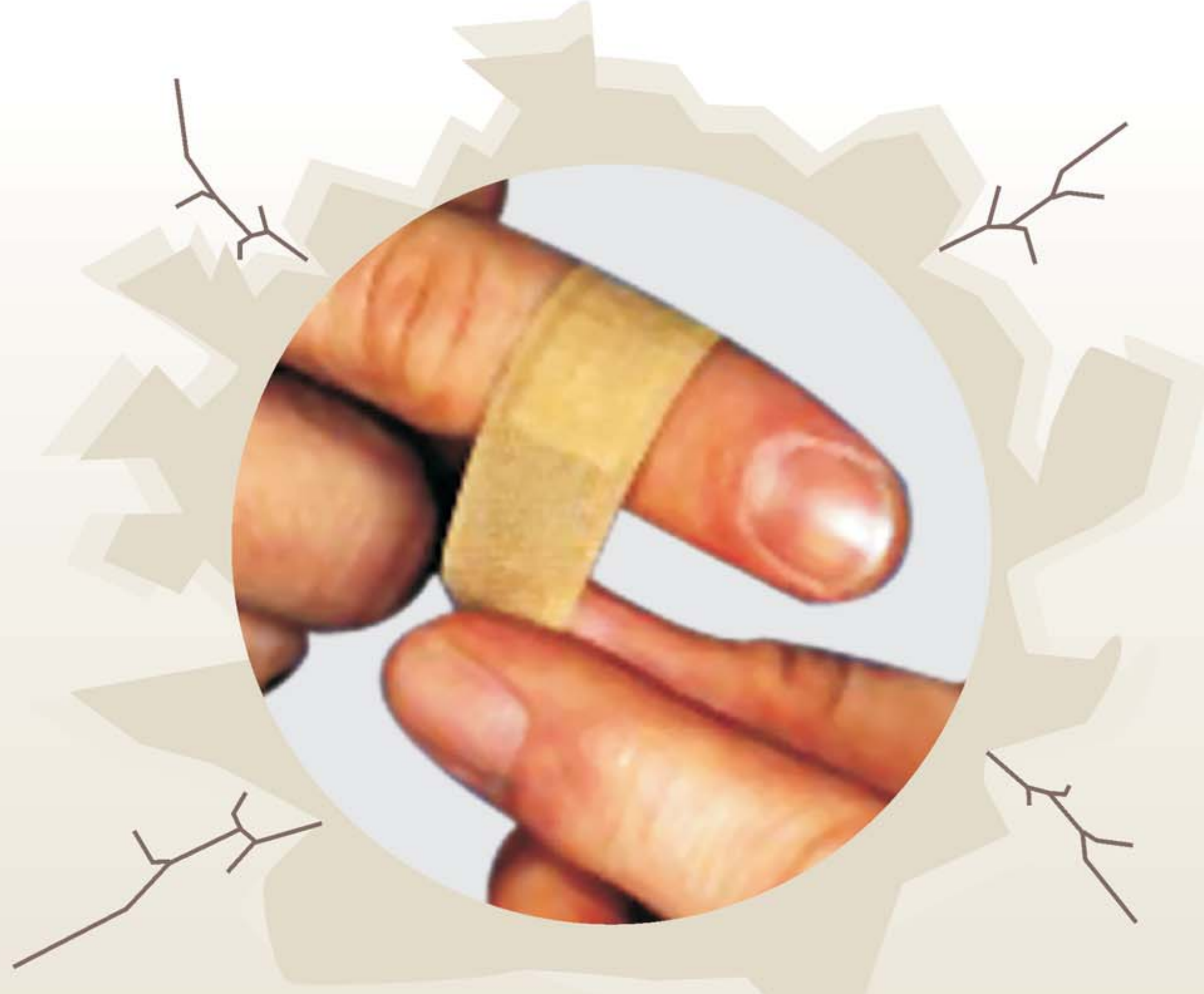
Volume IV, No. 2

Journal

JANUARY 2006



Band-aid or Bypass

The Motor Liability Portfolio

बीमा विनियामक और विकास प्राधिकरण

Editorial Board:
C.S.Rao
P.A. Balasubramanian
S.V. Mony
K.N. Bhandari
A.P. Kurian
Nick Taket
Ashvin Parekh
Nimish Parekh
Hasmukh Shah
A.K. Venkat Subramaniam
Prof. R.Vaidyanathan

Editor:
K. Nitya Kalyani

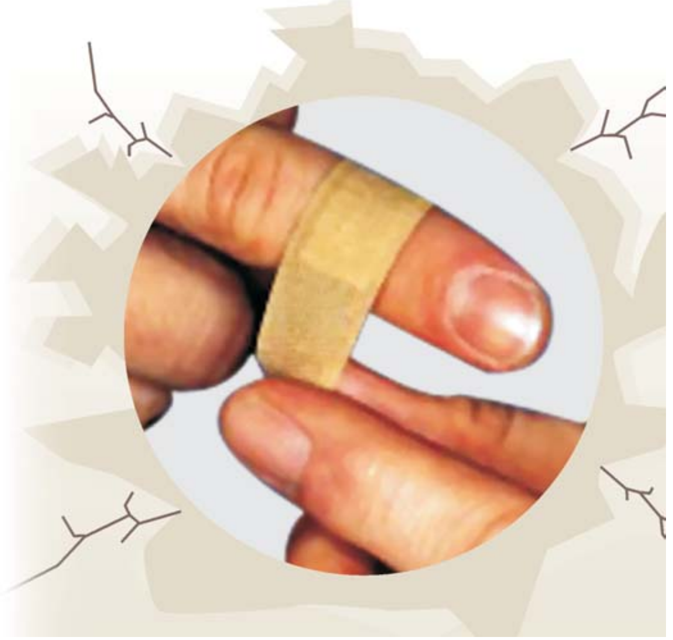
Design concept & Production:
Imageads Services Private Limited

Printed by P. Narendra and
published by C.S.Rao on behalf of
Insurance Regulatory and Development Authority.

Editor: K. Nitya Kalyani

Printed at Pragati Offset Pvt. Ltd.
17, Red Hills, Hyderabad 500 004
and published from
Parisrama Bhavanam, III Floor
5-9-58/B, Basheer Bagh
Hyderabad 500 004
Phone: 5582 0964, 5578 9768
Fax: 91-040-5582 3334
e-mail: irdajournal@irdaonline.org

© 2006 Insurance Regulatory and Development Authority.
Please reproduce with due permission.
Unless explicitly stated the information and views published in this Journal may not be construed as those of the Insurance Regulatory and Development Authority.



From the Publisher

Motor liability insurance is a socially important instrument, but one that costs the general insurance industry dear in almost every market, placing significant pressure on the bottom lines of companies. Yet it is an irresistible business portfolio, not the least because it can boost the top line significantly, enhance cash flow and contribute towards the investment portfolio. In India there is the added duty that companies are obliged to write Motor Third Party Liability business when approached by the prospective customer.

Yet, the problem remains of managing the business so that its negative effects are contained. This issue of **IRDA Journal** examines this aspect. We bring you analyses of this contentious issue by many practitioners and analysts, trying to prescribe ways and means for solving the problem.

The next issue will look back on ten years of insurance sector reforms. It was a decade ago, in early 1996, that the Insurance Regulatory Authority was set up. This was an interim body that later became Insurance Regulatory and Development Authority when the IRDA Act was passed in 1999.

Looking back is a good thing to do at the beginning of a New Year so that looking ahead can be more purposeful. 2006 holds many challenges and points of action for the insurance industry in India. Let me wish you a very Happy New Year, and one in which we will see collectively the further healthy growth of the industry.

C.S.Rao

C.S.RAO

Vantage Point - *K. Nitya Kalyani* 4

In the Air 5

Statistics - Life Insurance 6

Escalating Claims, Tumbling Profits -*K. K. Bhat* 10

The Insurer's Call - *S.Giridharan* 13

Naming the Figure - *R.Suresh* 18

प्रकाशक का संदेश 34

कुछ तो लोग कहेंगे 35

सुरक्षा करने, सेवा करने के लिए - *ज्ञानसुन्दरम कृष्णमूर्ति* 36

दावा और निपटान के बीच में बेलविक्स करे।- *जी वी रॉव* 39

Statistics - Non-Life Insurance 42

News Briefs 44

The Bottom Line

G.V. Rao

8

Skilled Underwriting

P. C. James

22

Legally Speaking

H. Ananthakrishnan

26

31

The Big Con Game

T. Babu Paul

The Weakest Link

Motor Liability insurance is one of the biggest drags on general insurance profitability not only in India, but in many world markets. Even with market pricing and strong administrative control on claims, the portfolio bests the best of companies. In India, general insurance companies work with their hands tied behind their backs in several respects including lack of time and geographical limitations for claims, unlimited liability going hand in hand with a constraining liability cover tariff and a slow moving legal system.

This month's issue of **IRDA Journal** takes as its central theme the question of how to deal with Motor Third Party Liability (Motor TP) insurance.

We bring you a longer than usual list of writers (for Motor TP seems as popular a topic as Health Insurance!) this month.

We have Mr. K. K. Bhat, Assistant General Manager, The Oriental Insurance Company writing on the remedies to this ill, Mr. G. V. Rao retired CMD, The Oriental Insurance Company Ltd. discussing the portfolio from the financial angle, Mr. S. Giridharan, Deputy Manager, Oriental Insurance Co. Ltd. drawing up a wish list of the amendments that the insurance industry would want in the Motor Vehicles Act and Mr. R. Suresh, General Manager - Liability Claims, Royal Sundaram Alliance Insurance Company examining the Motor Third Party Liability compensation levels in the country and spelling out the issues that need to be factored into the settlement amount.

Mr.T. Babu Paul, Assistant Manager, National Insurance Co. Ltd. rues the high prevalence of malpractices in Motor TP claims and examining the causes and reflecting upon the remedies, Mr. H. Ananthakrishnan, Officer on Special Duty, IRDA writes on what the law has to say about Motor TP claims and taking a look at the way the Indian legal system deals with Motor TP claims and Mr. P. C. James, Executive Director (Non-Life), IRDA points out that rather than just trying to control claims, underwriters should seek to change the behaviour of the portfolio through various strategies.

The next issue of underwriting will bring you a perspective of a decade of reforms. Starting with the formation of the Insurance Regulatory Authority (IRA), the precursor of the Insurance Regulatory and Development Authority (IRDA) which was formed subsequently by an Act of Parliament, till the present day different writers will look at where we have progressed to.

A little over three years ago, in the Editorial of the inaugural issue of the Journal, I had said that I wanted to start off within the insurance industry a dialogue, a process of sharing concerns and knowledge towards the common good of the industry.

I have the satisfaction of seeing that come to pass and, with this issue of the **IRDA Journal**, I hand over the baton to my successor and bid goodbye to all you readers who have supported me through many, many appreciative and critical letters and emails and the sheer number of requests for copies!

I am sure the dialogue that the Authority has begun through this unique communication medium will be continued ably and that you will continue to derive benefit from it. I have much to thank the Authority for including the privilege of working on a project like this from scratch and for the support and freedom given to me to carry out my work as best I could. It is not an opportunity that one gets everyday or one that can ever be forgotten.

I do look forward to meeting all of you again in the future. I can be reached on 94440-74482 and on knityakalyani@gmail.com and would always appreciate hearing from you.

Good bye and here's wishing that the New Year brings you much happiness and progress!

K. Nitya Kalyani

A Decade...

is a long time for an individual. For an industry, especially one that was waiting to realise its immense potential, it is a drop in the ocean. *K. Nitya Kalyani* looks ahead at the theme of the February issue of **IRDA Journal** that seeks to trace the developments related to opening up the insurance industry with the formation of the Insurance Regulatory Authority in early 1996.

Insurance, as anyone will tell you, is a long term game. Its India history also tends to longer rather than shorter periods.

When the new industrial policy was implemented in 1991 by the then new Union Government, things started happening rapidly. Industrial licensing was dismantled, Committees were set up to recommend reforms in the banking and financial sectors, banking reforms introduced in one quick shot and the Committee on Insurance Sector Reforms headed by Mr. R. N. Malhotra, Former Governor, Reserve Bank of India, set up to recommend the future course the industry should take to become competitive and ultimately benefit the customer.

The Malhotra Committee too gave its report in a short time. It was after that that the waiting started. Broad basing the industry by allowing private, Indian and foreign, capital was debated for a long time, till the end of the decade virtually, when the final decision was taken and the Insurance Regulatory and Development Authority (IRDA) Act was passed in November 1999. After over four to five decades, the industry moved from being fully in the state sector to broad based ownership possibilities.

Long as the process of implementing reforms took, the Government expressed its clear intention to tread the reform path with reference to insurance earlier. Post the Malhotra Committee's report, a Cabinet Resolution was passed in January 1996 to form an 'interim,' 'voluntary' regulatory body called the Insurance Regulatory Authority (IRA). This body was the precursor to the IRDA of today, and the setting up of the body was the manifestation of the reforms process in the industry.

Later, at the end of the decade, the IRDA was set up. The writ of the Authority was to register, and monitor according to well laid out prudential norms, new companies wishing to enter the insurance business and those already in it. Its responsibility is also to nurture the industry through a period of change and ensure its healthy growth for the larger good of the society and the economy.

The first of the new insurance companies was registered in October 2000 and today, there are 30 direct insurers doing business in the Indian market with the GIC being designated as the national re-insurer.

Ten years after the IRA was created, the industry is vibrant and growing at an admirable clip. It is going through typical growing pains too. Significantly, the new companies have expanded the market, more so in life insurance, and established a market share among themselves of over 20 per cent. The sheer expansion of the number of companies from six earlier to about five times that number has meant that the message of insurance fills the air and the average citizen is more aware of the financial instrument than ever before.

It is the journey from there to here that we try to trace in the next issue of **IRDA Journal.** The purpose is to gain a perspective on the industry's status and its future potential.

Procedure for Opening Liaison Offices

IRDA has issued a circular dated December 7, 2005 outlining the procedure for obtaining permission by a foreign insurance company to open a liaison office in India. Earlier it was the Reserve Bank of India (RBI) that was authorised to give such permission. The circular reads as follows:

Procedure for Opening of Liaison Office in India by an insurance company registered outside India

The existing procedure for grant of permission by RBI for opening of an office by an insurance company registered outside India has been revised in consultation with the Government of India and it has been decided that hence forth such permission would be granted by IRDA.

In this context a "Liaison Office" would mean a place of business to act as a channel of communication between the Principal place of business or Head Office by whatever name called and entities in India but which does not undertake any commercial/ trading/ industrial activity, directly or indirectly, and maintains itself out of inward remittances received from abroad through normal banking channel.

Persons desirous of opening liaison offices shall apply to the Insurance Regulatory and Development Authority in Form IRDA- FIC -1 attached as Annexure "1".

The applicant company shall be required to comply with the terms and conditions of the General Permission granted by RBI under the Foreign Exchange Management Act, 1999 and any other law in force.

The permission for opening of liaison office in India by an insurance company registered outside India are subject to the terms and conditions as may be additionally stipulated by the Authority from time to time.

(Sd/-)

C.S. Rao

Chairman

IRDA Allows TPAs to Service Government Healthcare Schemes

IRDA has allowed Third Party Administrators (Health Services), (TPAs), to undertake servicing of non-insurance healthcare schemes promoted, sponsored or approved by Central or State Governments provided there was no conflict with their work with insurance companies and on bringing in additional capital earmarked for this business. IRDA, while not taking responsibility for the transactions between TPAs and governments, has reserved the right to take action on complaints by the latter if any.

The circular to all TPAs to this effect, issued on December 16, 2005 reads as follows:

A query is being raised by several Third Party Administrators-Health services and other agencies whether TPAs can enter into agreements with entities other than insurance companies for servicing their healthcare schemes.

It is hereby clarified that if the task undertaken by the TPA Company is to undertake servicing of non insurance healthcare schemes promoted, sponsored or approved by Central or State Governments, the IRDA has no objection to the TPAs undertaking that function.

Since TPAs also undertake claims processing on behalf of insurers it should, however, be ensured that there is no conflict of interest between the work undertaken on behalf of the Central and State Governments and the work taken up on behalf of the Insurance Companies. It is also further clarified that the working capital requirements for attending to the work relating to the Central and State Governments shall be worked out separately and brought in additionally so as to ensure that the processing of claims on behalf of the Insurance Companies is in no way impaired.

The IRDA will not be responsible for administrative or financial transactions between the TPAs and the Central or State Governments. It, however, reserves its right to take appropriate action against the TPAs for serious acts of omission and commission brought to its notice by the Central or State Governments.

Sd/-

(C. S. Rao)

Chairman

IRDA Guidelines on Unit Linked Life Insurance Plans

IRDA issued, on December 21, 2005, to guidelines to insurers in respect of design of products under Unit Linked Life Insurance Plans. The Guidelines are intended mainly to ensure that they lead to greater transparency and understanding of these products to the insured, since, the investment risk is borne by the policyholders.

The Guidelines concurrently envisage extension of minimum insurance cover to be offered under the products (with exceptions in respect of the pension and the annuity products) and certain prudent practices on other features of ULIP products like partial withdrawals, top-up premiums, etc., to meet the objective of greater flexibility and long term protection to the insured.

The Guidelines define the nomenclature of various charges and how they are to be levied, so that the customers are clearly aware of various charges under the product and are apprised of the unit prices on a daily basis. For more details, the IRDA's website may be consulted at www.irdaindia.org, says a press release issued by Mr. C. R. Muralidharan, Member, IRDA.

Report Card:LIFE

Premiums Rise 46% up to November

First Year Premium Underwritten by Life Insurers for the Period Ended November, 2005

Sl	Insurer	Premium					No. of Policies / Schemes					No. of lives covered under Group Schemes				
		Nov. '05	Up to Nov. '05	Up to Nov. '04	Growth	Market share	Nov. '05	Up to Nov. '05	Up to Nov. '04	Growth	Market share	Nov. '05	Up to Nov. '05	Up to Nov. '04	Growth	Market share
1	**Bajaj Allianz**	**19,827.70**	**1,01,581.49**	**27,899.78**	**264.09**	**6.12**	**53,841**	**2,99,439**	**1,36,679**	**119.08**	**2.01**	**6,889**	**1,21,272**	**1,02,246**	**18.61**	**1.14**
	Individual Single Premium	12,737.39	56,675.26	10,451.70			11,313	45,479	10,755							
	Individual Non-Single Premium	7,015.06	43,555.33	17,202.18			42,519	2,53,853	1,25,859							
	Group Single Premium	39.46	97.98					1				138	280			
	Group Non-Single Premium	35.79	1,252.92	245.90			9	106	65			6,751	1,20,992	1,02,246		
2	**ING Vysya**	**1,655.93**	**10,474.97**	**5,226.23**	**100.43**	**0.63**	**8,772**	**58,273**	**59,737**	**-2.45**	**0.39**	**4,953**	**18,764**	**9,133**	**105.45**	**0.18**
	Individual Single Premium	65.35	67.73	32.65			40	390	6,513							
	Individual Non-Single Premium	1,396.36	9,407.14	4,806.71			8,728	57,837	53,196							
	Group Single Premium	104.37	689.67	361.47					3			242	1,824	674		
	Group Non-Single Premium	89.85	310.43	25.41			4	46	25			4,711	16,940	8,459		
3	**AMP Sanmar**	**1,538.31**	**8,909.12**	**4,483.94**	**98.69**	**0.54**	**4,568**	**34,408**	**20,459**	**68.18**	**0.23**	**14,626**	**1,02,535**	**70,946**	**44.53**	**0.97**
	Individual Single Premium	1,205.82	6,522.90	2,791.51			1,750	9,774	4,686							
	Individual Non-Single Premium	262.08	1,882.68	1,443.75			2,799	24,555	15,712							
	Group Single Premium	17.60	94.08	46.64					1					190		
	Group Non-Single Premium	52.81	409.46	202.04			19	79	60			14,626	1,02,535	70,756		
4	**SBI Life**	**4,727.86**	**25,228.53**	**25,871.14**	**-2.48**	**1.52**	**18,945**	**1,10,488**	**59,437**	**85.89**	**0.74**	**1,03,445**	**5,60,334**	**8,21,856**	**-31.82**	**5.27**
	Individual Single Premium	925.56	3,262.02	4,391.78			1,410	5,275	3,159							
	Individual Non-Single Premium	1,277.06	7,426.15	3,718.68			17,378	1,04,055	54,142							
	Group Single Premium	1,877.88	12,303.87	14,576.34				2	4			13,717	1,31,714	1,53,237		
	Group Non-Single Premium	647.36	2,236.49	3,184.34			157	1,156	2,132			89,728	4,28,620	6,68,619		
5	**Tata AIG**	**7,209.00**	**29,632.08**	**17,825.58**	**66.23**	**1.78**	**31,872**	**1,84,725**	**1,42,262**	**29.85**	**1.24**	**22,584**	**4,41,665**	**1,88,377**	**134.46**	**4.16**
	Individual Single Premium	68.23	350.70													
	Individual Non-Single Premium	4,209.81	23,482.92	14,493.24			31,850	1,84,529	1,42,101							
	Group Single Premium	250.26	1,418.35	383.54			2	2				10,655	97,661	61,335		
	Group Non-Single Premium	2,680.70	4,380.12	2,948.79			20	194	161			11,929	3,44,004	1,27,042		
6	**HDFC Standard**	**6,330.22**	**49,097.31**	**18,575.85**	**164.31**	**2.96**	**31,803**	**1,92,791**	**93,694**	**105.77**	**1.30**	**2,595**	**70,093**	**93,148**	**-24.75**	**0.66**
	Individual Single Premium	836.37	6,594.73	4,624.14			13,891	60,792	22,575							
	Individual Non-Single Premium	5,383.48	36,904.79	12,955.41			17,908	1,31,917	71,003							

	Individual Non-Single Premium	5,383.48	36,906.79	12,955.41			17,908	1,31,917	71,003							
	Group Single Premium	89.69	3,458.54	715.61			3	64	102			2,489	55,976	83,165		
	Group Non-Single Premium	20.67	2,137.25	280.69			1	18	14			106	14,117	9,983		
7	**ICICI Prudential***	**18,098.76**	**1,17,988.12**	**68,193.17**	**73.02**	**7.11**	**58,928**	**4,01,683**	**2,89,203**	**38.89**	**2.70**	**93,848**	**2,49,112**	**51,828**	**380.65**	**2.34**
	Individual Single Premium	550.34	4,169.15	8,406.96			3,888	20,878	5,356							
	Individual Non-Single Premium	14,944.28	1,01,274.53	53,200.06			54,990	3,80,632	2,83,784							
	Group Single Premium	2,604.14	12,544.43	63.23			50	173	11			93,848	2,49,112	9,313		
	Group Non-Single Premium			6,522.92					52					42,515		
8	**Birla Sunlife**	**4,279.66**	**30,509.74**	**33,136.96**	**-7.93**	**1.84**	**18,440**	**1,26,312**	**91,569**	**37.94**	**0.85**	**944**	**9,704**	**53,659**	**-81.92**	**0.09**
	Individual Single Premium	202.23	1,181.59	801.55			6,707	37,281	23,776							
	Individual Non-Single Premium	3,816.44	27,774.48	26,584.27			11,729	89,005	67,739							
	Group Single Premium	104.14	556.66	298.73								590	4039	2,602		
	Group Non-Single Premium	156.85	997.01	5,452.40			4	26	54			354	5,665	51,057		
9	**Aviva**	**3,038.86**	**18,611.48**	**9,598.70**	**93.90**	**1.12**	**14,042**	**75,348**	**47,158**	**59.78**	**0.51**	**10,074**	**1,23,580**	**1,01,870**	**21.31**	**1.16**
	Individual Single Premium	170.66	521.26	230.01			100	2,080	426							
	Individual Non-Single Premium	2,841.53	17,846.57	9,193.81			13,942	73,259	46,710							
	Group Single Premium	9.76	83.75	32.20					1			65	543	267		
	Group Non-Single Premium	16.92	159.90	142.68				9	21			10,009	1,23,037	1,01,603		
10	**Kotak Mahindra Old Mutual**	**1,748.42**	**11,718.76**	**7,905.27**	**48.24**	**0.71**	**6,306**	**45,246**	**30,415**	**48.76**	**0.30**	**15,875**	**58,149**	**54,380**	**6.93**	**0.55**
	Individual Single Premium	258.45	1,351.07	1,502.06			345	1,960	977							
	Individual Non-Single Premium	1,314.16	9,773.60	5,634.28			5,949	43,232	29,400							
	Group Single Premium	36.83	122.86					2				2,258	8,047			
	Group Non-Single Premium	138.98	471.23	768.93			12	52	38			13,617	50,102	54,380		
11	**Max New York**	**3,298.39**	**21,914.62**	**11,508.90**	**90.41**	**1.32**	**29,191**	**2,46,503**	**1,24,160**	**98.54**	**1.66**	**2,563**	**27,258**	**54,459**	**-49.95**	**0.26**
	Individual Single Premium	13.70	102.63	171.84			19	151	165							
	Individual Non-Single Premium	3,266.47	21,729.44	11,253.60			29,163	2,46,303	1,23,933							
	Group Single Premium															
	Group Non-Single Premium	18.22	82.55	83.46			9	49	62			2,563	27,258	54,459		
12	**Met Life**	**1,072.17**	**6,644.30**	**2,807.34**	**136.68**	**0.40**	**8,233**	**53,256**	**21,719**	**145.20**	**0.36**	**31,287**	**2,01,765**	**1,27,528**	**58.21**	**1.90**
	Individual Single Premium	29.98	349.78	93.78			119	813	274							
	Individual Non-Single Premium	980.37	5,772.54	2,301.67			8,104	52,317	21,368							
	Group Single Premium															
	Group Non-Single Premium	61.82	521.98	411.89			10	126	77			31,287	2,01,765	1,27,528		
13	**Sahara Life**	**194.68**	**948.41**	**1.34**	**70,676.57**	**0.06**	**1069**	**15,249**	**12**	**1,26,975.00**	**0.10**	**53**	**626**			**0.01**
	Individual Single Premium	176.39	622.29				411	1,575								
	Individual Non-Single Premium	18.24	325.49	1.34			657	13,666	12							
	Group Single Premium	0.05	0.62				1	8				53	626			
	Group Non-Single Premium															
	Private Total	**73,019.96**	**4,33,258.95**	**2,33,034.20**	**85.92**	**26.09**	**2,86,010**	**18,43,721**	**11,16,504**	**65.13**	**12.39**	**3,09,736**	**19,84,857**	**17,29,430**	**14.77**	**18.68**
14	**LIC**	**2,11,064.22**	**12,27,104.27**	**9,00,724.63**	**36.24**	**73.91**	**19,17,171**	**1,30,33,112**	**1,08,66,383**	**19.94**	**87.61**	**4,88,338**	**86,38,360**	**26,25,396**	**229.03**	**81.32**
	Individual Single Premium	67,065.19	4,45,830.91	1,62,960.74			16,32,33	12,15,113	3,82,693							
	Individual Non-Single Premium	85,359.03	5,68,512.64	5,60,658.06			17,52,758	1,18,08,548	1,04,75,007							
	Group Single Premium	58,640.00	2,12,760.72	1,77,105.83			1,180	9,451	8,683			4,88,338	86,38,360	26,25,396		
	Group Non-Single Premium															
	Grand Total	**2,84,084.18**	**16,60,363.22**	**11,33,758.83**	**46.45**	**100.00**	**22,03,181**	**1,48,76,833**	**1,19,82,887**	**24.15**	**100.00**	**7,98,074**	**1,06,23,217**	**43,54,826**	**143.94**	**100.00**

* The group single and non-single premium are clubbed together for FY 2005-06. Clarifications have been sought from the insurer.

The Bottom Line

— The impact of Motor TP losses on financial performance

G. V. Rao discusses the Motor TP portfolio from a financial angle to conclude that unless the current state of affairs is changed, the future of the industry is perilously at stake.

The insurer's year end financial accounts are expected to reflect the financial reality of the company as truthfully as possible. The estimated outstanding claims form a substantial portion of its future corporate liabilities. These numbers are based on the management's estimates and need to pass muster with the statutory auditors. One has, therefore, to closely monitor the management's assumptions in computing them and the comments their auditors have made on them.

This article will discuss the current scenario from a financial and accounting angle so that there is a better understanding of the magnitude of the tasks involved in controlling, predicting and managing the Motor Third Party (TP) business and its claims estimates. A point has now been reached, as the analysis will show, that unless the current tariff pricing is either dismantled or rates adjusted on experience basis, the financial future of insurers and the industry is perilously at stake. What is the current status of Motor business and, in particular, of Motor TP? Table 1 below of premiums will show its importance to the market.

Importance of Motor business

The Motor TP business of Rs. 2,114 crore forms only 11 per cent of the market. It grew by a mere Rs. 34 crore in 2004-05 that is rather surprising considering the premium adjustment permitted on vehicles that met with accidents in the previous year of insurance. A further analysis (no table given) showed that the established players wrote 91 per cent of the total Motor TP business in 2004-05, down from 94 per cent in the previous year. Their overall share of the Motor business was 82 per cent of the market, down from 87 per cent in the previous year. National Insurance led the Motor OD segment with 26 per cent and New India in Motor TP with 21 per cent of the total.

A further analysis showed that while United India Insurance dropped its Motor TP business in 2004-05 by Rs. 130 crore, Oriental increased its share by Rs. 60 crore. New India improved its share by Rs. 23 crore and National by Rs. 10 crore.

Two factors need further analysis: why is the premium growth in Motor TP so low? Are there any reporting errors? Over 20 lakh claims, amounting to about Rs. 15,000 crore, are outstanding for the market. About 65 per cent of these are in courts and over 33 per cent of them are unsettled for over three years. What impact will these developments have if and when detariffing takes place? The rating structures and claim provisions thus become very important in managing the Motor TP portfolio that can affect the finances of insurers.

> The Motor TP earned premium stood at just 16 per cent of the total, while the outstanding claims formed a massive 72 per cent of the total.

Analysis of the business

The importance of the assumptions made in the estimates of outstanding Motor TP claims and their impact on the total corporate financial performance can be better understood from the analysis of a major insurer's financial accounts for 2004-05. The position of other insurers may not be significantly different from the present sample.

The Tables 2 to 5 below highlight the significance of the Motor TP business, its outstanding claims in relation to the total outstanding claims and how the TP business has affected the insurers' corporate performance and why more disclosures may be necessary of the assumptions made by the operating offices of insurers.

Some number crunching

- The Motor TP earned premium of Rs. 342 crore forms just about 16 per cent of the total EP of Rs. 2,122 crore, *whereas Motor TP outstanding claims form a massive Rs. 2,066 crore (72 per cent) of the total O/S claims of the insurer of Rs. 2,859 crore.* It is this single factor that makes the Motor TP business a high-risk portfolio one from the financial accounting angle. Its impact on corporate performance is far too disproportionate compared to its revenue.
- The Motor TP net incurred claims are Rs. 832 crore out of the total incurred claims of Rs. 1,908 crore (43 per cent). It is obvious that its low premium base and high loss composition make the process of how Motor TP O/S claims estimates are made by the operating offices quite crucial.
- The total Motor business of Rs. 1,035 crore forms 48 per cent of the total EP of the insurer, a high composition; 32 per cent of this comes from Motor OD and 16 per cent from Motor TP. Net incurred losses from Motor quantum-wise constitute 64 per cent of the total net incurred losses of Rs. 1,908 crore; Motor TP alone forms 43 per cent of the total claims cost.
- On its own, the Motor TP loss ratio is 243 per cent. If other procurement costs of 35 per cent were added, this figure would touch nearly 280 per cent . The operating loss would be over Rs. 600 crore.
- These are the losses based on the present method of estimating Motor TP O/S claims. If this process of estimating were to undergo any

change requiring higher estimates to be provided, no one really knows what the loss ratios would look like. But one needs to progressively refine the methods of estimating losses based on realistic trends of the past and the future market vagaries.

- The Motor outstanding claims form 79 per cent of the total outstanding for this insurer; for another one it formed 77 per cent of the total.
- The settlement of TP claims through negotiated process is coming down for many insurers. This will raise the pendency of cases in courts.

Assumptions in estimating TP claims

The insurer depends upon its operating offices to make the estimated provisions on a case-to-case basis.

- TP claims are recognised usually when court summons are received and not as and when claim intimations are received from the insured.
- Claims that are repudiated or under dispute are not usually provided for in the O/S claims.
- Claims reported but waiting to be registered may not be brought on company accounts. They may not be recognised either through omission or other reasons such as insufficient information.

The points made above do get magnified in the case of Motor TP losses, considering the huge magnitude of its share of 72 per cent in the overall outstanding claim provisions. As yet, no way has been found to ensure that there is reasonable financial and administrative discipline within the system to work out the outstanding estimates in this sector that hardly contributes 16 per cent to the total corporate EP. The impact of Motor TP losses on the total performance of the insurer is disproportionately high, as can be seen from the above discussion on numbers. Hence more scrutiny and care are required in estimating the Motor TP O/S losses in insurer's own interests.

Auditors usually ask insurers to provide information on how the past estimates provided for in the previous year have actually been settled in the current year to determine whether the provisions made earlier justified the assumptions made by the insurer.

Such a "truing up" of estimates will show if there has been a consistent usage of "bad estimating' and if it is necessary to inject more discipline into the system. Is it possible for the insurers to own up the "truing up" by making such figures public in their financial statements?

Delayed intimations can be checked by asking for information *post-facto* up to the time of the finalisation of accounts. All claims whose occurrence preceded the end of the financial year can always be brought into the accounts of the year to be audited. By using this provision, this insurer's Motor TP O/S claims went up by net Rs. 145 crore in 2004-05.

Impact of Motor TP on total performance

- The above analysis of Motor TP business shows that while its EP income went up by a mere Rs. 50 crore in 2004-05, the net incurred claims went up by Rs. 138 crore and the net increase in the O/S claims went up by Rs. 241 crore. The total overall net O/S claims of the insurer having gone up by Rs. 307 crore in 2004-05, the increase of Rs. 241 crore in Motor TP alone is glaringly disturbing.
- The above analysis also shows that while the net incurred claims for Motor TP business over the EP was Rs. 402 crore in 2003-04, it was Rs. 490 crore in 2004-05, showing a higher trend. If the

Table 1: The Motor Portfolio

Rs. in Crore

Year	Total premium	Motor premium premium	Motor OD	Motor TP premium
2004-05	18,860	7,500 (40%)	5,384 (29%)	2,114 (11%)
2003-04	16,550	6,460 (39%)	4,377 (27%)	2,080 (12%)

Table 2: Company performance

Year	Earned premium of all portfolios	Net incurred claims	Net O/S claims end of year
2004-05	2,122	1,908 (90%)	2,859
2003-04	1,972	1,587 (80%)	2,552

Table 3: Motor Business

Year	Earned premium	Net incurred claims	Net O/S claims end of year
2004-05	1,035	1,238 (120%)	2,256
2003-04	916	981 (107%)	1,984

Table 4: Motor TP Busines

Year	Earned premium	Net incurred claims	Net O/S claims end of year
200405	342	832 (243%)	2,066
2003-04	292	694 (238%)	1,825

Table 5: Motor OD Business

Year	Earned premium	Net incurred claims	O/S claims end of year
2004-05	693	406 (59%)	190
2003-04	624	287 (46%)	159

distribution and management costs at about 35 per cent are added on to them, the losses from this segment will be significantly higher at over Rs. 600 crore.

- If the auditors insist on having their way on a few of the issues raised above, in matters relating to estimating, the financial performance on account of TP business may show a different picture.

One assumes though the estimates are not publicly 'trued up" in the subsequent financial accounts, the insurers in their self-interests at least must be aware of the evolving scenarios. If this assumption is wrong, then insurers must re-look the scenarios in their own interests. If they are aware, they need to fine-tune their estimating assumptions and processes.

Looking ahead

The figures in the tables show in clear terms the impact of Motor TP under the curent tariff scenario on the financial staements of insurers. Detariffing the Motor business will, of course, lead to rate adjustments; the segments where the rate increases are likely to be higher will aise their voices and bring their clout to effect. The public must be made to accept the inevitability of selective rate increases by preparing the market to accept the reality that the insurance industry will not make any progress and that its financial future is under strain.

Insurers must get customers on their side by being open with them and also explain to the public what steps they are taking to cut costs to price Motor TP and other products at reasonable levels. Ignoring market sentiment may make the insurers' task of selling their image and their wares even more difficult. The process of educating Motor clients must begin now. The huge drain on account of Motor TP losses must be met by those that cause these losses and not by the insured from other sectors.

But it is equally incumbent on insurers to become more efficient and effective in cuttig down their unacceptably high costs, now running at about 35 per cent and likey to go up with wage revisions. They must become more responsive in their claim settlement processes to reboot their images. They must also demonstrably improve their negotiating and straegic skills to contain losses. The public may like to know if these efforts are being made in mutual interest.

The author is retired CMD, The Oriental Insurance Company Ltd. He may be contacted at gvrao70@gmail.com.

Escalating Claims, Tumbling Profits

— TP makes a big dent in insurers' pockets

Why is Motor Third Party liability such an unenviable portfolio, and how can this state of affairs be remedied? *K. K. Bhat* examines the issue.

Indian roads are witnessing an increasing number of automobiles. Even as the road network and connectivity have improved, their condition remains pathetic. The growth in vehicles has also led to great demand for drivers and they, too, have increased manifold. The drivers manage to get licences without adequate training, leading to a sad state of affairs. There are no skill improvement courses or re-training imparted once a licence is obtained. Fake driving licences are also rampant, making the entry for unskilled drivers unnervingly easy. Yet another issue is the lack of observance of traffic norms. All these factors have cumulatively contributed towards more and more road accidents in the country - more than 3.5 lakh, of which almost one lakh were fatal. And the count goes on.

The largest number of road accidents stems from commercial vehicles, especially goods carrying and public transport vehicles such as buses. Due to their sheer size, weight and frequent mobility, these vehicles pose greater hazards to the public at large. Accidents by other segments of vehicles have also increased over the past years. Rampant bad practices like overloading, over speeding, poor maintenance of vehicles, unskilled drivers, poor traffic sense of vehicle drivers and victims alike, rash and negligent driving, apart from the the condition of the roads, have translated into a high rate of accidents.

A tough task

In such a scenario, the importance of Motor insurance assumes enormous proportions. The Motor insurance business accounts for over a third of the total general insurance business in the country. Yet, it is a loss making portfolio, owing to high outgo, the worst being the Third Party (TP) segment.

The Motor Vehicles Act [MV Act], which provides the framework for compensation to road accident victims in a quick manner, is undoubtedly

favourable to the victims. The unlimited liability with no accountability on the part of the wrongdoer, i.e., owner and driver of the offending vehicle, no time limit for filing a claim, with liberty to file it anywhere in the country, are some factors which have resulted in enormous hardship to the insurers. They have been put to further disadvantage by being denied the right to defend the case on all grounds – more so when the vehicle owners abstain from the proceedings before the tribunals.

Over the years the compensation claims have increased manifold, causing delay in their settlements. The insurers have thus adopted different conciliatory systems for the disposal of these claims, which have proved beneficial in many ways. Nevertheless, not all cases can be compromised. Despite earnest efforts by insurers, the accumulation of claims is increasing each year. The plausible reason is that the number reported is more than disposals.

Lately, for the sake of social obligation, the courts have insisted that the claims of victims be necessarily honoured by the insurers. Even in cases of no-liability, the insurer is asked to compensate the claimants and recover the sum from the owner. The chances of recovery are absolutely bleak for different reasons. Many a time, the insurer is saddled with the unwarranted liabilities as well.

The authorities refuse to accept the fact that this portfolio needs to be left to insurers to manage in terms of inflow and outflow. The courts have turned a blind eye to the pleas of the insurers. The public in general, rightly or wrongly, has a feeling that the insurers, though cash-rich, are averse to paying the compensations. No one realises that the insurers are custodians and trustees of the funds collected from the people and have to observe utmost care in managing the same.

To make matters worse, the courts now seem to be competing with each other in allowing liberal compensations. There was a case some years ago against United India, wherein the Supreme Court awarded over Rs. 12 crore for the death of an NRI. The award for over Rs. 14 crore against Oriental Insurance, by a tribunal in Delhi in April 2005, is another example of how the courts go overboard in granting compensations.

Burgeoning portfolio

The major reasons for such heartache over this class of business are obvious, as the insurers find this portfolio unmanageable and eating into their resources. This perhaps is the only class of business where the insurer needs to deal with a stranger to the insurer - not even a party to the contract - for the wrong doing of a party who, though in existence, does not come forward to strengthen the insurer's hands. The insurers provide a cover to the insured with an assurance to indemnify him for any amount he is legally required to pay to third parties arising out of use of his vehicle. By the terms of contract, he is bound to inform the insurer any incident giving rise to such a liability and also render all cooperation to the insurer. This intention is also apparent from S 149(2) of the MV Act. However, the insured hardly ever cooperate with the insurers. This weakens the insurers' position before the tribunals and in the end they are burdened even with avoidable and uncalled for liabilities.

The concerns before the insurers today are uncontainable growth in claims; increasing liabilities and loss; and delay in disposal of claims.

The concerns before the insurers today are uncontainable growth in claims; increasing liabilities and loss; and delay in disposal of claims. To address these issues, a long-term and multi-thronged strategy is necessary.

With more and more vehicles hitting the roads, accidents are bound to go up. Economic development has increased the earning capacity of the people. This pushes up the compensation levels.

Low rates

The flaw lies with premium rates now being charged. The premium is abysmally low and does not keep pace with the increase in the liabilities due to high risk involvement. If the outgo is high in this class of business, the pricing is a complete mismatch. At the root of this is unlimited liability. The demand of the insurers is to increase the premium and impose a statutory cap on the upper limit of compensation in respect of third parties, which at present is unlimited.

Other issues bothering the insurers are:

The Police, by law, are required to inform the insurer and the nearest tribunal immediately after a vehicular accident is reported, which is not followed. If done, it will enable the insurer to take immediate cognizance of the case, investigate, determine the liabilities right at the beginning and finally approach the claimants with an offer of settlement. This will also thwart subsequent exaggeration of claim by unscrupulous persons. On the contrary, many fraudulent claims have come to light, where the involvement of the police is suspected.

Correcting the wrongs

The malaise is not of recent origin. In the past, too, PSU insurers have requested the government to bring compensation for vehicular accident victims on par with those of air/train accidents. Consequently, the Surface Transport Ministry and the Finance Ministry set up a committee in 1999 with a view to:

- Review and modify the present structured formula; and ensure speedy disposal of claims through revised formula;
- Limit the maximum compensation.

The committee, represented by members from the Finance and Transport Ministries, the Tariff

Advisory Committee, General Insurance Corporation, the four General Insurance PSUs, BEST Mumbai, ASTRU & All India Motor Transport Congress, Delhi, after extensive deliberations, submitted its report with specific recommendations on the following:

- Cap on compensation
- Defined provision and procedure of claiming compensation on fault basis
- Compensation for minors and non-earning persons
- Time period & territorial jurisdiction for filing claims
- To decline claims in case of non-receipt of premium
- Removal of anomalies in various provisions of MV Act
- Conciliatory Authority to settle liability claims where Tribunals are not located
- Provision of interest as per RBI guidelines

The report was hotly debated in the Ministries and some issues were decided upon. However, nothing happened thereafter. The authorities should reconsider this report, make suitable modifications necessitated by the time lag and try to bring about legislative changes in the MV Act.

The judiciary, lawyers, legislature and the public in general insist that insurers have to meet social justice and obligations in vehicle accident cases. The insurers, on the other hand, have always tried to maintain their role of a true insurer governed by the MV Act, bound by the principles of insurance and the terms of the insurance contract. In this process, the insurers have suffered a setback in their image and credibility.

Viable alternatives

It is time for the government itself to take over this obligation as a true welfare activity towards the society. The insurers should be allowed to focus on/ develop other – more important – areas of insurance.

One proposal is to levy an additional cess on petrol, diesel, CNG and other vehicle fuels. This cess, pooled into a corpus, should be managed by the government itself or by some other independent agency to meet these liabilities. This scheme has many advantages. Firstly, the cess, even though nominal, will add up to an enormous fund to meet all these liabilities comfortably. Secondly, this will ensure automatic insurance of all vehicles on road. Vehicle owners will not have to run after the insurance companies for insuring their vehicles and shell out a hefty amount in one go. No documentation is involved. Thirdly, the contribution of each vehicle owner will be commensurate with the use of his vehicle and the risk involved. More the vehicle runs on the road, more the fuel it will consume and correspondingly more it will contribute to the fund.

> If the outgo is high in this class of business, the pricing is a complete mismatch. At the root of this is unlimited liability.

Private non-life insurers must not shirk their responsibility towards this social obligation. To make the private insurers underwrite TP risks, a suggestion has been made – when a Motor proposal is underwritten by any company, that company will retain the premium share other than that for basic TP. Of the TP basic premium, the company will retain 10 percent as its administrative expenses. The balance TP basic premium, less the proportionate commission paid under the policy, should be shared equally among all the general insurers including the primary insurer.

In the event of a TP claim, the company will settle the claim in full and recover the proportionate liability from other insurers. This way every insurer will be equally involved in the process of discharging the social obligation.

Another relief would be the imposition of limitation of time for filing cases before tribunals. Insurers are now never sure when an accident that took place a long time back will emerge as a claim and, moreover, they could well be continuing to offer insurance to the same party on old terms, on whose policy the claim has arisen. Similarly, the limit of jurisdiction for filing the claims should be reintroduced. The rate of interest should also be in parity with the prevailing rate.

Apart from seeking to minimise their obligation to meet the liability to third parties arising out of such accidents, the insurers should be permitted to re-transmit the costs to the manufacturer. Let there be a statutory obligation on a manufacturer to improve the technology to prevent accidents and reduce the risk on the roads. Apart from this, stringent norms for granting driving licences, curbing the menace of fake licences and, of course, exemplary punishments for erring drivers will reduce the number of accidents to a great extent. At the same time, improvement in road conditions, better traffic regulation and education on road safety will also go a long way in preventing such incidents.

This portfolio continues to cause problems for insurers due to causes beyond their control. The reasons are many and unless all concerned – the government, IRDA, judiciary, police, lawyers, etc. – strengthen the hands of the insurers, no tangible improvement can be anticipated. The malaise has reached such a monstrous stage that only a sincere and concerted effort by all together can now contain it.

The author is Assistant General Manager, The Oriental Insurance Company Ltd. The views expressed are his own.

The Insurer's Call

— Amendments that insurance companies are looking for

With the New Year just ushered in, **S. Giridharan** draws up a wish list of the amendments that the insurance industry would want in the Motor Vehicles Act.

Insurers have to reconcile themselves to the truth that amendments to the Motor Vehicles Act should ensure fair and speedier grant of compensation to the hapless victims of road accidents and their families. While the wish list of the insurers would contain references to the contrary, a presentation on the above subject would commence on a brighter note if it started with proposed amendments that acknowledge the spirit of the Act.

1) Expanding insurance coverage

Section 146 of the Motor Vehicles Act, 1988, which deals with Compulsory Insurance, has fallen far short of reaching its avowed objective. While it is difficult to hazard a guess on the percentage of vehicles that continue to ply our roads without valid insurance coverage, it remains an accepted fact that there is considerable cause for anxiety on the above score. It is long since most of the states have moved from the practice of collection of annual road tax for private cars and two wheelers to collection of life time tax for these vehicles at the time of their registration.

There is a pressing need for statutory and mandatory provision for Long Term Act only insurance for private cars and two wheelers. At the present Tariff Annual Premium Rates for these vehicles, long-term coverage for 15 years at the time of registration would cost the new vehicle owners only a portion of the amount that they are remitting towards life time road tax. The introduction of such a provision would pave the way for moving closer to achievement of total insurance coverage benefiting vehicle owners, insurers and, above all, the public. The incorporation of policy details in the Registration Certificate of the vehicle would facilitate their easy availability in the event of an accident.

2) Rectifying the solatium fund paradox

The creation of a Solatium Fund for payment of compensation in hit-and-run accidents came into force on October 1, 1982. Section 134 of the Motor Vehicles Act, 1988 makes it obligatory for the driver of the offending vehicle to render medical assistance to the victim. Hit-and-run accidents involve the violation of the above provision besides utter disregard of humanitarian gestures. The Solatium Fund at present provides for payment of compensation of Rs. 25,000 for death and Rs. 12,500 for grievous injuries. The above amounts are notably much less than even amounts payable under No Fault liability and therefore result in payment of less compensation than even in cases where the victim was solely at fault.

> There is a pressing need for statutory and mandatory provision for Long Term Act only insurance for private cars and two-wheelers.

It may not be incorrect to state that in actual practice, the existing provision in respect of Solatium Fund drives the victims to fall a prey to covert methods available to overcome the predicament. The fact that in almost all cases the identity of the unknown vehicle is subsequently established, resulting in a negligible number of claims reported for relief from the Solatium Fund, is ample testimony to the ground realities. The size of the Solatium Fund has to be enlarged and replenished every year to the extent of actual payments to facilitate payment of compensation even in hit-and-run accidents on merits to be decided by the tribunals.

3) Defences and right of recovery

It was always a standard practice for courts to look for avenues to fasten liability on insurers in keeping with the concept of welfare legislation. The mandate of the Parliament to provide succor and relief to accident victims would be reflected only if awards were passed against insurance companies.

There have been judgments aplenty of certain High Courts to the effect that the insurance company shall be liable to pay compensation to the victims at the first instance and thereafter look for recovery of the same from the insured.

As on July 1, 1989, there was an innocuous change made in Section 149 (4), which brought about a serious change in the nature of liability cast on the insurance company. It was settled law that the defences available to the insurance company are those specified under Section 149 (2) only. The insurer could successfully avoid liability by establishing any one of the said defences.

This meant that in cases where the insurance company established the defences open to them, they could avoid liability and they could not be compelled to pay to the claimant at first and then seek recovery from the insured later. It is under Section 149 2(a) and 2(b) that defences available to the insurer are specified. But under Section 149(4) it is mentioned as, 'other than those in clause (b) of sub section 2' instead of clause (a) and (b) of Sub Section 2, as it should have been. The use of clause b only makes all the difference.

While earlier the insurance company could establish any one of the defences open to them like absence of valid driving licence, use of vehicle contrary to purpose of permit etc. and avoid liability altogether, under the present dispensation, they cannot do so. It was perfectly open to a court to hold that though the insurance company had proved the defence available to them in Section 149 2(a), they would be liable to pay compensation to the victim at the first instance and would at best be entitled to seek reimbursement later from the owner of the vehicle.

This was a very significant and dramatic change and, being a parliamentary mandate, was enforceable against the insurance company.

From the insurer's point of view, this change was not noted prominently. Only in respect of a defence relating to the policy of insurance being void could the insurer claim to avoid liability altogether. It was open to a court in every case where the insurer establishes its defence by evidence in respect of any one of the clauses in Section 149 2(a), to direct the insurance company to pay the award amount to the victim at the first instance and claim reimbursement from the insured.

The above was precisely the contention against the insurance company before the Supreme Court in the SLP filed by National Insurance Co. Ltd. Versus Swaran Singh and others.

In its landmark and far reaching judgment (ACJ 1 of 2004), the Supreme Court ruled:

1. "Chapter XI of the Motor Vehicle Act 1988 providing compulsory insurance of vehicles against Third Party risks is a social welfare legislation to extend relief by compensation to victims of accidents caused by use of Motor Vehicles.
2. Insurer is entitled to raise a defence in a claim petition filed under Section 163 – A or Section 166 of the Motor Vehicles Act *inter alia* in terms of Section 149 2 A (ii) of the Act.
3. The breach of policy condition, e.g. disqualification of driver or invalid driving licence of the driver as contained in sub section 2(a) (ii) of Section 149 have to be proved to have been committed by the insured for avoiding liability by the insurer
4. The insurance companies must also establish breach on the part of the owner of the vehicle, the burden of proof which would be on them
5. The criteria as to how the said burden would be discharged would depend upon the facts and circumstances of each case

The Solatium Fund amounts are much less than even amounts payable under No Fault liability and result in payment of compensation less than in cases where the victim was solely at fault.

6. The insurer would not be allowed to avoid its liability towards the insured unless the breach is fundamental to have contributed to the cause of accident. The tribunals would apply the rule of main purpose and the concept of fundamental breach to allow defences available to the insurer under Section 149 (2) of the Act
7. The question as to whether the owner has taken reasonable care will have to be determined in each case
8. If a vehicle is driven by a person having a learner's licence, the insurance companies would be liable to satisfy the decree
9. The Claims Tribunal Constituted under Section 165 read with Section 168 is empowered to adjudicate all claims in respect of the accidents involving death or of bodily injury or damage to property of third party arising in use of Motor Vehicle. The said power of the Tribunal is not restricted to decide the claims *inter se* between claimant or claimants on one side and the insured, insurer and driver on the other. In the course of adjudicating the claim for compensation and to decide the availability of defence or defences to the insurer, the Tribunal has necessarily the power and jurisdiction to decide disputes *inter se* between the insurer and the insured. The decision rendered on the claims and disputes *inter se* between the insurer and insured in the course of adjudication of claim for compensation by the claimants and the award made thereon is enforceable and executable in the same manner as provided in Section 174 of the Act for enforcement and execution of the award in favour of the claimants.
10. Where on adjudication of the claim under the Act the Tribunal arrives at a conclusion that the insurer has satisfactorily proved its defence in accordance with the provision of Section 149 (2) read with sub-section (7) as interpreted by this court above, the Tribunal can direct that the insurer is liable to be reimbursed by the insured for the compensation and other amounts which it has been compelled to pay to the third party under the award of the Tribunal. Such determination of claim by the Tribunal will be enforceable and the money found due to the insurer from the insured will be recoverable on a certificate issued by the Tribunal to the collector in the same manner under Section 174 of the Act as arrears of land revenue. The certificate will be issued for the recovery as arrears

of land revenue only if, as required by Sub-Section (3) of Section 168 of the Act, the insured fails to deposit the amount awarded in favour of the insurer within 30 days from the date of announcement of the award by the Tribunal.

11. The provisions contained in Sub-Section (4) with proviso there under and Sub-Section (5) which are intended to cover specified contingencies mentioned therein to enable the insurer to recover amount paid under the contract of insurance on behalf of the insured can be taken recourse to by the Tribunal and be extended to claims and defences of insurer against insured by relegating them to the remedy before regular court in cases where on given facts and circumstances adjudication of their claims *inter se* might delay, the adudication of the claims of the victims.

The above judgment is virtually a mixed bag for insurance ompanies with both positives and negatives emerging from it.

If tribunals do not resort to or restrict themselves only in rare cases in relegating adjudication of claims *inter se* between the insured and insurer to a regular court, then it can be taken that the judgment has done enough good to the cause of the insurer.

Insurance companies may still look for an amendment in Section 149 (4) to use the expression clause a and b Sub Section 2 instead of clause b of Sub Section 2 to facilitate raising the defences available in Section 149 2 (a) and (b) meaningfully.

However, it can be said that the long-standing wish of the insurers that appropriate amendment in Section 149 (4) to see that orders directing recovery from the insured shall amount to a decree executable as such, has been met by the above judgment of the Supreme Court. Section 149 (4) of the current M. V. Act, therefore, requires to be amended to make such orders executable as a decree.

The above amendment is hence bound to result in the following positives accruing to the insurers:

a) Avoiding the need for initiating separate litigation involving time-cost and money-cost against the insured.

b) Imposing discipline among the insured in use of vehicle.

c) Making the insured also not take claims for granted.

Apart from the above, the insurers may also seek inclusion of a specific defence relating to cheque for premium paid being dishonoured under Section 149 (2). A corresponding change also

If tribunals do not resort to relegating adjudication of claims *inter se* between the insured and insurer to a regular court, then it can be taken that the judgment has done enough good to the cause of the insurer.

requires to be effected in Section 149 (1) that the insurer having issued, the insurer cannot cancel the policy unless the cheque for premium paid has been dishonoured.

4) Public place vs. any place

According to Section 146 of the Motor Vehicle Act, there is a compulsion to avail insurance for use of vehicle in a public place. Under Section 166 of the Act, the claims tribunal can be approached for compensation irrespective of the place of occurrence of the accident, be it public or private.

The contract of insurance, under both Liability only Policies and Package Policies, describes the geographical area as India. This would necessarily mean that the insurer would be liable to indemnity the insured in respect of accidents occurring in any place.

Over the years, various courts have held that insurers cannot avoid liability even for accidents in private place as the policy stands. As insurers have already broadened their liability on the above score, Section 146 can be amended in line with Section 166 to include all accidents irrespective of the place of occurrence.

5) Limitation

Section 166 of the Motor Vehicles Act has totally deleted the period of limitation. The Supreme Court has also since held that the benefit of such deletion shall accrue to the benefit of all claims except those which have already been brought to Court. The effect of this decision is that even old claims can be brought to court now. There is no distinction between those claims which had already been barred by limitation and those claims which were alive on the date of amendment to Section 166.

The result is that in view of the amendment to Section 166 read with the judgment of the Supreme Court, it would be eminently open to any claimant to file a claim petition today even in respect of accidents which occurred years ago. Such claim petitions have also been filed and have posed serious practical difficulties for verification of insurance policies, not to speak of any defences that may be available.

It may therefore be in the interest of insurers to moot an amendment to impose a time limit of three years for filing claim petitions under Section 166 instead of continuing to leave it wide open.

6) Jurisdiction

In view of the amendment of Section 166, it is now open to file a claim petition at any place, be it the place of occurrence of accident, place of residence of victim or place of residence of respondents.

Consequent to the above:

1. Several claims arising from an accident have been filed at different

centres and it has not been possible for insurers to have them heard together, as transfer applications are not entertained.

2. Serious problems have arisen due to duplicity of claims and due to separate claims by rival claimants.

Insurers may therefore propose an amendment that all claims shall be first filed before the court in whose jurisdiction the accident occurred and thereafter obtain the benefit of transfer to any centre according to their convenience. Even if insurers do not receive the benefit of joint trial, if may at least help them to keep track of the claims filed.

7) Section 163 A

Section 163 A was introduced for the purpose of speedy grant of compensation. A schedule was incorporated listing the compensation that would be payable given the age and income of the deceased. In respect of injury claims, specific amounts were earmarked with basis for computation. Though the said section was prospective in application, it has come to be accepted as worthy of being followed for the purose of uniformity and consistency, at least in the sphere of application of multiplier. But one provision that requires to be incorporated is that in the case of death of unmarried persons, the multiplier has to be fixed on the basis of the ages of the parents if they are the claimants.

It also has to be incorporated in the Act by specific mention that payment of compensation under Section 163A would imply that the claimants do not have recourse to claiming again under Section 166.

8) Right of insurer to dispute on merits

Under Section 170, there is a duty cast on the insurance company to obtain permission to contest on merits. More often than not, the owners of vehicles do not contest the claims and remain *ex parte*. This imposes an additional burden on the insurer in defending the claim.

It would only be fair for the insurer to seek an amendment under Section 170 to take over the defences of the owner of the vehicle as a matter of course instead of being compelled to seek permission.

A provision should be added under Section 170 to the effect that if the owner of the vehicle remains *ex parte* then the right to contest on all grounds shall be to the benefit of the insurer automatically. Considering the liberal times in terms of award and the fact that insurers file appeals only in accentuating circumstances, such a provision would do away with any technical hindrance if the award of the tribunal does warrant taking recourse to Appeal.

It may be in the interest of insurers to moot an amendment to impose a time limit of three years for filing claim petitions under Section 166 instead of continuing to leave it wide open.

9) Any person

It is the contention of the insurers that they are not liable to gratuitous passengers carried in a private car or a pillion rider on a two-wheeler in respect of an Act or Liability only Policy. It is only under a B or Package Policy that such coverage is contemplated and that too contractually. It is their case that the risk of such persons is not required to be covered as per requirement of Motor Vehicle Act. It is the further interpretation of the insurer that such persons were not required to be covered under Section 95 of the Motor Vehicle Act 1939 and since there was no specific amendment granting coverage to such persons under Motor Vehicle Act 1988, their liability to such persons was available only under B policies and not under Act Policies.

This stand of the insurance company had long since been rendered ineffective. Even prior to July 1, 1989, the expression 'any person' as used in the policy of insurance was held to include liability even in respect of gratuitous occupants carried in a private car. The use of the expression 'any person', be it under any policy, can fasten liability on the insurance company in respect of such persons also. It has also been held by the Supreme Court that in respect of all accidents occurring after July 1, 1989, be it any class or type of vehicle, gratuitous occupants were statutorily covered. Hence the law of the land is that both under Section 95 of Motor Vehicle Act 1939 and Section 147 of Motor Vehicle Act 1988, the risk of gratuitous passengers statutorily requires to be covered.

It may therefore be necessary for insurers to suitably modify the terms and conditions in all policies of insurance. If the insurers are of the view that they are expected to cover a wider risk then before under an Act policy without requisite premium, they should explore the possibility of charging commensurate premium.

It would also be in order for the insurers to include a term or condition in the Policy of Insurance that in the event of they being compelled to pay to more number of persons than the permitted number to be carried in the vehicle, they would be entitled to reimbursement from the insured. The general important notice in the policies may have to be specific in this context. Of course, there is a provision is Section 149 (5) enabling recovery to the insurer but it refers only to the amount payable. A term in the policy in the above regard is therefore bound to be more than useful.

The same decision (AIR 2000 SC 235) of the Supreme Court referred to earlier has also resulted in a serious transformation in the context of

gratuitous passengers in goods vehicles. The case of the insurers that such persons were not required to be covered and that it is only in the context of NFPP cover contractually entered into they would be liable has received a serious setback.

In the above judgment, the Supreme Court, in very clear and lucid language, has ruled that whatever be the class or type of vehicle, gratuitous occupants carried in the same and involved in accidents after July 1, 1989 would be automatically entitled to compensation from the insurance company.

Section 147 (1) has also been amended as on November 14, 1994 to include the phrase 'including owner of the goods or his authorised representative carried in the vehicle.'

In so far as amendment to Section 147 (1) (b) (1) is concerned, the introduction of the phrase must be restricted to goods vehicle only and could have been effectively employed in Section 147 (1) (b) proviso (c). If it is done so, then the liability to owner or authorised representative of the owner of goods would have been confined to the context of goods vehicles only.

The insurers may then confine to protect their last bastion by disputing liability to persons travelling in a goods vehicle on payment of hire by contending that it is opposed to the purpose for which the permit was granted.

10) Driving licence

Section 10 of Motor Vehicles Act 1988 has been significantly amended in respect of form and contents of the licences and, instead of sub clauses (e) to (h) of Sec 2, a singular clause in Sub Clause (e) viz. 'Transport Vehicle' has been introduced.

Previously, various categories of driving licences such as Heavy Goods Vehicle (HGV), Heavy_Passengers Vehicle (HPV), Medium Goods Vehicle and Medium Passenger Vehicle were specifically mentioned. All these have been replaced by an Omni Bus expression "transport vehicle". However, the replaced vehicles still find a place in the definition clauses in Section 2.

If a question arises whether an endorsement to drive a transport vehicle obtained after November 14, 1994 would entitle the driver to drive all classes of transport vehicles, the answer has to be in the affirmative, since it is now not open to the RTAS to issue specific categories of transport vehicles.

But as per Section 9 (6) of Motor Vehicles Act, the test of competence shall be carried out in a vehicle of the type to which the application refers.

It would only be fair for the insurer to seek an amendment under Section 170 to take over the defences of the owner of the vehicle as a matter of course instead of being compelled to seek permission.

This results in an anomaly as since Section 9 (6) test of competence is carried out in a specific type of vehicle, authorisation should be granted only in that type of vehicle. There is no Omni Bus type of vehicle called transport vehicle. Nobody can be tested in one type of vehicle and held competent to drive all classes of vehicles.

Hence, restoration of the various classes of transport vehicles as found earlier instead of a single class as transport vehicle may be in order.

Another contentious issue relates to the liability of the insurer in respect of expired licences. Previously, the insurance policies specifically contained the expression 'has held' in relation to the relevant clause. It therefore followed that it would be sufficient if the driver had held a permanent driving licence prior to the accident even if the licence had expired. After July 1, 1989, the expression 'has held' has been replaced by the expression 'holds an effective driving licence at the time of the accident'.

But even now, a twin obligation is cast on the insurance company to prove the following two contingencies:

1. that the driver did not hold a valid licence at the time of accident
2. that he was not disqualified from holding or obtaining one

Since the conjunction 'and' is used to join the two phrases in the said clause, there is a legal duty to prove both aspects to avoid liability. If the insurer desires to contest the case on grounds of expired licence it becomes imperative for the latter phrase on disqualification to be deleted from the Drivers Clause in Policy and also amend Form 51 framed under Rule 141 of Central Motor Vehicles Rules.

However, apart from any all amendments to the Motor Vehicles Act there are only two avenues for the insurers to make their Motor portfolio less crippling. The first is to make out a strong case for increase in TP premium by presenting complete and accurate premium and claims statistics. The second is to aggressively push for compromised settlement of MACT cases. Prompt, timely and reasonable offer of settlement in the early stages of filing a claim petition is always bound to be difficult for any claimant to spurn. The culture of such settlement is bound to help the companies considerably reduce their outgo.

The author is Deputy Manager, Oriental Insurance Co. Ltd. The views expressed here are his own.

Naming the Figure

– The nitty-gritty of arriving at the TP claim amount

Examining the Motor Third Party Liability compensation levels in the country, *R. Suresh* spells out the issues that need to be factored into the settlement amount.

In a developing economy, as the population crosses a billion and the purchasing power of various sections increases, the signs of prosperity do manifest themselves on the roads. The vehicular scene on the Indian roads has undergone a sea change. But, as is true with every development, increased vehicular traffic has given rise to its own problems.

Vehicular traffic is today the single largest killer in the country. Thousands of people die or get maimed in motor vehicular accidents every year. The National Crime Record Bureau of the Home Affairs Ministry states that about one lakh people have been killed and more than four lakh injured in 2003 due to road accidents. This data includes only accidents that have been reported to the police.

According to a study done by Tata Consultancy Services for the Ministry of Road Transport and Highways, our country has lost around Rs. 7,000 crore during 1995 alone due to road accidents. The levels are among the highest in the world for reasons not difficult to fathom. To name a few:

- Bad and insufficient roads
- Enormous growth of vehicular population
- Poor licensing norms
- Poor maintenance of vehicles
- Insufficient emergency care for accident trauma victims
- Overloading and lack of will to implement motor vehicle rules

The magnitude of the problem, both in terms of regulating the use of motor vehicles, as also the legal consequences that flow from their misuse, has called for a constant review of the laws that govern that field.

The victims of a road accident had to look forward to secure relief under the Common Law liability till the Motor Vehicles Act, 1939, was amended to create special tribunals to try claim cases to award compensation. The basis for the award of compensation arising out of the use of motor vehicles was necessarily built upon the Law of Torts. Negligence had to be proved as a fact to sustain a claim for compensation. The law in Minu Metha dropped anchor on strict proof of actionable negligence. It laid down that without proof of negligence, there could not be award of compensation.

> The desire of the insurance industry to contest the cases for compensation has been halted by the paradigm shift of the Indian courts.

The Apex Court in Gujarat Road Transport Corporation vs. Ramanabhai Patel clearly indicated that the rule of absolute liability is to be extended to a claim case based on a motor vehicle accident. Incidentally, the Apex Court ruled in the Ramanabhai Patel case that the issue of negligence never arose for consideration and, in fact, negligence was admitted as fact. Thus, the law in Minu Metha, which insisted on absolute proof based on proper plea regarding negligence in the use of motor vehicle, was done away with.

Recently, the Supreme Court in Kaushamma Begum vs. New India Assurance posed a question: “Should the claimant in a motor accident case be necessarily required to prove negligence in driving of the offending vehicle?” It then answered the same in the negative. The decision refers to the Common Law of Torts. The rule of absolute liability is made applicable to claim cases arising out of the use of a motor vehicle.

Leaning towards the claimant

Thus, the law and its interpretation have, over a period of time, been evolving strongly in favour of the claimants. The desire of the insurance industry to contest the cases for compensation and the prolific style of contest by insurers have been halted by the paradigm shift of the Indian courts. Some feel that these decisions ought to serve as the wake up call for the insurers but the repeated message of the Supreme Court is clear – that the insurers must act and serve as insurers and not as adversary parties.

Under these circumstances, the insurers are faced with the following challenges in their administration of the Motor Third Party (TP) claims:

- Unlimited liability
- Absolute liability
- Limited defences
- Liberal interpretation of the Act in favour of the insured and the petitioners
- Geographical disparities in awards
- Lack of consistent or uniform application of basis of compensation
- Ever changing trends
- Absence of time limit to file the petition for compensation

The computation of the final liability is to be based keeping in mind the above challenges and the insurers have to get it right all the time in order to ensure that the books reflect their liability which is adequate.

This leads to the question of how insurers estimate and provide the reserves that can be adequate. The courts have been reiterating that the

compensation has to be just and fair, keeping in mind the dependents who have been left to fend for themselves after the death of the breadwinner of the family.

The starting point is the amount of wages that the deceased was earning, the ascertainment of which to some extent may depend on the regularity of his employment. Then there is an estimate of how much was expended for his own personal and living expenses. The difference gives the basic figure that will generally be turned into a lump sum by taking certain number of years "purchase". That sum, however, has to be pruned, having due regard to uncertainties. For instance, the dependant ceases to be one. Also, there are matters of speculation and doubt. The general rule which has always prevailed in regard to the assessment of damages under the Fatal Accidents Act is well settled, namely that any benefit accruing to the dependant by reason of relevant death must be taken into account.

This method did not sustain for long on the premise that the wrong doer cannot benefit and has to accept the liability for his wrong doing in full.

Multiplier method

The English courts as well as Indian Courts followed the principle that were formulated by Lord Wright and came to be known as the "Multiplier Method". The Supreme Court has held that the following principle be observed and followed while assessing compensation:

- The compensation should address the pecuniary loss caused to the dependants by the death of the person concerned.
- Annual dependency of the dependants should be determined in terms of annual loss accruing to them due to abrupt termination of life.
- The suitable multiplier shall be determined by taking into consideration the number of years of dependency of the various dependents, the number of years by which the life of the deceased was cut short and the various imponderables such as early natural death, the prospects of remarriage of the widow and such other factors.

"The choice of multiplier is to be made by the court using its own experience and having due regard to the peculiar facts of each case, because the ultimate goal is not to adhere to any rigid formula, but to award a compensation which is just. In this approach the courts wanted to be sympathetic and realistic in their considerations because every assessment of compensation of this type rests more or less on conjectures of a fallible human being who is not able to know the ways of providence. Under the circumstances, what is required to be assessed is only reasonable probability as it appeals to reasonable persons."

> The choice of multiplier is to be made by the court using its own experience because the ultimate goal is to award a compensation which is just.

Principles of assessment

The assessment depends upon many uncertain factors. The tribunal needs to take an overall picture and form its estimate though, to some extent, it must be based on speculation. A just and fair calculation of compensation would be what the beneficiaries would have received from the deceased as a support for their maintenance had the deceased continued to live and earn.

The court can discharge its obligation by making reasonable estimates and justifiable guesswork. A precise determination on the basis of actual in the circumstances is impossible by human imagination. In the nature of claims involving fatal accident cases, what is being done is a *determination* of what "would have been" and not what "actually is". The courts feel that in matters of determination of compensation, all must approach the problem in a pragmatic and sympathetic manner. Of course, there must be some basis, though it cannot be expected to be foolproof or precise. Some reasonable estimates have to be considered which is fair to both the parties to the litigation.

The value of dependency

There remains the loss of pecuniary benefit arising from the relationship, which would have derived from the continuance of the life and which may consist of money, property or services, in other words, the value of the dependency.

General method of assessment

The courts have evolved a particular method for assessing the value of the dependency or the amount of the pecuniary benefit that the dependent could reasonably expect to have received from the deceased in the future. This amount is calculated by taking the present annual figure of the dependency, whether stemming from money or goods provided or services rendered, and multiplying it by a figure which, while based upon the number of years that the dependency might expect to last, is discounted so as to allow for the fact that, a lump sum is given now instead of periodical payments over the years. This later figure has long been called the "multiplier"; the former figure has come to be referred as "multiplicand".

Further adjustments, however, may have to be made to the multiplier on account of various factors like the probability of future increase or decrease in the annual dependency and the incidents of inflation and taxation. Moreover, the value of dependency can include not only that part of the deceased's earnings, which he would have expended annually in maintaining his dependents, but also that part of his earnings, which he would have saved and which would have come to his dependents by inheritance on his death.

As to what should be the multiplier has been the subject of great confusion and uncertainty although the Supreme Court held that the maximum multiplier ought not to exceed 18. Reported cases of the SC are available

where the multiplier of 13 has been applied for a person aged 37 and 15 for a person aged 52. Between 2001-2003, certain decisions of the SC brought some order in the issue by holding that the multiplier ought to be as specified in the Second Schedule of the MV Act for the sake of uniformity.

One would notice that the trend has been for the tribunals to estimate the earnings of the deceased more and more liberally, resulting in higher awards than ever before. The courts are inclined to consider a minimum income of Rs. 3,000 per month for any person who has died and this in a way only establishes that the average per capita income of our country is Rs. 36,000 per annum. It may be recalled that two-thirds of the population is below the poverty line as per World bank as well as Indian Government reports.

This trend has resulted in a marked increase in real terms for the insurance companies. The compensation was based on earnings of Rs. 2000 per month till two years back and the reason given by the tribunals is that there is an increase in cost of living due to inflation.

Assessment – injury case

The assessment in personal injury cases is somewhat different from the method involved in fatal accident actions. The broad general principle which should govern the assessment of damages in cases of bodily injuries is that the tribunal should award to the injured such sum of money as will put him in the same position as he would have been in if he had not sustained the injuries. The functional disability arising out of personal injuries, the resultant loss of earning capacity, loss of income from the date of accident till the date of trial and the loss of future income due to disability would all account for the compensation payable in injury cases. Loss of amenities, actual medical expenses, cost of special diet, conveyance incurred during the treatment, cost of attendant to take care of the injured person would be other heads of compensation.

The issues involved in injury cases are far more complex. At least in death claims, the Supreme Court, with the reiteration of the multiplier method, has evolved a formula. In injury cases, however, there is no uniformity even under the various heads under which compensation may be granted.

Rules for assessment

The following rules have to be kept in mind:

- The amount of compensation must be reasonable and must be assessed with moderation.Regard must be had to awards made in comparable cases.
- Sums awarded should, to a considerable extent, be conventional.

Despite a desire to enforce uniformity in the matter of award of compensation, it has been recognised that there is a deep variance in the amounts awarded as general damages. Of course, to a great extent, that has to depend on the difference in the nature of injuries involved in the diffrent cases and, therefore, ultimately the amount to be awarded as damages will be basically dependent on the nature of injuries in the case of a particular injured person.

> The issues involved in injury cases are far more complex. There is no uniformity even under the various heads under which compensation may be granted.

Evaluation of disability

The object of disability evaluation is to compensate the loss of wage earing capacity of an individual who is disabled. Disability is not a pure medical condition. It involves physical, social, psychological and vocational impairments, and hence before awarding all aspects are taken into consideration by the tribunal. This again does not have a magical formula but is based on a lot of subjectivity.

There are five factors influencing disability evaluation:

- The ratings of permanent disability as established by law
- Grading of disability as established through amputation values
- Functional evaluation by medical expert
- Wage earning capacity as affected by disability till his lifetime
- Consequential economic and social factors

Medical evidence through doctors certifying "disability" on account of injuries has been a severely contentious issue. For the same injury, as for instance a fracture in the hand or leg, certification of disability is found to be entirely different even in matters within the same court, indicating a high degree of arbitrariness.

A heavy responsibility falls on the orthopaedic surgeons because of the increased demand for their opinion in the overwhelming volume of claims. In most of the cases, the opinions are on the higher side, mainly arising out of an unscientific method of calculation and due to the fact that the sympathy rests with the injured. This, however, is at the cost of the insurers, who pay up substantial money under the head of disability.

The factors influencing disability evaluation require an understanding not only from the scientific approach but also from the legal point of view. Any doctor who is called upon to determine the extent of disability should be willing to add to his medical knowledge all other influencing factors that contribute to a trustworthy medical opinion.

As to the enormous variance in injury case awards, the reported judgments of the Supreme Court that may be referred to are as under:

In Kapil Kumar vs. Kudrat Ali (2002 ACJ 852) Rs. 50,000 was awarded for three fractures, whereas in NWKSRTC vs. M. S. Shettiar (2002 ACJ 215), Rs. 1,00,000 was awarded for one fracture of the wrist.

While in Zumar Ali vs. Nand Kishore (2001 ACJ 2007) and Imtiaz vs. National Insurance (2001 ACJ 1033) Rs. 2,00,000 was awarded for amputation of leg, in PTC vs. Jaganathan (2001 ACJ 5) Rs. 4,50,000

was confirmed. However, in Sashahendra Lahiri vs. UNICEF (1998 ACJ 859) Rs. 4,00,000 was awarded for shortening of leg involving no amputation.

The aforesaid judgments of the Supreme Court may be contrasted with the judgments of the Madras High Court in some cases as below:

For fracture of hip bone suffered by a post graduate involving 25 percent disability, an award of Rs. 45,500 was enhanced by the High Court to Rs. 3,55,000 (2004 ACJ 140). An award of Rs. 30,65,000 was granted to a lawyer who suffered grievous injuries (2002 ACJ 233). An award of Rs. 3,22,400 was confirmed by the Madras High Court involving a fracture of right hand middle finger and left shoulder disability of 45 percent. In 2005-1-CTC-38 Rs. 7,00,000 was granted for a fracture of leg with a slight shortening accepting a disability of 42 percent.

Administration of TP claims

As depicted above, it is clear that the courts cannot and O/o not apply a standard formula to decide on the final liability, as it is governed by various factors and some amount of subjectivity would be present in all its decisions. Hence, the insurer has the unenviable task of assessing its estimate on the actual loss that it may have to provide.

The assessment of liability in death cases is so different from the assessment in injury cases that the insurer has to keep this in mind while estimating the liability when the case gets reported. The insurer has to essentially tune itself to the different approach of various courts and accordingly estimate its reserves. Without doubt, it requires remarkable expertise and understanding of the subject on the basis of experience, failing which it may turn out to be gross miscalculation when the awards start coming in.

It would be prudent for the insurer to *evolve a standard reserving policy for death and injury cases separately* and the amount should be a reasonable estimate of the eventual liability. At the same time, it cannot afford to have more than what it could require.

What the insurer should do

- Prompt registration of claim intimations received from the court
- Process for receiving all information about death or injury to any third party from Own Damage intimations and registration of those cases as potential claims, thereby reducing the number in IBNR provisions
- Develop Standard Reserving policy which has the flexibility of review from time to time based on the trends of the courts
- Analysis of geographical trends based on the location of the tribunal, which would give a fair estimate of the probable award from that state or location. This is because the awards in each state are very different from the rest

It would be prudent for the insurer to evolve a standard reserving policy for death and injury cases separately.

- Prompt and proper investigation to ascertain the income and the disability that would eventually impact its reserves
- Immediate modifications of the reserves, upward or downward, based on any additional information that they might receive
- Monitor the time lag between the date of accident and the date of intimation/registration every month and form the basis for IBNR
- Factor interest on the outstanding claims/cases every month and ensure that these are reflected in the books of account
- Ensure that the reserves in WC cases are in line with the schedule of the compensation as provided in the Act

The insurance company will be able to reflect its liability with reasonable accuracy if the above methods are adopted on a regular basis.

Mitigation of loss

The evolution of the trends in relation to the quantum in Motor TP claims has left the insurance companies with no choice than to initiate compromise lest it faces the potential risk of being slapped with a bigger award than it would have provided for.

For some time now, Lok Adalats are being constituted at various tribunals in the country for the disposal, in a summary way and through the process of arbitration and settlement between the parties, of a large number of MACT cases. It has proved to be very popular with both the parties to the litigation that the petitioner gets the compensation in quick time and the insurance companies are able to restrict their losses by way of savings in interest and legal costs that are imposed in the event of a trial.

It has been now proved beyond doubt that the companies that have resorted to compromise settlements have been able to control their losses. Going forward, this would be the only way of having better administrative control on the huge number of cases that each company would be receiving.

Therefore, the thrust on compromise as a method of disposal results in:

- Finality of liability
- Savings in interest and costs
- Protection from volatility of future trends
- Better administrative control on ever-growing claims
- Limits on additional costs arising out of probable appeals against high awards
- Enhanced reputation of the company in the eyes of the judiciary as well as public

The author is General Manager - Liability Claims, Royal Sundaram Alliance Insurance Company. The views expressed here are his own.

Skilled Underwriting

— It can transform Motor Third Party Liability into a lucrative portfolio

Rather than just trying to control claims, underwriters should seek to change the behaviour of the portfolio through various underwriting strategies, writes *P. C. James*.

The motorisation of the economy is strikingly evident to anyone using the roads. This is inevitable as a country enters the rapid development mode. Transport is one of the key sustainers of the economy, as the movement of goods and services is integral to prosperity. In this, personal as well as commercial transport play an important role. Third party and passenger protection is an integral part of the responsibility that needs to be taken care of by the government. The Motor Vehicles Act, 1988 has done this, and insurers have been given the task of carrying the burden.

The Motor Vehicles Act casts an obligation on the insurer to manage this as a necessary duty and, at the same time, the insurer would need to do it profitably. Insurers have learnt to manage liability portfolios across the world and therefore it is not beyond the competence of any insurer to research the best methods to manage this portfolio despite the apparent legislative and regulatory constraints that may appear to inhibit its profitability.

The nature of liability insurance

The liability portfolio introduces a high level of subjective uncertainty for the insurer owing to the special features of the laws of tort/liability. These include:

1. The ever-expanding frontiers of liability. This means that what is not usually considered liability today can be considered a liability tomorrow.
2. The moving of all tort liability to absolute liability. This means that as times go on, the burden of proof will get increasingly mitigated so far as the victim is concerned and will eventually be limited to whether an accident took place and if so what is the extent of special and general damages.
3. The continuously expanding size of awards and costs. The legal landscape is moving in tandem with the deep pockets that insurance and other arrangements can bring to the succour of the insured.

> Globally it is seen that the underwriter has many tools to ensure that the opportunity for profit in this area is generated and even enlarged.

4. Once the course of litigation has been set there will be considerable utilisation of resources and costs to the insurer.

There are certain special features in the area of motor vehicles liability. These include:

1. The liability is potentially unlimited. However, in today's context, it is around rupees one lakh. The number of cases above Rs. 10 lakh in India is not too many as yet, though a dramatic change in the legal landscape in future cannot be ruled out.
2. Time and territorial limitations have been removed.
3. There is considerable delay in the judicial process. Cases may even drag for 15 years.
4. The possibility of frauds and exaggerations exists.
5. Defences for the insurer are few, and are said to be reluctantly and rarely permitted.

Insurers, therefore, need to bring back serious underwriting skills in this area of business. However, historically confusing the need for compulsion, underwriters seem to have abandoned any attempt to change the behaviour of the portfolio through underwriting strategies and looked to control claims alone. This is despite the fact that the portfolio was found to be perilous with many areas of concern for action on the part of the owner and the driver, the use of the vehicle, and the behaviour of the intermediary. The barriers that appear to have been created by considering the portfolio hopeless may have had an unexpected result of scaring away owners without risk of accident from insuring their vehicles. This deprives the industry of the good premium despite there being a compulsion to insure.

Globally it is seen that the underwriter has many tools to ensure that the opportunity for profit in this area is generated and even enlarged. Masterful insurers looking to make profits in underwriting work in detail in the following areas:

1. A deep analysis of the risks and vulnerabilities involved in the sector.
2. Detailed risk assessment through a combination of theoretical analysis of the risks that can befall vehicles in the Indian context vehicle type-wise, backed by the use of experience data can throw light on the measures to be taken for true loss control and pricing.

3. A proper risk analysis tries to unravel the risk chain in the portfolio. This consists of a detailed analysis of the motoring environment, the hazard/risk factors that operate in the sector, the exposure units (eg. the number of people and property that actually get exposed during the course of a day when a bus plies for 16 hours and carries thousands of passengers), the many perils that convert the exposure to losses both in severity as well as frequency and the actual outcome both in the short as well as long term.
4. Based on the above, there will be strong emphasis on underwriting, especially when adding a new client to the books. Discerning underwriters believe in the dictum of focus, focus and focus. Specialising through narrow focus helps to unravel the real causes of loss so as to work around such loss possibilities.
5. The important area of underwriting is the issue of insurability. The underwriter needs to work with the intermediary and the customer in reducing risks that can take place through the techniques of risk reduction (eg. ply less hours, use multiple drivers in case of long hours, compliance with all the Motor Vehicle Rules including local rules, etc.), risk control, loss prevention and loss reduction techniques.
6. Enforcement of all mandated risk and loss controls. Detailed understanding of the Act and Rules and the working of the RTO and the police may throw light on the mandates of law in the use of motor vehicles. All the rules and regulations that are enforceable should be strictly enforced.
7. Laying down clear underwriting norms based on the hazard/risk factors.
8. Using the insights gained by the underwriter, close attention can be paid to minimise the loss after the claim intimation.

Good underwriters also focus on the opportunities of the sector as well as the compulsions laid down by law. The motor sector is rapidly growing in India and shows the following patterns of change:

- As many as 20 lakh private cars enter the market and the extent of claims from this sector is not significant.
- As many as 60 lakh two wheelers are also entering the market every year with the likelihood of major losses being minimal.

Strategic analysis indicates that soundly trained intermediaries doing balanced business should be encouraged to enter the loop in insuring motor vehicles.

- Thus the character of the Motor TP market is moving away from commercial to private vehicles.
- The total number of vehicles plying the roads is in excess of seven crore.
- The quality of roads and other facilities are slated to improve.
- Training of drivers and control over licences, overloading of vehicles, etc. are receiving attention from various interested stakeholders.
- There is large-scale computerisation of court records taking place in the country. Fast track courts are also functioning, apart from judicial activism through full cooperation in lok adalats and other out-of-court settlements.

Underwriting considerations

a) New vehicles

Through a tie-up with the dealer it is possible to consider giving cover to brand new vehicles. In case cover notes are required to satisfy RTO requirements, the use of such cover notes would be in order for new vehicles. The other aspects of underwriting can also be conveniently checked while insuring new vehicles.

b) Old vehicles for renewal

Renewal of vehicles already covered with the same insurer can be considered subject to the claims history and loading and other underwriting controls. The cooperation of the insured in quick reporting of TP claims and assisting in the defence of claims need to be checked.

c) Old vehicles not insured in the same office

Acceptance of these vehicles becomes a matter for detailed and careful analysis along the following lines:

- Full details of earlier insurance policies
- Verification with the earlier insurer
- Explanation for gaps, if any, in insurance
- Reasons for change of insurer
- Full details of owner and driver and other details as required
- Experience of the insurer with regard to the type of vehicle offered
- Attestation by the intermediary bringing the business as to the soundness of the insured
- Inspection and photographs of the vehicle
- Copies of all vehicular documents

Further analysis of underwriting considerations includes:

1) Owner

The owner is the most important factor in ensuring that the vehicle plies lawfully, avoiding losses. The

underwriter will wish to ascertain the following:

a) Use of vehicle as per registration, and where applicable, as per permit
b) Employment of an experienced driver, if not self-driven
c) Evidence of proper care and maintenance of vehicle
d) The actual usage of the vehicle
e) Whether the owner has other vehicles and the details of these vehicles with their insurance history
f) Whether the owner is prepared to cooperate with the insurer in case of accident, including immediate information of the accident and assistance in the conduct of the case
g) Obtaining all details related to the insured, such as PAN number, phone number and business and employment details (particularly useful in case of recovery from the insured in case of violations)

2) The driver

As per reports, 80 per cent of motor vehicle accidents arise directly from driver negligence. Hence the importance of the driver in preventing accidents cannot be over-emphasised. The important areas to consider would be:

a) Whether the vehicle is owner driven
b) If a driver is employed, his age and experience
c) Detailed verification of the owner's licence and keeping a copy for record
d) Knowledge of procedures in case of accidents
e) Reference from previous employers, if any
f) Owner to have full details of the permanent address/details of the driver
g) Whether working in permanent or temporary capacity
h) The limit of duty hours and whether substitute drivers are used

3) The vehicle

a) Whether regular or improvised vehicle
b) Whether intended to be used for the use for which it has been registered
c) Whether registered in the area where it is intended to be insured, if not why
d) The average monthly kilometres of run
e) The routes it is plying
f) The areas in which it is to ply

4) The intermediary

Motor vehicle intermediaries are of various kinds. Acceptance of motor business from intermediaries who do only motor business would not be advisable, particularly if the experience in this regard is has been bad. Proper use of intermediaries would be an important part of profitable underwriting. Review of intermediary capabilities to advise and obtain the full details of the TP risk is of utmost importance.

> Insurers shying away from this portfolio may be making a strategic mistake, as it is often the starting point of personal insurance.

It is also important that the insurer analyses the composition of vehicles at the RTOs within the areas of its jurisdiction and ensures that vehicles of the profitable kind are attracted to take continuous cover. This is because it is felt that many customers, owing to possible harassments faced at the insurer's end, do not opt for insurancee. Most of such insurance can be attracted as part of the personal insurance portfolio of the vehicle owning customer. This will ensure higher premium per insured customer and balance the portfolio with a mix of other desirable business.

Good strategic analysis indicates that soundly trained intermediaries doing balanced business should be encouraged to enter the loop in insuring motor vehicles so as to ensure sound underwriting and claims follow up. Hence, there should be rewards for bringing in sound business and ensuring that the insured is made amenable to cooperate with the insurer in case of an accident as a matter of public duty. In personal insurance portfolio building, it would hardly do to discard the vehicles owned by the customer while insuring the other assets owned.

5) Rejection

The question of rejection of a vehicle having a valid permit is not allowed at this juncture. However, the insurer insuring the vehicle need to consider the various options in reducing the loss potential by ensuring that the vehicle owner complies with all the rules and regulations that are applicable. In this regard, the underwriter would need to familiarise himself with the MV Act, and rules of both state and central governments and make sure that owners comply with the regulatory regime dealing with motor vehicles. There are many controls that can be put on the insured, failing which the matter also could be put up to the MACT to pray for recovery from the insured.

Audit of TP claims by the underwriter

The underwriter needs to assert underwriting supremacy on the TP claims department, particularly as the business is under tariff. Hence, loss minimisation needs to be monitored and a fresh view needs to be taken on the claims cost incurred. The claim costs in TP claims could consist of the following:

1. Actual genuine cost of injuries sustained under special and general damages.
2. Additional amounts that could have been avoided if careful defence had been taken on grounds of contributory negligence, composite negligence and other extenuating factors that could emerge from the cooperation of the driver and the insured.

3. Amounts that could have been saved by better investigation and defence of the case. The skill and care of both the investigator and advocate need to be evaluated continuously.
4. Amounts that could be saved by cutting out opportunities for fraud, exaggeration, collusion etc.
5. Amounts that could be saved by avoiding needless appeals by better defence at the primary stage.
6. Amounts that could be saved by cutting out delays by the insurer, especially by speeding up settlement through alternative channels.
7. Delays that take place after awards are passed due to delay in decision taking.

The underwriting department should ensure that the additional losses that crop up due to the factors in claims management are not placed at their door. Every effort should be made to reduce claims costs through the proactive assistance of the claims department.

Insurers shying away from the portfolio of Motor vehicles may be making a strategic mistake considering that Motor insurance is the starting point of personal insurance. Many automobile manufacturers and dealers are entering the market as organised intermediaries with a view to move up the value chain by looking at the retail potentialities of their vehicle buyers and the profitability of renewal business. Good underwriting is forward looking and looks at profitable growth on the back of strong volumes and futuristic growth of the sector. The Motor market is expected to grow rapidly, particularly in the area of private vehicles. Detariffing is also in the air and the Motor market needs to be restudied in detail considering the various factors that create losses.

Good insurance always encourages sound intermediation by trained and capable intermediaries. They need to come into the loop so that profitable Motor business does not leave the market due to the ordeals faced by the insured in getting their vehicles insured. Further, their intermediation can help segments making losses to enforce loss minimisation efforts. The insurer can create an enabling environment whereby the owner, the intermediary and the insurer form a tight loop to ensure that TP insurance is not allowed to be exploited by external factors including exaggerations, falsities and frauds.

Good underwriting is forward looking and looks at profitable growth on the back of strong volumes and futuristic growth of the sector.

Developing good relationships with all the players in the Motor TP market is also a way to skirt around its many ways of adding to the losses underwriters face. The underwriting and claims department will work hand in hand to understand the real risks in the sector and try to change the risk profile so that all vehicle owners would find it easy to insure but at the same time know that the insurer would not allow for continuation of the ill effects of the sector that in no way benefits the insured or insurer but only third parties that have no stake in the well being of the industry.

The author is Executive Director (Non-Life), IRDA. The views expressed here are his own.

We welcome consumer experiences.
Tell us about the good and the bad you have gone through and your suggestions.
Your insights are valuable to the industry.
Help us see where we are going.

GOOD AND BAD

Send your articles to:

Editor, IRDA Journal, Insurance Regulatory and Development Authority,
Parisrama Bhavanam, III Floor, 5-9-58/B, Basheer Bagh, Hyderabad 500 004
or e-mail us at irdajournal@irdaonline.org

Legally Speaking

— What the law has to say about Motor TP claims

The Indian legal system deals with Motor TP claims in various ways. H. *Ananthakrishnan* takes a look at these with some interesting case studies.

Filing a Motor Third Party (TP) claim throws up a plethora of questions – who is actually entitled to make the claim, how, and when, to name a few. The Indian legal system has various laws relating to this issue, with its own set of intricacies and idiosyncrasies. A look at these, with a smattering of interesting cases, makes for a good read.

The law relating to Motor TP claim is codified in Chapter XII of the Motor Vehicles Act, 1988 (MV Act). While the chapter covers sections 165 to 176, this article deals with sections 165 to 169 and cases related to those sections.

The legal process for claims for TP liability is set in motion once a claim application is filed with the Motor Accident Claims Tribunal (MACT). MACT was established under Section 165 of the Act to adjudicate upon claims for compensation in respect of accidents involving the death of, or bodily injury to, persons arising out of the use of motor vehicles, or to damage to any property of a third party so arising, or both. An application for compensation is filed under Section 166 of the Act.

The decision to pay Motor TP claims depends on the answers to two questions:

i) Is the insured legally liable to the third party?

ii) Is the insurer liable to indemnify under the policy?

The first question is decided with reference to the law of negligence and, to a lesser extent, the law of nuisance. The second one is decided with reference to the terms and conditions of the policy as well as the provisions of the Motor Vehicles Act.

To remove doubts, the statute has expressly provided that the 'claims for compensation' includes claims for compensation under Section 140 of the Act. Accordingly, those claims where it is not required to prove negligence of the insured (No fault liability) also may be filed under Section 166 of the Act.

Combing through the Act

Section 166 of the Act states that –

(1) An application for compensation arising out of an accident of the nature specified in S.165 (1) may be made

a) by the person who has sustained the injury; or

b) by the owner of the property; or

c) where death has resulted from the accident, by all or any of the legal representatives of the deceased; or

d) by any agent duly authorised by the person injured or all or any of the legal representatives of the deceased as the case may be.

The proviso to sub section (1) states that all the legal representatives of the deceased shall be impleaded as respondents to the application.

The question of whether the Tribunal is a court subordinate to the High Court for purposes of section 115 C.P.C and revision against its order is maintainable has been the subject matter of many cases before different High Courts.

Sub section (2) Act was amended by Amendment Act 1994. Prior to the amendment, sub section (2) specified that application for compensation under sub section (1) shall be made to the Claims Tribunal having jurisdiction over the area in which the accident occurred, and shall be in such form and shall contain such particulars as may be prescribed.

With the amendment of sub section (2), every application for compensation arising out of an accident involving death or bodily injury shall be made at the option of the claimant, either to the Claims Tribunal having jurisdiction over the area in which the accident occurred or to the Claims Tribunal within the local limits of whose jurisdiction the claimant resides or carries on business or within the local limits of whose jurisdiction the defendant resides. Thus, three options of place have been provided to the claimant for filing an application for compensation.

Sub-section (3) specified the time limit of six months for the filing of application for compensation subject to condonation of delay by the Tribunal based on sufficient cause. The maximum time limit for filing the application even after condonation by the Tribunal was 12 months. This sub section has been deleted by the Amendment Act 1994. Courts have also held that the Law of Limitation does not automatically apply to special statutes.

These amendments have been the subject matter of discussions in many fora. While the intention of the legislature is to help the claimant, the

change has also brought in multiplicity of cases being filed before different Claims Tribunals by claimants arising out of a single accident, resulting in administrative and legal complexities. This, coupled with the removal of time limit for filing claim application, has compounded the difficulties for the insurer who have since been lobbying for restoration of the original sub sections (2) and (3) of section 166.

The Amendment Act has provided a new sub-section (4) for Section 166, as per which the Claims Tribunal shall treat any report of accidents forwarded to it under Section 158 (6) (by a police officer) as an application for compensation under this Act.

Apart from Section 166 and 140, one more avenue for compensation – Section 163 (A) — was added by the Amendment Act. This is a new provision for payment of compensation to road accident victims as per a determined formula. Unlike Section 140 where the compensation awarded is interim, the one awarded under Section 163-A is final. Under Section 163-B, the claimant may file for compensation under either Section 140 or Section 163-A, but not under both. Both sections dispense with the need of the claimant to prove negligence of the insured.

Section 167 of the Act clarifies that where the death or bodily injury to any person gives rise to a claim for compensation under this Act and also under the Workmen's Compensation Act, 1923, the person entitled to compensation may, without prejudice to Chapter X (Liability without fault), claim such compensation under either of those Acts but not under both.

Section 168 gives the tribunal discretion in arriving at compensation that it thinks is 'just'. Section 169 deals with the procedure and powers of Claims Tribunals.

We may see some interesting cases under the above sections. Cases highlighting the interplay of different sections have been chosen.

Claims Tribunal (Section 165)

In *Saramma v Mathai (2003 ACJ 213)*, the Tribunal, after framing issues, dismissed the claim application on the ground of default of the claimant without arriving at findings and without adverting to reasons after the stage of framing issues. On appeal, the High Court (Kerala) held that once issues have been framed, the Tribunal has to decide the issues on the basis of available records, whether the parties appear or not. Section 166 (4) directs the Tribunal to treat report under Section 158 (6) as application for compensation.

The question of whether the Tribunal is a court subordinate to the High Court for purposes of section 115 C.P.C and revision against its order is maintainable has been the subject matter of many cases before different High Courts. The case *Oriental Insurance v Basangouda 2004 ACJ 1652* considered the question of whether a civil revision petition lies under Section 115 of C.P.C to High Court against the judgements and awards or orders made under various statutes including the Motor Vehicles Act, 1988. After referring several cases, the Court held that the Tribunals are not subordinate to the High Court and the civil revision petitions filed are not maintainable.

> Tribunals have wider powers than civil courts for ascertaining the facts and controversies.

However, in *Moti Bai v Kapoor Chand alias Jamna Bai (2004 ACJ 1656)*, the Jabalpur High Court quoted *Krishan Gopal v Dattatreya, 1971 ACJ 372 (MP)*, in which it has been held that the Claims Tribunal is a court subordinate to the High Court and its orders are revisable under Section 115 of the Code of Civil Procedure. In the main case cited, the court accepted this view and held that the award passed by the Claims Tribunal falls within the meaning of the words 'order of any civil court' used in Article 136 of the Limitation Act, 1963.

There are cases where it has been held that Tribunals are not civil courts and strict rules of evidence are not applicable to claim cases. Tribunals have wider powers than civil courts for ascertaining the facts and controversies. Even the first Appellate Court should not interfere in the same as has been laid down in the case of *Madhusudan Das v Narayani Bai AIR 1983 SC 114.*

Choice of forum (Section 166 & 167)

In *Harsh Malik v Munna Burman & Ors (2005 ACJ 71)*, the High Court of MP considered the issue whether the Claims Tribunal has jurisdiction to decide the claim of the dependants of the driver who died in the accident. The contention of the appellants was that the remedy available to the dependants of the deceased driver was to file a claim petition before the Commissioner for Workmen's Compensation. The Court held that Section 167 gives the claimant a choice of forum to file claim application under the Workmen's Compensation Act or the Motor Vehicles Act.

In *Kore Laxmi v United India Insurance Co. Ltd (2005 ACJ 543),* the High Court of AP had the occasion to consider the question of choice of forum. This case was relating to the claim for death of driver of truck. The vehicle met with an accident due to the driver's negligence. A single judge held in appeal that accident had taken place due to the negligence of the deceased (in the course of his employment), hence the Tribunal under Motor Vehicle's Act had no jurisdiction and claimants are entitled to compensation under Workmen's Compensation Act. The High Court overruled this order and upheld the Tribunal's order that the claimants having exercised their option are

entitled to maintain their claim under the Motor Vehicles Act.

Legal representative (Section 166 (c))

In *Mansingh v Banne & Ors (2004 ACJ 1467),* the claim application was filed under Section 110-A (1) (b) of Motor Vehicles Act 1939 [Section 166 (1) (c) of 1988 Act]. The claimants were the father and brother of the deceased. The wife of the deceased remarried after the accident. The question for determination was whether the wife of the deceased, though not a party in the case, was also entitled to compensation. The Tribunal held that the widow be paid compensation, as the accident had occurred when she was the wife of the deceased and the application for claim can be filed by one or more legal heirs for others.

This decision is in consonance with the proviso to sub section (1) of section 166 that all the legal representatives of the deceased shall be impleaded as respondents to the application.

In another case *Ravindra Kumar Mishra v Dular Ram & Ors,* husband and wife filed the claim application jointly, as they had sustained injury in the same accident. The Tribunal dismissed the same on the ground that the joint claim application was not maintainable. The High Court of Chattisgarh held that the Tribunal should have a humane approach and not be technical or hyper-technical in performing its duties. The joint claim application was held to be maintainable. In this case, the claim application was time barred but during the pendency of appeal, the section providing for limitation (section 166 (3)) was omitted. The claim was held to be maintainable, as now there was no limitation. The Tribunals were advised to exercise the benevolent provision judicially but not arbitrarily and capriciously.

In an interesting case under section 166, *Himachal Road Transport Corporation v Subhdra Devi & Ors*, the widow of the deceased had instituted divorce proceedings but her petition for dissolution of marriage was dismissed. Since the matrimonial bond was subsisting, she was awarded compensation. The second wife was not awarded compensation, as her marriage to the deceased was void *ab initio*. However, the court treated the children of the second wife on par with legitimate children of the first wife and awarded compensation to them also. This case also highlights 'just compensation' under section 168 (1), wherein the court held that the compensation amount be divided equally between the first wife and *all* the children.

For awarding just compensation, the Judicial Officers are expected to do a lot of exercise and apply their mind before passing any award, fixing the compensation amount payable to the claimant.

Conversion of claim under Section 166 to claim under Section 163 - A

In the above case (*Kore Laxmi*), the counsel for the insurance company contended that the claimants filed application under section 166 of the Act and as such the court below erred in applying the Table given in Second Schedule to Section 163–A of the Act. The High Court rejected this contention and held that the Supreme Court, as early as in 1950, held that even if a party approaches the court invoking a wrong provision, the court is always bound to do justice by applying the correct law.

The case *Narshiji Nagaji Majirana v Mangilal Amturam Bishnoi & Ors (2005 ACJ 19)* explains the circumstances under which a claim under Section 166 may be converted into one under Section 163-A. The Court held that the object with which Section 163-A has been inserted and the *non obstante* clause with which sub-section (1) of section 163-A commences clearly indicate that the legislature did not intend to prevent the claimant from getting compensation as per the structured formula merely because in his original claim petition he had prayed for compensation on the basis of 'fault liability' principle. All that section 163-B prevents is consideration of claim by the Tribunal under section 140 of the Act as well as under section 163-A of the Act. Hence, in the absence of any period of limitation, there could be no objection to the claimant making an application under section 163-A of the Act even after making an application under section 140 of the Act, if the accident took place on or after November 14, 1994.

It may be recalled that Section 163-A and 163-B were introduced by the amendment Act effective from that date. Thus, as long as an order under section 140 of the Act is not passed, it is open to the claimant to apply for amendment of the claim petition for invoking the powers of the Tribunal under section 163-A of the Act and not the power under section 140 or sections 166/168 of the Act.

Interestingly, the High Court of Jammu & Kashmir, in *Oriental Insurance Co. Ltd v Ghulam Mohd (2004 ACJ 1811),* held that the court could grant additional compensation to the victims in terms of section 163-A of the Act when compensation in terms of section 140 has already been granted provided the accident had taken place on or after November 14, 1994, subject, of course, to the claimants satisfying other requirements indicated in the Second Schedule. The court held that the right to claim compensation on the basis of no fault liability under Section 140 is in addition to the right to claim compensation on the principle of fault liability or the right to claim compensation under any other law for the time being in force.

On a literal interpretation of section 163-B, what is barred is perhaps the filing of the claim application under both sections 140 and 163-A. It appears from the J&K case quoted above that there is no bar in awarding compensation under Section 163-A even after compensation is awarded under Section 140. The fact that both sections deal with 'no fault liability', where the need to prove negligence is dispensed with could be one reason. The other could be that the award under Section 140 is interim and not final. However, once compensation under Section 163-A is awarded, there is no going back to Section 140, as the compensation under Section 163-A is final.

These decisions, though seemingly contradictory, are not anomalous as the proviso to Section 140 (5) clarifies that the amount of compensation payable under any other law for the time being in force is to be reduced from the amount of compensation payable under sub-section (2) or under section 163-A.

Limitation

In *Mutteppa Nagappa Karegar v G.B. Attar (2004 ACJ 1929),* the Karnataka HC considered the effect of omission of sub-section (3) of Section 166 of the Act. The accident took place when the 1939 Act was in force but the claim was filed when this Act had been replaced and the 1988 Act had become operative. Application was filed one month and 10 days from the date of accident and it was dismissed by the Tribunal. Appeal against its dismissal was pending when sub-section (3) of Section 166 was omitted and no limitation governed the presentation of a claim application. The court held that the application is not barred by limitation.

The Punjab & Haryana HC considered a similar issue in *Raj Rani Puri v Union of India (2004 ACJ 1598).* The question was what should be done in cases where the accident and the award of the Tribunal had happened long before the amendment had been enforced. The Supreme Court in *Dhannalal v D.P. Vijayvargiya (1996 ACJ 1013 (SC))* observed _

"The matter will be different if any claimant having filed a petition for claim beyond time which has been rejected by Claims Tribunal or the High Court, the claimant does not challenge the same and allows the said judicial order to become final. The amendment Act (1994) shall be of no help to such claimant. The reason being that a judicial order saying that such petition of claim was barred by limitation has attained finality. But that principle will not govern cases where the dispute as to whether petition for claim having been filed beyond the period of 12 months from the date of accident is pending consideration before the Tribunal, High Court or the Supreme Court. In such cases, the benefit of amendment of sub-section (3) of section 166 shall be extended."

It is generally felt that the Motor Vehicles Act, being a social legislation, is loaded against the insurers.

Does it imply that it pays to keep the case alive by protracted litigation in the hope of favourable amendment of statute?

Just compensation (Section 168)

Finally, a case under section 168 (1) of the Act wherein the final words of the learned judge serve as an object lesson to judicial officers, the insurer and the advocates of insurer and claimants alike. In *Ajmeera Govind v Principal, Arvindo Residential School, Bodhan & another (2005 ACJ 1436),* the Tribunal awarded compensation in lump sum without specifying the amount under various heads. The High Court of AP held that it is imperative to award compensation under different heads. While awarding the compensation, the judge observed:

" I am inclined to state that most of the District Judges are not applying their mind to the principles evaluated by the series of decisions written by the superior courts, as well as the provisions of the *Motor Vehicles Act* while awarding compensation. Though they are expected to award compensation under several heads taking the gravity of the injuries sustained by the victim, the income and status of the individual, they are awarding compensation arbitrarily, in some cases very low and in some cases fanciful amounts, forgetting the fact that they are directing the insurance companies to part with the taxpayers money towards compensation…. For awarding just compensation, the Judicial Officers are expected to do a lot of exercise and apply their mind before passing any award, fixing the compensation amount payable to the claimant. Unfortunately, the counsel engaged by the insurance companies do not even cross-examine the witnesses, pointing out the loopholes in the evidence produced on behalf of the claimants. With the result, in many a case, the compensation awarded by the Tribunals is lacking in objectivity. They are disposing of the cases in a very casual manner. Unfortunately, while advocates appearing for the claimants are not even taking the minimum care in producing the proper evidence like examining doctors, or other witnesses, production of medical records etc., in getting just and reasonable compensation to the victims. Advocates appearing for the insurance companies are not trying to cross-examine the witnesses who are being examined on behalf of the claimants, even on the shabby evidence produced by them"

A just observation in a case relating to just compensation!

General observations

It is generally felt that the Motor Vehicles Act, being a social legislation, is loaded against the insurers. This feeling is further accentuated by the expansion of the jurisdiction clause in section 166 (2) and deletion of limitation clause in section 166 (3). Add to this the provision of unlimited liability in section 147 (2), restricted defences available to the insurer under section 149 (2), compulsory payment of compensation to a third party combined with difficulty in recovering the same from the insured – despite Section 149 (5), difficulty in obtaining permission from the Tribunal under Section 170 to contest the case on merit and we have a perfect case for commiseration with the insurer.

However, perhaps due to these factors or otherwise, it must be admitted that the insurer has been lax on many fronts. A look at the MACT cases over the past five years would reveal that on an average a case has prolonged from three to five years. The courts, having developed a mindset against the insurer-perhaps due to stubbornness of the insurer in denying claim to the insured - even in cases where insurers' defences were weak and amicable settlement could have been reached have also been liberal in awarding penalties. With proper documentation, tightening of available defences and diligent follow-up of the cases filed before the Tribunal / High Court, it would still be possible to stem the leakage of claim costs in the Motor Third Party portfolio.

Over the past 40 years, the Law of Torts, which is the touchstone on which the 'fault liability' is based, has evolved into what has been called law of 'contorts' – a system focused less on rights and wrongs than on finding a source of compensation for any injury, regardless of fault. A perusal of the MACT cases actually reveals that even where the insurer could rightfully repudiate liability based on the meagre defence available to them, they still have had to pay compensation with a provision to recover the same from the insured.

One gets a feeling that whether or not the Law of Torts has taken roots in the Indian legal system; the law of 'contorts' is certainly threatening to take its place sooner than later, at least in the Motor portfolio.

The author, Deputy Manager with the Tariff Advisory Committee, is Officer on Special Duty, IRDA. The views expressed here are his own.

GET ALL BACK ISSUES OF IRDA JOURNAL HERE

on the web!

http://www.irdaindia.org/irdajournal.htm

The Big Con Game

— Rampant fraud in Motor TP cases

Ruing the high prevalence of malpractices in Motor TP claims, *T. Babu Paul* examines the causes and reflects upon the remedies.

Have you ever wondered why it is so difficult, say almost impossible, to get third party insurance for your old car or scooter? You cannot use the vehicle without an insurance cover, as it is mandatory. In case you are, you are not only violating the law but also taking a risk, as your vehicle just might injure some other person. All insurers – both in the public and private sector – are duty bound to provide third party (TP) insurance coverage to vehicles.

However, in reality, the private sector companies do not and the public sector insurers are not at all happy giving the coverage. The only reason for this is the high payouts in this portfolio which has taken away three times the premium the insurers receive. One of the reasons for this heavy outgo is the prevalence of frauds and malpractices.

Easy game

Why do frauds take place? Insurance companies all over the world are easy game for frauds and India is no exception to this. Frauds are the means for greedy minds to milk the system which was intended for social good. On the one hand, there are unscrupulous elements working against the company and, on the other, a faulty legal system coupled with the indifferent attitude of the insurance company's personnel at all levels. These factors ensure that such malpractices thrive.

The Motor TP portfolios of all PSU insurers have a claims ratio of over 300 per cent, which means that for every Rupee of premium earned, the outflow is over rupees three. This is the reason that none of the private sector insurers is accepting TP stand-alone policies. Commercial vehicles as a single category contribute to the largest number of claims. Probably if all frauds are removed and the cases are awarded purely on the merits of the case, the TP portfolio, in the worst case scenario, will not produce an outgo greater than the income. This means that as much as two-thirds of the outgo is on account of frauds. Difficult to believe, but random checks reveal similar trends, too.

> Insurance companies all over the world are easy game for frauds and India is no exception to this.

Frauds in TP cases take place in various ways. There are frauds taking place both within the company and outside. The list that follows is only indicative, not exhaustive.

There are frauds taking place within the insurance company relating to TP claims, such as pre-dating the cover to accommodate a vehicle that had an accident and misuse of cover notes and the computer system to provide coverage to vehicles already involved in an accident. The following are the main ways in which frauds are committed within the office or with the knowledge and connivance of some employees of the insurance companies:

- Issue of bogus and fabricated cover notes and / or policy document.
- Pre-dating the cover in the cover notes.
- Forging the cover note/policy document after inserting different dates/vehicle details/ insured person's name.
- Misuse of blank cover notes.
- Issuing the original cover note without details which can be filled up conveniently so as to accommodate a fraud.
- Acceptance of cover after a loss has occurred, fully knowing the facts.
- Tampering with computer database/late cash entries to provide coverage to a vehicle that had an accident. This practice is more prominent during weekends and holidays.

The internal frauds, as we can call them, are on the decline, as the main accessory to these frauds was the cover notes which are now used with much care. The introduction of more secure software and controls has helped in reducing such malpractices. The employees are also sensitised on this issue, which has also brought down such internal frauds to considerably lower levels.

The following is an indicative list of the ways in which the frauds are

committed outside the span of the insurance companies:

1. Converting non-road traffic accident cases into RTA cases

These refer to accidents/injuries that have no relation to a motor vehicle. The injuries could be due to various reasons such as industrial or domestic accidents. In some cases, there may not be an accident at all, but just to cover the cost of treatment, accidents are faked on records with the connivance of the police and doctors.

2. Substitution of the vehicles - various combinations thereof

Here, the accidents are genuinely due to a vehicle but, as the vehicle involved is not covered by a valid insurance policy, the case is directed to another vehicle that has a valid insurance cover. It is the law of the land and matter of common knowledge to all vehicle owners that a vehicle cannot be used in a public place without valid TP insurance coverage. But the compliance is far from the requirements of law. From our experience, not more than 50-60 percent of the vehicles (that too on cities and major towns) have a valid insurance policy. It is much less in the rural areas. The police will also vouch for this. All the accidents are latched on to some of the vehicles having a valid insurance policy. Experience shows that at least 10 to 20 per cent of the total cases fall within the category.

3. Substitution of driver

In addition to swapping of vehicle, change of drivers is also common for various reasons. This may be because the drivers may not have a valid licence to drive the vehicle in question. This is rampant in commercial vehicles and in two-wheelers. In commercial vehicles, the cleaner or the helper may drive the vehicle. The cleaner sometimes may have a regular licence but not a heavy licence and badge to drive a commercial vehicle. In two–wheelers, we often come across minors driving the vehicle who have not reached the required age for procuring a licence.

4. Addition of persons not involved in the accident

In the case of commercial vehicles (public transport, especially), if an accident takes place, the chances of all the occupants/passengers getting injured is unlikely. But invariably we end up getting as many claims as the registered carrying capacity of the vehicle. The claims are made either in fictitious names or in the names of persons who had other accidents. Sometimes we find agents of lawyers striking a deal with some persons who are undergoing treatments for fractures and other motor accident look-alike injuries to put up a case as a passenger of the vehicle involved in the accident. Sometimes we also get a greater number of claims than the capacity of the vehicle and the courts direct the insurers to "pay and recover". But the recovery seldom takes place. The fact that most of the public transport vehicles are overloaded is not overlooked but the insurers are to pay for both the overloading as well as for the frauds.

> One way of defrauding the company is of exaggeration, be it of income, age, occupation or disability of the victim.

4. Inflated medical bills and such other documents

One way of defrauding the company, which happens in almost each and every claim, is the exaggeration, be it the income, age, occupation, disability, status, medical expense or employment of the victim, in all categories possible. This has now become an industry practice and is an essential ingredient to every claim. TP claims have even been put up with the unclaimed dead bodies in hospital morgues.

5. Hit and run cases

Where hit and run cases occur, vehicles whose documents are in order are implicated with the cooperation of their owners and drivers to put up a claim, as the compensation for hit and run cases are limited to Rs. 50,000 for death and Rs. 25,000 for serious injuries. The so-called drivers also plead guilty before the court, thus sealing all chances for a fair trial. This takes place with the cooperation of some people in the police department.

Frauds are a state of mind and are a part of any insurance claim. We cannot segregate TP claims from the others, as frauds are common in all types of insurance claims. Those who get away are smart and those who do not are labeled as crooks. There is a general perception that the insurance companies are sitting on a pile of cash and defrauding is not even considered morally incorrect. One reason could be that the general insurance premium are non–returnable, unlike most of the life insurance contracts, which provides for at least the paid monies being returned.

Through such fraudulent methods, people try to make up their premium by way of inflated claims or even non-existent claims. Globally, insurance frauds are estimated at any 15-20 percent of the total payouts and in India the scenario is no different. In Motor insurance, the frauds constitute at least 50 percent of the

outgo, out of which the TP claims account for the major share.

What makes TP claims more fraud prone? The reasons are many.

The first and foremost is that insurance companies are not the ones deciding on the TP claims. They also do not process the claims and the whole process or action is at the Motor Accident Claims Tribunals (MACT). As per law, the full and final settlement only in a Motor TP claim can be given by the courts, as we provide legal liability cover and, whatever we pay, the courts can increase the amount based on the merits of the case. Because of this, insurers have traditionally shied away from settling the claims without the intervention of the courts. The GIC and its subsidiaries in 1992 launched a programme called Jald Rahat Yojana, for the settlement of TP cases without the claimants having to approach the court. Although the intentions were good, it suffered on some practical aspects and was withdrawn within a year of launch.

The next is that the cases are reported after a considerable time lapse, so a reality check on the correctness of the incidents itself is lost. There is also no time limit for claiming compensation in a motor accident claim. The geographical jurisdiction is also removed from such cases, making it very difficult for the companies to investigate and take up proper defence. These provisions are more misused than used to give relief to a needy victim. There have been instances of the same person filing claims at different tribunals at different places for the same accident.

Legal aspects

There are many lacunae in the legal system, which helps to facilitate fraud on the insurers via false claims. But by taking effective recourse to some of the provisions of the Motor Vehicles Act, the fraud can be contained to a certain extent.

The Motor Vehicles Act enjoins that:

"as soon as any information regarding any accident involving death or bodily injury to any person is recorded or reported under this section is completed by a police officer, the officer in charge of the police station shall forward a copy of the same within 30 days from the date of recording of information or as the case may be, on completion of such report to the Claims Tribunal having jurisdiction and a copy thereof to the concerned insurer, and where a copy is made available to the owner, he shall also within 30 days of receipt of such report, forward the same to such Claims Tribunal and insurer." (Motor Vehicles Act, Sec. 158(6)).

> The end result of these fraud claims is that it pushes up the cost of insurance.

In case this provision is strictly complied with, the insurer will be served a copy of the report and this can be utilised for ascertaining whether the claim preferred in a Tribunal is genuine or not.

The Motor Vehicles Act has been amended taking away the jurisdiction clause, which makes it easier to file fraudulent claims, as investigation to ascertain the genuineness of the claim at another jurisdiction may not be effective for the insurer. The jurisdiction should be confined to the place of accident, or where the claimant or the defendant resides. The amendment taking away limitation has also made a severe impact on the insurance industry, as a claim can now be preferred at any point of time. With the technological advancements in this century, the justifications of the legislature for taking away the limitation is no longer applicable and so there should be a reasonable period of limitation in preferring claims for motor accidents.

Cost of frauds

The end result of these fraud claims is that it pushes up the cost of insurance. At present, both the pricing and the payouts of TP insurance is fixed by the Government and the insurers are in an unenviable position of administering a portfolio over on which they have very little control. There are, of course, several methods to detect and take necessary legal measures to protect the interests of the company and the society at large. But the process is painstaking and the support of the legal system is not easily forthcoming.

The free pricing of TP insurance, which is likely within a year, will have a disastrous effect on the common man, as the rates will shoot up three to four times, especially for commercial vehicles. The only way is to control the claims, at least ensuring that the system is not misused by fraudulent means. The society has a larger responsibility than the insurers in ensuring this as insurance neither generates nor extinguish funds but merely manages it.

The biggest beneficiary will again be the commoner who will not be required to run from pillar to post to insure his old scooter.

The author is Assistant Manager, National Insurance Co. Ltd. The views expressed here are his own.

प्रकाशक का संदेश

मोटर देयता बीमा सामाजिक तौर पर बहुत मुख्य यंत्र है, पर यही कंपनियों के बॉटम लायनों पर विशिष्ट प्रभार उत्पन्न करके, सामान्य बीमा उद्योग को लगभग सभी मार्केटों में हानि पहुँचाता है। पर भी यह अरोध्य व्यापार पोर्टफोलियो है क्योंकि यह टॉप लायन को विशिष्ट रूप से ऊपर उढाता है, नकद बहाव को बढा देता है तथा निवेश पोर्टफोलियो की ओर अंशदान देता है। भारत में, एक अतिरिक्त दायित्व है कि प्रतयाशित ग्राहकों से अप्रोच किये जाने पर, कंपनियों द्वारा मोटर तृतीय पार्टी देयता व्यापार लिखा जाना है।

पर भी, व्यापार को व्यवस्थित रखना एक समस्या रहता है, ताकि नकारात्मक प्रभावों को कम किया जा सकें । आईआरडीए जर्नल का यह अंक इस विषय को परीक्षण करता है। हम, ज्यादा अभ्यासकर्ताओं तथा विश्लेषकों द्वारा इस विवादस्पद समस्या पर प्रदान किये गये विश्लेषणों को यहॉं प्रस्तुत कर रहे हैं, जिससे कि इस समस्या का हल निकालने रास्ता प्रदान करने प्रयत्न कर रहे है।

अगले अंक बीमा सेक्टॉर संशोधनों के 10 वर्षो पर ध्यान देगी । एक शताब्दी के पहले, 1996 के पूर्व में, बीमा नियंत्रक प्राधिकरण को निर्माण किया गया । यह अंतरिम बॉडी था जो 1999 में आईआरडीए अधिनियम के पारित हो जाने के बाद, बीमा नियंत्रक तथा विकास प्राधिकरण बन गया।

एक नये वर्ष के प्रारंभ में पीछे देखना बहुत ही अच्छा कार्य है, तथा आगे भविष्य की ओर ध्यान देना भी बहुत ही उद्‌देश्यपूर्ण रहेगा। 2006, भारत में बीमा उद्योग के लिए, बहुत ही चुनौतियों तथा कार्यकारी बिन्दुओं को अपने यहॉं रखा है। मैं आपको नववर्ष की शुभकामनाऍं प्रदान करूँ तथा इस वर्ष ऐसा रहेगा जिसमें हम एकत्रित होकर उद्योग का स्वास्थ्यपूर्ण विकास देखंगे ।

सी. एस. राव

सी. एस. राव

“ कुछ तो लोग कहेंगे ”

मार्केटों द्वारा 2005 में लाभ पाने
की संभावना बहुत ही कम है ।

सितंबर 11, 2001, आतंकवादी हमला से लगभग +5 बिलियन से अधिक स्टार्म पेआउट पर श्री लुक सेवेज, वित्तीय निदेशक, लायड्स ऑफ लंडन।

मध्वर्तीयों के लाभार्थ एक समान खेल क्षेत्र है, इसे सुनिश्चित करने के लिए अनुपयुक्त संगठनों को बाहर रखा जाना आवश्यक है ।

2004 में कानून ने जब से उन्हें निगरानी में लाया, उस समय से 600 बंधक तथा सामान्य बीमा संगठनों के प्रचालन पर रूकावट लगाये जाने के संबंध में श्री अन्ड्रू हनी, बीमा के अध्यक्ष, स्मॉल फर्मस डिविशन ऑफ फाइनेन्शियल सर्वीसस अथारिटी ;एफ एस एद्ध यू के ।

... अगर तूफान जोखिम का ठीक से लागत लगाया गया तो इसके परिणामस्वरूप अन्डरव्राईटिंग लाभ,, अतिरिक्त निवेश पूँजी आकर्षण करने के जैसे बडे होंगे। दुर्भाग्यवश, पूँजी में वृद्धि मार्केट जगह में प्रतियोगिता उत्पन्न कर सकता है, जो कुछ व्यक्तियें के लिए लागत को कम कर देगा। उच्च जोखिम जगहों में पर्याप्त दरों को रखना सुनिश्चित करने के लिए कभी अनुशासन काफी नहीं हो सकता है।

मेसर्स अलाइस गेनॉन, वरिष्ठ उपाध्यक्ष, यू एस एक्चुअरीज असोसियेशन

वित्तीय प्रणाली के मुख्य भागों में उच्च रूप से उछलनेवाला आईटी सिस्टम के उपलब्ध होने के जैसे दीख पडता है जो द्रुत गति से चतुर फंक्शन को पूनः प्राप्त करने देते है। यह इस सेक्टॉर को बेहतर दिखाता है और हमें इस स्थिति में विस्तारित नियम लिखने की जरूरत नही है कि संगठनों को उनके द्वारा क्या व्यापार अनुवर्ती व्यवस्था अपनाना है,।

आतंकवादी हमला या प्राकृतिक विपत्ति जैसे घटनाओं से मुख्य प्रचालन भंग होने पर सामना करने की यू के वित्तीय सेक्टॉर की क्षमता पर ट्रिपेरटाइट अथारिटीस ; हेचएम ट्रेशरी, एफ एस ए और बैंक ऑफ इंग्लैंड द्ध से किये गये सर्वेक्षण की परिणामों पर श्री हेक्टॉर सन्त, मैनेजिंग निदेशक, होलसेल फर्मस डिविजन, फाइनेन्शियल सर्वीसस अथारिटी ; एफएसए द्ध, यूके का बयान

छः वर्षों के बाद, यू एस नियंत्रकों के बीच इस समस्या पर एक मूवमेंट दीख पडा, जिन्हें यूएस पुनःबीमाकरण व्यापार को अन्डरव्राईट करना है तो यू एस ट्रस्ट निधियों में विदेशी पुनःबीमाकारों द्वारा विशेष स्तर के कोलेटरल रखने की जरूरत है ।

यू एस बीमा नियंत्रकों द्वारा विदेशी पुनःबीमाकारों के बारे में पुनःसोच के बारे में लार्ड पीटर लिवेन, अध्यक्ष, लायड्स ऑफ लंडन,

टीआरआईए का दो वर्ष विस्तार, जिसपर कांग्रेस ने अभी कार्यवाही पूर्ति किया तथा राष्ट्रपति को भेजेंगे, ये हमारे विधायी नेताओं से मान्यता है कि फेडेरल सरकार को हमारे राष्ट्रीय वित्तीय तथा आर्थिक सुरक्षा के लिए, निजी बीमा मार्केट के साथ भागीदारी करना है ।

टेररिसम रिस्क इन्शुरेन्स अधिनियम ;टीआरआईएद्ध पर श्री जो प्लूमेरी, अध्यक्ष और सीईओ, विल्लिस ग्रूप होल्डिंग्स लिमिटेड

सुरक्षा करने, सेवा करने के लिए

— ग्राहक सुरक्षा बहुत ही मुख्य स्थान अपनाता है

ज्ञानसुन्दरम कृष्णमूर्ति लिखता है कि सरकार और उद्योग से ग्राहक तक, सभी स्टेकहोल्डर,, ग्राहक हक को पुष्ट करने के लिए कर्तव्य बद्ध है।

ग्राहक का व्याख्या देना आसान है। ये वही है है, जो एक भुगतान किये गये रकम या आश्वासित प्रतिफल के लिए और एक अवाणिज्य कार्य के लिए, सामग्री प्राप्त करता है, सामग्री उपयोग करता है किसी भी सेवा को किराये में लेता है या अपनाता है। जवाब देने में बहुत ही कठिन प्रश्न यही है कि, ग्राहकों को क्यों परंपरागत तौर से सरल, कायर, निर्दोष और चयनित अनभिज्ञता के लिए मार्क किया जाता है? इन फीचरों की प्रबलता ही उनके शोषण की ओर ले चला है, जो शक्तिशाली व्यापारियों के हाथों में अहासयक मूर्ख बना देते हैं ।

यह, यू एस और यू के जैसे विकसित देशों में ग्राहक सुरक्षा आंदोलन के निर्माण के लिए रास्ता प्रदान किया है। इस आंदोलन बाद में भारत को सम्मिलित करके अन्य देशों में फैला । अंत में, समय समय पर उचित कानून द्वारा ग्राहकों को सुरक्षा करने का कर्तव्य देशों पर आ गया है । .

अनुचित व्यापार प्रक्रिओं से तथा सेवा में कमी से ग्राहकों को रक्षा करने के संबंध में ग्राहक क्रियाकलापों के परिणामस्वरूप भारत में, ग्राहक सुरक्षा अधिनियम 1986 पारित किया गया । यू एस और यू के जैसे, इसके पहले विभिन्न कार्यकलापां के क्षेत्रों में बहुत सारा कानून पारित किया गया । पर भी, इस अधिनियम को देश के समाजीय आर्थिक कानून के इतिहास में एक स्तम्श्र माना गया तथा ग्राहकों की सुरक्षा के लिए पारित कानूनों में से व्यापक तथा प्रगतिशील कानून माना गया ।

बहुत ही मुख्य अधिनियम

यही प्रथम अधिनियम है है जो ग्राहक को अपने में एक विभिन्न वर्ग माना और केन्द्र, राज्य तथा जिला स्तर में ग्राहक सुरक्षा परिषद की स्थापना के लिए रासता प्रदान किया । इसका उद्देश्य था, सुरक्षा का अधिकार, विवरण पाने का अधिकार, चुनने का अधिकार, सुने जाने का अधिकार, निवारण पाने का अधिकार तथा ग्राक शिक्षा अधिकार जैसे ग्राहकों के अधिकारों का सुरक्षा करना तथा बढाना । जिलाओं, राज्यों तथा राष्ट्रीय स्तरों में ग्राहक समस्याओं को न्यायनिर्णयन करने के लिए ग्राहक डिस्प्यूट रेड्रसल एजेन्सी को भी स्थापित किया जिससे कि आसान, द्रुतगति तथा कम लागत तथा शिकायतों के लिए क्षतिपूर्ति निवारण सुनिश्चित हो सकें ।

एससीडीआरसी हरियाणा के शब्दों में, '' विशिष्ट रूप से ग्राहकों को अतिरिक्त अधिकार

देश के सामाजिक आर्थिक वैधीकरण के इतिहास में गाहक सुरक्षा अधिनियम को एक मुख्य स्तंभ माना जाता है।

प्रदान करने के लिए तथा कानून में अब उपलब्ध अधिकारों को सुरक्षा करने के लिए यह अधिनियम एक हितकारी संविधि है'' तथा एक ''असाधरण अधिकार क्षेत्र'' है ।

अधिनियम द्वारा विस्तारित ग्राहक सुरक्षा, और भी द्रुतगति से सेक्टोरल आशाओं को सुरक्षा करने के लिए, उसमें व्याख्याक त सामग्री तथा सेवाओं को अपनाता है, रिजर्व बैंक ऑफ इंडिया ने 1995 में बैंकिंग ऑमबुडस्मेन योजना को प्रस्तावित किया जिसको 2002 में संशोधन किया गया । इस योजना ने वाणिज्य बैंकों, क्षेत्रीय ग्रामीय बैंकों तथा अनुसूचित प्राइमरी को:आपरेटिव बैंकों को ओमबडस्मेन योजना के अधिकारक्षेत्र में लाया जिसका उद्देश्य था बैंकिंग सेवाओं से संबंधित शिकायतों का समाधान करना तथा बैंक और उसके संघटकां के बीच तथा एक बैंक और दूसरे बैंक के बीच शिकायतों का समाधान प्रदान करना ।

नवंबर 11, 1998 को केन्द्र द्वारा अधिसूचित रिड्रसल ग्रीवियन्स नियम, 1998 द्वारा इस योजना को पालन किया गया। इससे बीमा अधिनियम 1938 के धारा 114, उप धारा 1 के अधीन बीमा ओमबड्समेन की नियुक्ति किया गया। पर भी, ओमबड्समेन के सामने शिकायती वि ाय को, दावा के कुल या आंशिक निराकरण, दावाओं की निपटान में विलंब, ऐसे दावाओं से संबंधित शिकायतों का कानूनी निर्माण, पॉलिसी के संबंध में देय प्रीमियन या जो प्रीमियन जमा किया गया है तथा प्रीमीयम प्राप्त करने के बाद भी किसी बीमा डाकुमेंट को जारी न करने तक सीमित किया गया । पर अधिनिर्णय कंपनी पर बंधनकारी है और बैंकिंग ओमबड्समेन योजना के जैसे, नियमों के अधीन काई पुनर्विलोकन का प्रावधान नहीं है।

ग्राहक शिकायत से संबंधित कानूनी फ्रेमवर्क पूँजी मार्केट तथा म्यूचुअल निधियों में थोडा सा भिन्न है। उद्योग के अधीन गाहक सुरक्षा के लिए इस सेक्टार में कोई असाधारण अधिकार क्षेत्रीय प्राधकारी नहीं है । निवेशकों के लिए रेगुलेटर एसईबीआई, कंपनी लॉ बोर्ड, आब्रिट्रटर, ग्राहक शिकात निवारण एजेन्सी या न्यायपालिका ही उपलब्ध मार्ग है। वास्तव में, बहुत समय पहले, एसईबीआई ने इस सेक्टॉर के लिए ओमबड्समेन संस्थान की स्थापना का अधिसूचना दी पर इस अधिसूचना का कार्यानवयन, रोका गया, जिसका कारण रेगुलेटर ही उचित रूप से जानता है।

इनहाउस मशीनरी

ग्राहक शिकायतों तथा समस्याओं का हल निकालने के लिए, बैंकिंग, बीमा तथा पूँजी मार्कैटों में कानूनी संरचना की उपलब्धि के अतिरिक्त, इस सेक्टॉर में इनहाउस रेड्रसल मेकनिसम भी उपलब्ध है। उच्च स्तरीय अधिकारी ग्राहक शिकायतों को देखता हैं । एलआईसी में, न्यायपालिका के पूर्व सदस्य को दावा पुनर्विलोकन समिति में दाखिल किया गया है, जिससे कि प्रचालनों के लिए विश्वसनीयता तथा पारदशिकता मिलता है। आईआरडीए नियंत्रणों के अनुसार, सभी बीमाकर्ताओं को शिकायत निवारण मशीनरी निर्माण करना है ।

पर भी, शिकायत निवारण, ग्राहक सुरक्षा का अंतिम लक्ष्य नहीं है, जो एक व्यापक घटना है जो वाणिज्य मार्केट में उपलब्ध है जिसमें शिकायत निवारण मशीनरी का स्थान अंतिम है ।

उद्देश्यों को निर्माण करना, सेवाओं के साथ व्यवहार करने के लिए उद्देश्य और मूल्य, तथा विपणन के चार पी : प्राडक्ट, पीसिंग, प्रमोशन तथा प्लेसमेंट तक एक व्यापारी संघटन को अपने प्रत्येक कार्यकलाप में ग्राहक सुरक्षा पर ध्यान देना आवश्यक है । इसके अतिरिक्त, नये ग्राहकों की तलाश में रहने वक्त, पहले ही उपलब्ध ग्राहकों को सुरक्षा प्रदान करन पर भी ध्यान देना है।

ग्राहकों की सुरक्षा के लिए युनाइटेड नेशन मार्गदर्शिका ;जी.बी. रेड्डी द्वारा लॉ ऑफ कन्स्यूमर प्रोटेक्शन **(The United Nations Guidelines* (Law of Consumer Protection by Dr. G. B. Reddy)** में, उद देश्य के रूप में, ग्राहकों की सुरक्षा उपलब्धि ा तथा रखरखाव, ग्राहकों की आवश्यकता तथा अपेक्षा के अनुसार वितरण पैटर्न तथा उत्पादन सुविधाएँ उपलब्ध करना, व्यापार में लगे व्यक्तियों के लिए उच्च स्तर के नैतिक व्यवहार को प्रोत्साहित करना, गाली व्यापार पद्धतियों को कम करना, स्वतंत्र ग्राहक ग्रूपों को विकसित करना तथा ग्राहकों के सामने कम लागत में अधिक विकल्प प्रदान करना, रखा है।

भारत में ग्राहक सुरक्षा परिषद का अजेन्डा यू एन मागदर्शिका में धोि ात सामान्य तत्वों से ही फैलता है। इस दृष्टिकोण से देखने पर, जब ग्राहक सुरक्षा अधिनियम के अधीन कानूनी फ्रेमवर्क इन उद देश्यों को चुने तौर पर अड्रस करता है इस संबंध में वाणिज्य माकेट पर ही बहुत सारे निर्भर है। उत्पादन तथा वितरण पैटर्नों को ग्राहकों की आवश्यकताओं और आशाओं के प्रति उत्तरदायी बनाते हुए, नैतिक व्यवहार को प्रोत्साहित करना, ग्राहक शिक्षा आयोजित करना, अधिक विकल्पों को कम लागत में उपलब्ध कराना आदि ऐसे क्षेत्र है जिसमें उद्योग को ध्यान देना है। इसके अलावा, किसी भी व्यापारी संगठन के लिए प्राथमिक चिन्ता है ग्राहकों को उनके निधि के लापरवाह उपयोग से बचाना तथा सामान्य विश्वास स्थापित करना । यही वह जगह है जहाँ नियंत्रक, उद्योग और ग्राहक ग्रूप मुख्य कदम अपनाता है ।

उचित नियंत्रण, अधीक्षण तथा मागदर्शन घोषणाओं के अधिदेशित कृत्या द्वारा इन उद्देश्यों को नियंत्रक पाने का प्रयत्न करता है। पॉलिसीहोल्डर इन्टरेस्ट रेगुलेशन का आइआरडीए द्वारा सुरक्षा, एनबीएफसी द्वारा जमाओं की प्राप्ति पर प्रतिबंधन और बिना प्रार्थना किये क्रेडिट करने के सबंध में मार्गदर्शिका और म्यूचुअल फण्ड के लिए एसईबीआई के विज्ञापन कोड, गाहक सुरक्षा के लिए नियंत्रीय अतःक्षेप का कुछ उदाहरण है।

पब्लिक तथा प्राइवेट दोनों सेक्टॉरों में उद्योग को बोर्ड प्रबंधित कंपनियों द्वारा प्रबंधन किया जाता है। पॉलिसी निर्णय, जिसमें सामग्री डिजाइन अनुमोदन भी सम्मिलित है, यह बोर्ड

ग्राहक सुरक्षा के लिए अतिम लक्ष्य शिकायत का निवारण मात्र नहीं है, जो व्यापक घटना है, जिसमें शिकायत निवारण मशीनरी अपना स्थान अंत में लेता है ।

स्तर पर लिया जाता है। नियंत्रणीय नियमों को अनुपालन करने के साथ साथ, बोर्ड, निष्पादन को पूर्ण रूप से विश्लेि ात करके कंपनी का मार्ग का निर्णय लेता है और इसलिए ग्राहकों को सुरक्षा प्रदान करने की दायित्व से विस्म त नही हो सकते है। आज के बजवर्ड, कार्पोरेट गवर्नन्स, पूरे से पूरे, कंपनी द्वारा व्यापार में नैतिक व्यवहार के बारे में है ।

इसके साथ जुडे है स्व नियंत्रित संगठनों का दायित्व, जिनका ग्राहक सुरक्षा की ओर कर्तव्य भी है। उनका सरकार तथा नियंत्रकों के साथ रिश्ता, ग्राहक सुरक्षा पर ध्यान देते हुए विपणन से संबंधित वि यों में उद्योग का अंतर्निहितता को बढाता है । उदाहरण के लिए, आर आर डी ए के अधीन म्यूचुअल फन्ड तथा बीमा परिषदों के लिए असोसियेशन (बीमा अधिनियम के अधीन निर्माण किये जाने पर भी) ग्राहक सुरक्षा को प्रोत्साहित करने में स्व नियंत्रित संगठन का कार्य नि पादन करता है।

दोनों सांविधिक तथा असांविधिक दोनों ग्राहक ग्रूप, अपनी ओर से ग्राहक कल्याण के लिए बहुत अंशदान देते हैं। सांविधिक परिषदों, जिन्हें ग्राहक सुरक्षा अधिनियम के अधीन निर्माण किया गया, संबंधित सरकारों के पॉलिसियों को अपने वर्किंग ग्रूप द्वारा प्रभाव डालते हैं। 1997 में सरकारी विभागों तथा पब्लिक सेक्टॉर अन्डरटेकिंग द्वारा सिटिजन चार्टस को अपनाये जाना, जिसे भारत के ग्राहक सुरक्षा की इतिहास का मुख्य घटना माना जाता है, इन परिषदों के कार्य का परिणाम है ।

असांविधिक गाहक संगठन सामान्यतः व्यक्तिगत शिकायतों पर ध्यान देते है और उद्योग के साथ आदान–प्रदान करते हुए उसका हल निकालने का प्रयत्न करता है। पर भी, उसमें से कुछ, जैसे अहमदाबाद के मनुभाई शा के सीईआरसी, ग्राहक द्वारा सामग्री तथा सेवाओं को खरीदने या किराये में लेते वक्त उन्हें प्रकट होनेवाले जोखिमों को सामने लाने का बेहतर सेवा प्रदान कर रहा है।

देश में ग्राहक सुरक्षा को सुनिश्चित करने के लिए इससे संबंधित दल विभिन्न कदम ले सकते हैं। इसमें कुछ निम्न है:

केन्द्रीय सरकार

1. सिटिजन चार्टर को पुनःप्रवर्तन तथा पुनर्विलोकन करना तथा उसे प्राइवेट सेक्टॉर बीमा कंपनियों तक ले जाना
2. उनसे न्यायनिर्णयन के अधीन आनेवाले शिकायतों के विषय वस्तु को विस्तार करके बीमा ओमबडसमेन की संस्थान को सुदृढ करना। यह हाल ही में ध्यान में आया है कि, बीमा परिषद के गवर्निंग बॉडी ने नानलाइफ पॉलिसियों के पुनःनवीकरण को इनकार करने से सबंधि ात शिकायतों को प्राप्त न करने के लिए निदेश दिया है विशिष्ट रूप : मेडिक्लेइम, इस बात के बावजूद भी कि, आरपीजी नियम 1998 के धारा (12) (3) के अधीन, ओमबसमन को ही, शिकायत विचार करने योग्य है या या नहीं, इस निर्णय लेने का अधिकार दिया गया है । ऐसे अंतःक्षेप, ग्राहक सुरक्षा के लिए, ऐसे संस्थान की स्थापना का उद्देश्य को ही नाश कर देता है ।
3. ओमबड्समेन को उचित प्राधिकरण सौंपना जिससे कि निर्देशों तथा अवार्डों का अनुपालन सुनिश्चित किया जाए ।

4. पुनःविलोकन प्राधिकारी, जैसे मुख्य ओमबडस्मेन से अवार्डों के विरुद्ध अपील करने अनुमति देना ।

आईआरडीए

1. फाइल अण्ड यूस प्रणाली को निकालते हुए सामग्री अनुमोदन को सुद ढ तथा स्ट्रीमलाइन करने । प्रतियोगी सिनेरियो में सामग्री विभेदीकरण की स्वतंत्रता एक आवश्यक या अनिवार्य स्थिति *(Sine qua non)* होते हुए भी, कछ मूल नीतियों ा प्लेयरों के बीच सामान्य होना चाहिए, जिसेनियंत्रक द्वारा सुनिश्चित किया जाना है। उदाहरण के लिए एलआईी पॉलिसियों में दुर्घटना लाभ ध ारा को लीजिए जिसमें मूल में कहा गया था कि म त्यु, दुर्घटना से 90 दिनों के अन्दर हो जाना है। ग्राहक गूप तथा कानून निर्माणकर्ताओं के अंतःक्षेप से, उसे 120 दिनों तथा बाद में 180 दिनों तक संशोधन किया गया । पीएसयू नान–लाइफ पॉलिसीयों के विषय में 12 महीने तक अवधि दिया जाता है। पर कुछ निजी सेक्टॉर पॉलिसियॉ अब भी 90 दिनों की अवधि रखा गया है। फिर, पीएसयू मेडिक्लेइमू पॉलिसीयॉ, जिनहें व्यापार पूर्वसर्ग के बजाय, एक हेल्थकेर की सामाजिक आवश्यकता को पुर्ति करनेवाले के रूप में देखा जाता है रोगों के पूर्व उपलब्धता को निर्धारण करने के संबंध में अन्य पीएसयू पॉलिसियों से अवच्छिन्नता प्रदान करता है, जबकि प्राइवेट सेकटॉर पॉलिसियॉ पॉलिसिहोल्डरों के लिए इस लाभ से इनकार कर दता है।
2. कुछ पीएसयू के जैसे, बीमा कंपनीयों के बोर्ड में कम से कम ग्राहक ग्रूप के एक सदस्य रहते हैं इसे सुनिश्चित करना ।
3. नियमित अवधि में मीडिया द्वारा ग्राहक शिक्षा कार्यक्रम आयोजित करने तथा इस कार्य के लिए निधि प्रदान करना । कम प्रभावी फोन इन कार्यक्रमों को पैनल वार्तालाप से प्रतिस्थापना करना, जिससे कि समय का उचितउपयोग हो सके तथा स्पष्ट भी रहें ।
4. पर्याप्त कर्मचारियों के साथ ओमबडस्मेन कार्यालयों को सुद ढ करने तथा दबावपूर्ण केन्द्रों में अतिरिक्त ओमबड्समेन का नियुक्त करना। जहॉ रिक्तता है वहॉ पुनःस्थापन ीघता से करना सुनिश्चित करें ।
5. सुप्रसिद्ध एजेनसियों द्वारा कंपनियों का रेटिंग प्रस्तावित करना
6. ग्राहक सुरक्षा की आवश्यकताओं को मन में रखते हुए मध्यवर्तीयों के लिए प्रशिक्षण तथा लाइसेन्सिंग पैरामीटरों का पुनःविलोकन करना.
7. सामग्री साहित्य में तथा कंपनियों के वार्षिक प्रतिवेदनों में पर्याप्त विवरण का प्रकटन सुनिश्चित करना

ग्राहकों का बूहतर रूप से विवरण प्राप्त तथा मॉग भरे व्यक्ति बन जाने के कारण, जब वे सुरक्षा की मॉग करते हैं तब उन्हें अपनी ओर से एबोव बोर्ड रहना अनिवार्य है ।

कंपनियॉ

1. बोर्ड स्तर ग्राहक कार्यकलाप समिति का निर्माण करना, ग्राहक कार्यकारों को सम्मिलित करना, ग्राहक सुरक्षा से संदर्भित करते हुए कृत्यों को निर्धारित अवधि में पुनःविलोकन करना । इस संबंध में एलआईसी का उदाहरण उल्लेखनीय है ।
2. ग्राहक सुरक्षा प्रकरणों में सांविधिक, क्वासि न्यायिक तथा न्यायिक प्राधिकरणों द्वारा जारी किये गये निर्णयों के संदर्भ में सामग्री विकास तथा पुनःडिजाइन करना अपनाना । पहले ही उपलब्ध ग्राहकों को बाधा पहुँचाते वक्त, भवि यलक्षी प्रभाव रूप से ही सामग्री के निबंधन तथा शार्तों का संशोधन करना।
4. कार्पोरेट गवर्नेन्स पर मुख्यतः ध्यान देना

स्व–नियंत्रण संगइन

1. नान टैरिफ सामग्री मूल्य पर एक निगरानी रखने तथा इस कार्य के लिए विश्वसनीय डाटाबेस को निर्माण करना । इस दिशा में लाइफ इन्शुरेन्स परि ाद द्वारा एमएमआईबी का निर्माण करना एक स्वागत योग्य कदम है।
2. ग्राहक सुरक्षा निधि निर्माण करना और उसे कंपनियों के तथा ग्राहक ग्रूपों के ग्राहक सुरक्षा कार्यकलापों को समर्थन देने तथा वित्त प्रदान करने के लिए उपयोग करना ।

ग्राहक

ग्राहक, मूर्ख रहने का अपने व्यक्तित्व को छोड रहे है तथा उचित रूप से विवरण प्राप्त, मॉग भरे तथा बुद्धिमान व्यक्ति बन रहे है, जिससे ग्राहक शक्ति समीकरणों में बदलाव अपना रहे है, जब वे सुरक्षा मॉग कर रहे हैं तो अपनी ओर से ओवरबोर्ड होना बाध्यकर है ।

एससीडीआरसी हरियाणा के शब्दों में " विधि का व्यवहारशास्त्र का पवित्र नियम बहुत दीर्घावधि से ऐसा रह चुका है कि जो न्यायसंगत असाधारण अधिकारिता के लिए मॉग करता है (कानून में साधारण तथा औपचारिक को छोडकर) उन्हें उसे अत्यंत ईमानदारी से तथा तथ्यों को न छिपाकर व प्रत्यक्ष रूप से दबाये या भ्रामक बयान के बिना करना है । आदेश में सिद्धांत का निष्कर्ष दिया गया है कि आवेदक को ऐसे अधिकार क्षेत्र के जगहों में साफ हाथों के साथ आना चाहिए । "

लेखक है सेवानिवृत्त अध्यक्ष, लाइफ इन्शूरेन्स कार्पोरेशन ऑफ इंडिया तथा महाराष्ट्र और गोवा में बीमा ओमबडसमेन का सेवा किया है ।

दावा और निपटान के बीच में बेलविक्स करे।

— नान लाइफ इन्षुरेन्स में ग्राहक सुरक्षा

अपने ठेकेदारी दायित्व के भाग के रूप में बीमाकर्ता अपने ग्राहक के लिए बहुत सारे कर सकते है, लिखते है *जी वी रॉव,* इसके अतिरिक्त यह भी लिखते हैं कि ये उनका कर्तव्य ही नहीं बल्कि प्रतियोगी मार्केट में बडे भिन्नकर्ता है।

अन्य किसी व्यवसाय, व्यापार और पेषाओं के तुलना में बीमा व्यापार का व्यक्तित्व अलग है। बीमा भविश्य का कवर है, यह ठेके के अधीन कवर किये गये अनावास घटना के घटने पर फुटकर है। अगर ठेके भार्तों का अनुपालन किया जाता है तो यह भविश्य में क्षतिपूर्ति करने के लिए लिखित अ्र वासन है।

बिक्री के समय लिखित आ वासन का कागज मात्र ही आदान प्रदान किया जाता है। बीमाकर्ता ग्राहकों को ठेके के शब्दो, विश्वास तथा निष्ठा के अनुसार विश्वसनीय पार्टी मानते है । जब पूछा ताहा है, तब इस आश्वासन को रिडीमू करने की शक्ति,, बीमाकर्ता के पास ही हैं। इन्शूर किये गये व्यक्ति इस विषय में शक्तिहीन है और अपने प्राप्य को प्राप्त करने के लिए पूर्णतः बीमाकर्ता पर निर्भर है ।

समस्या का हल

ज्यादातर समस्याएँ अक्सर प्रदान किये जानेवाले आश्वासनों के विषय से उत्पन्न होता है और यह ग्राहकों को कठिनाईयों में डाल देता है। समस्याओं का हल कानूनी तौर पर निकालना बहुत ही महंगा है तथा समय अपनाता है। जबकि बीमाकर्ता के पास, अंत तक अपने विचार पर दढ रहने के लिए कार्पोरेट वित्तीय शक्ति है, ग्राहक, मुख्यतः रीटेइल व्यक्ति के पास ऐसे करने के लिए कम वित्तीय संसाधन उपलब्ध है ।

जैसे कि बीमा, समाज को लाभ प्रदान करने के लिए एक आर्थिक सुरक्षा नेट है, अधिकारियों ने इसमें अंतक्षेप करके, वयक्तिगत निर्णायकों से संदर्भित करके, सुनिश्चित किया है कि समस्याओं का एकमद निपटान दृतगति से हो जाए। सरकार ने, कापोरेट शक्ति की दुरुपयोग से ग्राहकों को सुरक्षा चाहिए ऐसे समझकर, वैकल्पिक निवारण मैकनिसम प्रस्तावित किया है ।

इसमें कौन सी मेकनिसम उपलब्ध है और यह कितनी प्रभावी कार्य कर रही है?

अपने स्वेच्छा से, ग्राहक शिकायतों का हल निकालने के लिए, बीमाकर्ता, स्वयं आंतरिक सेल का सेट अप करते है।

सरकार में आम जनता के शिकायतों के लिए निदेशालय उपलब्ध है, जो ग्राहक शिकायतों पर कार्रवाई लेता है।

1. ग्राहक सेवााओं में विलंब के बारे में कार्रवाई लेने के लिए फॉरमों को ग्राहक सुरक्षा अधिनियम 1986 के अधीन स्थापित किया गया है । इनमें प्रदायकों पर बंधकारी सार निर्णय जारी करने का अधिकार रहता है।
2. रु 20 लाख तक रकम के लिए व्यक्तिगत दावाओं को परीक्षण करने, बीमाकर्ता और बीमाकृत के बीच मध्यस्तता तथा सुलह करने के लिए सरकार ने एक ओमबडस्मेन का चेइन सेटअप किया है।
3. निर्धारित तरीके से बीमाकर्ता द्वारा, ग्राहकों की शिकायतों पर ध्यान देने के लिए, आइआरडीए ने बंधनकारी नियंत्रण जारी किया है। वास्तव में, आईआरडीए का मुख्य कार्यकलाप, बीमाकर्ताओं से कार्रवाई करने में ग्राहकों की मॉग का सुरक्षा करना है।
4. जहाँ देयताओं को मान लिया गया तथा देय रकम की मात्रा के बारे में समरूा है, पॉलिसी सामान्यतः माध्यस्थम के लिए प्रदान करता है।
5. अगर देयता ही समस्यायुक्त है तो, बीमाकृत को सिविल न्यायालय में जाने का विकल्प उपलब्ध है।
6. मोटॉर टीपी दावाओं के बारे में कार्रवाई लेने के लिए अलग एमएसीटी ट्रिब्यूनल उपलबध है।
7. मोटार टीपी समस्याओं को निपटाने के लिए और मेकनिसम के रूप में लोक अदालत काम करता है।

जब बीमाकर्ता के पास अपने स्टान्ड में निश्चित रहने के लिए वित्तीय यशक्ति है, पर ग्राहक, मुख्यतः रीटेइल व्यक्ति के पास, ऐसे करने के लिए सीमित संसाधन ही रहता है।

समस्याओं का हल निकालने के लिए इतने बडी संख्या के मेकनिसम होते हुए, ग्राहक अक्सर शिकायत करते हैं कि बीमाकर्ता अक्सर सही दावा को इन्कार करने या विलंब करने के लिए सुराख के लिए देखते हैं । निर्णय पाने में लगनेवाली अवधि पर ध्यान देते हुए तथा बीमाकृत के पक्ष में जारी न्यायिक अवार्डों के विरुद्ध उच्च फारमो में जाने के संबंध में बीमाकर्ताओं के ज्ञात हठीलापन के कारण से ग्राहक सामान्यतः सिविल न्यायालय में जाने हिचकते हैं।

एडीआर संसाधन कितने अच्छे है ?

- प्रचालन कार्यालयों में निर्मित शिकायत निवारण सेल ग्राहकों के बीच विश्वास को निर्माण करने में विफल हुए है, प्रचालन कार्यालय वही है जिसके विरुद्ध शिकायते किया जा रहा है। उनसे या उनसे नियंत्रित विंगों से कुछ विचार शक्ति देखेने या किसी भी समस्या में अपने स्थिति बदलने की आशा करना बहुत ही उच्च आशा है । प्रचालन कार्यालयों के स्तर में बीमा में भ्रातृत्व और एक तथ्य है।
- आम जनता शिकायत निदेशालय एक अनियंत्रित शासन है और यह अनियंत्रित ाासन कैसा कार्य करता है इसे जाननेवाले को छोडकर अन्यों के लिए, किसी समयावधि ा में कोई अर्थपूण मूल्य नहीं दिया है । यह रीटेइल ग्राहक के लिए उपयोगी नहीं है ।
- ग्राहक फारम निणय लेने में विलंब से संबंधित समस्याओं पर कार्रवाई लेता है और सामान्य तौर पर देयता संबंधित समस्याओं से कार्रवाई नहीं लेता हैं । पर ये रीटेइल ग्राहकों के लिए अच्छा सेवा प्रदान किया है। पर भी, कार्पोरेट ग्राहक को भी ग्राहक फॉरम में जाने अनुमति दिये जाने के कारण, न्याय पाने में विलंब होता

है। रीटेइल ग्राहकों को बहुत बाधा पहुँचता है। और भी, बीमाकर्ता, अंतनिर्हित नीतियों से असंबद्ध होते हुए वे रा ट्रीय फॉरम के ऊपरी स्तर पर जाते हैं । यह प्रक्रिया के लिए सेटबैक के रूप में कार्य करता है ।

- ओमबड्समेन, बीमाकर्ता के मध्यवर्ती के द्वारा सेट अप किये जाने पर भी, वे जितने प्रभावी हो सकते है उस हद तक उद्योग से समर्थन नहीं पा रहा है । उनमें मध यस्थ करने के लिए अधिकार नहीं है औरस उनके निर्णय पर भी आपत्ति प्रकट कर सकते है। वे समस्यागत क्षों के बीच मध यगता और सुलह कर सकते है। ये दलों के बीच भिन्न को ब्रिजकरने में उन्हें कम प्रभावी बना देता है ।
- आईआरडीए ने, निर्णय पर ही न होते हुए भी, ग्राहकों के लिए तुरंत दावा निपटान प्रक्रिया के लिए आ ा देनेवाले दृढ व बंधनकारी नियंत्रण को जारी किया । पर बीमाकर्ता के पास, समयावधि के अनुपालन को अनुवीक्षण करने के लिए कोई आंतरिक प्रणालियॉ नहीं है । बीमाकर्ता को आइआरडीए शिकायतें जो उन्हें संदर्भित किया जाता उस पर अधिक गंभीरता दिखाने की आव यकता है।
- मध्यस्थता मेकनिसम भी समय लेता है, क्योंकि दल अपने अडवकेट को नियुक्त करते है और न्यायालय प्रक्रियाओं का अनुपालन करना है। जेसे कि इस प्रणाली में अडवकेटों को नियुक्त किया जाता है, मध्यस्थ व्यक्तियों को हफते के अंत में बैठने के लिए कहा जाता है ताकि उनके न्यायालय कार्यालय में कोई बाधा पडें । लगातर सिटिग्स कठिन हो जाता है, जिससे कि बिलंब होने लगता है।.
- ग्राहकों को सिविल न्यायालय में भगाने के लिए, अनाव यक कारणों पर दावाओं को इन्कार करने में लगे बीमाकर्ता आज का विकसित ट्रेंड हो रहा है। अक्सर कोई कारण नहीं दिया जाता । दावा धारणीय नहीं है यह बयान ही दावाओं को इनकार करने के लिए पर्याप्त है।.

ग्राहक फॉरमों के अलावा, और कुछ हद तक ओमबड्समेन के अलावा, एडीआर मेकनिसम, ग्राहको की आ ााओं को सुरक्षा करने में बहुत ही अपर्याप्त निरूपित हुआ है ।

बैकों में ओमबड्समेन का भाग

ओमबड्समेन योजना में 2002 को संशोध ान किया गया और अब विशिष्ट समस्याओं में एक मात्र मध्यस्थ के रूप में काम करने का अधिकार प्रदान किया गया है। ऐसे प्रकरणों में, बाधित दल द्वारा ओमबड्समेन को एकमात्र मध्यस्थ के रूप में पूछकर नोटराइज किये गये शपथपत्र प्रस्तुत करना है। शिकायत में, गवाहों के अलावा दस्तावेज जो प्रस्तुत किया गया है उसे परीक्षण करके समस्याओं पर ध्यान देना है । ओमबड्समेन से उसके निपटान के लिए समस्यायुक्त दलों को अन्य फॉरम से पेश करने के लिए सुझाव दिया जा सकता है। वे आब्रिट्रेशन तथा कनसिलियेशन अधिनियम 1996 के प्रावधानों को अप्लाई करेगे ।

ओमबड्समन , यह बहुत प्रभावी हो सकता है इस दशष्टिकोण से, उद्योग के समर्थन से संतोष होने के जैसे नहीं दीखते हैं ।

सुलह तथा मध्यगता के अधीन अवार्डों के प्रवर्तन के लिए साफ पॉलिसी भी है। तथ्यों की गीलत प्रस्तुति से या बैंकिंग प्रणालियों के लिए एक गलत पूर्व उदाहरण प्रस्तुत होने से अगर एक बैंक को बाधा पहुँचता है तो बैंक, अपने मुख्य कार्यपालक से आरबीआई, जो पुनःविलोकन प्राधिकारी है, के सामने एक पुनःविलोकन अर्जी पे ा कर सकता है। अगर यह प्रकरण पुनःविलोकन के लिए योग्य पाता है तो पुनःविलोकन प्राधिकारी, विरोधी पक्ष और ओबड्स्मेन को अपनी टिप्पणी भेजने के लिए कहेगा। उसके बाद पुनःविलोकन प्राधिकारी, ओमबड्समेन को अपने स्वयं के अंतिम दृष्टिकोण से निदे ा दे सकता है।

ऐसे लगेगा कि उपयुक्त साम्ययुक्त तथा उचित प्रक्रियाओं को दोनों आंतरिक ि ाकायत प्रणालियों तथा बीमा उद्योग में ओमबड्समेन द्वारा अब प्रदान किये जा रहे अवार्डो में कार्यान्वयन किया जा सकता है। जैसे कि बैंकिंग सेक्टॉर में किया गया ह वैसै बीमा में ओमबड्समेन योजना को उसके प्रारंभ से सं ोध ान नहीं किया गया है।

आईआरडीए से शिकायत करने के पहले ग्राहकों द्वारा पहले ओमबड्समेन से या बीमाकर्ताओं के शिकायत निवारण सेल से संदर्भित करना अनिवार्य करने से, बीमाकर्ताओं से किये जा रहे विलंब के तुलन पर बीमाकर्ता के कार्यों पर ध्यान देने में सहायता करेगा। आईआरडीए को ग्राहकों के बीच असंतुश्टता के दो सेट के बीच विभेद करना है।

बीमाकर्ताओं को क्या परे ाानी है?

बीमा उद्योग के लिए सच्चाई का घडी है दावा हैंडलिंग । एकाधिपत्य भाक्ति और पिछले तीन द ाकों से विकसित संस्कृति ने कर्मचारियों के बीच, अगर वे साधारण दायित्व निभा रहे तो भी, पक्षपात निपटान की प्रवृत्ति को बढा दिया है। न तो उदारता की भाक्ति या नियत्रणीय दबाव उनके कार्य करने की तरीका को या ग्राहकों की ओर नैतिकता को बदला है ।

ग्राहकों से फीडबैक तथा समस्या का समाध ाान देनेवाले अस्तित्व को बीमाकर्ताओं द्वारा दुर्लभ से पडा जाता है, वि लेशित किया जाता है या अपनाया जाता है । विभिन्न न्यायिक उत्प्रेरणाओं के बाद भी अपने पूर्व मानकों पर स्थिर रहना अक्षुण्ण रूप से जारी है जिससे कि अब तक अन्डरव्राइटिंग या दावा हैंडलिंग प्रक्रियाओं में कोई विकास नहीं है ।

पूर्व गलतियों से सीखने से इनकार करना, स्वतंत्र रूप से दिखाने पर भी, गलत छवि के लिए जिम्मेदार है। बीमाकर्ता को यह जानना है कि वे क्यों ऐसा करना जारी रखे हैं ? यह समय है कि वे अपने अभिप्रेरणा को आम जनता से वास्तविकता दिखाये ।

इस उद्योग में अब भी 15 लाख दावा बिना निपटान किये पडे है, जो 2004:2005 के अंत में रु.18,000 करोड तक लॉक अप किया है। लगभग 80 प्रति ात, अधिसूचना से 6 महीने को पार करके बकाया है। उद्योग ने दावा की ओर औसतम रु.10000 करोड भुगतान किया है। उसका सकल प्रीमियम वसूली रु.18000 करोड है।

ग्राहक अपेक्षाओं के साथ व्यवहार करना

ग्राहक बीमाकर्ता के तुरंत कार्रवाई, अपने दावा का सही मूल्यांकन की अपेक्षा करते है तथा उनके दावा को क्यों एक विशिष्ट रकम से निपटाया जाता है या उनके दावाओं को क्यों कारण जो उनकी ओर से सही लगता है

के बावजूद भी निरस्त किया जाता है ये जानने अपेक्षा रखते है। दावा हैंडलिंग प्रक्रियाओं को ग्राहक की आव यकताओं के अनुसार उनके परिप्रेक्ष्य में सरेखण करना है।

ग्राहको को उनकी अपेक्षा को व्यवस्था करने के जैसे पर्याप्त तथा उचित विवरण प्रदान करना है – प्रक्रिया का स्पश्टीकरण, दावा पर व्यवहार करनेवाले व्यक्ति, प्रक्रिया में लगनेवाले समय तथा निपटान रकम के लिए कारण तथा उसके निरस्त करने का कारण ग्राहक को प्रदान करना । अेपक्षाओं की व्यवस्था करने के लिए सुस्पश्ट संप्रेशण एक माध्यम है तथा बीमाकर्ताओं ने अपनी संपर्क क्षमता तथा प्रक्रियाओं को विकसित करने के लिए बहुत कम प्रयत्न किये है।

बीमाकर्ताओं के बीच बहुत ही बडी भेदक, सच्चे तथा दृतगति के दावा निपटान में है और दाम या कवरेज पर नहीं। बीमाकर्ता इस विशय में सच्चाई पर ध्यान देने से इनकार कर रहे हैं ।

विभिन्न एडीआर मेकनिकसमों के द्वारा उनके विरुद्ध प्रचार किये जानेवाले ग्राहक उदासीनता को पार करने के लिए बीमाकर्ताओं को बहुत कार्य करना है। निम्न में से कुछ सुझावों पर विचार किया जा सकता है:

- ग्राहकों को अधिक शिकायत करने प्रोत्साहित करें, वे ही उस व्यक्ति है जो आपमें कया गलती है उसे बता सकते है ।.
- हैंडलिंग प्रक्रियाओं को ऐसे पुनःव्यवस्था करें जिससे कि ग्राहक जो मुख्यता चाहता है उससे अनुक्रिया ील हो सकें ।
- आपके शिकायत निवारण सेल तथा प्रक्रियाओं को विकास करने के लिए नियमित रूप से लेखाकृत करें ।
- ग्राहकों को आपपर वि वास उत्पन्न करने के लिए वि वसनीयता तथा फैसला में स्वतंत्रता को लाने के लिए सेलों को पुनःआयोजन करें ।
- आपके दावा हैंडलिंग विभाग में ऐसे कार्य प्रकृति को ले आयें कि वह ग्राहक के लिए कार्य करता है तथा उनके परिप्रेक्ष्य में काम करता है।
- निर्णयों में सच्चाई, तत्काल तथा एकरूपता को सुनिि चत करें ।
- उच्च न्यायिक फारमों में प्रकरणों को अंतर्निहित लागतों का आकलन करें । यह नीतिपरक रहना है न कि ग्राहकों को दंड देनेवाला ।
- न्यायालय के विभिन्न फॉरमों में आपके विरुद्ध किये गये निर्णयों के त्रटियों से सीखें । लगातार त्रुटियॉ करने में लगना बहुत ही महँगा है।
- एमआईएस के भाग के रूप में ग्राहक वाद विवादित दावाओं का पुनःविलोकन करें ।
- शिकायत प्रणालियॉ कैसे काम करते है इसका अनुवीक्षण करें और सेल सेटअप का निश्पादन को मूल्यांकन करें ।

उनके निर्णय लेने की क्षमता पर प्रश्न नहीं किया जाता है पर निम्न स्तरों के असावधान और कठोर अभिवश्ति ही ग्राहकों को दुख देता है ।

एफएसए का मॉस्टर प्लान

यू के के वित्तीय सेवा प्राधिकारी (एफडीएसएद्ध) ने हाल ही में यूंके बीकर्ता के दावा हैंडल्गि प्रक्रियाओं पर तथा रीटेइल ग्राहकों की ओर व्यवहार के बारे में चिन्ता व्यक्त किया है। उसने भविश्य निरीक्षण को सुदृढ करने के लिए बीमाकर्ता द्वारा रीटेइल ग्राहकों के दावा हैंडलिंग में अन्तर्दृश्टि प्रदान करने तथा समझने के लिए एक ि क्षण आयोजन करने का निर्णय लिया ।

वह प्रथमतः बीमाकर्ता को एक प्र नावली भेजने प्रस्तावित किया है ताकि आंतरिक सेवा मानकों के बारे में जान सकें, जिसके बाद प्रणालियों तथा आंतरिक नियंत्रणों के अनुपालन सुनिि चत करने के लिए तथा विवरण पाने के लिए उनके कार्यालयों में दौरा प्रस्तावित किया है। उन्हें इसके लिए गवाह चाहिए कि बीमाकर्ता अपने दावा हैंडलिंग सेवाओं को वि लेशण करने तथा विकसित करने के लिए एम आई एस का उपयोग कर रहे है तथा वरिश्ठ प्रबंधन को इससे अक्सेस है तथा विवरण पर कार्यवाई कर रहे है। एफएसए ने धोखा को उस क्षेत्र के रूप में चिन्ता प्रकट किया है, जिसपर बीमाकर्ता को ध्यान देना है । निरीक्षण में धाखा के विरोध रणनीति को कवर करेगा तथा जॉच करेगा कि यह ग्राहक दृश्टित आंतरिक दावा हैंडलिंग मानक से संतुलित है । ऐसे मानकों को कर्मचारी पालन कर रहे है इसे सुनिि चत करने के जैसे नियमित रूप से पुनःविलोकन किया जाना है।

विथिन्न एडीआर संसाधनों के फैसलाओं से पर्याप्त गवाह है कि बीमाकर्ता अपने ठेके दायित्वों को पूर्ति करने के अंग के रूप में ग्राहकों को सुरक्षा करने के लिए ज्यादा कर सकते है । ग्राहक अपेक्षाओं को व्यवस्था करना निि चत रूप से उनका व्यापार है। विपणन क्षेत्र में यह एक बडे डिफेरेनि ियेटर का अवसर है।

जब समस्याएँ उठते हैं, अपने स्टान्ड को पुनःपरीक्षण करने के बारे में केन्द्रीकृत अतनिर्हितता, बीमाकर्ता में रहना आवश्यक है जिससे कि एडीआर संसाधनों को अपने निर्णयों तथा निर्णय लेने में उचितता से मनवा सकते। हारनेवाले प्रकरण अत्याचार का भाव उत्पन्न कर सकता है तथा लगातार हानि उनके प्रणालियों और प्रव त्तियो तथा प्रतिक्रियॉ का पुनःविलोकन करने देना है।

उनके निर्णय लेने की क्षमता पर ज्यादा प्रश्न नहीं उठता पर ग्राहक शिकायत से व्यवहार करने में निम्न स्तरों के कठोर तथा असावधान अभिवृत्ति ही ग्राहकों को बाधा पहुँचाता है। गलतियों को स्वीकृत करने को अहम् या प्रतिष्ठा की समर्पण के रूप में नहीं देखना है।

पर जब वसूली की व्यापार अजेन्डा के उच्च कोटि में है और ग्राहक तथा उसकी समस्याएँ निछले भाग में है, यह वस्तु बदलेगा इस आशा के तुलन में उम्मीद का प्रश्न है ।

लेखक ओरियन्टल इन्शुरन्स कंपनी लिमिटेड के सेवानिवृत्त सीएमडी है।

Report Card: GENERAL

G. V. Rao

November Growth Lower at 16.4%

Performance in November 2005

The non-life industry has recorded an accretion of Rs. 174 crore at a growth rate of 13.1 per cent. Both these parameters are lower than those recorded in October 2005 of 18.4 per cent and an accretion of Rs.273 crore. This has demonstrated that the market has shown a comparative downward swing in premium volume and growth rate in November 2005.

New Players

As has been customary, the new players have again shown their domination of the growing market by recording an accretion of Rs.111crore of the total Rs.74 crore. ICICI with an accretion of Rs.62 crore has kept up its leadership role in market accretions. Keeping company with it are its fellow new players, Bajaj with Rs. 32 crore and IFFCO with Rs. 16 crore accretion.

Established players

The established players with an accretion of Rs.63 crore and a growth rate of 6.2 per cent in November 2005 have slid to their old growth rate pattern. Compared to their October 2005 accretion of Rs.121 crore and a growth rate of 10.3 per cent, the contrast is rather more noticeable. Oriental leads with an accretion of Rs. 43 crore followed by New India with Rs. 40 crore and United India with Rs. six crore. National Insurance has dropped yet another Rs.26 crore in November 2005.

Market pattern

Four players viz. ICICI (Rs.62 crore), Oriental (Rs.43 crore), New

GROSS PREMIUM UNDERWRITTEN FOR AND UPTO THE MONTH OF NOVEMBER, 2005

(Rs.in lakhs)

INSURER	PREMIUM 2005-06		PREMIUM 2004-05		MARKET SHARE UPTO NOVEMBER, 2005	GROWTH OVER THE CORRESPONDING PERIOD OF PREVIOUS YEAR
	FOR THE MONTH	UPTO THE MONTH	FOR THE MONTH	UPTO THE MONTH		
Royal Sundaram	3,046.69	29,146.78	3,036.66	21,169.88	2.17	37.68
Tata AIG	4,925.81	38,919.31	3,738.04	31,008.23	2.90	25.51
Reliance General	1,169.99	10,025.44	2,135.88	12,547.30	0.75	-20.10
IFFCO-Tokio	7,189.27	56,441.61	5,636.78	31,921.45	4.21	76.81
ICICI Lombard	12,805.89	1,09,396.14	6,602.61	56,618.44	8.15	93.22
Bajaj Allianz	10,086.91	85,651.75	6,933.97	53,597.53	6.38	59.81
HDFC Chubb	1,749.03	12,580.05	1,573.02	11,335.55	0.94	10.98
Cholamandalam	1,490.50	16,042.67	1,620.13	11,875.00	1.20	35.10
New India	33,653.00	3,09,396.00	29,656.00	2,73,832.00	23.05	12.99
National	25,319.00	2,31,537.00	27,917.00	2,51,418.00	17.25	-7.91
United India	23,067.00	2,09,975.00	22,482.00	2,01,498.00	15.64	4.21
Oriental	26,153.00	2,33,128.00	21,853.00	2,05,113.00	17.37	13.66
TOTAL	1,50,656.09	13,42,239.75	1,33,185.09	11,61,934.37	100.00	15.52
SPECIALISED INSTITUTION:						
ECGC	4,628.05	36,680.85	4,387.48	32,628.10		12.42

Note: Effective October, 2005 the mode of presentation of non life premium numbers stands modified. Since ECGC is providing cover exclusively for credit insurance, inclusion of the business underwritten by it with that of other insurance companies was reflecting an inaccurate position with respect to the industry as a whole. Henceforth premium underwritten by ECGC would be indicated separately.

India (Rs.40 crore) and Bajaj (Rs.32 crore) have chipped in a total accretion of Rs. 177 crore of the total of Rs. 174 crore by 12 players in November 2005. National Insurance and Reliance are two players that have kept low profiles in growth volumes by dropping Rs. 35 crore.

The pattern that seems to be emerging is that about five of the 12 players are determined to go in for expanding their market shares; and with detariffing being in the air for the future, acquisition of new customers and consolidation of existing ones as quickly as possible seems to have emerged as an important corporate strategy.

Market share in November 2005

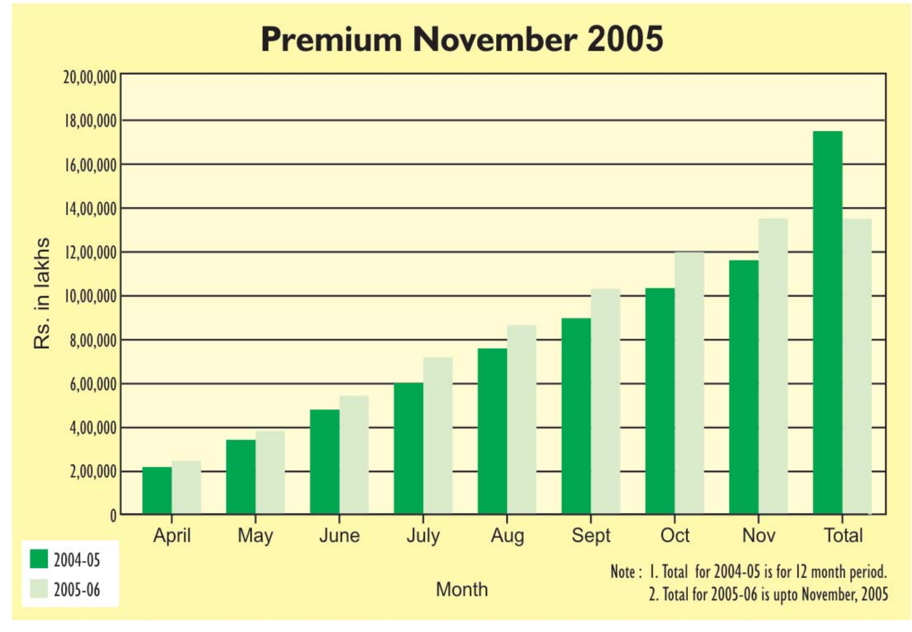
The market share of the new players in the premium derived in November 2005 is 28.2 per cent while it was 23.5 per cent in November 2004. ECGC also seems to be under pressure from other players with its monthly growth rate at 5.5 per cent.

Performance up to November 2005

The market premium grew by Rs. 1803 crore to touch Rs.13,422 crore at a growth rate of 15.52 per cent. This growth rate is slightly lower from the one of 15.95 per cent at the end of October 2005. The new players have touched Rs.3,582 crore and recorded an accretion of Rs.1,281 crore, with a growth rate of 56 per cent over the corresponding period. In contrast, the established players have an accretion of Rs.532 crore to touch Rs.9,840 crore with a growth rate of 5.6 per cent.

New Players

ICICI is the first new player to cross the Rs.1,000 crore premium mark, which it did in November 2005. It also leads in quantum of market premium accretion with Rs.528 crore, as its contribution to the overall market contribution of Rs.1,803 crore. Bajaj with Rs.321 crore and IFFCO with Rs.245 crore are the next ranked new players. These three players have dominated the non-life market premium growth with a combined Rs.1094 crore accretion of the total Rs. 1,803 crore.



Established Players

New India has crossed Rs. 3000 premium mark in November with an accretion of Rs. 356 crore. Oriental has grown to second position with Rs. 2,331 crore and an accretion of Rs. 280 crore. United India that is now fourth ranked has an accretion of Rs.85 crore. National Insurance has dropped its premium by Rs.200 crore, an unexpected trend from that of its strategy last year.

Emerging market pattern

Five players have contributed to almost the entire market accretion as at November 2005. These are ICICI with Rs.528 crore, New India with Rs. 356 crore, Bajaj with Rs. 321 crore, Oriental with Rs. 280 crore and IFFCO with Rs.245 crore. The accretions of these five players account for Rs.1,730 crore of the total market accretion of Rs. 1,803 crore.

ICICI has taken less than five years after its incorporation to reach a premium level of 50 per cent of the total premium of many established players. The latter have taken over three decades to build their premiums to their present levels. With two other new players wanting to catch up fast with the premium volumes of the established players, competition seems to have worked well so far to boost the premium trends in the market.

With the road map to detariffing having created a frenzy in the market, there should be other developments like improvement in customer service levels and newer standards of underwriting to look forward.

Market Shares

The new players have improved their market share from 19.8 per cent as at November 2004 to 26.7 per cent at November 2005. It was 26.5 per cent last month. The remaining four months seem to herald interesting times for all the players.

The author is retired CMD, The Oriental Insurance Company.

Maharashtra Chief Justice calls for speedy settlement of Motor TP claims

The Chief Justice of Maharashtra convened a meeting of Chairmen and Managing Directors of all the four PSU general insurance companies to discuss speedy settlement of cases relating to Third Party Motor claims, it has been reported. The Chief Justice is understood to have requested the CMDs to ensure that their officers submit documents and provide other kinds of assistance for speedy disposal of the cases.

While solutions such as Lok Adalat have been suggested, no alternative has materialised till date, say insurance analysts.

The TP portfolio has been bleeding the insurance companies, it has been observed. Many of the private insurers have, in fact, stayed away from offering TP covers, especially to commercial vehicles.

The IRDA recently mooted the idea of a pool for TP insurance. A 'pool' is a fund created out of the commitments from insurance companies as per their individual exposure. In the case of claims, the reserves are used to make payouts.

General insurance firms plan 'natural catastrophe' pool

General insurance companies have decided to create a 'natural catastrophe pool' to cushion themselves against rising international reinsurance rates, say media reports. The General Insurance Council (GIC) has appointed a technical group to examine the feasibility of creating such a pool for the insurers.

The technical group consists of reinsurance experts from insurance companies. The group will submit a report that will in turn have to be approved by the CEOs of private general insurance companies through the GIC. The report is slated for submission in January and GIC will serve as the coordinator.

According to analysts, the hurricanes in the US have lashed the global insurance industry with claims of over $40 billion. This has led to fears of hardening of reinsurance rates. The floods in Mumbai, Chennai and Bangalore and the earthquake in Jammu and Kashmir have also made dents in the balance sheets of the domestic insurance companies. The losses from the Mumbai flood itself were pegged at Rs. 3,700 crore, the bulk of which was reinsured.

In the aftermath of 9/11, even insurance companies in developed markets were not able to get terrorism covers. In India, insurance companies then put together what is called a "terrorism cover pool". Today, this pool can cover an indemnity of Rs. 500 crore in any location.

Shimla finds household insurance a cool idea

Household insurance business is picking up in Shimla as families leaving the hill resort for warmer places during winters have begun to take precaution against theft and fire, it has been reported.

In the Himachal Pradesh capital, which is home to 175,000 residents, four general insurance companies have sold 4,275 fire and 2,399 household insurance policies in this fiscal year, according to the latest figures. With the rise in fire and theft incidents during the chilly months, insurance has picked up.

It has been observed that there is a growing awareness to opt for house insurance in Shimla and other towns in the region. In the past two decades, there have been numerous incidents of fire in Shimla, destroying some majestic buildings of the British era.

Robbery also becomes rampant once Shimla receives snowfall.

UP launches farmers' insurance scheme

Uttar Pradesh has become the nation's first state to launch a unique farmers' insurance scheme, according to newspaper reports. Ambika Choudhury, UP Revenue Minister, has said that the farmers will be insured for a maximum amount of Rs. 1 lakh for accidental deaths, while monetary benefits will be given to them due to physical handicap caused by accident.

The government has paid the premium to the insurance company till September 2006. It handed over Rs. 16 crore as the first premium to New India Insurance Company to cover more than 25 million farmers spread out in 70 districts. The farmers insurance project is the major achievement of the Mulayam Singh Yadav government in UP during 2005 even as other states were in the primary stage of implementing the programme.

A crop insurance scheme had already been launched by the state government and the new insurance would be an additional facility for the UP farmers.

Lights, camera, insurance: Bollywood takes up risk cover

With some of the top Bollywood stars going out of action due to illness or injury, an increasing number of filmmakers are opting for film insurance, say media reports. In 2005, most of the prominent Hindi movies opted for film insurance, including Ashutosh Gowarikar and UTV project *Swades*, Ketan Mehta's *The Rising*, Mukta Arts' *Kisna*, Yash Chopra's *Bunty Aur Babli* and Karan Johar's *Kaal*. This is seen as a marked difference from last year, when only action flicks like *Lakshya*, *Deewar* and *Dhoom* were insured.

This trend has been prevalent for long in Hollywood. Given the reliance of the Mumbai-based studios on just a handful of stars, it has come as a blessing for most. Thanks to insurance, filmmakers are not too badly hurt by the fact that a number of stars like Amitabh Bachchan, John Abraham and Abhishek Bachchan have not been able to work. Insurance cover assures that a film that cannot be completed because the key cast member has left can get compensation.

However, several producers do not go in for insurance because it raises the film's budget.

United India Insurance is one of the leading insurance companies delving into film insurance, reports say. Ever since it began insuring films, United India has insured 96 films in all. Industry analysts are of the view that the concept of insuring films is finally gaining momentum in the country, with a consciousness to cover risk not only limited to Bollywood but among regional filmmakers as well. United India recently insured a Bengali film and a Bhojpuri film.

Unlike other general insurance products, film insurance is usually a customised offering. The premium could vary from film to film and the extent of risk cover of the production. The product usually covers, fire, serious illness or death of lead actors, failure of equipment, etc.

After establishing themselves in filmdom, company United India Insurance is foraying into insurance for television production.

Indian insurers take a positive look at AIDS cover

AIDS will shortly become another disease to be covered by Indian insurers for a premium, it has been reported. Life insurers, in particular, are currently examining the prospect of covering the terminal disease that is now being covered by the insurers in other countries at a high price.

"We will examine the issue. The market has gone totally untapped," Sam Ghosh, CEO and Managing Director, Bajaj Allianz Life Insurance, has been quoted as saying. "In the US, the cover is available, but at a high price. The entire thing has to be evaluated from the pricing point of view," he said.

According to Shikha Sharma, CEO & MD, ICICI Prudential Life Insurance, it has not been possible to take a view on the issue of covering AIDS, as the data is not available. "We will take a call after we collect data and do an in-depth study," she has been quoted as saying. The threat of AIDS spreading in the country is also a cause of worry to the life insurers. Experts suggest that before taking the first premium, they could insist on prospective customers filling out a special AIDS questionnaire before accepting the first premium. Policyholders could be asked to undergo an AIDS test every five years till the policy matures.

All the insurers should evolve a uniform code relating to genetic information and AIDS while underwriting a proposal. As a safeguard measure, insurers can issue only five-year policies renewable at the end of the fifth year subject to the policyholder testing HIV negative.

State-run companies allowed to buy insurance from private players

The Central Government has reportedly done away with a policy that required government-owned companies to buy insurance from public sector companies even if alternatives were cheaper by 10 percent. This development will be an added incentive for public sector enterprises, which have already broken tradition and started inviting private companies to bid for their insurance programmes.

The purchase preference policy aims to bolster PSU business by requiring government undertaking to subtract a hypothetical 10 percent from bids by state-owned companies. A memo clarifying this was issued by the Government to the IRDA and the state-owned insurance companies in end-October.

A large number of public sector companies have already placed business with private insurers. Ratnagiri Gas and Power (formerly Dabhol Power) has placed its insurance programme with ICICI Lombard. The company has also provided insurance cover for universal health insurance programme of a couple of state governments.

The turning point has been Indian Oil, the largest on-shore energy risk owned by the government, which placed its entire risk with Bajaj Allianz General Insurance. IOC, which paid a premium of over Rs. 42 crore, is the largest on-shore risk in the country and the second largest insurance account after ONGC.

The trend began with Air India and Indian Airlines inviting private companies to bid alongside state-owned companies. Although the insurance went to the PSUs, it increased the confidence on the private sector.

Bird flu spreading its wings, insurers warned

Even as new reports of deaths caused by the bird flu virus are coming in from Indonesia and Vietnam, the insurance industry received an additional warning about its potential exposures.

An article on the Lloyd's web site [www.lloyd's.com] reports that the impact of avian flu may not be confined to the virus turning into a human pandemic. "Cara New, resident expert in chemical, biological, radiological and nuclear technology for intelligence company Exclusive Analysis said that insurers could be faced with further problems if the virus leaps from fowl to pigs or horses," the bulletin indicated.

Scientists, political and business leaders have focused their main concerns on the virus being transmitted to humans from infected birds, and then mutating into a form that could spread between infected individuals. The result could be a worldwide pandemic causing the loss of millions of lives.

So far the disease has been found responsible for 70 deaths – all of them in Southeast Asia – and all as a result of contact with infected birds. Two new deaths were recently reported from Indonesia, and two from Vietnam, where the infected individuals failed to respond to anti-viral drug treatments.

Lloyd's of London expects to post annual loss

Lloyd's of London, the world's biggest insurance market, has reportedly said it might post its first annual loss since the 2001 terror attacks after the costliest hurricane season on record triggered claims of about £2.9 billion. "The chances of the market making a profit in 2005 are now small," said Lloyd's, an umbrella group for about 62 insurance businesses providing £13.7 billion, or $23.7 billion, of coverage this year. "The market expects to be able to meet all its liabilities."

The storm payouts by the 300-year-old market - about $5 billion - would exceed claims from the 9/11 terrorist attacks, which cost Lloyd's about $3.3 billion in its single biggest loss. The market is expecting "another bad year" for hurricanes in 2006, said Luke Savage, Finance Director at Lloyd's. Lloyd's increased estimated net losses from Katrina to £1.9 billion from £1.4 billion. Hurricane Rita will probably cost £535 million and claims from Wilma may reach £483 million, the market said.

The hurricane payouts illustrate the weight of financial services in Britain's economy: Britain's trade gap narrowed to £5.4 billion in September, from a record £5.9 billion in August, when storm-related payouts from Lloyd's reduced the surplus on services, the Office for National Statistics said. The drain on funds has not undermined the market's ability to keep doing business. Lloyd's is "financially robust" and all its insurers will probably be able to meet their hurricane liabilities, Savage said. The 9/11 attacks pushed Lloyd's insurers into a £3.1 billion loss in 2001 and forced them to cut revenue targets.

Since then, insurers have sold stock, raised money and tightened underwriting standards in an attempt to ensure that a major catastrophe would not threaten the market's stability.

Humana acquires Corphealth for $54 million

Humana Inc. has acquired Corphealth, Inc., a behavioral healthcare management company based in Fort Worth, Texas for cash consideration of approximately $54 million.

"The acquisition of Corphealth allows Humana to seamlessly integrate coverage of medical and behavioral health benefits," said Thomas J. Liston, Senior VP - Strategy and Corporate Development for Humana. "Corphealth's focus on the integration of behavioral and medical care management fits well with Humana's strategy to improve the well-being of its members. The integration of these elements is expected to enhance results from existing disease management and population health initiatives while providing simplicity for our members - a key element in furthering consumerism in healthcare."

Corphealth offers a nationwide network of 22,000 behavioral health providers and currently serves approximately 2 million members, including employers, health insurance companies, and union trusts. Humana expects this transaction will have no material effect upon its earnings for the year ending December 31, 2006.

Humana Inc. is one of the US' largest publicly traded health benefits companies, with approximately 7 million medical members. It offers a diversified portfolio of health insurance products and related services - through traditional and consumer-choice plans - to employer groups, government-sponsored plans and individuals.

US insurers support red light cameras for traffic safety

The American Insurance Association has voiced its support to the call of traffic safety advocates to reinstate red light camera enforcement in the state of Virginia. The law that allowed seven Virginia communities to use automated technology to enforce red light running was allowed to expire this year.

According to AIA, cameras have been shown to significantly reduce red light violations and intersection crashes.

Studies show that violation of red lights and other traffic controls, such as stop signs and yield signs, is the most frequent type of police-reported urban crash.

"Red light cameras can help communities enforce traffic laws by automatically photographing vehicles whose drivers run red lights," said David Snyder, AIA Vice President and Assistant General Counsel. "A nationwide study of fatal crashes at traffic signals in 1999 and 2000 estimated that 20 percent of the vehicles involved failed to obey signals. In 2004 alone, more than 900 people were killed, and an estimated 168,000 were injured, in crashes that involved red light running. About half of all deaths in red light running crashes are pedestrians and occupants in other vehicles who are hit by the red light runners."

According to new statistics released by the Virginia Beach Police Department, red light running violations at several intersections formerly equipped with red light cameras have spiked approximately 99.5 percent since July, when the law expired. The same cameras, which previously had been authorized for enforcement, have continued to monitor violations. At just four intersections, these cameras have seen an increase of red light runners from 488 in June to 1,056 in November.

The insurers maintain that the actions of the Virginia legislature run contrary to the primary recommendation of a 2004 study by the Virginia Transportation Research Council, which urged extension of the camera programmes for at least one year. The study also directly credited the cameras with reducing red light running crashes in four Northern Virginia communities; found that the cameras reduced red light running violations by 34 percent; were technologically reliable; and, had widespread public support.

"Top Ten" insurance crimes in Canada

The Insurance Bureau of Canada has released its annual Top Ten Insurance Crimes list, which highlights "some of the strangest and most audacious insurance frauds and auto theft cases uncovered by insurance investigators this year."

Topping the list was a con artist, who specialised in staging accidents in parking lots. He pretended to be struck by a car, usually selecting one driven by an elderly person, or a woman. He made 10 successful personal injury claims, before a "sharp-eyed" adjuster spotted the fraud and alerted authorities.

The other 9 "winners" were:

2. Pirate Shipping – a man exported his expensive car to Europe and 90 days later reported it had been stolen. The vehicle had already spent weeks impounded in Belgium, raising questions as to why it had taken him so long to realise it was missing.

3. Fender Bender Fraud – A body shop sent a huge bill to an insurer following what should have been minor repairs. The owner alerted the company, who found that the damaged parts, which the body shop employees claimed had been removed from his car, were actually from another vehicle. Police are investigating.

4. The Chop Shop King – A man in Quebec was found to be operating "two bustling chop shops – illegal garages where stolen cars are stripped for parts." Police seized 40 stolen vehicles with a cash value totaling C$1 million. The trial took 119 days and resulted in a 6-year prison term and a C$774,000 fine.

5. Field of Schemes - A man reported that his high-end pickup truck had been stolen, and he collected $68,000 from his insurer. However, several months later, investigators found the truck in a field where he was selling off parts of it piece by piece.

6. Phantom Injuries - The "victims" weren't even in the car when it crashed, but they filed injury claims totaling over C$200,000. A crooked paralegal and a clinic concocted the scheme, which fell apart when one of the "victims" revealed the truth.

7. Too Good To Be True – Several car dealers were charging $500 as a "finder's" or "consulting" fee to arrange for cheap insurance. They then intentionally put bogus information on the applications so that customers would be placed into a cheaper rate group. However, because the policies were purchased under false pretenses, they were invalid. The subsequent investigation and dismantling of the scheme found that hundreds of such policies totaling around C$1 million had been obtained.

8. Persistence Doesn't Pay - A woman was found to have persuaded friends and family to join her in staging car accidents and filing false claims. Business was good, so she decided to expand. She began pestering other neighbors and friends to join the scheme, but eventually a would-be recruit revealed the fraud.

9. The Invisible Workers - Investigators noticed that the employees of one particular firm seemed to be very unlucky. A great many of them were getting involved in car accidents and filing injury claims. The company's owner, however, was unaware of the claims. When he looked at the list he found that none of the people had ever worked for him. A paralegal was the driving force behind a staged accident ring and, to boost the compensation claims of his "victims," he had forged their employment forms.

10. Very Bad Advice – Another paralegal had a client "sign a pile of legal forms without explaining what they meant and, all the while, assured him that he would look after him. The paralegal went on to negotiate on the man's behalf with the insurance company without telling his client, then forged the man's signature on the resulting check and cashed it. Despite denials the paralegal was convicted of fraud.

INSTITUTE OF INSURANCE AND RISK MANAGEMENT

Established jointly by the Insurance Regulatory and Development Authority (IRDA) India and the State Government of Andhra Pradesh

International Post Graduate Diploma in

Life Insurance *

General Insurance *

Risk Management

* Granted accreditation to 7 subjects of IIRM courses by the Charted Insurance Institute (CII), UK. IIRM Diploma holders need to complete only 3 more papers leading to the ACII designation, subject to CII Membership rules

Eligibility: Graduates from any discipline (including engineering, chartered accountancy, cost accountancy and others) from a recognized University or an approved Institution with a minimum of 50% marks can apply. Candidates who are in final Year may also apply.

Special features:

- Internationally recognized
- Specialized
- Innovative
- Challenging and
- Rewarding

Last Date for submission of completed application forms 31st May 2006

Education loan facility available from Andhra Bank under special scheme

INSTITUTE OF INSURANCE AND RISK MANAGEMENT

Plot no: 310, Road No: 25, Jubilee Hills,Hyderabad 500033, Andhra Pradesh, India

Ph No: 91 40 23556470, Fax No: 91 40 23556471

For further details visit our Web site: www.iirmworld.org.in

The chances of the market making a profit in 2005 are now small.

Mr. Luke Savage, Finance director at Lloyd's of London commenting on the storm payouts of about $5 billion exceeding claims from the September 11, 2001, terrorist attacks.

It is essential that unfit firms are kept out, to ensure that there is a level playing field for the benefit of intermediaries.

Mr.Andrew Honey, Head of Insurance, Small Firms Division of the Financial Services Authority (FSA), the UK on more than 600 mortgage and general insurance firms having been barred from operating since legislation brought them under the watch of the FSA in 2004.

...if the hurricane risk was priced accurately the resulting underwriting profits would be large enough to attract additional investment capital. Ironically, the increase in capital could create marketplace competition which, in turn, might drive down prices for some individuals. There may never be enough discipline to assure you keep adequate rates in the highest risk places.

Ms Alice Gannon, Senior Vice President, US Actuaries Association

...the core parts of the financial system appear to have highly resilient IT systems that allow them to recover critical functions with impressive speed. This stands the sector as a whole in good stead.

Mr. Hector Sants, Managing Director, Wholesale Firms Division, Financial Services Authority (FSA), UK on the results of the survey by the Tripartite Authorities (HM Treasury, the FSA and the Bank of England) of the UK financial sector's ability to cope with major operational disruption, such as a terrorist attack or natural disaster.

After six years, there finally looked to be movement on the issue amongst U.S. regulators, who require foreign reinsurers to place significant levels of collateral in U.S. trust funds if they want to underwrite US reinsurance business.

Lord Peter Levene, Chairman, Lloyd's of London, about US insurance regulators' rethinking on terms for foreign reinsurers.

The two year extension of TRIA, which Congress has just completed action on and will send to the President, is a recognition by our legislative leaders that the federal government must partner with the private insurance markets to protect our national financial and economic security.

Mr. Joe Plumeri, Chairman and CEO of Willis Group Holdings Limited about US Congressional action on the Terrorism Risk Insurance Act (TRIA)

RNI No: APBIL/2002/9589

Events

January 9-11, 2006
Venue: Pune
Insurance Regulations (Non-Life)
by NIA Pune

January 9-11, 2006
Venue: Pune
Creating Competitive Edge in Non-Tariff
Regime by NIA Pune

January 9-14, 2006
Venue: Pune
Management of Strategic Issues for
Insurance Executives by National
Insurance Academy, Pune

January 13-14, 2006
Venue Pune
Seminar on Wireless Technology - Mobile
Computing by NIA Pune

January 16-19, 2006
Venue: Pune
Reinsurance Management by NIA Pune

January 16-19, 2006
Venue: Pune
Information Security Management (Life)
by NIA Pune

January 23-25, 2006
Venue: Pune
Actuarial Practices in Life Insurance by
NIA Pune

January 23-24, 2006
Venue: Singapore
2nd Asian Conference on Corporate
Governance and Directors' &
Officers' Liability Insurance by Asia
Insurance Review

January 30-February 2, 2006
Venue: Pune
Workshop Motor TP Claims by NIA Pune

February 20-22, 2006
Venue: Bangkok
6th CEO Insurance Summit by Asia
Insurance Review