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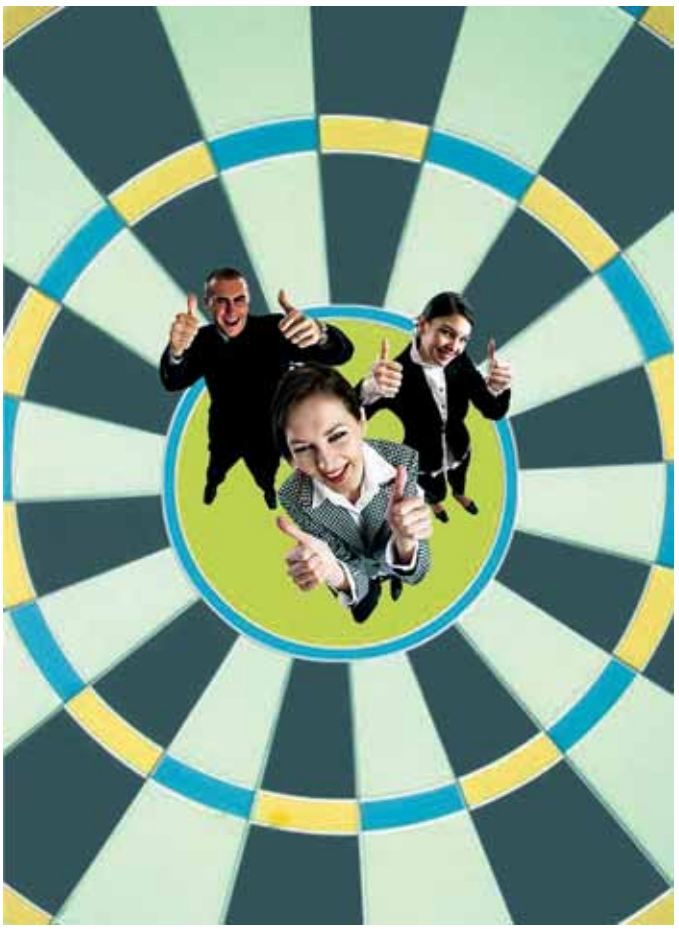

Best Practices in Insurance -
Sure Shot Recipe for Success

बीमा विनियामक और विकास प्राधिकरण

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From the Publisher

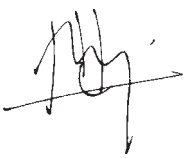
Customer satisfaction in a domain that deals with intangibles, like the financial services, for example, is hugely challenging. Within this space, insurance occupies an even more important position — considering that the moment of truth viz. the claim settlement may arise at the end of a very long term in some cases. In several others, it may never arise in view of the fact that the claim becomes payable only on the contingent happening of the event. In such a scenario, to achieve high standards of customer satisfaction is a tall order; and adopting best practices of service delivery would go a long way in building up one's reputation.

The adoption of best practices should not merely be a routine exercise wherein a player sets a standard list of activities that have to be achieved within certain limits. It has to be a part of the mind-set and the best practices have to be followed, and also demonstrated; in their true spirit. For a player to be able to achieve this in the Indian insurance domain has additional challenges, for obvious reasons.

The need for best practices should begin at the very beginning and insurance companies should make the proposal form a document of comprehensive and purposeful questions that aim to elicit the right answers from the proponent. In a contract where it forms the pedestal of the huge edifice of the insurance contract, best practices in designing a meaningful questionnaire will be instrumental in drawing a clear road-map. It is very essential that the underwriters make use of the information provided in a very objective manner; and arrive at decisions that take care of the business priorities and at the same time render the best services to the clientele.

Emphasis should be placed on communicating the intricacies of the contract to the prospect, especially with regard to the limitations / exclusions so that the scope for a later heartburn or controversy is reduced to the barest minimum. Where a rejection or repudiation of a claim is inevitable, it should be dealt with a great deal of sensitivity and an element of empathy with the claimant. It should be the endeavour of the players to ensure that adoption of best practices of business is a way of life; and that they go beyond mere customer satisfaction.

'Best Practices in Insurance' is the focus of this issue of the **Journal**. It is around a decade since the industry has been opened up; and during this period, several new initiatives have been taken. 'Innovations and Developments in the Insurance Industry' will be the focus of the next issue of the **Journal**.



J. Hari Narayan

INSIDE

ISSUE FOCUS

THINKING CAP

KNOW YOUR REGULATIONS

Adopting Best Practices - Survival of the Fittest

For a business entity, one factor that puts it apart from the others is the reputation that it enjoys over a period of time in rendering the best services to its clientele. This reputation, however, should be based on the sustained best practices that the organization puts into its regular operations, rather than one based on a one-off achievement or a short-term initiative. More recently, corporates have been vociferously announcing several measures that they have been adopting in pursuit of rendering best customer service. This has been a global phenomenon that has come to catch the attention of everyone although it needs a closer scrutiny of assessment to know the extent to which it is really being achieved.

The need for a visible adoption of best practices is more emphatic in a service that is intangible – like insurance, for example. It needs no special mention that it is all the more important in an emerging domain like the Indian insurance industry. There have been several new initiatives that have been taken in the post-liberalized scenario but the fact remains that insurance business still remains one with lots of misapprehensions and a few misgivings. There is urgent need to put these behind us and ensure that the progress of the industry is on a smoother note.

In order to derive the best results in the fulfillment of contractual obligations, insurers would do better to make the proposal form very plain and explicit. There may be need for explaining the contents of the proposal form and the implications of the answers thereto, in light of the low awareness levels of the Indian populace. It should be the endeavour of the players as well as the distributors to ensure that the essence of the underlying facts is clearly understood by the proponents before taking their sign of approval. It should also be the effort of all the stakeholders to ensure that at every stage of interaction, best corporate practices are in place. While the Indian insurance industry has made a lot of progress in this regard, it has to be realized that the road ahead is long and bumpy; and calls for a high degree of concerted effort.

'Best Practices in Insurance' is the focus of this issue of the **Journal.** Mr. S.L. Mohan, Secretary General, General Insurance Council opens the debate with a detailed note on what the general insurance players can do in demonstrating their zeal in adopting best practices. Best practices in reinsurance are absolutely essential if the insurance industry is to be run on sound lines. Mr. K.L. Naik emphasizes the nuances of reinsurance business in his article. The role of the Third Party Administrator has always been facing challenges of different kinds. Ms. Malti Jaswal brings home a detail of the best practices being followed by the TPAs which is eventually leading to more meaningful equations between the service providers and the insured.

The success of a life insurer has often been measured by the top-line growth of its business which may not be a wholesome indicator. Mr. R. Venugopal brings in all his experience in highlighting some of the priorities that should drive a life insurer. In the last article on the issue focus, Dr. Somil Nagpal talks about the various initiatives taken by different stakeholders in bringing Health insurance to higher levels of growth. In the 'thinking cap' section, we have an article by Mr. Anil Swarup that narrates the success of the Rashtriya Swasthya Bima Yojana (RSBY); and what lies ahead. In the end, we have an article by Mr. K. Subrahmanyam in which he throws light on the aspect of insurable interest that is so essential for an insurance contract.

The opening up of the insurance industry, approximately a decade ago, has led to the innovation of several new initiatives that were hitherto unknown in the Indian insurance industry. 'Innovations and Developments in the Liberalized Regime' will be the focus of the next issue of the **Journal.**

U. Jawaharlal

Report Card:LIFE

First Year Premium of Life Insurers for the Period Ended June, 2009

Sl No.	Insurer	Premium u/w (Rs. in Crores)			No. of Policies / Schemes			No. of lives covered under Group Schemes		
		June, 09	Up to June, 09	Up to June, 08	June, 09	Up to June, 09	Up to June, 08	June, 09	Up to June, 09	Up to June, 08
1	**Bajaj Allianz**									
	Individual Single Premium	27.11	51.10	71.55	6433	14520	16939			
	Individual Non-Single Premium	193.89	428.49	735.98	146193	342282	480898			
	Group Single Premium	4.71	8.41	0.51	1	3	0	5228	5912	856
	Group Non-Single Premium	11.08	89.66	21.20	102	182	120	1511887	2561086	758734
2	**ING Vysya**									
	Individual Single Premium	0.82	1.90	10.41	97	268	1227			
	Individual Non-Single Premium	46.95	119.02	146.41	23819	64761	82007			
	Group Single Premium	0.80	2.15	4.19	0	0	0	202	722	870
	Group Non-Single Premium	0.01	0.09	0.93	0	0	30	306	1208	6723
3	**Reliance Life**									
	Individual Single Premium	13.68	22.51	125.47	2759	5563	32511			
	Individual Non-Single Premium	216.53	433.13	401.27	170451	401007	255915			
	Group Single Premium	10.64	39.53	26.81	0	1	4	306	382	14536
	Group Non-Single Premium	3.65	9.84	3.78	31	128	86	24399	248463	143024
4	**SBI Life**									
	Individual Single Premium	27.18	59.17	146.33	4920	11214	20703			
	Individual Non-Single Premium	208.31	487.58	457.64	60980	148913	132990			
	Group Single Premium	11.81	42.16	49.02	0	0	0	4985	28033	25722
	Group Non-Single Premium	41.49	483.82	495.68	11	33	17	53337	200403	441928
5	**Tata AIG**									
	Individual Single Premium	1.43	4.46	13.32	249	1167	2856			
	Individual Non-Single Premium	66.89	174.84	212.24	56971	148376	146588			
	Group Single Premium	2.63	5.39	12.77	0	1	1	2842	7449	44019
	Group Non-Single Premium	7.14	12.74	22.30	2	18	21	8458	29445	52228
6	**HDFC Standard**									
	Individual Single Premium	9.69	25.46	33.32	18302	20957	16369			
	Individual Non-Single Premium	161.46	357.55	428.82	52144	131126	144161			
	Group Single Premium	5.80	26.77	20.07	13	48	36	9480	74386	76562
	Group Non-Single Premium	1.83	2.86	8.18	0	0	2	54	279	12641
7	**ICICI Prudential**									
	Individual Single Premium	10.74	33.61	71.30	1333	3632	12706			
	Individual Non-Single Premium	258.69	541.27	1166.51	132745	356400	601624			
	Group Single Premium	19.74	49.04	76.90	21	134	101	56992	222733	189471
	Group Non-Single Premium	34.37	183.15	275.56	34	223	249	15403	239789	373560
8	**Birla Sunlife**									
	Individual Single Premium	3.23	11.50	9.42	9262	28131	30111			
	Individual Non-Single Premium	184.87	368.23	479.64	122832	301620	139174			
	Group Single Premium	0.06	0.15	1.34	0	0	0	279	325	2215
	Group Non-Single Premium	9.74	60.52	11.13	22	55	36	25800	94507	38622
9	**Aviva**									
	Individual Single Premium	11.37	23.79	4.56	1242	3163	659			
	Individual Non-Single Premium	42.24	103.88	155.88	15203	39771	75887			
	Group Single Premium	0.00	0.00	0.04	0	0	0	0	0	63
	Group Non-Single Premium	1.51	6.44	4.84	10	22	18	137031	284149	175178
10	**Kotak Mahindra Old Mutual**									
	Individual Single Premium	1.32	2.62	6.21	206	378	719			
	Individual Non-Single Premium	56.79	121.75	211.29	25220	52417	107075			
	Group Single Premium	3.34	6.76	7.09	4	4	2	10611	21358	33953
	Group Non-Single Premium	4.67	13.36	9.47	32	141	102	45085	142940	148632
11	**Max New York**									
	Individual Single Premium	15.48	51.49	67.09	5626	7932	5124			
	Individual Non-Single Premium	139.93	379.02	418.61	96933	250169	293763			
	Group Single Premium	0.02	0.08	4.63	-1	5	7	-27	206205	187072
	Group Non-Single Premium	1.48	4.21	10.84	51	246	181	-9417	196375	189120

12	**Met Life**									
	Individual Single Premium	0.87	1.40	1.09	146	225	222			
	Individual Non-Single Premium	71.40	134.12	175.13	24766	47578	44348			
	Group Single Premium	2.48	6.04	4.66	0	0	22	1133	2418	50223
	Group Non-Single Premium	1.04	9.70	0.00	18	54	0	13608	80796	0
13	**Sahara Life**									
	Individual Single Premium	1.88	4.54	8.99	589	1395	2329			
	Individual Non-Single Premium	4.57	11.37	14.35	5159	12400	16175			
	Group Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Group Non-Single Premium	2.94	7.32	0.00	1	1	1	360909	915321	27
14	**Shriram Life**									
	Individual Single Premium	8.45	13.98	48.09	1315	2248	7750			
	Individual Non-Single Premium	12.92	42.65	29.44	10658	28947	14546			
	Group Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Group Non-Single Premium	0.10	0.10	0.00	2	2	0	8003	8003	0
15	**Bharti Axa Life**									
	Individual Single Premium	0.20	0.67	1.68	22	81	409			
	Individual Non-Single Premium	24.01	63.31	41.21	10456	29938	28375			
	Group Single Premium	1.88	4.38	1.94	0	2	1	1142	3600	6970
	Group Non-Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
16	**Future Generali Life**									
	Individual Single Premium	0.84	1.68	0.02	139	284	4			
	Individual Non-Single Premium	26.11	48.71	1.09	24034	44720	3323			
	Group Single Premium	0.02	0.02	0.00	0	0	0	91	91	0
	Group Non-Single Premium	0.37	6.36	1.56	8	28	12	9715	80112	19208
17	**IDBI Fortis Life**									
	Individual Single Premium	8.96	21.60	14.39	1668	3460	2118			
	Individual Non-Single Premium	19.63	41.67	11.23	5350	12198	4795			
	Group Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Group Non-Single Premium	0.00	0.01	0.00	0	2	0	2294	7524	0
18	**Canara HSBC OBC Life**									
	Individual Single Premium	1.58	2.34	0.00	49	103	0			
	Individual Non-Single Premium	43.70	119.16	0.20	5924	13543	19			
	Group Single Premium	0.07	0.07	0.00	1	1	0	42	42	0
	Group Non-Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
19	**Aegon Religare**									
	Individual Single Premium	0.06	0.18		11	27				
	Individual Non-Single Premium	4.66	11.44		2399	5068				
	Group Single Premium	0.00	0.00		0	0		0	0	
	Group Non-Single Premium	0.00	0.00		2	2		2745	2745	
20	**DLF Pramerica**									
	Individual Single Premium	0.02	0.02		0	0				
	Individual Non-Single Premium	2.16	4.34		1488	3064				
	Group Single Premium	0.00	0.00		0	0		0	0	
	Group Non-Single Premium	0.00	0.00		0	0		0	0	
21	**Star Union Dai-ichi @**									
	Individual Single Premium	3.13	5.75		395	842				
	Individual Non-Single Premium	7.55	13.47		2710	5114				
	Group Single Premium	1.45	1.45		1	1		1705	1705	
	Group Non-Single Premium	0.34	0.34		0	0		3056	3056	
	Private Total									
	Individual Single Premium	**148.05**	**339.75**	**633.24**	**54763**	**105590**	**152756**			
	Individual Non-Single Premium	**1793.27**	**4005.02**	**5086.95**	**996435**	**2439412**	**2571663**			
	Group Single Premium	**65.44**	**192.38**	**209.97**	**40**	**200**	**174**	**95011**	**575361**	**632532**
	Group Non-Single Premium	**121.76**	**890.52**	**865.48**	**326**	**1137**	**875**	**2212673**	**5096201**	**2359625**
22	**LIC**									
	Individual Single Premium	1289.31	2490.49	2139.96	345245	667634	519837			
	Individual Non-Single Premium	1342.21	3473.15	3135.75	2254220	5237305	4296967			
	Group Single Premium	1042.24	3065.04	2248.85	1480	3473	2742	1327286	3318230	2620798
	Group Non-Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Grand Total									
	Individual Single Premium	**1437.36**	**2830.23**	**2773.21**	**400008**	**773224**	**672593**			
	Individual Non-Single Premium	**3135.48**	**7478.17**	**8222.70**	**3250655**	**7676717**	**6868630**			
	Group Single Premium	**1107.68**	**3257.42**	**2458.82**	**1520**	**3673**	**2916**	**1422297**	**3893591**	**3253330**
	Group Non-Single Premium	**121.76**	**890.52**	**865.48**	**326**	**1137**	**875**	**2212673**	**5096201**	**2359625**

Note: 1. Cumulative premium / No.of policies upto the month is net of cancellations which may occur during the free look period.
2. Compiled on the basis of data submitted by the Insurance companies.
3. @ Started operations in February, 2009.

CORPORATE AGENTS GUIDELINES

July 3, 2009

IRDA/AGENTS/ORD/17/JULY 2009

Re: Guidelines on Qualifications of Corporate Insurance Executives and Faculty of Agents' Training Institutes.

The large scale recruitment of agents by insurers in last few years and phenomenal growth in sales through corporate agencies has necessitated large number of professionals in the fields of training and marketing. Firstly, the insurers have expanded their training facilities to accommodate new agent recruits and are making efforts to recruit the faculty required. Secondly, the corporate agents of insurers required large number of persons who are qualified to be specified persons or corporate insurance executives. In the above context several insurers represented to IRDA to suitably modify the training requirements for the faculty of Agents' Training Institutions, Corporate Insurance Executives, Specified Persons etc.

As per IRDA Guidelines on Licensing of Corporate Agents, the minimum qualification of Chief Insurance Executive (CIE) is FIII / AIII or such other qualification or experience that IRDA, may at its sole discretion, consider adequate. As of now only these two qualifications are being considered.

To identify the qualifications which are suitable for the above positions in insurance company and evaluate their equivalence to presently specified qualifications, Chairman, IRDA constituted the standing panel with the following members:

1. Executive Director (Administration), IRDA, Hyderabad (Chairman & Convenor)
2. Managing Director, IIRM, Hyderabad
3. Secretary General, Life Insurance Council, Mumbai
4. Secretary General, General Insurance Council, Mumbai
5. Secretary General, Insurance Institute of India, Mumbai

The Standing Panel considered various issues connected with the qualifications and made recommendations which are submitted to the Authority.

After considering the recommendations of the Standing Panel, Authority accepted the following recommendations and ordered that this be incorporated in Circulars concerned:

1. The qualifications required for Corporate Insurance Executive (CIE), Specified Person, Faculty of ATI shall include the following qualifications:
   a. An Associate / Fellow of the Insurance Institute of India, Mumbai.
   b. an Associate / Fellow of the Institute of Chartered Accountants of India, New Delhi; with diploma in Insurance and Risk Management.
   c. an Associate / Fellow of the Institute of Costs and Works Accountants of India, Calcutta;
   d. an Associate / Fellow of the Institute of Company Secretaries of India, New Delhi;
   e. an Associate / Fellow of the Actuarial Society of India, Mumbai;
   f. possessing Certified Associate ship of Indian Institute of Bankers (CAIIB)
   g. MBA (Two year) Course / PG Diploma (One year) course in Insurance from Amity School of Insurance & Actuarial Science, Noida
   h. PG Diploma (One year) course in Insurance from Institute of Insurance and Risk Management, Hyderabad
   i. MBA (Two year) course in Insurance from National Insurance Academy, Pune
   j. PGMBA (Two Year) course in Insurance from National Law University, Jodhpur
   k. PGMBA (Two year) course in Insurance from MET, Mumbai
   l. MBA (Two year) course in Insurance from Birla Institute of Management Technology, Noida

2. **The persons with above qualifications (except at (a)) shall undergo a "Workshop for Insurance executives" at National Insurance Academy, Pune or Insurance Institute of India, Mumbai or Institute of Insurance and Risk Management, Hyderabad as prescribed by the Authority.**

3. **Faculty of Agents Training Institute:**

   With regard to the qualification of faculty of Agents' Training Institutes, point no. 6 of STANDARD INSTRUCTIONS AND GUIDELINES issued on October 4, 2004 is modified as below:

   "Every Institute should have at least one qualified permanent faculty who is an Associate or Fellow from the Insurance Institute of India for each stream i.e. for Life and Non-Life. However, the training institutes can employ faculty with more than 15 years of service in the insurance company with last three years in managerial capacity i.e. Scale III Officer and above in the public sector insurance companies".

The above guidelines come into force with immediate effect.

(A Giridhar)
Executive Director

CIRCULAR

July 9, 2009

No.018/AML-CIR/IRDA/E-Payments/Jul-09

To

All CEOs of Life Insurance Companies,

We draw you attention to the AML Guidelines dt. 31st March 2006 issued by the Authority and in particular to the clause 3.1.9 (i) of the Guidelines which among others specifies that all payments should be made after due verification of the bonafide beneficiary through 'account payee' cheques.

The above stipulations were aimed at having audit trail and also a control mechanism on all payments in light of the vulnerability of such fund transfers for money laundering purposes. Recognizing the increasing utility of electronic payments, which also ensure safety and speed of such payments, it has been decided to permit payments to all policyholders and beneficiaries through electronic payment methods such as ECS, NEFT Systems (as per details enclosed) as approved by the Reserve Bank of India in addition to account payee cheques as stipulated in the clause mentioned above.

(C.R. Muralidharan)
Member (F&I)

CIRCULAR

22nd Jul, 2009

Circular No: 20/IRDA/Actl/ULIP/09-10

Sub: Unit linked products – Cap on charges

The Insurance Industry has introduced ULIPs which have found favour with insurance customers in India. These products prescribe certain charges which are deducted either from contributions or from the fund. In 2005, the IRDA had in its Circular No.032/IRDA/Actuary/DEC-2005 dated 21/12/2005 defined various charges which could be levied for the management of the ULIPs. The IRDA has observed that the insurance industry is generally following these definitions.

However, there are several heads of charges and in order to enable the customers to comprehend ULIPs, the IRDA had also mandated a signed customer-centric benefit illustration to be included as part of the policy document. This was to ensure that the customers would have a clear understanding of the product before making an investment decision.

In order to further enhance clarity and to ensure that the charges are reasonable, relevant to the services being provided and clearly understandable by the customers, the IRDA through this Circular mandates an overall cap on all charges put together. Care has been taken to enable the insurers freedom to distribute charges across the policy term in order to impart flexibility and facilitate product innovation.

It is important to keep in mind that insurance is a long term business and policy measures should encourage such long term savings through various instruments available in the insurance sector. On an analysis, it is established that the majority of the products have a tenor of 10 years and above and a smaller proportion is with a tenor of less than 10 years.

Hence to encourage long term business and enable policyholders to earn additional returns thereby and taking into account the product features and the current cost structure, it is mandated that the cap on charges will be based on the difference between gross and net yields of any product. The net yield is the gross yield adjusted for all charges. For insurance contracts which are of a tenor of less than or equal to 10 years duration, the difference between gross and net yields shall not exceed 300 basis points, of which fund management charges shall not exceed 150 basis points. For other contracts, i.e., those whose contract period is above 10 years, the difference between gross and net yields shall not exceed 225 basis points, of which the fund management charges shall not exceed 125 basis points.It is relevant to note that in many markets across the world the Regulators have prescribed gross and net yield to the customer for ULIPs.

Further, the following must be observed.

Extra premium due to underwriting emanating from extraordinary health conditions, cost of all rider benefits, service tax on charges (as applicable) and any explicit cost of investment guarantee shall be excluded in the calculation of net yield

In these calculations, all charges should be as per the 'file and use' document as approved by the IRDA.

Please refer IRDA circular letter IRDA/ACTL/ULIP/2008-09 of January 25, 2008 on 'benefit illustration'. There should be a specific mention of the gross yield and net yield to the customer at the point of sale. This benefit illustration must be approved by the IRDA.

At the time of sale, for benefit illustration purpose, the insurer may assume a growth rate of 10% per annum of the investment as a model, as suggested by the Life Council. This will help the

customer to understand the product and charges easily so that the prospect could consider the gross yield and net yield while making an informed decision.

At the time of maturity, the insurer must issue the policyholder a certificate showing year-wise contributions, charges deducted, fund value and final payment made to the policyholder taking into account partial withdrawals, if any. In addition, this certificate must also show the actual gross yield and net yield taking into account the actual charges deducted. This certificate must confirm adherence of above prescription.

The charges for the ULIPs as filed under the File & Use guidelines as approved by the IRDA, shall not be modified or changed without obtaining the prior approval of the IRDA.

The circular comes into effect from October 1, 2009 so that all products which are approved by the IRDA on or after October 1, 2009 will be governed by the provisions of this circular. All existing products that do not meet the requirements of this circular should be withdrawn or modified by 31 December 2009.

Sd/-
(R. Kannan)
Member (Actuary)

PRESS RELEASE

July 22, 2009

Motor Insurance Data (2007-08)

The Motor Insurance data for all classes of vehicles was hosted on the website of the Tariff Advisory Committee for the period 2006-07 with a link provided in the IRDA website. The tabulations in the form of Summary Reports contain (i) Public Sector aggregate data, (ii) Private Sector aggregate data and (iii) Industry level data.

Similar tabulations have been generated for the period 2007-008. They relate to both, Public Sector and Private Sector insurance companies as well as Industry level aggregate data. Three types of tabulations have been generated as detailed below:

MR1 gives the vehicle class-wise details of total number of policies, total premium and total incurred claims and claims paid.

MR2 gives the vehicle class-wise details of Premium and claims break-up of Own Damage (OD) and Third Party (TP).

MR3 gives the vehicle class-wise details of claims ratios (claims paid ratio, incurred claims ratio)[Claims paid ratio is a percentage of claims paid to premium. Incurred claims ratio means claims paid during the year plus closing provision at the end of the year less opening provision at the beginning of the year expressed as a percentage to the premium]

The Summary Reports of the data have been collated from the transactional level data submitted by the respective insurance companies. The summary statements have been duly verified and validated by the concerned insurance company. The Summary Reports do not include (i) one public sector company, viz M/s United India Insurance Company as they have note submitted the transactional level data and (ii) One private sector company, viz M/s Royal Sundaram General Insurance Company as they have not validated their data.

The Summary Reports for the period 2007-08 have now been hosted on the TAC website (www.tac.org.in). A link to the TAC site is also available in the IRDA website (www.irdaindia.org)

These reports are hosted for the benefit of all stakeholders and general public. Comments and suggestions, if any, may be sent to Data Centre, 9th Floor, United India Insurance Towers, 3-5-817/818, Hyderguda, Hyderabad 500 029.

CIRCULAR

23 July, 2009

Circular No: 021/IRDA/LIFE/PAN/Jul-2009

To
All Insurers,

Re:Requirement of PAN for Insurance Products

It has been decided to mandate the requirement of PAN on all high value insurance products.

All Insurers are therefore advised to collect PAN from all persons purchasing insurance products where the contracted annual premium payable on the insurance policies, per policy basis, exceeds Rs. 1.00 lakh.

This circular comes into force with immediate effect. All Insurers are advised to comply with the directions issued in this circular under confirmation to the Authority not later than 01.08.2009.

(J. Hari Narayan)
Chairman

A Decade of Innovations

More in Store ...

'IT HAS BEEN A BUSY DECADE FOR THE INSURANCE INDUSTRY AND THE SUPERVISORS. WE HAVE WITNESSED SEVERAL NEW INITIATIVES BEING TAKEN DURING THE PERIOD WHICH HAVE CONTRIBUTED TO AN ALL-ROUND GROWTH; AND ONE LOOKS FORWARD TO MANY MORE' WRITES U. JAWAHARLAL.

During the period of liberalized environment in the insurance industry which is around a decade now, a tremendous business growth has been achieved in both life and non-life domains. There has been a progressive transition in the penetration and density of insurance, although we are yet to reach international standards. Another gratifying fact is that the growth has been observed across most classes of insurance, although it is higher in some classes than others. Above all, health insurance which is so vital for the overall improvement of healthcare delivery in the country has been growing by leaps and bounds; and this augurs well for the health of the nation itself.

It cannot however be presumed that all the growth that has been noticed was without any hiccups. Further, it would also amount to complacency to treat this growth as the resultant of any single initiative. There have been several factors that have made the growth possible as also the surge of a few classes that remained dormant earlier. There have been a spate of initiatives that have been taken during the post-liberalization period which have contributed to business growth as also the emergence of practices that will contribute towards drawing a road-map for the future. The trend continues; and hopefully, will take the Indian insurance industry closer to global standards.

The intermediary plays a very crucial role in insurance business world over. In the Indian domain, it is even more pronounced. The agent has been a key factor especially in the life insurance domain and during the period of liberalization, several initiatives have been taken to ensure that the agent is himself well-trained and facilitates the process of the average applicant taking an informed decision. Similarly, the brokers' regulation brought into place the active role that a broker can play in corporate risk management — not merely broking a deal. Another important development to promote the cause of health insurance is the introduction of Third Party Administrators. The institution of TPAs ran into rough weather initially but lately it is falling into place and can certainly claim to be an important element of all the growth that we have been witnessing in health insurance.

A landmark development during the period has been the detariffing of non-life insurance business. When it was originally mooted, there have been several reservations whether the Indian players have sufficient maturity to operate in a free environment. More than a couple of years after detariffing, no major upheavals have been observed; and the prices are certainly showing a stabilizing trend that should indicate stronger relationships between the insurers and the insured. It has often been said that life insurance in India has its roots only in traditional forms of products. The surge of ULIPs has set this argument at naught, although it has been perennially debated whether we have a healthy mix of market-related products and the traditional ones. Promoting micro-insurance products has been another key reform that aims at making financial inclusion a reality. Above all, there have been rapid strides of progress in the realm of monitoring and supervision which are so vital for the confidence of the average policyholder.

'Innovations and Developments in the Liberalized Environment' will be the focus of the next issue of the **Journal.** We look forward to a healthy debate on the issue.

Years of Innovations

in the next issue...

Adding Value to Your Client

Best Practices in Non-life Insurance

S. L. MOHAN REMARKS THAT THERE IS NEED FOR INSURERS TO EMPHASIZE ON THE BEST PRACTICES WHILE RENDERING CUSTOMER SERVICE WHICH WILL IN DUE COURSE BE THE DIFFERENTIATOR BETWEEN THE BEST AND THE 'ALSO-RAN'S.

To understand and appreciate the best practices prevailing today in the insurance industry, there is need to recall the history of origin and gradual development of insurance practices over the centuries.

In 2500 B.C., rich people in Babylonia gave loans to small caravan traders, who had to repay the loan with interest on safe arrival of their goods. Rig Veda (one of the four Vedas of the Aryans in India) refers to "Yogakshema" suggesting prevalence of 'community insurance' amongst the Aryans in India around 1000 B.C. The origin of life insurance can be traced to ancient Rome, where burial clubs formed by the citizens would pay for their members' funeral expenditure as well as make some payments to rehabilitate survivors of deceased members. With the progress of civilizations, social institutions and welfare practices took deep roots. Insurance, as we see it today as a well-developed financial sector industry, owes its existence to the year 1688 in Lloyd's Coffee House in London where merchants, ship-owners and insurance underwriters conceived the concept of insurance for encouraging entrepreneurs by sharing the loss incurred by them because of fortuitous events during their adventure, particularly losses arising from maritime voyages.

In the early days, insurance was practiced without any written document simply to make good the genuine seen loss / losses of known members. As gradually unknown parties and unseen losses started entering the scene, there was need to write the rules of the game and enter into clear unambiguous insurance contracts, which paved the way for evolution of insurance principles like Utmost Good Faith, Insurable Interest, Indemnity, Contribution, Subrogation, Proximate Cause and so on to ensure that the practice of insurance did not result in the victim profiteering out of a calamity, but just rehabilitated the victim to the position which he enjoyed on the eve of the calamity.

Over the centuries, the insurance and the insurance of insurance (namely, Reinsurance) have attained the status of an industry. Insurance and reinsurance companies render valuable services in the financial sector. These institutions practise sound ethics and transparency and are subject to supervision by government and regulators. Management of insurance fund calls for absolute professionalism, transparency and efficiency on the part of all stake-holders, viz. insurers, inter-mediaries, insuring public, policy-holders, regulating authority, Government and so on. Today's corporate world firmly believes that they owe their existence to the consumer; and that 'consumer is king'. This has led to self-regulation and voluntary adoption of best practices by all stake-holders in all segments of the economy. Falling in line with these pro-consumer developments, association of insurers in most of the countries, including General Insurance Council in India, have adopted codes of best business practices with the following objectives in mind:

Today's corporate world firmly believes that they owe their existence to the consumer; and that 'consumer is king'.

- Make clear the standard of good insurance practice that can be expected while entering into insurance contracts and in the event of claims there-under;
- Disclose information which are relevant and useful so that customers can make informed decisions and contract insurance policies effectively;
- Enlighten the customers about their rights and obligations under insurance policies;

- Commit to high standards and professionalism in all transactions and recognize and respect the rights and interests of customers; and
- Promote and enhance the insurance industry's image and standing as a responsible service-provider and good corporate citizen by
  - conducting business based on the basic spirit of respect for human dignity,
  - observing the laws and rules sincerely and responding to the expectations of society at large;
  - exchanging communications with all concerned parties in a positive and pro-active manner; and
  - rendering easily comprehensible and user-friendly insurance services, and thereby cementing the *raison d'etre* of insurance business;
- Strengthen the role of Regulator by practicing self-regulation and encourage independence, accountability, transparency, integrity and market responsiveness;

We shall examine some of these practices which are in vogue globally today:

Before and at the time of conclusion of insurance contract:

- Insurers to try and ensure that all information contained in their sales materials/prospectus/brochure/ leaflets/illustrations is current, correct and expressed in plain language and is not misleading to the public;
- 'Consensus ad idem' is applicable to all contracts and is more pronounced in the case of insurance contracts, which seek to sell intangible security to the policyholder (or insured). To ensure that this aspect is well addressed, the insurers to furnish all material information about the insurance product in their prospectus in plain and simple language so that the customers can beforehand read and understand the insurance coverage and exclusions under the policy in question. (Rule 11 of Insurance Rules, 1939);
- Proposal form as well as the accompanying additional questionnaire, if any, shall ask questions in plain language and, if appropriate, illustrate how the questions are to be answered.
- Proposal form calling for the disclosure of material facts, shall:
  - prominently explain the consequences of a failure to disclose all "material facts" (i.e. facts relevant to the insurers' decision whether or not to provide coverage) and
  - highlight that, in addition to answering questions asked in the proposal, the proposer must also include any facts that an insurer would regard as likely to influence the insurer's assessment and acceptance of the proposal; and
  - warn that if the applicant is uncertain as to whether or not some facts are material, those facts should be disclosed
- It shall be insurer's duty to ask clear and specific questions in the proposal form/ accompanying questionnaire for eliciting all information/data/facts considered to be material to the particular type of insurance;
- Insurers to avoid questions which will require a knowledge of certain facts and which an average applicant is unlikely to have;
- The insurers and intermediaries working on behalf of the insurers to present a true and fair view of the product being sold to the proposer.
- The scope of cover, the exclusions and limitations of cover, the conditions that the policyholder is required to comply with, the claims intimation and documentation requirements, loss minimization requirements before and immediately after a loss, the in-house machinery for grievance redressal and the external avenues for resolving disputes etc. to be informed to the proposer or policyholder in clear and simple language at the point of sale.

Proposal form as well as the accompanying additional questionnaire, if any, shall ask questions in plain language and, if appropriate, illustrate how the questions are to be answered.

- Insurer to keep in mind the best interests of the policyholders while designing insurance products and offer appropriate protection without jeopardizing underwriting standards and at rates and terms that are fair as between the client and the insurer.
- Insurers not to use unlicensed intermediaries or sales channels that have the effect of circumventing the legitimate sales channels or use of unprofessional sales methods.
- Insurers not to provide any remuneration or financially significant facility to the licensed intermediaries or others that have the effect of exceeding the prescribed limits in whatever manner.
- Insurer not to engage in any activity that has the effect of offering an additional inducement to the insured or any one associated in the purchase of insurance, in any form, to influence

the placement of the insurance with any given insurer;

- Insurer not to be a party to any insurance plan where the benefit of the financial terms accrues to an intermediary or person associated with the insurance plan at the cost of the insured persons. Insurers shall aim that any reductions in premiums accrue to the benefit of the persons insured.
- As far as practicable, every proposal for insurance shall be based on a proposal form that contains questions dealing with all information that is relevant to the assessment of risk and ensures disclosure of all material information by the proposer.
- Where the proposer completes a questionnaire in addition to the proposal form for the purpose of assessment of the risk, the questions shall be comprehensive and in simple language and the proposer shall be made aware that the duty of full disclosure applies equally to the questionnaire.
- In types of insurances where the policyholder has a reasonable expectation of renewal, the insurer shall make it clear even at the point of first sale, if it wishes to retain the right not to renew or to offer renewal at higher terms or with restrictions on cover. Where the insurer wishing to exercise this right shall give reasonable notice to the policyholder before the date of expiry of the current cover with regard to the renewal and the terms so that the policyholder has adequate time to look for cover elsewhere if he so wishes.
- Consideration in insurance contracts — Premium – "No risk to be assumed unless premium is received in advance" (Sec. 64VB of Ins. Act) — This is the best practice prevailing in India.

After conclusion of insurance contract:

- Insurers to draft policy document, as far as possible, in simple and plain language. The documentation to be designed and presented with the aim of aiding comprehension by consumers;
- Insurers to use only the prescribed policy and endorsement wordings for various covers as far as possible.

Indian market and policy documentation

- Hon'ble Courts in India have time and again expressed difficulties in understanding the non-life insurance policies, and have appealed to the insurers to simplify the language used in their policies;
- Non-life insurance companies in India are now considering issuance of one-page policy and of policy in electronic form.

Claim Servicing

In the event of any claim under the insurance contract, the insurers shall:

- handle all claims efficiently, speedily and fairly.
- not impose arbitrary and unreasonable time limits for reporting claims. A policyholder is required under the policy terms to report a claim and subsequent developments as soon as reasonably practicable, unless there are valid reasons requiring claims to be reported within a specified time/ period.

The proposer shall be made aware that the duty of full disclosure applies equally to the questionnaire.

- not repudiate a claim by a policyholder on the grounds of
  - non-disclosure of a material fact which the policyholder could not reasonably have been expected to disclose, or if the insurance was issued without the policyholder being requested to submit a proposal;
  - on the grounds of misrepresentation unless this is a deliberate or negligent misrepresentation of a material fact,
  - on the grounds of a breach of warranty or condition if the loss is unrelated to the breach in the absence of fraud by the policyholder;
- make claim forms readily available to claimants free of charge;
- explain what information is required for a claim and the procedures for making a claim in plain language;
- promptly respond to reasonable requests by claimants for assistance in making a claim; and
- provide information as to the internal dispute resolution procedures of the insurer and the availability of the external dispute resolution procedures, if any dispute remains unresolved.
- use plain language in claim forms and design them in a manner that aids comprehension, identify in the first communication all the information/ requirements that the insurer needs to process the claim and also explain the manner in which such information/ requirements are to be provided/ complied with.
- promptly consider and determine the claim, once all of the information/ requirements of the insurer have been received/complied with;
- keep relevant persons reasonably informed as to the progress of the claim
- advise a claimant within the specified time - as to whether a claim has been accepted or rejected. If a claim has been rejected the insurer shall advise the claimant of the grounds, in general terms

at least, for the rejection. (Note: However, the insurer is not required to disclose anything that may prejudice the insurer in the event of the rejected claim being pursued through judicial forums);

- make payment of the claim as soon as is practicable, if a claim is admitted and the amount payable determined;
- ensure that third party appointed by insurer for investigation of the claim is member of relevant professional body, practice professionalism and comply with the relevant rules, regulations, laws, codes of conduct, etc.
- insurers shall establish claims settlement procedures in a time-bound manner to assure prompt, fair and friendly settlement of claims. The claims procedures and time schedules shall be publicly disclosed at the insurer's offices and website. The claims forms and instructions for documentation of a claim shall be posted on the website to enable any person wishing to file a claim to download and print them for his use. Insurers may also consider on-line filing of claims intimations.
- As far as possible, the claimant shall be informed of all documentation requirements and all queries arising from the claims documents shall be raised at one time. The insurer shall not be seen as reluctant to process a claim to settlement.
- An in-house review machinery to resolve any disagreements in respect of a claim between the claims staff of the insurer and the claimant shall be established and activated in cases of claimant dissatisfaction

For management of insurance agents, the insurers to

- ensure that the insurance agents engaged by them comply with the requirements prescribed by the insurance regulator and are not disqualified in any manner whatsoever;
- be liable for the actions of their appointed agents in the course of their agency;
- establish procedures/systems for dealing with complaints against their insurance agents;
- provide education, training, support facilities and materials to the insurance agents to enable them to render proper service to the customers;
- ensure that insurance agents act honestly, in carrying out business on behalf of the principal, particularly when dealing with clients' money;
- ensure that insurance agents keep client information confidential.

As far as possible, the claimant shall be informed of all documentation requirements and all queries arising from the claims documents shall be raised at one time.

Conduct by insurers

- to conduct their affairs honestly and fairly and in a manner consistent with the public interests;
- to promote image building of the industry;

Inquiries, complaints and disputes; and grievance redressal machinery

Insurers to handle inquiries in a fair and timely manner, and have documented internal complaint-handling mechanisms which meet the following minimum standards.

Internal Inquiry and Complaints Arrangements

Insurers to have in place internal complaint-handling procedures for attempting to resolve complaints by policyholders. The procedures shall

- be readily accessible to all persons who have an interest in a policy and be free of charge to the complainant so that the procedures can be easily invoked;
- provide for the appointment of a complaints officer who has authority to resolve most complaints within a reasonable period and without further referrals within the insurer; and
- advise the complainant in writing of the outcome of the complaint and, if the complaint has not been resolved to the satisfaction of the complainant, of the grounds for arriving at this decision as well as information on further actions that the complainant can take through external dispute resolution mechanisms.
- The grievance redressal machinery of an insurer to act in an impartial manner and handle grievances with sympathy for the claimant.
- Grievances to be disposed off within specified time schedule so that the complainants are not put to unnecessary delays in being attended to.
- While communicating final decision, aggrieved party to be given details of further avenues open to him to seek redressal of his grievance.
- Insurers to participate in the external dispute resolution mechanisms as prescribed under the laws.

Healthy competition

- Insurers to refuse to quote for business where they are not allowed an opportunity to seek underwriting information to help them assess the risks;

- Insurers to use market standard information forms to elicit information on risks offered for insurance as a minimum standard of information to be provided. This will be without prejudice to the right of an underwriter to require more information or an inspection of the risk prior to offering quotation for cover;
- Insurers to report to the Authority any cases of improper conduct or non-compliance with the Rules/Regulations;
- Insurers not to offer illegitimate inducements to influence business to themselves.
- When competing for business, insurers to bear in mind the importance of sound underwriting and to exercise discretion in judicious manner;
- Where a client (or its broker) decides to move an insurance from one insurer to another, the insurer who is taking over the account to be entitled to check with the previous insurer regarding the claims experience and other matters relevant to underwriting and the previous insurer to furnish the information promptly.
- After an account is introduced to an insurer by a broker for quotation of terms, the insurer not to approach the client to place the insurance directly with it. However, there is no bar on an insurer who is already trying to win over a client's account from refusing to quote to a broker on that account.

General: Insurers to:

- compile their respective companies' business statistics/data with accuracy and regularity and share them with all stake-holders and enforce market discipline;
- invest the policy-holders' funds safely, generate optimum yields and bring down the cost of insurance for the consumers at large;
- introduce latest Information Technology solutions for minimizing cost, enhancing productivity and improving servicing standards;

Consumers to receive disclosure of any actual or potential conflict of interest in relation to the transaction in question.

- pro-actively promote and participate in public financial education;
- continuously engage themselves in Research & Development and bring about innovative practices and products for the benefit of consumers;
- be mindful of the effects of their decisions both at the macro level as well as at the micro level;
- assist their governments in designing insurance regulation attuned to basic principles of economics and insurance; and
- conduct open, transparent, ongoing, and meaningful consultation with industry and other stakeholders, routinely;
- incentivize desired behaviours and dis-incentivise undesirable ones for promoting orderly growth all around;
- adopt a zero tolerance approach to misconduct and indiscipline
- encourage and promote risk management and actuarial science for fundamental discipline in the market;
- adapt their business strategies for servicing consumers in different segments of markets and create sound market conditions where professionalism prevails.

Indian Insurance Act, 1938 read with Insurance Rules 1939 specifically provide for addressing the above-referred matters. These statutory provisions have been further reinforced by subsequent Regulations framed by Insurance Regulatory & Development Authority vide IRDA (Insurance Advertisements and Disclosure) Regulations, 2000; IRDA (Protection of Policyholders' Interests) Regulations, 2002; IRDA (Manner of Receipt of Premium) Regulations, 2002; etc.

Insurers' Councils constantly monitor and make amendments in their Codes of Business Practices in the light of developing market circumstances from time to time. The following three principles are used to test whether a given practice in the insurance industry is the best one which can instill consumer confidence:

- Client's interests come first or in other words "Priority of the client's interest": Whether the practice puts the interests of policyholders and purchasers of insurance ahead of interests of other stake-holders;
- Disclosure of actual or potential conflicts of interest: Consumers to receive disclosure of any actual or potential conflict of interest in relation to the transaction in question;
- Ensuring product suitability, in other words that the product sold is the right one: Product sold meets the needs of the consumer.

In a way, these Business Practices indicate that the insurance industry of today is by and large of the consumer, for the consumer and by the consumer.

The author is Secretary General, General Insurance Council. Views expressed in this paper are personal views of the author and not of the institution/organization he represents.

Best Practices in Reinsurance

In the Best Interests of the Industry

K.L. NAIK OBSERVES THAT IN THESE TUMULTUOUS TIMES, THE EMPHASIS FOR INSURERS AND THE REINSURERS SHOULD BE ON UNDERWRITING PROFITS RATHER THAN DEPENDENCE ON INVESTMENT INCOME TO TURN THE CORNER.

Introduction

The basic principles and practices of reinsurance are uniform and are universal. Utmost good faith in reinsurance by Treaty method is believed to be utmost blind faith of all reinsurers in good underwriters and good underwriting standards of insurance companies.

Trust becomes a tradition in long-term relationship of insurers, reinsurers and retrocessionnaires. Reinsurers 'Follow the Fortunes' of insurers in legal and technical aspects of claims settlements. Reinsurers are not only carriers of risks underwritten by insurers but they are experienced advisers in risk-management for insurers in the risk transfer trade of insurance.

After the WTC attack losses, in practice there is a visible shift of Afro-Asian insurers to rely more on Afro-Asian reinsurers.

Reinsurers provide automatic capacity to insurers by accepting a share on reinsurance treaties and also extend support of their higher financial strength to insurers who have limited equity base. After the WTC attack losses, in practice there is a visible shift of Afro-Asian insurers to rely more on Afro-Asian reinsurers. This trend is further accentuated after the global recession which has impaired the financial strength of many western reinsurers in greater grips. It is as if the recession has resulted in the cart being put before the horse.

As 'parameters of economies', both insurers and reinsurers have to look for underwriting profits irrespective of investment return, particularly during current trends of recession in global economies.

Reinsurance In Theory And Practice

Reinsurance is like a shock-absorbing device in a Motor Car. Its function is to make the journey comfortable on Roads with Humps-Bumps-Potholes — of losses! Reinsurance is to neutralize the damaging impact of large man-made and natural cat losses. In summing up the insurer-reinsurer relationship, one may say:

- When loss of Insurer ONE
- Is shared by Reinsurers MANY
- All Survive — it breaks not ANY.

Insurers have a limited equity base and especially in recessionary trends, more capital is required. The solution is more reinsurance which provides support of the capital base of reinsurers with their huge free reserves. New capital is not needed by insurers. Reinsurance protection keeps them safe as a disaster management tool to avoid management disaster!

Capacity for Insurers

Coverage of All Perils of Direct Policies
+ Confidence In the Security of Reinsurers
+ Continuity of Reinsurance Relationship after losses during Reinsurance Treaty Period
= Capacity to cover any Risk accepted by Insurer Automatically, Simultaneously and Continuously!

Reinsurance is an International Trade with transactions in foreign exchange. If writing a risk is like eating, reinsurance underwriting of a risk can be likened to digesting.

Reinsurance Underwriting =

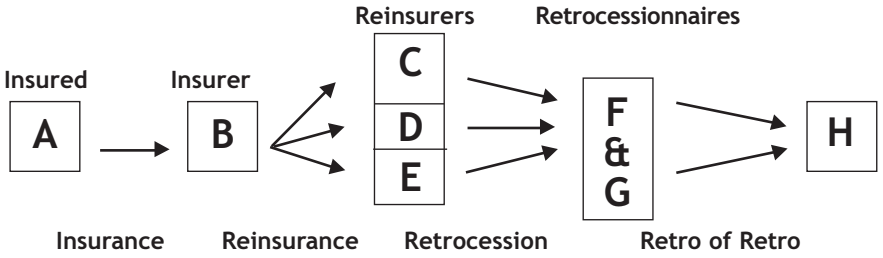
— Fixing of retentions for any one risk
— Creating Treaty arrangements with capacity class-wise to minimize Fac Re.
— Protecting net retention by XL treaties.

Example:
Company's Financial Strength is 1,000 mn.

Fire Surplus Reinsurance Treaty is created as under:

Net Line : 30,000,000 Any One Risk SI

Reinsurance by Global Risk Transfers — Global Spread of Risks



20 Lines Fire Surplus Treaty : 600,000,000 Any One Risk SI

Total Automatic Capacity : 630,000,000 Any One Risk SI

Net Capacity of 30 mn. is increased to 630 mn. by Fire Surplus Treaty which creates a capacity of 600 mn. supported by all participating reinsurers.

Reinsurance programming for each insurer is done for each year. Reinsurance programme is designed — reviewed and renewed every year for each class of business. Facultative reinsurance is not a part of reinsurance programming as it is for balance of a risk sum insured after automatic capacity.

Facultative reinsurance is not a part of reinsurance programming as it is for balance of a risk sum insured after automatic capacity.

Again there may be 50 risks with maximum retention up to 30 mn. for each risk and there may be a flood loss of 300 mn.

An Excess of Loss Reinsurance Treaty programme is arranged to protect the insurer as under:

Layers	XL Cover (mns.)
I	30 x 20
II	50 x 50
III	100 x 100
IV	300 x 200
	480 x 20

Out of the flood loss of 300 mn., reinsurers pay 280 mn. and insurer's net loss is only 20 mn. Thus, reinsurance by treaty method creates capacity as well as 'protection against accumulation of many risks in an event of loss'. Prompt payment of premiums by insurers and prompt settlement of losses by reinsurers are very vital.

Facultative reinsurance is for single current risks and Treaty reinsurance is for portfolio of future risks. Treaty reinsurance is a relationship with future obligations for a very long time! It is obligatory for both parties.

Reinsurance Broker's Role

Reinsurance brokers handle 87% of global reinsurance premium of approximately US$300 Bn!

A reinsurance broker builds bridges and breaks barriers as a 'reliable, reasonable, reachable, responsible, resourceful' intermediary of international reinsurances with the best of know-how as also know-who.

The precision with which reinsurance brokers generate reinsurance relationships can be said to be a combination of the report of a scientist, the intuition of an artist and the insight of a businessman.

Value Added Services which are rendered by reinsurance brokers are:

- Organising in-house training to insurance company's staff; and officers of underwriting and accounts departments.
- Organising market seminars for participants from market's insurance companies.
- Providing current information data.
- Assisting with analytical review for renewal of reinsurance programmes with possible improvements.

Security rating of reinsurers

Rating agencies like Standard & Poor and A. M. Best are acceptable agencies. But during a period of recession, best securities can be collapsing! It is being reduced to poor standards of rating. Is it really a time to rate the rating agencies?

Rating requirements prescribed by regulators in various markets are followed by insurers when they reinsure their programme. 'AAA' is the best rating. 'BBB' is reliable rating. Below 'BBB' is vulnerable rating.

Reinsurers with huge capital base and reserves have also been weakened by WTC attack losses. Out of 14 'AAA' rated reinsurers only two reinsurers retained 'AAA' and the others were down graded! Recession has added to the downward rating levels. (It is ironical that a reinsurer like GIC Re is not rated although their rank is 16th among the first 25 reinsurers rated by Standard & Poor as on 16th March, 2009).

Health and Microcare

Risks of Health and Microcare have a number of small losses with large aggregate loss ratio in an erratic movement of losses over a period of 3 to 5 years! Stop Loss XL reinsurance method is suitable to protect the balance sheet results by stopping the loss ratio at a pre-decided point and transfer the balance of losses to reinsurers.

Example:

Est. annual premium is 100 Mn.

Stop Loss XL Cover: 50% of 100 Mn. x 75% of 100 Mn.

If losses of actual premium are 100% reinsurers pay 25% and balance sheet loss is of 75%.

Reinsurance of Terrorism

After WTC attack losses, reinsurers exclude sabotage and terrorism from reinsurance treaties. Reinsurance slips are with complete lists of exclusions, main clauses with latest wording. Sabotage and Terrorism market pools are created and reinsured, like the Indian Market Terrorism Pool for Fire — Engineering Classes.

This pool was affected by terrorists' attack on Mumbai on 26th November, 2008 and insured losses are approximately 5,000 to 6,000 Mn. Indian rupees. The reinsurance protection is renewed with increase in premium base of the pool; and reinsurance premium is also increased. Market terrorism pool gets cessions from each insurer as a member of the pool. The rates of risks are prescribed by the pool management. Reinsurance protection is also arranged by them.

Reinsurance of Agricultural Risks

Agriculture Insurance Company of India reinsures agricultural risks of staple crops, commercial crops etc. Reinsurances of these risks are arranged by Proportional reinsurance treaties. Plant diseases and crop failures are covered by insurances and reinsurances.

Reinsurances of life insurance risks

Reinsurance requirements of life insurance are in respect of life related Health, Group life liabilities or large risks life insurances or losses due to Tsunamis and Natural Catastrophes. AIDS is to be covered as a 'disability' rather than a 'disease'! Reinsurance of AIDS affected people is arranged as is the case in many countries in Africa.

Reinsurance in practice is a long term, stable, mutually supportive relationship between insurers and reinsurers; and among retrocessionnaires.

Commercial vehicles TPL pool has aggravating loss ratios and reinsurance protection is so far not arranged!

Reinsurance of private motor vehicles TPL is arranged by respective Indian insurers along with Motor O.D. vide their Motor & Liability XL reinsurances.

Response Time in reinsurance

- Reinsurer as a leader should provide quotes to the ceding company very promptly and should finalise all terms mutually well in time for renewal date of the reinsurance programme. Best practices in this regard demand that if renewal date is 1st January, the terms must be finalized by the 10th December every year.
- Placement of reinsurance programme should be completed by the end of third week of the last month. Signed lines of reinsurers should be finalized and advised by the ceding companies before the attachments of risks.
- Accounts should be rendered within 15 days of the end of the quarterly period and confirmation should be given immediately to avoid delay of remittances from either side.
- Cash Loss calls should be promptly attended with remittance by reinsurers.
- Preliminary loss advices and details of claims must be provided to reinsurers with all details of survey report etc. to avoid delay.

All that is ideal is not real, therefore ideals are to be realized by best practices.

Conclusion

Reinsurance in practice is a long term, stable, mutually supportive relationship between insurers and reinsurers; and among retrocessionnaires.

A suspicious reinsurer or a non-cooperative reinsured cause fractures in the reinsurance relationship. 'Faith in the Future', — 'Fear of the Unknown' — 'Mutually Co-operative and Supportive' approach helps to make reinsurance relationship longer lasting. 'Back to the Basics' is the main lesson to be learnt by insurers and reinsurers to survive through best practices in the world of reinsurance.

IRRM = International Risk Research and Risk Management is a continuous process in the global market scenario for insurers and reinsurers. The same acronym IRRM may also be interpreted thus for a healthy reinsurance industry to be in place:

Insurance is Risk Transfer Trade; Reinsurance is Risks Global Spread.
Retain part and Reinsure the rest; Maintain Utmost Good Faith best.

The author is CEO, J. B. Boda Reinsurance Brokers Pvt. Ltd. Mumbai.

Braving the Turbulence

Best Practices in Third Party Administration

MALTI JASWAL ASSERTS THAT ALTHOUGH THE INSTITUTION OF TPAs STARTED WITH THE PRIME OBJECTIVE OF PROVIDING CASHLESS HOSPITALIZATION, IT HAS CURRENTLY GROWN INTO A WIDER DOMAIN OF OUTSOURCING OF CLAIMS AND CUSTOMER SERVICE.

Background

Third Party Administrator, or more popularly known as TPA (Health), is a relatively new entity in the Indian insurance industry and came into being after IRDA brought out the TPA Regulations in 2001 and first set of licences were given in 2002.

Against the backdrop of predominance of 'Mediclaim' by public sector insurers, the role of TPA during initial period was primarily to ensure:

- Member enrolment and issuance of ID card
- Organising cashless hospitalisation through network hospitals
- Processing of claims
- Redressal of customer grievance

There is a growing interest and awareness about health insurance as it emerges as an important source of healthcare financing.

Sensing a good opportunity to fill the gap, 8-10 TPAs started operations, mostly managed/owned by ex-staff of public sector insurance companies, some supported/financed by a few corporate groups. Besides capital requirement of Rs.1crore, at the minimum a 24*7*365 call centre, a few medical doctors, insurance qualified professionals and a basic IT capability was all that was required to set up a TPA operation and continued to be so for initial years. What started primarily to provide facility to health insurance customer to avail cashless hospitalisation eventually took the shape of outsourcing of customer service and claims management to a large extent over a period of time as we shall examine.

During the last few years, the health insurance segment has undergone a tremendous change from being one of the miniscule lines of business to a major focus segment for all insurers. Products with different features and benefits for an entire range of customers from HNIs to BPL population are now being offered by all insurers to cater to current times. There is a growing interest and awareness about health insurance as it emerges as an important source of healthcare financing.

Alongside, a high incurred claim ratio (ICR) due to various reasons has brought into focus the necessity to control claims cost without compromising:

1. Quality of health care

2. Customer satisfaction

Being an intrinsic part of health insurance industry, the above developments have led to a perceptible change in the role of TPA and it now includes, but not limited to

- Controlling/managing the healthcare cost through various ways:
  1. Negotiating best deals (tariffs / packages / discounts) with hospitals
  2. Negotiations at the time of extending cashless approval
  3. Making necessary deductions for charges that go against the established medical protocols, examining necessity of treatment, length of stay, case management etc
  4. Verifying the insured patients at the hospital
  5. Investigating and plugging fraud / malpractices
  6. In-depth MIS analysis to highlight abnormal trends / patterns and also to make use of insight based on the historical data available
- Acting as facilitator for various parties involved in health care and health insurance i.e. care providers, insurers and policy holders.
- Meeting stringent service delivery requirements with the primary aim of enhancing customer experience
- Providing value added services – health check-ups, wellness programs etc

- Playing a vital role in regularizing the health care practices, standardization of providers, standard treatment protocols, disease / investigation codes and their rational pricing etc.
- Providing detailed MIS and analytics to support prudent underwriting.

The response of the TPA industry to the growing expectations has been slow in the beginning but getting established gradually. Depending on size and strength of particular TPA, all major players have invested in building capacity and capability to serve the requirements and meet the service delivery expectations of the policy holder.

Best Practices

A popular definition of Best Practices is – "the most efficient and effective way of accomplishing a task to the best satisfaction of end user and yielding best results in a particular profession or industry, based on repeatable procedures that have proven themselves over time for large number of people / transactions. The idea is that with proper processes, checks and testing, a desired outcome can be delivered with fewer problems and unforeseen complications."

From the above definition, it is evident that in the case of TPA industry, best practices have been difficult to establish and the reasons are not difficult to guess:

- TPA industry was new as also the concept of cashless hospitalisation
- Work assigned to the TPAs was mostly unstructured and requirements changed frequently without support of detailed Manuals, guidelines, process clarity etc.
- Managing continuous and endless conflict of interest of 3 key stake holders – malpractices, adverse selection, unreasonable charges, lack of customer education and awareness etc
- Non-standard practices and non-existent regulations in regard to healthcare service providers
- Lack of trained and skilled manpower (a result of employee market and tight operating budget with irregular fee cycle)
- Lack of framework and transparent process for utilising different TPAs.

The best practices pertaining to TPAs could very well be termed as best practices for serving the health insurance customers and managing their claims.

The above limitations notwithstanding, TPA industry has moved forward and has facilitated utilisation of cashless facility by health insurance customers to the extent of 50% approximately while ensuring delivery (at least partially) on newly emerging requirements. Certain practices have been standardised and industry is geared to perform its role in the emerging dynamics of health insurance market.

The best practices pertaining to TPAs could very well be termed as best practices for serving the health insurance customers and managing their claims, though in case of TPAs, the added responsibility (and limitation) remains that of an outsourced vendor.

Following is a list of activities performed by TPAs and best practices to deliver on those activities:

1.Member enrolment: Creation of customer unique id valid throughout multiple policy periods/products/insurers, issuance of membership card with necessary details and guidebook, capturing of benefits and policy plan with different cappings, medical history, pre-existing conditions, past insurance details etc. goes into member enrolment. Once the policy data is available in soft form, the system should be capable of spontaneously generating downloadable E-Card (externally) and member profile (internally) with all necessary details on single page for ease of reference by all departments subsequently and available on-line to the insured members. Member enrolment is one of the most critical activities at the back end which facilitates smooth delivery of service subsequently. A robust system would automatically update member profile each time a claim is reported, denied or paid, reduce sum insured and maintain necessary record on the profile page.

Often there is a change in TPA by the insurance company servicing a particular set of customers; the enrolment database should be able to integrate previous policy and claims data so that customer is not inconvenienced due to change in the serving TPA.

To further remove all glitches and enhance customer experience at the time of claim, it is desirable for insurance companies to provide proposal details, copy of customer identity proof and customer bank account number at the time of enrolment data transfer.

2.Provider Network management: Creation of network of healthcare providers with adequate representation of geography, medical specialities, infrastructure, customer preference; strict due-diligence and benchmarking against set criteria; negotiations for tariffs, procedures and discounts forms part of standard best practices. A robust system captures all details of empanelled hospitals with unique id assigned to each provider and tracks the

transactions and performance of different hospitals against agreed SLAs. The Tariffs/discounts/packages and terms should be captured in the processing system with built-in checks to ensure implementation in an automated mode without need for manual intervention and minimising possibility of error. Since there may be frequent additions and modifications in empanelled hospitals, updated list should be available on TPA's website for immediate reference by insured members at any point of time.

Comparison of Providers

A robust system should facilitate customer's choice of provider from the network, comparison of facilities, infrastructure and tariffs transparently available to all. This would also address the issue regarding over charging by hospitals, at least in part. To check the malpractice among some hospitals to charge differential tariffs and terms to different TPAs and insurers, every hospital which is empanelled by any TPA/ insurer should be required to submit in writing that agreed tariffs are similar for all and are not higher than those applicable for cash paying patients.

MOU Implementation

The relationship between healthcare service providers and TPAs has been tumultuous from the inception, hence a good system should provide for standardised agreement template and pre-defined protocol for empanelment, depanelment, monitoring of service levels, timely payments etc. with provision for penalties for non-compliance. On the part of TPA, it is paramount that claim proceeds are released within time period agreed with explanation on deductions, if any and on part of hospital to cooperate in providing correct information and necessary documents on time. To bring in greater responsibility and transparency, may be a tri-partite agreement including insurer may serve the purpose in future.

System integration between TPA, insurer and hospital network would further ease the process, exchange of information and documents and lead to reduction in issues and TAT.

Registration of non-network hospitals

Though TPA industry has sufficient data in regard to empanelled hospitals offering cashless facility, not sufficient data has been captured in regard to non-network hospitals wherein customers have preferred to lodge reimbursement claims. A robust system should capture details of all hospitals that insured customers visit for treatment, in order to develop comprehensive master data of all healthcare providers. This will also help in checking fraud in re-imbursement claims.

Cost Control

Though TPAs play the role of aggregator of claims for the purpose of negotiating with network hospitals, the individual TPA strength however cannot be sufficient to garner best discount and tariffs from network hospitals. At the industry level, there is urgent need to adopt uniform practices as regards network hospitals empanelment, sharing of information and collective bargaining for the benefit of entire insured community pool. From a Rs.600 crore industry in 2002 to Rs.6600 crore in 2009, the volume in health insurance has grown at a fast pace but not corresponding discounts from hospitals, due to fragmented approach.

A robust system should capture details of all hospitals that insured customers visit for treatment, in order to develop comprehensive master data of all healthcare providers.

Various ways which can help in cost reduction without hurting the interests of policyholders are:

- Negotiating best deals (tariffs/ packages / discounts) from hospitals
- Rationalising hospital network - size and composition
- Negotiations at the time of cashless approval
- Making deductions for charges that go against the established medical protocols observed, necessity of treatment, case management etc
- Verifying the insured patients at the hospital
- Investigating and plugging fraud/ malpractices
- In-depth MIS analysis to pick up abnormal trends / patterns.

3. **Cashless Hospitalisation (enhancing customer experience)**: Facilitating cashless hospitalisation at network hospitals is the *raison d'etre* for the TPAs coming into being. The future growth of health insurance, its shape and content, is also dependent on this to a great extent. To increase the utilisation of cashless facility for the twin purposes of customer service and for overall control on claims, it is necessary that the suggested protocol and practices are followed by TPAs supported by other parties — hospital, insured, insurer (as case may be):

- 24*7*365 Call Centre to help the customer at any time of day or night
- Professional and qualified staff to confirm benefits, claims status, attend queries in a polite and prompt manner
- Pre-defined and published service standards for sanction of cashless facility, raising of query, denial of cashless facility etc. Continuous follow-up till closure is the responsibility of TPA, though it depends on the cooperation of the hospital
- SMS alerts during various stages – intimation, approval, query, denial etc to keep the customer informed at all times and preclude anxiety out of the process
- System generated record to track TAT, in and out time, audit trail of all activities
- Availability of medical staff round the clock to attend to all cashless requirements, to monitor line of treatment, medical protocol, length of stay, seek clarification from treating doctor etc and to ensure cost of care is reasonable and customary for the ailment/procedure (to work as kind of 'gate keeper' in the best interest of all even though 'medical activism' on part of TPAs is resisted strongly by healthcare providers and practioners)
- On-line facility for submission and approval of cashless request, downloading of forms, query letters, vouchers etc
- Defined responsibility and observation of uniform practices by hospitals as regards documentation, discharge protocol and billing pattern
- Timely availability of underwriting details – proposal form and 64VB compliance from insurer whenever required (most underwriting offices do not work 24*7*365 leading to problems during weekends, holidays and after office hours)
- A robust IT system enabling on line access to all-encompassing information and data pertaining to enrolment, member profile, hospital tariffs, policy benefits, past claims etc to facilitate quick and accurate processing of cashless pre-authorisation.

TPA's role is to ensure that the letter and spirit of the contract should prevail in fairness to all parties.

4. **Claims adjudication and payment:** Timely processing and payment of claims is another important responsibility of TPAs for which two most critical requirements are qualified and trained staff and a robust IT system. The best practices as mentioned above pertaining to cashless department are also applicable for claims adjudication, except the fact that correspondence and interaction with different parties is mostly in writing.

There is an external dependency on release of float funds / claims money from insurer which affects the overall service delivery and timelines. Besides each insurer has its own practices as regards claims authority matrix, repudiation, endorsements etc which play a crucial role in smooth processing of claims at TPA's end. If the line of command and communication at insurer end is multiple, it is likely to lead to confusion and delay, sometimes conflict also.

It would not be out of place to mention here that sometimes, inadvertent underwriting lapses come to light at the time of a claim and TPA is at the receiving end from customers and hospitals for this but finds itself caught in-between a delicate situation given the nature of relationship. Being a service provider to the contract between insurer and insured, TPA's role is to ensure that the letter and spirit of the contract should prevail in fairness to all parties.

To speed up payment process, zero balance account / single window system is one of the best practices at insurer end. Direct printing of cheques from bank and despatch to concerned party or direct transfer of proceeds to account through electronic transfer is another best practice which ensures that multiple handling of cheque by different parties / staff members is curtailed as also associated risks. Direct fund transfer would also help in checking fraudulent/benami insureds.

5. **Fraud and leakage control:** To tackle the issue of fraud and leakage control, best practice is to have a tiered approach which includes:
   - Raising of 'Red Flag' / Alerts based on past experience and knowledge
   - Business intelligence tools to incorporate alerts in the processing system to facilitate detection of fraud during early stage of claim
   - Random verification of patients in the hospitals
   - Detailed and thorough investigation of suspect cases
   - Use of predictive modelling, analytics and trend watch to detect nexuses, 'outlier' cases and trends
   - Internal audit and quality control process.

There is an urgent need for the different players in the insurance industry to share and exchange information pertaining to fraud and malpractices and take concerted action. A standard process for the same needs to be established at the earliest,

though exchange of information is happening on informal basis amongst different parties. Beyond denying a fraudulent claim and / or 'depanelling' respective provider, the insurance industry has been slow to take strict legal action to stamp out the fraudulent practices.

6. **Underwriting support and value add services**: TPAs are in a position to offer value added services in the form of pre-policy health check up, health camps, talks, doctor on chat etc to encourage and spread healthy lifestyle and habits among insured customers. On the health check up front, a robust system should offer real time data sharing and on-line storage of medical records to the customer and to underwriters so that record is available at all times without difficulty. The system should facilitate roll out of wellness and screening programs on a large scale, can be possible only with help of IT enabled application and network of diagnostic centres, physicians.

   TPA is also in a unique position to analyse the claims and to give valuable inputs to support prudent underwriting. Underwriting anomalies can also be highlighted and dealt with, at system level.

7. **Grievance Reduction and redressal:** A grievance arises mainly when a customer feels that promises made at the time of policy sale have not been met, his/her claim has been denied/ delayed unjustifiably, uncalled for deductions have been made from claim or treatment meted out during the claim process was unprofessional and impolite.

   If TPA would follow best practices to ensure prompt and fair settlement, respond quickly to customer queries with accurate information, exercise caution while denying or repudiating claims and to do so on valid grounds backed by policy terms, the customer distress shall be reduced to a large extent. Support from underwriters in terms of customer education and awareness would also go a long way in mitigating the hardship.

Support from underwriters in terms of customer education and awareness would also go a long way in mitigating the hardship.

   However, despite best efforts, grievances and complaints in the arena of health insurance cannot be avoided, thus there needs to be a transparent and effective mechanism to address customer issues. Best practice in this regard is to have web enabled tool to register grievances which provides 'ticket number' to the customer and tracks the grievance till the time of final resolution with in-built mechanism to escalate internally to the highest authority if resolution time goes beyond commitment. In no case, grievance redressal should exceed 48 hours.

9. **Manpower:** The most valuable asset for any business is its manpower. However in case of TPA industry the dictum applies even more because service delivery cannot happen without trained and qualified manpower. The manpower requirements of TPA industry are varied:
   - Insurance professionals
   - Medical professionals
   - Back office staff — IT, Operations, Call centre, Accounts
   - Relationship and field staff
   - Audit and Investigation staff

TPA should have system for regular internal trainings for knowledge upgradation on medical and insurance side for claims handling staff; and on soft skills side for staff interacting with customers.

Conclusion

The above is just a summary of prevailing best practices that some of the TPAs have adopted to meet the challenging demands of current times. There is an increased focus to ensure customer satisfaction and retention while bringing the claims cost down, in deed a tight rope walk which can be performed with help of a robust IT platform and capability to derive operating cost efficiency through large volumes.

Needless to mention, the imperfections prevailing in eco-system surrounding health insurance have had their impact on TPA industry also and all the players may not reflect similar vision and commitment. Having come thus far, TPA industry is looking forward to its further evolution to delivery of Managed Care, ensuring the best healthcare at fair and reasonable cost to customers of health insurance, to make health insurance viable and sustainable for all - a goal which cannot be accomplished without adequate support from regulator, insurance industry and healthcare providers.

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Market Share or Market Leadership?

Obvious Choice

R. VENUGOPAL ARGUES THAT IT WOULD BE IN THE BEST INTERESTS OF THE LIFE INSURERS TO CONCENTRATE MORE ON PROVIDING THE BEST AVENUES FOR CUSTOMER SERVICE RATHER THAN BEING OBSESSED WITH THEIR MARKET SHARE.

Market share has become the buzzword today in the market – be it in the aviation sector, insurance sector or retail marketing. The media too concentrates on this subject so much that not a single day passes without an article on market share in some portfolio in the national newspapers. The public at large and customers in particular draw their conclusions on the relevant issue. Life insurance is not an exception in this matter. Especially the public sector vs. private sector domination in this industry is a pet subject among the journalists. It may not be surprising to find that sometimes even heads may roll on the basis of loss of market share.

But the moot question is whether market share by means of percentage in the premium income is important or market leadership of a company by virtue of following the best practices and setting an example for others to follow is important. Market share may go up or down in a quarter or a year but market leadership can remain constant and the company can remain as the beacon-light for the entire industry by setting proper standards and pursuing blemishless and ethical practices. This factor has become particularly significant in the aftermath of a huge fraud in a very well-known IT company; and Corporate Governance in all the sectors, including insurance, is assuming wider importance.

Better awareness among the public, innovative products, multi-distribution channels for insurance, reduction in premium rates, better servicing techniques and more effective CRM initiatives are some of the gains of the competition.

In this article a few uniform standards and best practices in the life insurance sector are discussed.

After the opening up of the life insurance industry in 2000, it has been a golden period for the customers. Better awareness among the public, innovative products, multi-distribution channels for insurance, reduction in premium rates, better servicing techniques and more effective CRM initiatives are some of the gains of the competition. We should be thankful to the IRDA for these benefits.

However, the fact still remains that there are different standards followed by various companies with regard to proposal formats, policy formats, grace period for paying the premiums, policy revival rules, claims concession clauses and so many factors pertaining to policyholder's servicing standards.

Some initiatives have been taken by the Life Insurance Council to provide a uniform policy format for all the life insurance companies after obtaining one such format from the National Insurance Academy (NIA). NIA undertook this job as per the

The company should give some discount to the policyholder who pays his premium by e-method as it saves a lot of expenditure for the company – just as airlines and the hospitality industry give for e-booking.

direction of the IRDA. However, Life Council has not so far succeeded in this endeavor, as uniformity cannot be assumed totally in the proposal formats as it depends on the underwriting strategies and standards of each company, although there also can be a few common questions.

Normally, 30 days' time may be given to the policyholder to remit his premium and the revival / renewal procedure is supposed to be simple with minimum requirements. But above all, servicing a death claim settlement assumes a lot of importance as it is the function after the contract has ended and the person seeking the service of the insurance company is not the person who got himself insured but the claimant – may be the wife or the children and it is of paramount importance that there are no hassles in this service.

First of all, the benefits available under the policy are to be made clear to the customer. Although legally the policyholder is responsible for what he has signed, it is the moral responsibility of the agent or the representative to explain the features and benefits of the product to the customer. For this to happen, it is essential to ensure that effective sales training and product knowledge inputs to the field force have been done.

Then comes the post-sale customer calling to know the feedback of the customer, which will create the right atmosphere in the long term. Although there are some provisions like proper illustrations and free-look period to return the product – (actually how many policies have been returned under this clause is one's guess) – nothing like a personal touch by the agent after the sale. This will also remove the age-old complaint that no agent meets the party after the closure of the deal.

Then comes the conservation of the policy or the emphasis on Persistence Ratio factor whereby the policy remains in the books of the company – obtaining a new customer is four times more costly than the retention of one existing customer. Innovative methods of collection of premia are the answer for this. Besides the direct bank debits, mobile collection units etc, nothing can beat the age-old mode of keeping collection boxes in important areas of the city as it will be convenient for the customer to drop the cheque wherever he goes. But at the same time the company should give some discount to the policyholder who pays his premium by e-method as it saves a lot of expenditure for the company – just as airlines and the hospitality industry give for e-booking.

The investigation (followed by a possible repudiation) of certain early death claims cannot be fully avoided in view of the principle of Utmost Good Faith and Section 45 of the Insurance Act. Although it is easy to say that the company can be more strict in the beginning while underwriting so that it can be more liberal while settling the death claims, practically it may be difficult to implement the same in view of the huge number of proposals to be underwritten; and time and cost involved.

However, the company has to keep itself abreast of the changing environment and also needs to be sensitive that minor or insignificant misrepresentations / suppressions are not taken as a ruse to repudiate the claims. The life insurer should not take shelter under the umbrella of Section 45, which gives freedom to the insurer to repudiate the death claim within two years of taking the policy without showing concrete evidence of suppression of material facts. Actually the benefit of a life insurance policy comes out in the form of payment of its death claim and not otherwise. The insurer should be more humane in its approach in settlement of claims, especially in the case of lower and middle-income groups, and the insurer may use its discretion to pay all the death claims up to a certain amount say Rs.50000 without any question; unless there is a deep, deliberate fraud involved. This is the opportunity for the insurer to demonstrate that he is a friend in need, by empathizing with the bereaved family members. Many decisions of insurance Ombudsmen in different parts of the country emphasize the same sentiment.

Since the difference between the premium paid and the claim amount to be received is very huge, there is bound to be a temptation on the part of some people to

de-fraud the insurance company. Hence it is the duty of every company to be ever vigilant and prevent any kind of insurance fraud. Not only should the company prevent the fraud but also take appropriate action against the fraudster so that it is a deterrent to the wrongdoer and it also restores the confidence of the customers that their money is safe.

Regular communication with the customers is a must in these days of high expectations of the policyholders. This is with particular reference to new products, new interpretations with the existing provisions, the different duties and obligations on the part of the insurer and the insured. This will keep the dialogue always open between the customer and the company. This is needed in view of the long-term relationship between the two. Many a customer has complained that he has never received any communication from the insurer excepting the premium notices or the default notices.

There is a need to introspect whether the practice encourages some undesirable elements getting into business without any moral responsibility and walking away with the money.

There has been a lot of debate about a recent practice that has come to light called the 'Referral Fee' paid by an insurer to any person who gives the reference of a prospective policyholder by giving his address and other details. This person receiving the referral fee need not be an agent. He can be just anybody. That means anybody without understanding the nuances of life insurance contracts or undergoing any training can get money by just giving some reference. Is this a good practice to be followed by the insurers? There is a need to introspect whether the practice encourages some undesirable elements getting into business without any moral responsibility and walking away with the money. If any complaint is to be lodged against the referral person by the customer, the company does not have any records. Is this not tantamount to indirect rebating as this referral person may share his booty with the prospective policyholder; and rebating is prohibited under the Insurance Act? Since a substantial amount of Rs.1000 or more is paid by some of the life insurers per referral, this is a serious practice needing the thorough examination by IRDA. This may even lead to under/non-recruitment of regular agents by the companies as the referral fee method may work out cheaper for the insurers as there is no cost of training.

In an increasingly competitive environment it is imperative on the part of the insurer to keep in touch with the customers more often. This will help in the long run as life insurance is a long-term contract. It does not lead to success for the company alone; it always wins over the customer's confidence. If this is the motto of every life insurance company and it follows the best practices in each one of its activities, that day will be a glorious day for the customer and the company. The insurers will not unduly worry about their market share but they will be more focused about maintaining market leadership.

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Working in Tandem

Best Practices in Health Insurance

DR. SOMIL NAGPAL EMPHASIZES THAT THE GROWTH REGISTERED IN HEALTH INSURANCE IN MORE RECENT TIMES IS THE RESULT OF SEVERAL INITIATIVES TAKEN AS ALSO THE COMBINED EFFORTS OF SEVERAL STAKEHOLDERS.

Health insurance continues to be one of the most dynamic and fast evolving sectors in the Indian insurance industry. During 2008-09, the general insurance industry recorded a total health insurance premium of Rs.6625 crore, which is a 30% improvement over the previous year, and more than twice the level seen just two years ago[1]. By the end of 2008-09, Health insurance premium has grown ten-fold from the level in 2001-02, in just seven years. From being largely a single product marketed by four non-life insurers, today more than 300 health insurance products are offered by over 30 insurance companies, both general and life. There are also innovations to target specific segments of the insured population. For example, we now have six specific policies for senior citizens and over 30 recent health insurance products which allow entry up to 65 years of age[2].

We now have six specific policies for senior citizens and over 30 recent health insurance products which allow entry up to 65 years of age.

Despite this impressive growth, insurance and other organized forms of payment for health services, including ESIS, CGHS and other such employer schemes; only cover about 16-18% of all people in the country, which includes a substantial contribution from recent, large scale government-sponsored health insurance programmes, particularly the Rajiv Aarogyasri scheme in AP (which covers 18 million households) and the centrally-sponsored Rashtriya Swasthya Bima Yojana (RSBY) (covers about 4.9 million households as of June 2009)[3]. Even today, however, insurance constitutes less than one-tenth of all hospitalization payments in the country.

To address the issues concerned with orderly growth in numbers as also the challenges of ensuring accessibility, affordability and efficiency in the health insurance system, the importance of sustained and focused efforts on the part of all stakeholders in the health insurance eco-system cannot be over-emphasized. The redeeming factor is that the Indian health insurance sector has recognized the importance of joint initiatives by multiple stakeholders in developing best practices and standards for the health insurance industry. In a pioneering initiative by the industry – including healthcare providers as well as insurers, TPAs, and the regulator; a unique methodology which is perhaps an example for many other countries to follow, several multiple-stakeholder working groups have worked on these issues, and the emerging results are already very encouraging.

To start with, the FICCI report on Health insurance already released in July 2009 which includes Standard Treatment Guidelines for 21 common causes of hospitalization developed by the eminent clinical experts and other professionals forming part of the FICCI working group on health insurance, is an important landmark, being the first ever joint insurance-provider effort in India for this purpose. The methodology has involved an exhaustive process, wherein the content for each guideline was developed by a leading expert in the field, which was professionally edited and then peer reviewed by other experts from the same field, and again reviewed by an independent Technical Board constituted by FICCI[4].

1 *Source*: Data published in corresponding issues of the IRDA Journal
2 *Source*: Address by Chairman, IRDA in FICCI Health Insurance Conference, July 2009
3 *Source*: Websites of RSBY and Rajiv Arogyasri
4 *Source*: FICCI working group reports available at the FICCI website

Similarly, the standard definitions of Critical Illnesses which have also been worked upon in another FICCI group will not only enhance the customer's understanding of these terms but also ensure easier comparison of the product offerings in the market. Only a small number of countries like Britain, Malaysia etc have undertaken standardization of Critical Illness definitions across the market, which has now been attempted in India, and also gaining from prior international experience on the subject. The approach to make the critical illness policies even being descriptively named so that they do not provide any incorrect impression to a prospective insured (like, stating that the policy covers 'Cancer of Specified Severity', 'Stroke resulting in permanent symptoms', 'Open Heart repair or replacement of heart valves' instead of just saying Cancer, Stroke or Valve replacement, to more transparently reflect the actual coverage), is a very desirable move. The third exercise in the FICCI report, on standardizing the list of non-medical expenses should also smoothen the interaction between the patients, hospitals, TPAs and insurers by minimizing the ambiguities on what is payable under health insurance policies.

In another similar initiative, the CII working groups on health insurance had earlier disseminated their recommendations in May 2008. These working groups, however, continued to be involved with further work on these recommendations as also the implementation thereof. Standardization of important documents in the health insurance system, like the pre-authorization form and the claim form has been worked upon in these groups; and evolution of common, IT-enabled formats will certainly boost operational efficiency in the system. The availability of a simplified ICD-10 coding tool, which is available on the IRDA website, renders the task of assigning ICD-10 codes substantially simpler and easier, which then yields valuable data for the health eco-system. Similarly, the work on creating common hospital masters, and common definitions for health insurance terms, are best practices which will have long-lasting positive effects for the system.

The process of sharing these documents created in multi-stakeholder groups more widely for comments and feedback by all other entities in the health insurance eco-system, ensures that the same stands further enriched in its content and acceptability through wider dissemination and consultation.

IRDA's other initiatives, including the circulars on renewability of Health insurance policies and on Health insurance for Senior Citizens, also are examples of best practices which have been codified for implementation through official mandate. The circulars have many provisions which primarily lay emphasis on adequate disclosures, and promoting transparency and fair treatment for policyholders. These best practices will certainly contribute to enhancing the confidence of policyholders in the health insurance system, and its further development[5]. The recent IRDA committee on evaluation of performance of TPAs, in its report hosted on the IRDA website, has, in fact, a whole section devoted to best practices and customer service standards for the health insurance industry with many far reaching recommendations.

The General Insurance Council, comprising of all non-life insurers, has also contributed to the development of the above documents, as also undertaken its own activities in the above direction. The consensus on a uniform definition of 'Pre-Existing Diseases' and also on its exclusion wordings, which has come into effect from 1st June 2008, will further help the insured by minimizing ambiguity on a definition which, earlier, has been responsible for many aggrieved policyholders due to its variable interpretation.

The work on creating common hospital masters, and common definitions for health insurance terms, are best practices which will have long-lasting positive effects for the system.

The health insurance sector of the country has, thus, demonstrated its commitment to further the cause of best practices in the sector. The involvement of all stakeholders in a collaborative manner is an example for many other sectors, and countries, to emulate, without which the pace of development could have been much slower or much less smoother. The sector, however, does need that these efforts be sustained over a longer period of time, so that the Indian Health insurance system evolves in a manner conducive to all its stakeholders, be it insurers, providers or policyholders.

The author is Special Officer (Health Insurance), IRDA. This article is contributed in his personal capacity and views expressed herein do not reflect those of any organization to which he is currently or previously affiliated.

5 *Source:* IRDA website

Rashtriya Swasthya Bima Yojana

Providing Health Insurance Cover to the Poor

ANIL SWARUP EMPHASIZES THAT ALTHOUGH THERE HAS BEEN SOME SIGNIFICANT IMPROVEMENT IN THE OVERALL STANDARDS OF HEALTHCARE DELIVERY, THE ECONOMICALLY DOWNTRODDEN SECTIONS OF THE INDIAN POPULATION STILL HAVE LIMITED ACCESS AND IN SUCH A SCENARIO, RSBY CAN MAKE A GREAT DIFFERENCE.

Introduction

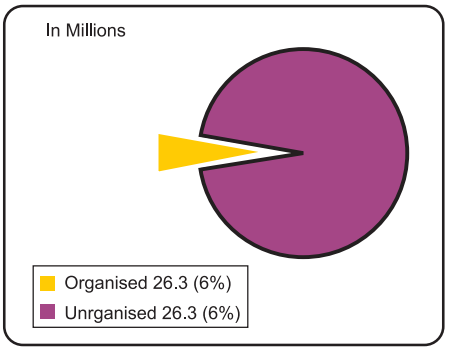
One of the most urgent and vexing problems in the developing world, more so in India, is how to finance and provide health care for more than a billion persons, most of whom are impoverished or belong to low income group. This is brought out clearly in the World Development Report 2000/2001. In most Asian countries, health care is financed by out-of-pocket (OOP) payments by individuals. These expenditures result in jeopardizing an equitable health system in developing countries. In the absence of financial risk pooling, the poor have to meet the costs of health care from their own pocket, pushing them further down the abyss.

The Indian Context

In India, around 94% of the total workforce is in the unorganized sector. In absolute terms too, the numbers (around 433 million) are mind boggling. One of the major insecurities of these workers and their families is the frequent incidence of illness and need for medical care and hospitalization. Despite expansion in the health facilities, illness remains one of the most prevalent causes of human deprivation.

It has been clearly recognized that health insurance is one way of providing protection to poor households against the risk of health spending leading to poverty. However, most efforts to provide health insurance in the past have faced difficulties in both design and implementation. The poor are unable or unwilling to take up

Fig.1: Total Workforce



health insurance because of its cost or lack of perceived benefits. Organizing and administering health insurance, especially in rural areas, is also difficult.

The common dilemma facing policy makers is with regard to the need for a Government sponsored health insurance cover when health services are being provided 'free' by the Government itself. However, the fact is that the 'free' government health services are not meeting the needs of the community. This is the reason why a lot of out-of-pocket expenses are still taking place which in turn lead to indebtedness, as is evident from table 1. It is also evident that the poorest bear the brunt of it.

The Scheme

Target Group

The unorganized sector workers below poverty line (BPL) and their families are proposed to be covered under Rashtriya Swasthya Bima Yojana (RSBY) during the next five years (2008-09 to 2012-2013).

Understanding the characteristics of the target group was found to be absolutely imperative in evolving a scheme that could have a meaningful impact. An analysis of this group reveals that they are primarily:

- Poor
- Self employed
- Illiterate
- Migratory, and
- Unskilled

Thus, the scheme had to be cashless because there was no way by which the beneficiary could raise the financial resources and then claim reimbursement from any agency. The reimbursement process itself is normally so cumbersome

Table 1: Out of pocket payments and indebtedness in some States in India (Rural)

	All India	Poorest	Low Income	Middle Income	High Income
% of people who do not use health services	18	24	24	18	11
% of people who use government services for OP	22	30	26	22	18
% of people who use government services for IP	42				
Average OOP payments made for OP (Rs)	257	191	237	243	426
Average OOP payments made for OP in Government facilities	11	9	19	9	12
Average OOP payments made for OP in private facilities (Rs)	246	163	190	211	377
Average OOP payments made per hospitalization (Rs)	5695				
Average OOP payments made per hospitalization in Government facilities (Rs)	3238	2530	2950	3017	6374
Average OOP payments made per hospitalization in private facilities (Rs)	7408	5431	5777	6781	10749
% of people who are indebted due to OP care	23	21	31	32	20
% of people who are indebted due to IP care	52	64	65	60	52

Source: NSSO 60th round 2004, Govt. of India

that it would have been virtually impossible for those below poverty line, even if they could raise the resources upfront, to claim the benefit. A large number of workers in India migrate from one State to the other in search of employment. So far, none of the health insurance schemes, or for that matter any other scheme, addresses this aspect. An added complexity emerges when only some in the family migrate and rest of them stay back. On account of illiteracy, repeated documentation cannot be resorted to and, in this sense, the cashless system was the only alternative.

Benefits

The beneficiary, under RSBY, is eligible for the following minimum benefits:

- Total sum insured of US $750 per BPL family per annum on a family floater basis. (A family would comprise the household head, spouse and up to three dependents)
- Pre-existing conditions to be covered, subject to minimal exclusions.

Coverage of health services related to hospitalization and services of a surgical nature which can be provided

- on a daycare basis. (Though OPD facilities are not covered under the scheme, OPD consultation is free)
- Cashless coverage of all health services in the insured package.
- Provision for pre and post-hospitalization expenses for one day prior and 5 days after hospitalization.
- Provision for transport allowance (actual with limit of US $2.5 per visit) but subject to an annual ceiling of US $25.

Funding

- Contribution by Government of India: 75% of the estimated annual premium of US $19, subject to a maximum of US $14 per family per annum. Additionally, the cost of the smart cards to be borne by the Central Government @ US $1.5 per card.
- Contribution by the respective State Governments: 25% of the annual premium, as well as any additional premium in cases where the total premium exceeds US $19.
- The beneficiary would pay US $0.75 per annum as registration / renewal fee.
- Any administrative and other related cost of administering the scheme in each State, not otherwise included in the premium cost, shall be borne by the respective State Governments.

Estimated Coverage and Allocation for the Scheme

An estimated 60 million BPL families (300 million persons) in 600 districts of the country are targeted for coverage by 2012-13. When all these families are covered, there would be an annual recurring expenditure of around US $ 880 million.

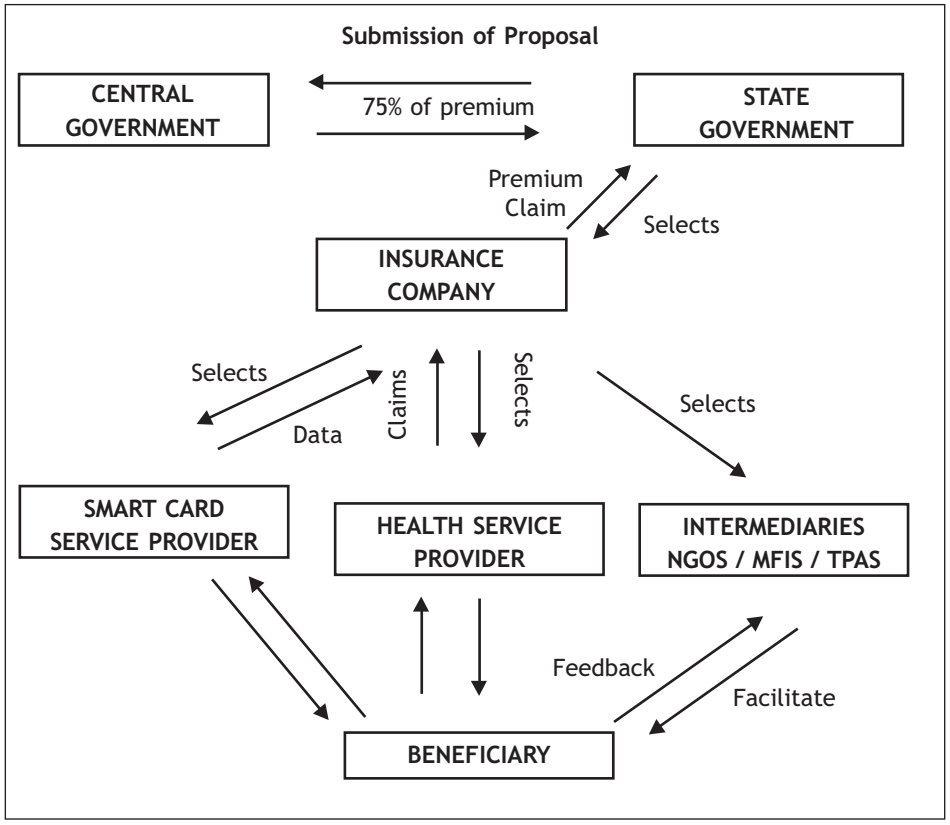
Roll-out of the Scheme

Process Flow:

The process flow under RSBY is given in ***Annexure-1***.

After the identification of the Districts to be taken up in a particular year, the State Governments are required to select one or more health insurance service providers on a periodic basis according to a tender process which would take account of both

Fig 2: Scheme Design



the price of the insurance package and technical merit of the proposal. The tender is open to both public and private insurers who meet the standards fixed by Insurance Regulatory Development Authority (IRDA).

The selected insurance company has to have back to back arrangement with:

- Health service providers
- Smart card service providers
- Intermediaries

Only such health service providers are empanelled by the insurance company as are able to meet the predefined criteria. The idea here is to ensure that though an attempt is made to keep the number as large as possible to facilitate competition and easy access, some minimum standards are adhered to. The hospitals have also to agree to a predetermined package of medical and surgical procedures and the costs thereof to obviate subjectivity. No preauthorization is required in case of predetermined packages. Majority of the ailments fall within these packages. However, in case the ailment does not fall in such packages, the procedure for preauthorization has been prescribed.

Information Technology Application

Smart Card is central to RSBY, as it enables cashless transaction as well as inter-operatibility in network hospitals throughout the country. It also enables foolproof biometric identification of the beneficiary.

The smart card is issued by the smart card service providers on behalf of the insurance company to the beneficiary. However, ownership of the card remains with the Central Government for its use in subsequent years and for other purposes. The card is personalized and delivered on the spot.

The cost, if any, is borne by the insurance company as a part of the overall bill.

The presence of the head of the family or the spouse is mandatory as his/her photograph has to appear on the face of the card. However, it can be issued in the absence of other members. Their details

can be added subsequently at the district kiosk, to be maintained by the insurance companies.

In view of the possible migration of BPL workers, there is a facility of split card under the scheme. These cards can be split at the time of first issue or subsequently at the district kiosk. Split value can be decided by the head of the family, provided the total amount on both the cards is equivalent to the total amount available on the primary card before the split. The insurance company will authorize issue of these cards.

A new card can be issued in case of loss of smart card. However, the beneficiary will have to bear the cost of duplicate card. As the details of the family are available in the database, the card can be issued at the district kiosk.

The hospitals are mandated to possess necessary hardware of predetermined specifications to read and operate the data on the smart card. Transaction software, based on the specifications, is to be prepared by the service provider for use in the hospitals.

A back-end data base management is to be put in place for transmission from hospitals to a designated server and for electronic settlement of claims to make the scheme not only cashless but also paperless. An elaborate MIS is being developed for close supervision and monitoring at various levels.

As indicated in Annexure.2, in all, 11 sets of software are being used for effective use of smart cards under RSBY.

Security

With a view to imparting security to the entire process of issuing and use of smart card, an elaborate key management system (KMS) has been evolved by the National Informatics Centre (NIC). A Central Key Generation Authority (CKGA) has been set up for creating root keys and to manage the entire key management system at the central level. The district keys are generated by CKGA. Thereafter, the keys for field key officers (FKOs) are generated at the district level. The district keys are transferred by the CKGA to the district key managers. An elaborate training schedule has been worked out for the field key officers. On the occasion of district level workshop, the FKO cards are issued to them, using the DKMA software developed by NIC.

Role of Intermediaries

The intermediaries between the insurance companies and the beneficiary have a very important role in carrying the scheme to such beneficiaries. These intermediaries can be in the form of TPA, NGOs, MFIs, Panchayat Raj Institutions or a combination of these depending upon the requirement in each region and the capacity and capability of the intermediaries. However, without such 'social aggregators' it will be virtually impossible to roll out the scheme.

The intermediaries can leverage existing network of beneficiaries and existing infrastructure in the administration of the product, thereby reducing the overall administrative cost. The intermediaries, specially the local NGOs, know the people in the area and their language. This helps them prepare an effective communication plan for awareness generation which results in a greater participation of beneficiaries in the scheme and its better understanding. Such intermediaries can also provide advice to beneficiary households wishing to avail health facilities.

Monitoring and Evaluation

Monitoring of the progress under the scheme takes place at various levels (District, State and National) by respective Governments and Insurance Companies. The parameters for monitoring relate to:

- Cards issued
- Visits to the hospitals
- Admissions and deaths while admitted
- Claims made by the hospitals and settlement thereof by the insurance companies
- Payment of premium

A robust IT enabled back-end database management is being evolved to facilitate monitoring.

The scheme also entails evaluation and impact analyses. The World Bank has already engaged an external agency to carry out a bench mark survey which would be used subsequently for evaluating the scheme as well as for undertaking an impact analyses. The two key areas likely to be covered would relate to consumption smoothing/poverty reduction and hospital utilization/health outcomes.

Challenges Faced so Far

The complex nature of the scheme, the commitment required in terms of time and finances and the preconceived notion about the social sector being an exclusive domain of the government threw up major challenges in terms of marketing of the scheme amongst the States. Similarly, on account of negative perception about government schemes and in view of upfront investments in procuring hardware, in developing software and putting in place the required manpower, there was initial reluctance on the part of insurance, smart card and health service providers in coming on board. Hence, the scheme had to be

marketed through a well defined strategy amongst each of the stakeholders.

Personal visits by senior officials to the States to market the scheme, organizing video conferences to provide on-the-spot clarifications and dispelling misapprehensions and prompt response to queries, lending a helping hand, both in terms of understanding the technology as well as in organizing sensitization workshops and standardization documents and templates went a long way in providing comfort to the States. They have gradually come to 'own' the scheme.

The scheme has been sold as a business model to the other stakeholders as there was an in-built business opportunity for them. A series of interactive sessions facilitated in conveying this message as also the fact that government meant business.

The biggest challenge for the scheme, however, has been the problems faced with regard to the data base of the beneficiaries. Such data base either incomplete or when complete, was not in the desired format. Considering the volume of the data, it has been a stupendous task to get the data in shape.

RSBY Gets Going

The response of the State Governments and other stakeholders has been very encouraging. The Scheme became operational from 1.4.08. Till 30.6.09, 24 out of 29 State Governments had advertised to seek quotes from insurance companies. 22 proposals have already been approved and, out of these, smart cards have started rolling out in 18 of them. By the end of June 2009, around 4.9 million cards have already been issued. Around 40,000 persons have already availed of free hospitalization facility.

Some of the complex IT applications have been put into operation and are gradually stabilizing.

Unique Features of the Scheme

- **IT tools for poorest of the poor**
  In all 60 million cards will be issued under RSBY during the next five years. This will be the biggest ever exercise involving IT applications for BPL families in India or anywhere else in the world. So far, IT applications had been used primarily in the urban areas. The smart card is now traveling to rural areas on such a large scale.
- **Empowering Below Poverty Line families**
  Unlike the previous Government sponsored schemes, where the beneficiaries did not have option to select the service delivery point, under RSBY, the beneficiary can choose the hospitals from a list of network hospitals, including private hospitals, for seeking treatment.
- **RSBY operates on a business model**
  In view of the numbers and the fund involved, there are business opportunities for all the key players, like insurance companies, hospitals, smart card service providers and the intermediaries. On an average, around Rs.1.5 million will be pumped in each district. This would create the business opportunity as there would be incentive for private sector health providers to set up health related infrastructure. Similarly, on account of sheer volumes, smart card service providers will have the incentive to deliver the cards even in the rural areas. The insurance companies obviously can also make decent money on account of the proposed volumes.

  A healthy tension between hospitals and insurance companies, where the former would want more patients and operations while the latter would want the opposite, will enable monitor claims data as it comes in.
- **Security of Cards**
  A key management system has been evolved by National Informatics Centre to ensure that the smart cards are fully secure. There would be no scope of cards being duplicated or being misused. The smart card also envisages use of biometrics (finger print verification).

The Challenges Ahead

The front end of the scheme is quite simple but the back-end, specially in the context of Information Technology applications, is quite complex involving a number of players, both in the public and private sector domains. Vertical and horizontal coordination poses the biggest challenge even after the stabilization of a variety of software that is being used to roll out the scheme.

The back-end data base management throws up a different challenge in terms of developing the structure and putting in place the hardware. There are some issues yet to be resolved: Who will own and manage these structures? Who will own and manage this database?

Reaching out to such huge numbers in far flung areas is a stupendous task. Evolving communication modules and delivering them on such a scale will test the capacity and capabilities of the insurance companies whose task is to sell this product.

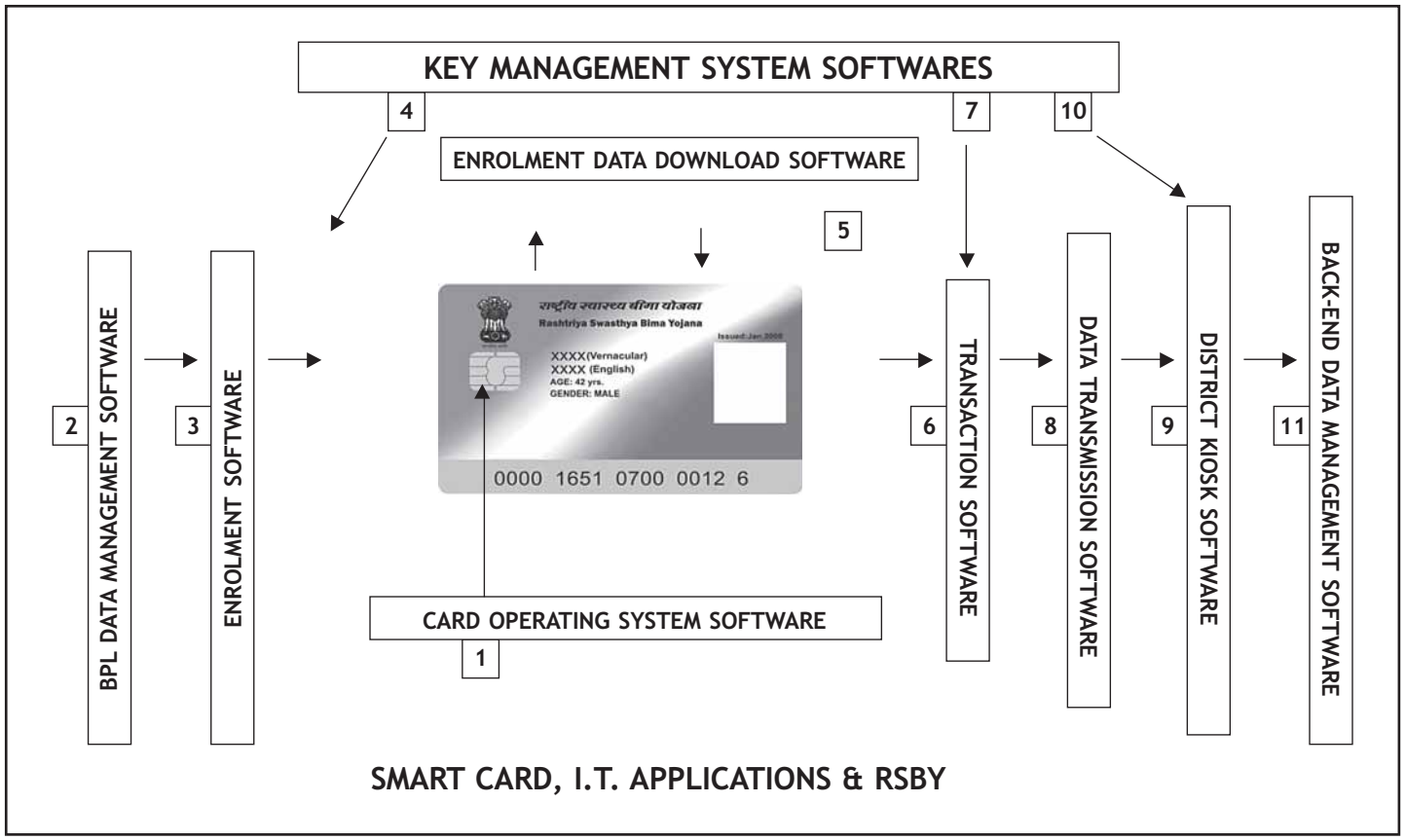
And finally, the challenge is not merely of quantity but also of quality of service by various service providers.

The journey has just begun…. there are huge challenges ahead.

Annexure I

1. The State Government selects the districts and identifies the State Nodal Agency.
2. The Nodal Agency advertises to seek quotation from the Insurance Companies.
3. Submission of quotations / bids by Insurance Companies.
4. Examination and evaluation of quotation and selection of the Insurance Service Provider.
   - Arrangement by the Insurance Service Provider with
     a) Health Service Providers
     b) Smart Card Service Providers
     c) Inter-mediaries
5. Preparation and submission of proposal to the Central Government.
6. Evaluation and approval of the proposal by the Central Government.
7. Signing of MoU between the Central and the State Government / Nodal Agency.
8. Signing of MoU between the Nodal Agency and the Insurance Service Provider.
9. Handing over the BPL Data by the State Government to the Insurance Service Provider.
10. Preparation of village-wise plan by the Nodal Agency / State Government fordelivery of smar cards in consulatation with the Insurance Company.
11. Village-wise delivery of smart cards, along with a brochure collection of Rs.30 as registration fee to be adjusted against the premium.
    - Prepa-ration of a brochure by the Insurance Co. listing out the benefits and the contact numbers as well as the hospitals.
    - Premium claim by the Insurance Company from the State Nodal Agency.
    - Claim of 75% of the premium from the Central Government.
12. Vist to the Hospital by I.P.
13. Verification of the Thumb impression.
14. Admission of the patient, blocking of the anticipated amount (on the basis of the amount indicated in the medical procedures) on the card and payment of transportation charges.
15. Treatment of the patient and taking care of the expenses thereon.
16. Discharge of the patient and debitting of the final amount from smart card.
17. Lodging of claims by the Health Service Providers from the Insurance Companies.
18. Settlement of claims.

Annexure II



The author is Director General, Ministry of Labour Welfare, Government of India.

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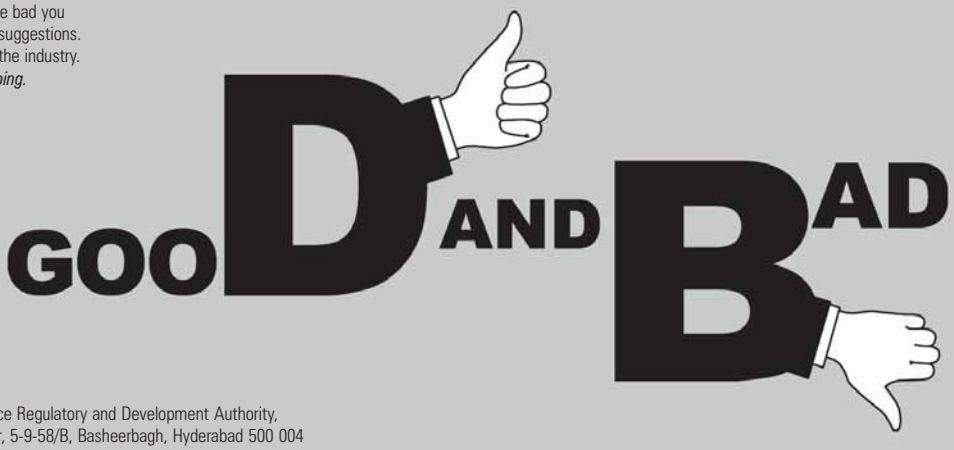

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Insurable Interest

INDISPENSABLE FOR INSURANCE

K. SUBRAHMANYAM EMPHASIZES THAT LACK OF INSURABLE INTEREST IN INSURANCE CONTRACTS STRIKES AT THE VERY ROOT OF THE PURPOSE OF INSURANCE AND REDUCES THEM TO AGREEMENTS OF WAGER.

1. The phrase 'Insurable Interest' is often not noticed or used. Section 14 of the IRDA Act, 1999 stipulates this in order to protect the interests of policyholders (the extract is given below):

14. DUTIES, POWERS AND FUNCTIONS OF AUTHORITY

(1) Subject to the provisions of this Act and any other law for the time being in force, the Authority shall have the duty to regulate, promote and ensure orderly growth of the insurance business and re-insurance business.

(2) Without prejudice to the generality of the provisions contained in sub-section (1), the powers and functions of the Authority shall include:

(a) issue to the applicant a certificate of registration, renew, modify, withdraw, suspend or cancel such registration;

(b) protection of the interests of the policy holders in matters concerning assigning of policy, nomination by policy holders, insurable interest, settlement of insurance claim, surrender value of policy and other terms and conditions of contracts of insurance;

2. Why Insurable Interest?

If there is no 'insurable interest' in an insurance policy, then the purpose of 'protection element' is defeated; it only encourages 'gambling', and 'selection against insurer'. This can be understood more in detail, once we know what is meant by 'insurable interest'?

3. What is Insurable Interest?

An exhaustive definition given with explanations goes thus:

3.1 Definition

True, valid, determinable, and direct economic stake of an insurance policy holder (or of the beneficiary of the policy) in the continued existence or safety of the insured property or person. Often stated as "an interest in the outcome of a contingency other than that arising under the contract of insurance," an insurable interest means that the policy holder (or the beneficiary) must stand to suffer a direct financial loss if the event (against which the insurance cover was bought) does occur. A tenant may not necessarily have a direct insurable interest in the rented property but the landlord may. An employer may not necessarily have such claim in the life of an employee, but a married couple may in one another's life. To an insurance company, an insurable interest is the basic reason for issuing a legal insurance cover, to an insured (or beneficiary) it gives the legal right to enforce an insurance claim.

To an insurance company, an insurable interest is the basic reason for issuing a legal insurance cover, to an insured (or beneficiary) it gives the legal right to enforce an insurance claim.

According to legal precedents:

(1) in life insurance, an insurable-interest must be present when the insurance policy is taken, but not necessarily when a claim occurs; for example, anyone who takes a life insurance policy on his or her spouse, and continues to pay premium even if the marriage breaks up, is entitled to collect death benefits under the policy,

(2) in marine insurance, an insurable-interest must be present when a claim occurs, but not necessarily when the policy is taken; for example, a supplier may obtain a blanket policy for the goods to be shipped in an year but must show that the goods were actually shipped when making a claim for loss or damage, and

(3) in most other types of insurance (such as fire or auto insurance), an insurance interest must be present, both at the time the policy is taken and when a claim occurs; for example, a homeowner who sells the house on which fire insurance was taken, cannot collect on it in case of a fire. Insurable interest is one of the foundations of insurance because, in its absence, insurance would be no different from gambling and (even if legal) would not constitute a binding agreement.

A few other definitions attributed to insurable interest are as follows:

3.2 Insurable Interest

Having a financial interest in an individual or a thing. To have an insurable interest, an individual must be in a position to suffer an assessable financial loss if a person should die or a thing is damaged, destroyed, or lost.

3.3 Insurable Interest

An interest in a person or thing that will support the issuance of an insurance policy; an interest in the survival of the insured or in the preservation of the thing that is insured

3.4 Definitions of Insurable Interest on the Web:

An interest in a person or thing that will support the issuance of an insurance policy; an interest in the survival of the insured or in the ... (wordnetweb.princeton.edu/perl/webwn)

A person has an insurable interest in something when loss or damage to it would cause that person to suffer a financial loss or certain other kinds of losses. ...(en.wikipedia.org/wiki/Insurable_interest)

An economic interest in the safety or preservation of the subject of insurance from loss, destruction or financial impairment. (www.ohiocasualty-ins.com/omapps/ContentServer)

A sufficient interest in property that loss of it or damage to it would entail financial loss to the owner. (https://www.fntic.com/wordsphrases.asp)

A legal right to a property which results in the holder of that right suffering damages in the event of the destruction of the property. (www.gibbons-realty.com/dictionary/I.html)

Condition in which the person applying for an insurance policy and the person who is to receive the policy benefit will suffer an emotional or financial loss if the event insured against occurs. (www.h-kinc.com/glossary.htm)

A direct monetary interest in the insured property sufficient to result in monetary loss should the property be damaged or destroyed. (www.lombard.ca/Glossary.htm)

Is a kind of property right the value of which may be calculated and compensated in money in the event of a loss.(www.greatamericaninsurance.com/insuranceGlossary.html)

A close family relationship, by blood or by law, and/or a substantial economic interest in the continued life, health, or bodily safety of the insured. (www.cfglife.com/cfgcgterms.htm)

Liability that may apply when a person suffers an economic loss due to personal injury or damage to his or her automobile.(www.ratemarketplace.com/insurance/auto-insurance-glossary.html)

Exists when an individual would suffer an economic loss as the result of damage to property or body. (www.carabinshaw.com/lawyer-attorney-1230612.html)

Any interest in something that is the subject of an insurance policy or any legal relationship to that subject that will trigger a certain event ... (ezinearticles.com/)

The interest of an owner, lessee, mortgagee, or trustee which is insured against financial loss in the case of specified events. (www.portlandhomesavers.com/)

Insurable interest exists when one party has a close and/or dependent financial relationship to the other. ... (www.life-insuranceuk.co.uk/glossary.html)

For a contract of insurance to be valid the policyholder must have an interest in the insured item that is recognised at law whereby he benefits from its safety, well being or freedom from liability and would be prejudiced by its damage or the existence of liability. ... (www.insure-commercial.co.uk/Default.aspx)

4. Explanation of 'Insurable Interest'

The adjective is more attractive. We have 'interest' in many things in life. 'Interest' means:

(1) desire to know about something or someone;

(2) the quality of making someone curious or holding their attention;

(3) a subject about which one is concerned or enthusiastic;

(4) money that is paid for the use of money lent;

(5) a person's advantage or benefit;

(6) a share, right, or stake in property or a financial undertaking.

We use 'compound interest' to mean interest on interest (interest has to be paid not only on the principal but also on the interest that has accrued). 'Financial interest' is used to mean 'interest element' in monetary terms. When we think of insurance contracts, we get events insured; the events can be 'death', 'disability', 'accident', 'damage to property due to specific cause', etc. Insurer, before granting insurance, shall ensure that events are insurable. The person buying insurance (referred to as 'policyholder' or 'policy owner') should have insurable interest in the event that is insured; the event could be 'damage to vehicle/thing', 'death of an individual/person' and where such event causes financial loss to the person (policyholder). If the policyholder demonstrates that he has insurable interest in the event, he can be granted insurance by the insurer. These can be understood with examples.

4.1 Example I: Mr A is the banker who has given loan of Rs. 10 lakh to Mr B, an individual. Mr A buys insurance on the life of B to cover the event - death of B, to protect himself against the financial loss in the event of death of B, as B would not be able to repay the loan (obviously after death). A has insurable interest in the insurance policy, and can be granted insurance by an insurer.

4.2 Example II: Mr X has insurable interest on his own life as he is the financial supporter for his family (to protect his family financially).

If the policyholder demonstrates that he has insurable interest in the event, he can be granted insurance by the insurer.

4.3 Example III: An employer has an insurable interest in his employees (as his turnover / profit depends upon their performance).

4.4 Example IV: Mr X has insurable interest in his car (to the amount of replacement of car in case of damage to /theft of his car).

4.5 Example V: An airlines company has insurable interest not only in the aircraft but also in respect of the individuals in the aircraft (pilot, airhostesses/crew, passengers)

Examples where 'Insurable Interest' does not exist.

4.6 Example VI: Lender has no insurable interest beyond the amount of loan granted to his borrower.

4.7 Example VII: No person has insurable interest beyond an estimated amount of financial loss on the event (to be insured). For instance, an individual earning Rs.1000/- p.m. cannot get insurance cover for Rs.1 crore, as his financial worth (human value!) does not exceed Rs.400,000/- (Approximately 20 to 22 times of annual income when the person is aged below 40). A person who has income (not earned income) only from rents/perpetuity has no insurable interest (since such income can continue even after his death to his estate)!

4.8 Example VIII: A person X cannot take insurance on the life of a person Y who is not related to X or who has no financial interest towards X. Reason X has no insurable interest in such policy.

There are several other areas where insurable interest does not exist; and as a result, are out of the purview of insurance contracts.

5. Conclusion

The Act says (see above) with regard to insurable interest that its purpose is to protect the interests of the policyholders. If this is ignored, insurance contracts could be misused by some unscrupulous elements to derive benefits from insurers which could cause concern to other policyholders (who may have to pay higher premium rates / charges). This needs to be made known to all to act in public interest.

The author is Executive Director (Actuary), IRDA. The views expressed are personal.

प्रकाशक का संदेश

ग्राहक संतुष्टि एक क्षेत्र है जो अगोचर स्वरुप उदाहरणतः जैसे वित्तिय सेवाओं से व्यवहार करता है जो बडी चुनौती है। इसी स्थान के भीतर बीमा अधिक महत्वपूर्ण स्थान रखता है - इस सत्य क्षण को मानते हुए की दावा समझौता कुछ मामलों में बहुत लम्बे समय के बाद आयेगा। अन्य में यह कभी भी नहीं आयेगा इसे ध्यान में रखते हुए की दावे का भुगतान तभी किया जायेगा जब घटनाएं घटित होती है। इस परिपेक्ष में ग्राहक के लिए उच्च मानक संतुष्टि प्राप्त करना एक लम्बा अनुक्रम है तथा समुदेशी के लिए बेहतर सेवाओं को प्रदान करना प्रतिष्ठा बनाने में दूर तब जायेगा।

बेहतर परिपाटी का चुनाव मात्र एक नित्य अभ्यास होना चाहिये जिसमे एक व्यवसायी ऐसे मानक की सूची रखता है जिससे निश्चित सीमा में प्राप्त करना होता है। यह मस्तिष्क समुच्चय का एक भाग होना चाहिये। तथा बेहतर परिपाटियों का अनुभरण तथा प्रदर्शन करना चाहिये अपने सच्चे तात्पर्य के साथ किसी व्यवसायी को यह प्राप्त करने के लिए भारतीय बीमा क्षेत्र में अतिरिक्त चुनौतियाँ हैं जिसके प्रत्यक्ष कारण भी हैं।

प्रारंभ से ही बेहतर परिपाटी की आवश्यकता महसूस की जानी चाहिये तथा बीमा कंपनियाँ एक प्रस्ताव पत्र ऐसा विस्तृत तथा कारणबद्ध प्रश्नों के साथ बनाये जिसका उद्देश्य ठीक उत्तर प्राप्त करना है प्रस्तावक के द्वारा एक ऐसे संविदा में जहाँ इमारत की भूर्ति बीमा संविदा है, अच्छी प्रथाएं एक अर्थपूर्ण प्रश्नावली तैयार करेगी जो औजार बनेगा एक स्पष्ट मार्ग चित्र बनाने के लिए। यह बहुत आवश्यक है कि बीमा लेखन करने वाले इस सूचना का प्रयोग करे जो बहुत वस्तुपरक रूप से दी गई है। और एक निर्णय पर पहुँचे जो व्यवसाय की प्राथमिकताओं को देखरेख करे और उसी समय अपने ग्राहकों को बेहतर सेवा उपलब्ध करवाये।

संविदा की गूढ़ता को संचरित करने पर बल दिया जाना चाहिये जो भावी के लिए होगी। विशेष रूप से सीमाओं / अपवर्जन के लिए जिससे बाद में हृदय को जलाने वाले विवाद के लिए स्थान न बचे जो कम से कम हो जाए। जब किसी दावे को रद्द करना अथवा स्वीकार करना असंभव हो जाए इसको बडी संवेदनशीलता तथा सहानुभूति के साथ दावेदार तक पहुँचना चाहिए। सभी व्यवसायियों को यह प्रयास हो की व्यवसाय में सर्वोत्तम परिपाटी जीवनशैली हो तथा वह ग्राहक संतुष्टि से आगे निकले।

'बीमा में सर्वोत्तम परिपाटी' जर्नल के इस अंक के केन्द्र बिन्दु में है। एक दशक से यह उद्योग खोला गया है और इस अवधि में कुछ नये उद्यम किये गए है। 'बीमा उद्योग में वित्तीय नवीकरण तथा विकास' जर्नल के नए अंक के केन्द्र बिन्दु में होगा।

जे. हरि नारायण
अध्यक्ष

दृष्टि कोण

आई.ए.आई.एस इसे लेकर प्रतिबद्ध है कि यह सुनिश्चित किया जाए की बीमा पर्यवेक्षण औजार लगातार बेहतर हो तथा विकास के साथ अछतन रहें।

श्री पीटर ब्राउमूलर

अध्यक्ष, आई.ए.आई.एस कार्यपालक समिति

एक एकल संघिय रूप-रेखा सभी राज्यों में प्रभावशाली नहीं हो सकती, क्योंकी हैल्थ कैयर की सुपुदर्गी प्रणाली जनसंख्यकीय, ग्रामीण तथा शहरी मिश्रण, अर्थशास्त्र तथा श्रम बाजार बहुत सविशेष है और वह विनियमन जो इस सविशेष के लिए असफल हुए है यह बाजार तथा उपभोक्ता का प्रभावित करेगा।

सूश्री सेंडी प्रेगर

कंसास की बीमा कमीशनर तथा एन.ए.आई.सी की हैल्थ इंश्योरेंस तथा कैयर कमेटी की अध्यक्ष

विनियामक से यह अपेक्षित नहीं है कि वह प्रचालन के सूक्ष्म-प्रबन्धन मे भाग लेगा। यह अपेक्षा की जाती है की व्यवसायी इतनी परिपक्वता का प्रदर्शन करेगे कि खुले बजार के लिए किया गया कठिन परिश्रम व्यर्थ नहीं जायेगा।

श्री जे हरि नारायण

अध्यक्ष, बीमा विनियमक विकास प्राधिकरण, भारत

दबाव परिक्षण ने यह बताया है कि वित्तीय संस्थाएं वित्तीय स्त्रोत पर कम संपत्ति मूल्य का प्रभाव पडेगा, साख दर को बढाने से तथा लाभ को संयत करने से वह दबाव की अवस्था मे आ जाते हैं।

श्री हैग स्वी कैट

प्रबन्ध निदेशक, सिंगपुर मौनेटरी प्राधिकरण

भौगोलिक वित्तीय संकट की विविध अनुक्रिया अलग अलग अवस्था मे बडी सफलता हासिल की है। वित्तीय बाजारों में स्थायित्व को हासिल करना उद्देश्य है जिससे साख का बहाव तथा भरोसा लौट सके।

डा. जेटी अख्तर अजीज

गवर्नर, बैंक निगाए, मलैशिया

विश्व अर्थव्यवस्था ने एक अपूर्व संकट वैश्विक मंदी के चलते देखा है जिसके परिणामस्वरूप वित्तीय तथा पूँजी बाजार में उत्पाद उत्पन्न हुआ है ऐसे वित्तीय संकट का अनुभव होने के कारण हमें अधिक वादानुसार जोखिम प्रबन्धन करना होगा। जिससे भविष्य के लिए हम वित्तीय भूमि मजबूत कर सके।

श्री मैसाटोशी साटो

अध्यक्ष, जापान की साधारण बीमा एसोसिएशन

जीवन बीमा पॉलिसी अंतर्गत दुर्घटना लाभ - आवेदन के विषय

गीता सरीन का कहना है कि जीवन बीमा कॉन्ट्रेक्ट अंतर्गत दुर्घटना लाभों के बारे में और अधिक स्पष्टता होनी चाहिए, जिससे कि एक सामान्य व्यक्ति भी इसे आसानी से समझ सके।

दुर्घटना क्या है? और जीवन बीमा कॉंट्रेक्ट अंतर्गत इसका लाभ कब-कब लिया जा सकता है? दूसे शब्दों में किसी की मृत्यु को जीवन बीमा पॉलिसी अंतर्गत दुर्घटना की श्रेणी में रखा जा सकता है। लगभग डेढ़ सदी के दौरान विभिन्न अदालतें और अंडर राइटर्स इस 'यक्ष प्रश्न' का जवाब तलाशने में जुटे हुए हैं। निश्चय ही इस सवाल का उत्तर दुर्घटना लाभ दावों के इतिहास और कोर्ट द्वारा समय-समय पर सुनाए गए फैसलों से प्रास किया जा सकता है।

दुर्घटना (एक्सीडेंट) का शाब्दिक अर्थ

दुर्घटना बीमा अंतर्गत 'दुर्घटना' का शाब्दिक अर्थ अेसे किसी भी आकस्मिक घटना से है जिसके बारे में कोई पूर्वानुमान हनीं लगाया जा सके अथवा गया हो। जानबूझकर अथवा सोच-समझकर बीमित की जोखिम भरे शारीरिक कार्य में हुई मृत्यु को दुर्घटना की श्रेणी में नहीं रखा जा सकता है, ना ही मौसम अथवा परिस्थितिजन्य कारकों के कारण रोग अथवा मौत दुर्घटना है। लेकिन आकस्मिक और असामान्य चोट अथवा मृत्यु को बीमा की शब्दावली में दुर्घटना माना जाता है।

भूकंप, तापाघात और आकाशीय बिजली गिरने की आकस्मिक घटना के कारण मृत्यु कारित होने को दुर्घटना माना जाता है। साथ ही यदि किसी कार्य क्षेत्र में कोई कर्मचारी बॉयलर की भीषण गर्मी से अचेत हो जाए, अथवा बर्फीले पानी में कार्य करते रहने के कारण निमोनिया और किसी खान में जलभराव की स्थिति के चलते मांसपेशियों की जकड़न का शिकार हो जाए तो इसे दुर्घटना की श्रेणी में रखा जा सकता है।

दुर्घटना

'सामान्यत तौर से विपरीत आकास्मिक रूप से घटित होने वाले घटित होने वाले घटनाक्रमों के फलस्वरूप चोट को दुघर्टना कहा जा सकता है। अतः ये ऐसी घटना है जिसके बारे में अंदाजा नहीं लगाया जा सके और जो अचानक घटित हो। दूसरे शब्दों में कहें तो ऐसी घटना जिसके बारे में कोई आशेका ही नहीं हो और जिसका कोई पूर्व लक्षण भी ना हो उसे दुर्घटना कहा जाता है।' (ब्लैक लॉ डिक्शनरी के अनुसार)

दुर्घटनाजनित

यदि कोई व्यक्ति किसी दूसरे को इरानपे की नीयत से उसकी ओर बंदूक तानता है और गोली चला देता है तो इसे दुर्घटना नहीं माना जा सकता। इस प्रकार की घटना में जानबूझकर हालात पैदा किए गए हैं। जबकि आकाशीय बिजली गिरने, तापाघात अथवा भूकंप के कारण चोट अथवा मृत्यु कारित होने को दुर्घटना की श्रेणी में रखा जा सकता है।

दुर्घटनारूपी

उदाहरण के रूप में शराब पीना एक स्वप्रेरणा आधारित कृत्य है, लेकिन इसके बाद नशे की हालत में ड्राइविंग करना स्वप्रेरणा प्रेरित नहीं है।

किसी भी पॉलिसी कवर अंतर्गत दुर्घटना लाभ के उपबंध के जरिए दुर्घटना के जोखिम को शामिल किया जाता है। लेकिन दुर्घटना के कारण हुई मृत्यु की सूरत में प्रत्येक मामले को पृथक-पृथक ढंग से निष्पादित किया जाता है। जिसमें इस बात को प्रमाणित किया जा सके कि मृत्यु का कारण बास्तव में दुर्घटना ही था। बीमा से अभिप्राय किसी भी बाहरी, हिंसक अथवा अन्य किसी प्रत्यक्ष कारण से हुई दुर्घटना जनित मौत के हर्जाने के तौर पर मिलने वाली रकम है।

व्यावहारिक जीवन में जीवन बीमा के इस उपबंध के विभिन्न पहलु और चरण हैं। स्पष्ट रूप से किसी भी चोट के कारण हुई मौत के हर्जाने के रूप में ही बीमा का भूगतान प्राप्त किया जा सकता है। दुर्घटना नाम शब्द की व्याख्या के दौरान बाहरी, हिंसक और प्रत्यक्ष कारण सहित पूरी तरह से और सीधे तौर पर घटना का ही हाथ हौना उल्लेखित किया जाता है। किसी भी चोट अथवा जख्म का कारण दुर्घटना ही होने को निम्न विवेचना से समझा जा सकता है।

बाहरी

बाहरी (एक्सटर्नल) - शब्द से अभिप्राय वे कारक हैं जो कि आंतरिक नहीं होकर पूरी तरह से बाहरी प्रभाव के कारण ही उत्पन्न हो। बीमारी अथवा शारीरिक कमजोरी से जुड़े मामलों में बाहरी शब्द का विरोधाभारी प्रत्यय के रूप में इस्तेमाल किया जाता है। दृष्टिगोचर (विजिबल) - आँखों के द्वारा स्पष्ट रूप से दिखाई देने वाला, स्पष्टतया, आसानी से दिखाई देने वाला और प्रत्यक्ष बोध। (ब्लैक के अनुसार)

हिंसक माध्यम (वॉयलैनट मीन्स) - इसके अंतर्गत कोई भी बाहरी और गैर व्येक्तिक कारण जैसे डूबवा, गैस रिसाव और यहां तक कि बीमित की शारीरिक क्षमता का क्षय सम्मिलित किया गया है। हिंसात्मक शब्द का उपयोग किसी भी हिंसा के बिना (wihout any violence at all) के एंटी थीसिस में किया जाता है। (राउल कॉलिनवॉक्स द्वारा लॉ ऑव इंश्योरेंस में उल्लेखित)

मृतक के शरीर पर स्पष्ट रूप से परिलक्षित बाहरी, दृष्टिगोचर और हिंसात्माक लक्षणों का इस्तेमाल दुर्घटना बीमा निष्पादन में सहायक होता है।

उपरोक्त को विस्तृत रूप से समक्षने के लिए हम पुरुषोत्तम सिंह के मामले का अवलोकन करेंगे।

पुरूषोत्तम सिंह को चुनाव ड्यूटी के दौरान एक गांव में नियुक्त किया गया। शाम के वक्त पुरुषोत्तम खुद को तरोताजा करने की नीयत से गांव से होकर बहने वाली गंडक नदी के किनारे-किनारे चहलकदमी कर रहा था। थोड़ी देर बाद ही पुरुषोत्तम सिंह हांफता-दौड़ता और बुरी तरह घबराई हुई अवस्था में अपने कैम्प में वापस लौटा। उसने अपने साथियों को बताया कि उसे नदी के किनारे चहलकदमी के दौरान कुछ हथियारबंद लोगों ने घेर लिया और अगले दिन होने वाले मतदान के दौरान उन्हें फर्जी मतदान में रहयोग के लिए धमकाया। साथ ही उन्होंने पुरुषोत्तम सिंह को धमकी दी कि यदि वह उनसे सहयोग नहीं करेगा तो उसे जान गंवानी पड़ेगी। इसके थोड़ी देर बाद रात लगभग नौ बजे पुरुषोत्तम सिंह को सीने में दर्द की शिकायत पर गांव के अस्पताल ले जाया गया। वहां से लौटने के बाद आधी रात के करीब पुरूषोत्तम सिंह ने स्कूल में बने अपने कैंप में हार्ट अटैक के कारण दम तौड़ दिया। बाद में उसके परिवारजनों द्वारा बीमा कंपनी के समक्ष क्लेम आवेदन किया लेकिन बीमा केंपनी ने इसे खारिज कर दिया।

इस पर हाईकोर्ट में अर्जी लगाई गई, जहां कोर्ट ने पाया कि पुरुषोत्तम सिंह की मौत का एकमात्र कारण हार्ट अटैक ही था। जो कि उसे नदी के किनारे इथियारबंद लोगों द्वारा दी गई धमकी के बाद ही हुआ था। कोर्ट ने व्यवस्था दी कि इस हालात में धमकी को बाहरी, हिंसात्मक और प्रत्यक्ष कारक मानते हुए क्लेम दिया जाए।

दुर्घटना दावा आवेदन में मृत्यु का कारण दुर्घटना ही होने को प्रमाणित किया जाना चाहिए। दुर्घटना के कारण बीमित के शारीरिक रूप से जख्मी अथवा अपंग होने अथवा दुर्घटना के 120 दिन के भीतर मौत होने पर समस्त परिलाभ दिए जाते हैं। जानबूझकर, शारीरिक थकान अथवा बीमित द्वारा समझते हुए भी जोखिम उठाने के परिणामस्वरूप हुई मौत को दुर्घटना दावा पॉलिसी अंतर्गत दावे का हकदार नहीं माना जा सकता। लेकिन जिन मामलों में दुर्घटना से पूर्व चोज कारित हो उसे दुर्घटना मृत्यु माना जाएगा।

निम्न उदाहरणों के माध्यम से दुर्घटना की तात्कालिकता और क्रमिक प्रक्रिया को समझा जा सकता है।

उदाहरण 1

इसिट बनाम रेलवे इंश्योरेंस कंपनी मामले में बीमित रेलवे स्टेशन पर गिर गया और कंधा उत्तर जाने के कारण उसे अस्पताल में भर्ती कराया गया। लेकिन इस दुर्घटना के बाद उसका शारीरिक बचाव तंत्र उसे सर्दी से बचाने में नाकाम हो गया। इसके चलते उसे निमानिया हो गया और सेलवे स्टेशन हादसे के एक माह के भीतर उसकी मौत हो गई। जांच के बाद पाया गया कि दुर्घटना के बाद उत्पन्न हुए शारीरिक विकार और जख्मों के चलते ही उसकी मौत हुई।

उदाहरण 2

एथेरिगटन बनाम लंकाशायर और यॉर्कशायर एक्सीडेंट इंश्योरेंस कंपनी (1909) केस में एक व्यक्ति घोड़े से गिरकर जख्मी होने के कारण चलने-फिरने में असमर्थ हो गया। काफी समय तक गीले ऐर सर्द स्थान पर पड़े रहने के कारण उसे निमोनिया हो गया तथा बाद में उसकी मौत हो गई। जांच में पाया गया कि उसकी मौत का कारण घोड़े पर से गिरना था ना कि निमोनिया।

दुर्घटना आधारित क्लेम के निस्तारण के लिए मौत की असल वजह को स्थापित किया जाना बेहद जरूपी है। दुर्घटना बीमा उपबंध अंतर्गत बीमाकर्ता कंपनी द्वरा अपनी लाइबिलिटीज को स्वीकार करना बेहद जरूरी है। ऐसे मामले जिनकी पॉलिसीज में दुर्घटनाजनित मौत को कवर प्रदान किया गया है उसे साधारण नल का पानी पीकर भी यदि किसी की मौत हो तो फिर उसे दावा मिलना चाहिए। इस मामले में ये माना जाता है कि मृतक ने नल के पानी को ये विश्वास करते हुए पिया कि वह शुद्ध है, जो कि असल में दुर्घटनावश विषाक्त हो गया था।

दुर्घटना लाभ में शामिल नहीं होने वाले उपबंध

दुर्घटना बीमा (एबी) पॉलिसी कवर में मुख्य उपबंध 'दुर्घटना में बीमित के जख्मी अथवा मृत्यु कारित होने पर उसे अथवा उसके परिजनों को पॉलिसी अंतर्गत सुमचित क्लेम प्रदान किया जाएगा।' का उल्लेख किया जाता है। साथ ही कुछ ऐसी परिस्थितियों का भी उल्लेख किया जाता है कि जिनके पाए जाने पर लाभ नहीं दिया जाएगा।

1 – कोई भी बीमारी अथवा जख्म

जिन मामलों में मृत्यु का कारण पहले से ज्ञाता जोखिम माना जाता है। लेकिन ऐसे मामले जिनमें दुर्घटना उपरान्त ऑपरेशन अनिवार्य होता है तो ऐसे में मौत का कारण ऑपरेशन ना होकर दुर्घटना को माना जाता है। ये भी ध्यान रखना जरूरी है कि ऐसे मामलों में ऑपरेशन के बाद बीमित की मृत्यु को ऑपरेशन का साधारण जोखिम माना जाएगा। हां, यदि बीमित की मौत में ऑपरेशन के दौरान डॉक्टरों की लापरवाही के तथ्य पुष्ट होते हैं तो इसे दुर्घटना करार दिया जाएगा।

2– चेतन अथवा मानसिक असंतुलन की हालत में जानबूझकर खुद को चोट पहुंचाना, खुदकशी अथवा खुदकशी की कोशिश

दुर्घटना बीमा अंतर्गत जानबूझकर खुद को चोट पहुंचाने अथवा खुदकशी अथवा खुदकशी की कोशिश करने को दुर्घटना नहीं माना जाता है।

अतः उबी अंतर्गत कोई लाभ देय नहीं होता है।

3 – बीमित द्वारा अत्यधिक शराब, मादक पदार्थ, मनस्वापी औषधि (शाइकोट्रॉपिक ड्रग्स) के प्रभाव में होने की स्थिति में मौत अथवा चोटिल होना

दुर्घटना दावा अंतर्गत बीमित व्यक्ति का किसी भी प्रकार के मादक पदार्थ के सेवन से मौत अथवा चोटग्रस्त होने की स्थिति में इसे साबित कर खारिज किया जाना चाहिए। खारिज करते समय ये साबित करना चाहिए कि अमुक बीमित नशे की हालत में था अतः वह दुर्घटना से अपनी रक्षा करने में असमर्थ था।

4 – यात्री के अलावा किसी भी प्रकार की उड्डयन क्रियाओं में शामिल होना जोखिम भरे खेलों में भाग लेना अथवा पैराशूटिंग अथवा पैरा ग्लाइडिंग में शामिल होना

दुर्घटना बीमा अंतर्गत विमान जो कि अपनी निर्धारित और स्वीकृति उड़ान पर हो में बतौर यात्री सफर में शामिल हो को ही लाभ दिया जा सकता है। इसके अलावा कोई भी अन्य उड्डयन संबंधी जोखिम भरे कार्य में लिप्त होकर जान गंवाना अथवा चोटग्रस्त होने पर बीमा लाभ से वंचित किया जाना चाहिए।

5 – दंगों, जनअंदोलन, युद्ध, बागियों का हमला वगैरह में बीमित की मृत्यु अथवा चोटग्रस्त होना

पांच या उससे अधिक व्यक्तियों का समूह के रूप मे गुट बनाकर गैरकानूनी तरीके से जमावड़ा कर हिंसात्मक कार्रवाई को अंजाम देना दंगे की परिभाषा में आता है। इस प्रकार की परिस्थितियों में जान गंवाने अथवा बीमित को शारीरिक नुकसान पहुंचने की हालत में उसे दुर्घटना बीमा का लाभ देया होगा।

6 – कानूनी ढंग से गुट मे शामिल होकर आपराधिक कृत्य को अंजाम देते समय मौत अथवा चोट

सामान्यतः ऐसे हालात जिनमें कि बीमित कोई भी गैरकानूनी ढंग से किसी अपराध कारित करते समय जान गंवा बैठे अथवा चोटिल हो जाए तो उसे बीमा का लाभ नहीं दिया जाता है। मौत को केवल उसी हालात में दुर्घटना माना जाएगा जिसमें कि प्रतिपक्षी ने कानून का उल्लंघन किया हो। उदारहण के तौर पर यदि कोई डकैत लूट की बारदात को अंजाम देते समय पुलिस एन्काउन्टर में मारा जाए अथवा बीमित व्यक्ति को मर्डर के मामले में फांसी पर चढ़ा दिया जाए तो इस दोनों ही मामलों को दुर्घटना की श्रेणी में नहीं रखा जा सकता। इस मामलों में कानून का उल्लंघन के कुछ अपवाद भी है। जैसे कि यदि कोई बीमित व्यक्ति भीड़-भाड़ अधिक होने पर सिटीबस के पायदान पर खेड़ होकर सफर कर रहा होता है और बस का एक्सीडेंट हो जाता है तो इसे खारिज नहीं किया जा सकता। क्योंकि बीमित बस के पायदान पर सफर खुद को जावबूझकर चोट पहुंचाने अथवा खदकशी की नीयत से नहीं कर रहा था। बेशक बस की स्पीड चाहे निर्धारित सीमा से अधिक हो और ड्राइवर द्वारा कानून का उल्लंघन किया गया हो। ये एक दुर्घटना ही माना जाएगी और बीमित को दुर्घटना बीमा का लाभ देय होगा।

7 – सेना, पुलिस अथवा अन्य सैन्य सेवाओं में नुयुक्त बीमित ड्यूटी के दौरान मुत्यु

चाहे युद्ध का औपचारिक एलान किया गया हो अथवा नहीं, सैन्य बलों में तैनात बीमित की मृत्यु अथवा चोटिल होने पर बीमा कंपनी को लाभ देना होगा। यहां ये ध्यान में रखा जाना चाहिए कि बीमित हो होने वाला शारीरिक नुकसान अथवा मृत्यु के हालात में लाभ तभी देय होगा जबकि ये उसके रोजगार से जुड़ी हो। उदाहरण के तौर पर यदि कोई पुसिलकर्णी ड्यूटी के दौरान तूफान की चपेट में आ जाता है और उसकी मौत हो जाती है तो बीमा शब्दावली में उसकी मौत को रोजगार से उत्पन्न कारकों से मृत्यु नहीं माना जा सकता। इसके लिए उसे दुर्घटना बीमा अंदर्गत ही लाभ देया होगा।

जब दुर्घटना बीमा अंतर्गत ही लाभ को हाथ-पैर गंवा देना अथवा नेत्रज्योति खो जाने के उपबंध में शामिल किया जाता है तो इसे एक्सीडेन्टल डेथ एंड डिसमैंबरमेन्ट बेनेफिट (Accidental Death and Dismemberment Benefit) कहा जाता है। दुर्घटना से मृत्यु उपरान्त देय लाभ प्रत्येक परिस्थितियों में अलग-अलग होते हैं। अतः ये सलाह दी जाती है कि आप ऐसे किसी भी भुगतान से पहले सभी उपबंधों और शर्तों से सालधानी पूर्वक पढ़े और समझें। दुर्घटना बीमा पॉलिसी अंतर्गत उल्लेखित लागू नहीं होने वाली परिस्थितियों का भली-भांति अध्ययन करें। अक्सर ये ऐसे उपबंध अथवा नियम-शर्तें होती हैं जिनके बारे में एजेन्ट ना तो कभी बनाते हैं और ना ही इसका उल्लेख करते हैं। इस छद्म से बचने में ही सामान्यजन का लाभ है।

वर्तमान में विभिन्न बीमा कंपनियों द्वरा पॉलिसीज में कई प्रकार के उपबंध देकर इसे काफी परिवर्तनशील और सुगम बनाया गया है, साथ ही ये भूगतान भी अधिक प्रदाना करती हैं। कुछ उत्पादों में एक्सीडेंट बेनेफिट सम्मिलत (इन बिल्ट) होता है, अतः इसे अलग से खरीदने की आवश्यकता नहीं होती। जबकि एडीबी के रूप में जारी पॉलिसीज में बीमित की दुर्घटना में मृत्यु पर उसके परिजनों को अतिरिक्त राशि भी प्रदान की जाती है। पॉलिसीधारक की सिफारिश पर बीमा कंपनी बहुत ही कम प्रीमियम पर बीमित की दुर्घटना में मृत्यु होने पर पॉलिसी में उल्लेखित राशि से अतिरिक्त रकम का भुगतान भी प्रदान करती है।

लेखक गाजियाबाद स्थित आईएमटी सेन्टर फॉर डिस्टैन्ट लर्निंग में एसोसिएट प्रोफेसर हैं।

व्यक्तिगत दुर्घटना बीमा अंतर्गत क्लेम - तथ्यपरख विवेचना

मीना नायर का मानना है कि विशेषकर व्यक्तिगत दुर्घटना अंतर्गत बीमा दावाकर्ता के प्रति हमदर्दी प्रदर्शित करना और उसे क्लेम के लिए उपयुक्त मानना, दो अलग - अलग विषय हैं।

क्लेमः अंतहीन बहस

कार्यालय, सड़क अथवा घर के भीतर होने वाली दुर्घगनाएं दुखद, लेकिन जीवन का यथार्थ है, इसे अनदेखा नहीं किया जा सकता। इसलिए इससे उबरने के लिए हम व्यक्तिगत दुर्घटना बीमा (पर्सनल एक्सीडेंट इंश्योरेंस यानी पीए) करवाते हैं। पीए अंतर्गत प्लेन क्रैश, ट्रेन हादसे, मर्डर, हीट एंड रन सहित सर्पदंश के कारण मौत की घटना तक को शामिल किया गया है। जबकि लाइफ कवर से विपरीत पीए अंतर्गत बीमारी अथवा प्राकृतिक मृत्यु की स्थिति में क्लेम नहीं दिया जाता है। यही नहीं ज्यादातर पॉलिसीज में 'जानबूझकर जोखिम वाली परिस्थिति में खुद को डालने' के तथ्य को ध्यान में रखते हुए ही क्लेम दिया जाता है। जैसे कि तैराक लाल झंडी को अनदेखा कर खतरनाक जगह पर तैरते रहते हैं और अंतः मौत का शिकार हो जाते हैं। ज्यादातर पॉलिसी अंतर्गत बीमित को उसी सूरत में क्लेम दिया जाता है जिसमें कि बाहरी, हिंसात्मक और स्पष्ट कारण से दुर्घटनावश चोट अथवा मृत्यु कारित हो।

> वैसे ऊपरी तौर पर क्लेम की ये प्रक्रिया काफी सहज और सरल प्रतीत होती है, लेकिन यदि इसे थोड़ा भी विस्तार से देखा जाए तो इसमें कई बाधक भी छिपे हुए हैं, विशेषकर दुर्घटना के कारण।

सामान्यतः ज्यादातर क्लेम के मामले स्पष्ट और आनास होते हैं, यदि बीमित पॉलिसी अंतर्गत उल्लेखित परिस्थितियों के कारण जख्मी हुआ हो। दुर्घटना की स्थिति में बीमित को तुरंत बीमा कंपनी को सूचना तथा संबंधित दस्तावेज देने चाहिए। दस्तावेज सुपुदर्गी के समान्यतः एक माह के भीतर बीमा कंपनी क्लेम का सैटलमेन्ट कर देती है। वैसे ऊपरी तौर पर क्लेम की ये प्रक्रिया काफी सहज और सरल प्रतीत होती है, लेकिन यदि इसे थोड़ा भी विस्तार से देखा जाए तो इसमें कई बाधक भी छिपे हुए हैं, विशेषकर दुर्घटना के कारण। वैसे सरसरी तौर पर दुर्घटना का कारण आसान सा लगने वाला सवाल प्रतीत होता है। जैसे कि अमुक को दुर्घटना के कारण अमुक शारीरिक तुकसान कारित हुआ। लेकिन यथार्थ में ये काफी पेचीदा है। दुर्घटना के ज्यादातर मामलों में कई परिस्थितियां और प्रकरण भी जिम्मेदार होते हैं। जिन मामलों में एक से अधिक सहसंबंधी कारक किसी दुर्घटना के दौरान होते हैं तो विसेधाभास और शंकाएं भी उठ खड़ी होती है।

मुख्य बाधक सवाल है कि क्या जख्म अथवा चोट का एकमेव कारण वही दुर्घटना है जिसको आधार बनाकर क्लेम किया जा रहा है? संदिग्ध मामलों में ये देखा जाता है कि क्या उल्लेखित दुर्घटना में बीमित की ओर से जोखिम को जानबूझकर तो नहीं लिया गया? अतः एसी स्थिति में 'निकटतम कारण का सिद्धांत' सामने आता है।

इस लेख के द्वरा हम कुछ ऐसे पीए क्लेमस को देखेंगा जिनमें चोट अथवा शारीरिक नुकसान का एकमात्र कारण दुर्घटना का कारण अन्य कारक है। इससे हमें किसी भी पॉलिसी अंतर्गत मांगे गए क्लेम्स के निस्तारण में विवेचनात्मक सहायता मिल सकेगी।

अस्थाई बीमारी - ट्रेन से गिरकर दुर्घटना

ट्रेन में सफर के दौरान एक बीमित व्यक्ति को उल्टी की हराकत होती है। ऐसे में वह कम्पार्टमेंट में ही बने टॉयलेट की ओर भागता है, लेकिन टॉयलेट की ओर भागता है, लेकिन टॉयलेट के लॉक होने के कारण वह जल्दबाजी में ट्रेन के दरवाजे की ओर भागत है और झटके से दरवाजा खोलने के कारण वह रफ्तार के वेग के कारण ट्रेन से नीचे गिरकर मौत का शिकार हो जाता है। इस

> 'अ' की शारीरिक अक्षमता का एक मात्र कारण मैदान पर हुई दुर्घटना नहीं है, प्राकृतिक अथवा अन्य किसी कारण से हुआ रीढ़ का विखंडन 'अ' की अक्षमता का कारण सामने आया है अतः क्लेम अमान्य है।

मामले में बीमा कंपनी का तर्क था कि पीए पॉलिसी अंतर्गत इसके क्लेम का निस्तारण नहीं किया जा सकता है। साथ ही इस मामले में कोर्ट ने भी व्यवस्था दी कि ट्रेन में सफर के दौरान बीमित को हुई अस्थाई शारीरिक अक्षमता के कारण ये साबित नहीं होता कि ट्रेन से गिरना किसी बीमारी के कारण नहीं था। बीमारी से अभिप्राय एक स्थाई और प्रमाणित शारीरिक अक्षमता अथवा लक्षण है, ना कि अस्थाई शारीरिक विकार।

दुर्घटना से चोट-डिस्क प्रोलैप्स - सहसंबंधी कारक

पॉलिसी के द्वारा एक क्लब ने अपने खिलाड़ियों को चोट और बीमारियों के कारण फुटबॉल नहीं खेल पाने के विरुद्ध बीमित किया। एक प्रेक्टिस मैच के दौरान एक खिलाड़ी 'अ' बॉल झपटने की कोशिश में दूसरे खिलाड़ी से टकरा कर मैदान पर गिरकर चोटिल हो गया। दर्द से कराहते 'अ' को चिकित्सा सुविधा मुहैया कराई गई, जांच में पता चला कि उसकी रीढ़ी की हड्डी (प्रोलैप्सड डिस्क) में चोटें ईई है। साथ ही उसकी रीढ़ में विखंडन की प्रक्रिया (डिग्री ऑफ डीजेनेरेशन) भी दृष्टिगोचर हुई।

बीमा कंपनी ने उपलब्ध रिपोर्ट के आधार पर बीमित खिलाड़ी को किसी भी प्रकार के भूगतान से स्पष्ट इनकार कर दिया। कंपनी ने तर्क दिया कि 'अ' हुई शारीरिक अक्षमता का एक मात्र कारण मैदान पर हुई दुर्घटना नहीं है, उसकी रीढ़ में विखंडन की प्रक्रिया भी इसका प्रत्यक्ष अथवा परोक्ष कारक है। साथ ही 'अ' लोवर लुम्बर स्पाइन यानी रीढ़ के निचले हिस्से में एक पुराने रोगग से भी ग्रसित था। इसके जवाब में क्लब ने कहा कि 'अ' का रीढ़ के विखंडन की बीमारी से ग्रसित होना उसकी उम्र के किसी भी अन्य व्यक्ति के समान सामान्य शारीरिक अवस्था है।

मामले में कोर्ट ने व्यवस्था दी कि 'अ' की शारीरिक अक्षमता का एक मात्र कारण मैदान पर हुई दुर्घटना नहीं है, प्राकृतिक अथवा अन्य किसी कारण से हुआ रीढ़ का विखंडन 'अ' की अक्षमता का कारण सामने आया है अतः क्लेम अमान्य है। साथ ही कोर्ट ने कहा कि बीमित खिलाड़ी रीढ़ के विखंडन से ग्रसित था, अतः ये पॉलिसी कवर अंतर्गत हनी आता है।

बीमित के मुंह पर घूंसा - रक्त विष - मृत्यु

एक बीमित व्यक्ति की किसी के साथ हाथापाई हो गई। बीमित ने दूसरे व्यक्ति के मुंह पर घूंसा जड़ दिया, इस दौरान दूसरे व्यक्ति ने बीमित की हथेली को अपने दांतों से चबा दिया। मारपीट के कुछ दिनों बाद बीमित का रक्त विषाक्त हो गया। नतीजतन उसका काट ऑपरेशन कर काटना पड़ा, लेकिन कुछ दिनों बाद बीमित की मृत्यु हो गई। बीमित की ओर से बीमा कंपनी से क्लेम का दावा किया गया, लेकिन कंपनी ने क्लेम को खारिज कर दिया। कंपनी ने तर्क दिया कि बीमित ने जानते-बूझते हुए वह कारित किया जिसका कि उसे जोखिम ज्ञात था, अतः बीमित की मौत दुर्घटना नहीं है। क्लेमकर्ताओं ने फिर तर्क दिया कि बीमित की मृत्यु पॉलिसी अंतर्गत उल्लेखित बाहरी, हिंसक और दुर्घटनात्मक तरीके से हुई है। कोर्ट ने व्यवस्था दी कि बीमित उसे हमले का दोषी है जिसमें कि उसने दूसरे व्यक्ति को घूंसा जड़रा और इस दौरान खुद का ही हाथ जक्ष्मी करवा लिया। रक्त में विष फैलने के फलस्वरूप बीमित की मौत हो गई। मानसिक रूप पूर्णतः स्वस्थ होने और इसका परिणाम जानने के बावजूद बीमित द्वारा प्रदिर्शित हिंसक रवैया ही उसकी मौत का कारण बना। दुर्घटना का प्रावधान यां कतई दृष्टिगोचर नहीं होता, अतः बीमित को क्लेम नहीं दिया जा सकता।

हिंस और आवेश - मानसिक आधात

दावाकर्ता रेल्वे में सिगनलमैन के रूप में कार्यरत था। एक दिन उसने इंजीनियर को सिगनल देकर भीषण ट्रेन हादसे को टालने का प्रयास किया। इस दौरान उत्पन्न हुए भय और आशंका के भाव के कारण सिगनलमैन को गहरा मानसिक आघात पहुंचा। परिणामस्वरूप वह ५० समाह तक अपनी ड्यूटी का निस्तारण नहीं कर सका। पीए पॉलिसी अंतर्गत बीमित सिगनलमैन ऐसी स्थिति में लाभ का हकदार था। बीमा कंपनी ने उसके दावे को मानसिक आघात बता कर खारिज करर दिया। लेकिन कोर्ट ने बीमा कंपनी के निर्णय को खारिय कर कहा कि बीमित पॉलिसी अंतर्गत उल्लेखित दुर्घटना की परिस्थितियों के कारण ही ५० समाह तक काम पर नहीं जा सका, अतः उसे लाभ दिया जाना चाहिए।

पॉलिसीधारकक की मृत्यु अथवा जख्मी होने की

परिस्थितियों में चिकित्सीय जटिलताएं भी बाधा उत्पन्न करती है। कई बार बीमा कंपनी व्यक्तिगत दुर्घटना दावे को बाहरी, हिंसक अथवा दृष्टिगोचर कारक के आधार पर नहीं मानते हुए दावो को खारिज कर देती है। प्रत्येक सर्जरी में कुछ जोखिम अंतरनिहित होते हैं, लेकिन सामान्यतः हम ऐसे मामलों को चिन्हित कर सकते हैं, जिनमें कि चोट का कारण दुर्घटना होती है।

उदाहरण के तौर पर निम्न दो मामलों का अध्ययन करें।

समान नुकसान, भिन्न परिणाम

केस 1

प्रोलैप्सड डिस्क के कारण 'टी' का छोटा ऑपरेशन हुआ। ऑपरेशन के दौरान किसी प्रकार की जटिलता सामने नहीं आई।

> प्रत्येक सर्जरी में कुछ जोखिम अंतरनिहित होते हैं, लेकिन सामान्यतः हम ऐसे मामलों को चिन्हित कर सकते हैं, जिनमें कि चोट का कारण दुर्घटना होती है।

लेकिन, स्वास्थ्य लाभ के दौरान 'टी' ने गर्दन में अकड़न की शिकायत की, उसे आईसीयू में दाखिल किया गया। जहां उसकी मौत हो गई। पोस्टमार्टम की रिपोर्ट से पता चला कि 'टी' की मौत का कारण उसकी वर्टिब्रल आर्टरी से हुआ रक्त रिसाव था 'टी' की बेवा द्वारा पीए अंतर्गत किए गए क्लेम को बीमा कंपनी ने खारिज कर दिया। इसके बाद मामला कोर्ट में दाखिल हुआ। जिरह के दौरान उपलब्ध कराए गए मेडिकल सबूतों से उजागर हुआ कि डॉक्टर ने ऑपरेशन के दौरान लापरवाही बरतते हुए 'टी' की एक आर्टरी को काट दिया था अतः ये कदम पॉलिसी में उल्लेखित सामान्य जोखिम की परिधि में नहीं आता, कोर्ट ने इपने पैसले में कहा कि 'टी' की बेवा को पीए पॉलिसी अंतर्गत क्लेम दिया जाए।

केस 2

गर्दन से मां के एक लोथड़े को निकालने के लिए 'श्रीमती जी' का एक ऑपरेशन हुआ। स्वास्थ्य लाभ के दौरान घाव में से अत्यधिक रक्त स्राव होने लगा, इसके परिणामस्वरूप रक्त अल्पता पैदा हो गई। कुछ दिनों में 'श्रीमती जी' के पति द्वारा पीए पॉलिसी के अंतर्गत किए गए क्लेम के दावे को बीमा कंपनी ने खारिज कर दिया। कंपनी का कहना था कि 'श्रीमती जी' की मृत्यु किसी दुर्घटना में नहीं होकर एक प्लांड सर्जरी के बाद पैदा हुई चिकित्सीय जटिलताओं से कारण हुई है। कोर्ट ने भी उपलब्ध मेडिकल रिपोर्ट्स के आधार पर ये नहीं पाया कि मौत का कारण दुर्घटना है। पोस्टमार्टम की रिपोर्ट में भी कोर्ट ने डॉक्टरों द्वारा ऑपरेशन के दौरान कौई भी त्रृटि कारित किए जाने के सबूत नहीं पाए। साथ ही ऑपरेशन के दौरान अन्य कोई चिकित्सीय गड़बड़ी सामने नहीं आई। 'श्रीमति जी' उन कुछ मरीजों में शामिल थी जिनका कि शरीर इस प्रकार की सर्जरी को झेल नहीं पाता। इस केस में शारीरिक जख्म सर्जरी का एक सामान्य परिणाम थी, साथ ही ऑपरेशन के बाद के जोखिम के प्रति भी 'श्रीमती जी' को भान था। उन्हें ऑपरेशन के बाद की जटिलताओं की आंशकओं से पूरी तरह परिचित करवा दिया गया था। अतः 'श्रीमति जी' की ऑपरेशन के बाद हुई दुर्भाग्यपूर्ण मृत्यु पर बीमा कंपनी के फैसले को कोर्ट ने सही मानते हुए क्लेम को खारिज किए जाने के आदेश दिए।

सारांश

बीमा दावों संबंधी तथ्य जोखिम के संभावित परिणामों के मद्देनजर काफी जटिलता पूर्ण होते हैं। इसके चलते दावों के बारे में कभी बीमा कंपनी तो कभी बीमित के पक्ष में फैसला आता है। अतः बीमा पॉलिसी और बीमित की सोच के बीच कई 'किन्तु-परन्तु' भई छिपे होते हैं।

लेखक इंडिया इंश्योरेंस रिस्क मैनेजमेंट और इंश्योरेंस ब्रोकिंग सर्विसेज प्राइवेट लिमिटेड की एसोसिएट वाइस प्रेसिडेंट हैं।

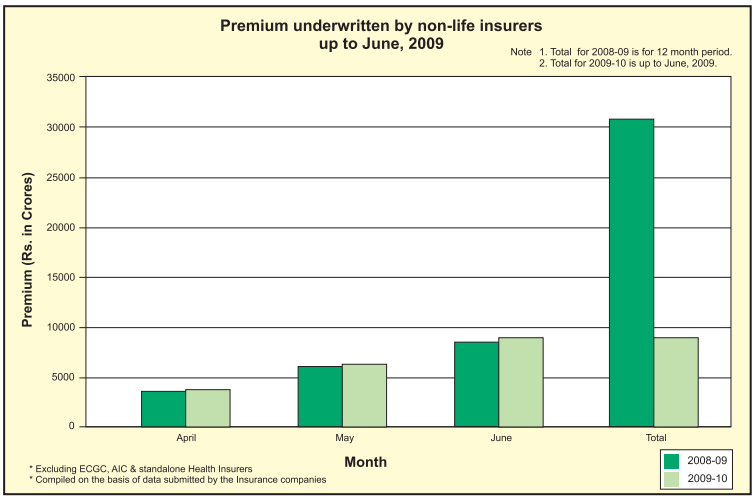
Report Card: General

GROSS PREMIUM UNDERWRITTEN FOR AND UP TO THE MONTH OF JUNE, 2009

(Rs.in Crores)

INSURER	JUNE		APRIL - JUNE		GROWTH OVER THE CORRESPONDING PERIOD OF PREVIOUS YEAR
	2009-10	2008-09*	2009-10	2008-09	
Royal Sundaram	66.43	59.46	209.09	190.51	9.76
Tata-AIG	53.46	66.63	260.40	288.68	-9.79
Reliance General	171.86	130.22	557.48	556.44	0.19
IFFCO-Tokio	141.76	139.85	425.94	414.18	2.84
ICICI-lombard	220.88	276.28	852.25	1077.12	-20.88
Bajaj Allianz	210.08	224.69	634.67	733.53	-13.48
HDFC ERGO General	45.21	21.03	181.38	52.25	247.13
Cholamandalam	65.91	52.89	232.77	200.35	16.18
Future Generali	29.06	8.26	91.55	27.81	229.18
Universal Sompo	7.79	0.73	35.02	0.91	3756.70
Shriram General @	18.14	0.00	62.48	0.00	
Bharti AXA General @	13.24	0.00	41.58	0.00	
Raheja QBE $	0.03	0.00	0.03	0.00	
New India	465.94	429.57	1643.91	1536.39	7.00
National	378.58	354.59	1152.04	1174.13	-1.88
United India	368.38	315.77	1266.43	1115.61	13.52
Oriental	336.25	334.14	1172.66	1066.09	10.00
PRIVATE TOTAL	**1043.84**	**980.04**	**3584.64**	**3541.78**	1.21
PUBLIC TOTAL	**1549.15**	**1434.07**	**5235.04**	**4892.22**	7.01
GRAND TOTAL	**2592.99**	**2414.12**	**8819.68**	**8434.00**	4.57
SPECIALISED INSTITUTIONS					
1.Credit Insurance					
ECGC	65.57	60.11	189.71	164.70	15.19
2.Health Insurance					
Star Health & Allied Insurance	75.13	62.07	226.29	124.75	81.40
Apollo DKV	4.74	1.51	19.45	6.95	179.94
Health Total	**79.88**	**63.58**	**245.75**	**131.70**	86.60
3.Agriculture Insurance					
AIC	51.46	10.52	131.70	53.70	145.24

Note: Compiled on the basis of data submitted by the Insurance companies.
@ Commenced operations in July, 2008. *$ Commenced operations in April, 2009.*
** Figures have been revised by Insurers*



FICCI organized a Health Insurance Conference "Health Insurance: Social and Economic Imperative" on 10th July 2009 in New Delhi. This conference was organized under the aegis of FICCI's Insurance and Pensions Committee; and FICCI's Health Services Committee. The focus of this year's conference was to disseminate the work done so far by the FICCI's Sub-Group on Health Insurance to a larger audience and seek their response. In addition to this, the Conference also discussed the way forward to deepen health insurance market.

Photograph shows **Mr. J. Hari Narayan** Chairman, IRDA delivering the key-note address.

A report of FICCI Health Insurance Working Group was released on the occasion. Standing (L to R) are: **Mr. Shivinder Mohan Singh**, MD & CEO, Fortis and Chairman, FICCI Health Committee; **Mr. Harsh Pati Singhania**, President, FICCI; **Mr. J. Hari Narayan**, Chairman, IRDA; **Mr. V. Vaidyanathan**, MD & CEO, ICICI Prudential Life Insurance Co. and Chairman, FICCI Insurance Committee; **Mr. Ruedger Krech**, GTZ; and **Mr. S.L. Mohan**, Secretary General, General Insurance Council.

A panel discussion in progress — Seated L to R are: **Mr. G. Srinivasan**, CMD, United India Insurance Company Ltd., **Dr. Somil Nagpal**, Special Officer (Health), IRDA; and **Mr. S.L. Mohan**, Secretary General, General Insurance Council.

"ക്ലെയിമിനെ സംബന്ധിച്ച എല്ലാ രേഖകളും അയച്ചു കൊടുത്തിട്ട് 3 ആഴ്ചയായി. അവർ പണം വേഗം അയച്ചു തരുമെന്നാണ് എന്റെ പ്രതീക്ഷ."

"തീർച്ചയായും തരും. എല്ലാ കടലാസ്സുകളും നിയമാനുസൃതമാണെങ്കിൽ 30 ദിവസത്തിനകം അവർ ക്ലെയിം തീർപ്പു കല്പിക്കണം. അതാണ് നിയമം !"

ഇന്ത്യയിലെ ഇൻഷുറൻസ് കമ്പനികളുടെ മേലന്വേഷണച്ചുമതലയുള്ള സ്ഥാപനമായ ഇൻഷുറൻസ് റെഗുലേറ്ററി ആൻഡ് ഡെവലപ്മെന്റ് അതോറിറ്റി (ഐ ആർ ഡി എ) പോളിസി ഹോൾഡേഴ്സിന്റെ താല്പര്യങ്ങൾ സംരക്ഷിക്കുന്നു. ഐ ആർ ഡി എ കല്പിച്ചിട്ടുള്ള ചില ചട്ടങ്ങൾ താഴെ പറയുന്നു:

- പ്രസക്തമായ എല്ലാ രേഖകളും കിട്ടിയ30 ദിവസത്തിനകം ഒരു ഇൻഷുറൻസ് കമ്പനി ക്ലെയിം (അവകാശം) കൊടുത്തു തീർക്കണം അല്ലെങ്കിൽ പ്രസക്തമായ കാരണങ്ങൾ കാണിച്ച് ക്ലെയിം ചോദ്യം ചെയ്യണം.
- ഒരു പ്രൊപ്പോസൽ അംഗീകരിച്ച് 30 ദിവസത്തിനകം ഇൻഷുറൻസ് കമ്പനി ഭാവി പോളിസിഹോൾഡർക്ക് പ്രൊപ്പോസൽ ഫോറത്തിന്റെ ഒരു പകർപ്പ് യാതൊരു ചാർജ്ജും വസൂലാക്കാതെ നല്കണം.
- ഇൻഷുറൻസ് കമ്പനി പ്രൊപ്പോസലുകൾ കിട്ടിയ 15 ദിവസത്തിനകം അവ കൈകാര്യം ചെയ്ത് തീരുമാനം അറിയിക്കണം.
- ആവശ്യമായ എല്ലാ രേഖകളും സമർപ്പിച്ച ശേഷവും ക്ലെയിം കൊടുക്കാൻ കാലതാമസം ഉണ്ടായാൽ ഒരു നിശ്ചിത നിരക്കിൽ പലിശ കൊടുക്കാൻ ഇൻഷുറൻസ് കമ്പനി ബാദ്ധ്യസ്ഥമായിരിക്കും.
- ഒരു ലൈഫ് ഇൻഷുറൻസ് പോളിസിഹോൾഡർക്ക് പോളിസി നിരസിക്കുന്നതിന് 15 ദിവസത്തെ (പോളിസി കിട്ടിയ ദിവസം മുതൽ) ഫ്രീ ലുക്ക് പിരിയഡിന് (സൗജന്യ പരിശോധന സമയം) അർഹത ഉണ്ടായിരിക്കും.
- പോളിസി ഹോൾഡേഴ്സിൽ നിന്നും ലഭിക്കുന്ന കത്തുകൾക്ക്, കിട്ടിയ10 ദിവസത്തിനകം ഇൻഷുറൻസ് കമ്പനി മറുപടി നലക്കണം.

പൊതു താല്പര്യാർത്ഥം ഇറക്കുന്നത്:

ഇൻഷുറൻസ് റെഗുലേറ്ററി ആൻഡ് ഡെവലപ്മെന്റ് അതോറിറ്റി,

3-ാം ഫ്ലോർ, പരിശ്രമ ഭവനം, ബഷീർബാഗ്,
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view point

The IAIS is committed to ensuring that insurance supervisory tools are continuously improved and kept up-to-date with developments.

Mr. Peter Braumuller
Chairman, IAIS Executive Committee

A single federal blueprint is unlikely to be effective in every state since health care delivery systems, demographics, rural and urban mix, economies and labor markets are distinctive; and regulations that fail to take those distinctions into account will damage markets and consumers.

Ms. Sandy Praeger
Kansas Insurance Commissioner
and Chair of the NAIC Health Insurance and Managed Care Committee

It is not desirable for the regulator to take part in micro-management of operations. It is expected that the players display enough maturity in ensuring that the hard work done to ensure a free market will not go waste.

Mr J Hari Narayan
Chairman, Insurance Regulatory & Development Authority, India

The stress tests revealed that while financial institutions' financial resources would be affected by lower asset values, rising credit costs and moderating earnings; they are generally resilient even under stress conditions.

Mr. Heng Swee Keat
Managing Director, Monetary Authority of Singapore

Varying responses at different stages of the (global financial) crisis have shown wide ranging degrees of success. The objective to be achieved is the restoration of stability in the financial markets, the resumption of credit flows and the return of confidence.

Dr. Zeti Akhtar Aziz
Governor, Bank Negara Malaysia

The world economy has faced an unprecedented crisis following the global recession triggered by the turmoil in the financial and capital markets. Having experienced such a financial crisis, we are now required to ensure more sophisticated risk management, and to further strengthen our financial ground.

Mr. Masatoshi Sato
Chairman, General Insurance Association of Japan