of the Insurance Company, most importantly the policyholders.

Over the last 15 years post privatization of Life Insurance in India, the service standards of life insurance companies including the management of death claims have improved substantially. The internet revolution and the high service standards set up by other industries like Banks, e-commerce firms have transformed the way people demand services in today's world. As a result, claims handling has also evolved over a period of time.

Life Insurance is truly a peoples' business and any prudent life insurance company has to be committed to customer centricity. Death claim is the biggest moment of truth in life insurance. Hence, a sound claims function of every life insurer should strive to offer the most professional service by assessing claims in a fair, prompt and consistent manner while being compliant to all applicable legislative and industry codes. Equally important is a zero tolerance approach towards fraudulent claims to protect the interests of all the stakeholders including the genuine policyholders. Claims management once it is effective plays a key role in building profitable business by enabling sound underwriting, product design capabilities and setting high service standards.

Life Insurance is truly a peoples' business and any prudent life insurance company has to be committed to customer centricity. Death claim is the biggest moment of truth in life insurance. Hence, a sound claims function of every life insurer should strive to offer the most professional service by assessing claims in a fair, prompt and consistent manner while being compliant to all applicable legislative and industry codes.

The role of a claims function in Insurance Company would broadly entail the following:

1. Assessment of claims within the ambit of statutory and regulatory framework and accepted,fair industry practices

2. Keep up the brand image of the Organization by creating competitive and efficient claims management processes

3. Participate in building sound risk management practices

Section 8 of Protection of Policyholders' Interests Regulations, 2002 issued by IRDAI is applicable to Life Insurance claims processes. The claims processes should conform to various subsections of these regulations noted (in abridged form)below-

(1) A life insurance policy shall state the primary documents which are normally required to be submitted by a claimant in support of a claim.

(2) A life insurance company, upon receiving a claim, shall raise additional information if required, all at once within a period of 15 days of the receipt of the claim.

(3) A claim under a life policy shall be paid or be disputed giving all the relevant reasons, within 30 days from the date of receipt of all relevant papers and clarifications required. In case investigation is warranted, it should be completed no later than 6 months from the time of lodging the claim.

(4) Where a claim is ready for payment but the payment cannot be made due to any reasons of proper identification of the payee, claim will be paid with interest at the rate applicable to a savings bank account.

(5) Where there is a delay on the part of the insurer in processing a claim, the insurer shall pay interest on the claim amount at a rate which is 2% above the bank rate.

One of the biggest concerns of a life insurance company is that they should not end up paying a claim that is not valid. This is the primary reason why the claims process can take sometime. Most of the contestable death claims are primarily reviewed for misrepresentation of material information.

Claims from the point of view of how are they assessed can be segregated into contestable and non-contestable claims. This is elaborated under Section 45 of Insurance Act, 1938 that has been recently amended in the year 2015. A contestable claim refers to a life insurance policy that is less than three years(from the date of the policy, i.e., from the date of issuance of the policy or the date of commencement of risk or the date of revival of the policy or the date of the rider to the policy, whichever is late, on the ground of fraud)when the insured person dies. The insurance company has the contractual right to investigate the validity of the original application for any reason(s) they should not have issued the policy. In case of repudiation of the policy on the ground of misstatement or suppression of a material fact, and not on the ground of fraud, the premiums collected on the policy till the date of repudiation shall be paid to the insured or the legal representatives or nominees or assignees of the insured within a period of ninety days from the date of such repudiation. Thus, in such case, the policy will be cancelled and the premium paid till then would be refunded, and no death benefit will be paid.In the cases fraud is established, the insurer has to communicate in writing to the insured or the legal representatives or nominees or assignees of the insured the grounds and materials on which such decision is based. A non-contestable claim is the one that cannot be contested by the insurer because the policy has been in force for 3 years. Non-contestable does not imply the claim will be paid immediately. Specific documentation, such as the insurance companies' claim form, a certified death certificate and KYC proofs etc .required as per the regulation, must first be provided by the beneficiary in order to collect the death benefit.

One of the biggest concerns of a life insurance company is that they should not end up paying a claim that is not valid. This is the primary reason why the claims process can take sometime. Most of the contestable death claims are primarily reviewed for misrepresentation of material information. In other words, investigating the validity of the information supplied by the applicant, as that would have impacted the life insurance company's decision to offer the policy. Wrong information provided, whether intentionally or unintentionally, can delay the death claim process. This brings to force the fact that the education of policyholders is important to prevent rejection of claims. Among other things discussed later in this article, an effective claims handling process will also take care of educating the customers about how to prevent death claims getting declined.

The stage when a death claim arises is probably the most difficult stage in the family of the policyholder. The emotional strain at such times, impacts the comprehensiveness with which the process is followed by the family. The life insurance company can play an important role in such times.

Some of the key practices by life insurance company that can contribute to an efficient claims process are:

1. Customer oriented claims philosophy- This is pivotal to effective handling of claims. Life Insurance company must have a well laid out claims philosophy that serves as a guiding principle for all the people and processes dealing with claims management. The life insurance company should start with the philosophy that they are in the business for serving others.

2. Personalized service with simplified process- Approaching every claim as an opportunity to treat the beneficiary in such a manner that he/she believes that his/her claim is handled with empathy and a high level of professionalism. The process needs to be simple and easy to understand to a common man. In the last few years, some of the private life insurance companies have come up with such services like Personalized Claims Officer, Claims Handler, Claims Mitra etc.

3. Fair & Consistent practices- Practicing integrity and honesty in the handling of each and every claim is an absolute must. Additionally assessing claims in a fair and consistent way is equally critical.

4. Promptness with Regular communication- Proactivity in claims handling can play a critical role in an attempt to bring a timely and efficient conclusion to all matters related to claims management. Regular communication at every stage allays the anxiety that beneficiary has when raising a claim. To give confidence to the policyholder and claimant on promptness and timeliness in payment of claims, some life insurers have come up with concepts such as Claims Guarantee or Claims Promise in the last few years.

In today's world, well structured automated platforms are pivotal to the success of an effective claims management process. When handling claims, life insurance companies are basically fulfilling the promises that they have made to the policyholder at the time of selling the policy.

In today's world, well structured automated platforms are pivotal to the success of an effective claims management process. When handling claims, life insurance companies are basically fulfilling the promises that they have made to the policyholder at the time of selling the policy. While this sounds very basic, yet reiterating this belief that life insurance companies are in the business of serving others can transform the whole claims handling process. Providing claims service grudgingly or reluctantly defeats the purpose of Life Insurance. Courtesy and respect should not be any extras, but have to be the rights of every beneficiary.

Every claim denied by a life insurance company (unless deliberate fraud) is a potential dent to the reputation of not only that company but that of the Life Insurance industry in general. Hence, it is within the ambit of an efficient claims function to proactively work on minimizing the instances of claims getting declined. It is the responsibility of the Claims function to share feedbacks with acquisition teams as well as the product development functions.

Within this context, some of the things that an efficient claims function should contribute to are:

1. Simplification of policy document- Some of the life insurance contracts are vague in their language and the benefits as well as the process of claiming those benefits are not clear to a layman. Writing a policy contract in an easy to understand and unambiguous language is important to ensure that claims handling remains efficient.

2. Education of End sellers- Sellers are the face of life insurance company and most of the times the preferred contact point between the life insurer and the policyholder and his family. It is imperative that sellers are well trained so that they can explain the benefits clearly to the policyholders. This helps the consumer take informed decisions and to prevent any issues when a claim arises.

It is within the ambit of an efficient claims function to proactively work on minimizing the instances of claims getting declined. It is the responsibility of the Claims function to share feedbacks with acquisition teams as well as the product development functions.

3. Robust governance on fraud management- Claims function should be active in curbing any fraud trends within or outside the company.

To summarize, claims handling stands as a moment of truth that has a significant impact on customer loyalty. Depending on how they perceive the experience at claims stage, it can turn customers into stalwart promoters or detractors of the company. Superior claims management offers a means of competitive differentiation, whether that's through faster payout, easier filing through digital channels or higher-quality interactions between customers and claims representatives. Every claim handled well provides a fillip to the Life Insurance Industry by reaffirming the belief of common man in this risk management tool.

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Fixing the Health Insurance's Health

In this article, Mr. Munish Daga talks about the scenario of the health insurance claim settlements system and the disconnect between the efficient deployment of innovative technologies and the customer service. Besides, he critically observes the necessity to ameliorate this situation and various means to bridge this gap.

- Munish Daga

Fixing Health Insurance's Health

India, a massive country with a population of 1.2 billion (source: wikipedia.com) stands on the historically rich soil where Ayurveda was born and surgery techniques once flourished. It is ironic how its people are perishing in the absence of the same healthcare services in the present era. Innovations in science and technology have certainly improved the very field of healthcare but at the same time, have done from little to nothing for the masses at large. A major part of the population does not have access to basic healthcare services while, the benefits of the innovations are enjoyed by the ones with deep pockets only. For around 70% (source: world Bank) of the population living in the rural areas, the healthcare facilities are in a dismal condition. The inadequate number of Public Healthcare Centres adds further to the woes. .

Unfortunately, healthcare costs are also the reason that pushes many below the poverty line every year. Recent figure published by NSSO amply justify this - only 18.1% of the urban population is insured while the numbers are as low as 14.1% in rural areas despite the numerous government schemes. This sheds light on a different aspect altogether. Thus, it is evident that health insurance is the best possible solution to bridge the gap in affordable and accessible healthcare. (source: NSSO 71st round)

At the heart of the entire claims process is the patient who is the policyholder and the customer for the hospital as well as the payer. Thus, ensuring customer happiness goes way beyond providing a suitable health cover.

Current Industry Scenario:

The developments in science and technology have certainly benefitted the US$ 100 billion (source: IBEF) worth health sector but the vertical of health insurance is yet to jump in to that wagon. Though, health insurance has a lot of catching up to do, the opportunities and scope for growth and success are tremendous. Whether an insured individual is making a cashless or a reimbursement claim, the claims exchange process does not enjoy the same speed, efficiency, and a robust and reliable electronic process that several other counterparts in banking and finance sector do. Both the processes are to a great extent manual in nature, heavily relying on manual interpretation which leads to a higher turnaround time and poor customer service.

Apart from being a laborious process, it is very complicated as well for the consumer. The involvement and handling of the paper documents create further struggles. Like a Domino effect, the last tile is the policyholder who faces the hassle of continous back and forth with the insurance desk and high waiting time.

Currently, the sector is witnessing a bias towards cashless health insurance, with the government at the centre planning for a universal scheme. Cashless insurance is a step ahead of reimbursement insurance as the patient need not shell out any upfront cash at the hospital. The hospital and payer settle the claim, with the patient paying a minimal sum. Cashless health insurance claims exchange calls for quick-response technology solutions that enable the hospital and the payer to approve and settle claims in real-time, ensuring a hassle-free experience for everyone involved.

A major problem with the current system is that from the time a policy is purchased to the time a claim is made, it is to a great extent the agent who guides the entire process. It creates an element of dependency and the policyholder has very little knowledge regarding the process. Furthermore, in the typical claims exchange process today, insurance desks at hospitals collect information from the policyholder through a physical form, interpret that information, enter it into their hospital information systems and e-mail the information to the payer. The payer interprets this information, enters it into their back office system and sends a response. This process is repeated every time an enhancement is made on the claim. Thus, the policyholder is left out of this loop, with little or no

The payer as well as the policyholder on a real-time and electronic platform will make the entire process accountable and thus, transparent. On an electronic platform, the payer nor the hospital need interpret any data after it is entered the first time.

transparency, information is interpreted at each step of exchange which could lead to leaks and inconsistent exchange of information and hence, result in an unreliable process.

While the private sector is mulling on an electronic claims exchange process, various state governments have taken the leap to provide cashless health insurance through various health schemes to their citizens. Some of these schemes are exemplary as they are using technology as a scalable solution. They function in a completely paper less format and make utility very simple for the beneficiary. For example; very recently the state government of Punjab introduced mobile e-cards for health insurance. The scheme makes use of an app which contains all the policy details.

However, there is still a long way to go to ensure that 1.2 billion have access to affordable healthcare.

Need for focused health insurance solution – investment in innovative solutions

To make a change on such a large scale that will strengthen the health insurance sector from the root, support and buy-in from every single stakeholder is key. Just like research and development form strong pillars of other subsidiaries of healthcare such as medical equipment, pharma and immunology, health insurance too, needs focused research for development and implementation of technology tools that can bring the change and boost required. Perhaps, technology advancements implemented by the banking sector, the way it has synced with mobile and online wallets so as to ensure access to and utilization of products and services is available at the fingertips of consumers.

Taking the example of mobile phones; technology in the form of mobile devices and applications can help address the problem of accessibility to healthcare insurance to a large extent. It has been a topic of constant debate as to whether mobile phones are a boon or bane to humankind, both sides have concrete reasons to prove their point but its enormous reach and ease of use definitely count as positives. In India, mobile phones have a reach of around 1 billion; (source: Trak.in) the figure includes the rural population as well. The number of people using this technology is certainly to be considered while looking for a solution for healthcare insurance.

The potential of a focused technology solution:

Transparent transactions for all: Bringing the hospital, the payer as well as the policyholder on a real-time and electronic platform will make the entire process accountable and thus, transparent. On an electronic platform, the payer nor the hospital need interpret any data after it is entered the first time. Drop-down and rule-based options eliminate the need to manually enter data related to the treatment and the necessary items it would entail. Furthermore, the technology solution would also bring the policyholder in the loop where the platform would enable SMS or app notifications alerts. The poliycholder will not be dependant on the insurance desk for updates and will have access to information incase there is misuse or fraud.

Technology facilitates automation: With an electronic platform in place that facilitates transparent and reliable transactions, health insurance claim settlement can become automated where the rule-based platform can adjudicate claims without any manual intervention. Development of and investment into such technology would prove tremendously beneficial for outpatient health insurance as outpatient has a 98% (source: NSSO 60th Round) share of the total healthcare needs but no insurance to cover the same.

Providing Outpatient Health Insurance: Due to a lack of suitable outpatient insurance cover, a common practice is often making the patient stay overnight for a treatment that could be completed within 24 hours. While this ensures that the treatment is covered by insurance, it has a negative impact on the availability of hospital beds and other resources where they are really needed and leads to malpractice. If patients have access to outpatient insurance and are able to easily use it, not only will the burden of healthcare expenditure reduce but also, resources will be more optimally and appropriately used.

With an electronic platform in place that facilitates transparent and reliable transactions, health insurance claim settlement can become automated where the rule-based platform can adjudicate claims without any manual intervention. Development of and investment into such technology would prove tremendously beneficial for outpatient health insurance as outpatient has a 98% (source: NSSO 60th Round) share of the total healthcare needs but no insurance to cover the same.

Having outpatient cover will yield better results and the problem of fast payments too, can be tackled by an automated digital platform. Before visiting the healthcare clinic or facility, the consumer can fill the claim form on a mobile app which will send alerts to the insurers as well as the hospital. The patient, the payer and the hospital will be connected through the same app with different functions for the three. The doctor can select the ailment the patient is being treated for, the drop-down menu will show patient's eligibility, cost incurred and the treatment required. This information will reach the payer at the click of a button. If the information sent meets all the eligibility criteria, the app will automatically sanction payer's approval. Similarly, the diagnostic center and the pharmacy too, can be brought into this loop.

Customer Happiness: At the heart of the entire claims process is the patient who is the policyholder and the customer for the hospital as well as the payer. Thus, ensuring customer happiness goes way beyond providing a suitable health cover. The consumer should be able to make use of it in time of need without any hassle. Today, a customer still needs to fill forms manually at admission, wait in long queues at the insurance desk for a status update, and wait for several hours for a discharged to get processed. In the case of reimbursement claims, the entire cycle lasts upto a month or more with the patient or their relative making several trips to the payer's desk.

To make health insurance customer-friendly, a lot of work needs to be done to make utilization simple. Simple solutions such as sending SMS-based alerts, mobile apps that can enable the patient to send all policy related information to the hospital and the payer before coming to the hospital in the case of pre-empted treatment, will eliminate the admission process. A mobile app will also enable the policyholder to have history of usage and related documents in a completely paperless format, just like the way taxi-hailing apps such as Uber allow the customer to save service utility data that is easily accessible. Thus, it is clear that just the way mobile apps have changed the way we consume and have access to products and services, health insurance too, can be utilized

Conclusion: We need all hands on deck

Inform and educate:The responsibility of appropriately using the health policy lies equally on the policyholder's shoulders. Thus, we must ensure that the fine print, and clauses and exceptions are well known before we enroll for a particular type of insurance. Insurers too, must employ more transparent means while selling policies and ensure that their customers have all the information required to use the policy and file a claim.

Support and buy-in from all stakeholders: The ecosystem of healthcare insurance, including the governments at the state and the center must come together to ensure that specialized and suitable technology solutions are implemented. While this mandates a few cultural and infrastructural changes for any organization, support from key management and success case studies from foreign and Indian counterparts can become the foundation for the road ahead.

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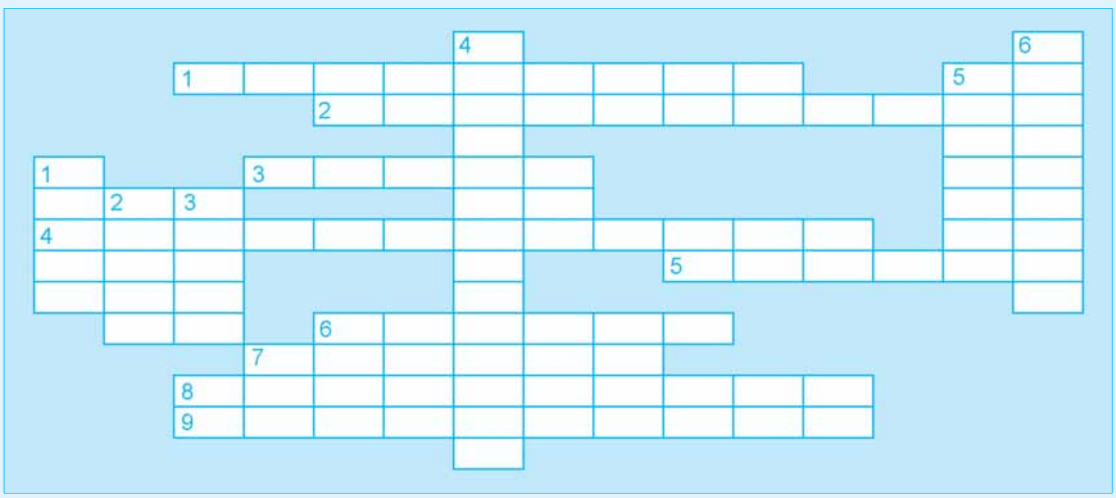
CROSS WORD - JUNE 2016



CLUES

ACROSS

1. To free or clear from guilt or blame
2. Sudden and widespread of disaster
3. New Institution for financing small units set up under Budget 2016
4. Something given for loss, injury or suffering
5. A person who is given loan
6. Type of Group Assurance Plan
7. A Pizza delivery Chain
8. Exceeding the bounds of propriety, custom or reason
9. Great work, especially chief work

DOWN:

1. A crop insurance scheme
2. A scheme designed to dupe investor
3. Flagship crom scheme of present government
4. A Crop season in India
6. No yet over

Solutions will be published in the next edition

ISSUE FOCUS

Manoeuvring the Monitoring
The Nitty-Gritty of Regulating Insurance Sector

In this article Mr. DVS Ramesh talks about the concept of insurance and the need for its regulation. He also pressed the need for functional autonomy of the regulatory bodies. The article also talks about various levels of regulation, their roles and finally the need for a gloabl level coordination amongst the insurance supervisors for best supervision.

- D V S Ramesh

With the evolution of novel nomenclature, from the stage of 'controller' in early nineties to 'regulator' now and if we observe the usage of words like 'supervision'/'monitoring' as synonymous to 'regulation' it is interesting to see the changing paradigms of regulatory approaches. Stability of financial sector influences the stability of economy. For a nation to be on sound economic footing a stable financial sector is an essential prerequisite. Though, developmental factors like growth of agricultural, services and industrial sectors determine the pace of economic development, financial sector that purveys a stable financial infrastructure to these sectors, works like an umbilical cord in the overall growth of the economy. Though, the regulated entities are aware of the fact that the functioning of the financial sector will be influenced by various external and internal factors, it is rare that they are hundred percent happy to accept the existence of a regulator. However, it is the presence of the regulator that promotes the growth of business and its sustenance. In its objective of ensuring self-sustainability, for ensuring continuous reposing of faith by the gullible public in the financial system, successive Governments preferred independent surveillance on the markets for regulating those sectors and institutions that are likely to be diversifying their networks across wide geographical areas reaching a wide gamut of population both directly and through new entities.

Insurance evolved as a branch of financial sciences, is in existence since time immemorial in the form of risk sharing and risk diversification in various clusters of social economy. Changing socio economic factors together with technological developments placed insurance in a prominent position in the financial sector. Insurance in the larger perspective is considered as a social security tool.

Insurance evolved as a branch of financial sciences, is in existence since time immemorial in the form of risk sharing and risk diversification in various clusters of social economy. Changing socio economic factors together with technological developments placed insurance in a prominent position in the financial sector. Insurance in the larger perspective is considered as a social security tool. As the costs incurred for insurance services are paid up-front, while the real benefits (of insurance) are contingent, the monies involved in certain classes like life insurance are paid over generations, it is essential that the business of Insurance is subject to the rules.

It is opined by economists that monopoly of any sector would be detrimental to the price and choice of the customers apart from restricting the flow of capital and generation of newer avenues. Accordingly, various sectors are opened to private participation, leading to ushering of multiple players competing one another to offer the best services with the best possible lower prices both to attract the customers and to capture a leading market share. In their attempt to capture the market share, some companies may be tempted to follow such market practices that may likely hamper sustainable growth thereby affecting the sustenance of the industry in the long run. As part of their obligation though Governments may monitor/ regulate the activities of these businesses, regulation being a complicated activity, managing the same within the overall framework of other executive activities may not receive the desired attention. Functional autonomy of regulatory bodies is recognised as one of the essential pre-requisites for an apt and sound regulatory regime. To ensure the autonomy of a regulatory body there is a deliberate action by legislations separating the task of regulations from the rest of its departments. While the functioning of regulators is within the overall ambit of the legislative framework, this separation leads to grooming the regulatory bodies on professional lines with the main objective of protecting the interests of its respective stakeholders. A standalone regulatory activity also concentrates on the technical aspects of the regulated subjects leaving no scope for external influences on its decisions at various points of time. Given this valuable evolution, it is important that the regulated entities understand the intricacies of the regulation in order to appreciate the role of regulator.

On the other hand, industry bodies have a role in chalking out a strategy for the entire industry, in putting in place the best practices / code of conduct and nudge the players of the industry to fall in line. For their critical role these industry bodies are historically referred to as Self-regulatory Organisations.

Regulatory Layers: Though, the statutory regulatory regime is in place with adequate regulatory framework, Regulators recognise, amongst others, the criticality of regulated entities' internal processes, their ability to administer the business, their credibility in terms of their Governance, which is referred as due diligence in regulatory parlance. While it is essential for the regulator to pay credence to these factors, it is more important to the regulated entities to adhere and continue with these values for their growth, stability and to maintain their unique identity. Sound operational systems, better market conduct, the best Governance practices are some of the important aspects that are expected and recognised by the Regulators. In order to adhere to and maintain these internal norms, regulated entities need to pay the same regard as how they regard the regulation, hence warrant treating them as their own internal regulations. On the other hand, industry bodies have a role in chalking out a strategy for the entire industry, in putting in place the best practices / code of conduct and nudge the players of the industry to fall in line. For their critical role these industry bodies are historically referred as Self-regulatory Organisations. All these different objectives, are different layers of Regulation of a regulated entity i.e., internal regulation, self-regulation and statutory regulation. Internal regulation is the base on which the growth or evolution of the companies depend. As a next stage as how self-discipline is hailed as the best discipline, self-regulation of the industry by a body of association of its own members establishes the market discipline. At ultimate stage the statutory regulation has its own role as per the charter of statutes.

Regulatory Layers

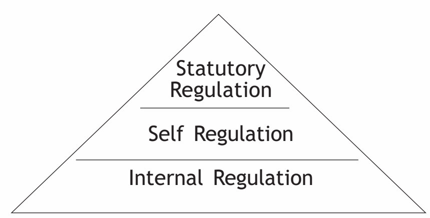


Diagram - 1

Internal regulation shall be self-adopted concept encompassing the well-established internal controls, internal checks, governance norms and market conduct practices etc. While measures like internal controls and internal checks address the micro aspects of day to day transactions, issues like governance and business practices address the macro policies of the company for effective implementation. Practices adopted by the regulated entities work more on the lines of internal regulations, as these entities also monitor and rate their practices/ policies vis-à-vis their corporate objectives and industry growth. Certain issues like, issues relating to the self-sustainability of the products, market conduct practices, performance of investment could be better gauged by companies themselves before gaps, if any, are surfaced.

Self-regulation is the next stage wherein all the market players would come forward voluntarily and adhere to the best business practices across the industry. Self-regulation though voluntary, occupies a prominent role in enforcing the discipline amongst the players. However, for its enforcement, markets need to be an established (read as matured) one.

On the other hand statutory regulation, being the regulation imposed by the statute forces the insurers to demonstrate their adherence to regulatory framework during the conduct of the business and its operations. The intricacies involved and the objective of the statutory regulation are discussed in later stages of this article.

In the early 2000s, prior to the period of financial crisis, there was a school of thought that the Self-Regulation of the industries shall be allowed to have a prominent role so that the markets determine their own course of action. However, post financial crisis the core of the regulation re-diverted and focussed on statutory regulation. The views of Dr Y V Reddy placed in the following box item bespeak itself on this approach.

Therefore, despite their respective strengths, when it comes to supervising / monitoring, the statutory regulation oversees the rest of two. While internal regulations framed are within the overall framework of self-regulations and statutory regulations, statutory regulation also oversees if market players adhere to their own self regulations and internal regulations. And in turn the regulatory interventions would be based on their adherence to self-regulation and internal regulation. As may be observed from Diagram – 1 the higher the importance to the internal regulation by the Insurers the lower the scope for the remaining and so on.

Overseeing Regulatory Tracks

The regulatory economics of insurance sector are quite dynamic with the nature of insurance business dealing with uncertain magnitudes of unknown risks. The need for extending the risk coverage to various sections of individuals in case of retail insurance and to various businesses in case of Group or Commercial risks opens a plethora of business avenues prodding them to breach various layers of the regulations referred

There is a virtual consensus that the regime of financial sector regulation in major developed countries needs a thorough overhaul. Several reports have taken this issue on board. The recommendations of all these reports is to: strengthen regulation; reverse the process of deregulation of recent years; increase the scope of regulation; make regulation countercyclical; emphasise macro-prudential regulations; take cognizance of liquidity risks; explore methods to tackle the 'too big to fail' institutions; alter the framework of managerial incentives; widen the range as well as scope of instruments of regulation consistent with the multiplicity of objectives and complexities in the market; enhance the scope for discretion of regulatory authorities while upgrading their skills; focus on structures and systems rather than only on mathematical models; and expand the obligation of financial instruments to be traded on exchanges.

Dr Y V Reddy
On Re-Regulation and Innovation in the Financial Sector
In Global Crisis Recession and Uneven Recovery

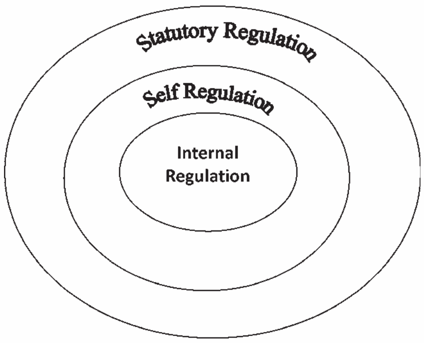


Diagram - 2

above. Therefore, it is interesting to sense an overseeing mechanism where a well-established self-regulatory framework is in place, it also oversees the internal regulatory framework of the players. Also as depicted at Diagram-2 the statutory regulation oversees the both. It is important for the regulated entities to prioritise adhering to their own internal norms (referred as regulation here) lest they may be subjected to oversight of the next layer. Where the self-regulation of the industry bodies is ineffective, the statutory regulation will have rebounding oversight.

Evolution of Regulations: Of the regulatory concerns of insurance industry, continued financial soundness (termed as solvency) of insurers, the business practices (termed as market conduct) entities involved and prudential / operational practices that meet the expectations of policyholders are the prime ones. While statutes outline the broad framework empowering regulator to further intervene or prescribe the detailed regulations wherever warranted, prescribing regulations/guidelines is a continuous cyclical regulatory event. The operational and business practices of insurance companies may force business expansion which generally leads to product (e.g. ULIPs) and service (say online services) innovations. These innovations force the regulator to re-visit adequacy of regulatory framework to the prevailing business and operational environment. It is a wrong notion that regulations stifle the innovation. In fact the regulation that follows the innovation solidifies the business growth. Further, it is but for the regulator, the entities adopt the innovation. Thus, the regulatory circle, as depicted at diagram – 3, is a never ceasing process and is well understood by matured market players.

Regulatory Cycle

Enforcing Regulations as important as framing Regulations: The regulator has various regulatory tools at its disposal like market intelligence, international cooperation for sharing of information and inter regulatory coordination to regulate and

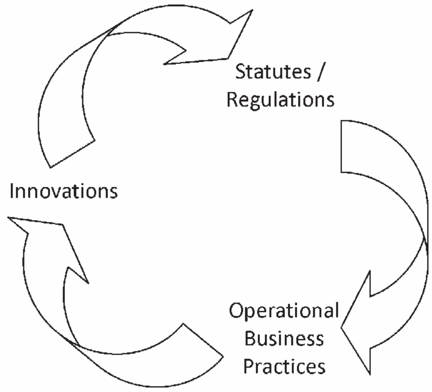


Diagram - 3

supervise the markets, in brief it keeps monitoring the market conduct, prudential aspects and operational / governance practices through two main tools, (i) offsite and (ii) onsite mechanisms. Offsite monitoring is the activity at the regulator's office, while onsite activity is the activity carried out at the premises / offices of insurers. A close off-site mechanism reveals, amongst others, early warnings, operational/systemic inadequacies and governance/business practices which may trigger an onsite inspection. By virtue of its role regulator carries out periodical onsite inspection of insurance companies which may bring out issues that have regulatory concerns leading to the tightening of offsite mechanism. Thus, onsite inspections complement offsite mechanism of regulatory bodies. The onsite and offsite supervisory tools may be aptly portrayed as the pedestals (Diagram – 4) on which monitoring of insurance sector actuates on an ongoing basis.

Regulatory Pedestals

As internal controls and checks that are in place with insurance companies constantly monitor the minuscule to majuscule transactions and policies of the company which are expected to be in accordance with statutory regulation; and self-regulations, if any, the regulator develops such systems for an ongoing off-site monitoring like periodical reports/returns, pre-approval procedures and grievances reporting etc. that provide flow of information. Every information,

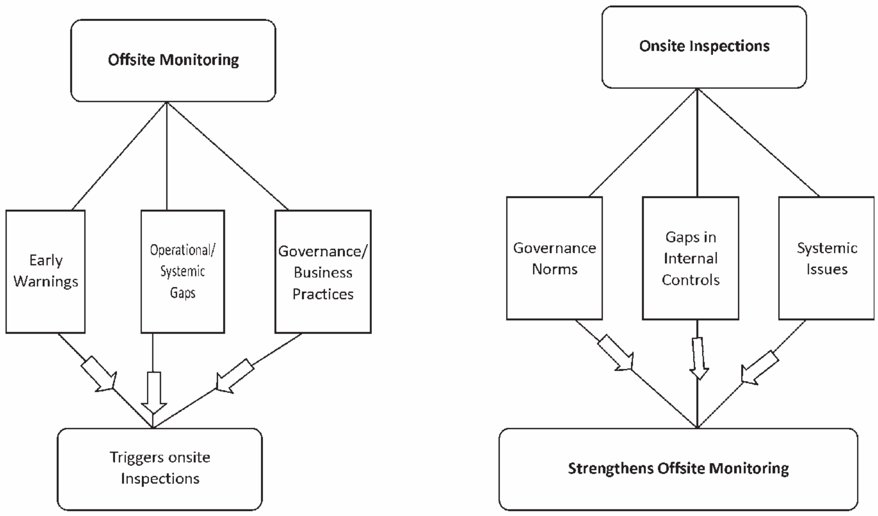


Diagram - 4

report / return received or application filed for prior approval offers opportunity for peeping into the possible conduct or the potential practices of insurers. These two pedestals also stand as a base for possible regulatory interventions.

Those regulated entities that closely follow the regulatory making process do appreciate that, quite often, it is because of the gaps that surfaced in the procedures / governance aspects of their offices, the regulator intervenes through a regulatory framework. Therefore, the better the conduct / operational procedures, the lesser (relatively) the role for repeated regulatory interventions.

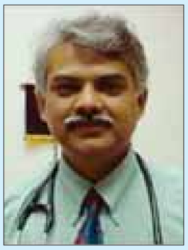
Convergence of global standards: With the globalisation of world economy the barriers of business boundaries are being erased. Further there is also a need on the other hand, for a cohesive effort at global level to synergise the efforts of each country's regulators. Be it Basel for banks or IOSCO for securities or IAIS (International Association of Insurance Supervisors) for insurance, the main objective of these global level apex bodies is to share the information on regulatory matters for strengthening the regulatory mechanisms. Of these three, IAIS provides guidance notes not only in supervisory matters but also on developmental roles of supervisory bodies of insurance sector. The need for global level co-ordination is evident with the common concerns that exist in Insurance business like Solvency, Anti Money Laundering and Insurance Frauds which needs to be tracked continuously. Apart from this, global level coordination also facilitates exchange of information about the regulated entities for better supervision. Therefore, the regulated entities shall be always in their best attention, as the regulatory radars monitor their manoeuvres.

With the globalisation of world economy the barriers of business boundaries are being erased. Hence there is a also a need for a cohesive effort at global level to synergise the efforts of each country's regulators.

D V S Ramesh, Deputy Director (Health Policy) IRDAI, Hyderabad dvsramesh@gmail.com. Views expressed are personal

Solving the Intricacies of Heart Failure

This artilce talks about the various causes, stages and symptoms of heart failure besides mentioning the various theurapatic options available to deal with Heart failure



- Dr. Amit Vora

The Heart: An Introduction

The Heart is one of the most important organs in our body. It serves as a physical pump that tirelessly supports other organs by providing oxygen and nutrients to the body and removing toxins via the blood.

The heart is made up of four chambers - two at the top (the atria) and two at the bottom (the ventricles). With every heartbeat, the right atrium receives used blood from the body and pumps it out via the right ventricle into one of the main blood vessels (called the pulmonary artery), where it travels to the lungs to exchange carbon dioxide for oxygen. Simultaneously, the left atrium receives oxygen-enriched blood from the lungs and pumps it to the body from the left ventricle into the biggest blood vessel in the body (the aorta) (see figure 1). 1. The pumping function of the heart is a very mechanical process but each heartbeat is controlled by electrical impulses generated by a natural timer (the SA node) located in the muscle of the right atrium. A healthy heart requires that its mechanical function and electrical conduction system stay intact to maintain a normal rhythm.

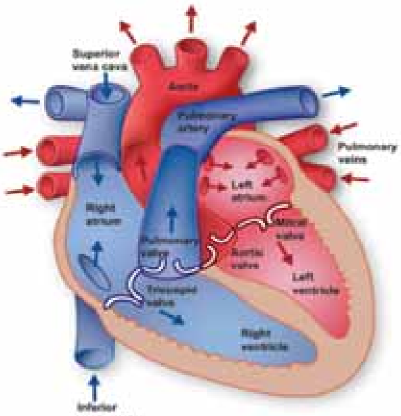


Figure 1: The Heart[1]

The electrical system of the heart supports the blood pumping machinery. Originating from the SA node, the electrical impulses spread throughout both atria, which cause them to contract. This squeezes the blood from the atria into the ventricles. There is a pause in the conduction of the electrical impulse from the atria to the ventricles, allowing the atria to finish contracting and the ventricles to fill with blood, after this short pause the ventricles contract forcing the blood out of the heart and around the body. Now the ventricles relax and the cycle starts again producing another heartbeat. 2 Any abnormality in this cycle can lead to faster, slower or irregular heartbeats, a condition called cardiac arrhythmia. Cardiac arrhythmias if left untreated can affect the heart's ability to pump blood and in severe cases cause death3.

Heart Disease - What is Heart Failure?

Like any other organ, underlying conditions and disease can lead to

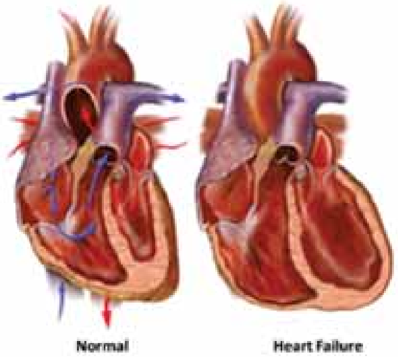


Figure 2: Illustration of heart failure

abnormal functioning of the heart. Heart disease is a serious concern worldwide and the single largest cause of death. One type of heart disease is Heart Failure (HF) (see figure 2). Globally, 26 million people are affected with HF.5 In India; the estimated prevalence of HF is 1.3-4.6 million with an annual incidence of 0.5-1.8 million.

Unlike the literal meaning, HF need not necessarily mean that the heart has completely stopped working; instead it refers to a condition where the heart's capacity to pump blood is reduced and therefore it is unable to fully meet the body's needs for blood and oxygen, indeed the term for heart failure in French and German translates as "heart insufficiency". The pumping ability of the heart gets affected when the heart muscle becomes weak and is unable to supply the body with the flow of blood it needs. Due to this limitation in blood supply, other organs begin to work less efficiently; for instance, the kidneys do not remove enough fluid and toxins from the blood. Fluid starts to build up in and around the body, notably in the lungs, making it hard for patients to breathe and requiring hospital treatment, without which in these situations patients may die.

What causes Heart Failure?

Heart Failure maybe caused due to an underlying or pre-existing health condition. Narrowing of blood vessels that supply oxygen enriched blood to the heart called Coronary Artery Disease (CAD) is the most common cause of heart failure. Other common risk factors associated with heart failure include high blood pressure, diabetes, valvular and other structural heart diseases, cardiac arrhythmia, alcohol or drug abuse, thyroid problems, and obesity, among others.

What are the symptoms of Heart Failure?

The symptoms of HF may not be visible in the early stages but may range from mild to severe in the progressive stages. Common symptoms of HF include persisting cough, dyspnea (shortness of breath), fatigue (unexplained weakness), edema (swelling and excess fluid build-up on hands and legs), reduced ability to exercise or an unexplained and sudden increase in body weight.

Stages of Heart Failure -The NYHA HF Classification

To ascertain the best possible and appropriate treatment for the patients' condition, the severity of the HF needs to be classified. The New York Heart Association (NYHA) provides a symptom based classification for HF which is widely used to guide patient management (see table 1).

Therapeutic options available to manage Heart Failure

Even though HF is an incurable condition, improvements can be made in outcomes and quality of life by careful management of patients and their condition. Modern technologies and therapeutic options allow effective management of HF. Physicians may prescribe different therapies depending upon the severity of the disease and clinical guidelines.

Some common therapies available to physicians include diuretics

NYHA Class	Ability to carry out ordinary physical activity	At rest	Presence of symptoms such as tiredness, quivering of the heart, shortness of breath, chest pain
I	Without limitation	Comfortable	No Symptoms with ordinary physical activity
II	Slight limitation	Comfortable	Symptoms present with ordinary physical activity
III	Marked limitation	Comfortable	Symptoms present with less than ordinary physical activity
IV	Unable to carry out physical activity without discomfort	Uncomfortable. Symptoms may be present even at rest	Discomfort increases with physical activity

Table 1: Patients with Cardiac disease are classified in four severity classes of Heart Failure by NYHA15

(drugs which help remove excess fluid from the body) for symptom relief and drugs such as ACE inhibitors and beta blockers to improve the efficiency of the heart.

Surgical interventions may also be recommended which include angioplasty/bypass surgery, valve surgery and as a last resort heart transplant. One of the important advances in heart failure treatment is to use implantable devices that help correct the problems caused by heart failure. It is effective in improving symptoms and also extends the lives of heart failure patients.

What is Cardiac Resynchronization Therapy?

The mechanical efficiency of the heart may be affected by disruption in the normal coordination between the atria and the ventricles or in-between ventricles. In addition, there could be a delay in the normal activation and contraction of the LV which affects the efficiency of the heart. The delay in the contraction of LV is common in HF patients, this leads to insufficient amount of blood pumped out and consequently affects the blood supply to other organs of the body.

Cardiac Resynchronization Therapy (CRT) is a well-established therapy to manage HF and as the name suggests, CRT devices ensure that normal coordination between the heart chambers in maintained, so that they work together in sync. CRT helps to restore mechanical coordination in the heart and reduces the delay in ventricular contractions.

A CRT device is a sophisticated implantable cardiac pacemaker. A standard pacemaker typically consists of a metallic can which has a battery and timer connected to the heart by one or two thin wires called leads. The pacemaker is implanted under the skin of the chest and the leads are attached to the heart's right atrium (RA) and the right ventricle (RV). The pacemaker is then able to manage the timing of each heart beat and make sure that the heart continues to beat at a regular and appropriate rate. These conventional pacemakers are essentially used for patients with bradyarrhythmia (slow pulse).

Unlike the normal pacemaker, CRT devices consist of an additional lead that is attached to the left ventricle (LV). This additional lead simultaneously stimulates the LV and maintains the synchrony between the pumping action of left and right ventricle. These devices are also sometimes known as biventricular pacing therapy or CRT-P devices. The aim of CRT is to make sure the sick heart pumps blood as efficiently as possible, maximizing the effect of every heartbeat. CRT device is ideally suited for patients with heart failure who have electrical conduction weakness of the left ventricle i.e. left bundle branch block (LBBB). This is easily identifiable on a standard ECG test.

Depending on whether the patient's heart rate is slower or faster than normal, there are two types of CRT devices available,

- CRT-Pacemaker (CRT-P) that are used for patients with a normal or slow heart rate
- CRT-Defibrillator (CRT-D) which is a combination of CRT pacemaker and defibrillator, this is typically helpful for patients with very fast and potentially lethal heart rhythm (ventricular tachycardia/fibrillation). Defibrillation is delivered by the device in response to a life-threatening event to electrically shock the heart and correct the heart rhythm.

Improving Quality and Reducing Cost

Randomized clinical studies conducted across the world over the long term time have established that CRT devices are highly efficacious in treating HF.Studies have shown that CRT leads to better patient outcomes compared with other available device therapy (ICDs, Pacemakers) and optimal medical therapy (pharmacological drugs) alone.

When comparing optimal medical therapy alone with optimal medical therapy plus CRT, it was found that hospitalization rates were reduced by 44% for patients implanted with CRT-P and 41% for those implanted with CRT-D.19 Further more patients implanted with CRT-D demonstrated a relative reduction of 36% in mortality rates.

In addition to the improvement in clinical outcomes, CRT devices have also proven to be highly cost-effective compared to other therapies. Over a patient's lifetime, CRT-P in addition to medical therapy appears cost-effective in patients of all age groups.

Quadripolar Pacing – Further improving CRT

As we have seen in previous sections, CRT is an effective treatment for heart failure patients. However, CRT has its own challenges in LV pacing. This is largely due to two factors, first, the minimum electrical impulse required to effectively stimulate LV istypically higher than for the RV; these high pacing "thresholds" often interfere with the optimal positioning of the LV lead for cardiac resynchronization. Second, the presence of the phrenic nerve (nerves which help in exchanging signals between the brain and the diaphragm) close to the heart frequently leads to their accidental stimulation during LV pacing, which is uncomfortable for patients resulting in permanent or frequent episodes of "hiccups".

To overcome these challenges, a new technology known as the quadripolar lead pacing has been developed which allows greater flexibility in electronic selection of pacing positions and reduces the need to surgically reposition the lead.

In contrast to traditional lead pacing, which allows limited pacing position configurations due to the availability of only unipolar (with one electrode) or bipolar (with two electrodes) leads, quadripolar technology offers a multipolar lead with multiple electrodes. This allows the treating physicians to easily select from up to 10 possible pacing configurations and determine the position that is the most appropriate to target for pacing (see figure 3).25,26

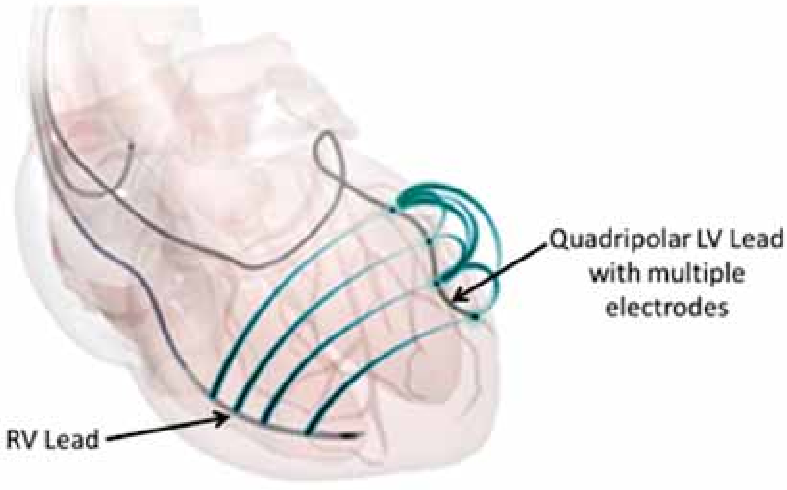


Figure 3: Multiple pacing vectors available with Quadripolar leads27

Evidence from clinical studies validate that difficulties with the traditional lead pacing can be managed by selecting appropriate pacing configuration using non-invasive programming mechanism in quadripolar leads. This allows optimal lead positioning without the interference of high pacing thresholds and unintentional stimulation of phrenic nerves, subsequently increasing the battery longevity and the flexibility during CRT implantation.

Relevance to Healthcare Payers

As health insurance and reimbursement coverage expands from a small section of the population to the masses in the country, concepts of health economics such as cost-utility and cost-effectiveness that are prevalent and accepted in some of the world's mature health systems need to be considered while evaluating treatment options.

Health economic evidence supports that CRT-P and CRT-D therapies meet the incremental cost-effectiveness ratio (ICER) value of \$50,000/QALY (quality-adjusted life years), a standard commonly used for validating therapeutic interventions in the USA, as well as similar thresholds used in Europe, signifying that improvements in patients' health-related quality of life and clinical outcomes of CRT can be achieved at a reasonable cost.

Over a two-year time frame, costs associated with HF-related hospitalization were reduced by 29% for CRT-D patients and by 37% for CRT-P patients. Furthermore, an analysis of CRT cost-effectiveness in a middle-income country's public health system, revealed that the ICER of CRT-P was $15,723/QALY and that of CRT-D was $ 36,940/QALY over prevailing standards of care, this is well within the acceptable cost-effectiveness threshold of $50,000/QALY.30

I recommend that such modalities should be considered while making decisions of reimbursement and pricing, this will help us in moving from the current perspective of one-time procedure costs to the long-term health outcomes and overall disease management costs over the patient's lifetime.

Conclusion

Heart Failure is a disease associated with major morbidity and mortality as well as considerable healthcare costs; hence, it is important that it is managed early and with the most appropriate therapeutic option. If managed well, the advancement of HF can be prevented, decelerated or even in some cases reversed. CRT has proven to be a clinically efficacious and cost effective therapy to manage HF in select patients. CRT devices are proven to improve the functional status of the patients' health, increase survival, and reduce the risk of hospitalizations. A recent advance in the form of Quadripolar pacing in CRT devices has provisioned additional capabilities to deal with challenges existing in traditional systems. Management of HF has now become more effective to improve the quality of life and improve longevity in heart failure patients, aiding in a reduction in the overall health economic burden of the disease over the long term.

References

1. Henderson, R. (2013). How the heart works. Netdoctor. Retrieved 26 March 2015, from http://www.netdoctor.co.uk/conditions/heart-and-blood/a1171/how-the-heart-works/

2. Shea, J. B. (2003). Cardiac Resynchronization Therapy A Patient's Guide. Circulation, 108(9), 64e-66e. http://dx.doi.org/10.1161/01.cir.0000085657.09097.38

3. About Arrhythmia. Heart.org. Retrieved 26 March 2015, from http://www.heart.org/HEARTORG/Conditions/Arrhythmia/AboutArrhythmia/About-Arrhythmia_UCM_002010_Article.jsp

4. Anatomy of the Heart. Texasheart.org. Retrieved 26 March 2015, from http://www.texasheart.org/HIC/Anatomy/images/fig1_crosslg.jpg

5. López-Sendón, J. (2011).The heart failure epidemic. Medicographia, 33, 363-369. http://www.medicographia.com/2012/02/the-heart-failure-epidemic/

6. Lee, S., Khurana, R., & Leong, K. (2012). Heart failure in Asia: the present reality and future challenges. European Heart Journal Supplements, 14(suppl A), A51-A52. http://dx.doi.org/10.1093/eurheartj/sur037

7. Heart Failure Overview. WebMD. Retrieved 26 March 2015, from http://www.webmd.com/heart-disease/heart-failure/heart-failure-overview

8. What Is Heart Failure? - NHLBI, NIH. Nhlbi.nih.gov. Retrieved 26 March 2015, from http://www.nhlbi.nih.gov/health/health-topics/topics/hf

9. About Heart Failure. Heart.org. Retrieved 26 March 2015, from http://www.heart.org/HEARTORG/Conditions/HeartFailure/AboutHeartFailure/About-Heart-Failure_UCM_002044_Article.jsp

10. Meritus Health Maryland | Congestive Heart Failure Program. Meritushealth.com. Retrieved 26 March 2015, from http://www.meritushealth.com/Our-Services/Meritus-Medical-Center/Heart-Stroke/Cardiac-Services/Congestive-Heart-Failure-Program.aspx

11. What is Heart Failure? (p. Range of pages). Retrieved from https://www.heart.org/idc/groups/heart-public/@wcm/@hcm/documents/downloadable/ucm_300315.pdf

12. Heart Failure Symptoms. WebMD. Retrieved 26 March 2015, from http://www.webmd.com/heart-disease/heart-failure/heart-failure-symptoms

13. Heart failure Symptoms - Mayo Clinic. Mayoclinic.org. Retrieved 26 March 2015, from http://www.mayoclinic.org/diseases-conditions/heart-failure/basics/symptoms/con-20029801

14. Mosterd, A. & Hoes, A. (2007). Clinical epidemiology of heart failure. Heart, 93(9), 1137-1146. http://dx.doi.org/10.1136/hrt.2003.025270

15. Classes of Heart Failure. Heart.org. Retrieved 26 March 2015, from http://www.heart.org/HEARTORG/Conditions/HeartFailure/AboutHeartFailure/Classes-of-Heart-Failure_UCM_306328_Article.jsp#.V1UcgPl95dg

16. Review -ThePathology of Ventricular Dyssynchrony and the Role of Cardiac Resynchronization Therapy. Medscape. Medscape.org. Retrieved 31 March 2015, from: http://www.medscape.org/viewarticle/493887

17. Bleeker, G., Bax, J., Steendijk, P., Schalij, M., & van der Wall, E. (2006). Left ventricular dyssynchrony in patients with heart failure: pathophysiology, diagnosis and treatment. Nature Clinical Practice Cardiovascular Medicine, 3(4), 213-219. http://dx.doi.org/10.1038/ncpcardio0505

18. Forleo, G., Di Biase, L., Bharmi, R., Dalal, N., Panattoni, G., &Pollastrelli, A. et al. (2014). Hospitalization rates and associated cost analysis of cardiac resynchronization therapy with an implantable defibrillator and quadripolar vs. bipolar left ventricular leads: a comparative effectiveness study. Europace, 17(1), 101-107. http://dx.doi.org/10.1093/europace/euu290

19. Anand, I., Carson, P., Galle, E., Song, R., Boehmer, J., &Ghali, J. et al. (2009). Cardiac Resynchronization Therapy Reduces the Risk of Hospitalizations in Patients with Advanced Heart Failure: Results From the Comparison of Medical Therapy, Pacing and Defibrillation in Heart Failure (COMPANION) Trial. Circulation, 119(7), 969-977. http://dx.doi.org/10.1161/circulationaha.108.793273

20. Tang, A., Wells, G., Talajic, M., Arnold, M., Sheldon, R., & Connolly, S. et al. (2010). Cardiac-Resynchronization Therapy for Mild-to-Moderate Heart Failure. New England Journal of Medicine, 363(25), 2385-2395. http://dx.doi.org/10.1056/nejmoa1009540

21. Stahlberg, M., Lund, L., Zabarovskaja, S., Gadler, F., Braunschweig, F., & Linde, C. (2012). Cardiac resynchronization therapy: a breakthrough in heart failure management. Journal of Internal Medicine, 272(4), 330-343. http://dx.doi.org/10.1111/j.1365-2796.2012.02580.x

22. Yao, G., Freemantle, N., Calvert, M., Bryan, S., Daubert, J., & Cleland, J. (2006). The long-term cost-effectiveness of cardiac resynchronization therapy with or without an implantable cardioverter-defibrillator. European Heart Journal, 28(1), 42-51. http://dx.doi.org/10.1093/eurheartj/ehl382

23. Huizar, J., Kaszala, K., Koneru, J., Kowalski, M., Thacker, L., Wood, M., &Ellenbogen, K. (2012). Disparity in Left Ventricular Stimulation among Different Pacing Configurations in Cardiac Resynchronization Therapy. Circulation: Arrhythmia and Electrophysiology, 5(1), 140-146. http://dx. doi: 10.1161/CIRCEP.111.965475

24. Goetze, S., Defaye, P., Bauer, A., Merkel, M., Bizeau, O., &Treusch, S. et al. (2013). Phrenic nerve stimulation in CRT patients and benefits of electronic lead repositioning: the ERACE trial. J Interv Card Electrophysiol, 38(1), 1-9. http://dx.doi.org/10.1007/s10840-013-9811-9

25. George H Crossley. (2014). The challenge of left ventricular lead placement: What is the role of quadripolar leads?. Retrieved from http://www.cxvascular.com/crn-

features/cardiac-rhythm-news---features/the-challenge-of-left-ventricular-lead-placement-what-is-the-role-of-quadripolar-leads

26. Shetty, A., Duckett, S., Bostock, J., Rosenthal, E., & Rinaldi, C. (2011). Use of a quadripolar left ventricular lead to achieve successful implantation in patients with previous failed attempts at cardiac resynchronization therapy. Europace, 13(7), 992-996. http://dx.doi.org/10.1093/europace/eur032

27. Diseases. Professional.sjm.com. Retrieved 26 March 2015, from http://professional.sjm.com/solutions/diseases

28. Boriani, G., Mantovani, L., Biffi, M., Schalij, M., Martignani, C., &Leclercq, C. et al. (2011). Cardiac resynchronization therapy: a cost or an investment?. Europace, 13(suppl 2), ii32-ii38. http://dx.doi.org/10.1093/europace/eur079

29. Feldman AM, de Lissovoy G, Bristow MR, Saxon LA, De Marco T, Kass DA, Boehmer J, Singh S, Whellan DJ, Carson P, Boscoe A, Baker TM, Gunderman MR et al. (2005). Cost effectiveness of cardiac resynchronization therapy in the Comparison of Medical Therapy, Pacing, and Defibrillation in Heart Failure (COMPANION) trial. J Am CollCardiol, 46(12):2311-21. http://dex.doi:10.1016/j.jacc.2005.08.033

30. Bertoldi, E., Rohde, L., Zimerman, L., Pimentel, M., &Polanczyk, C. (2013). Cost-effectiveness of cardiac resynchronization therapy in patients with heart failure: The perspective of a middle-income country's public health system. International Journal of Cardiology, 163(3), 309-315. http://dx.doi.org/10.1016/j.ijcard.2011.06.046

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LIFE INSURANCE JUMBLE-Q1-2016-17

THEME: POINT OF SALE

Sr No	JUMBLED WORD	ANSWER
1	EDACIV	
2	SCTPEROP	
3	EDRRI	
4	LOSPPORA	
5	RCEOV	
6	ERAIDMNTEYIR	

ANSWERS TO LIFE INSURANCE JUMBLE
1. ADVICE, 2. PROSPECT, 3. RIDER, 4. PROPOSAL, 5. COVER, 6. INTERMEDIARY

Insurance Awareness Day

Continuing the tradition of celebration of IRDAI's 'Formation Day' as Insurance Awareness Day, IRDAI celebrated it on 19th April, 2016 at Hyderabad. Shri Yaga Venugopal Reddy, Chairman,14th Finance Commission and Former Governor, Reserve Bank of India, graced the occasion as 'Chief Guest'.

The celebrations, on the very day, were started with Finals of Pan India Quiz Competition. Teams from four insurance companies participated in the finals after qualifying semi-finals. Prior to the finals of the Competition, there were eight groups for quarter finals consisting

Winner, the team from Exide Life Insurance Co. Ltd. was the Runner-up of the quiz competition.

The quiz competition was followed by a 'Panel Discussion' on 'Best Insurance Awareness Policies of the insurers' moderated by Shri PJ Joseph, Member (Non-Life). The panel was unanimous about having a multipronged and multi-agency approach towards insurance awareness with print, electronic and social media involving all stakeholders viz. insurance companies, educational institutions, insurance councils, other regulators, government along with IRDAI. The members of the panel said in one voice that simple social insurance schemes launched by the government and their publicity by all stakeholders for popularizing these schemes, will certainly improve insurance inclusion. The members were of the view that three 'Cs' Customer Education, Claim Handling and Complaint Resolution can create confidence and trust in the insurance industry, which may lead to greater insurance inclusion both in life and general insurance including health insurance segments.

The main function started with the lighting of the lamp by the Chief Guest, Dr YV Reddy followed by launching of the IRDAI's Consumer Education Material in Telugu and Hindi.

Prizes were distributed to the winners of the Pan India Quiz Competition-2016 and South Zone winners of the third National Financial Literacy Assessment Test – 2015-16 (NFLAT 2015-16)

conducted by National Centre for Financial Education (NCFE) to measure the level of financial literacy among school student.

The NCFE-NFLAT 2015-16 was conducted on 28 & 29th November, 2015 in which more than 1,25,000 student from over 2000 schools registered from all over the Country in more than 340 locations.

Shri TS Vijayan, Chairman, IRDAI in his welcome address, briefed about the latest important developments

of the insurance sector following the delegation of greater regulatory powers to IRDAI through various regulations including Insurance Laws (Amendment) Act, 2015. With the amendment in the Insurance law, it has paved the way for opening of branches by reinsurers from outside India and the entry of these reinsurers will help Indian Insurance Companies to access the global capital. He said both life and general insurance sector achieved a double digit growth in the last financial year while the health insurance registered 35-40% growth in premium collection. He hoped that the insurance industry would do well in the current financial year since the monsoon was expected to be good.

Chief Guest, Dr YV Reddy, while addressing the participants, congratulated all the prize winners of various Competitions for their excellence and talked about the importance of insurance awareness. He further spelled out the peculiarities of financial services in comparison to any other goods or services as financial services are exchange of claims over time, space, uses and risks, information asymmetry between the financial

intermediary and the customer, limited liability and highly leveraged nature of entities. The role of financial regulator would be to repose trust of the members of public on the financial sector and the financial intermediaries. He stated that the emphasis of financial regulators on financial inclusion started with the global financial crisis. However, he cautioned that financial inclusion is a means and not an end for economic development and other aspects of progress. While appreciating the efforts of the IRDAI in promoting insurance literacy through a call centre, consumer education website etc., he urged upon IRDAI to consider realigning the call centre as a query centre to provide generic information for financial literacy at the point of need on a 24X7 basis in regional languages. He appreciated the efforts taken by IRDAI in building a competitive and sound insurance sector, thereby fulfilling the dual roles of policyholder protection and ensuring orderly growth of the insurance sector, making it unique and respected insurance regulators in the world

Thereafter, the Cultural Programme was begun with the Comedy Show followed by spectacular performances of music and dance by the staff of IRDAI as well as their Children. The audience was enthralled by the performances and everyone appreciated the IRDAI for organizing such a gala event.

Snapshot of Life Insurance Industry as at 30.06.2016

The Life Insurance Sector loggedRs.31392.55 croreFirst Year Premium with a growth of 33.20% as at 30thJune, 2016. LIC procured Rs 22594.22 Cr with a growth of 37.53% where as Private Sector procured Rs 8798.34 Cr posting a growth of 23.23%. Public and Private sector both experienced a growth in Individual and Group NB.

The number of individual policies has shown a growth of 0.33% by public sector and 6.64% by private sector and a overall growth of 1.66%. The number of lives covered under Group policies has shown a growth by38.41% at the industry level.

Linked business has registered a growth of 1.68% up to the period ended 30th June, 2016. In absolute volume of FYP it is Rs.2883.88Cr as at 30th June, 2016 as against Rs.2836.19Cr for the corresponding period of previous financial year. This entire growth may be attributed to the Private Sector (growth of 1.51%) while LICI has procured Rs.4.93 Cr against NIL business in the previous year.

The share of Pension (30.98%),Annuity (10.90%)segments has shown growth where as Life (58.02%) and Health (0.10%) segments have shown a decline when compared to last year's performance.The individual pension business shows agrowth both in terms of number of policies and premium. Group Pension premium has a growth of 6.52% for private sector and 56.80% for LICI.

The number of individual agents* in life insurance sector stood at 19,87,686 with a net reduction of 28,879 (1.4%) for the period. There is anet reduction of 21,437(2.2%) agents in private sector which has ended up with a total of 9,33,568 agents while there is a net reduction of 7,442 (0.7%) in case of LIC which closed the month of June 2016 with a total of 10,54,118 individual agents.

(* Source data is from Life Council's MIS for the month of June, 2016)

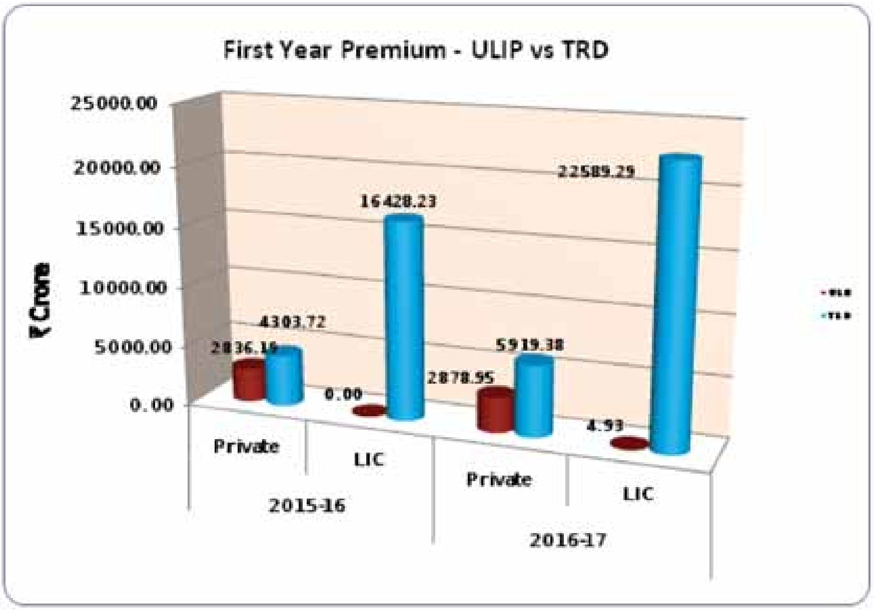
Analysis of Traditional Business:

The Life Insurance Industry has procured Non-Linked Premium of Rs.28508.67crore as at 30th June, 2016 as against Rs.20731.95 crore for the same corresponding period of previous year. It shows a growth of 37.51%.

LIC's Premium is Rs.22589.29crore (PY Rs. 16428.23crore), a growth of 37.50%.

Private players have collected Non-linked Premium of Rs.5919.38crore (PY Rs.4303.72crore), an increase of 37.55%.

Compiled by Life Dept., IRDAI



New Business Data as at 30.06.2016 (Line of Business wise)

INDIVIDUAL SINGLE PREMIUM (INCLUDING RURAL & SOCIAL)

(₹ in Crores)

Sl. No.	PARTICULARS	PREMIUM		POLICIES		SUM ASSURED	
		June, 2015	June, 2016	June, 2015	June, 2016	June, 2015	June, 2016
	Non linked*						
1	**Life**						
	with profit	1609.97	1703.41	214930	203560	8044.26	6215.37
	without profit	20.91	72.43	41016	29420	391.88	1995.21
2	**General Annuity**						
	with profit	0.00	0.00	0	0	0.00	0.00
	without profit	384.98	1821.38	9113	41495	37.28	41.09
3	**Pension**						
	with profit	6.04	4.69	148	171	8.91	6.94
	without profit	22.18	171.10	61	81	0.09	0.78
4	**Health**						
	with profit	0.00	0.00	0	0	0.00	0.00
	without profit	0.01	0.14	7	108	0.16	0.96
A.	**Sub total**	**2044.09**	**3773.15**	**265275**	**274835**	**8482.58**	**8260.35**
	Linked*						
1	**Life**						
	with profit	0.00	0.00	0	0	0.00	0.00
	without profit	243.04	242.71	11895	8788	438.43	755.38
2	**General Annuity**						
	with profit	0.00	0.00	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0.00	0.00
3	**Pension**						
	with profit	0.00	0.00	0	0	0.00	0.00
	without profit	23.30	84.95	138	123	17.58	3.50
4	**Health**						
	with profit	0.00	0.00	0	0	0.00	0.00
	without profit	0.00	-0.01	0	0	0.00	0.00
B.	**Sub total**	**266.35**	**327.65**	**12033**	**8911**	**456.02**	**758.88**
C.	**Total (A+B)**	**2310.44**	**4100.80**	**277308**	**283746**	**8938.60**	**9019.23**
	Riders:						
	Non linked						
1	Health#	0.00	0.00	0	0	0.30	0.00
2	Accident##	0.11	0.05	494	170	23.14	10.23
3	Term	0.000360	0.00	2	1	0.02	0.01
4	Others	1.10	0.43	0	0	1.32	1.09
D.	Sub total	1.21	0.49	496	171	24.78	11.33
	Linked						
1	Health#	0.00	0.00	-1	0	-0.01	0.00
2	Accident##	0.06	0.02	799	162	46.67	5.03
3	Term	0.00	0.00	0	0	0.00	0.00
4	Others	0.00	0.00	0	0	0.00	0.00
E.	Sub total	0.06	0.03	798	162	46.65	5.03
F.	Total (D+E)	1.27	0.51	1294	333	71.43	16.36
G.	****Grand Total (C+F)**	**2311.71**	**4101.31**	**277308**	**283746**	**9010.03**	**9035.59**

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

NEW BUSINESS DATA AS AT 30.06.2016 (LINE OF BUSINESS WISE)

INDIVIDUAL NON - SINGLE PREMIUM (INCLUDING RURAL & SOCIAL)

(₹ in Crores)

Sl. No.	PARTICULARS	PREMIUM		POLICIES		SUM ASSURED	
		June, 2015	June, 2016	June, 2015	June, 2016	June, 2015	June, 2016
	Non linked*						
1	**Life**						
	with profit	4652.43	5207.74	3707717	3728640	71636.93	83028.45
	without profit	601.15	755.76	356391	394766	52706.45	68295.76
2	**General Annuity**						
	with profit	0.00	0.00	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0.00	0.00
3	**Pension**						
	with profit	24.48	33.79	5794	5906	363.64	388.00
	without profit	10.31	18.89	1097	2027	28.68	99.28
4	**Health**						
	with profit	0.00	0.00	0	0	0.00	0.00
	without profit	35.91	31.36	77179	69721	3253.39	3701.15
A.	Sub total	5324.29	6047.55	4148178	4201060	127989.09	155512.64
	Linked*						
1	**Life**						
	with profit	0.00	0.00	0	0	0.00	0.00
	without profit	1565.52	1780.36	205261	223743	17332.32	18752.70
2	**General Annuity**						
	with profit	0.00	0.00	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0.00	0.00
3	**Pension**						
	with profit	0.00	0.00	0	0	0.00	0.00
	without profit	81.13	90.22	6271	5485	15.89	11.17
4	**Health**						
	with profit	0.00	0.00	0	0	0.00	0.00
	without profit	-0.02	-0.03	-12	-6	-0.18	-0.09
B.	**Sub total**	**1646.62**	**1870.55**	**211520**	**229222**	**17348.03**	**18763.79**
C.	**Total (A+B)**	**6970.91**	**7918.10**	**4359698**	**4430282**	**145337.12**	**174276.43**
	Riders:						
	Non linked						
1	Health#	1.14	1.69	10792	10762	221.02	328.85
2	Accident##	2.81	3.95	135691	104276	6073.50	6702.81
3	Term	1.11	1.17	10706	8580	223.87	245.10
4	Others	0.64	1.09	7074	7715	14.54	148.44
D.	Sub total	5.71	7.92	164263	131333	6532.93	7425.19
	Linked						
1	Health#	0.01	0.02	-1	-1	0.08	-0.11
2	Accident##	0.30	0.02	9620	5144	444.35	228.69
3	Term	0.00	0.00	-5	0	-0.68	-0.66
4	Others	0.18	0.01	1817	22	10.45	0.67
E.	**Sub total**	**0.50**	**0.05**	**11431**	**5165**	**454.20**	**228.59**
F.	**Total (D+E)**	**6.20**	**7.97**	**175694**	**136498**	**6987.13**	**7653.78**
G.	****Grand Total (C+F)**	**6977.12**	**7926.06**	**4359698**	**4430282**	**152324.26**	**181930.21**

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

NEW BUSINESS DATA AS AT 30.06.2016 (LINE OF BUSINESS WISE)

GROUP SINGLE PREMIUM (INCLUDING RURAL & SOCIAL)

(₹ in Crores)

Sl. No.	PARTICULARS	Premium		No. of Schemes		Lives Covered		Sum Assured	
		June, 2015	June, 2016	June, 2015	June, 2016	June, 2015	June, 2016	June, 2015	June, 2016
	Non linked*								
1	**Life**								
a)	Group Gratuity Schemes								
	with profit	9.28	12.92	2	3	0	0	0.00	0.00
	without profit	3712.07	3954.04	30	9	115199	26066	105.91	64.52
b)	**Group Savings Linked Schemes**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	-0.01	-0.06	0	0	2	0	0.00	0.00
c)	**EDLI**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	10.18	9.95	16	25	90942	114739	3325.81	8742.96
d)	**Others**								
	with profit	0.70	0.00	0	0	0	0	0.00	0.00
	without profit	1681.56	2995.15	315	533	6226004	15652008	105667.60	204882.56
2	**General Annuity**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	1193.16	1596.83	0	1	67799	1893	8.58	0.06
3	**Pension**								
	with profit	68.01	189.65	1	1	17	0	0.00	0.00
	without profit	5542.44	7993.27	8	3	2689	15571	20.59	104.09
4	**Health**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0	0	0.00	0.00
A.	**Sub total**	**12217.38**	**16751.75**	**372**	**575**	**6502652**	**15810277**	**109128.50**	**213794.19**
	Linked*								
1	**Life**								
a)	**Group Gratuity Schemes**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	187.41	215.07	11	12	15099	31494	1.51	3.15
b)	**Group Savings Linked Schemes**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	-0.36	-0.10	0	0	0	0	0.00	0.00
c)	**EDLI**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0	0	0.00	0.00
d)	**Others**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	185.37	124.84	9	10	27449	22376	94.14	78.41
2	**General Annuity**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0	0	0.00	0.00
3	**Pension**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	261.45	96.19	4	2	6696	4909	0.00	0.00
4	**Health**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0	0	0.00	0.00
B.	**Sub total**	**633.87**	**436.01**	**24**	**24**	**49244**	**58779**	**95.65**	**81.56**
C.	**Total (A+B)**	**12851.25**	**17187.76**	**396**	**599**	**6551896**	**15869056**	**109224.16**	**213875.75**
	Riders:								
	Non linked								
1	Health#	1.45	14.14	16	21	4271	48237	422.18	1971.09
2	Accident##	7.91	12.76	18	20	85342	192290	3153.94	6000.69
3	Term	0.00	0.00	0	0	0	0	0.00	0.00
4	Others	0.00	0.00	0	0	0	0	0.00	0.00
D.	Sub total	9.37	26.90	34	41	89613	240527	3576.12	7971.78
	Linked								
1	Health#	0.00	0.00	0	0	0	0	0.00	0.00
2	Accident##	0.01	0.01	0	0	0	0	0.00	0.00
3	Term	0.00	0.00	0	0	0	0	0.00	0.00
4	Others	0.00	0.00	0	0	0	0	0.00	0.00
E.	**Sub total**	**0.01**	**0.01**	**0**	**0**	**0**	**0**	**0.00**	**0.00**
F.	**Total (D+E)**	**9.37**	**26.91**	**34**	**41**	**89613**	**240527**	**3576.12**	**7971.78**
G.	****Grand Total (C+F)**	**12860.62**	**17214.66**	**396**	**599**	**6551896**	**15869056**	**112800.27**	**221847.53**

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

New Business Data as at 30.06.2016 (Line of Business wise)

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

(₹ in Crores)

Sl. No.	PARTICULARS	Premium		No. of Schemes		Lives Covered		Sum Assured	
		June, 2015	June, 2016	June, 2015	June, 2016	June, 2015	June, 2016	June, 2015	June, 2016
	Non linked*								
1	**Life**								
a)	**Group Gratuity Schemes**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	216.99	78.77	687	469	554959	642408	2298.32	5766.32
b)	**Group Savings Linked Schemes**								
	with profit	0.20	0.00	0	0	-1	0	-0.02	0.00
	without profit	5.71	0.03	0	0	-14	-13	-0.41	-0.47
c)	**EDLI**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	17.16	23.07	151	108	599764	557915	23902.29	26154.00
d)	**Others**								
	with profit	0.00	0.00	0	0	18478	14995	-39.55	1.21
	without profit	579.70	774.99	5919	5949	27692636	32417528	444244.42	298179.46
2	**General Annuity**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0	0	0.00	0.00
3	**Pension**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	306.80	1016.51	57	55	382147	17945	24.70	68.21
4	**Health**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0	0	0.00	0.00
A.	Sub total	1126.57	1893.37	6814	6581	29247969	33650778	470429.74	330176.80
	Linked*								
1	**Life**								
a)	**Group Gratuity Schemes**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	271.55	226.44	88	140	151994	301164	268.70	29.40
b)	**Group Savings Linked Schemes**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	1.05	1.94	8	5	44624	813	4.46	0.08
c)	**EDLI**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0	0	0.00	0.00
d)	**Others**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	1.48	8.57	0	1	-1758	1860	-0.01	17.86
2	**General Annuity**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0	0	0.00	0.00
3	**Pension**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	14.71	12.64	21	10	4154	936	5.50	4.89
4	**Health**								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0	0	0.00	0.00
B.	**Sub total**	**288.79**	**249.60**	**117**	**156**	**199014**	**304773**	**278.65**	**53.15**
C.	**Total (A+B)**	**1415.36**	**2142.97**	**6931**	**6737**	**29446983**	**33955551**	**470708.39**	**330229.95**
	Riders:								
	Non linked								
1	Health#	2.71	6.91	57	170	151075	180090	14838.81	25841.23
2	Accident##	0.39	0.64	18	22	24242	12739	1680.69	1221.00
3	Term	0.25	0.01	0	0	1198	1098	56.78	74.06
4	Others	0.00	0.00	0	0	-99	-66	-166.72	-53.14
D.	Sub total	3.34	7.55	75	192	176416	193861	16409.56	27083.16
	Linked								
1	Health#	0.00	0.00	0	0	0	0	0.00	0.00
2	Accident##	0.00	0.00	0	0	0	0	0.00	0.00
3	Term	0.00	0.00	0	0	0	0	0.00	0.00
4	Others	0.00	0.00	0	0	0	0	0.00	0.00
E.	Sub total	0.00	0.00	0	0	0	0	0.00	0.00
F.	Total (D+E)	3.34	7.55	75	192	176416	193861	16409.56	27083.16
G.	****Grand Total (C+F)**	**1418.70**	**2150.52**	**6931**	**6737**	**29446983**	**33955551**	**487117.96**	**357313.11**

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

SUMMARY OF NEW BUSINESS PERFORMANCE OF LIFE INSURERS FOR THE PERIOD ENDED JUN-2016 (PROVISIONAL)

INDIVIDUAL NON - SINGLE PREMIUM (INCLUDING RURAL & SOCIAL)

(₹ in Crores)

Sr. No.	Particulars	Premium in Rs. Crore					No. of Policies / Schemes				
		Month of Jun-16	Upto Jun-16	Month of Jun-15	Upto Jun-15	YTD Variation in %	Month of Jun-16	Upto Jun-16	Month of Jun-15	Upto Jun-15	YTD Variation in %
A	B	C	D	E	F	G	H	I	J	K	L
1	**Aegon Life Insurance Co. Ltd**										
	Individual Single Premium	0.21	0.39	0.11	0.29	31.55	8	144	3	27	433.33
	Individual Non-Single Premium	6.04	13.85	9.31	18.76	-26.19	2890	6622	3329	7742	-14.47
	Group Single Premium	0	0	0	0	0	0	0	0	0	0
	Group Non-Single Premium	0	0	0	0	0	0	0	0	0	0
	Total	**6.25**	**14.23**	**9.42**	**19.05**	**-25.3**	**2898**	**6766**	**3332**	**7769**	**-12.91**
2	**Aviva Life Insurance Co. Ltd**										
	Individual Single Premium	0.93	2.06	0.37	0.97	112.68	12	295	23	89	231.46
	Individual Non-Single Premium	11.63	20.98	12.28	37.03	-43.34	1729	4134	3085	8729	-52.64
	Group Single Premium	0.01	0.02	0.01	0.02	-2.98	0	0	0	0	0
	Group Non-Single Premium	3.8	10.81	33.38	48.09	-77.51	7	8	11	22	-63.64
	Total	**16.37**	**33.88**	**46.04**	**86.11**	**-60.66**	**1748**	**4437**	**3119**	**8840**	**-49.81**
3	**Bajaj Allianz Life Insurance Co. Ltd.**										
	Individual Single Premium	4.31	10.05	18.27	42.11	-76.12	168	569	1312	3049	-81.34
	Individual Non-Single Premium	56.31	125.2	31.28	92.76	34.97	17460	41188	15300	44124	-6.65
	Group Single Premium	61.09	272.53	81.76	402.03	-32.21	12	16	7	13	23.08
	Group Non-Single Premium	62.99	171.98	50.75	136.52	25.98	19	37	8	50	-26
	Total	**184.69**	**579.76**	**182.06**	**673.41**	**-13.91**	**17659**	**41810**	**16627**	**47236**	**-11.49**
4	**Bharati AXA Life Insurance Co. Ltd**										
	Individual Single Premium	0.27	0.47	0.28	0.64	-26.04	10	20	7	24	-16.67
	Individual Non-Single Premium	29.37	68.61	25.07	61.82	10.97	7712	17953	5944	15708	14.29
	Group Single Premium	17.6	46.67	12.69	33.08	41.11	0	1	0	0	0
	Group Non-Single Premium	0	0	0	0	0	0	0	0	0	0
	Total	**47.24**	**115.76**	**38.04**	**95.54**	**21.16**	**7722**	**17974**	**5951**	**15732**	**14.25**
5	**Birla Sun life Insurance Co. Ltd.**										
	Individual Single Premium	2.58	10.54	1.61	4.5	134.34	89	242	75	172	40.7
	Individual Non-Single Premium	59.67	122.18	55.8	106.98	14.2	25555	51647	23410	49593	4.14
	Group Single Premium	0.88	3.15	1.02	2.63	19.66	0	1	2	2	-50
	Group Non-Single Premium	109.55	317.45	129.59	293.22	8.26	38	101	47	147	-31.29
	Total	**172.67**	**453.32**	**188.02**	**407.34**	**11.29**	**25682**	**51991**	**23534**	**49914**	**4.16**
6	**Canara HSBC Oriental Bank of Commerce Life Insurance Co. Ltd.**										
	Individual Single Premium	1.47	8.82	1.36	7.05	25.05	16	52	14	49	6.12
	Individual Non-Single Premium	42.18	81.58	24.55	67.27	21.27	8499	15421	3911	10479	47.16
	Group Single Premium	36.55	91.88	9.29	35.21	160.97	3	8	1	5	60
	Group Non-Single Premium	0.27	0.69	0.27	0.55	26.29	0	0	0	0	0
	Total	**80.47**	**182.97**	**35.47**	**110.08**	**66.22**	**8518**	**15481**	**3926**	**10533**	**46.98**
7	**DHFL Pramerica Life Insurance Co. Ltd.**										
	Individual Single Premium	0.95	1.67	0.76	1.35	24.35	138	213	47	86	147.67
	Individual Non-Single Premium	12.3	31.93	10.63	34.52	-7.5	6536	12011	4143	11995	0.13
	Group Single Premium	47.49	114.63	38.49	110.7	3.55	29	87	0	0	0
	Group Non-Single Premium	0	0	2.5	9.72	-100	0	0	6	28	-100
	Total	**60.75**	**148.24**	**52.37**	**156.28**	**-5.15**	**6703**	**12311**	**4196**	**12109**	**1.67**
8	**Edelweiss Tokio Life Insurance Co. Ltd.**										
	Individual Single Premium	0.59	1.61	0.28	0.75	115.71	19	52	13	300	-82.67
	Individual Non-Single Premium	7.83	18.72	7.24	15.62	19.87	2474	5193	2231	4475	16.04
	Group Single Premium	1.86	2.97	0.88	1.94	53.4	1	1	0	0	0
	Group Non-Single Premium	1.14	9.91	0.21	0.43	2180.1	9	23	4	11	109.09
	Total	**11.42**	**33.22**	**8.62**	**18.74**	**77.25**	**2503**	**5269**	**2248**	**4786**	**10.09**
9	**Exide Life Insurance Co. Ltd.**										
	Individual Single Premium	22.76	171.56	6.57	24.06	612.93	44	109	33	45	142.22
	Individual Non-Single Premium	47.88	108.55	35.74	71.44	51.94	15687	32567	14923	29858	9.07
	Group Single Premium	0	0	0	0	0	0	0	0	0	0
	Group Non-Single Premium	8.06	11.4	0.79	7.92	43.96	18	49	26	116	-57.76
	Total	**78.7**	**291.5**	**43.09**	**103.42**	**181.86**	**15749**	**32725**	**14982**	**30019**	**9.01**
10	**Future Generali India Life Insurance Co. Ltd.**										
	Individual Single Premium	0.92	1.71	0.22	0.57	197.01	38	686	22	59	1062.71
	Individual Non-Single Premium	10.03	23	5.32	15.37	49.62	2767	6347	1731	4274	48.5
	Group Single Premium	0.97	3.44	0	0	0	2	3	0	0	0
	Group Non-Single Premium	9.24	55.7	5.02	42.69	30.48	2	24	12	24	0
	Total	**21.17**	**83.84**	**10.56**	**58.64**	**42.99**	**2809**	**7060**	**1765**	**4357**	**62.04**
11	**HDFC Standard Life Insurance Co Ltd**										
	Individual Single Premium	91.89	160.66	21.03	90.08	78.35	11950	13063	21147	33981	-61.56
	Individual Non-Single Premium	212.03	538.81	245.43	483.05	11.54	62621	159048	70535	147540	7.8
	Group Single Premium	300.4	709.81	184.12	520.8	36.29	29	145	15	112	29.46
	Group Non-Single Premium	0	0	0	0	0	0	0	0	0	0
	Total	**604.32**	**1409.29**	**450.58**	**1093.94**	**28.83**	**74600**	**172256**	**91697**	**181633**	**-5.16**
12	**ICICI Prudential Life Insurance Co. Ltd.**										
	Individual Single Premium	51.08	132.61	14.63	45.71	190.13	3261	8778	646	2198	299.36
	Individual Non-Single Premium	445.06	922.83	378.97	838.03	10.12	48204	125856	40823	95227	32.16
	Group Single Premium	97.4	203.45	76.3	337.05	-39.64	59	188	20	81	132.1
	Group Non-Single Premium	0	0	0	0	0	0	0	0	0	0
	Total	**593.55**	**1258.89**	**469.9**	**1220.78**	**3.12**	**51524**	**134822**	**41489**	**97506**	**38.27**

Sr. No.	Particulars	Premium in Rs. Crore					No. of Policies / Schemes				
		Month of Jun-16	Upto Jun-16	Month of Jun-15	Upto Jun-15	YTD Variation in %	Month of Jun-16	Upto Jun-16	Month of Jun-15	Upto Jun-15	YTD Variation in %
A	B	C	D	E	F	G	H	I	J	K	L
13	**IDBI Federal Insurance Co. Ltd.**										
	Individual Single Premium	13.67	34.59	16.68	40.06	-13.66	1100	2647	1066	2456	7.78
	Individual Non-Single Premium	27.24	55.25	21.07	50	10.49	8650	17368	8098	18421	-5.72
	Group Single Premium	15.77	34.75	1.35	26.44	31.43	6	12	6	27	-55.56
	Group Non-Single Premium	0.15	1.03	0.7	3.15	-67.24	0	0	0	0	0
	Total	**56.84**	**125.62**	**39.79**	**119.65**	**4.99**	**9756**	**20027**	**9170**	**20904**	**-4.2**
14	**IndiaFirst Life Insurance Co. Ltd.**										
	Individual Single Premium	1.31	2.52	2.19	8.48	-70.27	28	103	84	310	-66.77
	Individual Non-Single Premium	15.04	40.24	7.93	24.54	63.99	7127	18601	4185	13187	41.06
	Group Single Premium	119.53	293.56	60.03	163.96	79.04	5	11	11	18	-38.89
	Group Non-Single Premium	0	0	0	0	0	0	0	0	0	0
	Total	**135.88**	**336.32**	**70.14**	**196.98**	**70.74**	**7160**	**18715**	**4280**	**13515**	**38.48**
15	**Kotak Mahindra Old Mutual Life Insurance Ltd**										
	Individual Single Premium	8.35	35.57	4.73	15.57	128.5	389	6584	2619	5183	27.03
	Individual Non-Single Premium	64.37	137.39	50.84	123.72	11.05	16425	31603	13487	29323	7.78
	Group Single Premium	26.4	140.25	36.69	96.36	45.55	5	17	6	13	30.77
	Group Non-Single Premium	51.86	163.69	33.32	151.18	8.27	47	294	62	247	19.03
	Total	**150.98**	**476.9**	**125.58**	**386.82**	**23.29**	**16866**	**38498**	**16174**	**34766**	**10.73**
16	**Max Life Insurance Co. Ltd.**										
	Individual Single Premium	56.24	129.39	41.42	103.18	25.41	59	173	92	258	-32.95
	Individual Non-Single Premium	192.54	370.48	142.48	305.01	21.46	39661	78221	39864	87286	-10.39
	Group Single Premium	20.77	59.24	16.29	41.14	44	4	29	3	25	16
	Group Non-Single Premium	5.44	10.87	4.88	9.81	10.76	37	234	40	187	25.13
	Total	**275**	**569.98**	**205.07**	**459.14**	**24.14**	**39761**	**78657**	**39999**	**87756**	**-10.37**
17	**PNB MetLife India Insurance Co. Ltd.**										
	Individual Single Premium	2.18	2.74	1.12	1.62	69.16	37	80	21	49	63.27
	Individual Non-Single Premium	69.55	167	61	153.03	9.13	17279	39715	18180	44388	-10.53
	Group Single Premium	3.9	9.09	1.47	4	127.46	0	0	0	0	0
	Group Non-Single Premium	3.68	9.42	4.71	14.18	-33.55	17	53	48	112	-52.68
	Total	**79.31**	**188.25**	**68.3**	**172.83**	**8.92**	**17333**	**39848**	**18249**	**44549**	**-10.55**
18	**Reliance India Insurance Co. Ltd.**										
	Individual Single Premium	2.01	4.81	1.2	4.79	0.51	83	227	82	309	-26.54
	Individual Non-Single Premium	46.71	111.72	67.7	162.04	-31.06	20620	52172	28985	75951	-31.31
	Group Single Premium	4.7	17.86	4.44	24.89	-28.22	4	27	12	35	-22.86
	Group Non-Single Premium	4.77	48.21	46.1	108.73	-55.66	3	10	6	21	-52.38
	Total	**58.19**	**182.6**	**119.45**	**300.45**	**-39.22**	**20710**	**52436**	**29085**	**76316**	**-31.29**
19	**Sahara India Life Insurance Co. Ltd.**										
	Individual Single Premium	1.52	1.95	0.54	1.78	9.82	334	461	135	361	27.7
	Individual Non-Single Premium	0.92	1.59	0.64	1.59	0.25	944	1431	710	1640	-12.74
	Group Single Premium	0	0	0	0	0	0	0	0	0	0
	Group Non-Single Premium	0	0	0	0	0	0	0	0	0	0
	Total	**2.44**	**3.54**	**1.18**	**3.36**	**5.3**	**1278**	**1892**	**845**	**2001**	**-5.45**
20	**Sbi Life Insurance Co. Ltd.**										
	Individual Single Premium	46.42	116.56	49.93	104.06	12.01	2427	5751	2598	5308	8.35
	Individual Non-Single Premium	394.26	710.82	231.89	416.51	70.66	105175	195629	75956	139881	39.85
	Group Single Premium	127	980.7	107.21	352.65	178.1	5	8	11	20	-60
	Group Non-Single Premium	20.64	54.39	147.32	169.44	-67.9	35	92	54	80	15
	Total	**588.32**	**1862.46**	**536.34**	**1042.66**	**78.63**	**107642**	**201480**	**78619**	**145289**	**38.68**
21	**Shriram Life Insurance Co.Ltd.**										
	Individual Single Premium	5.58	9.62	3.62	10.08	-4.55	321	675	410	1122	-39.84
	Individual Non-Single Premium	32.44	73.36	29.67	68.3	7.42	17050	48655	23366	53843	-9.64
	Group Single Premium	30.77	72.14	7.62	32.81	119.92	3	4	1	2	100
	Group Non-Single Premium	6.54	19.95	3.08	9.12	118.64	5	22	9	30	-26.67
	Total	**75.34**	**175.08**	**43.99**	**120.31**	**45.53**	**17379**	**49356**	**23786**	**54997**	**-10.26**
22	**Star Union Dai-ichi Life Insurance Co Ltd**										
	Individual Single Premium	1.56	5.35	13.34	19.47	-72.53	78	225	599	900	-75
	Individual Non-Single Premium	30.84	57.05	25.74	44.23	28.98	8043	15697	7504	12731	23.3
	Group Single Premium	1.7	4.1	2.05	5.26	-22.07	0	0	0	0	0
	Group Non-Single Premium	61.03	66.82	53.81	132.17	-49.44	0	6	11	36	-83.33
	Total	**95.13**	**133.32**	**94.94**	**201.13**	**-33.71**	**8121**	**15928**	**8114**	**13667**	**16.54**
23	**Tata AIA Life Insurance Co. Ltd.**										
	Individual Single Premium	0.26	0.88	1.05	4.52	-80.53	9	32	35	118	-72.88
	Individual Non-Single Premium	56.79	128.21	28.83	68.87	86.18	11955	26345	7006	16673	58.01
	Group Single Premium	0.01	0.11	0.7	2.48	-95.55	0	0	1	1	-100
	Group Non-Single Premium	3.44	10.17	2.63	17.39	-41.52	7	43	5	37	16.22
	Total	**60.5**	**139.38**	**33.22**	**93.26**	**49.44**	**11971**	**26420**	**7047**	**16829**	**56.99**
	Private Total	**3455.52**	**8798.34**	**2872.16**	**7139.91**	**23.23**	**476092**	**1046159**	**448234**	**981023**	**6.64**
24	**Life Insurance Corporation**										
	Individual Single Premium	1282.66	3255.17	668.22	1780.03	82.87	89725	242565	74549	220855	9.83
	Individual Non-Single Premium	1678.09	3996.71	1667.45	3716.62	7.54	1571109	3426858	1614297	3436630	-0.28
	Group Single Premium	6083.53	14154.29	4524.05	10667.19	32.69	8	41	42	42	-2.38
	Group Non-Single Premium	310.24	1188.04	184.76	264.39	349.34	2687	5741	2709	5783	-0.73
	Total	**9354.52**	**22594.22**	**7044.48**	**16428.23**	**37.53**	**1663529**	**3675205**	**1691597**	**3663310**	**0.32**
	Grand Total	**12810.04**	**31392.55**	**9916.64**	**23568.14**	**33.2**	**2139621**	**4721364**	**2139831**	**4644333**	**1.66**

FLASH FIGURES -- NON LIFE INSURERS

GROSS DIRECT PREMIUM INCOME UNDERWRITTEN FOR AND UPTO THE MONTH OF APRIL, 2016

(Rs INR in crores)

INSURERS	APRIL	Growth of April 2016 over April 2015		CUMULATIVE UPTO APRIL		% of Growth Upto April 2016 over the year April 2015	Market Share %	
	2016-17	2015-16		2016-17	2015-16		2016-17	2015-16
Private Sector Insurers								
Royal Sundaram	204.53	160.58	27.4%	204.53	160.58	27.4%	1.96%	1.73%
Tata-AIG	444.97	418.67	6.3%	444.97	418.67	6.3%	4.27%	4.52%
Reliance General	391.48	374.85	4.4%	391.48	374.85	4.4%	3.76%	4.05%
IFFCO-Tokio	419.81	385.12	9.0%	419.81	385.12	9.0%	4.03%	4.16%
ICICI-lombard	1,110.72	924.62	20.1%	1,110.72	924.62	20.1%	10.67%	9.98%
Bajaj Allianz	600.24	483.74	24.1%	600.24	483.74	24.1%	5.76%	5.22%
HDFC ERGO	373.45	362.75	2.9%	373.45	362.75	2.9%	3.59%	3.92%
Cholamandalam MS	200.07	161.73	23.7%	200.07	161.73	23.7%	1.92%	1.75%
Future Generali	199.86	167.55	19.3%	199.86	167.55	19.3%	1.92%	1.81%
Universal Sompo	75.14	97.42	-22.9%	75.14	97.42	-22.9%	0.72%	1.05%
Shriram General	120.74	107.46	12.4%	120.74	107.46	12.4%	1.16%	1.16%
Bharti AXA	121.16	143.45	-15.5%	121.16	143.45	-15.5%	1.16%	1.55%
Raheja QBE	4.20	2.87	46.3%	4.20	2.87	46.3%	0.04%	0.03%
SBI General	193.88	150.04	29.2%	193.88	150.04	29.2%	1.86%	1.62%
L&T General	56.29	47.01	19.7%	56.29	47.01	19.7%	0.54%	0.51%
Magma HDI	28.48	33.51	-15.0%	28.48	33.51	-15.0%	0.27%	0.36%
Liberty Videocon	62.44	51.61	21.0%	62.44	51.61	21.0%	0.60%	0.56%
Kotak Mahindra $	2.15	-	#DIV/0!	2.15	-	#DIV/0!	0.02%	0.00%
Private Sector sub Total	**4,609.61**	**4,072.98**	**13.2%**	**4,609.61**	**4,072.98**	**13.2%**	**44.27%**	**43.98%**
Public Sector Insurers								
New India	1,924.81	1,724.05	11.6%	1,924.81	1,724.05	11.6%	18.49%	18.61%
National	1,156.00	1,114.65	3.7%	1,156.00	1,114.65	3.7%	11.10%	12.03%
United India	1,402.50	1,226.36	14.4%	1,402.50	1,226.36	14.4%	13.47%	13.24%
Oriental	1,001.14	874.44	14.5%	1,001.14	874.44	14.5%	9.61%	9.44%
Public Sector sub Total	**5,484.45**	**4,939.50**	**11.0%**	**5,484.45**	**4,939.50**	**11.0%**	**52.67%**	**53.33%**
Stand-alone								
Health Insurers								
Star Health	143.02	108.49	31.8%	143.02	108.49	31.8%	1.37%	1.17%
Apollo Munich	62.18	51.87	19.9%	62.18	51.87	19.9%	0.60%	0.56%
Max Bupa	40.00	33.41	19.7%	40.00	33.41	19.7%	0.38%	0.36%
Religare	62.03	52.16	18.9%	62.03	52.16	18.9%	0.60%	0.56%
Cigna TTK	11.14	3.37	230.6%	11.14	3.37	230.6%	0.11%	0.04%
Stand-alone Health sub Total	**318.37**	**249.30**	**27.7%**	**318.37**	**249.30**	**27.7%**	**3.06%**	**2.69%**
Specialised Insurers								
ECGC	77.57	92.51	-16.1%	77.57	92.51	-16.1%		
AIC	38.56	50.07	-23.0%	38.56	50.07	-23.0%		
Specialised sub Total	116.13	142.58	-18.6%	116.13	142.58	-18.6%		
Grand Total	10,528.56	9,404.36	12.0%	10,528.56	9,404.36	12.0%		
Total (excl specialised)	10,412.43	9,261.78	12.4%	10,412.43	9,261.78	12.4%	100.00%	100.00%

Notes:-

Compiled by GI Council on the basis of data submitted by the Insurance companies

$ Commenced operations in Dec 2015

FLASH FIGURES -- NON LIFE INSURERS

GROSS DIRECT PREMIUM INCOME UNDERWRITTEN FOR AND UPTO THE MONTH OF MAY, 2016

(Rs INR in crores)

INSURERS	APRIL		Growth of April 2016 over April 2015	CUMULATIVE UPTO APRIL		% of Growth Upto April 2016 over the year April 2015	Market Share %	
	2016-17	2015-16		2016-17	2015-16		2016-17	2015-16
Royal Sundaram	177.72	134.55	32.1%	382.25	295.13	29.5%	2.07%	1.84%
Tata-AIG	237.17	220.66	7.5%	682.14	639.33	6.7%	3.69%	3.99%
Reliance General	225.15	227.25	-0.9%	616.63	602.10	2.4%	3.33%	3.76%
IFFCO-Tokio	380.84	289.71	31.5%	800.65	674.83	18.6%	4.33%	4.21%
ICICI-lombard	827.79	581.98	42.2%	1,938.51	1,506.60	28.7%	10.48%	9.41%
Bajaj Allianz	462.27	404.65	14.2%	1,062.51	888.39	19.6%	5.74%	5.55%
HDFC ERGO	239.00	222.63	7.4%	612.45	585.38	4.6%	3.31%	3.65%
Cholamandalam MS	208.08	158.16	31.6%	408.15	319.89	27.6%	2.21%	2.00%
Future Generali	134.73	134.88	-0.1%	334.59	302.43	10.6%	1.81%	1.89%
Universal Sompo	75.89	51.91	46.2%	151.03	149.33	1.1%	0.82%	0.93%
Shriram General	145.15	130.31	11.4%	265.89	237.77	11.8%	1.44%	1.48%
Bharti AXA	114.57	103.98	10.2%	235.73	247.43	-4.7%	1.27%	1.54%
Raheja QBE	3.91	2.21	76.9%	8.11	5.08	59.6%	0.04%	0.03%
SBI General	156.97	122.57	28.1%	350.85	272.61	28.7%	1.90%	1.70%
L&T General	43.64	33.35	30.9%	99.93	80.36	24.4%	0.54%	0.50%
Magma HDI	33.14	31.05	6.7%	61.62	64.56	-4.6%	0.33%	0.40%
Liberty Videocon	40.60	26.97	50.5%	103.04	78.58	31.1%	0.56%	0.49%
Kotak Mahindra $	3.62	-	#DIV/0!	5.77	-	#DIV/0!	0.03%	0.00%
Private Sector sub Total	**3,510.24**	**2,876.82**	**22.0%**	**8,119.85**	**6,949.80**	**16.8%**	**43.89%**	**43.39%**
Public Sector Insurers								
New India	1,232.54	1,005.80	22.5%	3,157.35	2,729.85	15.7%	17.06%	17.04%
National	1,164.91	1,002.79	16.2%	2,320.91	2,117.44	9.6%	12.54%	13.22%
United India	1,068.38	955.05	11.9%	2,470.88	2,181.41	13.3%	13.35%	13.62%
Oriental	785.16	663.95	18.3%	1,786.30	1,538.39	16.1%	9.65%	9.61%
Public Sector sub Total	**4,250.99**	**3,627.59**	**17.2%**	**9,735.44**	**8,567.09**	**13.6%**	**52.62%**	**53.49%**
Stand-alone Health Insurers								
Star Health	160.27	121.58	31.8%	303.29	230.07	31.8%	1.64%	1.44%
Apollo Munich	69.57	52.50	32.5%	131.75	104.37	26.2%	0.71%	0.65%
Max Bupa	40.25	33.77	19.2%	80.25	67.18	19.5%	0.43%	0.42%
Religare	43.26	36.96	17.0%	105.29	89.12	18.1%	0.57%	0.56%
Cigna TTK	14.92	5.23	185.3%	26.06	8.60	203.0%	0.14%	0.05%
Stand-alone Health								
sub Total	**328.27**	**250.04**	**31.3%**	**646.64**	**499.34**	**29.5%**	**3.49%**	**3.12%**
Specialised Insurers								
ECGC	94.58	103.31	-8.5%	172.15	195.82	-12.1%		
AIC	83.37	66.20	25.9%	121.93	116.27	4.9%		
Specialised sub Total	177.95	169.51	5.0%	294.08	312.09	-5.8%		
Grand Total	8,267.45	6,923.96	19.4%	18,796.01	16,328.32	15.1%		
Total (excl specialised)	**8,089.50**	**6,754.45**	**19.8%**	**18,501.93**	**16,016.23**	**15.5%**	**100.00%**	**100.00%**

Notes:-
Compiled by GI Council on the basis of data submitted by the Insurance companies
$ Commenced operations in Dec 2015

FLASH FIGURES -- NON LIFE INSURERS

GROSS DIRECT PREMIUM INCOME UNDERWRITTEN FOR AND UPTO THE MONTH OF JUNE, 2016

(Rs INR in crores)

INSURERS	APRIL		Growth of April 2016 over April 2015	CUMULATIVE UPTO APRIL		% of Growth Upto April 2016 over the year April 2015	Market Share %	
	2016-17	2015-16		2016-17	2015-16		2016-17	2015-16
Private Sector Insurers								
Royal Sundaram	161.87	121.07	33.7%	544.12	416.20	30.7%	2.03%	1.82%
Tata-AIG	242.13	212.85	13.8%	924.27	852.18	8.5%	3.44%	3.72%
Reliance General	268.64	230.36	16.6%	885.27	832.47	6.3%	3.30%	3.63%
IFFCO-Tokio	327.50	245.49	33.4%	1,128.15	920.33	22.6%	4.20%	4.01%
ICICI-lombard	941.89	540.76	74.2%	2,880.40	2,047.36	40.7%	10.72%	8.93%
Bajaj Allianz	453.95	405.19	12.0%	1,516.46	1,293.59	17.2%	5.64%	5.64%
HDFC ERGO	270.20	225.64	19.7%	882.65	811.02	8.8%	3.29%	3.54%
Cholamandalam MS	241.24	158.65	52.1%	649.39	478.54	35.7%	2.42%	2.09%
Future Generali	121.92	122.06	-0.1%	456.51	424.50	7.5%	1.70%	1.85%
Universal Sompo	72.97	65.21	11.9%	224.00	214.26	4.5%	0.83%	0.93%
Shriram General	154.87	139.61	10.9%	420.76	377.38	11.5%	1.57%	1.65%
Bharti AXA	96.85	91.30	6.1%	332.58	338.73	-1.8%	1.24%	1.48%
Raheja QBE	4.23	2.32	82.3%	12.34	7.42	66.3%	0.05%	0.03%
SBI General	155.63	122.05	27.5%	506.48	394.67	28.3%	1.89%	1.72%
L&T General	34.42	32.25	6.7%	134.35	112.62	19.3%	0.50%	0.49%
Magma HDI	31.33	30.63	2.3%	92.95	95.20	-2.4%	0.35%	0.42%
Liberty Videocon	43.43	33.19	30.9%	146.47	111.77	31.0%	0.55%	0.49%
Kotak Mahindra $	4.44	-	#DIV/0!	10.21	-	#DIV/0!	0.04%	0.00%
Private Sector sub Total	**3,627.51**	**2,778.63**	**30.6%**	**11,747.36**	**9,728.24**	**20.8%**	**43.73%**	**42.43%**
Public Sector Insurers								
New India	1,503.06	1,227.44	22.5%	4,660.41	3,957.28	17.8%	17.35%	17.26%
National	1,017.13	994.57	2.3%	3,338.04	3,112.01	7.3%	12.43%	13.57%
United India	1,132.84	1,000.37	13.2%	3,603.72	3,181.17	13.3%	13.41%	13.87%
Oriental	721.51	637.20	13.2%	2,507.81	2,175.59	15.3%	9.33%	9.49%
Public Sector sub Total	**4,374.54**	**3,859.58**	**13.3%**	**14,109.98**	**12,426.05**	**13.6%**	**52.52%**	**54.19%**
Stand-alone Health Insurers								
Star Health	176.98	144.88	22.2%	480.27	374.94	28.1%	1.79%	1.64%
Apollo Munich	79.03	57.61	37.2%	210.78	161.99	30.1%	0.78%	0.71%
Max Bupa	41.93	33.42	25.5%	122.18	100.60	21.5%	0.45%	0.44%
Religare	45.93	34.84	31.8%	151.22	123.95	22.0%	0.56%	0.54%
Cigna TTK	17.52	6.07	188.6%	43.58	14.66	197.3%	0.16%	0.06%
Stand-alone								
Health sub Total	**361.39**	**276.82**	**30.6%**	**1,008.03**	**776.14**	**29.9%**	**3.75%**	**3.38%**
Specialised Insurers								
ECGC	106.21	119.44	-11.1%	278.36	315.27	-11.7%		
AIC	52.57	48.10	9.3%	174.50	164.38	6.2%		
Specialised sub Total	158.78	167.54	-5.2%	452.86	479.65	-5.6%		
Grand Total	8,522.22	7,082.57	20.3%	27,318.23	23,410.08	16.7%		
Total (excl specialised)	8,363.44	6,915.03	20.9%	26,865.37	22,930.43	17.2%	100.00%	100.00%

Notes:-
Compiled by GI Council on the basis of data submitted by the Insurance companies
$ Commenced operations in Dec 2015

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PUBLIC NOTICE

Bima Bemisaal

IRDAI CAUTIONS PUBLIC AGAINST SPURIOUS CALLS AND FICTITIOUS OFFERS

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

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- IRDAI does not announce any bonus for policyholders or insurers.
- Any person making any kind of transaction with such individuals/agents will be doing the same at his own risk.

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

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

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Bima Bemisaal

BEWARE OF FAKE TELEPHONE CALLS

IRDAI Kisi Bhi Tarah Ki Telephone Calls Nahi Karta, Aise Fraud Calls Se Raho Hoshiyaar, Police Mein Karo F.I.R.

I.R.D.A of India:

- Never sells any insurance or financial products
- Never invests the premium of insurance companies
- Never endorse any bonuses

Report the name, phone number and other details of such callers to your nearest Police Station.

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