Journal

Claiming Loyalty Through Claims Settlement

Journal

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From the Publisher

Claims Management has always been the most important function of an insurer. It has to be handled delicately as the policyholders tend to look at any delay as a breach of contract. The insurer, however, has to ensure that only genuine claims get the eventual nod so that fraudulent tendencies of potential tricksters are arrested. This is very essential for the success of the industry which is largely vulnerable to frauds.

It needs no emphasis that the function of claims management is closely associated with the other vital function at the upfront - Underwriting. Insurers would do well to ensure that their underwriting skills are at a high pedestal so that settlement of claims, whenever they arise, becomes a much simplified job. The trends of accepting all risks in order to enhance the business portfolio; and then indulge in 'claims underwriting' should be avoided.

It is also essential that insurers undertake an analysis of the various classes of insurance, particularly in those areas with huge claims ratios. They should eventually work towards attaining self-sufficiency in all classes of business. Cross-subsidization, among policyholders or within classes of insurance, is detrimental to the success of the industry in the long run. Claims Management is the focus of this issue of the Journal and we have different perspectives and viewpoints on this vital function, authored by a cross-section of experts.

Of late, the subject of money laundering is assuming great importance in financial circles. Although insurance has not been seen as a major conduit for money launderers, the possibility cannot be totally wished away. The next issue of the Journal would focus on 'Money Laundering and Insurance'. We are inviting experts to share their thoughts with us in this vital area.

C.S.Rao

C.S.RAO

ISSUE FOCUS

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APPARAO MACHIRAJU

Gaining Customer Confidence...

In an emerging market, where the awareness levels are still at a low ebb, it would be ambitious to expect the average policyholder to understand the nuances of the insurance contract in their entirety. Even equating the premium paid to purchase an insurance policy and an investment made that assures a return; also cannot be totally ruled out. It should be realized that payments in insurance contracts are contingent on the happening of the event which is covered.

With the exception of several of the life insurance products, there is no assurance and this must be thoroughly ingrained into the mindset of the clientele. Further, in most of the insurance contracts (barring life, once again), there are covered perils and excluded ones. It should be analyzed properly whether there is in fact a claim, and if so to what extent, before putting up a claim.

Insurers, on their part, would do well to separate the genuine claims from the others so that, in the end, the very mechanism of insurance emerges victorious. Even in case a claim is to be repudiated for whatever reasons, it should be done with absolute clarity and justification so that the claimant is not disillusioned. It is, however, easier said than done. The success of the insurer depends on how efficiently he has managed to accomplish this task.

Claims Management forms the focus of this issue of the journal. Considering the huge popularity of this subject and various experiences associated with it, we have several articles written by practitioners - some present, and some past. To start with, Mr. Shiva Belavadi highlights the importance of proper handling of the claims portfolio in life insurance, with an emphasis on contractual obligations. Mr. Swaraj Krishnan talks about the importance of adopting a holistic approach in claims management.

Mr. G.V. Rao takes a critical look at the role of the insurers in this domain and goes on to suggest measures for improvement. The role of the claims manager in different areas like catastrophes, frauds and litigation is brought home succinctly by Mr. Antony Jacob. Liability insurance is a world in itself and poses several challenges to the insurer. Ms. Uttara Vaid talks about the multiplicity of claimants in this vital area. Handling claims to the utter satisfaction of the policyholder is the 'dharma' of the insurer in the words of Ms. Yegnapriya Bharath. Mr. Ganesh Iyer underlines the importance of personal touch in settling life insurance claims. In the end, we have Mr. D.V.S. Ramesh discussing the salient aspects with a touch of practical experience in the settlement of claims in life insurance.

We also have an article by Mr. Appa Rao Machiraju that discusses the role of insurance in the overall economic development; in the 'thinking cap' section. Besides, we have the statistics of life insurers and non-life insurers for the year ended March, 2006.

The focus of the next issue of **IRDA Journal** would be 'Money Laundering and Insurance'. Several experts would be penning their thoughts on this very topical issue.

U. Jawaharlal

Report Card:LIFE

Premiums rise 41% for the year ended 31st March 2006

Individual Premium:

The life insurance industry underwrote Individual Single Premium of Rs.10,99,898.97 lakh during 2005-06, of which private insurers garnered Rs.2,24,590.09 lakh and LIC garnered Rs.8,75,308.88 lakh. The corresponding figures for the previous year were Rs.590461.13 lakh for the industry with private insurers underwriting Rs.101578.32 lakh and LIC Rs.488882.81 lakh. The Individual Non-Single Premium underwritten during the year ended 31st March 2006 was Rs.19,88,904.29 lakh, of which the private insurers underwrote Rs.6,94,322.40 lakh and LIC Rs.12,94,581.89 lakh. The corresponding figures for the previous year were Rs.1524582.74 lakh of which the private insurers underwrote Rs.386512.42 lakh and LIC Rs.1138070.32 lakh.

Group Premium:

The industry underwrote Group Single Premium of Rs.4,40,624.12 lakh of which the private insurers underwrote Rs.45,996.35 lakh and LIC Rs.3,94,627.77 lakh: the lives covered being 1,23,29,399; 8,61,391 and 1,14,68,008 respectively. The corresponding figures for the previous year were Rs.401397.94 with private insurers underwriting Rs.31,125.55 lakh and LIC Rs.3,70,272.39 lakh; and the lives covered being 8707628; 5,65,254 and 81,42,374 respectively. The Group Non-Single Premium underwritten during the year ended 31st March 2006 was Rs.60,368.13 lakh and was underwritten entirely by the private insurers, covering 28,51,686 lives. The corresponding figures for the previous year were Rs.36,523.30.07 lakh covering 22,45,355 lives.

Segment-wise Segregation:

A further segregation of the premium underwritten during the year indicates that Life, Annuity, Pension and Health contributed Rs.26,38,529.36 lakh (73.57%), Rs.1,54,382.34 lakh (4.30%), Rs.7,92,852.43 lakh (22.11%) and Rs.736.56 lakh (0.02%) respectively to the total premium. In respect of LIC, the break up of life, annuity and pension categories was Rs.16,95,656.80 lakh (66.12%), Rs.1,40,275.38 lakh (5.47%) and Rs.7,28,586 lakh (28.41%) respectively. In case of the private insurers, Rs.9,42,872.56 lakh (92.26%), Rs.14,106.96 lakh (1.38%), Rs.64,266.06 lakh (6.29%) and Rs.736.56 lakh (0.07%) respectively was underwritten in the four segments.

Unit Linked and conventional premium:

Analysis of the statistics in terms of linked and non-linked premium indicates that 55.22% of the business was underwritten in the non-linked category, and 44.78% in the linked category, i.e Rs.19,80,433.27 lakh and Rs.16,06,067.42 respectively. In case of LIC, the linked and non-linked premium was 29.76% and 70.24% respectively; as against which for the private insurers taken together, this stood at 82.48% and 17.52% respectively.

First Year Premium Underwritten by Life Insurers for the financial year 2005 -06

Sl	Insurer	Premium U/W (Rs. In Lakhs)			No. of Policies / Schemes			No. of lives covered under Group Schemes		
		March	Year Ended 31st March'06	Year Ended 31st March'05	March	Year Ended 31st March'06	Year Ended 31st March'05	March	Year Ended 31st March'06	Year Ended 31st March'05
1	**Bajaj Allianz**									
	Individual Single Premium	37729.30	150623.62	45144.52	43278	127571	41940			
	Individual Non-Single Premium	39172.37	118483.96	40122.97	218131	653913	246107			
	Group Single Premium	105.76	332.28	0.00	0	1	0	452	1196	0
	Group Non-Single Premium	531.85	2122.20	734.31	36	200	144	96025	394990	362531
2	**ING Vysya**									
	Individual Single Premium	787.61	1735.35	57.06	606	1656	8393			
	Individual Non-Single Premium	7116.14	24341.37	26625.83	29831	124407	102655			
	Group Single Premium	38.14	932.28	985.22	0	0	0	105	2508	2282
	Group Non-Single Premium	480.64	1398.95	494.35	12	72	82	28971	53951	46763
3	**Reliance Life**									
	Individual Single Premium	1628.71	12019.13	6235.98	2516	17663	7639			
	Individual Non-Single Premium	2478.84	6455.29	2325.60	20851	61708	27554			
	Group Single Premium*	0.00	0.00	185.87	0	0	1	0	0	190
	Group Non-Single Premium	157.71	869.35	370.99	9	93	74	10681	129335	95116
4	**SBI Life**									
	Individual Single Premium	5283.28	12865.78	6992.69	8458	20379	7963			
	Individual Non-Single Premium	14492.32	30937.15	9839.46	82045	263118	118351			
	Group Single Premium	5029.86	24177.84	26582.93	0	2	6	32636	212604	265614
	Group Non-Single Premium	6801.50	14870.75	4878.48	239	1943	3654	180452	856633	702769
5	**Tata AIG**									
	Individual Single Premium	127.89	607.61	0.00	0	0	0			
	Individual Non-Single Premium	5083.64	38049.58	25020.74	37429	295690	228640			
	Group Single Premium	453.75	2575.42	533.71	2	4	0	16970	156556	81773
	Group Non-Single Premium	138.92	5115.69	4467.63	29	255	254	14462	417993	234377

6	**HDFC Standard**									
	Individual Single Premium	2190.56	11902.74	8344.83	13898	118647	79135			
	Individual Non-Single Premium	15696.34	77476.64	35323.04	49386	255536	207227			
	Group Single Premium	5790.26	10623.25	2064.18	31	119	155	70417	185481	157517
	Group Non-Single Premium	1377.63	2891.40	2883.03	10	29	42	8145	22444	49176
7	**ICICI Prudential**									
	Individual Single Premium	17143.92	25099.41	12810.02	20103	51955	7305			
	Individual Non-Single Premium	42831.01	210103.21	134439.74	145598	786008	607214			
	Group Single Premium	1753.00	5943.64	193.99	9	121	51	28758	267382	52913
	Group Non-Single Premium	6415.40	22601.94	10964.71	36	158	103	101206	207311	56449
8	**Birla Sunlife**									
	Individual Single Premium	810.18	2765.86	2330.19	4135	68833	50447			
	Individual Non-Single Premium	14428.01	56295.48	50780.14	56651	196979	147836			
	Group Single Premium	113.54	985.50	468.52	0	0	1	786	6648	4163
	Group Non-Single Premium	4653.61	7762.98	8549.47	41	83	86	35461	47959	77484
9	**Aviva**									
	Individual Single Premium	259.03	1102.79	652.40	287	2774	1611			
	Individual Non-Single Premium	9477.51	39131.10	17962.72	35005	161215	81567			
	Group Single Premium	16.63	139.08	111.14	0	0	1	108	894	802
	Group Non-Single Premium	49.30	380.86	503.01	10	26	30	14497	190647	295736
10	**Kotak Mahindra Old Mutual**									
	Individual Single Premium	1004.90	3291.18	18518.39	3576	6836	2224			
	Individual Non-Single Premium	14710.74	34884.69	17450.32	21395	89802	61174			
	Group Single Premium	60.73	280.73	0.00	2	4	0	3878	18068	0
	Group Non-Single Premium	594.94	1297.06	1506.50	29	108	70	30032	131585	94344
11	**Max New York**									
	Individual Single Premium	51.19	201.84	226.79	42	274	238			
	Individual Non-Single Premium	7860.41	43936.42	21602.36	57908	423404	216344			
	Group Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Group Non-Single Premium	81.25	189.29	639.86	19	102	89	32466	66919	68933
12	**Met Life**									
	Individual Single Premium	164.73	648.39	265.45	274	1396	622			
	Individual Non-Single Premium	3192.51	12746.77	4854.80	16846	94025	45940			
	Group Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Group Non-Single Premium	163.14	867.65	528.58	19	184	122	46675	331919	159297
13	**Sahara Life**									
	Individual Single Premium	543.06	1726.39	0.00	1390	4387	0			
	Individual Non-Single Premium	72.29	449.48	164.71	3470	18910	10201			
	Group Single Premium	5.01	6.34	0.00	9	23	0	8637	10054	0
	Group Non-Single Premium	0.00	0.00	2.38	0	0	13	0	0	2380
14	**Shriram Life**									
	Individual Single Premium	0.00	0.00		0	0				
	Individual Non-Single Premium	1012.58	1031.25		20237	20797				
	Group Single Premium	0.00	0.00		0	0		0	0	
	Group Non-Single Premium	0.00	0.00		0	0		0	0	
	Private Total									
	Individual Single Premium	67724.37	224590.09	101578.32	98563	422371	207517			
	Individual Non-Single Premium	177624.70	694322.40	386512.42	794783	3445512	2100810			
	Group Single Premium	13366.68	45996.35	31125.55	53	274	215	162747	861391	565254
	Group Non-Single Premium	21445.88	60368.13	36523.30	489	3253	4763	599073	2851686	2245355
15	**LIC**									
	Individual Single Premium	202580.17	875308.88	488882.81	492681	2274387	1625292			
	Individual Non-Single Premium	388979.09	1294581.89	1138070.32	10214329	29298160	22334411			
	Group Single Premium	89492.79	394627.77	370272.39	3716	18160	18420	1557220	11468008	8142374
	Group Non-Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Grand Total									
	Individual Single Premium	270304.54	1099898.97	697725.96	591244	2696758	1887549			
	Individual Non-Single Premium	566603.79	1988904.29	1524582.74	11009112	32743672	24435221			
	Group Single Premium	102859.47	440624.12	401397.94	3769	18434	18635	1719967	12329399	8707628
	Group Non-Single Premium	21445.88	60368.13	36523.30	489	3253	4763	599073	2851686	2245355
	Grand Total									
	Individual Single Premium	270304.54	1099898.97	590461.13	591244	2696758	1832809			
	Individual Non-Single Premium	566603.79	1988904.29	1524582.74	11009112	32743672	24435221			
	Group Single Premium	102859.47	440624.12	401397.94	3769	18434	18635	1719967	12329399	8707628
	Group Non-Single Premium	21445.88	60368.13	36523.30	489	3253	4763	599073	2851686	2245355

*Group single premium numbers have been revised by Reliance Life

Note: Cumulative premium upto the month is net of cancellations which may occur during the free look period.

Cleansing Ill-gotten Wealth

Although insurance has thankfully remained out of reckoning as a conduit for money laundering, to a great extent; it would be naïve to believe that it is totally safe argues **U.Jawaharlal.**

The year 2001 remains to be a vastly significant year in the annals of world history, so much so that there is no wonder if sometime in future, one refers to a particular period of time as pre-WTC or post-WTC. The impact of terrorism on humanity has been so severe and deep-rooted. Terrorism existed even earlier but WTC marked altogether a new beginning about the impact that a single event could make. It showed how it could affect various aspects of human life; and the geographical spread that it could reach.

In the aftermath of WTC, a series of legislations with global significance have been made - USA PATRIOT ACT 2001, TRIA 2002 etc., to name just a few. The hallmark of most of these legislations has been that they focus on countering and combating the financing of terrorism; and they are closely associated with money-laundering. A great deal of importance has been attached to prevention of money laundering activities also; and almost every major economy has come out with its own version of this vital legislation.

Money laundering has become a global menace and several unscrupulous elements are on the prowl, waiting for opportunities to find a conduit for cleansing their ill-gotten wealth. It has become more virulent in the liberalized environment as organized nefarious groups generate huge sums of money in various criminal activities like drug trafficking; arms smuggling; and financial crime above all; and hence the need to launder. Looking at the large sums that are generated, the possible avenues that are the usual targets are movie industry, real-estate etc. where there is scope for pumping in huge funds.

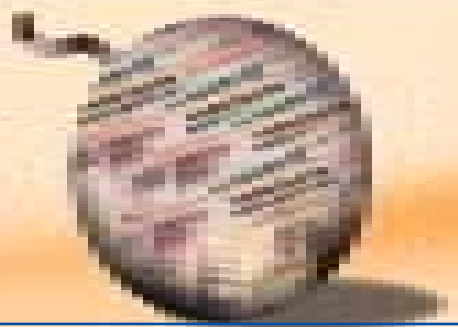
Even banks, the financial pillars of any economy, could become a target as they solicit funds in large quantities in order that their other main function - credit dispensation - does not suffer from a lack of funds. Accordingly, there is a lot of emphasis on knowing one's customer before entertaining any major relationship. Insurance has thankfully remained out of reckoning to a great extent but the vulnerability cannot be totally ruled out. Some sensitive areas could be the single premium or unit-linked products in life insurance; a tendency to surrender life policies frequently etc.

One area of insurance business which could be a sitting duck for money-launderers is the secondary dealing of life insurance policies. As of now, secondary market for life insurance policies does not exist in India; and to this extent, the insurance industry can be said to be secure. All the same, there is need for being alert at all times and hence it has been felt right to make it mandatory for all insurers to be compliant with the various requirements in this domain.

In order that any tendencies for using insurance as a medium for disguising one's illegally acquired wealth are thwarted, it is important that there is quick flow of information across the players, cutting down their professional confidentialities. The staff, at all levels, should be trained about the implications of the possible avenues, from time to time. Above all, insurers should take care to avoid pitfalls in the form of big business opportunities and strictly comply with all the requirements of the statute.

'Money Laundering and Insurance Industry' is the focus of the next issue of **IRDA Journal**. We will be bringing you some precious thoughts in this domain from experts in the field.

Money Laundering and Insurance Industry



In Our Next Issue....

Re: IRDA (Assets, Liabilities and Solvency Margin of Insurers) Regulations, 2000-Clarifications

31st March, 2006

To

All Life Insurers, Non Life Insurers and Re-insurers.

Queries have been raised by insurers on various matters relating to the manner of computation of solvency margin as provided in the Regulations. To ensure consistency in the interpretation of the Regulations, the following clarifications are issued. Insurers are required to ensure compliance with these clarifications while computing the solvency margin as at 31st March, 2006 and thereafter.

1. Table I to Form KG: Statement of Solvency Margin: (General Insurers) - (a) Gross Premium for the purpose of Solvency Margin shall be the aggregate of gross direct premium and reinsurance accepted premium; and (b) Incurred claims: Explanation (ii) to Section 64VA of the Insurance Act, 1938 stipulates that net incurred claims means the average of the net incurred claims during the specified period of not exceeding three preceding financial years. It is now clarified that: i. the Gross Incurred Claims and Net Incurred Claims (inclusive of IBNR and IBNER) shall be taken as the average of the previous three years (excluding the financial year with reference to which the solvency of the insurer is being computed) and shall in no case be less than the amounts of Gross and Net incurred claims for the financial year ending on the reporting date; and ii. The incurred claims should also include claims pertaining to reinsurance accepted.

2. Valuation of Assets: Schedule I of the Regulations - Clause 2 (3) of the Regulations provides that all assets of an insurer, other than those specified at (1) and (2), have to be valued in accordance with the IRDA (Preparation of Financial Statements and Auditor's Report of Insurance Companies) Regulations, 2002. However, as a matter of prudence and also consistent with the requirement of section 64 V (1) (i) of the Insurance Act, 1938 which states that "assets shall be valued at values not exceeding their market or realizable values", for the purpose of computation of solvency margin, debt securities shall be valued at lower of the amortized cost and the market value.

   It is, thus, clarified that while for the purpose of preparation of financial statements the debt securities would continue to be valued at the amortized cost, for the purpose of computation of solvency margin, these shall be valued at lower of the amortized cost and the market value.

3. Clause 2 (ii) to Schedule II-B of the regulations lays down the manner of determination of Reserve for Unexpired Risk. Some insurers have misinterpreted this provision to mean that even where the actual reserves maintained in the Accounts of the insurer are higher, it is adequate to use the percentages stated in the Regulations for assessing the solvency margin.

   It is clarified that it will not be prudent to consider a reserve for computation of solvency margin which is less than that created in the financial statements.

   Accordingly, the Reserve for Unexpired Risks taken into account for the purpose of computation of solvency margin should be the higher of (i) the actual reserve maintained in the books of accounts of the insurer and (ii) the URR arrived at based on the percentages stated in the Regulations for each class of business stated therein.

4. Deferred Tax Assets: Section 64 V (1) of the Insurance Act, 1938 and the regulations list out the assets which shall be assigned value "zero". While "Deferred Tax Assets" have not been listed there under, as a matter of prudence, it is hereby advised that such assets shall also be assigned "zero" value for the purpose of computing solvency margin.

   All insurers are advised to ensure compliance with the clarifications issued herewith effective from the statements as at the end of financial year 2005-06.

Sd/-
(C.S. Rao)
Chairman

Re: Guidelines on Anti Money Laundering programme for Insurers

31st March, 2006

To

All the Insurers.

Dear Sir/Madam

1. The Prevention of Money Laundering Act, 2002 (PMLA) has been brought into force with effect from 1st July 2005. Necessary Notifications / Rules under the said Act have been published in the Gazette of India on 1st July 2005 by the Department of Revenue, Ministry of Finance, and Government of India.
2. As per the provisions of the Act, every banking company, financial institution (which includes Insurance company) and intermediary shall have to maintain a record of all the transactions; the nature and value of which has been prescribed in the Rules notified under the PMLA.
3. The Guidelines are being issued to the insurers in the context of the recommendations made by the Financial Action Task Force (FATF) on anti-money laundering standards.
4. You are advised to ensure that a proper policy framework as per the Guidelines on anti-money laundering measures is put into place by 1st July 2006. You are also advised to designate an officer as 'Principal Compliance Officer' who would be responsible for ensuring compliance of the provisions of the PMLA. Names, designation and addresses (including e-mail addresses) of 'Principal Compliance Officer' should be intimated to the Office of the Director-FIU, 6th Floor, Hotel Samrat, Chanakyapuri, New Delhi 110021 India and to the Authority immediately.
5. This circular is being issued in exercise of powers conferred under Section 34 of the Insurance Act, 1938.

Yours faithfully,
(C. R. Muralidharan)
Member

Tendering for Insurance Covers

19th April, 2006

To,

All CEOs of General Insurance Companies

It has been reported to IRDA that a practice of calling for tenders for insurance cover required by some clients has developed and that in some of these tender exercises, the insurer is required to pay some amount for buying the tender documents and also to pay an earnest money deposit.

It has also been reported that in some cases clients invite bidding through the internet where the portal is kept open for a short window of time and insurers are expected to compete on price.

Insurers are reminded that competition should not result in introduction of practices that are not suitable to technically sound transaction of insurance business. Insurance cannot be transacted like sale of a commodity. Proper underwriting requires that the insurer fully understands the requirements of the client and is able to ask for and receive all the information required to support a technically sound rating of the covers required. This is obviously not possible in the sealed tender system or e-bidding system. Besides, limiting competition to price alone is against the interests of the client to whom quotation is offered and since the policyholders' fund ultimately is affected by the results of the business, it is generally against policyholders' interests.

Insurers are therefore, advised to inform any client seeking to use the tender process about the impropriety of that system for insurance business and offer to provide competitive quotations for the covers best suited to the needs of the client after obtaining all the required underwriting information. Insurers should not canvass business through a non-participative process of tendering or e-bidding.

The Authority reserves the right to require an insurer to state the process of quoting terms for a particular client and to technically justify the premium quoted for its covers.

SD/-
(C. S. Rao)
Chairman

Press Release Regarding Motor Third Party insurance cover

16th March 2006

Regional Transport Authorities, Transporters and members of the insuring public have brought to the attention of the Authority instances of refusal of motor insurance by general insurance companies.

Members of the public are informed that the Authority has on several occasions instructed all General Insurers that Motor Third Party insurance cover cannot be refused. Motor Third Party Insurance cover is a mandatory requirement under Section 146 of the MV Act 1988 and cannot be denied by any insurer.

Members of the public may bring to the notice of the Authority any refusal of Motor Third Party insurance(s), of vehicles used by them, by general insurers along with evidence thereof so that the Authority can take necessary action in this regard.

(C. S. Rao)
Chairman

Empathizing with the Claimant

-- A Perspective on Life Insurance Claims

The golden key for success of a life insurer is the deliverance of the promise. No moment of truth can be greater than a claim handled well writes **Shiva Belavadi.**

Introduction

Claims Activity is popularly perceived to be the 'end of the spectrum' activity in the insurance process. It is considered to be the logical end of the insurance life cycle which comprises of Prospecting, Assessment, Premium Payments, Policy Delivery, Policy Servicing and finally Claims. Is this a correct reflection of the realities and a fair representation of the expectations of the stakeholders in the insurance process? This probably does not reflect the full picture.

Defining the Purpose

When the proposer/insured pays insurance premium due, consequent upon an application for insurance, he/she substantively fulfils his/her part of the insurance contract. The other significant performance in the contract is the payment of a claim either upon maturity or on the occurrence of a contingent event. This, as we all know, is the primary performance obligation imposed upon the insurer by the insurance contracts. The delivery of the promise from the insurer's side is by payment of a claim. Delivering the promise is indeed that moment of truth, a culmination of the cycle which completes the obligations placed upon the insurer in the insurance process.

If we reflect further, there is a deeper purpose. It is innate in man to take risks. We have people climbing the Himalayas today as did the sailors who circumnavigated the globe in the 14th and 15th centuries. What starts off as an adventure of brave men, transcends to a loftier purpose when the same activity could be done repetitively for economic gain. With economic activity there is generation of wealth; and with wealth, well being of people at large. When there is repetitive economic activity with exposure to risks, participants form a pool to collectively seek redressal from at least some common risks to which all participating members are exposed.

The delivery of the promise from the insurer's side is by payment of a claim. Delivering the promise is indeed that moment of truth, a culmination of the cycle which completes the obligations placed upon the insurer in the insurance process.

Claim settlement activity is the only activity which finally delivers to the unfortunate few who need solace and succor from the pool. All other activities in an insurance company are usually sources of inward remittances for insurance companies. The purpose of claims activity is to quickly put the unfortunate members of the group or their dependents, who have encountered the insured contingent event, back on rails, so that further economic activity can take place; and serve mankind by creation of wealth.

Life Insurance - Purpose of Claims Activity

In life insurance the purpose is served by fairly assessing the economic value of man to his family, trade or occupation. At the first level the person who buys insurance gets the comfort that his family will indeed be taken care of in the event of his death. He is thus enabled to participate in economic activity without worries. Admittedly productivity without worries would be much higher.

Thereafter, at the subsequent level, when a claim is paid to the family, this puts the family out of economic distress and on to normal human productive activity. These family members in turn, become wealth generators for the economy.

The fact that the claim monies being paid usually belong to the spouse and children of the person insured/deceased makes the purpose of life insurance claims that much more altruistic, immediate and relevant.

Ultimately, the pristine purpose of insurance!!!

Applying First Principles into Life Insurance Contracts:

It is imperative that we understand the applicability of the fundamental principles of insurance to appreciate the relevance in the claims activity.

(a) Utmost Good Faith

Life insurance is a mere promise; a promise which holds far greater significance and sensitivity than any other; a promise which at the end of the day crystallizes only on a piece of paper. These are words of honor given

with a commitment in which *uberrima fides* becomes one of the cornerstones of this commitment. The principle becomes operational from the time of application for insurance and pervades through the life of the insurance contract. Compliance with this is usually checked out preceding a claim payment.

It must be recognized that *Caveat Emptor* is no more in fashion today. Utmost good faith should be on exhibit from both parties to the insurance contract. Whatever be the end, in the hour of conflict on interpretation of intent and meaning, *contra proferentum* - interpretation of the document against the person who drafted it - should be invoked. Breach of *uberrima* fides would have serious repercussions on the existence and implementation of the contract. Thus it cannot be a mere mechanical application of the letter of an insurance contract, but jointly of the letter and spirit of the contract. This is a core function of the claims activity.

(b) Insurable Interest

Since the subject matter of insurance is precious human life, the benefits of the contract when invoked, would not go to the promisee but to those whom he deems fit - the nominees/assignees. Hence, it is a fair premise to ensure that the nominees/assignees indeed have a legitimate interest and hence ensure the fulfillment of the second fundamental principle of insurance.

(c) Indemnity

It is often stated that there is no relevance of the principle of indemnity in life insurance and is applicable only in general insurance. A prognosis will reveal there is indeed some relevance. The purpose of insurance is not to enable a profit but to mitigate a loss. The loss to the family is the income of the provider upon his death. This is usually limited to the economic value of the life assured.

Adherence to this principle is made sure at the time of underwriting of a proposal. Through financial underwriting, the insurer ensures that no person is worth more dead than alive. Insurers of all hues shun profiteering!

Critical aspects in claims handling

(1) Trusteeship element in the Claims function

The business of insurance revolves around distribution of risk. A pool of funds of/from the customers is created, the objective being to allow a payback to the customer in his hour of need. This outage from the pool needs to be monitored stringently and ensure that it goes to the right people. It therefore goes unsaid, that the persons sanctioning claims have to demonstrate a high degree of integrity and trustworthiness essentially because these persons sit in a position of trustees of the pool, which although unannounced, is one of immense importance and responsibility.

Documentation should be principally intended to establish the fact, cause of the event along with surrounding circumstances. It should not be converted into a ritual which would have a significant effect of slowing down claim payment.

Claims Department, as trustees of the policyholders, are representatives of the faith which has been reposed in the Insurers by the customers at the time of paying the premiums and it is a responsibility cast upon them to be fair, just and honorable at the time of opening the sluice gates of this pool.

(2) Documentation

It must be recognized that a document always follows a fact. For instance, death occurs first and the death certificate follows. As much as the focus has to be on proving the legitimacy of the claim, in the current scenario, exhaustive documentation mandated for claims processing is *passé*. Documentation should be principally intended to establish the fact, cause of the event along with surrounding circumstances. It should not be converted into a ritual which would have a significant effect of slowing down claim payment. Whilst completing documentation we should not lose sight of the fundamental purpose mentioned above.

Exhaustive documentation may assist in proving the legitimacy of the claim. However, in the process, the onus of proving the legitimacy of intent as well as of the claim is being shifted onto the insured and /or the beneficiary. It is unequivocal that the responsibility of proving the legitimacy of the claim, or otherwise, is on the insurer, rather than on the customer.

Processes and sub-processes need to be detailed to achieve the goal of sifting claims -"legitimate" from "illegitimate"; and "valid" from "invalid". Circumstances and exigencies hampering production of the requisite documents should not automatically push the claim into a state of suspended animation. Further, insistence on calling for facts and documents for the purpose of fulfilling statistical needs or because "it is meant to be done" or because "we need to know" irrespective of the outcome on the final decision regarding the claim is unjustified.

In that tone, it goes unsaid that factual circumstances surrounding the event, not supported by official documentation, have to be as much taken into consideration as the available documents, especially when it is in favor of the client.

However, declinations have to be explicitly on the strength of the written document and should be dissected thread-bare to establish the "legitimacy" of the insurer's decision. In the final analysis, every claim decision will also have to stand the test of scrutiny in a court of law.

(3) Interpretation of the Contract

It is important that the text of the contract has to be interpreted in spirit along with the word. It should not to be used as an offensive weapon against the customer. However, any waiver of the stringent checks and conditions in the contract at the time of a claim to facilitate interpretation of the spirit of the contract in favor of the customer has to be controlled and monitored because of the risk of inconsistency in interpretation and implementation.

That said, under extenuating circumstances, when a clear fraudulent intent is established beyond doubt, it is imperative that the policy conditions are unleashed in full strength to demonstrate that a "pro-customer" approach is not to be interpreted as a sign of weakness, but one of supreme strength.

The spirit of the trusteeship in the claims function should always be maintained in interpretation since one or more policyholders cannot have undue benefits to the exclusion of others.

(4) Investigations

Professional investigation of life insurance claims is at an embryonic stage. The investigators are largely drawn from the pool of investigators who were working for the general insurance industry.

The absence of experienced workforce, in the field as well as within the insurers, is impeding the healthy development of this art. Both the assignor and the assignee grapple with relative inexperience and try to piece together a jigsaw. With no clear directives forthcoming, investigators tend to handle investigation of life insurance claims rather tentatively taking a lot of time for submission of reports. There is also a tendency to use investigations as a convenient device to pass on responsibility of ascertaining data, facts or information; and drawing conclusions therefrom to prevent potential audit queries.

The tone of investigations has to border on sensitivity as the entire process revolves around a deceased person and a bereaved family. This could, not only offend sensibilities in the Indian scenario, but could also run the risk of intruding upon zones of privacy being privy to information which the man on the field may not be equipped to carry.

The spirit of the trusteeship in the claims function should always be maintained in interpretation since one or more policyholders cannot have undue benefits to the exclusion of others.

The challenge is, therefore, not only to streamline the process to meet our end requirements but to do the same without crossing the thin line separating tact from brusque so as to make the customer a part of the loop, thereby buying his cooperation in speedily closing out the process.

(5)Fraud - An exception

All Insurers are in the business of paying claims to serve the purpose of insurance. Most claims would be from honest contracts and from persons having the first rights on the funds in the insurance pool.

Notwithstanding this, it does not imply that all claims would get paid. Only legitimate claims warrant settlement. Legitimacy of a claim is a contentious issue and the objective is to establish this by causing least possible inconvenience to the client. The sanctified legal principle is *'Innocent until proven guilty'*. Considering the nascent stage of the private life insurance industry, where most of the target population has practically no knowledge of the industry, it would be extremely unproductive for claim analysts to consider all claimants being *'Fraudulent until proven otherwise'*.

In Conclusion

Section 45 of the Insurance Act, rulings of ombudsmen and consumer courts all over are pointers to the fact that the room for 'forcing decisions on gullible insureds' is progressively a thing of the past.

Through the entire insurance life cycle from prospecting through policy issuance and servicing a claim, the golden key is the deliverance of the promise. No moment of truth can be greater than a claim handled well.

The core value which a claims analyst must embrace at all times is 'empathy'. Without stepping into the shoes of the bereaved family, it is very difficult to do justice from a distance. In payment as also in declination, what is most important is to be sensitive to the policyholders, who indeed have first rights over the pool of funds they create.

Admittedly, handling the claims function involves balancing and managing the interests of multiple stakeholders including policyholders and shareholders. If this is indeed done, there will be scope for co-opting insured persons as active participants into the insurance process rather than being a mute bystander at best or a victim in the worst. This will, in turn, sow the seeds for greater growth of the industry as a whole in the long term.

The author is Director - Claims, MetLife India Insurance Co Pvt. Ltd., Bangalore. The article expresses the personal views of the author; and not those of MetLife India Insurance Co Pvt. Ltd.

Prompt Claim Settlement

- The Success Mantra

Due to the diverse nature and myriad claims that we face, a natural extension of a claims department is in the form of claims trending and risk management input opines **Swaraj Krishnan**.

When the industry was opened up in 2000, the new players could just talk about the strength of their promoters to win over customers, as there was little product differentiation. However the real credibility and trustworthiness of an insurance company is put to test when a claim actually arises. It is the empathy towards the customer/client and a sound understanding of the terms of cover, which determines the strength of the insurance company. In other words an insurance company's reputation is evaluated by its ability to fulfill its promise of being there when the customer needs them the most i.e. when they submit their claims for the risks chosen. Moreover an insurance company also has an arduous task to ensure an equitable and rational claims settlement. Claims settlement or more appropriately prompt claim settlement should be the maxim for any insurance company. We have been striving for quick settlement since our inception as we realized that this could also be used as an effective marketing tool.

It would not be an exaggeration to say the customer service begins with claims settlement and need not necessarily begin with the policy issuance. Claims settlement plays an intrinsic role in providing a whole consumer centric insurance solutions. You could to certain extent, cherry pick the business that you want to underwrite in line with your underwriting policies, but not the claims, which has to be paid.

Process changes - Over the years, the process of claims settlement has also improved drastically and has witnessed several innovations. Cashless settlement is one of the prominent changes, which has benefited the customers. This process is available in case of hospitalization claims and has been extended to motor repair claims much to the relief of the customers. These procedures have also helped insurance companies to improve their customer service.

> It is the empathy towards the customer/client and a sound understanding of the terms of cover, which determines the strength of the insurance company

A lot of claims processing jobs have also generated new intermediaries like Third Party Administrators (TPA) for hospitalization claims. In motor insurance, many insurers have tied up with motor garages / workshops for quick settlement of claims of their customers.

Use of technology - Technology also has been used to improvise the process of settling claims. Now customers can register a claim, view the claim status and monitor its progress till its settlement. Claims can be registered on-line and the claimant need not visit the insurer's office. What is more, they can download the relevant forms and even track the status.

Transparency - For new players the only way to demonstrate their earnestness in prompt settlement of claims is to be as transparent as possible. A regular evaluation of the performance and benchmarking against the best insurance companies worldwide is a good way of monitoring the process. For example, MIS reports in the form of ageing analysis assists in ensuring awareness among the claims team. This, coupled with performance monitoring, ensures day-to-day updates on claims position.

An escalation mechanism for any non-settlement of claims is a good practice to ensure transparency and quick action by the operational team.

Payment of claims - Once the loss is assessed and procedures are set, the most crucial aspect is the payment of claims. Here also there have been massive changes, which benefit the customers. Apart from the standard practices of On-Account payments, improvement in technology from the banking side has also made possible of electronic transfer of funds directly to the claimants' designated bank accounts. This has reduced the time lag and all its associated problems.

Natural calamities, an opportunity- The recent floods in Mumbai and other cities, provided an opportunity to the private insurers to prove their ability to handle large claims. Many of them have used this to ramp up their claim settling operations.

Several insurers issued advertisements in print and television displaying the claim hotline numbers and the persons to get in touch with, to register the claim. Many of the insurers were able to settle the claims within a reasonable time period given the

magnitude of the damages. This was also a learning process for some of the private insurers in handling large volumes of claims.

Pro-active approach - It has been observed that issues related to claims handling effectively boil down to Claims Management - a pro-active and hands-on approach.

Claims Settlement requires accurate engineering and legal support within the contractual context of our insurance product as well as the relevant governing law and legal precedents affecting our contracts of reinsurance and claims made.

This approach necessarily means -

- Early key decision making during the initial claims process
- Efficient turnaround process handling time
- Prompt response to our claimants and business partners
- Hands on approach for all claims

It is also presumed that -

- Loss adjusters / Surveyors are appointed for claims with appropriate expertise
- Legal team is conversant with policy terms and insurance law are in place to assist in interpretation

In short our goal should be 'To deliver a high quality claims product'.

Claim analysis and link to Risk Management / Underwriting - Due to the diverse nature and myriad claims that we face, a natural extension of a claims department is in the form of claims trending and risk management input. It also includes study of legal implications of policy wordings, suggest ways and conduct research to improve the drafting of policy wordings.

Claims Settlement requires accurate engineering and legal support within the contractual context of our insurance product as well as the relevant governing law and legal precedents affecting our contracts of reinsurance and claims made.

This provides our clients with the assurance of accurate and clearer drafting of wordings that respect the contractual intention of the parties; and also helps in meeting the legal principles of insurance law governing the relevant language or parts of our contracts of reinsurance.

A Holistic Approach to Claims - Claims Department should have a well balanced and organically growing team of various disciplines coupled with its experience and expertise to leverage synergies; and strive to provide a claims management service that is holistic from all relevant contractual, legal and technical legal inputs.

The author is Head - Claims, Bajaj Allianz General Insurance

Promises vs. Performances

- Dilemmas in Claims

A willingness to reach out to the consumer, who regards his need as an emergency; and giving him an emotional crutch, makes good business sense says **G V Rao**.

Are insurers redeeming their promises?

Insurers, in the policies they issue to their consumers, make promises to reimburse them their financial losses (claims) in the event of the occurrence of specified insured events. These promises come with a number of qualifications. The reliability of the actual performance of the insurers on the redemption of these promises, therefore, often comes under a cloud, as the content of the promise itself becomes contentious.

Insurers also outsource several steps in relation to their claims' settlement to surveyors, investigators et al. Since the consumers deal largely with an unsympathetic company staff that is not internally held accountable for the results of its performance, the dilemmas facing them to find solutions seem much harsher. The consumers argue that one had to necessarily put up with these attitudes in a monopoly; but should that culture prevail in a freed and competitive market as well?

What are the dilemmas?

What respective dilemmas do the insurers and the claimants confront, when faced with the harsh reality of claims processing, their settlement; and their possible rejection, or the promise to pay has been misread or misinterpreted by either? What can a consumer do, if an insurer were to play a teasing game of dragging him to the court proceedings, with its endless delays, as the safest way, as is now customarily seen in motor TP claims; and being extended to other claims as well? Do consumers really have a choice to take on the might of the corporate power, if they chose to act in a punishing mode?

Consumer attitudes:

Consumers, when buying an insurance cover, tend to pay little attention to the content of the qualified promises; and seem more concerned with the price of the product. As hardly 20% of insurance buyers ever report claims; insurers' competitiveness, their differentiating capabilities and their fair reputations are hardly experienced by 80% of the buyers. That puts insurers more on the defensive with the 20% that put in claims.

As hardly 20% of insurance buyers ever report claims; insurers' competitiveness, their differentiating capabilities and their fair reputations are hardly experienced by 80% of the buyers.

The price of a cover matters very much to all the consumers in a pre-sale situation; but if a claim were to occur, hell will break loose and emergencies will arise and defensive techniques of blaming insurers go into higher gear. They usually claim that they have not been advised enough on the fine print. Have insurers devised mechanisms to deal with this discontent? Facts and feelings get mixed up. Insurers address facts ignoring feelings of consumers. Problems then arise.

This situational dilemma of insurers, of having to compete for consumers' attention initially on the product price but having to be judged by them on actual delivery of superior claim service expectations--based on their understanding of the coverage-- is what characterizes the non-life business. The general verdict is: insurers do come up a whole lot short on public expectations. Is this fair to insurers? What are they actively doing to brush up their fair images to seem credible and trustworthy to consumers? The consumers are no longer captives.

Insurers' attitudes:

There are claims wherein interpretation of terms and coverage are contested; there are also claims where amounts payable are in dispute. Insurers occasionally confuse consumers by mixing these two aspects. There are also claims that are endlessly delayed for tactical reasons, because of insurers' inability to decide on either liability or quantum; or where the outsourced units sow doubts without providing provable evidence or because the latter have too much work to do. It is the attitude that determines the approach; and insurers have clearly given an impression that they would like to tie up consumers into knots, if there is the slightest sign of ambiguity on the claim progression.

Our discussion:

This article proposes to address a few of the issues of this dilemma on both

sides. Insurers continue to be inward looking, and look at their role in the rapidly changing market, as mere suppliers of insurance products than as market makers bent upon revolutionizing the buying patterns of customers and reinforcing their faith in insurance buying, as a worthwhile proposition.

Consumers, when claims do occur, regard them as emergencies and want the entire force of insurers to bear on a speedy settlement, regardless of the imposed restrictions in the policy coverage. But given that this situation plays out with a monotonous regularity, it is necessary for insurers to develop a business model for claims that is fair, transparent and speedy. They should take full responsibility for explaining their decisions to the claimants with full disclosure. Recognizing the claimant's rights for a fair and prompt consideration is an important aspect of the policy contract of utmost good faith. But insurers, by their attitude and conduct, tend to give him an unintended impression that he is a hostage.

We will analyze a few figures on claims, based on the statistical data put out and examine the obstacles that are hindering insurers' customer relationships and how they can improve their real performances to be in line with the promises made.

A few claim-related figures:

The non-life market produced a gross premium of Rs.17,600 crore in 2004/05. It paid out about Rs.12,000 crore in gross claims, an increase of about Rs.1,000 crore over the previous year. The unsettled claims in the form of net outstanding claims amounted to Rs.16,000 crore, up from about Rs.15,000 crore.

The four PSU insurers have about 16 lakh claims as outstanding. There are about 22 lakh claims that get reported annually. There are about 17 lakh claims outstanding waiting to be settled. Over 60 % of these claims are in courts waiting for court verdicts, showing that these are disputed, a high number indeed.

The four PSU insurers have made underwriting losses of Rs 2580 crores in 2004/05 up from Rs.2,220 crore .Their investment income was Rs.4,330 crore, up from Rs.3800 crore. While losses grew by Rs.360 crore, the investment incomes grew by Rs 530 crores. The insurers have an incentive to hang on to cash long enough to generate investment incomes that essentially are their monies, though notionally treated differently in the financial statements.

Recognizing the claimant's rights for a fair and prompt consideration is an important aspect of the policy contract of utmost good faith.

The losses made are not wholly due to the result of claims made by the claimants. They include the very high cost of about Rs.4,500 crore to procure and manage the non-life business by insurers.

Current business model:

Policies are now mostly sold to consumers under pressure from insurers/ banks except in regard to motor and health covers. But all claims are, however, required to be 'managed' by consumers on their own. There is little publicized assistance to claimants from insurers on the intricate steps they should comply. They are handed over to surveyors/ investigators. The entire claims' settlement process is outsourced to surveyors, investigators, lawyers, courts, TPAs and others; and the claimants are left entirely to their own devices. This discontinuity in the mutual relationship, at a time of what is considered as an emergency need by a consumer, creates mistrust of the motives of insurers.

Mental models:

The mental models held of each other, therefore, come to dominate their relationship during claims processing stage; that claimants are usually untrustworthy or that the insurers are always looking out for ways to deny or reduce their claim. Can a claimant be allowed to meet insurers and seek their involvement in the progression of the claim? A claim is an emergency need for the consumer; but it is an everyday occurrence to the insurer. A willingness to reach out to the consumer, who regards his need as an emergency; and giving him an emotional crutch, makes good business sense. Does anyone own the customer, who also has a claim to deal with?

What do claimants want?

- Claimants want transparency with full and speedy disclosure from insurers at all stages of the claim's progression. They expect insurers to fulfill the regulations protecting their interests in letter and in spirit. These twin qualities enhance the value addition of the service providers.
- Since insurers have outsourced the issues of liability and quantum to surveyors, it is up to them to prod the surveyors and others; instead of expecting claimants to knock at their doors for speedy solutions. Unfortunately, insurers do not regularly evaluate the quality of the services provided to them by the outsourced outfits; their services are

primarily provided to the insurers and not so much to the claimants. This insight is lost sight of. Claimants are left to handle these outfits on their own, bringing in several malpractices.

- A claimant wants a speedy settlement of a claim; or if it is rejected, clear reasons for it. Insurers are known to deliberately resort to all kinds of subterfuges to either reduce the amount or totally deny liability. They seem to want to take full advantage of legal delays involved in fighting civil cases. Where they lose cases they insist on going on appeals for issues of prestige and not on legal grounds. Since there is no institutionalized discouragement of such tactics, they are proliferating more and more.
- Grievances should be handled with defined structures, composition or concern and not with utter contempt for claimants. These cells should be audited for their performances. If someone in the hierarchy declines a claim, the spirit of brotherhood and the fear of vigilance should come in the way of any revision. Consumers are advised to go to consumer courts. Insurers should encourage independent decision-making and not rely on precedent of rejection only.

What should insurers do?

First, insurers must accept that there are problems in their claims handling from the customers' perspective. Only then can they begin looking for possible solutions. There are, of course, process problems for them constraining their leverage; it is difficult for them to change the Govt. culture of the process overriding the outcome. They are also unable to perceive anything else as worthwhile pursuing than premium income, as a measure of executive success. They are more concerned with how their competitors are outwitting them in business growth than of how their customers are being treated. They need to decide if claims settlement is an important strategy to build reputations to attract customers; or use premium price as the differentiator.

In my interactions with insurers, I am informed, that there is no serious problem relating to customer dissatisfaction on claims front. They really believe that the problems, if any, are customer-created and exaggerated. If business is being consistently lost, it is because of unethical competition and not due to customer apathy. Once detariffing takes place, they will ride again the crest of the business wave. Without entering into debate on this issue, there are a few simple things that insurers can easily do.

If someone in the hierarchy declines a claim, the spirit of brotherhood and the fear of vigilance should come in the way of any revision.

- Improve the effectiveness and transparency of their grievance redressal cells - have the cells audited every quarter on their performance at all centers.
- Learn from the cases insurers have lost in consumer forums, Ombudsmen, Civil Courts, MACT courts and redraw underwriting lessons and other procedural improvement they should be making. Losing a case in an independent court must cause outrage and not contempt for the decision-makers that their decisions should be contested. Learning from proven mistakes is valuable.
- Be sensitive to customers' aspirations. They are money-rich and time-poor. They are learning that quality improvements are taking place all over. E-literacy is rapidly gaining ground. Railways, MTNL/ BSNL, and Airlines are showing that these corporations are getting more customer-savvy. They expect improvements in the business models of insurers as well
- Detariffing will put further pressure on insurers; they will have to compete on price and service in the form of claims as well. They need to improve claims effectiveness if they want the prices to be high. As they cannot cut their present costs, private players may take a march with more volumes, reducing costs.

Final word:

IRDA is presently benevolent towards insurers' compliance of the regulations for protection of policyholders. Testing customers' patience is not a worthwhile game to play for long. It is in the interests of insurers themselves to be seen as a friendly and responsible bunch. The days of favor-dispensation are rapidly disappearing. Tougher times are indeed ahead for insurers.

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Effective Claims Settlement Procedure

-- Need of the Hour

In order to reduce litigation, insurers should sensitize those dealing with claims to have regard for the feelings of claimants argues **Antony Jacob**.

When you buy an insurance policy, your most serious concern should be the company's reputation in settling claims. Brilliant salesmen, friendly and courteous call centre people, customised policies at terrific bargains are all useless if the company does not act promptly and fairly at the hour of need or grief for the policyholder and his family. The fairness and speed with which the insurance company acts when the money is needed badly overrides all other concerns.

The claims function plays a strategic role in differentiating a company from its competitors. The claims function has to monitor costs and provide claims service that goes "Beyond Expectations" of customers and operate within budget.

The claims philosophy of all insurance companies is to provide fair, quick and efficient claims service. In the UK, the non-life insurance industry (Association of British Insurers) has a "General Insurance claims code". The claims code sets out clear and specific deadlines to apply, when claims are first made; when they are processed and settled; and to complaints that companies may receive.

In India, the IRDA has issued a similar set of guidelines named "Protection of policyholders' interests". In their attempts to build brand names and establish corporate identities, insurance companies are placing their claim function (nature, speed and efficiency) in the forefront of their promotion activities.

Since the source of the largest outflow of money within an insurance company is the claims department, claims management is the key to developing operational excellence. The claims team must endeavour to provide claimants with appropriate indemnity whilst ensuring that any such payments are justified. In short, they should be able to distinguish between valid and invalid claims quickly and fairly.

Brilliant salesmen, friendly and courteous call centre people, customised policies at terrific bargains are all useless if the company does not act promptly and fairly at the hour of need or grief for the policyholder and his family.

This requires competent and well-trained staff, efficient administrative support, efficient claims procedures, efficient record keeping and clear claims philosophy.

While all insurance companies would strive to achieve excellence in these areas, I would like to focus on three areas, which pose a major challenge to the claims function.

- Catastrophe management
- Frauds
- Litigation

Catastrophe:

This very word brings to our mind the Mumbai floods that happened about almost a year back. The picture of submerged buildings, factories and vehicles flashes through our memory and while the rescue operations by the government machinery attracted a lot of criticism, the insurance companies came out with flying colours in managing the deluge of claims.

A leading international reinsurance company defines catastrophe as 'an occurrence which claims more than 20 lives, injures more than 50 people, makes more than 2000 people homeless or causes insured damage of over $29 million or a total loss of over $457 million'. By this definition, insurance companies were affected by an equivalent of 20 catastrophes during the Mumbai floods. Such events lead to a huge number of claims. Since Indian insurers had adequate risk control, risk funding and organizational catastrophe plans, they could manage these claims without difficulty. The effect of such a devastating single loss event was wide ranging and included a huge cost in claims to both insurance and reinsurance companies, short term and long term workload on the staff in the claims process and large number of individual properties

Catastrophes have been growing in both frequency and severity worldwide. Predicting the occurrence, frequency and severity of catastrophes is extremely difficult.

Effects on the claims department

In a catastrophe like the Mumbai floods, the claims department is expected to face the following problems:

- A sudden and unprecedented increase in the number of claims.
- A sudden increase in the number of enquiries from customers, intermediaries, the press and the general public.

Claims' handling in a catastrophe context requires special efforts on the part of the insurer. Those involved in handling claims should:

- Ensure good communication between all parties involved in the claims process
- Investigate immediately after the occurrence of a disaster
- Concentrate on settling as many claims as possible - losses become more expensive the longer the negotiations continue
- Prepare for the worst - catastrophe plans are necessary before the event.

Problems can seem insurmountable; they can be overcome if planned for efficiently

Fraud:

Insurance fraud is almost as old as the history of insurance itself. Fighting fraud has become one of the key objectives of modern claims management.

Fraud can take a variety of forms, such as:

- Inflation of a genuine claim
- Creating an entirely fictitious event
- Causing deliberate damage to insured property

Insurers have a hard-nosed approach to fraud and do not hesitate to take legal action in appropriate cases. The recent Madras High Court judgment directing CBI investigation into Third Party cases is an outcome of such proactive action by the insurers.

Experienced claims personnel identify a large number of fraudulent claims quite efficiently. Frequent change of insurers, uncharacteristic increase in the level of cover, and unclear ownership of goods, are some instances of possible fraudulent behaviour. Besides excessive pressure to settle, an inconsistent story, lack of co-operation, and even perfect documentation make it possible for claims personnel to detect fraudulent cases.

It has always been very difficult to prove fraud in civil litigation. The high burden of proof frequently leads insurers to resort to technical pleas of non-disclosure, misrepresentation and breach of good faith rather than attempting to prove fraud itself.

The high burden of proof frequently leads insurers to resort to technical pleas of non-disclosure, misrepresentation and breach of good faith rather than attempting to prove fraud itself.

Litigation:

Though the intention of the insurer is to settle claims where they can, and repudiate only where they must, there will be occasions when a claimant may take recourse to litigation or alternative methods of dispute resolution like a consumer court or ombudsman.

In order to reduce such litigation, insurers should sensitize those dealing with claims to have regard for the feelings of claimants - an hour spent in the beginning explaining why no valid claim exists may save many months of fruitless correspondence ending in a reference to the Ombudsman. Correspondence with claimants should use words and ideas familiar to him and jargon is best avoided. It should be kept in mind that people always read the promises in the insurers' advertisements but they rarely read them in the policies.

Conclusion:

The Core objective of an insurance company should be to optimise a successful, effective and realistic approach to claims handling that will save your company money and increase profits. From the insurance company's viewpoint, claims management is a key element in the competition between insurance providers and for the improvement of industry's public image. There is room for improvement in this area of client service and some companies have already demonstrated this with international certifications like ISO 9001 for their claim processes. The need of the hour is to codify the "Best practices" to guide both the insurers and the customers.

The author is Managing Director, Royal Sundaram Alliance Insurance Company Limited.

The World of Liability Claims

- A Deep -Rooted Analysis

Unlike the other classes of insurance, Liability claims tend to be more complicated because of the sheer number of the parties to the claim observes **Uttara Vaid.**

Moments of Truth

For any insurance company a "moment of truth" arises each time a policy holder lodges a claim with the company under his policy. The handling of that claim from the start to its resolution, whether the claim be simple or complicated; from an individual or one of the Fortune 500 companies differentiates a top class insurance company from mediocre. It also makes or mars the insurance company's reputation and prospect of repeat business in the market, both of which are essential for the longevity and growth. In this scenario, Liability Claims deserve more attention because often they involve untested circumstances, a fresh look at policy wording vis-à-vis intention of coverage.

Why so? Why are liability claims so unique? - May be, on account of the following characteristics.

Claims transcending coverage triggers of non-intended exposures

Consider these:

A case is brought by a woman on a Fortune 500 company who claimed her severe birth defects were the result of her mother's exposure to chemicals at the defendant's plant.

The claimant, who had sued for $100 million, claimed she was retarded because her mother inhaled noxious fumes which resulted into her deformed skull and absence of kneecaps.

Cell phone users are now burning the Employer's legal liability and Workmen's Compensation books. Pray how would that happen? Employees who have been taking official calls while driving themselves to work have been involved in car accidents and are claiming that such injuries are "arising out of and in course of employment "

In both the above cases, liability claims have been triggered in classes of business other than where they were anticipated. When the unborn baby of an employee exposed to hazardous chemicals claims bodily injury it moves out of the realm of Workmen's Compensation (Employee Injuries) to third party injuries (Public Liability).

The claimant, who had sued for $100 million, claimed she was retarded because her mother inhaled noxious fumes which resulted into her deformed skull and absence of kneecaps.

Office risks generally considered safe for WC (though World Trade Centre losses quite changed that perception effectively), now become hazardous on account of rampant usage of cell phones which turn every waking and working hour to being "on duty" and every such accident to "arising out of and in course of employment"

Multiplicity of Parties to the Claim

Liability claims tend to be more complicated because of the sheer number of the parties to the claim. Picture this; Liability claims often involve as many as 6-7 parties involved in the claim. Here is not a straightforward policyholder v/s insurer issue but involves many third parties such as the original claimant and his lawyer; the policyholder and the lawyers representing him; and the insurance companies and should need be, coverage counsel representing the insurance company's interest. Each liability policy has different nuances in its wording which invite complicated interpretations; add to that, different jurisprudence in different jurisdictions, ingenuity from lawyers across all parties, and we have a perfect recipe for a dramatic potboiler.

Claim handling largely dependent on Policy Wording.

Since the handling of the claim is rooted in the policy wording, it is important to understand the difference between the Right-to-defend also widely known as Reimbursement Wording; and Duty-to-defend wordings, both of which are now prevalent in the Indian market.

(*Though as a thumb rule this is generally the practice, and most Errors and Omissions/ Professional Indemnity (E & O) policies covering Corporate Liabilities to mainly the IT sector have been issued on a Duty -to-defend wording, the trend is now changing with respect to E&O policies and most clients and insurers are now seen to be favouring the Right to defend/ Reimbursement wording. This is because allegations of Errors and Omissions are highly sensitive issues which go to the fundamentals of Client Relationship Management and some insureds are preferring to handle these claims themselves backed by a more intimate knowledge of their own operations and contractual liabilities

Sl. No.	Points	Right to Defend	Duty to Defend
1.	Who handles the claims	The policyholder handles the claims. He must however inform the insurance company, seek their prior consent in any settlement	The insurance company upon receiving notice of the claim handles it from start to resolution.
2.	Defence Costs (In both cases defence costs reduce the Limit of Liability, unless the wording specifies otherwise. In some countries, policies with defence costs in addition to limits are more popular.	Initially defence costs are borne by the policy holder but are reimbursible with the damages when the claim is adjudicated	Since the insurance company handles the claims; it bears the defence costs subject to the adequacy of the limit of liability
3.	Practice*	Right to defend wording is normally given to cover personal liability such as in a D&O policy	Normally liability policies intending to cover corporate liabilities such as Public /Product Liability may be issued on a Duty-to-defend wording.

arising therefrom. From the insurance company's point of view, however, their rights of investigating the facts of the case, the legality and the tenability of the claims and assessing appropriate quantum, remain.)

Unmatchable Claims handling Service through Duty-to-defend wording.

The Duty-to-defend wording provides unmatchable Claims handling benefits and in a world where outsourcing everything but your core activity is seen as a prudent business practice, this wording provides to the hapless insured an opportunity to outsource the handling of his claim. The insured can avail of expert Litigation Management System of the insurance company, Home Court advantage in foreign countries banking on a worldwide insurer's presence and peace of mind knowing that his claim is being handled by expert lawyers who are paid by the insurance company without him disturbing his cash flow.

When the lawyer is appointed by the insurance company, who does he actually work for; the insurer or the Insured ?

What is essential to understand here is that the lawyer appointed by the insurance company in discharge of Duty-to-defend obligation also represents primarily the policy holder and not the insurance company who has appointed him. This becomes extremely important when the adequacy of Limit of Liability assumes critical importance. Therefore, whilst the Insurance Company is entitled to disassociate themselves from legal proceedings once the limit of liability is exhausted, the same lawyer can continue to represent the policy holder till the resolution of legal proceedings, depending of course on the comfort level enjoyed between the Lawyer and his client.

It can take many years after the policy is written to determine final results of the original claim made in any one year.

Long Tail Nature of liability claims and resultant spiralling costs :

What also makes the task for the Liability Claim assessor more arduous is the Long Tail nature of liability business which manifests itself in two ways:

- It can take many years after the policy is written to determine final results of the original claim made in any one year.
- Claims themselves can be made many years after a policy has expired.
- Length of litigation and the judicial attitude prevailing in the jurisdiction in which the claim is filed.

And obviously this leads to an increase in claims costs which balloon because of increased future health care costs and the practice of granting annuity settlements in some jurisdictions.

Jurisdiction in which the claim is filed and in which the Liability policy needs to respond as per wording :

Anyone who does business in the U.S. or with U.S. companies recognizes the complexity of the tort system and the potential for a claim. Not only does each one of the 50 states have its own laws and court system, there are more than 1 million attorneys in the USA. Add to this the fact that the media have provided substantial publicity of large awards, further providing incentive for litigation. In an era when jury verdicts are returned in the hundreds of millions of dollars, it is essential to manage the liability claims proactively when the claim is filed in litigious jurisdictions such as USA or Australia.

The obvious effect of the Retro or the Sunrise Clauses in the Claims Made or Occurrence Based Wording respectively :

Liability policies may be issued either on a Claims Made or an Occurrence Based wording. What is the difference between Claims Made and Occurrence Based wordings?

The Claims Made wording mandates that :

The event, giving rise to the claim, should have occurred during the period of insurance.

The claim should be made during the policy period (12 months during which the policy is in force). The period of insurance is defined as the period between the dates of inception of the First Claims Made policy (continued without a break and the expiry of the current policy.

In an Occurrence Based wording, the event giving rise to the claim, must occur during the policy period and, typically, the insurer would respond whenever the claim is thereafter made on the Insurance Company

Retro or Sunrise clauses have the effect of increasing the period of insurance (not the policy period) as per the intention of the parties to the insurance contract.

Liability Claims handlers have to contend with the fact that claims surface sometimes long after the cause of action/accident has occurred. Validity of the insurance claim will then need to be determined with reference to wording (Whether on a Claims Made or Occurrence Based format), whether the claim or notice of circumstances of claim fell within Prior Acts Exclusion or met with the Retro requirements of the coverage granted.

And last but not the least at which layer is the insurance company participating ?

Large liability programmes are often layered between Primary and Excess layers and the handling of the primary claim as compared to the handling of an excess claim varies greatly. Sometimes if a large Excess layer sits over a very low underlying, then the Excess underwriter may be justified in rolling his sleeves and getting down to work as proactively as a Primary underwriter and wordings which mandate notice and Claims Control / Co-operation are often observed in such contracts which give him the legal wherewithal to do so.

Though it does repeat a cliché, the above is merely illustrative and not exhaustive and gives an idea of the complex weave of the large tapestry of Liability claims. To round off this article, it would still be necessary to give the reader an idea of the steps involved in handling such claims.

Steps in handling a liability claim

As a starting point the Liability claim technician will:

Liability Claims professionals will vouch that there is "No Typical Liability" Claim and each claim needs a different approach.

- Gather all the relevant facts pertaining to the claim
- Assess liability and determine a resolution strategy
- Determine an accurate damage exposure
- Analyse potential tort costs including awards for economic loss and non- economic loss (such as administrative and defense costs), as well as claimant's attorney fees
- Assign qualified defense counsel by specialty, if litigation is involved
- Establish accountability and methods to measure performance

With this foundation in place, liability claims professionals investigate the validity of the claim to understand the claimant's grievance.

No Typical Liability Claim

Liability Claims professionals will vouch that there is "No Typical Liability" Claim and each claim needs a different approach. While expertise and experience do count, nothing matters more than the empathy of the insurer and his willingness to go beyond the letter of the law and line of duty in settling the same whether it be through the long arms of law or through the Alternate Dispute Resolution channels open to it or through just old- fashioned but most favoured road of a negotiated settlement!

On the policyholder's part also there is need for increased transparency, trust and resultant co-operation towards the insurance company; and an awareness that both the insured and insurer are on the same side of the fence and are working towards the same objective of a speedy and fair resolution of the legal matter. In that respect a Liability Claim is a firm reminder to both the insured and insurer of the Utmost Good Faith which is the invisible glue that binds the insurance world together!

The author is Vice President - Marketing and Product Development, Tata AIG General Insurance.

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Handling Claims

- The Dharma of the Insurer

For a claim to be processed smoothly and quickly, the insurer should ensure that its claims handling staff are skilled and knowledgeable avers **Yegnapriya Bharath**.

I had just been posted to the Claims department and was pretty excited to have got an opportunity to handle something 'technical.'

As it happens in any organisation, when you join as a raw hand and are no professional, you can't choose your department. You have to begin with whatever you are asked to handle, which is usually one of the supporting departments rather than the core activity of the company. Then you try and push your way through to what is regarded as 'core'. I remember being told in the interview I attended for the job "Insurance is a highly technical subject. Do you think you can cope with it?" I don't remember how exactly I responded to this question but at least it did not cost me my job.

Within a short span of my joining the Divisional Office, I managed to get out of handling 'Establishment' and 'Personnel,' and joined the claims department. I was eager to take up something substantial. When asked I chose "Marine" as if I knew everything about Marine Insurance claims! Of course I had gathered by then that Marine Insurance was the most interesting and challenging area and did have some exposure to the subject as we had been trained for six months in all branches of insurance. But then training is only training; and especially in insurance, it is experience that is the best teacher. For experience I had to begin somewhere, sometime. Anyway I was promptly posted to the Claims department and asked to handle Marine as well as Motor Claims. Those were the days when, in the public sector, the Underwriting was done at the branches and claims centralised at the divisional offices.

Our Divisional Office had 12 branches spread all over Telangana in Andhra Pradesh. The first claimant who came to see me was a lorry owner. He seemed agitated and asked to see my predecessor in the department. I told him he was transferred and that in future he had to deal with me. He tried to calm himself and mumbled something before enquiring about his claim. Later I went through his claim file not understanding a word of the survey report! My interview question about 'technical expertise' haunted me as I realised I hardly knew a thing about motor vehicles or their parts. That evening I actually went and bought myself an encyclopedia on automobiles. Thus began my journey into insurance and its technicalities. This is just to make a point that claims processing is not a simple affair and for a claim to be processed smoothly and quickly, the insurer should ensure that its claims handling staff are skilled and knowledgeable.

It is important for a policyholder to go through the policy when he receives it and not just when there is a claim. It is seen that 'the small print' or the clauses, conditions and exceptions given in the policy document are rarely read till a claim arises.

It is also important for the claims handling staff to have good communication skills. The job requires tremendous patience. The insured has just had a loss. He is bound to be agitated. At a time when he is dogged by worries due to a financial loss, he might not pay full attention to claims procedures and documentation requirements. It requires special skills to get the insured round to meeting with the requirements for a claim since, from the insurer's point of view, every document and procedure is important.

When I was posted to the claims department I realised I had to learn underwriting first. That is, whatever little there was to learn of it, since it mostly meant being familiar with the contents of the tariff book and knowing where to look up a rate! When you start processing a claim, you begin with the policy to first understand what is covered and what is not. Processing of claims in general insurance could be simple or could get extremely complicated. While an insurer can indicate the documentation for a claim, it can never be exhaustive.

Claims vary widely and, along with it, documentation. However, it is necessary for an insurer to indicate to a policyholder even while a policy is issued as to what documents are, in general, required in the event of a claim. Policies are also expected to indicate the duties of an insured precedent to a liability and consequent upon a claim. It is important for a policyholder to go through the policy when he receives it and not just when there is a claim. It is seen that 'the small print' or the clauses, conditions and exceptions given in the policy document are rarely read till a claim arises.

Let us have a look at what the IRDA Protection of Policyholders' Interests Regulations (2002), which applies to all insurers, insurance intermediaries and policyholders, has to say about disclosures and duties. Apart from stipulating disclosures at the point of sale and matters to be stated in life and general insurance policies, the regulation deals with the claims procedure in both cases. One of the main stipulations is that "a policy shall state the primary documents which are

normally required to be submitted by a claimant in support of a claim." In case of general insurance, it stipulates that an insured or the claimant shall give notice to the insurer of any loss arising under the contract of insurance at the earliest or within such extended time as may be allowed by the insurer. On receipt of such a communication, a general insurer shall respond immediately and give a clear indication to the insured on the procedures he should follow.

In cases where a surveyor has to be appointed for assessing a loss/claim, it shall be so done within 72 hours of the receipt of intimation from the insured. Where the insured is unable to furnish all the particulars required by the surveyor or where the surveyor does not receive the full co-operation of the insured, the insurer or the surveyor as the case may be, shall inform in writing to the insured about the delay that may result in the assessment of the claim. The surveyor, in turn, shall communicate his findings to the insurers within 30 days of his appointment. In special circumstances a surveyor may take time up to six months to furnish his report, but only after intimation to the insurer, and taking his special permission.

An insurer may call for an additional survey report if the circumstances warrant it. On receipt of the survey report or the additional survey report as the case may be, an insurer shall settle a claim within 30 days offer settlement of claim to the insured. If the insurer decides to reject a claim, it may do so within 30 days. For prompt settlement of a general insurance claim, it is important that all parties involved co-ordinate and co-operate with each other. For instance, the insurer and the surveyor or a third party service provider, as the case may be, should ensure that they co-ordinate with each other and deal with the insured through a defined channel.

Quite often it is seen that both communicate with the insured without keeping the other informed. Sometimes the same information may be sought by both the parties. More often than not, information is sought on a piece-meal basis testing the patience of the insured. Every insurer must strive to have in place a claims handling system that creates the least drag in the processing chain. Insurance companies must leverage technology and communication tools to ensure that the whole process is speeded up.

Many a time, delays in claims disposal are a result of defective policies rather than due to inefficiencies in the claims handling system. A claim may reach a deadlock because of a policy wrongly underwritten. Insurers tend to sit on such claims rather than arrive at solutions thus driving claimants to approach adjudication channels. It would be worthwhile for insurers to

The effectiveness of the grievance redressal procedure also needs to be monitored by not only the senior management but also the board; and improvements effected wherever necessary.

analyse awards or judgements in similar cases that are in the nature of precedents and learn lessons from them. Unfortunately, what happens is far from it, and an insurer is willing to wait for the claim to go through the whole legal system and, at the end of the day, not only pay the claim but also a fat amount towards interest.

In the twenty years since I dealt with my first irate claimant, I have dealt with a variety of cross complainants. The miseries of claimants are compounded by the time they approach redressal channels other than that of their insurer. Not only have their claims been turned down, their complaints have not received the deserved attention, they feel.

Some complaints surely are not justified but many are. It must be frustrating for customers to have to go from channel to channel.

The Grievance Cell of the IRDA facilitates resolution of grievances by taking up the complaints with insurers for examination/re-examination. It does not decide on claims nor does it adjudicate. Generally complainants are advised to approach the Insurance Ombudsman for cases that come under the purview of that institution. Otherwise the complainant has to approach either the consumer courts or the civil court.

The innumerable complaints we come across indicate the need for a change in claims handling systems and procedures. The boards of companies need to be involved in the claims management philosophy of the company. The effectiveness of the grievance redressal procedure also needs to be monitored by not only the senior management but also the board; and improvements effected wherever necessary. That the existing systems in most insurance companies need to be made more effective and perhaps need overhauling is evidenced by the fact that there are increasing number of complainants approaching the Ombudsmen and the judicial channels. Can we not learn lessons from the cases disposed of by the various redressal mechanisms?

Efficient claims servicing is vital to an insurance company and the very reason for its existence. Mahatma Gandhi, the Father of the Nation attached great importance to the consumer. He said: *"A customer is the most important visitor on our premises. He is not dependent on us. We are dependent on him. He is not an interruption to our work; he is the purpose of it. We are not doing him a favour by giving him an opportunity. He is doing us a favour by giving an opportunity to serve him."* It would be a tribute to Gandhiji if every customer were made to feel so.

The author is Officer on Special Duty, Grievances (Non-Life), IRDA. The views expressed in the article are her own.

Claims Settlement In Life Insurance

- Need For Personal Touch

While there is an incidence of fraudulent attempts in enforcing claims, insurers should take care not to put a genuine claimant to hardship opines **Ganesh Iyer.**

Introduction:

Life insurance is an emotional business Unlike in general insurance, there are sentiments involved since it is the question of a human being - whether he / she has a critical illness or a severe disability or he / she is dead [in such a case for the family members]. If we, as insurers, delay a claim, then the family is unnerved and frustrated because a person is suffering and the insurer has not kept up his commitment. If we pay, then there is a feeling of gratitude, which can be personally seen in many eyes when they receive a cheque. If we reject, then the family members [in case of death / disability] feel low and dejected because there is a sense of being cheated [though from an insurer's point of view, we may be technically and legally correct]. In case of an illness, the client feels that the purpose of his / her insurance is lost because the insurer has not paid his / her claim when required most. It cannot be expected of the client to step into the shoes of the insurer to see the correctness or fairness of the settlement. So either way [whether we pay or reject or keep it pending], there is always a very emotional outcome.

Primary Role of an Insurer:

The primary role of an insurance company is to settle claims as that is the value add we provide to our clients. However, this does not mean paying all claims promptly but rather to pay the genuine claims and reject the non genuine claims. Thus the most important aspect to be understood here is the word 'settle'. "Settling a claim" does not necessarily mean paying a claim. A claim can and should be rejected if it is not legally payable. If an insurer pays all claims irrespective of the eligibility criteria, then either it will not remain in business or have to increase the rates for other policyholders. Thus by paying improper claims, the pool of genuine policyholders is disadvantaged.

Claim settlement is not a straight forward process. The basic premise is

> If an insurer pays all claims irrespective of the eligibility criteria, then either it will not remain in business or have to increase the rates for other policyholders.

to pay all "right" claims and reject all "wrong" claims. But that is easier said than done. Deciding on what is right or what is wrong is not an easy task.

What are the problems?

- The most problematic aspect, in majority of the cases, is that the client doesn't know what he has purchased and what the benefits are. Very few people read the actual policy contract and understand its requirements and implications, be it a literate class or otherwise.
- If problems in claims settlement were to be given a rating, then probably casual approach in proposal form filling would be rated at 99%. A life insurance proposal form is filled in like a credit card application, where just the basic address etc. is given and then signed off without even pondering over the other fields in the larger proposal form. The basic fact that a proposal form is the offer for a contract is forgotten.
- Apart from ignorance, many times the client does not want to disclose the facts and problems. Hence he purposely does not disclose information in the proposal form.
- Not to mention about fraudulent intentions.

A few examples :

i) Suffering from illness at the time of the application itself.

ii) Smoking / Drinking / Tobacco habits not disclosed in the proposal form.

iii) Family history not disclosed correctly.

iv) Suffering from chronic / severe ailments, viz., cancer, HIV, heart / kidney / lung diseases etc.

v) Fictitious Accidents, fake snake bites, murders, patient on the death bed seeking insurance cover, insuring dead people, non-existing people etc. constitute a few examples of frauds.

OUTCOME : Claim gets repudiated on grounds of material non-disclosure / frauds.

Rural Area Problems :

India consists of a large part of rural areas. Hence, invariably some proportion of the insured clients belong to this rural population. However, doing business in the rural areas is not a smooth road, whether it is New Business or claims. The difficulties encountered are:

a) Illiteracy and lack of understanding of the contracts.

b) Premium collection due to poor banking facilities or sometimes inability to bear costs regularly.

c) Non-availability of medical facilities and records

d) The cost of doing business in these rural places

e) Information verification.

Claims investigations become costly, time consuming and difficult affairs. Getting evidence in the rural areas is very difficult. Issuance of death certificates by the local panchayats and the doctors is more from a human angle than from the factual angle, due to proximity of relations. Sometimes there are no authentication checks involved in the issuance of such certificates. In some cases, there are delays in notification of claims to the insurer, sometimes beyond more than six months after the event, by which time the trail is very cold.

It is difficult to unearth frauds in the rural areas due to a small concentration of closed people, who are suspicious of any outsiders.

Snake bites are a relatively common occurrence in the communities and if genuine, would represent a proper claim. However, if a person dies from a non-disclosed illness but the body is bitten or is reported to have been bitten by a snake or any other animal, then proving or disproving the same is an uphill task.

Non-Disclosure of Existing Insurance Cover / Multiple Insurance Policies :

We have seen claims where the policyholder has taken a number of policies from different insurers. There is a high risk and a big financial underwriting issue with people taking insurance covers from various insurers without disclosing the facts of the existing covers. The industry is now recognizing this and is sharing claims information. In such cases, the person is more valuable dead than when alive.

Quality of Medical Records:

The developed countries around the world have Government health schemes which require public funding. Along with this go extensive computerized medical histories kept by the doctors and the government agencies. This is a critical tool in these countries for the discovery of non disclosures by insurance companies. This does not exist in India where the individual keeps the records and not the doctors.

There is a high risk and a big financial underwriting issue with people taking insurance covers from various insurers without disclosing the facts of the existing covers.

The biggest problem in India is that we do not have a proper medical records system. Hence, getting any medical history is very difficult. To prove non-disclosure of existing ailments, we have to rely on the client only to give his / her medical records.

Judicial System:

The policyholders or their nominees (in the event of death of the life assured) are insulated well by our judicial system. The clients can approach various forums for enforcing their rights viz. the Insurance Ombudsmen, the District Consumer Forum, the State Consumer Forum, the National Consumer Forum or any Court etc. in the event of their being not satisfied by the insurer's decisions. (Of course, these facilities are over and above the option available to the client to apply to the company for a reconsideration of the decision).

However, the judicial system, sometimes in its attempt to protect the clients, poses some hurdles for the insurers. At whatever forum mentioned above, the insurance companies have to have very strong cases as the tendency is to support the member of the public who has suffered bereavement.

The ombudsmen scheme is a very good one in principle and is also a very low cost option to the clients. It is also a fast track forum. Despite all this, it does create, at times, some problems for the insurers. Ombudsmen sometimes while deciding a case, go beyond the legal definitions and established court rulings.

The insurers cannot challenge the decisions of the ombudsmen though the client has an option to appeal if he is not satisfied.

It sometimes becomes practically difficult for the insurer when the courts expect the insurer to procure the primary claims documents or past medical records of the life assured on behalf of the clients, who refuse to produce the same, for whatever reasons. It sometimes seems unfair when non-production of documents is used as a defence by the clients and duly supported by the courts.

Control System:

In order to have proper documentation and control, it is advisable to keep records of all inward and outward communication. Wherever necessary, use Regd. AD system only and keep acknowledgments handy.

Pay cheques only ear-marked to a particular bank account only, e.g., "Pay to Mr. XYZ, A/c. 12345, ABC Bank,

Mumbai". This will give you a proper track of the movement of claim proceeds.

Personal Touch:

Be courteous in your communications, written or verbal. Feel for the client and the family. Be a part of the grief. Try to hand over the claim cheques and letters personally [somebody from the company] to the family. This adds value to your claims processing and gives it a personal touch.

Training:

Constantly train your sales force about the importance of claims and make them understand the problems faced by the claims department. Importance of disclosure of material facts has to be drilled into our system. Only when all proponents/policyholders believe in giving the facts, our system will improve on the claims front.

It won't be out of place to mention here that most claim cases, which were subjected to medical examinations during the underwriting stage or those risks accepted by the company based on knowledge of existing health problems get through easily and smoothly. It is mainly the non-medical cases with incorrect information in the proposal forms that get stuck at the claims stage.

Conclusion:

Life insurance business is a serious business meant to achieve a social cause. The insurers are striving hard to achieve this purpose. They need the best support from various systems and channels to achieve this goal so that the social security of our country can march in the right direction.

Importance of disclosure of material facts has to be drilled into our system. Only when all proponents/policyholders believe in giving the facts, our system will improve on the claims front.

Although the majority of people are honest hard working people, if there is a way of people enriching themselves at another's expense, a certain minority will take advantage of that especially if it is a big impersonal insurance company who is seen as having a lot of money.

But all said and done, what is to be remembered is:

- We are in this business to settle all fair claims.
- We have to render our best claims services to all clients at all times.
- Do not punish all the people for a handful of wrong doers.
- All claims are genuine unless proved otherwise.
- Insurance Claim is not the end - but the beginning of a new business.

The author is Chief Manager, Claims and Risk, Kotak Mahindra Old Mutual Life Insurance Company.

Ensuring Fair Claims Management

- Issues for Quick Disposal

If the personnel of Claims Settlement section are not specifically trained on the aspect of prudent claims settlement, there is a danger of the claimants losing faith in the system of life insurance, argues **D V S Ramesh.**

The basic tenet of philosophy on which the concept of life insurance evolved is; as the event of a death is certain in one's life, it is the undesirable consequences that the dependents are likely to face, that can be minimized by means of economic tools like life insurance. Of all those servicing aspects of a life insurer, the settlement of the claims occupies a prominent role, be it from the perspective of the insurer or from the point of view of the life assured/ claimant. It is the life assured who is going to face the brunt of all the services of the life insurer during his life time in case of deficiency in the services rendered. A lacuna in the services of the life insurer may be perceived by a policy holder as a potential threat to the assurance he reposed, as he cannot imagine his beneficiaries running from pillar to post for receiving the policy proceeds in the event of the policy resulting into a death claim. The hapless policyholders who receive deficient service quite often express the same before the insurance companies' personnel.

The life policies are considered as the estates of the life assured; it is the policy holder/life assured who has to manage the same, by paying the premium regularly. And the life insurer on his part is expected to meet the liability of claims as and when they are due. For a fair and equitable administration of claims, both the insurer and the insured have a role to play.

Role of Insurer: Ensuring fair and quick claims settlement is considered as one of the objectives of the insurer's business mission. In order to attain these business objectives the insurer plays a prominent role in establishing the best operational practices that include, inter alia, a prudent claims management policy; ensuring the expertise of the personnel involved in claims operations; monitoring the outsourced activities with reference to this specific activity of operation; and effective communication etc. These issues are discussed in detail hereunder.

a) **A prudent policy:** The life insurer is expected to place a prudent claims settlement policy for expeditious settlement of the claim. This policy, inter alia, shall contain the stipulated time lags within which the personnel shall reply to the queries of the claimants; the manner of calling for the requirements; the modus operandi of the conduct of investigation if that claim warrants one; the operational issues involved while dealing with the various types of claims like early death ones, minor cases, claims of annuitants, claims on health policies, riders etc.; this policy will have to be helpful like a guide to the dealing personnel. The macro issues on this policy could include the manner of settlement of ex-gratia claims; manner of conducting the claims investigation; the prerequisites for repudiation of the death claims like prior review, constitution and composition of claims review committees etc. Placing these issues in the claims policy of the life insurer will also indicate the best governance practices adopted by the life insurer. In the absence of such a clear cut policy, there is a possibility of the individual discretions prompting the lack of fair play. For e.g. Absence of ex-gratia policy may result in different decisions on the similar cases on different occasions by different personnel. Like wise the prior review of a claim at a higher level before its repudiation may ensure a fair decision. Applied which the discretion of the dealing personnel would vary widely from case to case booking the outstanding liabilities, reversing the entries on repudiation

Ensuring fair and quick claims settlement is considered as one of the objectives of the insurer's business mission.

b) **Expertise of the personnel:** Quite often the personnel, especially the new entrants, working with the claims settlement section do consider that the settlement of death claims is drainage on the sources of the insurer. The insurer should let the personnel know that the settlement of claims is a part of the business of life insurance. The insurer shall appraise its personnel the importance of settlement of claims periodically to inculcate an impression that it is the most promising part of their business. And all personnel at all levels, should service the claimants empathetically. Further the expertise of these personnel will be felt more when the settlement of claims under critical illness riders/ hospital cash benefit riders arises. The definition part of the diseases, the exclusions, the accelerated benefits, waiting period and survival period are important areas the personnel should pay attention while settling these living benefits. Convincing the claimants whose policy stands repudiated is a challenging task. If the personnel of this section are not specifically trained on this aspect, there is a danger of the claimants losing faith in the system of life insurance. An unsatisfied customer is a perennial liability to the insurer.

The existence of the clientele is a great source of new business avenue to the life insurers. The retaining capacities of the life insurers will

depend on the satisfactory services they render to their customers during the tenure of their policy life. An existing customer is considered to be more valuable than a new customer. By virtue of its business, the new business always results in a strain on the reserves of the life insurer owing to the factors influencing high costs of initial expenses. The number of death claims, especially the early death claims, prompts the life insurer to re-look the underwriting policy adopted by him. It also hints at monitoring the quality of new business brought in by the intermediary. The claims personnel do play an active role in recycling the claims proceeds towards the new business, like, influencing the policyholder whose policy matured to opt for an immediate annuity plan. However, the insurer has to take care that this should not result in any unethical practices like compelling the claimant to necessarily plough back a part of the claim amount towards the new business premium.

c) **Information on the documents:** The life insurance document which is considered as an evidence of insurance contract has to contain the terms and conditions governing the settlement of a claim, be it a death claim or a maturity claim. Though, generally the life assured's attention is not drawn to this part of the document during the prime of his life, it is expected to cover the comprehensive requirements of an ideal insurance claim. These contents will be quite handy to the claimants at the time of lodging the claim. If the contents of this part of the document are made self explanatory, the level of dependence of claimants on outsiders would be minimized. The same is the requirement of Regulation 8 (1) of IRDA (Protection of Policyholders' interests) Regulations, 2002.

d) **Communication:** Communication plays a prominent role in the administration of claims especially in the death claims. The communication received by a hapless claimant will be a great source of relief. At every stage of communication, the insurer has to infuse a sense of faith in the mind of the claimant. Even while repudiating the death claim the insurer has to inject a source of faith in the system of ombudsman. It shall be adopted by the life insurers as a prudent practice voluntarily. The insurer should draw the attention of the claimant to the available redressal mechanisms like claims review committees; ombudsman etc. while sending a convincing communication to a claimant whose death claim is repudiated. A death claim communication to the wrong person lands the life assured in an embarrassing situation. While calling for the requirements, the life insurers are expected to exercise maximum care and ensure that all the requirements are called for in one go, instead of a piecemeal basis. However, based on the need, the life insurer shall have to call for the further requirements to maintain a prudent claim settlement policy. The life insurers further are expected to exercise maximum caution at the time of underwriting the policy itself while admitting the age of the life assured. Calling for the age proof of the deceased policyholder from the claimants of the policy is nothing but subjecting the beneficiaries to avoidable hardship. However, the statute empowers the life insurer to call for the proof of age of the life assured at any time as per section 45 of Insurance Act, 1938.

The retaining capacities of the life insurers will depend on the satisfactory services they render to their customers during the tenure of their policy life.

e) **Claims notices through call centers - Issues involved:** It could be that the personnel who are attending to the calls of the customers may not be professionals in the subject of insurance. The life insurer should ensure that the personnel of the call center are aware of the intricacies of claims aspects of the life insurer. While receiving the claims notices helps the insurer for expeditious settlement, it would be better for the insurer to re-confirm particulars of the claimants for these cases (notices received through call centers) before proceeding further. Pleasantries exchanged by the personnel of call centers should vary based on the type of calls they receive. While it should be a pleasure to receive a maturity claim notice/ query, the vocal expression should differ on receiving a notice of death claim. The best intentions of the personnel in looking forward to serving the claimant again in the case of a death claim would certainly invite his wrath for the misplaced courtesy. The insurer cannot disown responsibility for a fault of the outsourced personnel. Hence, the insurer shall pay personal attention on the training inputs of these personnel as well.

f) **Early Claim investigations -** Issues while outsourcing: Investigations of early claims is another area of concern to the life insurer. It is the responsibility of the life insurer to ensure that the business carried out by him is not exploited by few individuals by exercising adverse selection against him. The consequences of adverse selection exercised by a few individuals would burden the costs of life insurance to the public in general. Also from the point of view of prudent business practices no business ethics will allow its businesses to be exploited. It is the minimum risk management practice of this class of business, to cause an investigation to find out the veracity of the claims received during the early stages of a life policy. However, statute has placed certain restrictions, which are discussed in the succeeding paras, on calling in question the policy of life insurance

by the life insurer. The privatization of the insurance sector has thrown open this area of operation as a source of income to some investigating agencies, surveyors and other individuals. Conducting the early claims investigation is a prudent operational practice of the life insurer. However, when it is outsourced, the life insurer is expected to choose the best agencies/ individuals with talented track record.

The possibility of individuals or associations involved in this activity to indulge in some unethical practices like frauds, demanding kickbacks for a favourable investigation report, compelling the claimants to take a fresh life insurance policy on their own life etc. should be totally ruled out. Hence, the insurer's role in selecting these agencies/individuals will be crucial for ensuring a fair claims settlement. Individuals having a bad track record on whom allegations are under investigation; individuals/entities that are black listed by an insurance company etc. are a few that pose a potential threat for a fair claims settlement. The life insurers shall have a self regulatory mechanism to overcome these potential problems by maintaining a data base of these individuals/entities through its council. On the other hand, claimants shall also be informed not to succumb to the influences of any of the organizations/individuals; and should feel confident that their company is going to exercise its decision on admitting the claim on professional lines, in their communications to the claimants.

g) Settlement of Social Security Claims: Proactive settlement of social security claims is the social responsibility of life insurers. These sections of society, whose insurance awareness is abysmally low, often consider owning a life policy as a bad omen to the family. Lack of proper identity of the claimants, existence of several persons with the same name etc. are some of the issues that are likely to be faced by life insurers. Not being aware of the insurance benefit itself; or failure to have bank accounts are a few constraints that are faced by the claimants of this section of business which is also an area of problem for the insurers while settling these types of claims. Availability of death certificates is also a cause of concern in some hamlets. There are instances that these sections of society send the photos of the dead bodies taken along with their beneficiaries as proof of the death of the life assured. A certificate like the one from the last attended physician is a far cry in such cases. In view of these difficulties the insurers generally waive these requirements where the amount of claim involved is relatively low. However, the potentiality of a possible adverse selection against the insurer is very much possible. Ensuring that the claim amount reaches the rightful claimant by way of drawing the instruments in their favour who do not possess a bank account is a tough task. However, issuing the instruments in favour of the nodal agencies will have a potential problem of not reaching the hands of the claimants. This system of settling the claims could even exploit these claimants. Looking towards other avenues of settling the claims like sending the monies through postal orders, encouraging the opening of the savings accounts with post offices, banks which in turn encourages the savings thrift, with the help of the local nodal agencies are some of the ways out for settling the claim. Establishing a liaison with agencies like Gram Panchayaths, reputed local NGOs who are working for the welfare of these hamlets/ villages is another possible solution for the insurers.

It would be better for the life assured specifically bequeathing the proceeds of the life policies while executing his will as the nominee will be only giving a valid discharge to the monies received from the life insurer.

Role of life assured: Though, the life assured/policyholder has a limited role, apart from making material disclosures while taking the policy and paying the periodical premiums in time, there are certain issues which he too has to take care of, for supplementing the life insurer's efforts.

- The life assured should let his beneficiaries know the existence of a life policy on his own life. Quite often the claimants may approach the life insurer for a claim very late, coming to know about the existence of a life policy belatedly on the life of the deceased. This could, however, happen in all the economic strata of policyholders. It appears difficult to educate the policyholders on this aspect, but the life advisors play a critical role by maintaining a personal rapport with the family of the policyholder in finding out a resolution of the problem.
- Nomination is considered to be one of the easiest ways of settling the liabilities of the life insurers. The life assured shall ensure the nomination of the intended beneficiary to avoid a rival claimant approaching subsequently. Settlement of the claim in favour of the real beneficiary will be a very time consuming process and subject to legal complications in the event of a rival claimant approaching the life insurer, this will ultimately defeat the very purpose of taking a life policy. It would be better for the life assured specifically bequeathing the proceeds of the life policies while executing his will as the nominee will be only giving a valid discharge to the monies received from the life insurer. The right to receive the monies is only personal and the nominee cannot own the full benefits; nor is this a heritable right. It would be appropriate for the life insurers to bring to the notice of the life assured that the nominee will not have a heritable right to the monies of the policy, in his

communications with the policyholders.

Other issues:

Liability of the life insurer: Unlike in other classes of business, a life insurer should carry his liability to pay the claim for a good number of years. In order to achieve that, he is guided by the following provisions of various acts.

- Section 107 of Indian Evident Act, 1872 leaves the burden of proving death of a person known to have been alive within 30 years, on the person who affirms it. Hence, it is the claimant who has to prove the death of life assured under these provisions.
- When the question is whether a man is alive or dead; and it is proved that he has not been heard of for seven years by those who would naturally have heard of him if he had been alive, he is presumed to be dead (Section 108 of the same Act). In such cases, the burden of proving that he is alive is shifted to the person who affirms it. Thus, it is the life insurer who has to prove that such person is alive under these provisions.
- Section 44 of the Limitation Act, 1963 enables the claimant of a life policy to apply for a claim within three years from the date of death or maturity. However, in case of repudiating a death claim the period of three years will be counted from the date of repudiation of such claims. Though, the provisions place a limit of three years, at times the liability could be carried for more than three years, when a death claim applied is repudiated at the end of say; two or three years, the claimant's time to proceed further would end only after a further period of three years means five to six years from the date of registering the notice of death.

Section 45 of the Insurance Act: This is a protective provision in the Insurance Act that restricts the insurer to arbitrarily repudiate the claims. As per the provisions of this section, the insurer cannot deny the claim after two years from the date of affecting the contract on the ground of suppression of material fact at the time of taking a policy. However, the provisions enable the insurer to deny the claim if it could prove that the insured has suppressed a matter which is material to disclose, it was with the fraudulent intent the matter was not disclosed and the policyholder was aware of such suppressed material matter. As a part of fair claims management policy, the insurers do not just deny a claim on the ground of misstatement if it is not material to underwrite such a risk.

Let us take a quick glance at some of the provisions of various sections and acts that are relevant to the administration of claims:

- As per Section 60 (kb) of civil procedure code the monies payable under an insurance policy on the life of a judgment debtor (a person against whom a judgment has been entered) are exempted from attachment. Thus these provisions provide immunity to both maturity claims and death claims.
- Section 88 of the civil procedure code enables the life insurers to pay to the court the monies of the claims payable, in the event of a dispute for a claim by the rival claimants. This is known as interpleader suit. These provisions will discharge the liability of the insurer.
- Married Women's property Act, 1874 protects the rights of the beneficiaries of a policy of life insurers from the creditors of the deceased policyholders. The extent of the statute is to safeguard the very interests of the beneficiaries in line with the objective of taking such a policy.
- Section 47 of the Insurance Act enables the life insurer to pay to the court the proceeds of maturity claims in the event of his inability to settle the claims due to conflicting claims or inadequate proof of title etc. It amounts to a valid discharge of the liability of the life insurer.
- Section 47A empowers IRDA to adjudicate the dispute between the life assured and the life insurer in case of a dispute of a life policy whose basic sum assured is not more than rupees two thousand, which shall be final and cannot be called in question in any Court. However, in view of the level of sum assured prescribed, there is no relevance of this section.

As a part of fair claims management policy, the insurers do not just deny a claim on the ground of misstatement if it is not material to underwrite such a risk.

Regulator's role: Being the guardian of the interests of the policyholders, the regulator requires the insurers for expeditious and timely settlement of the claims. Insurance Core Principle 25 (ICP-25) prescribed by the International Association of Insurance Supervisors (IAIS) requires the supervisory authority to set the minimum requirements to insurers and intermediaries while dealing with the consumers. This ICP further explains that for a fair treatment of consumers, good claims resolution process is essential. The IRDA (Protection of policy holders' interest) Regulations, 2002 stipulates the time lag for an expeditious settlement of the claim. These regulations also require the life insurers to pay an interest on delayed claims payments.

Managing better claims management is the lifeblood of the life insurance operation. Just as the proof of the pudding is in its eating, the sincerity of the players of this class of business will be evident by the efficient administration of the claims management.

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The Future And 'Insuring' Services

- Need for a Fresh Look

In the ever dynamic and fluid environment; the insurance industry must break from the grip of tradition and respond to the challenges of the new era feels **APPARAO MACHIRAJU**.

For the purpose of this write-up, I define 'Insurance' broadly as a social instrument to provide economic security to people as well as business enterprises. Few of our economic histories ever tell us that it is the application of insurance principle, which has facilitated expansion and advancement of modern economy and technology; with associated risks and absorption of such risks.

Institutions within a society are transitory. They flourish or languish according to adaptability to the temper of times. In the ever dynamic and fluid environment, particularly in the age of restlessness and social experimentation, the insurance industry must break from the grip of tradition and respond to the challenges of the new era. The new era demands new thinking. Students and professionals of the business must be equipped and prepared to examine constantly and critically the basic social attitudes and values in the changing environment. The need is to initiate macro insurance studies and research in the relationship between the principles of insurance and application of those principles within the socio-economic-political framework in which the insurance and institution operates.

Insurance business is so woven into the people's lives and economy that it deserves special attention just as the projecting likely issues need to be addressed. Despite some changes initiated to meet the pressing needs and demands of the public for some fundamental insurance protection in an era of rising expectations, both the adequacy and quality of the insurance services have become the subject of criticism. There are some critics who even suspect as to whether burdened by the static theory and practices developed in the past, the insurance industry has fallen a victim to its own traditions while loosing its own innovative spirit. Failure to act on internal initiatives and to recognize the social responsibility which is inherent in the concept of insurance that calls for keeping up to the needs of the public without outside stimuli has been the subject of criticism by consumer advocates.

The Common Minimum Program (CMP) of the United Progressive Alliance (UPA) includes a large number of economic social objectives. The CMP can be termed as a Charter of Economic and Social Actions (CESA) to take Indian economy reforms further and to strengthen the process of balanced growth. In the CMP, a reference has been made to the insurance industry, but the limited reference has a very wider connotation. The statement referred to above such as social role and social obligations of insurance companies, meeting social obligations through strong commercial performance, selectivity and strategic focus etc. have a strong bearing on insurance companies' functioning.

An expert group of CII (Confederation of Indian Industry) has attempted to project the size of the insurance market over the next ten years to grow over to Rs. 145,000 crores. An interesting aspect of the CII projections is that it expects an exponential growth in the pension business. The pension business is projected to rise at 29% per annum, effectively translating into an expansion of over 12 times over a period of ten years. Growth potential of insurance industry has been the topic of numerous reliable presentations.

Important as life and health insurance is today, its real progress is yet to come. A very large section of insurable population remains to be insured in the country. In 2003, life insurance density i.e. premium per capita, in USD was only 12.9 as against the global density of USD 267.1. Life insurance penetration i.e. premium as percentage of GDP in India was 2.26 per cent as the global penetration level of 4.59, and India's share in the global market remained below one percent (0.81 percent). As mentioned earlier, the expert group of CII has attempted to project the size of the insurance market over the next ten years (Premium income Rs.145,000 crore) translating into average annual growth of over 19.6 percent. The premium business from the pension schemes is projected over 22.5 percent. It is estimated that health insurance market potential is a minimum of Rs. 15,000 crore while so far only Rs. 1,700 crore up to 2004-05 has been tapped. Only 3% of the population is covered by health insurance Projected potential market remains latent unless the insurance companies draw up a long-term strategic action plan incorporating commercial and social agenda taking into account the context of current and emerging marketplace realities.

Breaking from the past

We are in a transitional stage. We need to focus on "on-transition facilitation". We need to address the issues truthfully basing on unfiltered feedback as to what is happening at all levels in order to be able to formulate appropriate strategies. Most of the major problems confronting the life insurance business in today's situation are marketing oriented and specially the intermediary channels current and emerging.

The insurance industry has neither closed its ranks to practicing incompetents, nor established an internal system for measuring or enforcing professional standards. The public, by and large, have no other recourse than to believe that incompetence or unethical practices are a norm with which it must learn to live with. Insurance services counseling covering life and health insurance as a vocation and career could advance and acquire stature and dignity in direct proportion to the education/training received by those in business. It is therefore with education and training that we no doubt need to be mainly concerned, the first and most important step in marketing methodology.

- We have recent history of marketing lessons to learn from (the USA and UK in particular) problems the insurance companies faced in the matter of sales practices and heavy fines the companies had to pay. As a remedial measure they have now Insurance Marketplace Standards Association (IMSA), which has formulated procedures to be complied with by the insurance companies. Insurance companies are to certify compliance of these requirements from time to time. There is also an independent organization called Life and Health Insurance Foundation for Education (LIFE), founded by the insurance companies in USA to propagate through non-partisan education, media publications to educate the public.
- We in India need to give a fresh approach to different practices vis-à-vis the current ones.
- Issues to be addressed:
  - i. Need to ally with academic institutions for introducing collegiate/university level education.
  - ii. Need to develop state of the art training institutes focusing on sales and marketing management.
  - iii. Put in place scientific selection/ recruitment of intermediaries.
  - iv. Market conduct regulation relating to policy replacement as a preventive measure.
  - v. Promote, encourage professional association of intermediaries and self-regulation concepts.
  - vi. Marketing support to distribution channels.
  - vii. Advertisement and sales materials that are clear as to purpose; and honest and fair in content.
  - viii. Applied as well as basic research in all aspects of marketing i.e. selection/retention of agents, lapsation of policies, consumer attitudes, and more importantly focus on net growth of business periodically.
  - ix. Claims by death: Those beneficiaries who are paid the sum assured should be interviewed to know as to what extent the funds help their families.
  - x. Maturity payments: The writer of this article disagrees with using 'Claims' for maturity payments. There should be research as to the duration of the premium payments as against the full term of the contract. It is suspected that most of the payments are under paid up policies.

All the issues cited are as challenging as the marketing of life insurance; and aim at revitalization of product-driven life insurance sales with customer-centered approaches.

Most importantly we need to address the following issues once again in view of the new contextual situation i.e. convergence of financial services.

- What is the nature of the business in which we are engaged and what should be our goals and objectives?
- The insurance companies are to meet just the life insurance needs or should they be engaged in the broad business of meeting personal economic security needs?
- Even more, corporate financial services should be included with the marketing portfolio of life insurance companies - including equity products - such as variable annuities, and mutual funds.

Also these issues lead to another fundamental question, namely, the future role of intermediaries. Are they going to be financial advisors in the broader sense of the term; counselling on personal life insurance, equity investments, and other financial matters? or will we witness the development of life insurance company agency staff composed of a variety of specialists in specific areas of insurance and financial planning?

The future however, depends on institution building process and professional service concepts put into practice.

The author is Director, International Institute for Insurance and Finance (IIIF).

Just as we are going to the press, we are informed that Mr.Apparao Machiraju suffered a massive heart attack; and passed away. We deeply mourn his death; and convey our heartfelt sympathies to the bereaved family.

MAY HIS SOUL REST IN PEACE.

आप इस विज्ञापन को अपने आंतरिक प्रकाशन
में बेहिचक मुद्रित कर सकते हैं।

प्रकाशक का संदेश

सदा से बीमाकर्त्ता का सबसे महत्वपूर्ण कार्य दावा प्रबन्धन रहा है। इसे बहुत ही सावधानी से संचालित किया जाना चाहिये क्योकि पालसी धारक इस सम्बन्ध मे हुई देरी को करार में विश्वासघात मानता है। बीमाकर्त्ता को चाहिये कि केवल प्रामाणिक दावों का भुगतान किया जाये तथा आदतन जालसाजी करने वाले लोगो को गिरफतार किया जा सके। यह ऐसे उद्योग के लिए आवश्यक है जो जालसाजी के लिए सुभेद्य है।

यहाँ इस बात पर अधिक बल देने कि जरूरत नहीं है कि दावा प्रबन्ध का सम्बन्ध प्रत्यक्ष रूप से बीमालेखन से भी है। बीमाकर्त्ता यह सुनिशचित करते हैं कि बीमालेखन उच्च कौशल के आधार पर किया जाये जिससे जहॉ कही भी दावे उत्पन्न हो तो उनका तुरन्त निपटान करना एक सरल कार्य हो जाये।

व्यवसाय पोर्टफोलियो को संवर्धित करने के लिए सभी जोखिमों को स्वीकार करने की प्रवृति है जिसके परिणमस्वरूप दावालेखन से बचना चाहिये।

यह भी आवश्यक है कि बीमाकर्त्ता बीमा के विभिन्न वर्गो का विश्लेषण करे। विशेष रूप से जहाँ ऊँची दावा दर है, उन्हें अन्ततः सभी बीमा वर्गो को स्वयं आत्मनिर्भरता प्राप्त करनी चाहिये। पालसीधारको के मध्य या उत्पादों की श्रेणी के मध्य अप्रकट समपार आर्थिक सहायता उद्योग में लम्बें समय के लिए सफलता का निर्धारण करेगी। **जर्नल** के इस अंक में दावा प्रबन्धन केन्द्र बिन्दू है जिसके लिए विभिन्न मनीषियों के विचार लिये गये हैं।

हाल मे, मनी लांडरिग ने वित्तिय क्षेत्र में विशेष महत्व प्राप्त किया है। वैसे बीमा को मनी लांडरिग के वाहक के रूप में नहीं देखा जाता लेकिन इसकी संभावनाओं को पुरी तरह से नजरअंदाज भी नहीं किया जा सकता। **जर्नल** का अगला अंक विशेष रूप से 'मनी लांडरिग तथा बीमा' पर होगा। इस विशिष्ट क्षेत्र में विशेषज्ञों के विचार हम आमंत्रित कर रहे हैं।

सी. एस. राव

“ कुछ तो लोग कहेंगे ”

सौ साल पहले, लायड्स के लिए जो दुर्घटना हुई थी उसने हमारी व्यवस्था को नीचे किया है। भूकंप के झटकों के बाद संयुक्त राष्ट्र अमेरिका से हमारे संबन्ध सच में बंद हो गये।

लायड्स के अध्यक्ष लार्डस लेविन, सानफ्रांसिसको के भूकंप पर बात करते हुए

भारत की और कई बहु राष्ट्रीय कंपनियां एक बड़े बाजार के रूप में भारत को पकडने के लिए इंतजार कर रही हैं। ग्लोबल व्यवसायी इसलिए रूचि रखते हैं क्योकि व्यापक संभाव्यता उपलब्ध है तथा बहुत सारी गृह बचत बैंकिग क्षेत्र में जमा की गई है।

सी एस राव, अध्यक्ष आई आर डी ए

हेल्थ बीमा मुख्य रूप से एक सामाजिक दायित्व है, जिसके अनुसार व्यक्ति को मूल हैल्थ केयर पालसी मिलती है। यह आवश्यक नहीं है कि हैल्थ बीमा को बाध्यकारी बनाया जाए तथा उस पर सभी का अधिकार हो ।

धनंजय दाते, एमडी, स्वीस री इंडिया

कुल परिधि का विनियमन एक आंतरिक भाग होना चाहिये और यह खुली तथा प्रभावशाली होनी चाहिये जिससे ग्राहक के लाभ के लिए प्रतिस्पर्धा लायी जासके ।

डा. हबीब अल मुल्ला, अध्यक्ष, दुबई फाईनान्शियल सर्विस प्रधिकरण (डी एफ एस ए)

वर्तमान समय में एक औसत व्यक्ति द्वारा जो संरक्षण लिया जाता है वह उसकी वार्षिक आय के डेढ़ गुणा के लगभग होता है जो बहुत कम है।

शिखा शर्मा, सी ई ओ, आई सी आई सी आई प्रुडेन्शियल इन्शुरेन्स

एक बार प्रशुल्क मुक्ति प्राप्त कर लेने के बाद साधारण बीमा उद्योग में हैल्थ बीमा की दर में तोड़मरोड़ समाप्त हो जायेगी

सी एस राव, अध्यक्ष आई आर डी ए

स्वास्थय बीमा तथा व्यवस्थित देखभाल

- सूचना तकनीक के उपयोग

टीया साहनी, आलम सिंह एवँ रिच मेयर के अनुसार "सांख्यिकीय वैद्य आंकडों की पर्याप्त संख्या में अनुपलब्धता के कारण नीति-निर्माताओं के लिये पारंपरिक तकनीक से संभावित महत्वपूर्ण तथ्यों की श्रेणी के प्रभाव का आकलन करना कठिन हो गया है।"

स्वास्थय बीमा तथा व्यवस्थित देख भाल में सूचना तकनीक के प्रयोग के कई फायदे हैं। समुचित संचालन के साथ परस्पर संबद्ध सूचना तकनीक प्रणाली समस्त बीमा धारकों के साथ उचित संपर्क बनाये रखा जा सकता ह। सेवा प्रदता इनका उपयोग रोगी की अवस्था तथा उपचार को बेहतर ढंग से समझाने साथ संपर्क बनाये रखने के लिये कर सकता है। इससे बीमा कंपनियाँ बीमा धारकों को और अधिक बेहतर सेवायें प्रदान कर सकती है तथा टी पी ए उपेक्षाकृत कम गलतियों के साथ अधिक दावों का निपटान कर सकती है। प्रस्तुत लेख में स्वास्थय बीमाकर्ता तथा व्यवस्थित देखभाल करने वाली कंपनियों द्वारा वैश्विक रूप से सूचना तकनीक को प्रयोग करने को एक विशेष तरीके की विवेचना की जा रही है तथा निकट भविष्य में भारत पूर्वानुमान विश्लेषण की संभावनाओं को बताया जा रहा है।

भारत में स्वास्थय बीमा

यद्यपि भारतीय स्वास्थय बीमा उद्योग का बेहतर विकास हो रहा है, लेकिन उसके जडीभूत विकास के बारे में सचनाओं के आदान प्रदान पर ध्यान दिया जाना भी महत्वपूर्ण है। ऐतिहासिक रूप से नियोक्ता स्वास्थय बीमा का असाधारण तेजी से विकास हुआ है, कभी कभी ग्राहकों से सहयोग शुल्क बचाने के लिये तो कभी बाजार में हिस्सा बढ़ाने के लिये। कीमतों में असाधारण वृद्धिके लिये जिम्मेदार उपरोक्त प्रथम कारण लंबे समय तक नही बना रह सकता, तथा बाजार में हिस्सा बढ़ाने के लिये कीमतों में कमी करना एक ऐसी योजना है, जिस पर कि कोई भी संख्या दीर्घावधि तक नही चल सकती।

भारत में स्वास्थय बीमा बाजार की अपार संभावनायें हैं। वृद्धिगत आय स्तर तथा बड़ी बीमारियों की स्थिति में वित्तीय जोखिम कम करने की जरूरत के प्रति बढती जागरूकता के कारण अधिकतर भारतीय शहरी स्वास्थय बीमा में रूचि ले रहे हैं। द्धि अंकीय वृद्धि जो कि यद्यपि कुछ प्रारंभिक अवस्था में ही हैं, स्वास्थय बीमा के प्रति एक बेहतर सोच तथा माँग में वृद्धि का सूचक है। वक्त के अनुसार अपनी नीतियों को परिष्कृत करने वालों के लिये यह उद्योग संभावनाओं से भरपूर है। इन परिवर्तनों के लिये तकनीक का प्रभावी उपयोग सर्वोपरि है।

समूह बीमा के अलावा व्यक्तिगत बीमा बाजार के विकास में भी प्रचुर संभावनायें हैं। बहुत से भारतीयों के लिये समूह बीमा अभिगम्य नही है। अतः वर्तमान में अबीमित व्यक्तियों को लाभदायक व्यक्तिगत स्वास्थय बीमा बेचकर उच्च श्रेणी का विकास करना वृद्धिगत मुनाफा देने का एक उपाय है। बहुत से मध्यमवर्गीय

बीमाकर्ता हालाँकि व्यवसाय में हमेशा अपना मनोवांछित मुनाफा कमाना चाहता है। परंतु उसके पास उपलब्ध अनुभवात्मक विश्लेषण की सीमितता के कारण यह बहुत मुश्किल होता है।

शहरी भारतीय कोई बीमा कुछ कीमत पर खरीदने में सक्षम हैं। लेकिन अभी तक यह उद्योग उत्पाद, मूल्य तथा बीमाधारकों के बीच सही समन्वय नही ढूंढ पाया है, कम से कम अभी तक वृहद् आकार में नही।

मुनाफा देने का दूसरा तरीका अग्रिम पंक्ति तथा मूल्य नीति है। ऐतिहासिक रूप से स्वास्थय बीमाकर्ता एक संपूर्ण स्तर पर लाभ प्राप्त कर संतुष्ट होते हैं, जैसे कि कोई खास बड़ा समूह अथवा एक राज्य। भविष्य के इस उच्च प्रतिस्पर्धात्मक बाजार में कुशल बीमा कंपनियाँ बढते हुये असमान स्तर पर घनात्मक लाभ प्राप्त करने की कोशिश करती है। यह कंपनियाँ किसी भी अन्य बीमाकर्ता की तरह वे जोखिम उठाने के लिये तो तैयार होती हैं परंतु व्यापक हानि उठाने को नही। हालांकि वह अन्य व्यवसाय से भी लाभ प्राप्त करती है।

कुशल बीमा कंपनियाँ लागत तथा मूल्य निर्धारण के लिये उनन्त विश्लेषणों का सहारा लेती हैं, तथा उसी के अनुरूप बाजार लक्ष्य करती है। परिणामतः सर्वोत्तम जोखिम के लिये उनकी कीमत अन्य प्रतियोगियों से बेहतर होती है जो कि उन्हें इस व्यवसाय का अनुपाततः काफी बड़ा हिस्सा प्रदान करता है। लेकिन यदि उनकी अग्रिम पंक्ति विकास नही करती है, जैसा कि होता है, वे बीमा किश्त अथवा मूल्य में बेहतर एकरूपता होने के कारण उच्चतर मुनाफा प्राप्त करते हैं।

हालाँकि ये भविष्य की बात लगती है, यद्यपि यह अन्य लोगों में अजमाया हुआ सिद्ध उदाहरण है तथा बड़े बड़े स्वास्थय बीमा नियोजक इसे आजमा चुके हैं। यह तकनीक उन्नत आंकडों तथा पूर्वानुमानित विश्लेषणों से जुडी कला तथा विज्ञान है।

वर्तमान में आंकडों का विश्लेषण

बीमाकर्ता हालाँकि व्यवसाय में हमेशा अपना मनोवांछित मुनाफा कमाना चाहता है। परंतु उसके पास उपलब्ध अनुभवात्मक विश्लेषण की सीमितता के कारण यह बहुत मुश्किल होता है। कुछ समय पूर्व तक ही उद्योग में वित्तीय आंकडों का विश्लेषण मानवीय श्रम से ही होता था, तथा अब भी व्यवसाय नीति निर्याता अपनी नीतियों के निर्माण के लिये चालू वित्तीय स्थिति की जानकारी के लिये स्प्रैडशॉट्स का सहारा लेते हैं। लेकिन कंप्यूटर की सहायता के बिना विश्लेषण प्राप्त करने में हफ्तों का समय लग जाता है।

आज के अग्रगामी उद्योगी आवश्यक जानकारी प्राप्त करने इंटरनेट तथा कंप्यूटर का उपयोग करने के साथ सूचना तकनीक का भी प्रयोग करते हैं। लेकिन भारत में अभी भी अधिकतर कंपनियाँ विस्तृत विश्लेषणात्मक आंकडे एकत्र करने के बजाय अपनी वांछित जानकारी प्राप्त करने के लिये वे समस्त आंकडों का विश्लेषण करती हैं। यद्यपि ये विशाल आंकडों का संचय बहुत सटीक जानकारियाँ देता है, तथापि ये आँकडें बहुत अव्यवस्थित होते हैं, इनमें एकरूपता नही होता है तथा ये हर जगह प्रयुक्त नही हो सकते। कर्मचारियों को इन्हें फिर से व्यवस्थित करना पड़ता है। जिन लोगों का काम इन आँकडों का अलग अलग छोटे छोटे विभागों में वर्गीकृत करने का होता है, उनके लिये इस तनावपूर्ण बोझिल मानवीय श्रम को मशीनों के प्रयोग से वांछित जानकारी अल्प समय में दे पाना आसान हो जाता है।

किसी भी संस्थान द्वारा अपने दैनंदिन कार्यों में पर्युक्त होने वाले आंकडों चाहे वह किसी भी प्रारूप में हो, अथवा किसी भी क्रम में हो, उनके विश्लेषण, विवरण तथा सूचना प्रदान करने वाले तरीकों के विकास ने नयी संभावनाओं को जन्म दिया है। उपयोगकर्ता तब इनमें निश्चित नियम तथा संबंध स्थापित कर सकता है, उन्हें क्रमबद्ध रूप में व्यवस्थित कर सकता है। बिना किसी लिखित जानकारी के। अभी तक, उद्योग उन कुछ मुट्ठी भर आंकडों के विश्लेषण पर ही निर्भर है, जैसे कि उम्र, लिंग, क्षेत्र तथा वर्ग। अब आंकडों का भंडार जैसे कि मेडिनसाइट, बेहतर सक्षमता प्रदान करता है और इस प्रकार उपयोगकर्ताओं की निर्णय क्षमता को विकसित करता है।

हालाँकि पर्याप्त सांख्यिकी वैद्य आंकडों की अनुपलब्धता ने निर्णयकर्ताओं के लिये पारंपरिक तकनीकों के द्वारा संभावित महत्वपूर्ण तथ्यों के प्रभाव की गणना को कठिन कर दिया है, तथापि निर्णयकर्ताओं की ज्ञात तथ्यों की संभावित भिन्नता का विश्लेषण करने की क्षमता अभी तक सीमित है। सामान्यतः स्वास्थय कीमत का स्वतंत्र कारक मानते हैं, परंतु भौगोलिक विभिन्नतायें कुछ विशेष आयु वर्ग से अन्यों की अपेक्षा अधिक सुसंगत हो सकती है।

प्रमुख औद्योगिक निर्णयकर्ताओं को ऐतिहासिक दावों का सामना करना पड़ता है, तथा उनके निदान संबंधी आंकडों की सीमित समझ है जिससे प्रमुख ग्राहकों से संबंधित आँकडे भी सीमित हो जाते हैं। स्वास्थय बीमा उद्योग के लिये महत्वूपूर्ण संभावना व्यक्त करने वाले आँकडों के समूह में उनके लक्षित बाजार के प्रमुख विभाग के आत्मिक स्वरूप तथा सामाजिक स्वरूप के आंकडे भी शामिल होते हैं। खुदरा तथा वित्तीय सेवा क्षेत्र द्वारा लंबे अरसे से प्रयुक्त सामाजिक तथा मानसिक स्वरूप का खाका उनके विशिष्ट लक्षणों अथवा किसी विशेष बाजार समूह के क्रिय प्रारूप के विवरणों से भरपूर है। इन आंकडों का संग्रह उन्हें पारंपरिक विश्लेषण तकनीक में सहायक नही होता है।

भविष्यवादी विश्लेषण का उपयोग

भविष्यवादी विश्लेषण वस्तुतः तकनीकी का एक ऐसा समूह है, जो पारम्परिक तकनीकी पर आधारित नही होता। उसके लिये एक दूसरे की व्याख्या करने वाले मुद्दों की भी आवश्यकता नही होती जैसे कि अन्य तकनीकों में अमल में लाये जाते हैं। निपुण व्यावसायियों के जरिये भविष्यवादी विश्लेषण काफी व्यापक रूप में किया जाता है, जिसके जटिल तथ्यात्मक विवरण से ऐसे अनाकलनीय संबंधों और प्रवाहों का ज्ञान हो जाता है जो अन्य स्त्रोतों के जरिये संभव नही होता। अन्य किसी भी तथ्यात्मक पहलुओं के विश्लेषण के समान भविष्यवादी विश्लेषण के लिये तथ्यों की गुणवत्ता, विश्लेषण की गुणवत्ता का सूचक होती है। भविष्यवादी विश्लेषण के लिये बीमाकर्ता ऐसे तथ्यों की आपूर्ति करने वाला बड़ा स्त्रोत है, जो कई मानदंडों से संबंधित तथ्य बड़े पैमाने पर मुहैया कर सकते हैं। और उनका उपयोग एक हथियार की तरह किया जा सकता है। लेकिन जबसे भविष्यवादी विश्लेषणात्मक सॉफ्टवेयर का उपयोग किया जा रहा है, तबसे तथ्यों के स्त्रोत इस विश्लेषण के कवच के समान बन गये हैं। आंतरिक तथ्यात्मक विश्लेषण बाह्य स्त्रोतों से उपलब्ध होने वाले गुणवत्तापूर्ण साइको - डेमोग्राफिक डाटा के साथ आसानी से मिलाया जा सकता है। भविष्यवादी विश्लेषण

> विश्लेषकों ने पाया कि आवेदक की व्यक्तिगत जानकारी अन्य स्त्रोत से प्राप्त करने के साथ चुनिंदा सवालों के जवाब अधिक बेहतर परिणाम हासिल हो सकते हैं।

के उपकरण एवँ तकनीक का उपयोग आज लाभ हासिल करने के लिये किया जा रहा है। जोखिम विश्लेषक भविष्यवादी विश्लेषण तकनीक का उपयोग बीमाकर्ता के स्वास्थय बीमा दावे की पृष्ठभूमि के बारे में विस्तृत विवरण के साथ आयु, लिंग आदि के आधार पर भविष्य के दावों का अनुमान लगाने के लिये किया जा रहा है। पारंपरिक विश्लेषण पद्धति की तुलना में इस विश्लेषण पद्धति के निष्कर्ष अधिक सटीक साबित होते हैं। जोखिम आंकलनकर्ता नवीनीकरण के समय ऐसी पृष्ठभूमि का प्राथमिक तौर पर उपयोग करते हैं। उदाहरण के लिये मिलीमन स्वास्थय बीमाकर्ता के निर्देशों के अनुसार चिकित्सा प्रश्नकर्ता द्वारा प्राप्त जानकारी के आधार पर भुगतान संबंधी मुद्दे सुलझाये जाते हैं।

बीमाकर्ता के भविष्यवादी विश्लेषण विभाग को एक्चूरियान विभाग के साथ कार्य करना चाहिये, जो पारम्परिक विश्लेषण पद्धति पर निर्भर होता है भले ही स्वास्थय बीमा उद्योग में भविष्यवादी विश्लेषण तकनीक का पहले से ही उपयोग किया जाता रहा है, और यह अपनी अकाल्पनिकता के कारण महत्वपूर्ण रही है। हालाँकि इसमें कुछ हद तक काल्पनिकता और अन्य उद्योगों की समीक्षा का सहारा लिया जाता है जिससे संभावित जोखिमों का अनुमान लगाया जा सके। यहाँ पर भविष्यवादी विश्लेषण के तीन संभावित प्रयोग प्रस्तुत किये जा रहे हैं।

1. *व्यक्तिगत बीमा धारण*

पहले आवास ऋण हासिल करना मतलब कई पन्नों वाला आवेदन लिखकर आवश्यक जानकारी प्रस्तुत करने के साथ लंबी प्रक्रिया से गुजरना था। आवेदन प्रस्तुत करने के बाद ऋण मंजूर करने अथवा नही करने संबंधी निर्णय लेने के लिये काफी अधिक समय लिया जाता था और यदि ऋण मंजूर नही हुआ, तो आवेदन वापस प्राप्त होने के लिये भी कई सप्ताह का समय लगता था। दूसरे शब्दों में कहा जाये आज व्यक्तिगत स्वास्थय बीमा प्रक्रिया के काफी समान प्रकिया थी। गिरवी व्यापार में भविष्यवादी विश्लेषकों ने पाया कि आवेदक की व्यक्तिगत जानकारी अन्य स्त्रोत से प्राप्त करने के साथ चुनिंदा सवालों के जवाब अधिक बेहतर परिणाम हासिल हो सकते हैं।

आज गिरवी व्यापार में आवेदन मात्र कुछ मिनटों में ही पूर्ण रूप से भरा जाता है साथ ही उसमें जोखिम संबंधी भी आर्थिक सुरक्षितता रहती है। इसके अलावा इस पद्धति से गिरवी व्यापार में गिरवी रखी जाने वाली संपत्ति संबंधी जोखिम अधिक सुलभ होता है और कई जोखिमों को टाला भई जा सकता है। व्यक्तिगत स्वास्थय बीमा बाजार भी इस प्रकार के परिवर्तन के लिये तैयार है।

2. *वृहद् समूह खंड और उत्पाद डिजाइन*

ग्राहक सेवा कंपनियाँ उन तकनीकों का उपयोग करती हैं, जिसमें बीमाकर्ताओं के वृहद समूह के लिये उपयोगिता मौजूद होती हैं। हालाँकि इसमें बीमाकर्ता के पास व्यक्तिगत बीमाधारक के बारे में निर्णय लेने की स्वतंत्रता नही रहती है। इसके अलावा बीमाकर्ता को अपने समूह के सभी कर्मचारियों के लिये एक समान मूल्य का निर्धारण करना पड़ता है। सेवा पैकेज उपलब्ध कराने वाली बीमा कंपनियाँ अधिकाधिक लोगों को बिक्री करने के लिये तैयार नही रहती। बल्कि वह अपने व्यापार को विभिन्न खंडों में विभाजित करने के लिये भविष्यवादी विश्लेषणात्मक तकनीको का उपयोग करती है। इसके लिये विभिन्न खंडों संबंधी कई तरह की रचनायें तैयार की जाती हैं और सही डिजाइन एवँ

मूल्य योजनायें बनायी जाती है। इसके बाद ग्राहकों की आवश्यकता के अनुसार उन्हें सही योजना का चयन करने में सहायता के साथ अपनी योजनाओं के प्रति अधिकाधिक संख्या में आकर्षित करने के लिये विभिन्न प्रकार की सामग्री प्रस्तुत कर विपणन किया जाता है। बाद में इस बात का मूल्यांकन किया जाता है कि निर्धारित खंड विभाजन और बिक्री का कुल लक्ष्य साध्य हुआ है अथवा नहीं। निश्चित रूप से, बीमाकर्ता भी खंड वर्गीकरण का निर्धारित लक्ष्य हासिल करने बहु- विकल्पी माहौल में अपने उत्पादों का डिजाइन तैयार कर बड़े समूह में उपयोग के लिये मूल्य तय कर रहे हैं। परिणामतः उत्पाद डिजाइन अधिकाधिक रूप से तथ्य विश्लेषण के रूप प्रवर्तित किया जाता है।

3. *चैनल प्रबंधन*

बीमा कंपनियों के लिये चैनल प्रबंधन खास तौर पर कठिन होता है। बीमाकर्ता लाभ दायिता (अथवा नुकसान) के लिये व्यक्तिगत रूप से अभिकर्ताओं अथवा प्रस्तुतकर्ताओं को उत्तरदायी ढहराने के लिये संघर्षरत रहते हैं। परिणाम स्वरूप अभिकर्ता व्यापार की मौलिक वांछनीयता पर होने वाले खर्च में ही उच्च विकास हासिल करने पर ध्यान देते हैं। भविष्य में विश्लेषण की भविष्यवादिता के आधार पर किये विश्लेषण के निष्कर्ष बीमाकर्ताओं को न केवल उच्चतम विकास का लक्ष्य हासिल करने में मदद करेंगे, बल्कि प्रत्येक बाजार के प्रत्येक खंड में लाभ और बेहतर प्रदर्शन का लक्ष्य हासिल करने में भी मदद करेंगे।

कल के बीमा बाजार के लिये भविष्यवादी विश्लेषण

भविष्यवादी विश्लेषण तकनीकियाँ कंपनियों को व्यापार के नये परिवेश उपलब्ध करवाती है। साथ ही उन्हें यह समझने में भी मदद मिलेगी कि व्यापार का गठन किस प्रकार किया जाता है। हालांकि विश्लेषण में संभावित प्रभावों का पूर्ण विश्लेषण करना तो संभव नही है। लेकिन निम्नलिखित प्रभाव आसानी से समझे जा सकते हैं।

रेटिंग पद्धति विज्ञान

स्वास्थय बीमा अनुपात दर ऐतिहासिक रूप से उपलब्ध सीमित मानदंडों पर आधारित है। जिसमें बीमा कराने के समय संबंधित व्यक्ति की आयु, लिंग एवँ क्षेत्र का विचार किया जाता है। भविष्यवादी विश्लेषण तकनीकियों का उपयोग वर्षों तक वाहन बीमा अनुपात के लिये किया जाता रहा है। व्यक्तिगत स्वास्थय बीमा अनुपात की गणना से अधिक वाहन बीमा अनुपात की गणना के लिये उसका विभिन्न तरह से उपयोग किया गया है। फिलहाल व्यक्तिगत एवँ लघु समूह व्यापार में परिवर्तन आरंभ हो चुका है।

लक्ष्य निर्धारण

जब बीमाकर्ता अपने सर्वाधिक लाभकारी बीमाधारकों की विशेषता पहचान पाये, तो वह स्वाभाविक तौर पर उसी प्रकार के बीमाधारकों की संख्या बढ़ाने पर अधिक ध्यान देंगे। यदि बीमाकर्ता संभाव्य ग्राहक की सायको डेमोग्राफिक विशेषता पहचान पाया, तो वह निश्चित रूप से अपने संभावित लक्ष्य में और अधिक वृद्धि करेगा। इसके बाद वह उपलब्ध तथ्यात्मक विश्लेषण का उपयोग करते हुये बाह्य स्त्रोतों से उस रूपरेखा का विपणन भी करवा सकते हैं।

लाभ रूपरेखा में धमाका

जब वांछनीय लक्ष्यों की पहचान की जाती है, तब अगला कदम सही रूप से डिजाइन किये गये मूल्य उत्पाद पेश करने का होता है, जो खासकर उसी लक्ष्य वेक अनुसार आकर्षक बनाये हुये होते हैं।

भविष्यवादी विश्लेषण तकनीकियाँ कंपनियों को व्यापार के नये परिवेश उपलब्ध करवाती है। साथ ही उन्हें यह समझने में भी मदद मिलेगी कि व्यापार का गठन किस प्रकार किया जाता है।

बाजार विशिष्ट स्थान बनाने के उद्देश्य से उतारे जाने वाले नये उत्पाद

भले ही सर्वाधिक प्रगति हासिल करने वाले बीमाकर्ता सर्वाधिक लाभ दिलाने वाले लक्ष्यों की सबसे पहले पहचान कर पाते हों, अन्य बीमाकर्ता भी शीघ्र ही उसका अनुकरण करेंगे और समान लक्ष्य का पीछा कर लाभ कम कर देंगे। नतीजतन बाजार में अपनी विशिष्ट पहचान बनायी रखने के लिये लगातार नये नये उपायों की खोज जारी रहती है। उचित मूल्य पर विविधता पूर्ण व्यापार से सकारात्मक लाभ तैयार किया जा सकता है। भविष्यवादी विश्लेषण पद्धति की खोज के बारे में उप प्रमुख गिरवी बाजार के साथ नुकसान के कारण दुर्बल हुआ वाहन बीमा बाजार में मानों धमाका सा हो गया। हालांकि इसके बावजूद इतिहास में कुछ देशों में वाहन बीमा बाजार में परिणाम काफी कम रहा है और घरेलू गिरवी बाजार के प्रति रूझान बढ़ा। उपभोक्ताकरण के चलते वित्तीय जिम्मेदारी के लिये स्वास्थय देखभाल संबंधी निर्णय लेने का कार्य फिर कर्मचारियों को सौंपा गया। परिभाषित अंशदान प्रक्रिया से कर्मचारी विभिन्न योजनाओं में से उपयुक्त योजना का चयन करने के लिये मुक्त है। बीमा कंपनियाँ कर्मचारियों की माँग के अनुसार अपने उत्पादों का स्वरूप तैयार करने के लिये भविष्यवादी विश्लेषण का उपयोग कर रही हैं और करेंगी। समूह बीमा स्वरूप को लगातार व्यक्तिगत ग्राहकों की आवश्यकताओं पर ध्यान देना पड़ेगा।

शीघ्र प्रतिक्रिया समय

भविष्यवादी विश्लेषण के उपकरणों का उपयोग भविष्य का अनुमान लगाने के अलावा पारम्परिक पद्धतियों से समस्याओं का पता लगाने के लिये भी किया जा सकता है। लेकिन वह जानकारी मात्र तभी उपयोगी साबित हो सकती है जब उस पर अमल किया जाये।

स्वास्थय बीमा एक प्रतिस्पर्धी उद्योग है। अन्य प्रतिस्पर्धी व्यवसायों के समान इसमें भी सफलता हासिल करने के लिये स्पर्धा में आगे रहना अनिवार्य है। हालांकि एक ही बार पूरी सफलता हासिल होगी ऐसा नही है। अग्रगामी सोच रखने वाले बीमा व्यवसाय प्रमुख निश्चित रूप से भविष्यवादी विश्लेषण का महत्व स्वीकार करेंगे। साथ ही बीमा पॉलिसियो की बिक्री रणनीति मूल्य निर्धारण और विपणन को मजबूती दिलाने के लिये नयी प्रक्रियाओं का उपयोग करने हेतु आवश्यक कडे कदम उठायेंगे वह संपूर्ण साफ - सुथरे तथ्यात्मक विश्लेषण का इंतजार नही करेंगे। वह अपने प्रतिस्पर्धियों से आगे बढ़कर लाभ उठाने के लिये कोई कदम बढ़ायेंगे वैसे वह सीखेंगें।

टीया साहनी फिलहाल मिलेनियम इन्कार्पोरेशन की स्वास्थय देखभाल प्रबंधन सलाहकार एवँ सोसाइटी ऑफ एक्च्यूरीज की सदस्या के रूप में कार्यरत हैं।

अलामासिंह फिलहाल मिलेनियम इंडिया के सहायक प्रबंध निदेशक हैं।

रिच मोयर फिलहाल मेडइन्साइड हेल्थ केयर वेयर हाउस के उत्पाद प्रबंधक और स्वास्थय देखभाल बीमा क्षेत्र ते उत्पाद सूट निर्णय सहायक है।

सूचना जोखिम प्रबंध

- विचार और प्रक्रिया

कंपनियाँ अपने व्यवसायिक लक्ष्यों तथा संचालन तथा प्रतिस्पर्धा शक्ति बनाये रखने के लिए वृहद् रूप से सूचना प्राद्योगिकी पर निर्भर रहती है। वैसे सूचना स्वयं ही दुरुपयोग के जोखिम से ग्रस्त रहती है। ***एडगर पी बाल्बिन*** **तथा आर एन के प्रसाद** सूचना प्राद्योगिकी के जोखिमों से बचने के कुछ उपाय सुझाते हैं।

कंपनियाँ अपना व्यापार लक्ष्य निर्धारित हासिल करने के साथ ही प्रतिस्पर्धा की क्षमता बनायी रखने के लिये अधिकांश रूप से सूचना प्रौद्योगिकी पर निर्भर रहती है। हालांकि सूचना ही गंभीर जोखिम से गुजरती है, लेकिन उसकी और अनदेखी बरती जाती है। लेकिन उसकी और अनदेखी बरती जाती है। एडगर बालबिन और आर एन के प्रसाद ने सूचना का ऐसी जोखिमों से संरक्षण करने के लिये कुछ उपाय सुझाये हैं।

घरेलू एवँ विश्वस्तर पर बीमा उद्योग कई चुनौतियों का सामना कर रहा है। यह चुनौतियाँ खास तौर पर नियमन के अभाव, वित्तीय सेवाओं के रूपांतरण, ग्राहकों की अपेक्षा में हो रही भारी बढ़ोतरी एवँ नये उत्पादों को स्वीकार करने की जरूरत के साथ अन्य कारणों से उभर रही हैं।

बीमा व्यापार में बढ़ती जटिलता के साथ अपना प्रतिस्पर्धी स्वरूप बनाये रखने के लिये बीमा कंपनियों को अपने व्यापार में बढ़ोतरी करनी चाहिये इसके लिये उन्हें अपनी सूचना प्रौद्योगिकी कार्य को ग्राहक अभिमुख करना चाहिये। इसके अलावा सूचना प्रौद्योगिकी कार्यों को मूल्यवर्धित लाभ दिलाने एवँ बाजार में प्रतिस्पर्धी लाभ दिलाने के लिये अधिकाधिक जिम्मेदार बनाया जाना चाहिये।

विगत समय के विपरीत फिलहाल पॉलिसी धारकों की न्यूनतम अपेक्षाओं के अनुरूप कार्य करने को तरजीह दी जा रही है। दूसरी और व्यापार मालिक और प्रबंधक सूचना प्रौद्योगिकी कार्यों को महत्वपूर्ण मानते हुये उनका उपयोग नये अवसरों का लाभ उठाने के साथ ही लंबे समय तक अपना अस्तित्व बनाये रखने के लिये कर रहे हैं। खास तौर पर बीमा कराने पॉलिसी जारी करने, प्रीमियम स्वीकारने और लेखा - जोखा रखने, दावा प्रबंधन अथवा पॉलिसी धारकों के लिये सेवायें मुहैया करने अभिकर्ता / दलाल प्रबंधन प्रारूप तैयार करने और अन्य व्यापरिक गतिविधियों की पूर्ति के लिये इनका उपयोग किया जा रहा है। इसी श्रृंखला में मुख्य सूचना अधिकारियों को भी कंपनियों का प्रतिस्पर्धी स्वरूप बनाये रखने, सूचना प्रबंधन एवँ संरक्षण, उद्योग इकाई की उद्यमशीलता तथा कंपनी की सूचना प्रौद्योगिकी व्यवस्था में स्वाभाविक जोखिम पहलुओं की पहचान कर उनका प्रबंधन करने के लिये कडी मेहनत करनी पड़ रही है। सूचना प्रोद्योगिकी और सूचना प्रौद्योगिकी आधारित पद्धतियों को उद्योग व्यवस्था से कई तरह के खतरे और असुरक्षितता बनी रहती है। इन खतरों में खास तौर पर संपत्ति और सूचना संबंधी नुकसान से व्यापार को कई तरह से प्रभावित करता है। इसके फलस्वरूप आर्थिक और गैर आर्थिक नुकसान का सामना करना पड़ता है।

> बीमा व्यापार में बढ़ती जटिलता के साथ अपना प्रतिस्पर्धी स्वरूप बनाये रखने के लिये बीमा कंपनियों को अपने व्यापार में बढ़ोतरी करनी चाहिये इसके लिये उन्हें अपनी सूचना प्रौद्योगिकी कार्य को ग्राहक अभिमुख करना चाहिये।

सूचना प्रबंधन के तहत सभी विभागों के लिये समान प्रक्रिया अपनाने के साथ सूचना संपत्ति एवँ सूचना प्रौद्योगिकी के परिवेश में एकता उपलब्धता एवँ गोपनीयता लायी जाती है। इस संपूर्ण प्रक्रिया का उद्देश्य किसी भी संस्थान के सूचना प्रौद्योगिकी संबंधी जोखिमों का ऐसे नियंत्रण से बेहतर प्रबंधन करना है, जिससे अति महत्वपूर्ण सूचना प्रौद्योगिकी, विवेचनात्मक सूचनाओं और सूचना संग्रहण तथा प्रेषित करने की प्रक्रिया का संरक्षण किया जा सके।

जोखिम प्रबंधन: सामान्य पद्धति

आमतौर पर जोखिम प्रबंधन पद्धति में जोखिमों की पहचान, जोखिमों का मूल्यांकन एवँ अधिकाधिक स्वीकार्यता बनायी रखने के लिये जोखिमों की संभाव्यता कम करने आवश्यक कार्यों, प्रक्रियाओं एवँ नीतियों के साथ सही प्रबंधन नियंत्रण तकनीक की अमलावरी करना शामिल है।

सूचना जोखिम प्रबंधन से कंपनियों को संपत्ति संबंधी सूचना की पहचान एवँ उन संपत्तियों के लिये उत्पन्न होने वाले संभावित खतरों की पहचान करना आसान हो जाता है। इसके अलावा वह जोखिमों का सही आंकलन कर आवश्यक मूल्यांकन भी कर सकती है। इस प्रक्रिया से संरक्षणात्मक मानदंडों की कम खर्च के साथ समुचित अमलावरी करना भी आसान हो जाता है।

इससे कंपनी की कार्यक्षमता में व्यवस्थित रूप से वृद्धि होती है। सूचना सुरक्षा के लिये कई कारणों से चुनौतियाँ उत्पन्न हो सकती हैं। इसमें मुख्य रूप से (क) तकनीकी मामलों के प्रति गंभीरता / बौद्धिक दृष्टि से विचार का अभाव (ख) सूचना व्यवस्थाओं की अनुचित अमलावरी (ग) सूचनाओं की अत्याधिकता (घ) गुणवत्ताहीन प्रशिक्षण एवँ (ड़) सूचना प्रौद्योगिकी आदि संबंधी कार्यों के लिये आवश्यक बजट का आबंटन नही करना शामिल है।

सूचना सुरक्षा एवँ प्रबंधन की सुनिश्चितता

कंपनियों को सूचनाओं की ओर महत्वपूर्ण संपत्ति की तरह ध्यान देना चाहिये। साथ ही व्यापार की सफलता और नुकसान में उनकी महत्वपूर्ण भूमिका स्वीकार करनी चाहिये। कंपनी की सफलता के लिये सभी बीमा धारकों के प्रति परोक्ष रूप से जिम्मेदार रहने वाले निदेशक मंडल के सदस्य की सूचनाओं और सूचना संपत्तियों के संरक्षण के लिये जिम्मेदार होते हैं। संरक्षण के इस लक्ष्य को तभी हासिल किया जा सकता है, जब निदेशकों की कडी निगरानी में प्रभावी तकनीकी तथा प्रबंधन नियंत्रणों की अमलावरी की जाये। कंपनी के निदेशकों के साथ मुख्य कार्यकारी अधिकारी (सीईओ), मुख्य वित्तीय अधिकारी (सीएफओ) एवँ मुख्य निरीक्षण अधिकारी (सीआईओ) जैसे महत्वपूर्ण पदों पर कार्य करने वाले सहयोगी अधिकारियों को भी ऐसे खतरों के प्रति जागरूक एवँ सतर्क रहना चाहिये, जो कंपनियों की सूचनाओं संबंधी निजती एवँ सुरक्षा के साथ समझौता करने पर मजबूर करते हों। यदि ऐसे खतरों के प्रति सजगता एवँ सतर्कता नही बरती गयी, तो भारी नुकसान का भी सामना करना पड सकता है।

कंपनियाँ अपनी सुरक्षा के बारे में कौन-कौन से सवाल पूछ सकती हैं

1. सूचना प्रौद्योगिकी स्त्रोतों संबंधी सामान्य जानकारी की सुरक्षा के लिये नियत कार्य की जिम्मेदारी सुनिश्चित करने हमें क्या करना चाहिये
2. सूचना सुरक्षा के महत्व के प्रति सभी संबंधित लोग जागरूक है अथवा नही इस बात की सुनिश्चिती के लिये हमें क्या करना चाहिये
3. क्या हम सूचना सुरक्षा नीति के बारे में संबंधित पार्टियों तथा रूचि रखने वाले लोगों के दृष्टिकोण एवँ शर्तों पर विचार करने के साथ सामंजस्य बना सकते हैं?
4. क्या हम अमल में लायी जाने वाली सूचना सुरक्षा नियंत्रण पद्धति पर होने वाले खर्च और उससे प्राप्त होने वाले लाभ का मूल्यांकन कर सकते हैं।
5. संपूर्ण सूचना व्यवस्था में प्रभावी सूचना सुरक्षा बनाये रखने के लिये आवश्यक प्रक्रिया और सभी नीतियों के साथ सूचना सुरक्षा नीति एवँ योजना को एकीकृत बनाया जा सकता है?
6. किसी प्रकार की असफलता का कंपनी अथवा उसकी सूचना संपत्ति पर विपरीत असर ना हो और वह कंपनी की संचालन संबंधी गतिविधियों को भी प्रभावित ना करे इस बात की सुनिश्चिती के लिये किस प्रकार के कदम उठाये जा सकते हैं।
7. प्रबंधन, निगरानी और नियमित जोखिम आंकलन सुनिश्चित करने किस प्रकार के कदम उठाये जा सकते हैं।
8. क्या सूचना सुरक्षा माक निष्पक्ष, वैधानिक एवँ स्वंयपूर्ण हैं?
9. सूचना और व्यवस्था को क्षति से बचाने के लिये कौन से मानदंड तैयार किये गये हैं, और क्या ऐसी कोई विश्वसनीय तथा क्षति के बाद सभी स्थितियों को पूर्ववत् करने वाली कोई नवीनतम व्यवस्था विकसित की गयी है?
10. क्या आपदा से फिर उबरने कोई योजना अमल में लायी जा सकता है? और समय-समय पर क्षतिपूर्ण योजना की समीक्षा किस प्रकार की जा सकती है।

सूचना प्रबंधन प्रक्रिया के लिये एक तर्क संगत संरचना होना आवश्यक है ताकि किसी भी जोखिम की अनदेखी ना हो। साथ ही सभी संपत्तियों की पहचान कर उनका लेखा-जोखा रखा जा सके। साथ में दिये गये आलेख में जोखिम सूचना प्रबंधन की सुनियोजित प्रक्रिया दर्शायी गयी है। जोखिम प्रबंधन एक प्रतिरक्षात्मक हथियार के समान है, जिससे संगठन अपना निर्धारित लक्ष्य निर्धारित कर सकते हैं। इसीलिये जोखिम प्रबंधन संबंधी सूचना ढाँचा तैयार करते समय इस बात का ध्यान रखना जरूरी है कि वह कंपनी के रणनीतिक लक्ष्यों एवँ रणनातिक सूचना योजना से मेल खाती हो।

सूचना परिवेश के लिये जब भी जोखिम मूल्यांकम किया जाये, उस समय यह ध्यान में रखना आवश्यक है कि सभी सूचना संपत्तियाँ व्यापार में पहचानी गयी जोखिमों अथवा गंभीर स्थिति के लिये सहायक है अथवा नहीं एवँ उनके बारे में विस्तृत सूची तैयार की गयी है, अथवा नही। इन संपत्तियों को इस प्रकार वर्गीकृत किया जा सकता है।

भौतिक और निश्छित संपत्तियाँ: इन संपत्तियों में शामिल हैं:

- हार्डवेयर एवँ सॉफ्टवेयर, मुख्य कार्य योजना, मिनी कंप्यूटर, माइक्रो कंप्यूटर, प्रिंट मीडिया संपत्ति, नेटवर्क तथा सूचना आदान-प्रदान संबंधी उपकरण आदि।
- अंतर्गत एवँ बाहरी संपर्क बहाली व्यवस्था

> जहाँ असुरक्षा नही रहती वहाँ चेतावनी का स्त्रोत कोई जोखिम उत्पन्न नही कर सकता। सूचना व्यवस्था के भय की पहचान सूचना जोखिम प्रबंधन के लिये महत्वपूर्ण होता है।

- सूचना प्रौद्योगिकी व्यवस्था का उपयोग करने वाले / समर्थन करने वाले लोग
- सूचना प्रोद्योगिकी व्यवस्था के लिये आवश्यक सुविधायें, जिनमें फर्नीचर, परिसर आदि शमिल हैं
- दस्तावेजीकरण जिसमें प्रषय, नियम पुस्तिका आदि शामिल हैं

अन्य संपत्ति: जो इस सूची में शामिल तो है लेकिन निम्मलिखित बातों के लिये आवश्यक नही

- डाटा (ज्ञात लिखित विवरण) एवँ सूचना
- एप्लिकेशन और कंप्यूटर सॉफ्टवेयर

चिन्हित उपरोक्त संपत्ति को निम्नलिखित रूप से विभिन्न श्रेणियों में वर्गीकरण किया जा सकता है

(ए) मिशन क्रीटिकलः इस श्रेणी में ऐसी संपत्ति आती है, जो व्यवसाय के संचालन के लिये आवश्यक है, तथा जिसके बिना व्यवसाय का संचालन करना संभव नही है।

(बी) अत्यावश्यकः इस श्रेणी में ऐसी संपत्ति आती है जो व्यवसाय संचालन आवश्यक तो है लेकिन यदि वह उपलब्ध ना हो, तो व्यवसाय का संचालन करना असंभव नही होगा।

(सी) सामान्यः इस श्रेणी में वह संपत्ति आती है, जो व्यवसाय संचालन के लिये आवश्यक तो है लेकिन उसके अभाव की स्थिति में व्यवसाय का कुछ समय तक संचालन किया जा सकता है।

पहचान की गयी संपत्ति एवँ सूचना की मौजूदगी में जोखिम आंकलन के लिये मानदंड तैयार करने महत्वपूर्ण है। आमतौर पर यह मानदंड निम्लिखित मुद्दों के आधार पर विकसित होते हैं

(ए) सूचना की गोपनीयता (बी) सूचना का एकत्रीकरण एवँ (सी) सूचना की उपलब्धता।

जबकि जोखिमों के मूल्यांकन के लिये उपयोग में लाये जाने वाले मानदंड निम्लिखित मुद्दों पर आधारित होते हैंः

(ए) ग्राहकों का ज्ञानबोध (बी) नियमन प्रभाव (सी) व्यापार प्रभाव एवँ (डी) संचालन प्रभाव

असुरक्षा संबंधी विश्लेषण के बाद पहचान की प्रक्रिया की अमलावरी की जाती है। जोखिम अर्थात् जानकारी पर विपरीत प्रभाव डालने वाली क्रिया है, जो सूचना के भय पर संभावित प्रभाव डालती है। भय विभिन्न कारणों से उत्पन्न होता है, लेकिन उसके निश्चित स्त्रोत की पहचान कर विशेष प्रबंध के जरिये उसे खत्म किया जा सकता है। जहाँ असुरक्षा नही रहती वहाँ चेतावनी का स्त्रोत कोई जोखिम उत्पन्न नही कर सकता। सूचना व्यवस्था के भय की पहचान सूचना जोखिम प्रबंधन के लिये महत्वपूर्ण होता है। भय आंतरिक, बाह्य अथवा पर्यावरण से संबंधित हो सकता है। किसी सूचना व्यवस्था के भय स्त्रोतों की असुरक्षा में शामिल रहती है। भय मुख्यरूप से सुरक्षा पद्धति, व्यवस्था के स्वरूप और मौजूद प्रबंधन नियंत्रण पद्धति की कमजोरी होती है। जिसके दुरूपयोग अथवा अचानक होने वाली दुर्घटना से नुकसान पहुँच सकता है। इस प्रकार के भय के मुख्य स्त्रोत (ए) कंपनी के हटाये गये कर्मचारी जो नेटवर्क में प्रवेश कर अपनी पुरानी पहचान और पासवर्ड डायल कर कंपनी के स्वामित्व की महत्वपूर्ण जानकारी हासिल कर सकते हैं। तथा (बी) हैकरः कंप्यूटर अपराधी अथवा अन्य अनाधिकारिक लोग कंपनी के सूचना नेटवर्क को भेद कर सूचना प्रोद्योगिकी व्यवस्था की खमियों का फायदा उठाते हुये उसका उपयोग या फिर व्यवस्था के ज्ञात

मार्गों के जरिये नेटवर्क में प्रवेश कर जानकारी हासिल कर सकते हैं कहे जा सकते हैं।

सूचना जोखिम प्रबंधन प्रक्रिया में अगला कदम जोखिमों का मूल्यांकन है जो बाहरी विशेषज्ञों के जरिये किया जा सकता है। यह विशेषज्ञ संपूर्ण व्यवस्था तथा सूचना संरचना की समीक्षा करते हैं ताकि खामियों के सुधार के लिये आवश्यक पहलुओं का पता लगाया जा सके। इस प्रक्रिया में सुधार की संभावनाओं के मूल्यांकन के अलावा संभावित नुकसान और जोखिमों का भी मूल्यांकन किया जा सकता है। इसके परिणाम स्वरूप कंपनी की मौजूदा जोखिमों की पहचान के साथ अन्य जोखिमों के प्रबंधन कार्यों का विकास किया जा सकता है। इसके अलावा ऐसे मूल्यांकन संबंधी विश्लेषण का उपयोग सूचना व्यवस्था में तत्काल खामियों का निर्मूलन करने अथवा सुधार नीति अपनाकर संबंधित खतरों अथवा संभावित नुकसान टालने के लिये किया जा सकता है।

किसी भी कंपनी को मात्र जोखिमों के मूल्यांकन के साथ खतरों के स्त्रोतों का विवरण तैयार करना काफी नही होता, बल्कि मूल्यांकन के प्रभाव के साथ इस बात की भी सुनिश्चिती करना आवश्यक है कि क्या सचमुच खतरा मौजूद है और क्या संस्थान के सूचना तंत्र समझौते की स्थिति से गुजर रहा है। खतरों का परिणाम कुछ निश्चित नुकसान अथवा प्रभाव के रूप में सामने आ सकता है जैसे राजस्व हानि, व्यवस्था के मरम्मत पर खर्च, नियमन मानकों रे उल्लंघन को कारण होने वाला आर्थिक नुकसान आदि। एक बार जोखिमों का पता चल जाये और उनका समुचित मूल्यांकन किया जाये तो क्या उचित है और क्या नही इस आधार पर उनका वर्गीकरण किया जाना चाहिये। सभी जोखिमों का पूर्ण रूप से उन्मूलन असंभव होता है। यह तो सर्वविदित है। जोखिम निवारण नीति को प्रबंधन रणनीति दस्तावेज के रूप में निम्नलिखित रूप से विभाजित किया जा सकता है

(क) परिहार (ख) खतरों की प्रभावशीलता पर नियंत्रण (ग) नवीनीकरण एवँ (घ) हस्तांतरण तकनीक। अन्य मूल्य लाभ मूल्याकन की तरह जोखिमों से निजात के लिये आवश्यक नियंत्रणों की अमलावरी कर उस पर होने वाले खर्च की तुलना की जा सकती है। इस प्रकार की प्रबंधन नीति पर आनेवाला खर्च लाभ अथवा कम से कम नियंत्रण मानदंडों की अमलावरी से प्राप्त होने वाले लाभ की तुलना में कम ही होता है। असुरक्षितता को कम करने के लिये सुझाये गये / सिफारिश किये गये प्रतिबंधात्मक नियंत्रण मानदंडों में नये प्रतिबंधात्मक नियंत्रण अथवा समीक्षा किये गये नियंत्रण शामिल किये जा सकते हैं।

जोखिम प्रबंधन के लिये नियंत्रित माहौल में तकनीकी एवँ प्रबंधन नियंत्रण भी शामिल किये जा सकते हैं। प्रतिबंधात्मक तकनीकी नियंत्रण सुरक्षा नीति जिसमें (क) प्रामणिकता (ख) अधिकारिता (ग) नियंत्रणों का उपयोग (घ) गैर अस्वीकृति (ड़) प्रतिबंधिक सूचनाओं का आदान-प्रदान एवँ (च) कार्य संपादन की गोपनीयता शामल है। खोज एवँ पुनर्लाभ नियंत्रण में (क) आई एस, ऑनटेड (ख) इन्सट्रूशन डिटेक्ट कंट्रोल (ग) सिस्टम इंटीग्रिटी कंट्रोल एवँ (घ) विभिन्न खोज एवँ अन्मूलन नियंत्रण शामिल हैं।

> किसी भी कंपनी को मात्र जोखिमों के मूल्यांकन के साथ खतरों के स्त्रोतों का विवरण तैयार करना काफी नही होता, बल्कि मूल्यांकन के प्रभाव के साथ इस बात की भी सुनिश्चिती करना आवश्यक है कि क्या सचमुच खतरा मौजूद है

आपदा पुनर्लाभ एवँ व्यापार नियमितता

सूचना परिप्रेक्ष्य में उत्कृष्ठ सुरक्षा नियंत्रणों की अमलावरी अर्थात् आपदा वरहित अवस्था की पूर्ण गारंटी नही। इसलिये व्यापार नियमितता संबंधी योजना म्प्यापार पुन आरंभ योजना, आपदा पुनर्लाभ योजना और संकट प्रबंधन का समावेश होता है।

व्यापार प्रभाव विश्लेषण खासतौर पर व्यापार नियमितता योजना के विकास के लिये गंभीर साबित हो सकता है क्योंकि इसमें महत्वपूर्ण व्यापर प्रकिया, गतिविधियों, आश्रितों एवँ अनाश्रितों आदि की पहचान कर उनके बारे में दस्तावेज तैयार किये जाते हैं। इस चरण के बाद पुनर्लाभ नीतियों के विकास, ३ विश्लेषण एवँ पुनर्लाभ के लिये सबसे सही रणनीति में उपयोग का कार्य आता है।

ऐसी पुनर्लाभ योजनाओं के केन्द्र में मात्र लोग, सुविधायें और सूचना व्यवस्था ही नही बल्कि दूरसंचार भी समान रूप से रहता है।

नुकसान की स्थितियों में पुनर्लाभ रणनीति में तथा व्यापार संचालन की नीतियों के किये जाने वाले सुसुत्रीकरण की प्रक्रिया को दस्तावेज के रूप में और संकट के समय संस्थान द्वारा आसानी से उपयोग में लाने योग्य रूप में सुरक्षित करना महत्वपूर्ण है। ऐसा दस्तावेज संकट से उबरने अथवा पुनर्लाभ हासिल करने के लिये आवश्यक सभी स्थितियों की पहचान करने और उन्हें लिखित रूप से प्रस्तुत करने में परिपूर्ण होता है। ऐसे दस्तावेज में आपातकाल घोषित किये जाने के बाद से गंभीर स्थितिययाँ मौजूद रहने तक आवश्यक कारवाही के लिये प्रक्रिया (क) सभी वैकल्पिक प्रक्रियाओं और संसाधनों के बारे में विवरण तथा (ख) व्यवस्था एवँ व्यापार संचालन को सामान्य बनाने के लिये प्रक्रिया शामिल होती है। व्यापार नियमितता योजना की जाँच समयानुकुल परिस्थितियों में की जानी चाहिये, जिससे कंपनी को यह सुनिश्चित हो जाता है कि आवश्यकता पड़ने पर उसका समुचित उपयोग किया जा सके।

निष्कर्ष: वर्तमान हाई-टेक परिवेश में जहाँ कंपनियाँ अपने व्यापार का लक्ष्य हासिल करने के साथ ही उसके संचालन और प्रतिस्पर्धा की अपनी क्षमता बनाये रखने के लिये जहाँ सूचना प्रौद्योगिकी पर काफी अधिक अंकित है, कंपनियों के प्रबंधमों को सुसूत्र रूप से गठित सूचना जोखिम प्रबंधन गंभीर समस्याओं से निपटने में महत्वपूर्ण सहयोग प्रदान करता है। साथ ही उनकी निर्णय क्षमता में भी काफी बढ़ोतरी कर यह सुनिश्चित करता है कि सभी व्यापार प्रक्रियाएँ एवँ संचालन विभिन्न तरह के खतरों एवँ असुरक्षा की संभावनाओं से पूरी तरह सुरक्षित है।

बॉक्स 2

निदेशक मंडल सदस्यों के पास क्या होना चाहिये

1. कंपनी के सूचना प्रौद्योगिकी स्त्रोतों का जानकारी और उनका नियंत्रण
2. योजनाओं, प्रक्रियाओं एवँ नियंत्रण की लागू किये जाने तथा उनके प्रभावी कार्य करने के बारे में सबूत और संकट के समय व्यापार नियमितता के लिये योजना

-/ शेष अगले अंक में ।

एडगर पी बाल्विन *वर्तमान में बेयरिंग प्वांइट के वरिष्ठ प्रबंधक हैं।*

आर एन के प्रसाद *वर्तमान में बेयरिंग प्वाइंट के निवासी तकनीकी सलाहकार हैं।*

Report Card: GENERAL

G. V. Rao

15.4 percent business growth in March 2006

Performance in March 2006

The non-life industry grew in March 2006 by 15.4 percent with an accretion of Rs.263 crore. The bulk of the accretion has come in from the new players that have added Rs.215 crore. The established players, who had performed spectacularly in the two previous months, adding accretions of Rs.164 crore and Rs.133 crore, could only add Rs.48 crore to their premium kitty in March 2006. National Insurance and New India together have dropped their renewal premiums in March 2006 by Rs.71 crore.

Oriental with an accretion of Rs.68 crore, ICICI Lombard with Rs.61 crore, IFFCO Tokio with Rs.60 crore and United India with Rs.52 crore are a few of the major growth players in March 2006. Only Cholamandalam among the new players shows a fall in its premium by Rs 4 crores. Among the established players, National's renewal premium has dropped by a substantial Rs.62 crore and that of New India by Rs.9 crore.

ECGC, the specialist insurer has raised its premiums in March 2006 by over Rs.10 crore.

GROSS PREMIUM UNDERWRITTEN FOR the financial year 2005 - 06

(Rs.in lakhs)

INSURER	PREMIUM 2005-06		PREMIUM 2004-05		GROWTH OVER THE CORRESPONDING PERIOD
	FOR THE MONTH	UP TO THE MONTH	FOR THE MONTH	UP TO THE MONTH	
Royal Sundaram	4653.72	45357.44	3422.42	33070.77	37.15
Tata-AIG	7222.75	61238.59	3934.93	46886.82	30.61
Reliance General	1766.43	16233.05	820.83	16168.42	0.40
IFFCO-Tokio	11696.11	89610.97	5730.43	50128.10	78.76
ICICI-lombard	12352.81	159199.58	6289.18	88516.71	79.85
Bajaj Allianz	12276.39	128767.78	8395.64	85607.41	50.42
HDFC CHUBB	2519.28	20237.41	2055.06	18383.74	10.08
Cholamandalam	1128.44	22042.00	1485.69	17009.83	29.58
New India	48054.00	476212.00	48962.00	421081.00	13.09
National	32211.00	352400.00	38419.00	379991.00	-7.26
United India	30721.00	314698.00	25521.00	294459.58	6.87
Oriental	32231.00	351864.00	25457.00	301778.00	16.60
PRIVATE TOTAL	53615.94	542686.82	32134.17	355771.80	52.54
PUBLIC TOTAL	143217.00	1495174.00	138359.00	1397309.58	7.00
GRAND TOTAL	196832.94	2037860.82	170493.17	1753081.38	16.24
SPECIALISED INSTITUTION:					
ECGC	6453.57	57846.49	5441.94	51554.50	12.20

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

Performance up to March 2006: (FY 2005-2006)

The performance up to March 2006 provides a view of how the non-life industry has performed in the financial year 2005/06 on a provisional basis. The year has ended with a robust growth of 16.2 percent and the gross written premium has crossed Rs.20,380 crore. Two new players, ICICI Lombard and Bajaj Allianz, have crossed the premium mark of Rs.1000 crore in the financial year.

The industry has added Rs.2848 crore in accretion to cross Rs.20,000 crore mark. Five players have dominated the growth scene during 2005/06; ICICI Lombard has added Rs.706 crore, New India Rs.552 crore, Oriental Rs.502 crore, Bajaj Allianz Rs.432 crore and IFFCO Tokio Rs.395 crore. Cumulatively, these five insurers have added Rs.2587 crore to the overall growth of Rs.2848 crore.

National Insurance has dropped its annual renewal premium in the year 2005/06 by about Rs.276 crore that represents over 7 percent of its previous year's business.

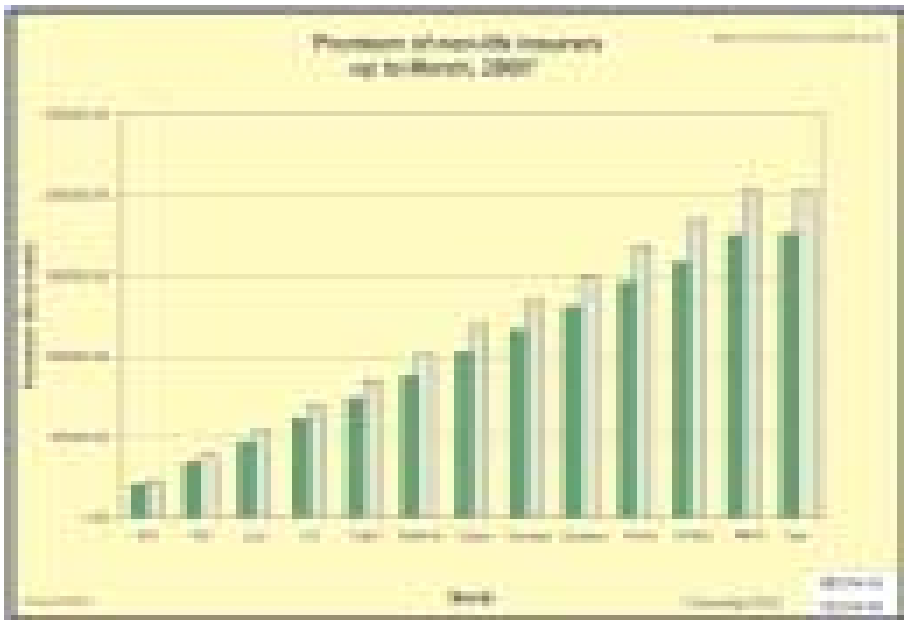
ECGC the specialist insurer has recorded a growth of 12 percent.

Market Share:

The new players have garnered a market share of 26.6 percent up from 20.2 percent in 2004/05. ICICI Lombard has improved its share from 5 percent to 7.8 percent; Bajaj Allianz has improved its share from 4.9 percent to 6.3 percent. Most other new players have also improved upon their market share.

Prospects:

Competition for business and customers is likely to heighten in the



financial year 2006/07, considering that there is likely to be competition on price front as well for most covers in 2007/08. Accumulating sizeable premium and a larger number of customers right now in 2006/07 will surely enhance the ability of respective insurers to hang on to their customers that are profitable and large.

National Insurance that maintained a low premium profile is likely to step up on its growth strategy in 2006/07. Reliance has lately shown signs of attempting to raise its market share. These two insurers may bring in a more fierce competitive spirit to the market in 2006/07.

The induction of new players has changed the market scenario that is now more vibrant and more demanding of better customer services. One expects the growth rate in 2006/07 to get a further boost, now that the non-life industry has been growing in its profile and more rapidly than before. It is likely that the new players will aim for a market share of 35 percent or more in 2006/07.

If customer services levels improve, the market can hope to attain a growth rate of 18 percent or more in 2006/07. Times have never been as bright for the non-life insurers as now. The market opportunities need more intensive harnessing by sustained efforts. Market has shown enough dynamism that this challenge can be met.

The interesting question is: 'Is the non-life industry poised for a growth of 20 percent or more in 2006/07?'

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

RISE IN INVESTMENT EARNINGS FOR INSURERS

The investment yields of public and private sector insurance players in the non-life arena have gone up in the past financial year; it is reported, as a result of the rise in the yields of government securities. As against a mean yield of 6.5 per cent on investments for insurance companies during the year 2004, the average yields on investment during the last fiscal were in the region of 8 percent.

While the insurers were not allowed to take part in the call markets in the last fiscal, they extended support to the banking sector through Collateralized Borrowing and Lending Obligations (CBLO) at rates close to 8 per cent during the last few weeks of the financial year. It is this exercise that is responsible for the insurers enhancing their profits, reportedly, as the CBLO market shot up to Rs.10,000 crore.

The improvement in the investment earnings, however, are not going to let the insurers take it easy on cutting underwriting losses; and the discipline that is associated with it is going to continue. The profits earned from the investments would be put to use for strengthening the capital of the insurers and for augmenting their solvency.

Bancassurance: The New Age Distribution Channel

Bancassurance, which aims at distribution of insurance products through banks, is proving out to be a very successful distribution channel in the liberalized insurance scenario. Insurance activity is expected to occupy one-third of banks' fee-based income reportedly, in the not-too-distant future. Apart from providing a third of the fee-based income for the bankers, bancassurance is also expected to be channel responsible for around 13 per cent of life business and 5 per cent of non-life business, reportedly, in the next five years.

Bancassurance, in fact, contributes quite a large chunk of the total new business among the private life insurance companies and is growing rapidly. Insurers are presently contemplating an enlarged reach to rural and semi-urban areas through co-operative banks and regional rural banks to act as a catalyst for further growth in these areas with a huge potential, it is reported.

Overseas Travel Without Insurance

It is reported that a huge majority of the overseas travelers really do so without obtaining travel insurance. While the number of overseas travelers is rapidly expanding, the incidence of a meager percentage that actually insure themselves is a big cause for concern. Among those who go for insurance voluntarily are those who are regular or at least frequent travelers; students for whom it is mandatory to have insurance; or such of those who intend a longer stay abroad.

Travel insurance provides protection against several risks like baggage loss, passport loss, acute financial requirement and medical expenses. With problems like environmental changes, dietary changes or the fall-out of severe jet-lag conditions and the associated susceptibility to fall sick; health risk is the most vital component of the travel insurance. With medical facilities proving out to be too expensive in several western countries, it is unfortunate that the majority do not appreciate the value of having sufficient insurance in place.

INSURANCE AS INCENTIVE FOR TAX-PAYERS

The Brihanmumbai Municipal Corporation (BMC) has introduced a novel scheme for the regular tax-payers of Mumbai city. It proposes to offer insurance cover to more than a million registered property tax-payers in order to boost collections. The scheme is likely to cost BMC an amount of Rs.1.5 crore reportedly.

Property tax is the second largest source of revenue for the corporation under which BMC collects around Rs.800 crore per annum. The incentive that is being introduced presently envisages widening the corporation's tax-base as also mopping up revenue. The corporation would pay the premium in cases where there are no tax arrears in the previous financial year.

It would apply to residential properties assessed by the corporation and includes assessees living in their own properties, members of housing societies that are assessed on a building basis and individual tenants in tenanted buildings. Under the scheme, four members of the family of the honest tax-payer would be covered against death and disability, as per reports.

Government Health Insurance for the Poor

Government of Andhra Pradesh has come out with health insurance scheme for Below Poverty Line (BPL) families that covers farmers, artisans and their families at a highly subsidized premium, as per reports. It envisages bringing about 40 lakh enrolled BPL families under the scheme.

The scheme is being worked out on the lines of Universal Health Insurance Scheme (UHIS); and the services of self-help groups are being roped in for enrolment. A statewide campaign is being contemplated in order that all the eligible BPL families are brought under the scheme, reportedly.

LIFE INSURANCE POLICY AS AN INCENTIVE

In order to act as an incentive for the Maoist rebels who are prepared to surrender arms, the Jharkhand government is offering a life insurance cover up to an amount of Rs.10 lakh, reportedly, besides the promise of free land and a house for every rebel who gives up arms.

The Home Minister of the state is reported to have said that this was the best of the kind in the country and hoped that it would act as a measure to curb Maoist violence. Apart from the life insurance coverage, the government policy also promises a payment of Rs.25,000 in two instalments and a stipend of Rs.2,000 per month for two years.

GROWING AWARENESS ABOUT INSURANCE FOR EVENTS

Organizers of major events are becoming additionally sensitive towards obtaining proper insurance for the successful completion of the events, particularly in the backdrop of the recent colossal fire tragedy at Meerut, it is reported. There is a strong feeling in the industry that such events should compulsorily be brought under insurance.

When a sanction is being accorded for such an event, it should be ensured that the event is insured against the possible perils. The covers could be brought under three areas viz. fire and personal accident cover; public liability cover; and purchase protection cover. Fire and personal cover insures the space and structure created for the event basically and could be extended to cover earthquake and terrorist attacks. Public liability cover insures the visitors against death, disability and injury due to short circuits and stampede; and purchase protection cover insures the goods and cash collections made, against burglary or mishap.

There are several policies that would provide an additional and optional cover for the cancellation of an event also. Depending on the exact nature of the event, cancellation risk is covered either due to the death of the performer in case of individual shows; or cancellation of a cricket match or the like, due to rain. Premium depends upon the length of the event (number of days) and other related factors. There is growing demand for such products in this world of increasing uncertainty, reports say.

The Benefits of Mortgage Insurance

Mortgage insurance is a profitable proposition for all the parties involved viz. the home loan borrower, the financier and the market. Fundamentally, the mortgage guarantee product enables the customer to have access to funds on much softer terms and on easier margins. At a time when property prices are touching the sky, this mortgage insurance product, reports say, would provide the right solution.

Mortgage insurance products help a person to buy a house with a low down-payment. The normal margin that lenders insist is around 20 per cent, which sometimes proves to be too unaffordable for the borrower; and in this context, mortgage insurance is a big help. These mortgage products are being introduced in the Indian market, reportedly, for the first time; by US-based Genworth Financial Inc. introducing residential mortgage guarantee products.

National Housing Bank (NHB) reportedly had a tie-up earlier with four international corporations (United Guaranty Company; The Asian Development Bank; The Canada Mortgage and Housing Corporation; and The International Finance Corporation) forming India Mortgage Guarantee Company (IMGC) for bringing a similar product into the Indian market. However, it could not be finalized as yet for want of proper regulatory framework in operating such a mortgage insurance company.

The primary product of the company would be a mortgage guarantee that would provide coverage to mortgage lenders in India in the event of a borrower default. It would be a three-way contract between the borrowers, the lenders and the mortgage guarantor. The scheme aims at allowing lenders to penetrate broader market segments with better terms and conditions thereby expanding home ownership in the country.

Higher Demand for Domestic Bonds in Japan

There is suddenly a huge demand for investments in domestic bonds rather than the foreign bonds by life insurers in Japan, it is reported. A substantial raise in guaranteed yields on new insurance policies and dividends to reward policyholders is on the cards as a result of higher investment returns for the life insurers. In light of the increased investment returns, it is further reported that a reduction in premiums is likely as policyholders would be disillusioned if the benefits from increase in returns is not passed on to them.

Several top-notch life insurers are planning to increase their investments in bonds by several billion yen. For life insurers, it has been a history of negative spread between relatively high yields guaranteed to policyholders and low investment returns, as a result of abysmally low interest rates. As a result of the steady economic recovery and an end to the quantitative easing policy by the central bank, long-term interest rates have begun to rise thereby providing life insurance companies with a better environment for boosting investment returns, reportedly.

LONDON-BASED INSURANCE BROKER PENALISED

United Kingdom's insurance regulator, The Financial Services Authority (FSA), has fined a broker for failure to apply for its approval with regard to a management level employee who was convicted earlier for fraud, reports say. It is alleged that the employee has committed a fraud also while working for the broker. The regulator fined the broker for the breach of rule and said that if the approval process has been adhered to, the previous convictions would have come to light and the subsequent alleged fraud could have been avoided.

The regulator is reported to have further added that compliance with these requirements is vital for the fulfillment of the objectives; and the failure to seek its approval in respect of the employee was an isolated example. The broker is a specialist in classes like aviation; marine; casualty; and professional and financial risks. The regulator granted a reduction in the fines it has imposed in view of the early settlement of the case at stage one of the enforcement procedures. Reports say that although the fine is relatively small, it emphasizes the importance of ensuring to obtain FSA approval in such cases.

SOUND REGULATIONS FOR TAKAFUL MARKET

The emphasis in the World Takaful Conference at Dubai was on the need for sound regulations for the growing markets. Speaking at the conference, Dr. Habib Al Mulla, Chairman of the Dubai Financial Services Authority (DFSA) mentioned that sound regulation is an integral part in takaful and further added that markets should be open and dynamic in order to induce innovation and competition, ultimately leading to consumer benefits. Further, he is reported to have said that compliance to Shariah is essential; and the regulation should consider this aspect along with industry growth and consumer protection.

The Director General of the Insurance Commission of Jordan, His Excellency Dr. Bassel Hindhawi, during his keynote address said that the growth in takaful should be supported by a good national regulatory framework aiming at creation of a level-playing field for the players. The Islamic Financial Services Board (IFSB) and International Association of Insurance Supervisors (IAIS) are working together on setting the standards, he added, while exhorting that transparency, regulation and market conduct would establish a mechanism that would create the intended harmonization. He also said that industry collaboration and international agreement would further develop takaful and the wider Islamic financial services sector.

The other aspects that came up for discussion during the conference are the existing takaful models; new business models on the anvil; and product innovation. The speakers reportedly hoped that greater co-operation and sharing would help eliminate risks in the underwriting products for life and family takaful.

CHANGE FROM DEFINED BENEFIT TO DEFINED CONTRIBUTION

The contractors under the US Department of Energy would not be reimbursed for defined benefit pension plans associated with the new employees, it is reported. The department announced that it will only reimburse the contractors for costs associated with defined contribution plans; and as long as they do not overshoot certain benchmarks, at that.

The new policy would enable the department to improve the predictability of contractor benefit costs and mitigate the growth of its liabilities, it is reported. There has, however, been some criticism of the stand and it is reported that 'it is curious that a government agency should threaten the retirement security of those working for its contractors while federal employees are covered by a generous defined benefit plan'.

Crop Insurance in Thailand

Bank for Agriculture and Agricultural Co-operatives (BAAC) of Thailand is looking at offering insurance coverage for crops against damages caused by drought or flooding; in association with similar organizations in India and China, reportedly. The pooling among the three countries would help in reduction of the risks and costs; eventually leading to strengthening the feasibility of the programme.

It is reported that initially rice and corn would be covered and the scheme would be operational by the end of the year. In order to reduce the burden for the farmers, the premium would be contributed also by the BAAC and the government. On the one hand, the farmers have benefited a great deal from the global rise in farm commodities prices; on the other, however, there is a fall in production owing to drought and flood damage. The proposed insurance coverage would bring in a great amount of relief against such natural havocs, it is reported.

Health Insurance for Travellers in Vietnam

Travelers bound for Vietnam are to be offered health insurance by the Vietnam Insurance Corporation (Bao Viet), it is reported. It would cover foreign travelers on various purposes - leisure; visiting friends; business; study; or attending workshops. It would cover all travelers up to the age 75 and would be valid for 180 days.

The amount of coverage would range between US $20,000 to US $100,000 under four different packages - all healthcare expenses; emergency transport within the country; repatriation and overseas emergency transport, and transport of a corpse; and expenses for burial and cremation within Vietnam.

The cover comes into effect when the insured completes entrance formalities and would be effective until all the agreed formalities are over, or up to 180 days of entrance into Vietnam. In due course, Bao Viet hopes to extend the service to cover trips to other Asian countries as well, reportedly.

DECISION ON WIND POOL RATE IN MISSISSIPPI

A decision with regard to the insurance rate increase for Mississippi Gulf Coast residents living in high risk houses is to be taken by the insurance commissioner. It is reported that The Mississippi Windstorm Underwriting Association filed a request for huge rate hikes in the region of 400 per cent for homeowners; 270 per cent for commercial buildings; and around 60 per cent for mobile homes.

The Department of Insurance is scheduled to consult its actuaries before deciding whether the recommendations are to be accepted in toto; or to lower the rates. The proposal for the huge raise is in view of the devastation caused by Hurricane Katrina in the year 2005, along the Gulf coast. The residents of six coastal counties might not be able to get wind coverage at normal homeowner's rates and as such, a pool has been created.

While insurance companies in the state can sell insurance policies, it has to be done under the supervision of the state. The decision with regard to the rate is not going to be an easy one for the commissioner as he has to decide between granting an increase to maintain the wind pool's stability; and ensuring there is a viable market that does not adversely affect citizens statewide, reports say.

Mr.C.S.Rao, Chairman delivering the KLN Prasad Memorial Lecture at Administrative Staff College of India (ASCI), Hyderabad on 21st April 2006. Also seen in the picture is Mr.M.Narasimham, Chairman, ASCI.

The Federation of Andhra Pradesh Chambers of Commerce and Industry (FAPCCI) conducted a one-day 'Seminar on Detariffing in Insurance' at Hyderabad on 25th March, 2006. Photograph shows Mr. C.S. Rao, Chairman, IRDA speaking at the seminar. Also seen (L to R) are Mr. C.V. Atchut Rao, President, FAPCCI; Mr. G.V. Rao, ex-Chairman, Oriental Insurance Co. Ltd.; Mr. Sohanlal Kadel, Co-Chairman - Banking, Insurance and Finance Committee, FAPCCI.

"For Lloyd's, what was a terrible tragedy 100 years ago somehow marked a watershed in our history too. It was in the aftermath of the earthquake that our relationship with the United States was truly sealed. "

- Lloyd's chairman Lord Levene,
talking about the San Fransisco earthquake

"India was being viewed by many multi-national insurance companies as a vast market waiting to be tapped. The global players were interested in this market since there is vast untapped potential with a major portion of household savings parked in the banking sector."

- C.S. Rao, Chairman, IRDA.

"Health insurance is more a social responsibility, where the individual should get basic health care facilities. It is not necessary to make health insurance compulsory to make health care facility a right of every individual."

- Dhananjay Date,
MD, Swiss Re Services India

"Sound regulation is an integral part in takaful and the markets should be open and dynamic so as to induce innovation and competition for consumers' benefits"

- Dr Habib Al Mulla, Chairman of the Dubai Financial Services Authority (DFSA).

"At present, the average size of protection that an individual buys is around one and a half times his annual salary, which is ridiculously low."

- Shikha Sharma, CEO, ICICI Prudential Life Insurance.

"The distortions in the general insurance market relating to pricing of fire and health insurance would get corrected once detariffing is done."

- C.S. Rao, Chairman, IRDA.

RNI No: APBIL/2002/9589

Events

15-20 May 2006
Venue: Pune
Service Differentiation & Relationship Management
By NIA Pune

24-25 May 2006
Venue: Shanghai
Claims Conference
By Asia Insurance Reviewe

22-27 May 2006
Venue: Pune
Linux Operations (Life)
By NIA Pune

05-06 June 2006
Venue: Singapore
1st Asian Conference on Branding in Insurance
By Asia Insurance Review

05-07 June 2006
Venue: Pune
Management of Motor Insurance (Own Damage)
By NIA Pune

12-14 June 2006
Venue: Pune
Ethical Values in Human Capital
By NIA Pune

15-17 June 2006
Venue: Pune
Harnessing Rural Business Potential
By NIA Pune

20-21 June 2006
Venue: Hong Kong
Catastrophe Conference
By Asia Insurance Review

26-28 June 2006
Venue: Pune
Actuarial Appreciation Program for Senior Executives
By NIA Pune

29-30 June 2006
Venue: Singapore
1st Asian Conference on Human Resource & Training Development in Insurance
By Asia Insurance Review