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Faith Betrayed?

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Editor: U. Jawaharlal

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Hyderabad 500 004
Phone: 5582 0964, 5578 9768
Fax: 91-040-5582 3334
e-mail: irdajournal@irdaonline.org

From the Publisher

There are several factors that lead to unhindered commitment of frauds in society. First and foremost, lack of deterrent punishment acts as a major constraint to check the fraudulent intentions of individuals. The confidence that one can get away with a very mild punitive action or even without that on occasions, gives one the courage to indulge in frauds. Further, the absence of social stigma also acts as a factor for the unabashed perpetration of frauds in society. The absence of sufficient measures to check frauds creates an environment that eventually and unwittingly encourages fraudulent intentions.

There is no business domain which is immune to commitment of frauds. Insurance industry, where there is promise to pay huge sums of money on the contingent happening of an event, in return for a regular payment of premiums; provides opportunities to committing frauds. Insurers should take care to put in place measures to check the incidence of frauds so that the institution of insurance emerges stronger in the long run.

'Frauds in the insurance industry' forms the focus of this issue of the Journal. There are several articles that deal in detail about the possibility of frauds being committed in different classes of insurance; and measures to keep them in check.

The quality of a product and the value it generates for the client decide the extent of success of a business enterprise, be it in the manufacturing or the services industry. This is particularly significant in a competitive scenario.

'Product Development' will be the focus of the next month's Journal.

C. S. Rao

ISSUE FOCUS | Inside

Insurance Frauds – A Universal Malady

Utmost Good Faith is the bedrock pedestal on which the success of insurance contracts rests. When this faith is eroded, either by a blatant abuse of the systemic deficiencies or by a deliberate intent of either party, it leads to perpetration of frauds. While accepting that the bottom line for any commercial activity is generating a profit, it should be ensured that the parties to a contract do not allow avarice to get the better of them.

The success of insurance contracts also rests heavily on reciprocal obligations. Unless the parties to the contract fully understand their role, it could lead to unavoidable friction in the end; and one of the parties outwitting the other by fraudulent practices. The problem is more pronounced in nascent markets where the nuances are not properly understood. For example, in life insurance, unless the proposer fully reads and comprehends the questionnaire before signing it, he can be held responsible for a seemingly innocuous statement he is believed to have made. In the absence of comprehensive and truthful replies to the queries, does it not amount to a fraudulent practice, albeit unwittingly?

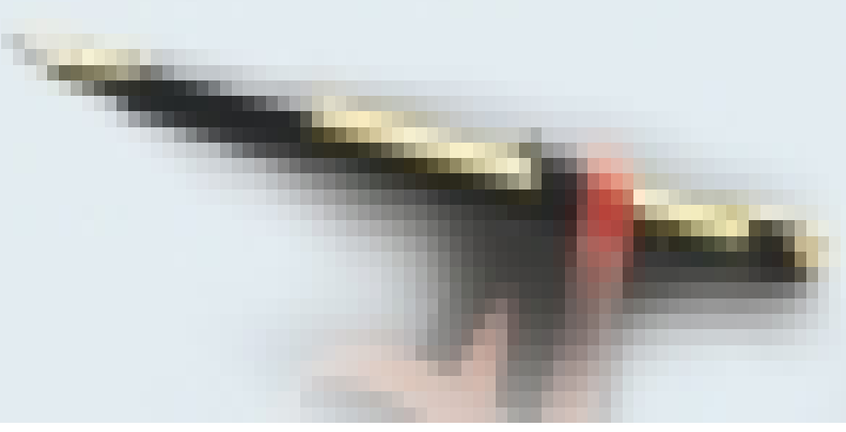
Similarly, in several other classes of insurance, there is need for openness in the risk proposed, interpretation of clauses, possible exclusions etc. In insurance, especially in emerging markets, there is a tendency on the part of several insured parties that there is nothing wrong in enforcing a claim after paying the premiums for some time. They should be made to realize the inherent fraud in such a practice. In all the above situations, the role of the intermediary is very crucial.

'Frauds in the Insurance Industry' is the focus of this issue of the Journal. Several authors, who are or have been practitioners in the industry, have exhaustively and critically examined all the aspects relating to frauds in different classes. To start with, we have an article by Mr. S.P. Subhedar, who emphasizes on the need for having a mechanism to detect frauds. Mr. Dalip Verma talks about the maladies of fraudulent practices and how they affect the bottom line of insurers. Mr. V.K. Sarma brings in his vast experience in both life and non-life classes to discuss in detail the vulnerability of the industry to frauds.

It is actually in the human psyche to derive a sense of heroism by defrauding others, in the words of Mr. Arman Oza, who goes on to describe various situations. Mr. V. Ramakrishna takes a holistic view of the ill-effects of fraudulent practices which eventually lead to higher prices. Mr. D.V.S. Ramesh describes several areas that make life insurers susceptible to frauds. Mr. A.K. Paul discusses in detail the various maritime frauds; and how they have a lasting effect on the insurance industry. In the end, we have Mr. G. Gopalakrishna analyzing the contractual obligations in life insurance; and how frauds can creep in.

The efficacy of a product and the customer perception about it, which is easily possible for a tangible product, cannot be judged easily in an industry like insurance. This assumes an even more complexity in a competitive environment. The focus of the next month's **Journal** would be 'Product Development'. We will be publishing articles on the importance of product development in different areas of insurance.

U. Jawaharlal



Report Card:LIFE

Premiums Rise 119.17% over May, 2005

Individual premium:

The life insurance industry underwrote Individual Single Premium of Rs.254977.82 lakh during April-May, 2006, of which the private insurers garnered Rs.35123.07 lakh and LIC garnered Rs.219854.75 lakh. The corresponding figures for the previous year were Rs.70990.81 lakh for the industry, with private insurers underwriting Rs.8152.03 lakh and LIC Rs.62838.78 lakh. The Individual Non-Single Premium underwritten during April-May, 2006 was Rs.244798.22 lakh of which the private insurers underwrote Rs.111407.77 lakh and LIC Rs.133390.45 lakh. The corresponding figures for the previous year were Rs.147678.03 lakh, Rs.47867.98 lakh and Rs.99810.05 lakh respectively.

Group premium:

The industry underwrote Group Single Premium of Rs.70584.20 lakh, of which the private insurers underwrote Rs.5524.65 lakh and LIC Rs.65059.55 lakh; the lives covered being 1027600, 121745 and 905855 respectively. The corresponding figures for the previous year were Rs.43030.94 lakh with private insurers underwriting Rs.2953.05 lakh and LIC Rs.40077.89 lakh; and the lives covered being 605689, 87770 and 517919 respectively. The Group Non-Single Premium underwritten during April-May, 2006 was Rs.16529.03 lakh which was underwritten entirely by the private insurers, covering 543541 lives. The corresponding figures for the previous year were Rs.6076.23 lakh, covering 252607 lives.

Segment-wise segregation:

A further segregation of the premium underwritten during the period indicates that Life, Annuity, Pension and Health contributed Rs.371020.63 lakh (63.26%), Rs.14854.39 lakh (2.53%), Rs.200434.18 lakh (34.17%) and Rs.189.06 lakh (0.03%) respectively. In respect of LIC, the break up of life, annuity and pension categories is Rs.219895.65 lakh (52.57%), Rs.11898.29 lakh (2.84%) and Rs.186510.81 lakh (44.59%) respectively. In case of the private insurers, Rs.151124.98 lakh (89.85%), Rs.2956.10 lakh (1.76%), Rs.13923.37 lakh (8.28%) and Rs.189.06 lakh (0.11%) 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 58.14% of the business was underwritten in the non-linked category, and 41.86% in the linked category; i.e., Rs.341003.11 lakh and Rs.245495.14 lakh respectively. In case of LIC, the linked and non-linked premium is 23.77% and 76.23% respectively, as against which for the private insurers taken together this stands at 86.84% and 13.16% respectively. During the corresponding period of the previous year, linked and non-linked premium indicates that 61.66% of the business was underwritten in the non-linked category, and 38.34% in the linked category; i.e., Rs.164852.44 lakh and Rs.102500.66 lakh respectively. In case of LIC, the linked and non-linked premium was 27.77% and 72.23% respectively; as against which for the private insurers taken together, this stood at 71.48% and 28.52% respectively.

First Year Premium Underwritten by Life Insurers for the Two Months Ended May, 2006

Sl No.	Insurer	Premium (Rs. In Lakhs)			No. of Policies / Schemes			No. of lives covered under Group Schemes		
		May'06	Up to May, 06	Up to May, 05	May'06	Up to May, 06	Up to May, 05	May'06	Up to May, 06	Up to May, 05
1	**Bajaj Allianz**									
	Individual Single Premium	12532.58	20170.83	4203.87	4395	7175	5137			
	Individual Non-Single Premium	10312.81	17151.31	4983.89	61509	102575	33949			
	Group Single Premium	27.61	60.49	0.00	0	0	0	97	266	0
	Group Non-Single Premium	80.03	170.86	526.75	20	26	20	21077	66446	5472
2	**ING Vysya**									
	Individual Single Premium	287.40	891.55	1.96	218	549	289			
	Individual Non-Single Premium	2469.28	5655.68	1032.57	11545	25157	5395			
	Group Single Premium	38.57	108.13	92.54	0	0	0	113	256	279
	Group Non-Single Premium	3.56	44.78	19.74	4	9	13	630	3195	1942
3	**Reliance Life**									
	Individual Single Premium	1757.10	3137.47	971.28	2749	4673	1601			
	Individual Non-Single Premium	3012.14	5182.26	389.32	17073	27976	5669			
	Group Single Premium*	10.43	45.70	29.69	3	6	0	4707	5216	0
	Group Non-Single Premium	8.82	113.25	89.20	3	28	8	7284	35447	22110
4	**SBI Life**									
	Individual Single Premium	1915.06	2545.83	589.22	1156	1980	933			
	Individual Non-Single Premium	5138.11	7048.36	1411.58	10031	18150	20295			
	Group Single Premium	1514.22	2236.96	2156.67	1	1	1	9456	14341	16795
	Group Non-Single Premium	3089.69	3311.99	442.57	42	72	229	81307	122230	55437
5	**Tata AIG**									
	Individual Single Premium	82.14	125.54	0.00	0	0	0			
	Individual Non-Single Premium	3687.66	6977.49	5032.11	28679	55210	41012			
	Group Single Premium	337.40	611.67	148.68	0	0	0	8195	18398	18882
	Group Non-Single Premium	119.64	223.91	170.66	7	29	50	3708	27615	84496
6	**HDFC Standard**									
	Individual Single Premium	1349.69	2056.73	1277.93	3341	5421	5792			
	Individual Non-Single Premium	5566.52	9993.29	5460.74	15553	27590	22417			

5	**Tata AIG**									
	Individual Single Premium	82.14	125.54	0.00	0	0	0			
	Individual Non-Single Premium	3687.66	6977.49	5032.11	28679	55210	41012			
	Group Single Premium	337.40	611.67	148.68	0	0	0	8195	18398	18882
	Group Non-Single Premium	119.64	223.91	170.66	7	29	50	3708	27615	84496
6	**HDFC Standard**									
	Individual Single Premium	1349.69	2056.73	1277.93	3341	5421	5792			
	Individual Non-Single Premium	5566.52	9993.29	5460.74	15553	27590	22417			
	Group Single Premium	674.23	1000.95	328.51	12	20	21	12503	35460	17898
	Group Non-Single Premium	410.63	1051.12	723.15	1	3	8	411	1049	6158
7	**ICICI Prudential**									
	Individual Single Premium	2436.01	4595.43	923.69	4072	7818	656			
	Individual Non-Single Premium	20828.29	30735.14	15805.75	86608	159942	70024			
	Group Single Premium	777.27	1186.56	103.01	24	47	17	24202	44081	32704
	Group Non-Single Premium	5076.51	7307.37	3720.26	48	80	36	31667	57967	1865
8	**Birla Sunlife**									
	Individual Single Premium	230.89	374.20	190.49	917	1303	3576			
	Individual Non-Single Premium	3946.84	6074.73	4361.20	13033	20325	13159			
	Group Single Premium	95.84	194.11	65.90	0	0	0	572	1140	669
	Group Non-Single Premium	1594.22	2100.03	94.85	14	15	6	11202	11212	3204
9	**Aviva**									
	Individual Single Premium	285.78	371.53	-38.61	164	244	281			
	Individual Non-Single Premium	5250.39	7779.08	2955.51	18541	29115	10598			
	Group Single Premium	16.81	37.00	22.06	1	1	0	116	262	172
	Group Non-Single Premium	217.84	843.11	38.92	10	18	1	14990	43422	24758
10	**Kotak Mahindra Old Mutual**									
	Individual Single Premium	384.70	617.89	-48.80	435	812	263			
	Individual Non-Single Premium	2054.21	3359.39	2043.04	7073	10768	8149			
	Group Single Premium	23.52	43.09	5.99	0	0	0	1293	2325	371
	Group Non-Single Premium	28.27	979.99	109.80	5	24	10	7396	17218	9849
11	**Max New York**									
	Individual Single Premium	4.18	8.13	27.31	16	23	35			
	Individual Non-Single Premium	4616.83	8752.39	3485.80	30990	62054	38270			
	Group Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Group Non-Single Premium	4.79	105.06	50.66	3	14	9	818	6023	5210
12	**Met Life**									
	Individual Single Premium	54.39	73.03	53.69	82	125	99			
	Individual Non-Single Premium	1681.18	2307.44	864.65	5887	9043	7574			
	Group Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Group Non-Single Premium	21.60	277.55	89.68	30	58	32	63780	151717	32106
13	**Sahara Life**									
	Individual Single Premium	101.50	154.89	0.00	240	385	0			
	Individual Non-Single Premium	12.20	19.37	41.83	675	1024	2183			
	Group Single Premium	0.00	0.00	0.00	0	0	0	0	0	00
	Group Non-Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
14	**Shriram Life**									
	Individual Single Premium	0.00	0.00		0	0				
	Individual Non-Single Premium	296.12	371.85		5643	704720797				
	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	21421.43	35123.07	8152.03	17785	30508	18662			
	Individual Non-Single Premium	68872.58	111407.77	47867.98	312840	555976	278694			
	Group Single Premium	3515.88	5524.65	2953.05	41	75	39	61254	121745	87770
	Group Non-Single Premium	10655.60	16529.03	6076.23	187	376	422	244270	543541	252607
15	**LIC**									
	Individual Single Premium	162615.75	219854.75	62838.78	288572	388127	193426			
	Individual Non-Single Premium	90936.67	133390.45	99810.05	1065366	1605699	1672522			
	Group Single Premium	29228.54	65059.55	40077.89	1048	1838	1565	384233	905855	517919
	Group Non-Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Grand Total									
	Individual Single Premium	184037.18	254977.82	70990.81	306357	418635	212088			
	Individual Non-Single Premium	159809.25	244798.22	147678.03	1378206	2161675	1951216			
	Group Single Premium	32744.42	70584.20	43030.94	1089	1913	1604	445487	1027600	605689
	Group Non-Single Premium	10655.60	16529.03	6076.23	187	376	422	244270	543541	252607

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

Generating a Viable Product

'The success of a product should be seen in the light of the value that it generates to the customer in the long run; and not an immediate return' feels **U. Jawaharlal.**

Product Development for any business entity is replete with lot of hard work - in conducting a thorough research; in getting to know customers' preferences; in analyzing the changing trends and the likely obsolescence; and finally in assessing the commercial viability. When it comes to intangible products, the complexities are much more intricate. In insurance, more so in an emerging market, product innovation is a task associated with all the above mentioned ingredients besides being of appeal to a large section of the population who are not given to know the nuances of insurance.

At the outset, it is essential that the innovations with regard to a new product or changes to an existing product are such that they add value to the customer. Further, the insurers should look at long-term sustenance of the product rather than a burst of ephemeral success. As the very business of insurance deals with making promises, insurers should take care not to promise something that cannot be delivered in due course. This would not only make the clients disillusioned but would also deal a death blow for the longer interests of the organization. In a very volatile interest rate scenario, for example, if an insurer promises guaranteed bonuses for a long term; he may put himself in a delicate situation.

Insurers should be open to the changing needs of the customers. There should be a system in place to get the customer feedback at least in some crucial areas. By being sensitive to the performance of a product among the clientele, the insurer puts himself in a position to attune to their needs; and this would lead to a normal emergence and evolution of new products. If a particular product is not performing well, there may be a need for obtaining feedback from either the customers themselves or the intermediaries. Especially in a sales driven market, the feedback of the intermediaries may be of immense value as he would be the frontline person that faces the hardship.

Insurers should ensure to follow the norms stipulated in generating a product. In the absence of this, despite a possible success in the market, there could be a situation that would lead to an enforced withdrawal of the product. The eventual embarrassment can be avoided by being proactive in this regard. The role of actuaries in innovating new products is monumental. By undertaking a thorough study of the past trends and extrapolating the results to future trends, the actuary can generate innovative products that would stand the test of time.

Product innovation and product development would form the focus of the August 2006 issue of IRDA Journal. Several experts associated with product development and the insurance industry would contribute their thoughts in the domain.

Possibilities of Fraud in Life Insurance

- Need for Early Detection

It is necessary to have in-built fraud detection mechanisms in the processes designed, so that alerts are sounded at different stages for necessary further checks;
avers S. P. Subhedar.

1. A life insurance contract is a long duration financial contract and this makes life insurance business vulnerable to frauds. A fraud could take place at any stage from submission of proposal for insurance till settlement of claim. Broadly, this could be divided into three parts, viz. proposal and policy stage; during the policy contract term; and during claim process stage, both death and maturity. In addition to this, frauds are also possible in other operational areas. Before getting into analysis of fraud possibilities, it will be helpful to outline as to what constitutes a 'fraud' in life insurance business.

2. IAIS Definition of 'Fraud'

2.1 According to the International Association of Insurance Supervisors (IAIS) questionnaire issued recently, "An activity is fraudulent (hereafter referred to as fraud) if it is intended to gain dishonest advantage for the fraudster or for the purposes of other parties. This may, for example, be achieved by means of:

- misappropriation and / or insider trading; and / or
- deliberate misrepresentation, suppression or non-disclosure of one or more material facts relevant to a financial decision or transaction; and / or
- abuse of responsibility, a position of trust or a fiduciary responsibility.

The following three categories of fraud are defined.

- **Internal fraud** - Fraud against the insurer by an employee, a manager or a board member on his/her own; or in collusion with others who are either internal or external to the insurer.
- **Policyholder fraud and claims fraud** - Fraud against the insurer in the purchase and/or execution of an insurance product by obtaining wrongful coverage or payment.
- **Intermediary fraud** - Fraud by intermediaries against the insurer or policyholders. For the purpose of this questionnaire, intermediary should be understood to mean 'independent broker/agent'.

A fraud could take place at any stage from submission of proposal for insurance till settlement of claim.

This definition gives a fair idea about the likely nature of frauds.

3. Fraud Detection and Consumer Interest

3.1 It may be mentioned here that a life insurance company, whether a proprietary or mutual, facilitates pooling or risks - demographic and financial - for the benefit of its consumers; and losses due to frauds ultimately fall on the consumers and need to be viewed in this perspective.

3.2 It is therefore necessary to have in-built fraud detection mechanisms in the processes designed, so that alerts are sounded at different stages for necessary further checks. The fraud possibilities as are outlined in para 1 are discussed hereinafter.

4. Fraud Possibilities at Proposal and Policy Stage

4.1 In any contract, all parties to the contract are fully aware of the implications of the contract that they are entering into and have full details of it. However, it is not so in the case of life insurance contracts. A life insurance contract is an asymmetrical contract in the sense that the person proposing to enter into an insurance contract with a life insurer has all details about the life insurer; but the life insurer does not have all particulars about the person on whose life, insurance is proposed. A contract of life insurance is therefore called a contract of utmost good faith as the life insurer who cannot verify all the material information enters into a contract accepting all the particulars, given by the proposer, in good faith. This exposes the life insurer to the risk of fraud; and fraud detection mechanisms have to be built into the processes to detect the possible frauds.

4.2 The risks that a life insurer faces are: identity of the life to be insured, the state of his health, financial position and

purpose of insurance. An intermediary representing the life insurer has a responsibility of establishing the identity of the life proposed for insurance and has to give his confidential report in respect of the life proposed for insurance and his lifestyle, otherwise the life insurer would be vulnerable to fraud. The state of health of life to be insured is of critical importance for covering the mortality / morbidity risk. This is checked through the personal statement of the life to be insured, medical reports and various diagnostic tests conducted by the doctors, information received through the intermediary and other sources. These checks ensure that identity of the life to be insured is established and adequate data is compiled for proper assessment of risk. The medical reports and diagnostic test reports are required to be obtained from empanelled doctors to facilitate this assessment. Otherwise the insurer is exposed to the risk of impersonation, faulty reports and inadequate assessment of mortality / morbidity risk.

4.3 It is essential that the fraud detection mechanism at this stage is robust to eliminate any attempt to defraud as it is not easy to deny a claim on account of material suppression of facts, however significant it might be. This is because, the suppression of facts might be significantly material from the risk assessment perspective but if a case is taken to court, what the courts generally look for is how relevant were the suppressed facts, intentional or otherwise, in influencing the immediate cause of death. If those were not, the courts generally decide in favor of the claimant. A couple of instances in support of this are mentioned here. In a proposal for insurance, the proposer, who was operated for cataract, had not disclosed this fact. A few months after the policy was issued, the life assured was knocked down by a truck. Investigations revealed that the life assured was operated for cataract and that this fact was not disclosed. The life insurer repudiated the claim on the ground that there was non disclosure of material information concerning the life assured's vision.

Police record showed that the life assured who was riding a two wheeler was hit by a truck from the rear. The court held that while there was suppression of information relating to vision of the life assured, it had no influence on the circumstance that led to his death as he was knocked down by a hit from the rear. In another case, the life assured was hospitalized for plural effusion a few years before he took the policy. This fact was not disclosed in the proposal form. The life assured died of disease related to bronchial system within one year of issue of policy. The legal advice to the life insurer was that before repudiation of claim, the life insurer should obtain a certificate from a specialist in diseases of chest that the plural effusion which was not disclosed could have had influence on the life assured's terminal illness. As persons having suffered from plural effusion are known to have led normal life, no specialist was willing to give such a certificate. The important point to be stressed here is that for repudiation of claim, it is necessary to establish that the suppressed information had significant influence on the immediate cause of death.

An insurer has to be careful in scrutinizing the financial position of the proposer and the purpose of insurance as these could pose serious moral hazards.

4.4 An insurer has to be careful in scrutinizing the financial position of the proposer and the purpose of insurance as these could pose serious moral hazards. The sum proposed must be commensurate with the financial position of the proposer. The purpose of insurance assumes great relevance when the proposer and life to be insured are different persons. The proposer must always have insurable interest in life to be insured and the amount of insurance must be commensurate with the insurable interest.

4.5 An intermediary has an important role in providing inputs to the life insurer for proper assessment of proposal. It is for this reason that an intermediary is termed as a 'field underwriter'. If this role is not adequately performed, vulnerability to fraud considerably increases.

4.6 It is also necessary to ensure that acceptance of a proposal does not help money laundering. The norms laid down in this behalf need to be strictly followed. Any deviation from those should be viewed seriously.

4.7 Economic Times of 30th May 2006 carried a story titled "Life insurance cos. believe in rebirth" describing how "Driven by compulsions to ramp up numbers - since customers are drawn to bigger players - select insurance companies are manipulating sales figures. They are simply recycling old policies to prop up new sales data". While the new IRDA guidelines on ULIPs would close this avenue, human ingenuity being what it is, alternate ways would be evolved to achieve the purpose. Even in non-linked domain, business is rewritten by discontinuing earlier policies on one pretext or the other; and writing new policies by misleading the customers. Sometimes, proposals are introduced on fictitious lives with low premium to boost the new business numbers. There are also instances of low premium policies being written on the lives of servants and other known persons, which result into first installment lapses, only to boost the new business numbers. A close monitoring is needed to detect such acts and severe penalties are required to be imposed when such acts are detected.

4.8 Life insurance industry has set up its declined life index which can be accessed by the life insurers. It may be useful if data bank of large frauds is created for the benefit of the industry.

5. Fraud Possibilities during the policy contract term

5.1 During policy tenure, particularly of the paid-up policies, robust processing systems are required for detecting attempts to fraudulently surrender the policies or obtain loans on such policies. Such frauds are possible only with the involvement of insurer officials. In these frauds, fake policy documents are prepared and applications for loan / surrender are made by forging signatures. Bank accounts are opened only for the purpose of encashing the surrender / loan cheques and the funds are siphoned off.

5.2 Premium collection is another area where frauds could take place. It is therefore necessary to educate the policyholders to ensure that premium payments are made by cheques and cash is paid only at the company collection centres. To the extent possible, third party cheques need to be controlled to avoid temporary misappropriation.

5.3 In premium collection, remittances received through drop boxes also exposes insurer to fraud in respect of cases which are not entitled to claims concession. If a premium under a policy, which is not entitled to claim concession, is not paid within the days of grace and the life assured dies thereabout, attempts are made with the help of insurer's officials to establish that the remittance in fact was received by the life insurer within the days of grace. This possibility has to be borne in mind when evolving the system for processing remittances received through drop boxes.

5.4 The policyholders should be advised to be very careful about policy documents as lost or misplaced policy documents could lead to fraudulent encashment of policies.

6. Fraud Possibilities at Claim Stage

6.1 In case of death claims, identity of the deceased should be well established. This assumes particular importance in cases of deaths due to accident as clear identification of the deceased is sometimes very difficult. It is also necessary to be very careful in establishing the identity of the beneficiary while settling the death claims as the bank account details from the claimants are obtained at the time of filing claim or after the claim is filed. Intermediary help would generally be helpful here.

6.2 While settling the maturity claims, particularly in respect of policies which are in paid up condition for a long time, it is necessary to ensure that the discharge forms reach the policyholders and do not fall in wrong hands. In respect of old paid up policies, many times the claim forms are returned undelivered.

In health insurance, like critical illness insurance, claims processing becomes highly technical requiring interpretation of medical conditions.

Proper control is required on such undelivered claim forms to ensure that those are not misused.

6.3 In death claim processing, it is of critical importance to ensure that there was no intention to defraud the life insurer at the time of taking the policy. In health insurance, like critical illness insurance, claims processing becomes highly technical requiring interpretation of medical conditions. The dividing line between what is insured and what has happened is sometimes so thin that even through a bona fide mistake, a claim which should not have been admitted could get admitted. This provides opportunities for frauds and it is required to be ensured that the claim processing system is such as would not allow malpractices to creep in. Admission of disability benefit claim also requires careful scrutiny as some subjectivity does creep in here, which makes it vulnerable to frauds.

7. Other Frauds Possibilities

7.1 Life insurance company investment transactions are large in value and there is a need to introduce a mechanism to ensure that the company officials who are privy to investment decisions do not use this information to their advantage. SEBI has prescribed certain disclosure norms in respect of investment transactions of officials of both the asset management company and the trust company; as also of the directors of both the asset management company and trust company. Similar norms may be desirable in life insurance area.

7.2 Possibilities of fraud in other areas are similar to those in other businesses.

8. Conclusion

8.1 A life insurer acts as a trustee of policyholders' money and it is the insurer's responsibility to ensure that a fraudster is not allowed to defraud the bona fide policyholders. In this context, the systems for underwriting of proposals, servicing of policies and processing of claims need to have adequate safeguards to detect frauds.

The author is Sr. Advisor, Prudential Corporation Asia Ltd. Views expressed in this article are strictly those of the author.

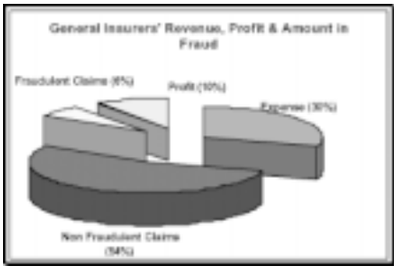
An Overview of Insurance Frauds

- Measures to Combat the Menace

Insurers operate in an already difficult environment; and fraud vitiates and marginalizes their profitability exhorts Dalip Verma. He further suggests that companies will require to have a well laid out policy which makes clear that they will not tolerate fraud.

Insurance sector is quite prone to frauds and insurance companies see substantial losses every year on account of fraud. As per **Coalition Against Insurance Fraud,** (a body set up in US in 1993 set up by insurance companies, National Association of *Insurance Commissioners (NAIC)* and National Insurance Crime Bureau (NICB), insurance fraud is estimated to cost between US$ 80 bn in US. In Australia, according to a study by Insurance Australia Group, it costs the sector about AU$2.1 bn; and in the UK, as per *Association of British Insurers (ABI), about £1bn.* There are no estimates about its magnitude in India. However, if one extrapolates the Australian statistic on to the size of the annual non-life insurance 'Gross Premium Written' (GPW) in India (about INR 20,380 crores), assuming 60% claims ratio and 10% of the claims paid as involved in fraud the amount comes to INR 1,222 crore.

While, by itself, the figure may not look impressive, especially when compared with US figures, one can understand the gravity of the problem when one keeps in mind that insurers strive to earn around 10% of GPW as profit. And, here, they are losing about 6% of GPW on account of fraud! Insurers operate in an already difficult environment; and fraud vitiates and marginalizes their profitability.



Consequences of fraud:

Apart from the obvious financial cost, insurance fraud means increased premiums for honest policy holders, has reputational implications for insurers and adversely affects the financial health as well as the stability of the insurance sector.

> By and large, the insuring public looks for genuine financial redress in the case of an insured loss.

Types of insurance fraud:

By and large, the insuring public looks for genuine financial redress in the case of an insured loss. However, a very small percentage of the insuring public could be tempted to commit a fraud. And looking at the types of fraud, human ingenuity knows no bounds!

The non-life insurance sector sees a fascinating - and at times, revolting - variety of frauds. Staged accidents and inflated bills of damage to vehicles are paralleled by fake bodily injuries to humans and exaggerated bills for health services. Patients can be billed for services not rendered; unnecessary procedures are carried out, by medical service providers in the hope of recovering from the insurers. Also, policies have been taken against non-existent persons and innocent persons have been killed for fraudulent claims.

Rogue industries inflate inventories, dump non-moving or expired stock into flood or fire-damaged goods. Home owners try to cover up typhoon losses by setting houses on fire.

Examples from India:

Recently, Ujjain & Jaipur police detected rackets of personal accident policies being taken for poor persons like rickshaw-pullers, tea-stall owners etc. and later eliminating them systematically one by one. There have been instances of a person taking policies with scores of insurers and cutting his own fingers so as to make a claim.

The Hon'ble High Court in Chennai recently entrusted to the Central Bureau of Investigation (CBI) investigation into scores of third party liability claims from the state.

The Mumbai floods last year saw some companies making exaggerated claims on their insurers. To cite an instance, a company lodged a grossly

exaggerated claim of Rs.3 crore with an insurer for damage to goods/ stocks/ machinery which was finally settled for just Rs. 24 lacs, less than 10% of the claimed amount!

Claims of loss of goods in transit due to pilferage, theft or robbery are also common. At times, the claimant fakes a claim, inflates value of goods lost, alters its quality or arranges the goods to be stolen/ robbed.

Fraud is not limited to claims; there can be fraud at the time of buying insurance as well. The Insurance Regulatory Development Authority (IRDA) regularly warns people from buying insurance from recalcitrant intermediaries by withdrawing their registration.

Global efforts in fighting fraud:

The developed countries - most notably, the US - take insurance fraud very seriously.

They have evolved various means of dealing with it. Many states in the United States have **laws** that define insurance fraud; prescribe penalties; create insurance **Fraud Bureaus** to investigate fraud; provide powers and funding to the bureaus. Some of the states also make it mandatory for insurance companies to have a **Special Investigations Unit (SIU)** to handle internal investigation of fraud and refer cases to Fraud Bureau. SIU is manned by ex-police/law-enforcement personnel or experienced investigators.

Some state laws make it mandatory to report fraud to the designated agency and mention a Fraud Warning on the proposal form and claim form. The warning mentions that furnishing false information is a punishable offence. A fraud plan, outlining measures conceived by the company to tackle fraud, may have to be filed with the Insurance Commissioner of the state; and its implementation is reviewed by the latter. Presently, 33 states have an Insurance Fraud Bureau, 12 states require insurers to have an SIU and 17 states require a fraud plan.

Definition of insurance fraud is very wide and covers all the aspects of insurance. Providing false/misleading information or withholding of material facts at the time of applying for insurance; making a claim, taking a claim/payment; making a claim for a health service not utilized or making multiple claims for same loss/injury; altering / destroying / fabricating documents/ records are all covered under the definition. Similarly, collecting premium, or soliciting business for an insolvent insurer, or conducting business in violation of the license terms and even diversion of funds/ premium collected/ other business property are all often covered under insurance fraud.

In a study carried out in Australia, it was found that as many as 9% of the insured persons had not disclosed their entire claims history.

In addition to the legal measures, the insurance companies and their regulators have very strong cooperation amongst them and share data. The National Insurance Crime Bureau (NICB) of US has a claims history database, which is subscribed to by about 1000 insurance companies. It is possible to search by a vehicle number, driver name, license number, advocate or medical practitioner's name etc. Similar databases exist in UK (Association of British Insurers) & Australia (Insurance Reference Service).

Such claims history databases are powerful tools, not only for claims settlement, but for underwriting also. For instance, while issuing a motor policy, an insurer can load premium if it finds instances of rash driving by the owner, from the database. In a study carried out in Australia, it was found that as many as 9% of the insured persons had not disclosed their entire claims history. Such instances can be reduced by having a shared database.

Fighting insurance fraud in India:

Some efforts are already being made in the country on some aspects that may have a bearing on fraud.

Delhi Police have brought together all the general insurance companies - in an initiative called **Insurance Companies Anti Theft Squad (ICATS)** - to create a database of stolen vehicles. This database can be used by individuals who are considering buying a pre-owned vehicle to check if it is stolen. Once it becomes operational, it can theoretically be expanded to cover sharing of data on fraudulent claims and claimants, as also to find out multiple claims lodged by a claimant or earlier claims made.

On an informal level, some insurance companies have taken a lead in bringing insurance companies together who have started, among other things, matching stolen vehicle data of one company with insured vehicle data of others, so as to detect stolen vehicles. This platform is also used to share information on frauds in motor claims (multiple claims, fake claims etc.) and also claims in other policies.

Measures suggested for India:

Many of the measures adopted by these countries can be brought to India.

i] Creation of a claims history database will go a long way in fighting fraud[1].

ii] It is desirable to have specific provision to define & criminalize insurance fraud and have a special agency to investigate and prosecute it.

iii] In the interim, since creation of special agency would take time, all the companies can come together and, along with IRDA, identify places/ areas which are throwing up fraud cases in large numbers; identify the types of frauds and consider requesting the police authorities to designate a police station, or alternatively, create a small team of investigating officers, to deal with the subject.

iv] On an internal level, companies will require to have a well laid out policy which makes clear that they will not tolerate fraud.

v] They will also need to have internal measures to detect, investigate and prevent fraud - or have a Fraud Plan.

vi] A dedicated unit to deal with fraud on the lines of SIU in US, manned by experienced investigators/ ex-law enforcement officers, is also a necessity. SIU can not only investigate cases of fraud much more professionally, it can refer the cases to police/designated agency, so that it establishes a deterrent.

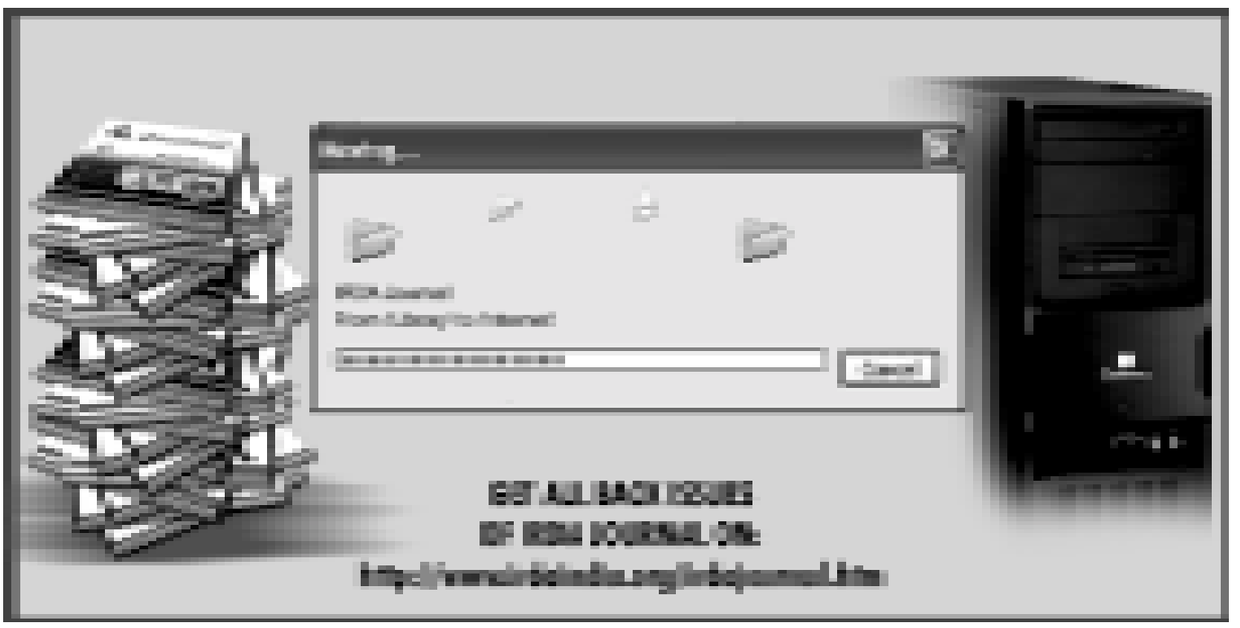
Creation of a claims history database will go a long way in fighting fraud.

Concluding remarks:

Insurance fraud is a serious issue that insurance companies, law enforcement agencies and the industry regulator are confronted with. The non-life sector of insurance is growing fast, leading to an increase in magnitude, complexity and variety of frauds. To tackle the menace, insurers, regulators and enforcement agencies all need to work together to minimize the ill effects of fraud on the General Insurance Industry.

[1] The insurance companies may need to be provided immunity from sharing information on fraudulent claims, amongst themselves, with other financial institutions, regulators and statutory agencies/departments.

The author is Managing Director of Tata AIG General Insurance Company. He can be reached at dalip.verma@tata-aig.com.



A Veritable Virus

- Frauds in Insurance

Although life insurance is not as vulnerable to frauds as non-life domain is; life insurers still have to be cautious against such fraudulent attempts as impersonation, transfer of rights in a contract without a valid purpose etc. opines V.K.Sarma.

Somebody - maybe a frustrated customer - described banking as a short-term fraud and insurance as a long-term fraud. What prompted him to comment in such a cynical manner is not known, but it certainly is a reflection of the public image; and perception of these two important and inter-related financial services.

In this article, we are concerned with frauds in insurance and one wonders as to who is committing fraud and on whom? Is it the insurance companies who are indulging in fraud and depriving their customers from insurance protection or is it the policyholders and claimants who buy or want to buy insurance policies with different intentions?

As far as insurers are concerned, they are corporate bodies and their corporate goals and objectives are clearly spelt out. They are supposed to provide insurance and allied services at a reasonable price and earn a reasonable amount of profit towards their expertise and cost of capital.

Their activities are highly controlled and regulated by the regulator mainly to ensure their solvency; and to protect the legitimate interests of the policyholders and other stakeholders. For this purpose, the regulator is armed with statutory and executive powers. All insurance companies are accountable to the regulator and should maintain transparency in all their transactions with all segments of the stakeholders. Over and above all these, they are subject to the jurisdiction of the judiciary and to the semi judicial bodies that are specifically constituted for this purpose.

Is it the insurance companies who are indulging in fraud and depriving their customers from insurance protection or is it the policyholders and claimants who buy or want to buy insurance policies with different intentions?

Source and motivation for fraud:

Insurance is essentially a transfer mechanism. It is also a funding mechanism, which is distributed according to the terms and conditions of the policy, which is the evidence of the contract. The payment under the policy gets triggered on the happening of a specified occurrence that is the coverage for which the insured has paid. This claim payment is a benefit under a life policy and indemnity under a non-life policy. Payment of claim under a life policy is comparatively easier for two reasons.

The triggering event being death/ disability cannot be manipulated easily and the instinct for self-survival protects the insurer from any foul play. Another reason is the amount of payment which is predetermined; and which is a benefit and not an indemnity. Further, there is no possibility of partial loss as in the case of non-life insurance.

Reasons for Fraud in Life Insurance:

Still, in spite of what is stated above, life insurance companies face the problem of fraud for two reasons.

Impersonation and bogus claim: The large amounts of claim is an attraction for claimants for manipulating documents and submit the required documents pertaining to somebody else in the name of the policyholder. The policyholder will disappear from the scene; and the insurance company has to either settle the claim or resort to investigation and litigation. If the local officials extend their helping hand, the task is much easier for the claimant to collect the policy amount. However, such instances are few and far between.

Misrepresentation and suppression of material facts:

This is the most common form of fraud made against the insurance companies. The physical hazard in life insurance is related to the age, health, habits, personal history, family history and occupation. Much of this information is collected from the proposal form and other special reports, wherever necessary. If the insured or the intermediary provides incorrect information for

• Getting favorable terms like lower premium and other benefits.

• Getting the insurance policy for which he is not eligible under normal circumstances, it amounts to breach of utmost good faith and false declaration, which is a promisory warranty. The insurer is within his rights to repudiate liability under the policy. If the repudiation is beyond two years from the date of the policy, Section 45 of Insurance Act 1938 protects the claimant, which makes the policy indisputable and the insurer has to shoulder the burden of proof. He is put to strict proof of evidence to prove the suppression of material facts. So the insurer has to be very careful if he wants to dispute liability beyond two years from the date of the policy.

This two-year period will be counted from the date of revival in case of lapsed policy. Thus, Sec. 45 of the insurance Act 1938 was exercised to protect the interests of the claimants and prevent the insurers from repudiating the liability on technical grounds. There are a number of cases, where the insurer could not prove to the satisfaction of the court that there is misrepresentation and lost their appeals. (Smt. B. Jayamma vs. Sr. BM. LIC Revision petition 2019/2010 N.C.)

However, there are also a number of cases, where insurers painstakingly collected evidence and were able to justify their repudiation. Some of the cases are discussed below to illustrate the above point.

1. Senior Divisional Manager of LIC of India vs. Gangamma and another - first appeal no. 797 of 1994 National Consumer Disputes Redressal Commission New Delhi. (NC).

In this case, the deceased who took the policy suppressed information about the pre-existing diseases. He was suffering from cancer and had been taking treatment. But at the time of death, the cause of death was recorded as heart failure. The LIC has repudiated liability under the Section 45 of the Insurance Act 1938. The claimant filed a complaint under the state commission who delivered a judgement in her favor. The state commission found no breach of utmost good faith and decreed for the claimant accordingly.

The claimant filed a complaint under the state commission who delivered a judgement in her favor. The state commission found no breach of utmost good faith and decreed for the claimant accordingly.

The LIC went on appeal to the national commission who felt that the state commission failed to appreciate the evidence fully. It is a fact that the life assured had been undergoing treatment for cancer though at the time of death, he suffered heart failure. Moreover, the life assured had taken two policies in succession, in January and March 1990 and the life assured died almost immediately in the same month.

Though he died of heart failure, it cannot be ignored that he was a cancer patient and suppression of this information violates the terms of contract and results in breach of utmost good faith. Thus, the national commission set aside the judgment given by the state commission.

2. In Sachdeo Mallavaiya vs. LIC -- Original petition 178 of 1998 in national commission - the commission decided that the claimant cannot take advantage of the typographical error in the policy. But he is entitled to only what is rightfully due to him. In this case, the complainant's mother Smt. Minta Devi had taken a pure endowment life policy from LIC for Rs.2,50,000 and a sum of Rs.1,04,975 was paid as a single premium. The period of the policy was 13 years. The policy was assigned to the complainant in 1992 and it was registered by LIC and the life assured died in 1994. In the policy, the sum insured was erroneously typed as Rs.25,00,000 and the complainant, who was the assignee lodged a claim for Rs. 25,00,000 which LIC had refused saying that Mrs. Minta Devi took a pure endowment policy for Rs. 2,50,000 and paid Rs. 1,04,975 towards single premium.

The single premium for a sum insured of Rs.25,00,000 would be Rs.16,00,51,100 whereas only an amount of Rs. 1,04,975 was collected @ Rs. 419.90 per 1000 sum insured. This is purely a clerical mistake and there was no intention of taking a policy of Rs.25 lakh on the part of the life assured. In the policy itself, it is

mentioned "you are requested to examine this policy and if any mistake be found therein, return it immediately for correction. "

So, as the policy provides for refund of premium paid with interest @ 2.5% per annum in case of death during the term if it occurs after 3 years from the date of the policy, the assignee is entitled only for that much amount and not for Rs. 25 lakhs. This is not a case of fraud in the strict sense, it illustrates the attitude of the claimant towards insurance and insurer.

In life insurance, the principle of insurable interest is applied and the absence of insurable interest will make it a wagering contract, which is prohibited under law. However this principle is circumvented to a certain extent, due to assignment. Though assignment may be effected, either for valuable consideration received or for natural love and affection, the insurer does not take any stand on its legal validity. The claim of the assignee is processed and treated as any other claim without questioning the motives and purpose behind assignment. In the USA a secondary market has been developed wherein lapsed life insurance policies are traded. Such viatical settlements of life insurance contracts may or may not encourage fraudulent claims but can possibly result in money laundering. In the Indian market, such transactions are not encouraged and life insurers refuse to register assignments of lapsed policies.

3. Even the landmark judgment in the well-known case of Mithoolal Nayak vs. LIC of India (AIR 1962 SC 814), the Hon'ble Supreme Court did not look into this aspect. Of course in those days, this problem of moral hazard in general, and viatical settlements in particular, was not so acute.

The life assured Mahajan Deolal submitted a proposal for Rs.10,000 in 1942 to the Oriental government security life insurance co. ltd. The medical examiner Dr. DD Desai examined the life assured thoroughly and submitted a full medical report in which he recorded that the prospect was uninsurable due to his health reasons.

Again in 1944, a second proposal was made for Rs. 25,000 and this resulted in a policy on 13-03-1945 (may be due to year-end rush). The first premium was adjusted from the deposit made in connection with the earlier proposal made in 1942. Thus, in the same company a person who was considered uninsurable in 1942 was covered in 1945.

Though assignment may be effected, either for valuable consideration received or for natural love and affection, the insurer does not take any stand on its legal validity.

Maybe his health would have improved, but the facts speak otherwise. The policy immediately lapsed due to non-payment of second year premium. On 18 - 10 - 1945, the policy was assigned to Mithoolal Nayak and the company registered it without expressing any opinion as to its validity or effect.

The lapsed policy was revived in July 1946. Obviously, the revival would have been done by the assignee. Thereafter the life assured Mahajan Deolal died on 12-11-1946. The assignee Mr. Naik claimed under the policy which LIC refused. This repudiation initiated the celebrated legal battle between the assignee and LIC who inherited the business from the previous company. The matter went right upto the Supreme Court who delivered the landmark judgment, which laid down the law regarding section 45 of insurance Act 1938, which is still considered the final word on this matter.

The person, who was anaemic, was 55 years old, having a dilated heart, right lung showing indications of pneumonia or pleurisy, and was in rundown condition. The doctor felt he was a total physical wreck and not insurable. Such a prospect was proposed for insurance again in 1945 and was insured by the same insurer. The record pertaining to the earlier proposal was obviously available in the office since the deposit lying with the office was adjusted towards the first premium in 1945 when the second proposal resulted in a policy.

During the intervening period, Mahajan Deolal had been taking treatment for his ailments. Though the Supreme Court did not express any opinion, Mithoolal Nayak merely gambled on the life of Mahjan Deolal when he got the policy assigned on 18-10-1945. He paid the second premium and got the policy revived in July 1946.

The life assured died on 12-10-1946 and Mr. Nayak claimed the sum insured. This is an example of viatical settlement, though such concept was not as much popular as it is now. But the question of insurable interest still remained a grey area. How much

consideration did Mr. Mahajan receive from Mr. Nayak to assign the policy?

Who guided and assisted Mr. Mahajan in his insurance transactions? The case is not so simple as it appears. When he submitted the first proposal in 1942, he went to a doctor who had brought his poor health on record and declared him uninsurable. Mr. Mahajan did not take back his deposit from the company, but submitted a second proposal in 1945 for increased sum insured after nearly three years.

Who was the medical examiner this time? What was the health condition as reported in the medical report? But the fact is, the proposal resulted in a policy. It means that the insurer thought that after a waiting period of nearly three years, due to improved health, the life had become insurable!

But two facts remain to be noted. In 1943 the life assured received treatment and possibly there was not much improvement in his health. The policy lapsed but was revived by the assignee, before the death of the life assured. What is the relationship between the life assured and the assignee? Who was the medical examiner at the time of the second proposal? It is not possible to ignore all these doubts and escape from drawing a presumption that there were people both in and outside the insurance company behind the whole transaction.

Who wanted to take and give advantage of insurance by committing fraud? One thing that can be stated is that insurance business is complex and it is not easily possible to commit fraud without the active or passive cooperation from people who are connected with the industry. There is not much change or improvement in the procedures and practices of life insurance offices during the last half a century. The same aggressive agents and field people, accommodating medical examiners, and obliging underwriting staff have been managing life insurance business.

Sins committed at the time of marketing and underwriting will surface at the time of claim settlement. Moral hazard will come to light. Frauds surface mainly at the time of claim. In life insurance business in India, most of the policies are of endowment type with predominant saving element; and the mortality risk can be more easily assessed than other type of statistical risks covered in general insurance. So, the problem of fraud is less acute in life insurance.

The policy lapsed but was revived by the assignee, before the death of the life assured. What is the relationship between the life assured and the assignee?

Frauds in general insurance are more complicated and maybe causing much more loss to insurers than in life insurance. IRDA has taken note of this problem and in its annual report of 2003-04 cautioned that frauds may be committed "at different points in the insurance transaction by different parties ". The IRDA identified them under four different categories. : -

a. Applicants for insurance
b. Policyholders
c. Third party claimants
d. Professionals who provide services to claimants. - surveyors, medical practitioners, hospitals, police, lawyers and others.

The IRDA listed the common frauds as under: -

a. Padding or inflating actual claims. - (Not possible in life)
b. Misrepresenting facts on the proposal. - (This is common both in life & non-life)
c. Submitting claims for injuries or damages that never occurred and staging accidents. - (This is mostly possible in non-life insurance).

There are a number of claims, which cover all the above instances. A considerable amount of case law has developed during the last century and a systematic study of these cases yield valuable lessons for the insurers in claims management and help them to render efficient service to the policy holders and claimants.

The author is Honorary Reader, Sri Sathya Sai Institute of Higher Learning, Puttaparthi.

Fraudulent Intentions in Insurance

- A Matter of Human Psyche?

Fraud, as a fashionable tool of economic sophistry, is perhaps the most dangerous motivator in the modern context opines Arman Oza. He further emphasizes 'it does not merely justify a wrongdoing; it accords virtue to it'.

"Nothing is easier than self-deceit. For what each man wishes, that he also believes to be true."

- Demosthenes

Fraud and deceit have perhaps been the oldest vices man has possessed. The Mahabharata is a classic portrayal of how these vices entangle even the fundamentally virtuous people and thereby destroy the society. It also vividly depicts the super-human power and commitment required to conquer these vices. Battles between dishonesty and fraud; deceit and fair-play have accompanied mankind since ages and one has never been quite sure as to who has been the clear winner - or loser. The fight nevertheless has continued.

In the modern sense, the demographic and geographic convergence of businesses - more popularly known as globalization - has while on one hand, increased the global wealth manifold, has also allowed the vice of financial fraud to pervade. Sophisticated technology coupled with legislative fortitude has strived to cope with rising challenges but as in the information technology (IT) world, where virus technology always remains a step ahead of anti-virus technology, white-collar crime has been expanding undeterred.

What is Insurance Fraud?

Dictionaries have defined fraud as (a) harming someone (by obtaining property or money from him) after making him believe something which is not true. (b) the act of deceiving someone in order to make money[1]. While the insurance lexicon does not provide a definition of the term 'Insurance Fraud', a fraudulent claim, which is practically considered to be synonymous with insurance fraud in general, has been defined as a claim where the insured has

- Made false statement of fact
- Made statements knowing them to be false or not believing them to be true or that he has made them recklessly without caring whether they were true[2].

Battles between dishonesty and fraud; deceit and fair-play have accompanied mankind since ages and one has never been quite sure as to who has been the clear winner - or loser.

Although no Indian law specifically deals with insurance fraud, various provisions of the Indian Penal Code do deal with crimes like cheating which covers within its ambit insurance fraud as well. Cheating has been defined as

"Whoever, by deceiving any person, fraudulently or dishonestly induces the person so deceived, to deliver any property to any person, or to consent that any person shall retain any property, or intentionally induces the person so deceived to do or omit to do anything which he would not do or omit if he were not so deceived, and which act or omission causes or is likely to cause damage or harm to that person in body, mind, reputation or property, is said to "cheat".

Explanation- A dishonest concealment of facts is a deception within the meaning of this section."[3]

The term 'fraudulently' for this purpose has been defined as "A person is said to do a thing fraudulently if he does that thing with intent to defraud but not otherwise."[4]

In the US where the issue of insurance fraud is apprised overtly, almost every state code has an enactment dealing with insurance fraud. Insurance fraud is exhaustively defined to include not only false representation on material facts pertaining to claims but also in relation to obtaining or renewing insurance coverage. Another intriguing aspect of US legislation on insurance fraud is that it also encompasses fraudulent acts on the part of insurers and intermediaries. Furthermore, abetment of fraudulent acts has also been made an offence.

Thus from the foregoing it can be summarized that any act on the part of anyone - the insured, the intermediary or the insurer - done with a mala fide intention to deceive or defraud the other party, with a view to obtain a wrongful financial gain would technically fall within the premise of insurance fraud. In India however, whatever little has been debated on insurance fraud, tends to revolve around fraudulent claims rather than anything else. Common instances of fraud relating to claims include the following in the ascending order of gravity.

- Inflation or exaggeration of claims.
- Factual manipulation to make a claim payable when it actually falls under some exclusion.
- Manipulation done with intent of morphing an uninsured person or property within the scope of coverage.
- Staging events that give rise to claims.

The Fraud Psyche

What is it in the human psyche that induces fraudulent conduct? Studies on this vital aspect of criminology indicate that socio-economic settings create motivations for fraud. The motivations may be monetary necessity, anger resulting from a feeling of being a social victim and economic sophistry.[5] Once a fraud is successfully executed, the mind tends to coin justifications like 'The system is like that', 'the whole world does it', 'if you do not commit fraud yourself, you end up being defrauded', 'the ends matter and not means' and the like. Fraud, as a fashionable tool of economic sophistry, is perhaps the most dangerous motivator in the modern context. It does not merely justify a wrongdoing: it accords virtue to it.

In the Indian context, fraud in some cases is looked upon as a right. The very probability of getting away with fraud is a motivation enough to commit it. Hence so long as it is "feasible" it will be done. Many people also opine that insurers make money at the cost of insuring public and hence there is nothing wrong in defrauding them, at the first opportunity. Absence of social stigma for fraud also acts as a motivator. The fact that criminals engaged in heinous crimes like murder are able to circumvent the criminal justice system also acts as a motivator. Hyped media coverage of such incidents tends to make the society more and more audacious towards sins like fraud. Thus the *mens rea* that stimulates culpable conduct begins with self-deception.

In fact, the misconceptions about insurance and insurers is one of the major motivators of insurance fraud. This is so even in the US where public awareness on insurance is supposedly much higher. In a recent study by Coalition Against Insurance Fraud (CAIF), when asked for reasons why people might commit insurance fraud, about two-thirds of the respondents said that insurance premiums increase regardless of claims history and that companies make undue profits. About 6 in 10 agree that people are only looking for a fair return on premiums paid; nearly the same number (56%) agree that rates are based on the assumption that fraud occurs. They are less likely to agree that people would not lie to insurance companies if they were treated with more respect (39%); that people are forced into this behavior to get insurance (33%); or that nobody tells the truth on applications (27%).[6]

Insurance contracts are aleatory as well as synallagmatic. The sacrifice is real and immediate; whereas the benefits are distant and contingent. The insured not only knows more about the interest covered but also exercises control over the interest during the currency of cover. All this gives more room for fraud.

In the Indian context, fraud in some cases is looked upon as a right. The very probability of getting away with fraud is a motivation enough to commit it.

Effect of Insurance Fraud

In the US insurance fraud is estimated to be at US$ 80 to 100 bn annually[7] and is acknowledged as costliest white-collar crime after tax evasion.[8] 10-15% of all property and casualty claims and 15 - 18% of all vehicle thefts are believed to be fraudulent. Carriers spend an average of $650 million annually to detect and deter fraud. The annual cost of insurance fraud could provide free prescription drugs for every American over age 65.[9]

The Indian story may not be much different, if not worse, though no formal studies are available on the subject. Fraudulent claims disturb the equilibrium of the insurer's portfolio and make it unviable. Reinsurance of such loss-making portfolio becomes costlier. The burden is finally passed on to the insured population in the form of hiked premiums. Even if competition makes premium hike the last resort, the insurer definitely tries to counter escalation in claim costs by imposing underwriting controls, deductibles and exclusions. This becomes a disincentive for the honest members of the population who either decide to fall in line with fraudulent population or stop buying insurance. This further skews the portfolio distribution and gets into a spiral. Limited outreach of vital products like health insurance evidences this phenomenon.

On the other hand, insurers have to spend heavily on investigations and claims management. Apart from adding to the claims processing costs and thereby the premium loadings it also adds to the resentment of insured. Investigations delay the claim settlement, and also irritate the claimant, if not carried out judiciously. Investigations have become almost routine in motor third party, group personal accident and workmen's compensation claims. This adversely affects the popularity of insurance in general and it continues to remain too complex an affair for a large section of the insurable population, which prefers to keep aloof of this vital risk transfer instrument.

Combating Insurance Fraud

As indicated earlier, the aleatory and synallagmatic nature of insurance makes it more vulnerable to fraud than any other financial service. Due to this the strategies for combating insurance fraud also have to be multi-pronged.

The onus of proving a fraud lies on the insurer. As such it is the insurer who has to collect all tenable evidence of fraud that is capable of succeeding judicial scrutiny. Since the courts will take a strict view against the insurers, it is extremely

important to collect proper evidence before arriving at a decision. In addition to thorough investigation, mutual co-operation amongst the insurers, sharing of databases, exchange of information, etc. is also crucial. Insurers will have to understand that while they can continue to compete for business, insurance fraud is an area where all competitors must co-operate with each other. In the US, insurers support separate entities like National Insurance Crime Bureau (NICB). Now entering its 90th year, it is supported by approximately 1,000 property/casualty insurance companies and self-insured organizations.[10] Robert M. Bryant, who worked with the Federal Bureau of Investigation (FBI) for 31 years, is presently the President of NICB. Professional organizations in line with NICB can assist insurers in developing strategies for combating fraud and can also work on research and policy advocacy regarding insurance fraud.

Regulation is another aspect relevant to combating fraud. The insurer has to be equipped with sufficient legal recourses, for collection of evidence from external parties like hospitals, government departments, revenue authorities, etc. in order to make it possible for an insurer to prove fraud 'beyond reasonable doubt' in a court of law. Unless some statutory muscle is provided to the insurers, they will keep fighting the battle against fraud with a wooden sword. Wider public interest demands finesse as well as fortitude in this battle against fraud.

Similarly, proper regulation of sectors touching insurance is also strongly required. For example the healthcare sector which is today a Rs.1500 bn. industry in India does not have a formal regulation at all. This is why insurers seldom get proper treatment case papers or medical history documents that are so essential in combating fraud. Lack of regulation allows unscrupulous healthcare providers to collude with delinquent policyholders in defrauding the insurers.

Criminal justice system in India is known to be tardy and cumbersome. Criminal cases take years to conclude. By the time a case comes up for final hearing, vital evidence is destroyed and witnesses turn hostile. While there is a case of suitable amendments in the Criminal Procedure Code (CrPC) and the Indian Evidence Act to take care of such instances, judiciary also needs to exercise firmness on issues like perjury. The socialist philosophy underlying judicial attitudes in civil litigation like motor third-party claims is promoting fraud and is resulting in unjust enrichment of vested interests. Judiciary should ensure that benevolent provisions of Motor Vehicles Act like the No-Fault Liability (S. 140), structured compensation (S. 163A) are not abused. Wherever detected, fraudulent cases should be handled most sternly.

On the other hand, the insurers also need to show determination in bringing fraudsters to book. Presently, the insurers' interest in detecting a fraud is limited to repudiation of liability and no further. If this menace has to be checked, insures have to look beyond their books and file criminal complaints against fraudsters wherever sufficient evidence is available. Unless there are some examples of conviction for insurance fraud, deterrence of this silent crime will remain far-fetched.

Unless some statutory muscle is provided to the insurers, they will keep fighting the battle against fraud with a wooden sword.

Last but not the least; insurers also have to bridge the credibility gap which leads an average insured to believe that insurers unfairly treat honest policyholders. Transparency and fair-play in underwriting and claim practices, consumer education, ethical marketing policies, and better engagement with customers are some of the things still to be done. In order to be reciprocated, honesty has to be first practiced in the right earnest. The common perception that insurers make money at the cost of policyholders and that premiums will increase regardless of claims, needs to be broken; through transparent and consistent business practices.

This is an ongoing tussle and as indicated earlier, one is never quite sure as to who is winning and who is losing. The battle nevertheless has to be fought; and fought tooth and nail. In India, insurance fraud may not be among the top financial crimes. But this is probably because of the limited penetration of insurance itself, more than anything else. As the market expands, fraud is bound to become a major concern. This is therefore the right time to organize the industry against fraud. Be thine enemy an ant, see in him an elephant.

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The author is a qualified Company Secretary and an Associate of Insurance Institute of India; and is a consultant based at Ahmedabad. He can be reached at armanoza@hotmail.com.

Forging a Stricter Regime

- Frauds in the Insurance Industry

Insurance fraud victimizes all of us in the form of higher premiums; or higher prices of goods and services writes V Ramakrishna.

Insurance Frauds :

Insurance fraud occurs when someone tries to make money from insurance transactions through deception.

- A homeowner falsely claims his home was burgled and that valuable items were stolen.
- The owner of a car offers a bribe to an insurance surveyor in exchange for an inflated repair estimate.
- A hospital charges for services not provided.
- A driver and his co-conspirators stage accidents, while doctors and lawyers "handle" the subsequent medical claims and lawsuits.
- A worker fakes an injury on the job in order to collect Personal Accident/ WC benefits.
- A contractor understates his labour list or misrepresents the type of work to enjoy a lower premium.

These are all examples of insurance fraud. Let us make no mistake - Insurance fraud is as much a white collar crime as Tax Evasion, Bank fraud, Forgery, Counterfeiting, or Embezzlement. Insurance fraud is a big bane for the insurance industry and for society in general. While Indian statistics are not available, it is estimated that insurance fraud costs the US economy more than **USD 80 billion** every year (2nd highest after tax evasion).

Criminals who defraud insurance companies not only steal from insurers, but they rip all of us off as well. Far from being a **"victimless"** crime - as it is commonly perceived - insurance fraud victimizes all of us in the form of higher premiums or higher prices of goods and services. Insurance industry studies indicate 10 percent or more of property/ casualty insurance claims are fraudulent. Insurance cheats range from organized criminal enterprises, to unscrupulous doctors and lawyers, to dishonest body shop operators, to your neighbours. Regardless of who they are, insurance criminals are motivated by one thing: money. It's all about greed and taking what isn't rightfully theirs.

Insurance fraud is as much a white collar crime as Tax Evasion, Bank fraud, Forgery, Counterfeiting, or Embezzlement.

What are Insurance Frauds?

Insurance fraud is any material misrepresentation to an insurance company made by a person claiming insurance benefits or applying for an insurance policy.

Fraud occurs when someone knowingly lies to obtain some benefit or advantage to which he/she is not otherwise entitled or someone knowingly denies some benefit that is due and to which someone is entitled.

What are the types of Insurance Frauds?

Arson: Sometimes people burn buildings, cars or other property in order to collect insurance proceeds. In addition to insurance fraud, arson carries additional penalties. Also, if someone is injured or killed as a result of arson, the perpetrator can be tried for assault or murder.

Maritime Fraud is a multi-billion dollar problem and probably the largest racket, the advantage to the fraudsters being the difficulty for the insurers in disproving the loss in the depths of the ocean. Misrepresentations in Bills of Lading; use of Phantom Ships; willful casting away of an over-insured and aged vessel - are all examples of Maritime Fraud.

Medical Provider Billing Fraud: Some healthcare providers, including doctors, dentists, nurses, chiropractors, psychiatrists, pharmacists, physical therapists, and others, may attempt to defraud insurance companies by submitting bills for procedures that were never performed, or "upcode" by charging an insurer for a procedure that is more expensive than the one they actually performed.

Staged Accident "Rings": Insurance fraud can be a sophisticated enterprise. In some areas, police and prosecutors have uncovered widespread organizations involving lawyers, doctors, and "runners" who stage car accidents and then sue insurance companies.

Benefits Fraud: This occurs when an uninsured person claims benefits under a policy eg: an uninsured

dependant or a room mate claiming health care costs.

These examples are only the "tip of the iceberg." Criminals constantly try to stay one step ahead of law enforcement and the insurance industry by inventing new way to commit fraud. All insurance fraud crimes have one thing in common: In the end, we all pay.

The types of fraud committed vary from class of business to class of business. For example, exaggerated or totally fabricated claims are common in travel insurance, because it is often easy for the insured to commit fraud, since the alleged loss probably occurred thousands of miles away, making a detailed and thorough investigation difficult and uneconomic for the insurer. In motor claims, exaggerated symptoms and falsified injuries (such as through staged accidents) are common for third party claims, while among household claims dropping laptop computers and spilling paint on the floor "accidentally on purpose" is very common.

Frauds according to "Class" of business

Auto Frauds: The different types of frauds involved in Auto claims include

Faked Damages, Inflated Damages, Vehicle, Vehicle Arson, Auto Property/ Vandalism Agent/Broker - Policy backdated prior to loss date and/or theft of premium intended for payment of coverage etc

Medical Frauds: Slip &Fall - Suspicious slip/fall claim, **Inflated Billing -** Inflated billing by any medical facility, doctor, laboratory, etc., **Disability** - Disability claim submitted against disability insurance policy while claimant on permanent or temporary disability and receiving continual benefits and/or vocational benefits and/or claimant reported working or performing activities exceeding alleged physical limitations, **Pharmacy** - Pharmacist or pharmacy inflates bills or falsifies billing; person illegally obtains medical prescriptions and submits prescriptions for habitual need.

Life Frauds: Questionable Death - Questionable circumstances surrounding reported death; staged death/false identity, **Suspicious/False Policy Application -** Suspicious or questionable actions by applicant or policyholder (insured's health misrepresented on application; suspicious timing of application in relation to insured's death); potential for monetary gain from life insurance policy. They include suspicious claims involving murder for profit and claims pertaining to viatical settlements.

Fire: Commercial Fire - Suspicious commercial/business fire damage, **Arson for Hire** - Suspected arson for hire, **Residential Fire** - Suspicious residential fire damage, **Inflated Fire Loss -** Inflated claims from fire loss.

All insurance fraud crimes have one thing in common: In the end, we all pay.

Property: Theft Residential - Suspicious residential theft, Theft **Commercial -** Suspicious commercial business theft, **Theft Commercial Carrier -** Insured reports baggage/cargo lost by commercial carrier (airline, bus, train, vessel), **Property Theft from Vehicle** - Suspicious theft of personal property while stored in a vehicle.

Agent/Broker -Policy backdated prior to loss date and/or theft of premium intended for payment of coverage.

Maritime Fraud: Sinking ships, phantom vessels, missing cargo etc.

Examples of some interesting frauds

Too Many Encores: His acting was quite good, and he also doubled as his own stuntman, but eventually his performance would earn him a very bad review. The man's act was simple and convincing. He would hang out in a parking lot until he spotted a woman or a senior backing out of a space. He would then step behind the car, bang the trunk with his fist and fall to the ground in apparent pain. At first, various insurers would settle his claim, so he gave a repeat performance every two weeks. He put on a total of eleven shows until a sharp-eyed adjuster gave him the thumbs down. After an investigation, his next appearance was in court, where he received a bad review and was ordered to repay his victims. His acting career is over.

Pirate Shipping: Stolen cars are one of Canada's fastest growing exports. Every year, an estimated 20,000 of them are loaded into shipping containers and sent overseas. One crook thought he'd try to cash in on both ends of this illicit trade. First, he arranged to export his brand new high-end vehicle to his home country in Europe. Ninety days later, he filed an insurance claim in Canada saying his car had been stolen. Problem was, his car had already been seized at a port in Belgium along with two other stolen Canadian cars found in the same container. Investigators were naturally suspicious of a theft report concerning a vehicle that had already spent weeks impounded in Belgium. They wondered why it had taken him so long to realize it was missing. So did the insurer. Claim denied.

Phantom Shipping Fraud: The owner of a missing cargo of palm oil worth US$ 2.5 million was defeated in his court battle to recover insurance for the loss. The ship carrying the cargo disappeared on the high seas along with its captain and crew.

The Pacifica left from a Malaysian port in 1998, but never reached her official destination, Beihai in China.

Investigations later revealed that neither the chartering nor ship owners' companies had ever existed, and that their official Manila address was false. The identity papers of captain and crew were also shown to be forged.

At the trial, the ICC's International Maritime Bureau (IMB) said the case showed all the signs of a phantom ship fraud, and gave expert evidence on what constitutes a phantom ship operation - when a vessel chartered by criminals is loaded with goods, and then given a complete identity change after leaving port. Instead of sailing to the contractual destination, phantom ship operators steal the cargo and discharge it illegally at a different port using fake identity papers for the vessel and cargo.

The court in Hong Kong heard how analysis of the evidence suggested the cargo of palmolein was the subject of a theft, well-planned and executed by the ship's fraudulent owners and operators.

How does the law view insurance fraud?

Although insurance fraud is considered an offence in all countries, there are surprisingly very few countries that have specific laws about insurance fraud. The few that do include Finland, Luxembourg, Czech Republic and Turkey.

The burden of proof: When an insurer repudiates a claim, then the onus is on the insured to establish that the loss falls within the scope of the insurance policy. However, if in its defense to the claim the insurer alleges that the insured has committed a fraud - then the onus, or the burden of proving the crime, is on the insurer. The onus of proving fraud is very difficult, which partly explains why in practice so few prosecutions for insurance fraud are made.

Although an insurer's claim of fraud is a civil suit, the standard of proof is the criminal standard of proof. Therefore the prosecutors of insurance fraud must prove the case of fraud "beyond all reasonable doubt". That burden has been described in mathematical terms as 90 percent certainty or more, in contrast to the usual civil burden of proof, "on the balance of probability", which is 51 percent or more.

Conclusion

It takes a concerted team effort to fight back against insurance criminals. No individual, organization or agency has the resources to single-handedly stop these criminals. Today the situation in India is that when a claim is found to be fraudulent by the insurer it is just repudiated. The insurer does not go beyond that point as he has avoided a financial loss ……. But the unfortunate reality is that the fraudster with this criminal bent of mind goes scot free and tries his luck with another insurer.

What can we do to combat this menace?

Insurers Coalition

To begin with, insurers should work closely together with the Regulator to combat fraud. Information on fraudsters should be exchanged and a national database maintained so that such elements are refused access to other 'unsuspecting' insurers. In India, banks and consumer finance majors have been practicing this for several years now to protect against chronic defaulters.

When an insurer repudiates a claim, then the onus is on the insured to establish that the loss falls within the scope of the insurance policy.

In the USA, spiraling insurance claims due to fraud led to the birth of the "Coalition Against Insurance Fraud", a not-for-profit organization formed by insurers, Government agencies and consumer groups. This coalition has been working towards enacting anti-fraud laws and regulations, educating the public on how to fight back, and serving as a national clearinghouse of fraud information. Interestingly, it also maintains an "Insurance Fraud Hall of Shame" on its website (url: http://insurancefraud.org/HallofShame). The Canadian Coalition against Insurance Fraud has been publishing newsletters and manuals ("the Fraud Indicators Guide to Detecting Questionable Claims") to help combat fraud.

Building Consumer Awareness

The biggest battle to be won is that of educating the insuring public on the evils of insurance fraud and ways to prevent it. A sustained campaign, similar to the ones released by the IT Dept to combat tax evasion, would be required to sensitise the average insured towards this issue. (An alarming statistic revealed in a Survey conducted in the USA among consumers was that "close to 36% of the respondents believed it was acceptable to increase the claim amount to cover the premiums paid"). It is only when insurance fraud is regarded as something

'shameful' and 'criminal' by a large section of consumers that all other efforts will begin to bear fruit.

Rewards for whistle blowers

As a sequel to building awareness, insurers and the regulator should actively encourage "whistle-blowing" or just plain "squealing" on fraudsters and publicly announce rewards for anybody who helps in preventing an insurance fraud eg: an employee of the fraudster or even a neighbour…..

Effective Legislation and Judicial Action

Insurance fraud deserves special legislation and judicial attention - a few quick, high-profile and highly publicised convictions are probably the strongest medicine for potential fraudsters. Without legislative and judicial support, all the activism of insurers and regulators will be rendered toothless.

The author is Managing Director, India Insure Risk Management Services Pvt. Ltd. The views expressed in this article are the personal views of the author.

Towards Ensuring a Fair Price

- Need to Intercept Frauds

While financial frauds are considered as a threat to the stability of the economy, insurance frauds may also be considered as a burden on the society to the extent that the public have to pay higher costs towards premiums says D.V.S. Ramesh.

Though presently frauds in insurance industry are not very significant in India, it may have serious ramifications on the finances of the insurers if unchecked. While frauds are well known in various businesses involving the regular rotation of money, insurance fraud is a rare phenomenon that comes to limelight when the fraudsters are attempting to explore the other safer avenues.

While control measures like internal check, internal audit etc. help in finding the abnormalities of the nature of transactions; it is only an in-depth investigation that can trace out its real face. However, the detection of a fraud is not an easy task; it involves the intellectual human skills and expertise in the relevant field to smell and judge the cases in time. In life insurance or critical illness insurance, underwriting and claims are the most vulnerable sections to the frauds. In claims, some of the areas where frauds can occur are; a claim in a policy taken with an abnormally high sum assured in the advanced ages of life; an early claim just after the expiry of the exclusion period; claimant not being closely related to the policyholder; insignificant amount of consideration for assigning the policy etc. A non-standard proof of death; death reported under suspicious circumstances etc. are a few events that trigger a closer scrutiny. At the underwriting stage, falsified medical reports are the possible areas where fraudsters can play a role. Getting the reports directly to the offices of the insurers, cross verifying the signatures of the applicants in all the related papers, calling for personal re-checks at the offices of the insurers in case of suspicious transactions etc. are a few acts that may sound caution at the entry stage itself.

Health insurance is one of the areas where the prevalence of fraudulent claims is in existence in various parts of the globe and this is a widely accepted fact. The nexus between the hospitals and fraudulent claimants is one of the factors for fraudulent claims in this area. Placing caps as a proportion to the sum assured on expenses like room rent; proper assessment of the diseases; and scrutiny of the documents while settling the claims may partially curtail the attempts of fraudsters in this segment.

While control measures like internal check, internal audit etc. help in finding the abnormalities of the nature of transactions; it is only an in-depth investigation that can trace out its real face.

Insurers have to be especially careful to avoid pitfalls in the following areas:

Assignment of life policies: The statute has placed no restrictions while assigning the policies of life insurance. The requirements for a valid assignment as per the provisions of Section 38 of Insurance Act are, inter alia, notice of assignment and valid consideration. The consideration could be out of love and affection as well. The statute also places no restriction to prove the veracity of the extent of the consideration involved while registering the assignment. The possibility of fraudsters exploiting these lacunae cannot be ruled out, in light of the falling interest rate regime.

Limitation Act: As the Limitation Act places a cap of three years within which a claim can be made, there is a possibility of potential fraud involving a deliberate delay in preferring claims. The fraudsters may resort to such a practice to ensure that the records pertaining to the health history of the deceased are not traceable for verification in case of early deaths warranting claim investigation.

The strategy adopted by the fraudsters will never remain the same. With the changes that are taking place in technology, the fraudsters would be changing their strategies from time to time. Insurers should exercise constant vigil to update both their systems and policies to counter the threat of frauds.

A constant vigil on the part of the dealing officials is of paramount importance as there will be no warning signals before fraudsters exercise their claims, especially during the financial year-end business. However, there should not be any hindrance to an expeditious settlement of genuine claims.

Money released in fraudulent claims is uncollectible: In view of the nature of life insurance transactions, attempting to collect back a fraudulent claim is not a feasible business proposition from the point of view of insurer. Also the costs involved and the time spent, especially to establish the proofs and to wage a legal battle, will also be a huge burden. The attempts by insurance companies to recover these monies may be counter-productive especially when the amount of claim involved is insignificant. The laxity on the part of the insurers to avoid a lengthy legal complication may also tempt the fraudsters to look for opportunities.

Threats of insurance frauds may be perceived in two different angles - by the individual policyholders with intent to deceive the insurer; and the other is the organized frauds by combination of a few individuals or the entities operating from various places with the same objective of committing frauds. This also involves the serious issue of moral hazard and may even lead to law and order problems. In view of the above facts, the insurance companies have to adopt preventive measures by establishing a comprehensive anti fraud policy in their organizations.

Constitution of special intelligence unit: These special units shall be established by the life insurers at their corporate office which may be manned by persons having an exposure and experience in law enforcement. Deploying the right personnel in these units may enable the insurers to identify and pinpoint the actual area of operation. There shall be free flow of information to this unit from various operating departments like underwriting and claims settlement; and the unit shall also report directly to CEO.

Education: Educated personnel are the sources of strength for an organization to counter the threats like frauds. Insurers shall develop special manuals for specific areas like underwriting, claims settlement, internal audit department and computer department. These are the few areas where the first level screening could filter the entry of fraudsters and will deter further attempts. Imparting awareness by way of education could be of many ways, especially when it comes to educating the insiders of an organization who deal with technical areas like insurance. With reference to developing an anti-fraud system within an insurer's office, it may include the probable lists of fraud indicators, hands-on job training, periodical seminars, workshops etc. These educative programmes shall also cover the life insurance advisors.

Internal Checks: Internal control mechanism adopted by the insurers plays a significant role in deterring the possibility of frauds in this class of business. Restricted access to claims settlement and underwriting new business; varying levels of approvals for settling the claims/underwriting the risk; quality management analysis reviews by the next higher levels; reviews by special intelligence units etc. help in prevention of frauds. While fixing the limits for seeking special reports, in settlement of claims or for underwriting the risks, care shall be taken to weigh more on accountability aspects than on quantitative details. It shall be ensured that the designated person who is expected to give his report shall be accountable for his task. For eg: allowing the insurance advisor to give a confidential report for a sum assured of Rs.20 lakh may not meet the purpose of obtaining such report.

While fixing the limits for seeking special reports, in settlement of claims or for underwriting the risks, care shall be taken to weigh more on accountability aspects than on quantitative details.

Whistle Blower policy: This is one of the ways of ensuring that the top management gets valid inputs directly from various layers of administration. This type of policy will also encourage the committed and loyal workforce to bring to the notice of their management certain issues of relevance which ultimately ensure prevention of frauds. However, to acquire the faith of its work force, one of the prerequisites is a robust human resources policy which allows its workforce to freely share its views on various matters affecting their working interests. This aspect may be a time consuming process as it will be very difficult for the workforce to develop a sense of confidence in the internal policies of the management to blow the whistle on matters of concern. If one examines the nature of some insurance frauds, it appears that collusion of company's own employees cannot be ruled out, as these are the first line people who are dealing with the transactions and would be in a position to suspect the transactions and report to the relevant heads/head offices of the company. Placing a whistle blower policy works as an antidote for this problem.

Rotation of work assignments: Compulsorily changing the assignments of its workforce from one department to another is one more ideal system of checking this rampant problem. Also, not involving the concerned personnel while the audit (internal or external) inspections are carried out in the department will further strengthen the anti fraud mechanism established within the organisation. It is reported in one of the surveys that 32% of financial frauds are committed by trusted employees of 10-25 years experience and 22% by those having an experience of 5-10 years. (Source: KPMG International fraud survey - 2004)

An interesting case study - Lessons to learn: Media is one of the main sources of information that bring to light the fraudulent cases in insurance industry. A cursory glance at one of the news items may indicate the areas where a deeper look is required at the macro level by the policy makers.

- A culprit has insured a drug addict for over Rs.60 lakh with an intention to kill him to get the insured money. Surprisingly, the insured was not aware of the cover of insurance on his life. The culprit has been running this racket with the help of insurance agents for about eight years. The culprit confessed before police that he had forged signatures and insurance documents on accidental deaths of seventeen persons for more than Rs.5.18 core. He further confessed that he insured the lives of those people who would die naturally; and paid the premium on their behalf to benefit out of their death. However, the police disputed the claim. (Source: The Week)
- On examining the case, it may be understood that the concept of insurable interest, the capacity of the individuals to pay the premiums etc. are the areas which the offices of the insurers failed to monitor. There are internal controls to check these practices, based on the level of the sum assured. The requirements of getting the confidential reports about the life to be insured varies; and two or even more officials will be involved while insuring the lives for a high sum assured.

Increasing trend of frauds in the financial sector: The constitution of a committee by RBI to recommend measures to curtail fraudulent practices in the financial sector is an indication of the prevalence of the frauds in the sector. The committee headed by Dr N L Mitra recommended the setting up of Financial Frauds Authority to deal with the frauds associated with the entire financial sector. The committee felt it necessary to associate the officials of the SEBI, RBI, IRDA, Police and Information Technology sector with the proposed Authority. However, it is learnt that the government is in favour of handing over all the major frauds in the financial sector to Serious Frauds Investigation Office (SFIO). Though, there is no data available on the extent of frauds in the insurance industry alone; as per the available figures with finance ministry during the year 2005, there were 2658 cases involving Rs.1134.39 crore detected by various agencies in the financial sector as a whole. In the first three months of this year alone there were 528 fraud and corruption cases detected involving a whopping Rs.225.74 crore. (Source Hindustan Times 15th June, 2006). However, investigation of financial frauds by a separate cell may not be a right thing. At a time when globally it is felt necessary to have single regulatory body for the entire financial sector, having multiple regulators in the sector may involve issues of co-ordination. With the convergence of the financial products and evolution of the financial conglomerates, a need is felt in some parts of the world to have a single regulator for the entire financial sector. Under these circumstances, having a separate financial frauds authority may only further complicate the coordination issues. Also, having a separate wing within the regulatory body to deal with these frauds will pass on certain regulatory inputs that may require further investigation. The enabling provisions in the laws of the land will encourage the insurance players to take proactive measures both for co-operating and coordinating with the law enforcement agencies. However, presently there are no enabling provisions in the Indian statute for exchanging information amongst the insurers and law enforcement agencies.

Though, there is no data available in India, it is widely accepted that curbing frauds in the insurance industry reduces the burden of excessive premiums on the public at large.

Building up the anti-fraud mechanism will be protecting not only the interests of policyholders but also its other stakeholders. Though, there is no data available in India, it is widely accepted that curbing frauds in the insurance industry reduces the burden of excessive premiums on the public at large. The industry shall develop a motto to establish a fraud free environment in the insurance sector for which there needs an understanding at a macro level amongst the insurers for detecting, sharing and investigating the fraudulent cases as it is apparent in life insurance that a fraudster may associate with more than one life insurance company to make a smart amount of money. There is also a need for single point monitoring agency, may be with the regulator, where there shall be regular flow of reporting the frauds. This can be managed well by the life insurers provided they develop an internal mechanism to counter this menace. The industry shall also work for coordination at a higher level with various law enforcement agencies.

The author is Senior Asst. Director (Life), IRDA. The views expressed in the article are his own.

Maritime Frauds

- Time to Take Stock

'Crime is always one step ahead of the law' insists A.K. Paul. He further goes on to suggest that lacunae in the system help fraudsters to exploit the situation and escape being punished.

When we talk of curbing or combating fraud in areas of activity involving international trade operations, it has always been seen that such efforts have met with limited success. Total eradication of such criminal activities by fraudsters transcending national boundaries has so far proven to be not only difficult but also virtually impossible. It is estimated that the cost of maritime fraud worldwide runs into millions of dollars.

Incidence of frauds in shipping business is not something new. The earliest incident on record goes back to 360 BC in Syracuse when a ship owner tried to cheat a buyer who had advanced money to him for bringing a cargo of corn, by scuttling the vessel after sailing for a few days without loading the cargo at all. In earlier times, trade between merchants of different countries was totally based on mutual trust. The transaction was invariably in cash; and as it happened sometimes unscrupulous agents or shipowners simply disappeared with the money, whilst others returned with false reports of robbery or piracy on high seas. Over the years, as trading activities increased manifold between the maritime nations, the simple process of dependence on mutual trust alone gave way to a written undertaking or pledge. It is reported that the Venetians first thought of and developed the system of trade between merchants through the mechanism of the Letter of Credit, which has, over the years undergone several changes and modifications to suit the requirements and complexities of modern trade.

In earlier times, trade between merchants of different countries was totally based on mutual trust.

Initially, the use of L/C gave rise to few incidents of malpractice and their ill effects were also limited. However, with the rapid expansion of trade worldwide, the trade practices have considerably changed and consequently the incidents of maritime fraud have become very complex and international in nature. In recent times, we have come across reports of marked increase in trade frauds arising out of chronic congestion in certain ports of the world resulting in high demurrage at those ports, which prompted the Shipowners / Charterers to divert the cargoes elsewhere; and actually sell it to unscrupulous buyers (i.e. illegal conversion of cargo by the Carriers). Sometimes economic sanctions against some countries by other nations of the world encourage fraudsters to take advantage of such situations of scarcity of essential commodities and follow the path of deception to make profits from fraudulent deals.

The word "fraud" is defined in Chambers' Dictionary as an act of dishonesty or intending to deceive. Thus Maritime Fraud can be described as a criminal act in international trade concerning the shipping industry. The term Maritime Fraud includes a host of wrongful acts. Experts involved in the investigation of such frauds feel that such acts have increased over the years with the growth of international trade. However, only a small proportion of fraudulent acts are at all reported. In fact, a large numbers of cases are never reported by the affected parties for fear of delays due to protracted investigation, increase in insurance premiums, bad publicity and stifling red tape.

Many a time, fraudulent acts remain undetected due to inept and perfunctory

investigation by surveyors as to the actual cause of loss. In some instances, insurers are innocent victims of maritime fraud - such as damage to ship's cranes and derricks due to under-declaration of the actual weight or measurement of cargo by unscrupulous shippers in consideration of lower freight. It is worth mentioning here of an incident when a small container feeder vessel capsized as a direct consequence of misrepresentation of facts in respect of actual weight of the cargo stowed within the containers loaded on the deck.

Criminal acts on high seas exist in a variety of ways as mentioned below:-

1) **Maritime Piracy -** These are illegal acts of violence or detention of a vessel on high seas by the crew of another vessel, generally outside the jurisdiction of any state. Sometimes, acts of piracy may lead to hijacking of a vessel.
2) **Marine Insurance Fraud -** Deliberate scuttling of over-insured vessel by the owners.
3) **Deviation Fraud -** This arises when the ship owner directs the cargo to another destination with the intention of selling the same for gain. Obviously, this involves change of name of the importer and non-arrival of the cargo at the appointed destination.
4) **Bill of Lading Fraud -** It involves forgery of Bills of Lading in respect of non-existing goods or differences in the quantity or quality of the goods. This can be described as a fraud by the seller or buyer against ship owners or the carriers.
5) **Charter party Fraud -** It is generally committed by the charterers against the ship owners.
6) **Agency Fraud -** It involves impersonation of agents and concealing of identities.
7) **Other documentary frauds -** It involves fraud in various other documents used in Maritime trade transactions.

In any international trade deal relating to export/import business, a number of parties are involved - Buyer, Seller, Ship owner, Charterer, Ship's master and crew, Insurer, Banker, Broker or Agent etc. Documents form the basis of such transactions and thus, numerous possible combinations and permutations can arise for fraudulent activities. From the record of various documentary fraud cases studied and investigated during the last couple of decades, the types of fraud can be broadly categorized as under :-

The buyer gets carried away by the favorable price and conditions quoted by the seller, thereby ignoring to exercise precautionary measures for avoiding a possible fraud situation.

- Fraud committed by a trader against another trader, ship owner, banker or insurer.
- Fraud committed by a charterer against a ship owner;
- Fraud committed by a ship owner or trader against an insurer;
- Fraud committed by a charterer or ship owner against a trader.

Manipulation or forging of documents is not a very big deal keeping in mind the ingenuity and resources of a smart fraudster. Documentary fraud is taking place more often than actually reported or noticed. Since the entire business of export / import trade is based on certain specified shipping documents in accordance with the universal practice of commercial transaction through the Letter of Credit, a fraudster solely relies on the gullibility of the victim to accept an "apparent bargain", claiming that the particular transaction is genuine. The buyer gets carried away by the favorable price and conditions quoted by the seller, thereby ignoring to exercise precautionary measures for avoiding a possible fraud situation. In recent times there have been some remarkable incidents of maritime fraud and sometimes, the innocent victim has been the negotiating bank or the insurer. A few of the reported cases are narrated here to illustrate typical frauds in the maritime world.

Case Study - I

It has been reported by the IMB, a division of ICC that of late, a number of incidents relating to theft of entire cargoes, particularly from the Far East areas, have come to light. The crime is generally perpetrated by certain groups known as 'syndicates', who either steal or purchase a vessel (at a very cheap price) which is then fraudulently registered in 'Flags of Convenience' countries. In a typical case, a syndicate will buy an old cargo vessel and fraudulently register under a new name. It then sets up an elaborate network of dummy offices and companies to

deceive port officials and shippers. The crew are hired and given false passports, usually obtained from cities of convenience. The syndicate selects its cargoes carefully, choosing those which are of high value, easy to transport and trade - e.g. timber, edible oils, raw rubber & sugar, textiles, etc. Ship names are circulated through broking channels. Eventually a desperate seller with a shortly expiring L/C responds to the lead; and a vessel with a false identity is fixed for loading the cargo at the nominated port of the seller. Bills of Lading are issued to the anxious seller for the purpose of negotiating his L/C. The syndicate is now in complete possession of the cargo with known specifications and quantity, which is then resold to other buyers through commodity brokers in places where policing is not very active. It proceeds to the new discharge port of the buyer for delivery under a new name. In this way the syndicate steals and sells the cargo carried by fictitious vessels. Nowadays these criminal gangs mostly in the Far East hijack loaded vessels (by acts of piracy), steal the cargo and then operate them as ghost or phantom ships as many times as possible for carrying out such illegal trading activities till such time a vessel is identified and seized by some national law enforcement authority.

Case Study - II

Investigations had revealed that an organized criminal group based in one of the Asian countries, was stealing multi-million dollar worth of cargo. It was reported that the gang was operating at least two vessels off the Eastern Mediterranean, North Africa and West African coasts fooling their victims out of cargoes. By offering bargain freight rates, the vessels' operators were easily obtaining cargo. Rather than discharging the cargo at the contracted ports, the vessels had been changing identity and illegally discharging the cargoes at other ports - often selling them at reduced rates. The cargo owners' suspicions concerning delay in delivery of the goods were invariably allayed by excuses ranging from bad weather to technical difficulties.

In the first case, a 30 year old Honduran registered vessel loaded steel cargo in Istanbul and headed for Lagos, Nigeria. On the way the vessel deviated from its chartered route and landed up selling its cargo at Lattakia, Syria. This same vessel after about a year under a different name and flying another FOC flag was chartered to carry a shipment of polyethylene from Libya to Morocco. Once again she proceeded to Lattakia, Syria and quickly discharged the cargo under false documentation. Further investigation revealed that the vessel changed her name after leaving Lattakia.

The negotiating bank also having issued the letter of credit was under no obligation to question the documents since they were required as per the international banking rules.

These cases had sparked renewed concern about a possible resurgence of ship deviations from contracted ports in this region. Unfortunately, it is the ease of registration of such dubious vessels in FOC countries, which have been hurting most the trading parties and banks, and sometimes insurers also.

Case Study - III

On 25th July, 1991, a Bulgarian buyer paid USD 3.80 million for 13,100 tons of Brazilian sugar by a Letter of Credit. The payment was released by an international bank on the basis of the usual documents which showed that the sugar was loaded on 17th July in the port of Santos on the M.V. Giovanna bound for Varna, Bulgaria. Neither the ship nor the sugar at all existed and the criminals have never been brought to justice.

In this case, the buyer was made to believe that he had struck a phenomenal deal, which would give him a quick profit. The negotiating bank also having issued the letter of credit was under no obligation to question the documents since they were required as per the international banking rules (Uniform Customs & Practice for Documentary Credits) to honour a L/C as long as the specified documents presented were correct. It was up to the buyer to make independent checks.

However simple reference to the Lloyds Register of Shipping would have revealed that that the M.V. Giovanna was nowhere near the Brazilian Port of Santos in July,1981. It had been renamed the M.V. Styliani in 1983 and broken up for scrap in Pakistan in 1984. As a matter of fact, a little bit of prudence on the part of either the buyer or the insurer would have clearly exposed the fraud by the seller.

Case Study - IV

The vessel "Tropical Queen" with a cargo of Palm Oil & Raw Rubber from Malayasia was on a voyage to Indian

Ports. It was in the year 1985; and STC was the canalising agent. Though the vessel was not fixed by Transchart, it can be assumed that a reasonable care went in before the vessel was selected.

The vessel reported engine trouble near the Andaman Sea. While the Coast Guard tried to locate the vessel in distress, which had lost radio contact by that time, the vessel was actually moving full steam to a port in Mainland China.

The insured reported non-delivery. The insurers plunged into action and an investigator was appointed. He traveled to China fast enough to photograph the vessel in the process of being painted. While her new name was painted on one side, the other side still had the old name. By the time it was reported to police the cargo was sold.

Insurers, with the help of Chinese lawyers, moved courts in Communist China and after protracted legal proceedings the insurers succeeded in obtaining the final verdict in their favour. That would be the first time a Chinese Court passed a verdict in favour of a non-Chinese National.

Ironically the Dollar appreciated and the compensation when converted to Indian Rupees fetched almost the same amount that the claim was settled for.

Investigation of such cases has shown that generation of false documents is relatively easy with the help of modern technology and the victims may find it extremely difficult to doubt the authenticity of the shipping documents. With the introduction of electronic system of communication and generation of documents thereof, the types of fraud carried out will change but it will certainly not reduce them. Perhaps, sellers committing fraud on the buyers may become a little more difficult. But more importantly the majority of the frauds engineered by the buyers and sellers acting in collusion against banks and also insurers will continue with the electronically generated documents lending greater creditability to them than the paper documents normally would have. After all, crime is always one step ahead of the law.

Jurisdiction is often a difficult issue in prosecution of international fraud cases. Fraudsters are well aware that international waters are outside the jurisdiction of various national law enforcement authorities. Because of territorial limits, the international waters remain relatively lawless and most often the perpetrators escape justice.

It is to be remembered that frauds are best avoided because once a fraud has occurred, options for remedy are very few and invariably expensive.

Finally, the most important single factor in the prevention of fraud is 'hands on knowledge' of the maritime trade particularly in regard to the origin and movement of various commodities and products. It is important that line managers in insurance companies dealing with Marine & Hull Cargo business underwriting are aware of the modus operandi of fraudsters in order that due diligence measures are in place. It is to be remembered that frauds are best avoided because once a fraud has occurred, options for remedy are very few and invariably expensive.

It is strongly felt that the best long term defense is to ensure that fraudulent stories are publicized and reported to the International Maritime Bureau in London. People are reluctant to report and keep such things under wraps because they do not want others to know that they have been duped. The IMB has been in existence for almost 25 years now (an organization specifically set-up for this purpose by the International Chambers of Commerce); and has investigated and exposed numerous maritime frauds on all the sea lanes. It has taken the initiative in gathering intelligence and advising those at risk. More importantly it has helped the maritime industry to guard against such frauds before they happen; and ensure that the whole system of maritime trading is not undermined.

The author is Executive Director, J. B. Boda Reinsurance Brokers Pvt. Ltd., Kolkata.

Guarding Against Frauds in Insurance

- Importance of Interpretation

The purpose for which insurance is obtained should properly be analysed so that the fraudulent tendencies of applicants can be kept on check opines G.GOPALAKRISHNA.

Generally stated, the policy of life insurance which evidences the contract entered into by the insurer and the applicant for insurance is primarily governed by the general rules relating to contracts, though a few special characteristics are enjoined to the policies of insurance contracts. On a broad analysis of the policy, a life insurance contract is, like other types of insurances, (1) an Aleatory Contract, (2) a Conditional Contract, and (3) a Contract of Adhesion, but not (4) a Contract of Indemnity.

1. Aleatory Contract - An Aleatory agreement is one in which there is an element of chance or uncertainty, as for instance a wagering contract. Depending upon chance, a party to such an agreement may receive a return out of all proportion to the value which he gives. In an insurance contract, the full sum assured may become payable even after the insured has paid one initial premium or a few premiums only, though this will not happen in the case of all policies issued by an insurer. Insurers are careful enough to see that on the whole, the sum total of all insurance transactions is also to their advantage.

The aleatory nature of insurance has induced many unscrupulous persons to resort to insurance for making fraudulent and illegal gain. It is to counteract this tendency that insurable interest is required in insurance and also the remedies of rescission and repudiation are provided to the insurers.

2. Conditional Contract or Contingent Contract - The life insurance contract is also a conditional contract because the promise of the insurer is conditioned on the timely payment of premium subsequent to the first by the insured. This is a condition precedent to the continuance of the contract under its original promise. If this condition is not fulfilled, the insurer is relieved of the basic promise of paying the sum assured but remains bound to honour other subsidiary promises contained in the contract, viz. the surrender and reinstatement provisions etc. In addition, the insurer's promise to pay the sum insured is also conditional upon the insured's forbearance during the specified initial period from committing suicide, furnishing satisfactory proof of death of the insured and proof of title of the persons claiming payment, of the sum assured and so on.

The aleatory nature of insurance has induced many unscrupulous persons to resort to insurance for making fraudulent and illegal gain.

3. Contract of Adhesion - A life insurance contract is said to be a contract of adhesion meaning thereby that the terms of the contract are not arrived at by mutual negotiations between the parties as in the case of ordinary contracts. The insurer has various types of policies to suit various needs and a person who applies for a policy of life insurance must accept one of these which may suit his needs. He is not in a position to bargain about the terms of the contract. If he wants a policy he must accept it or adhere to it in the form it is offered. Any negotiations or bargaining is only to do with selecting the one that is most suitable to him, out of the various types of policies that are available with the insurer.

This adhesive nature of the insurance contract has significant legal effect in regard to the mode of construing insurance policies generally against the interest of the insurer.

4. Contract to pay a stated sum - A life insurance contract is not a contract of indemnity but one to pay a stated sum, while property and casualty insurances are contracts of indemnity where the insured can recover only the amount of loss not exceeding the amount of the policy. In life insurance, even where the insured has reached a ripe old age and his economic value is not high, the insurers will pay the full sum initially agreed upon.

Parties to the Contract - There are two parties to the life insurance contract viz., the insurer and the applicant for insurance. The applicant is normally the person whose life is the subject matter of the contract, i.e., the person on whose life a policy is required to be issued. Sometimes the applicant may wish to take out insurance on the life of another person, in which case the person whose life is insured is not a party to the contract, unless he is also a joint applicant.

In view of the nature of the insurance business, its magnitude and its intimate bearing on the welfare of society; and the need for continuity and permanence of the insurer, in modern times the business is conducted exclusively by corporate insurers.

Competency of the Applicant for Insurance - Every individual, male or female, who has attained majority, i.e., completed 18 years of age according to the Indian Majority Act (or 21 where a guardian has been appointed for his person or property by any Court) and who is of sound mind, can apply for insuring his life, provided he is not disqualified from contracting by any law to which he is subject. Legal capacity to contract is restricted in the case of minors, persons of unsound mind, aliens etc.

Free Consent - In a contract of insurance the insurer and the insured must be in genuine agreement as to the subject matter of insured, sum assured and the term of the insurance, and every other particular relating to the contract. The contract carries with it an agreement by each party to be bound, in case of dispute, by the interpretation which a court of law puts upon the language of the contract, whatever may be the meaning the party attached to it in his mind.

Fraud is committed by a party when he or his agent with intent to deceive the other party or to induce him to enter into the contract, makes a representation which he does not himself believe to be true or actively conceals a fact having knowledge or belief of the fact or does any other act fitted to deceive etc. The principal difference between fraud and misrepresentation is that in one case the person making the suggestion or representation does not believe it to be true and in the other he believes it to be true, though in both cases it is a misstatement of fact which misleads the other party to the contract.

Consideration - As required by law, the consideration for the assured's act namely, payment of the first premium and of the future premiums, is the insurer's promise to pay the sum assured with bonus etc.; and the consideration for the insurer's promise to pay the sum assured with bonus etc., is the payment of the first premium and the due payment of the subsequent premiums by the insured.

Object means purpose or design that is the ultimate purpose which the contract subserves, and this should be a lawful one.

Legality of object - According to the Indian Contract Act, which governs insurance contracts too, in order that a contract may be valid, not only the consideration but also the object of the agreement should be lawful and an object that is not forbidden by law or is immoral or opposed to public policy or which does not defeat the provisions of any law; is lawful. In the case of an insurance contract, the proposer is asked to state in his proposal the object of the insurance. Usually the object stated is that it is a provision for his old age or for his dependents; or for the benefit of his wife and children under the Married Women's Property Act, 1874; or for the purpose of paying estate duty; or for the education of his children or for the marriage of his dependents and so on.

In legal language these are the motives which prompt him to enter into the agreement and not the object of the agreement referred to in the Indian Contract Act. Object means purpose or design that is the ultimate purpose which the contract subserves, and this should be a lawful one. To put it the other way, it should not have a tendency to encourage illegality or immorality or to offend well settled notions of public policy.

But life insurance which is recognized to be so beneficial to society has in the past been resorted to by unscrupulous persons for illegal purposes, as there is always a chance here of obtaining a disproportionately large sum in return for a small payment.

Inducement to Commit Murder - It has also been observed that a threat of murder is likely to arise by insurance of one person's life for the benefit of another, being left uncontrolled. If any one can insure the life of anyone else whether he is related to him by blood or not, the temptation to murder the insured cannot be ruled out in spite of the fact that there is the sanction of criminal law which punishes the murderer and of civil law which deprives him of the benefits, if any, proceeding from his criminal act. The Hindu Succession Act, 1956 lays down that a person who commits murder or abets the commission of murder shall be disqualified from inheriting (1) the property of the person murdered, or (2) any other property in furtherance of the

succession to which he committed and abetted the commission of the murder. The temptation to murder the insured life will be greatly reduced if one is permitted to insure the life of only those who are closely related to him by blood or by financial relationship, where one stands to gain more by the continued life than by the death of the life insured. The requirement of insurable interest is thus intended as a check over such wagering in human lives. In spite of it, however, instances are not wanting where the husband and wife have jointly insured their lives and one of them is murdered or forced to commit suicide so that the survivor may enjoy the benefit of the joint life insurance. Nothing could better illustrate the importance of insurable interest in life insurance.

What is Insurable Interest? Every day, newspapers bring reports of death of scores of people, naturally or by accident or otherwise, in a bus falling into a ravine or a boat capsizing midstream or in an airplane crash or a whole city being wiped out due to an earthquake or floods, etc. One does not even shed a tear at this; unless one's near relative or breadwinner or benefactor is among the dead, because human feeling apart, one has no interest in their continued existence or death. In other words, he has no risk of loss in the death of the person or any motive to support that person's life. If so, why should he have a right to insure that life, and get a chance to recover on the termination of that life, a disproportionately bigger sum than what he gives? On the other hand, it may even tempt him to bring about the destruction of that life and thereby make an unlawful gain. It is against public policy to allow such things to happen.

There is however no such danger to public welfare if a person is allowed to insure the life of a person whose continuance is to his advantage and whose death puts him to risk of genuine loss. By insuring that life he only protects himself against the risk of loss and is not creating any opportunity to make unlawful gain. Insurable interest is thus a financial or other lawful interest in the preservation of the life to be insured. Its existence guards against a contract of insurance becoming a wagering agreement or one obtained by means of fraud.

Insurable interest in India - Insurable interest in India need not be confined to a pecuniary interest. Sentimental interest or an interest based on close family relationship may constitute sufficient insurable interest. Only an insurance contract which is in the nature of a wager is void and it would be unreasonable to hold that an Indian father taking a policy on the life of his child is entering into a wagering agreement, or it would be against public policy to allow him to do so. The closeness of relationship operates as a protection to the life of the insured and does not place him in any danger of being murdered.

In life insurance, an inherent interest, is all that is necessary for the validity of the policy, whether it is procured by the insured or by a person other than the life insured.

Certain dependent relatives have a legal right of maintenance. The amount of insurance that can be recovered need not be the exact amount of maintenance or debt or other amount recoverable, because it has been accepted that life insurance is not a contract of indemnity and hence the contract does not purport to reimburse the loss that the beneficiary may incur. It is enough that the amount bears a reasonable relationship to the value of the interest and is not speculative or fraudulent.

Insurable Interest and Own Life Policies - When a person seeks insurance on his own life, the question of insurable interest is immaterial. There can also be no element of wagering, for, whatever gain may accrue, will be by his death, and that is no gain. No man would gamble on his own life to gain such a Pyrrhic victory. Law also permits a person to insure his life for any amount though for underwriting purposes, insurers limit it to that which the person's financial status and capacity justifies.

There are, however, cases where a person may apply for insurance on his own life, but at the instigation of a third person. In such a case, there is a possibility of the transaction serving as a cloak to a wager, there being an understanding between them that the person is to get the sole benefit of the insurance by an assignment or otherwise. It is also possible that the third person may really be paying the premiums as he is to be the ultimate beneficiary of the insurance. This may give rise to a strong inference that the transaction is speculative in nature. The insurers, therefore, are entitled to make enquiries about the beneficiary having insurable interest in the life insured, as a precaution against the existence of any wagering or other untoward moral hazard; and if they are not satisfied on the point they may refuse to issue a policy.

Assignment of policy immediately after issue - In life insurance, an incipient interest, is all that is necessary for the validity of the policy, whether it is procured by the insured or by a person other than the life insured. So long as it is a bona fide policy obtained by him for his own benefit, he may thereafter

assign the policy for value or as gift to any other person; it does not matter even though at the time when he effected the policy itself he had that intention or even that the assignee has no insurable interest in the insured. But where the insurance is really made by the beneficiary and the life insured assigns it to the beneficiary soon after the issue of the policy, the court can go behind the wording of the policy and ascertain the real nature of the transaction.

Inducement to commit suicide - It is also possible that a person may take a policy of life insurance on his own life with the ulterior object of enriching his estate by committing suicide soon after taking the policy. Thus, the taking of a life insurance policy may act as an inducement to commit suicide if the insured could enrich himself in this way. This has to be guarded against. Insurers, therefore, exclude from the risk, death by suicide occurring within a specified period - usually one year or two - from the date of the contract or insert a clause limiting their liability to a return of the premiums in such event. The idea is that any abnormal urge to commit suicide will be carried out or will pass away within that period, without any undue benefit accruing to the insured or his estate. Suicide committed, whether sane or insane, after this preliminary period is a hazard of life which according to some insurers has no element of abnormality requiring the imposition of any restrictive clause limiting their liability in the event of death from suicide.

Risk covered in Life Insurance - The life insurance policy issued by a life insurer states that the sum assured is payable upon the happening of the event, namely, "on the stipulated date of maturity if the life assured is then alive or, at his death if earlier." Thus the risk covered is 'death' which may occur in any manner before the stipulated date, that is including suicide, sane or insane. Here also the risk covered is subject to recognized exceptions as in other branches of insurance. The risk can also be extended or curtailed by express terms of the policy.

In non-life assurances, loss due to inherent vice of the subject matter of insurance and ordinary wear and tear, are excepted. But not so in life insurance, as death by disease and senile decay which are comparable to inherent vice and wear and tear are covered.

Life Insurance - Not a Contract of Indemnity - Fire, Marine, Motor and other accident insurances except life and personal accident insurances are contracts of indemnity. This means that the insured, in case of a loss against which the policy has been made shall be fully indemnified, but shall never be more than fully indemnified. The object of these contracts is to place the insurer in the same position in which he would be if the event causing the loss had not occurred.

The most fundamental feature that is at the root of the difference between life insurance and property insurance is that the subject matter of life insurance is a human life which cannot be owned or transferred like all kinds of property

Life insurance, on the other hand, is not a contract of indemnity but a contract to pay a stated sum, and neither the doctrine of subrogation nor the doctrine of contribution has any place here. Thus a person who has insured his life with more than one insurer for various amounts, is entitled to recover the sum assured under all the policies, and even where the insured's death is caused by the negligence of a third party, the insurer has no right to proceed against the third party as there is no right of subrogation in the case of life insurance.

The most fundamental feature that is at the root of the difference between life insurance and property insurance is that the subject matter of life insurance is a human life which cannot be owned or transferred like all kinds of property which are the subject matters of marine, fire and other kinds of insurances. Hence no question of loss to the legal owner, which is the basis of the doctrine of indemnity in property insurance, can arise. It may not be correct to put it - as is usually done - on the basis of the assumption that the value of a man's life to himself is unlimited. For one thing, this is not the reason to hold that life insurance is not a contract of indemnity. Secondly, no insurer will agree to offer unlimited cover on the life of any person despite the assumption that a person has an unlimited interest in his own life. Moreover, it is also not correct to say that no sum payable upon his death will be in excess of the loss suffered. If that were so, no court would be able to assess damages in fatal accident cases.

Life insurance differs from other kinds of property insurances in another way also. Though it has some indemnity aspects, it is largely a contract of investment which enables the insured to raise a fund for himself or for the benefit of his dependents whereunder frauds may be perpetrated. Insurers should, therefore, be on guard and remain alert at all times to ensure that no cheating takes place in any transaction.

The author is a Retired Senior Officer, Life Insurance Corporation of India.

प्रकाशक का संदेश

समाज में धोखाधड़ी के लिए ऐसे कारण बन जाते हैं जिन्हें रोका नहीं जा सकता। पहला और महत्वपूर्ण कारण व्यक्ति की धोखाधड़ी देने कि प्रवृति को न रोक पाना है। बहुत कम दांडिक कार्रवाई अथवा कई बार उसके बिना भी, व्यक्ति को धोखाधड़ी करने के लिए उत्साह प्रदान करता है। आगे, समाजिक कलंक की कमी भी समाज में धोखाधड़ी बढ़ाने के कारक बनते हैं। पर्याप्त कार्यवाही की कमी धोखाधड़ी की जाँच करने के लिए एक ऐसे वातावरण का निर्माण करती है जो अंतिम रूप से तथा अप्रत्यक्ष रूप से धोखाधड़ी की भावनाओं को प्रोत्साहित करती हैं।

ऐसा कोई व्यवसाय नहीं है जो धोखाधड़ी से पुरी तरह सुरक्षित हो, बीमा उद्योग जिसमें आकस्मिक घटना के परिणामतः एक वृहत राशि देने का वचन दिया जाता है जिसके बदले निरंतर बीमा शुल्क देय होता है ऐसी संभावना प्रदान करता है जिसमें धोखाधड़ी कि बड़ी संभावना होती है। बीमाकर्त्ता को ऐसे उपाय सोचने होगे जिससे धोखाधड़ी के मामलों को जाँचा जा सके जिससे लम्बे समय में बीमा संस्था मजबुत होकर उभरे।

'बीमा उद्योग में धोखाधड़ी ' जर्नल के इस अंक का केन्द्र बिन्दु है। यहाँ कई अनुच्छेद है जो विभिन्न प्रकार की बीमा श्रेणियों में धोखाधड़ी की संभावनाओं से बर्ताव करते हैं तथा उनसे बचने के उपाय।

उत्पाद कि गुणवत्ता तथा जो मूल्य वह अपने ग्राहको के लिए उत्पादित करता है वह अपने व्यवसाय उद्यम के लिए सफलता निर्धारित करता है, चाहे वह निर्माण क्षेत्र मे हो अथवा सेवा क्षेत्र में। यह प्रतिस्पर्धा के युग में अधिक सार्थक है।

जर्नल के अगले अंक का केन्द्र बिन्दु 'उत्पाद विकास ' होगा।

सी. एस. राव

"बीमा प्रदान करने कि उच्च लागत बीमा विभिन्न प्रकार की बीमा धोखाधड़ी को बढ़ाती है, इसमें शामिल है पहचान की चोरी तथा आंतरिक नेटवर्क में अपराध समूहन में तीव्रता।"

श्री बासेल हिन्दवानी,
जार्डन में बीमा आयोग के महा निदेशक

"करदाता चाहे शिकागों , लुजियाना, पियेर अथवा दक्षिण डकोटा में हो.- हम कई वर्षो तक खाड़ी क्षेत्र के पुर्ननिर्माण के लिए भुगतान करते रहेगें तथा दुख कि बात है कि इस सम्स्या के लिए कोई राष्ट्रीय निति नहीं है। हम सभी अगले हारिकेन के लिए बिल दे रहे होंगे।"

मैकेल मैग्राथ,
लूजियाना के बीमा विनियामक

"अच्छा होगा उपभोगता अपने हैल्थ बीमा विकन्ल्पों को जाने तथा अपने प्रिमियम देने की लागतए सह देयता तथा घटाव को भी जाने इससे वह अपने हैल्थ संबधित खर्च के बारे में योजना बना सकेगें ।"

अलीसंत्रो ए इयूपा, अध्यक्ष,
नैशनल एसोसियेशन आफ इंशूरेस कमिशनर, (एनएआईसी)

"ऐसा नहीं है कि विनियामक को अधिक शक्तियाँ चाहियें। भारत मैं बीमा अधिनियम 1938 का विधायक है। इसकी कुछ धाराएँ असगत हो गई है तथा कुछ को वर्तमान संदर्भ में अद्यतन बनाना आवश्यक है।"

सी.एस. राव, अध्यक्ष,
बीमा विनियामक और विकास प्राधिकरण (आईआरडीए)

"विनियामक बाजार में महाविपदा बीमा क्षमता बढ़ा कर एक महत्वपूर्ण भूमिका निभा सकता है, जिससे महाविपदा के प्रभावशाली नेटवर्क से स्पष्टता, पारिदृश्यता तथा महाविपदा बीमा बढ़ेगा।"

रिचर्ड यूआन,
हॉगकाग में बीमा कमीशनर का कार्यालय।

"यह उचित नहीं होगा कि हैल्थ कार्यक्रम की तुलना अन्य बीमा पालसियों से की जाए जो दुर्घटना तथा मृत्यु क्षतिपूर्ति की दरों पर होता है क्योकि दरों कि गणना अलग अलग आधार पर होती है।"

चू तुंग कुवान,
ताइवान में हेल्थ विभाग के संयोजक

जीवन बीमा के जरिये धन का अवैध लेन-देन

- एक प्रभावी तंत्र की स्थापना

संदीप बत्रा का कहना है कि ***'अपने ग्राहक को जानो'*** कार्यक्रम जिसे कि ***'बड़े परिश्रम से, ग्राहक बनाना'*** भी कह सकते हैं, किसी भी सशक्त ***'ए एम एल'*** ढाँचे का आधार कहा जा सकता है।

धन का अवैध लेन-देन की संकल्पना से ही पता चलता है कि यह वह प्रक्रिया है जिसके जरिये अपराधी अपनी आपराधिक गतिविधियों संबंधी लेन-देन का मुख्य उद्देश्य छिपाने का प्रयास करते हैं। इसके लिये वे विभिन्न वित्तिय संस्थाओं (जैसे बैंक, जीवन बीमा कंपनियाँ आदि) का इस प्रकार उपयोग करते हैं कि कुछ श्रंखलाबद्ध लेन-देन के पश्चात वह रकम संबंधित व्यक्ति के नाम हो जाती है और वह पूरी तरह वैध संपति के रूप में दिखायी जा सकती है।

मनी लॉड्रिंग (एम एल) के अंतर्गत मूल रूप से अवैध गतिविधियों से प्राप्त आय को, उनके मूल रूप जो प्राय: नगद ही होती है को अन्य रूपों जैसे जमा या सिक्योरिटीज अथवा जीवन बीमा में परिवर्तित कर दिया जाता है और एक वित्तीय संस्थान से दूसरे में अलग-अलग व्यक्ति या व्यवसाय के नाम से स्थानांतरित कर दिया जाता है।

एम एल चक्र: एम एल चक्र तीन मुख्य व्यवस्थाओं में संपूर्ण होता है- प्रथम, स्थापना अवस्था- यह वो अवस्था है जिसमें अवैध धन को किसी वित्तीय संस्थान में रखा जाता है, द्वितीय- प्रतिस्थापन अवस्था- जिसमें अवैध धन को विभिन्न जटिल, वित्तीय लेन-देन के द्वारा उसके अवैध स्त्रोत से पृथक किया जाता है। यह प्रक्रिया अंकेक्षण को खत्म कर देती है तथा अंतिम अवस्था- एकीकरण अवस्था- जिसमें अवैध धन का अर्थव्यवस्था में वैध धन के रूप में एकीकरण किया जाता है। एक बार जब अवैध धन अर्थव्यवस्था में वैध धन के साथ एकीकृत हो जाता है तब वैध और अवैध के बीच अंतर ढूँठ पाना मुश्किल हो जाता है।

इस समस्या के प्रति अंतर्राष्ट्रीय चिंता के परिणामस्वरूप अधिकांश वैश्विक संगठन तथा राष्ट्रीय सरकारें जो कि संयुक्त राष्ट्र साधारण सभा की सदस्य है- एमएल को हतोत्साहित करने के लिये रणनीति बनाने में जुट गये हैं।

अंतर्राष्ट्रीय प्रगति: एम एल के कारण अर्थव्यवस्थाओं के बढ़ते खतरों के मद्देनजर पाश्चात्य राष्ट्रों के संगठन जी-७ की एक विशेष बैठक का आयोजन 1989 में पेरिस में किया गया जिसमें एमएल तथा आतंकवादी वित्तीय गतिविधियों से संघर्ष हेतु नीतियों के विकस एवँ विस्तार के लिये एक जनसमर्थित अंतरसरकारी समिति 'वित्तीय कार्रवाई कार्यबल' की स्थापना की गयी।

1989 में स्थापित यह बल, एम एल के विरूद्ध आवश्यक वैधानिक तथा विनियामक सुधारों हेतु आवश्यक राजनीतिक इच्छा शक्ति को जाग्रत करने का कार्य करता है। वर्तमान में इसके 33 देश (अधिकतर ओईसीडी) सदस्य हैं।

> - एमएल के विरूद्ध संघर्ष के लिये कार्यनीति बनाना
>
> यूएसए देशभक्ति कानूनः 11 सितम्बर की घटना ने एमएल और आतंकवादी वित्तीय गतिविधियों पर सबका ध्यान आकर्षित किया है

एमएल आधारित एशिया-प्रशांत ग्रुप (एपीजी) जिसका भारत भई सदस्य है को बल के सर्वेक्षक का दर्जा हासिल है। एपीजी की स्थापना 1997 में एपीएसी क्षेत्र में एमएल के विरूद्ध संघर्ष के लिये किये जा कहे समन्वय के लिये की गयी।

भल ने 1996 में एमएल तथा आतंकवादी गतिविधियों के संबंध में 40 सिफारिशें की। 130 से अधिक देशों ने इन सिफारिशों का समर्थन किया। इन 40 सिफारिशों में से 11 जीवन बीमा क्षेत्र से संबंधित थी। निम्नांकित प्राप्त करने के लिये कुछ सिफारिशों को वित्तीय संस्थानों की मदद की आवश्यकता है:-

- कमर्ठता से ग्राहक बनाना (या ग्राहक को बेहतर जानना)
- राजनीतिक रूप से प्रसिद्ध हस्तियों के लिये कमर्ठता से बढ़ना
- औद्योगिक प्रगति के कारण होने वाले एम एल खतरे का आंकलन करना
- कर्मठता से ग्राहक बनाने में मध्यवर्तीयों पर विश्वास करना
- कुछ निश्चित वर्षों का रिकार्ड रखना
- बड़े आसामान्य तथा जटिल लेने-देन पर विशेष ध्यान देना
- संदिग्ध गतिविधियों की विनियामकों को जानकारी देना
- एमएल के विरद्ध संघर्ष के लिये कार्यनीति बनाना

यूएसए देशभक्ति कानूनः 11 सितम्बर की घटना ने एमएल और आतंकवादी वित्तीय गतिविधियों पर सबका ध्यान आकर्षित किया है तथा परिणामतः अमेरिकी सरकार ने यूएसए देशभक्ति कानून बनाया है। इस कानून के तहत टाइटल 3 में सभी वित्तीय संस्थाओं के लिये एमएल से सुरक्षा हेतु जाँच हेतु आधारभूत ढाँचा होना कानूनी रूप से अनिवार्य है। इसके लिये उन्हें आंतरिक नीति निर्धारण, कार्य विधि तथा नियंत्रण हेतु जिम्मेदारी निर्धारित करनी होगी। एक अनुपालन अधिकारी की नियुक्ति करनी होगी, कर्मचारियों के लिये प्रशिक्षण कार्यक्रम चलाने होंगे तथा एएमएल कार्यक्रम की क्षमता परीक्षण के लिये एक स्वतंत्र अंकेक्षण कार्यक्रम बनाना होगा ताकि एमएल गतिविधियों की सही जाँच तथा उनसे सुरक्षा सुनिश्चित की जा सके। इसके अंतर्गत संदिग्ध गतिविधियों वाले ग्राहकों की पहचान करनी होगी तथा उनके द्वारा किये जा रहे लेने-देन पर निगरानी रखनी होगी।

सितंबर 2002 में देशभक्ति कानून की एमएल विरोधी धारायें बीमाकर्ताओं पर लागू हो गयी। इससे बीमा क्षेत्र की एमएल विरोधी नीतियों में महत्ता का पता चलता है।

भारत में वैधानिक ढाँचा

एमएल कानून: जून 1998 में संयुक्त राष्ट्र साधारण सभा के विशेष अधिवेशन में पारित राजनैतिक प्रस्ताव के अनुरूप, भारत में एमएल कानून- प्रीवेंशन ऑफ एम एल एक्ट, 2002 पास हुआ तथा यह 1 जुलाई 2005 से अस्तित्व में आया।

इस एक्ट की धारा 3 के अनुसार एमएल के अपराध की व्याख्या इस प्रकार है 'जो कोई भी इस आपराधिक गतिविधि से प्रत्यक्ष या परोक्ष रूप से जुडा है अथवा जानबूझ कर उसमें सहयोग करता है या ऐसी गतिविधि का पात्र है अथवा वास्तव में ऐसे किसी कार्य या गतिविधि से संल्गन है तथा इस प्रकार प्राप्त लाभ-आय को दोषमुक्त निरूपित करता है- वह एमएल गतिविधि का अपराधी है।'

एक्ट के अंतर्गत आपराधिक गतिविधियों के कारण ही एमएल की स्थिति उत्पन्न होती है। कानू का उल्लंघन करके, उपार्जित ऐसा धन अथवा संपत्ति जिनका एक्ट की सूची में वर्णन है, 'आपराधिक गतिविधि' की श्रेणी में आते हैं।

निम्नांकित कानून इसके अंतर्गत आते हैं:

- नशीले पदार्थ एवँ मनोवैज्ञानिक दृढता कानून, 1985
- भारतीय दंड संहिता, 1860
- शस्त्र अधिनियम, 1959
- वन्य जीव (सुरक्षा) अधिनियम, 1972
- अनैतिक व्यवहार प्रतिबंध अधिनियम, 1956 तथा
- भ्रष्टाचार प्रतिबंध अधिनियम, 1988

एक्ट के अंतर्गत समाविष्ट मुद्दों में निम्नलिखित शामिल है:

- एमएल की व्याख्या तथा एमएल अपराध के लिये सजा
- एम एल द्वारा उपार्जित अवैध संपति की जब्ती तथा कुर्की
- एमएल मुद्दों से संबंधित बैंकिंग कंपनियों, वित्तीय संस्थानों तथा मध्यस्थों का दायित्व

एक्ट के अंतर्गत निर्धारित नियमों के लिये आवश्यकतायें:

- अनुपालन अधिकारी की नियुक्ति
- ग्राहकों तथा उनके पते की पहचान को सुनिश्चित करने के लिये के वाई सी कार्यक्रम (अपने ग्राहक को जानो) की अमलावरी
- प्रणाली में अवैध धन का प्रवाह रोकने के लिये उपयुक्त ढाँचे का विकास तथा व्यवस्था में ऐसे धन की शीघ्र पहचान के लिये जाँच की सुनिश्चिती
- एएमएल अधिकारियों के समक्ष विवरणीय तथा संदिग्ध गतिविधियों की जानकारी प्रस्तुति

पीएमएल एक्ट और नियमों पर आधारित आईआरडीए ने हाल ही में बीमाकर्ताओं के लिये एएमएल दिशा-निर्देश जारी किये है ताकि एमएल निवारण ढाँचे के लिये बीमाकर्ता को स्पष्ट निर्देश प्राप्त हो।

> एक सक्षम कार्यक्रम अवैध वित्तीय लेन-देन विरोधी ढाँचे का मजबूत आधार कहा जा सकता है। प्रभावी केवाईसी प्रणाली ईमानदार है तथा बीमा की जरूरत वाले ग्राहकों की सुनिश्चिती करती है।

विनियामक प्राधिकार

एएमएल कानून की अमलावरी हेतु वित्तीय सतर्कता ईकाई, आयकर विभाग तथा वित्त मंत्रालय उच्चतम प्राधिकार है। संदिग्ध तथा विवरणीय लेन-देन का विवरण वित्तीय सतर्कता ईकाई के निदेशक को देना (एफईएमए के अनुसार) अभियोजन का शक्ति में निहित बाध्यता है।

आरबीआई तथा सेबी ने भी बैंकिंग तथा पूंजी बाजार क्षेत्र के लिये समान मानक निर्धारित करते हुये दिशा-निर्देश जारी किये हैं।

बीमा उद्योग विनियामक की हैसियत से बीमा विनियामक तथा विकास प्राधिकरण को भी इस संबंध में नियम विनियम लागू करने का अधिकार है।

असमर्थ एएमएल ढाँचे से जुडे जोखिम:

एमएल की जाँच तथा निवारण में असफलता किसी भी संगठन के जोखिम को बहुगुणित कर सकती है जैसे

प्रतिष्ठा जोखिम: संस्थान की प्रतिष्ठा को पहुँचनेवाली क्षति से होने वाले जोखिम के परिणामः

यह संस्थान के व्यावसायिक हितों के लिये विशेष चिंता की बात होगी। प्रतिष्ठा को बनाये रखने के लिये पॉलिसीधारक तथा विनियामकों का विशेषतः तथा अन्य शेयरधारकों का सामान्य रूप से विश्वास बनाये रखना आवश्यक है।

अनुपालन जोखिम: कपंनी प्रतालन के आधारभूत विनियमों के अनुपालन में असफलता से हानि का जोखिम।

संचालन जोखिम: आंतरिक कार्य प्रणाली, कर्माचारी तथा प्रणाली अथवा बाह्य कारकों की असफलता या असमर्थता के परिणामस्वरूप होने वाली हानि का जोखिम।

वित्तीय जोखिम: उपरोक्त किसी एक जोखिम अथवा उनके संयुक्त कारणों से कंपनी की वित्तीय स्थिति पर पड़ने वाले नकारात्मक प्रभाव की वजह से होने वाली हानि का जोखिम।

अपने ग्राहक को जानो (केवाईसी)

एक सक्षम कार्यक्रम अवैध वित्तीय लेन-देन विरोधी ढाँचे का मजबूत आधार कहा जा सकता है। प्रभावी केवाईसी प्रणाली ईमानदार है तथा बीमा की जरूरत वाले ग्राहकों की सुनिश्चिती करती है।

इस प्रक्रिया में ग्राहक की पहचान तथा उसके पते की जाँच उचित दस्तावेजों के आधार पर करना आवश्यक होता है। इसके अलावा ग्राहक की बीमा आवश्यकता उसकी सामाजिक, आर्थिक स्थिति तथा वित्तीय स्थिति के परिपेक्ष्य में निर्धारित की जानी चाहिये। आवश्यकता पड़ने पर उसके आय के स्त्रोत के बारे में भी आवश्यक जानकारी प्राप्त की जा सकती है।

मध्यस्थ की भूमिका

मध्यस्थ चाहे वह अभिकर्ता हो या दलाल किसी भी उत्पाद की वितरण एवँ सेवा श्रंखला की महत्वपूर्ण कडी होते हैं। चूंकि वे बीमाकर्ता की तरफ से ग्राहक से

अंतर्व्यवहार करते हैं इसीलिये वह संबंधित आवश्यक जानकारियाँ प्राप्त करने में भी सक्षम होते हैं तथा उन्हें प्रस्तावक की आवश्यकता का प्रत्यक्ष अनुभव होता है।

एमएल की जाँच तथा निवारण तीन सुरक्षा रेखाओं से की जा सकती है। मध्यस्थ प्रथम रेखा का निर्माण करते हैं चूंकि वे ग्राहक से प्रत्यक्ष रूप से जुडे होते हैं औव उससे महत्वपूर्ण जानकारियाँ प्राप्त कर सकते सकते हैं जो कि एमएल गतिविधियों की स्थिति में जाँच का आधार होती है। यह किसी भी मध्यस्थ का महत्वपूर्ण दायित्व है कि वह किसी भी संदिग्ध गतिविधि को बीमाकर्ता की जानकारी दे।

हालांकि प्राधिकरण के दिशा-निर्देशो ने एएमएल पद्धति के प्रबंधन का दायित्व बीमाकर्ता पर डाला है, मध्यस्थ बीमाकर्ता की एएमएल पद्धति की आंतरिक भाग की संरचना करते हैं। मध्यस्थ से यह आशा की जाती है कि वे एक सक्षम केवाईसी कार्य प्रणाली द्वारा संबंधित सभी जानकारियाँ सही सही प्राप्त करें तथा बीमाकर्ता को सभी आवश्यक जानकारियाँ उपलब्ध करवायें।

असक्षम या असंतोषजनक केवाईसी कार्यक्रम मध्यस्थ को प्रत्यक्षतः प्रभावित करती है और अन्ततः बीमाकर्ता के लिये एमएल संबंधी जोखइम का कारण बनती है। ऐसे मध्यस्थ पर मुकदमा भी किया जा सकता है।

एमएल तथा जीवन बीमा

अन्तराष्ट्रीय तौर पर यह तथ्य काफी जोर पकड रहा है कि बीमा क्षेत्र भी पूंजी बाजार के अन्य संस्थानों जैसे बैंक, म्युचुअल फंड आदि की ही तरह एमएल पद्धति से काफी प्रभावित होता है। यह इस तथ्य के मद्देनजर कहा जाता है कि बीमा उत्पाद भी कुछ बैंकिंग उत्पादों की तरह ही संचित मूल्य प्रदान करती है तथा अपने व्यवसाय के लिये तीसरे पक्ष पर बहुत अधिक निर्भर करता है।

जीवन बीमा के द्वारा एमएल कई प्रकार से हो सकता है। इसका एक कारण यह भी है कि इसमें अधिकांश व्यापार मध्यस्थों के द्वारा किया जाता है, इस प्रकार बीमाकर्ता भी ग्राहक से प्रत्यक्ष व्यापार नही करता है। तकनीकी विकास ने भी एमएल की संभावनाओं को बढ़ावा दिया है।

एफएटीएफ द्वारा प्रकाशित रिपोर्ट इस बात पर प्रकाश डालती है कि किस प्रकार एमएल के लिये बीमा का उपयोग किया जाता है। यह रिपोर्ट एमएल की विभिन्न संभावनायें बताती हैं। जिसके अंतर्गतः

- एकमुश्त प्रीमियम प्रोडक्ट पॉलिसी का उपयोग
- समयपूर्व पॉलिसी का शोधन, विशेषतः जब समयपूर्व अलाभप्रद हो
- बीमाक्रय के लिये नगद भुगतान
- प्रीमियम वापसी की मांग- फ्रीलुक अवधि के दौरान
- ग्राहक तथा मध्यस्थ अथवा बीमा कंपनी के मध्य सांठ-गांठ
- तीसरे पक्ष के द्वारा प्रीमियम का भुगतान

एमएल गतिविधियों के लिये बीमा उत्पादों का प्लेसमेंट स्टेज तथा लेयरिंग स्टेज दोनों ही अवस्थाओं में प्रयोग किया जा सकता है। प्लेसमेंट स्टेज के दौरान नगदी का उपयोग किया जा सकता है जबकि लेयरिंग स्टेज के दौरान अवैध स्रोत से प्राप्त धन को, जो कि सिसी अन्य वित्तीय संस्थान में हो बीमा उत्पाद में निवेश करके आय के स्रोत को छुपाया जा सकता है।

एएमएल पर आईआरडीए के दिशा-निर्देश

आईआरडीए ने बीमा क्षेत्र के लिये एएमएल कारकों के लिये कुछ दिशा-निर्देश जारी किये गये हैं जो कि

जीवन बीमा के द्वारा एमएल कई प्रकार से हो सकता है। इसका एक कारण यह भी है कि इसमें अधिकांश व्यापार मध्यस्थों के द्वारा किया जाता है, इस प्रकार बीमाकर्ता भी ग्राहक से प्रत्यक्ष व्यापार नही करता है।

1. अगस्त 2006 से लागू होंगे। इनके अंतर्गत प्रमुख बिंदु निम्नलिखित हैः

- प्रत्येक बीमाकर्ता को एएमएल नीति बनानी आवश्यक है जिसके अंतर्गत निम्नांकित तथ्यों का समावेश होना चाहिये
  - एमएल गतिविधियों की जाँच तथा उनके निवारण हेतु आंतरिक नीतियो, नियंत्रण तथा कार्यप्रणाली
  - मुख्य अनुपालन अधिकारी की नियुक्ति
  - भर्ती और प्रशिक्षण
  - एमएमएल पद्धति का आंतरिक नियंत्रण तथा अंकेक्षण
- के वाई सी पद्धति की अमलावरी के लिये आवश्यक प्रक्रिया
  - ग्राहक की पहचान जिसके लिये उसकी पहचान तथा पते की जाँच हेतु संबंधित आवश्यक दस्तावेजों की प्राप्ति
  - वार्षिक 1 लाख रूपये से अधिक प्रीमियम देने वाले ग्राहक की विस्तृत जाँच पड़ताल
  - न्रगद लेन-देन के बारे में सतर्कता
  - भुगतान की अवस्था में भी के वाई सी पद्धति का उपयोग
- विभिन्न श्रेणियों के ग्राहकों के लिये जोखिम स्तर तालिका (उच्च, मध्य तथा निम्न जोखिम) का निर्माण करना तथा उत्पादों का भी उनके एमएल पद्धति से प्रभावित होने की आशंका के स्तर के अनुरूप वर्गीकरण।
- संदिग्ध लेनदेन की व्याख्या करना। यह शायद सर्वाधिक मुश्किल कार्य है क्योंकि अभी तक बीमा क्षेत्र में ऐसा कोई उदाहरण नही है विशेषतः भारत के संबंध में। हालाकि दिशा-निर्देश कुछ संदिग्ध लेन-देन की व्याख्या करते हैं फिर भी वक्त के साथ कुछ और लेन-देन संदिग्ध श्रेणी में आयेंगे।
- वित्तीय सतर्कता ईकाई को, पूर्वनिर्धारि व्यवस्था के अनुसार, सभी नगद तथा संदिग्ध लेन-देन की जानकारी देना।
- 10 वर्षो तक का रिकार्ड रखना।
- मध्यस्थों को के वाई सी के सख्त निर्देश तथा बीमाकर्ता के एएमएल कार्यक्रम का पर्यवेक्षण। मध्यस्थों द्वारा निर्देशों के अनुपालन में असफलता की स्थिति में उनके खिलाफ कार्रवाही करना।
- कर्मचारियों तथा मध्यस्थों के लिये एएमएल से संबंधित मुद्दों के लिये प्रशिक्षण की व्यवस्था करना।
- एएमएल पद्धति को आंतरिक जाँच पड़ताल ताकि उसकी सक्षमता की जाँच की जा सके तथा आवश्यक निर्देश दिये जा सकें।

एएमएल पद्धति संबंधित जोखिम

एएमएल पद्धति को विभिन्न श्रेणियों के ग्राहकों से जुडे जोखिम का संज्ञान लेना चाहिये क्योंकि किसी विशेष उत्पाद के द्वारा भी एमएल की संभावना होती है। एक जोखिम आधारित एएमएल पद्धति इसलिये भी आवश्यका है क्योंकि लेन-देन की संख्या बड़ी

भी हो सकती है। अतः ग्राहकों को उच्च तथा निम्न जोखिम स्तर की श्रेणी में वर्गीकरण किया जाना चाहिये। उत्पादों का भी जोखिम स्तर के अनुरूप वर्गकरण होना चाहिये। केवाईसी कार्यप्रणाली को ग्राहक के जोखिम स्तर तथा उसके द्वारा वांछित उत्पाद के जोखिम स्तर के अनुरूप प्रयोग में लाना चाहिये। उदाहरण के लिये वेतनभोगी ग्राहक को निम्न जोखिम जबकि एक आयात-निर्यात व्यापारी को उच्च जोखिम के अंतर्गत श्रेणीबद्ध किया जा सकता है। जोखिम का स्तर ग्राहक की भौगोलक स्थिति से भी प्रभावित होता है।

संगठनात्मक प्रभाव:

यद्यपि देखने में सरल प्रतीत होने वाला एक सशक्त एएमएल ढाँचा विकसित करने के लिये बीमाकर्ता को अपनी कार्यप्रणाली में महत्वपूर्ण फेर बदल करने पड़ते हैं। एएमएल ढाँचे से एक संस्थागत प्रभाव की अपेक्षा की जाती है। जिसमें कि वितरण, कार्य संचालन, ग्राहक सेवा, संगठन तथा प्रशिक्षण सभी शामिल हैं। इसका प्रभाव मध्यवर्तियों से लेकर केवाईसी पद्धति संचालकों पर भी पड़ता है। विभिन्न क्षेत्रों में पड़ने वाले इसके प्रभाव निम्नलिखित हैं:

वितरण

- अतिरिक्त जानकारी प्राप्त करने तथा उसके उचित अभिलेखन की प्रक्रिया
- ग्राहक की आय तथा संपत्ति के विवरण का अभिलेखन
- एएमएल मुद्दे से संबंधित अन्य जाँच योग्य तथ्य

संचालन / उत्तरदायित्व निर्धारण / ग्राहक सेवा

- उत्तरदायित्व निर्धारण प्रक्रिया में अन्तर्निहित एमएल निर्धारण
- लेन-देन पर सतर्क निगाह रखना तथा जहाँ आवश्यक हो सख्ती से काम लेना
- ग्राहक के व्यवहार तथा लेन-देन का सतत् विश्लेषण
- ग्राहक के पूर्व आपराधिक पृष्ठभूमि की जांच

सूचना तकनीक

- साधनों का नवीनीकरण तथा वृद्धि करना ताकि विभिन्न पहलुओं से उनका उपयोग किया जा सके
- कसी एक अथवा एक समूह से संबंधित ग्राहक की प्रति संदर्भित तथा प्रतिसंबंधित पॉलिसियाँ तथा लेन-देन
- संदिग्ध तथा काली सूची में डाले गये लोगों के नाम, धन संचय में देना तथा ग्राहक के बारे में इन आंकडों से जांच सुनिश्चित करना

प्रशिक्षण मानक

- एएमएल मुद्दों तथा मानकों का संबंधित कर्मचारियों तथा दलालों को प्रशिक्षण प्रदान करना तथा उन्हें इसके लिये संवेदनशील बनाना

निष्कर्ष

जैसे कि एक चीनी कहावत है हजारों मील की यात्रा पहले कदम से शुरू होती है। इसी प्रकार बीमाकर्ताओं के लिये एएमएल कहा जाने वाला एक लंबा रास्ता सामने है तथा यह एक शुरूआत है। एएमएल ढाँचे के निर्माण तथा संचालन हेतु साधनों तथा उच्च प्रशासकीय देख-रेख की आवश्यकता है ताकि एएमएल कानून के अंतर्गत निहित भारी दायित्व का सफलतापूर्वक निर्वहन किया जा सके। इसमें असफल रहने पर प्रतिष्ठा हानि के साथ-साथ, अधिकारी विनियमकों को अपना द्वार थपथपाते हुये तथा स्वंय पर अपराधिक कार्रवाइयों को आमंत्रित कर सकते हैं।

संवैधिानिक तथा विनियामक शर्तों की अमलावरी हेतु सच्चे अर्थों में नियमों की स्पष्ट जानकारी आवश्यक है ताकि इस अपराध की प्रकृति तथा भयावहता की लगाम कसी जा सके। बीमाकर्ताओं के लिये सामान्य तौर पर यह आवश्यक है कि वे एमएल की संकल्पना को समझें तथा इसकी पद्धति का विश्लेषण करे जो कि उनके संस्थान में एमएल जोखइम को कम करने के लिये अपनाना आवश्यक है। इसके लिये उद्योग में एक जोरदार बहस तथा चर्चा की आवश्यकता है जिसमें कि एएमएल को लागू करने के अनुभव तथा जानकारी का परस्पर आदान-प्रदान हो तथा उद्योग संगठनों का विनियामकों के साथ निरंतर संपर्क सुनिश्चित हो।

संवैधिानिक तथा विनियामक शर्तों की अमलावरी हेतु सच्चे अर्थों में नियमों की स्पष्ट जानकारी आवश्यक है ताकि इस अपराध की प्रकृति तथा भयावहता की लगाम कसी जा सके।

लेखक आईसीआईसीआई प्रूडेंशियल जीवन बीमा कंपनी में मुख्य वित्तीय अधिकारी तथा कंपनी सचिव हैं।

धन के अवैध लेन-देन की प्रक्रियाः

- बीमाकर्ताओं के लिये सीख

एस वी मोनी ने कहा है कि बाजार में लगभग पाँच दशकों के बाद यह तथ्य सामने आया है कि पहले बाजार हिस्सा सुरक्षा और उसके बाद जोखिम प्रबंधन सामान्य प्रक्रिया है। उन्होंने यह भी सुझाव दिया कि उद्योग क्षेत्र के साथ संपूर्ण देश के विकास के लिये एएमएल मानदंडों का ध्यान रखना महत्वपूर्ण है।

गत दशक में हम देख चुके हैं कि यदि व्यापार और वाणिज्य संबधी चुंगी वसूली पर रोक खत्म नही की गयी और देशभर में धन का निर्बाध प्रवाह नही रखा गया, तो विकास प्रक्रिया धीमी पड़ सकती है। इस स्थिति को दूर करने के लिये निम्नलिखित मुद्दे महत्वपूर्ण हैं:

- व्यापार विस्तार के लिये मदद
- पारदर्शिता में बढ़ावा
- प्रभावात्मकता के स्तर में वृद्धि और
- सर्वांगिण गुणवत्ता में सुधार

हालाँकि इससे देशभर में कुछ नुकसानदेह गतिविधियों के लिये पर्याप्त अवसर मिला। धन के अवैध लेन-देन का खास तौर पर आतंकवाद और नशीले पदार्थ के व्यापारा पर सामने आये प्रभाव से उसे हतोत्साहित नही किया जाना चाहिये। विश्व बैंक, एशियन डेवलपमेंट बैंक (एडीबी) और आईएआईएस जैसे अंतर्राष्ट्रीय संगठनों ने इस समस्या की पहचान कर विभिन्न देशों में किये जाने वाले लेन-देन को नियंत्रिण करने के लिये आवश्यक व्यवस्था भई ढूँढनिकाली। धन के लेन देन के दुरूपयोग से बचने के लिये बीमा क्षेत्र को संभावित प्रमुख माध्यम के रूप में पहचाना गया।

एडीबी ने इस मामले में महत्वपूर्ण कार्य किया है और धन के लेन-देन को इस तरह परिभाषित कियाः

यह संपत्ति का ऐसा रूपांतरण है, जो धन अथवा संपत्ति संबंधी सभी अथवा कुछ चुनिंदा अपराधों के लिये उपयोग में लाया जाता है, और राशि के मूल स्वरूप अथवा स्त्रोत को छिपाने के लिये प्रस्तुत किया जाता है। तस्करी, नशीले पदार्थों का व्यापार, हथियारों की खरीद-फरोख्त, घूसखोरी, अंतर्राष्ट्रीय घोटाले और संगठित अपराधों की गतिविधियों से बड़े पैमाने पर अवैध लाभ होता है और उनसे अर्थव्यवस्था में धन का प्रसार होता है। इस तरह के धन का दुरूपयोग विश्व में आतंकवादी गतिविधियों को अंजाम देने के लिये किया जाता है। इसलिये प्रत्येक देश एवँ प्रत्येक उद्योग का यह पहला कर्तव्य है कि इस तरह के धन के लेन-देन पर रोक लगायें।

यह लक्ष्य योग्य एवँ मजबूत व्यवस्था तैयार करने पर साध्य हो सकती है, जिससे अवैध गतिविधियों की पहचान भी की जा सके। खासतौर पर विकासशील देशों को इस बारे में अधिक सजगता बरतनी चाहिये।

मनी लांड्रिंग पर रोक लगाने अंतर्राष्ट्रीय मानक तैयार करने के लिये ओईसीडी ने फाइनांशियल एक्शन टास्क फोर्स (एफएटीएफ) का गठन किया है। एडीबी ने भी विभिन्न देशों के उपयोग के लिये एक टूल किट का विकास किया है। साथ ही एडीबी के कर्मचारियों की जानकारी में इस बारे में निरंतर वृद्धि करने के लिये

> मनी लांड्रिंग पर रोक लगाने अंतर्राष्ट्रीय मानक तैयार करने के लिये ओईसीडी ने फाइनांशियल एक्शन टास्क फोर्स (एफएटीएफ) का गठन किया है।

सामग्री की उपलब्धता, संसाधन केन्द्र एवँ प्रशिक्षण सुविधा के अलावा शिक्षा तथा ऑनलाइन फोरम के गठन पर भी ध्यान दिया जा रहा है।

आईएआईएस ने भी बीमा क्षेत्र से संबंध होने के नाते इस बारे में महत्वपूर्ण कदम उठाने के साथ कुछ आवश्यक कार्य पूर्ण किये हैं। इस लेख में मनी लांड्रिंग संबधी के लिये बीमा क्षेत्र में किये जा रहे उपयोग संबंधी संचालन पहलुओं से क्षेत्र में जानकारी दी गयी है। साथ ही बीमा क्षेत्र और कर्मचारियों के जरिये किये जाने वाले लेन-देन संबंधी जोखिम के बारे में जागरूकता लाने के लिये सभी को सहायता करने पर भी ध्यान दिया जाता है। इसके अलावा लेन-देन की गतिविधियों पर रोकथाम के लिये आवश्यक व्यवस्था तैयार करने के लिये भी सुझाव दिये गये हैं।

विभिन्न किताबों और दस्तावेजों में स्पष्ट किया गया है कि लेन-देन के लिये गैर जीवन बीमा क्षेत्रों की तुलना में जीवन बीमा क्षेत्र का उपयोग किये जाने की प्रबल संभावनायें हैं। आईएआईएस ने लेन-देन एवँ बीमा क्षेत्र के संदेहास्पद लेन की विस्तृत सूची जारी की है। इसमें दर्ज कुछ महत्वपूर्ण लेन-देन इस प्रकार हैं:

- प्रीमियम के अतिरिक्त प्रत्यक्ष साधन
- प्रस्तावकर्ता की बीमा जरूरतों के अनुरूप लेकिन अनियमित शर्तों वाले उत्पादों के विकल्प
- निवेश अंशदान में स्पष्ट बढ़ोतरी करने वाले आर्थिक लेन-देन
- प्रवासियों के खाते से निधियों का बड़ा प्रवाह
- अधिक निधि के परिणामतः ठेकों की शीघ्र समाप्ति खास तौर पर किसी अन्य के नाम
- असम्बद्ध व्यक्ति के नाम लाभ राशि का हस्तांतरण
- लाभार्थियों के बारे में गोपनीय परिवर्तन
- असम्बद्ध लोगों द्वारा प्रीमियम राशि का भुगतान
- नगद लेन-देन अथवा बड़े आर्थिक व्यवहार
- न्यायसंगत सूचना देने के प्रति अनिच्छा
- विभिन्न बीमाकर्ताओं के साथ कई पॉलिसियाँ
- भारी की एकल प्रीमियम वाली पॉलिसियाँ तथा नुकसान होने के बावजूद उन्हें शीघ्र रद्द किया जाना

एकल प्रीमियम तथा भारी लाभ वाले करार दुरूपयोग के लिये मुख्य रूप से इस्तेमाल में लाये जा सकते हैं। इसी कारण बीमाकर्ताओं एवँ मध्यस्थों को इन मुद्दों के बारे में अधिक सजग रहना चाहिये और लेन-देन से संबंधित पहलुओं की पहचान के लिये एक विशेष व्यवस्था तैयार करनी चाहिये।

निम्नलिखित परिच्छेद में कुछ मुद्दे दिये गये हैं:

आईएआईएस ने चेतावनी दी है कि प्रीमियम के भुगतान के साथ पॉलिसियों का रद्दकरण अवैध लेन-देन का सूचक कहा जा सकता है। किसी भी व्यक्ति अथवा अभिकर्ता द्वारा एक ही नाम से कई पॉलिसियों का उपयोग लघु राशि के भुगतान और भारी लाभ अर्जन के लिये किया जाना भी लेन-देन का सूचक

कहा जा सकता है। यदि इस प्रकार की पॉलसियों की नियमित अंतराल से खरीदी और रद्दकरण किया जाता है तो बीमाकर्ता को ऐसी गतिविधियाँ और प्रवृतियों की पहचान समय के भीतर करना महत्वपूर्ण होता है। सामान्य बीमा में प्रीमियम के जरिये भारी राशि का अतिरिक्त भुगतान और पुनःप्राप्ति की माँग को भी लेन-देन के महत्वपूर्ण स्त्रोत के रूप में देखा जाना चाहिये।

पॉलिसियों के लाभ असंबद्ध तीसरे पक्ष को हस्तांतरण भी लेन-देन का एक सुलभ मार्ग है। प्रीमियम में वृद्धि की जरूरत बाहरी क्षेत्र में कार्य करने वआले कर्मचारियों को इस तरह की गतिविधियों को अंजाम देने के लिये बाध्य कर सकती है। यह माना जाता है कि भारत में बीमाकर्ता किसी भी प्रकार के दबाव में आकर प्रीमियम में इस तरह की बढ़ोतरी को अनुमति देने में काफी सावधानी बरतते हैं। हालांकि यह तो समय ही बतायेगा।

हमने देखा है कि भारतीय बाजार में कीमैन के रूप में पहचाने जाने वाले बीमा की शीघ्र पूर्ति की पद्धति लेन-देन के लिये दुरूपयोग के लिये सहायक सिद्ध हो सकती है।

इसके कारण नियामक शीघ्र हस्तक्षेप के लिये प्रेरित होता है। कुछ स्थिति के प्रस्तुतीकरण के कारण इस तरह की गतिविधियों में कमी आयी है लेकिन अलग रूप में उनका अस्तित्व संभर है। इसी कारण कंपनियों एवँ नियामकों को सजग रहना जरूरी है।

आईएएस के दस्तावेजों में स्पष्ट किया गया है कि दलालों की उच्चाधिकार आयोग का भी उपयोग तीसरे पक्ष को लाभ पहुँचाने के लिये किया जा सकता है। भारत में आयोग एवँ दलालों पर लगाये गये नियंत्रण के कारण इस तरह की गतिविधियों का प्रतिशत कुछ कम है।

साधारण बीमा में अनियमितता वाले दावें एक ऐसा स्त्रोत हैं जिसमें सुधार की आवश्यकता है। गैर मौजूद माल परिवहन जहाजों से संबंधित समुद्री यात्रा बीमा के जरिये बड़े पैमाने पर लाभ अर्जित करने के लिये किया जाना भी लेन-देन का मुख्य आधार हो सकता है। इस प्रकार के दावे भी अनुचित लाभ की गतिविधियों की पहचान करने के लिये उपयोगी सिद्ध हो सकते हैं।

गैर कानूनी गतिविधियों में अपराधी अक्सर नियामकों अथवा जाँचकर्ताओं से कुछ कदम आगे रहते हैं। बीमा कंपनियों के जरिये लेन-देन मनी लांड्रिंग का माध्यम होने से बचाने के लिये और अवैध गतिविधियों का खात्मा ना सही, लेकिन उनकी रोकथाम के लिये सभी बीमा कंपनियों को पूर्व सूचना देने वाली एक व्यवस्था करना आवश्यक है।

सिफारिश किये गये प्रस्तावों में पूर बाजार के लिये गठित समिति को यह जानकारी नियमित रूप से देना आवश्यक है कि किस किस उपभोक्ता द्वारा संहेदाहस्पद लेन-देन किया जा रहा है। इस प्रकार की जानकारी के प्रति पूरी सजगता एवँ गोपनीयता बरती जानी चाहिये।

आईएआईएस द्वारा समय-समय पर प्रकाशित विभिन्न रिपोर्टों में दी गयी जानकारी एवँ किया गया विश्लेषण जिसे 'टाइपोलॉजीज' कहा जाता है, काफी महत्वपूर्ण है। इनमें निम्नलिखित शामिल हैः

1. एक मुश्त प्रीमियम पॉलिसी का उपयोग
2. बड़ी पॉलिसियों की शीघ्र पूर्ति
3. अवैध और गैर मौजूद वस्तुओं तथा संपत्ति संबंधी सामान्य बीमा दावों के घोटाले
4. प्रीमियम का नगद भुगतान, कभी कभी अभिकर्ताओं द्वार अपने चेक का नगद राशि में किया जाना वाला रूपांतर काफी खतरनाक सिद्ध हो सकता है
5. ग्राहकों एवँ बीमाकर्ताओं के कर्मचारियों अथवा अभिकर्ताओं के मध्य सांठ-गांठ
6. अभिकर्ताओं सहित तीसरे पक्ष द्वारा प्रीमियम का भुगतान तथआ तीसरे पक्ष को लाभ दिलाया जाना

यह भी पता तला है कि खरीदी (नगद भुगतान के लिये), बीमा सुविधा का लाभ, वितरण आदि जैसे बीमा करार दौरान भी मनी लांड्रिंग का जोखिम बना रहता है। इसलिये संभावित खतरों के क्षेत्रों की पहचान कर उन्हें बीमा चक्र से दूर रखना एवँ एक निरीक्षण प्रक्रिया तैयार करना आवश्यक है।

> बीमा सहित वित्तीय सेवाओं में कार्यरत कंपनियों के लिये बीमा सुविधा के जरिये धन के अवैध लेन-देन की रोकथाम के लिये समाधानपूर्ण मानकों की स्थापना करना और उन्हें सुनिश्चित करना जिम्मेदारी से भरा कार्य है।

इस परिप्रेक्ष्य में ग्राहकों की संपूर्ण व्यक्तिगत जानकारी एकत्रित करना महत्वपूर्ण है। इसी के तहत केवाईसी (अपने ग्राहक को पहचानो) योजना के निर्देश खामियों की पहचान का मुख्य हथियार सिद्ध हो सकता है। लेन-देन के मद्देनजर ग्राहकों का बर्ताव और वर्गीकरण ध्यान में रखना भी आवश्यक है। अभिकर्ताओं द्वारा सौंपी जाने वाली गोपनीय रिपोर्ट, क्षेत्र संबंधी जानकारी, भारी बीमित राशि संबंधी ग्राहक के आय के स्त्रोतों के बारे में जॉच-पड़ताल, किसी उत्पाद अथवा उत्पाद के विकल्पों का चयन (शीघ्र पूर्ति के संदर्भ में) पॉलिसी की अवधि में किसी भी समय प्रस्तावित लाभार्थी के नाम में परिवर्तन, बीमा राशि के बारे में शीघ्र दावे, प्रीमियम भुगतान के लिये विभिन्न चेकों का उपयोग, पॉलिसी के बारे में बड़े टॉप अप आदि संबंधई पारंपरिक तथा गुणवत्तापूर्ण मानक इस व्यवस्था में ऐसे क्षेत्र हैं जिनमें मनी लांड्रिंग के मामलों की प्रबल संभावना होती है और उनकी पहचान होना भी जरूरी है। बीमाकर्ता को भी इन पहलुओं को गंभीरता से लेते हुये करार प्राथमिक स्तर पर ही आवश्यक जॉच करनी चाहिये।

जोखिम प्रबंधन में आने वाली समस्याओं के रूप में पहचाने गये क्षेत्रों के साथ उन तक पहुँच एवँ उनके बारे में जानकारी देने वाले स्त्रोतों का पुख्ता प्रबंध होना चाहिये। हम देख चुके हैं कि बाजार में पाँच दशकों के बाद पहले बाजार हिस्सेदारी की सुरक्षा एवँ उसके बाद जोखिम प्रबंधन की आवश्यकता की खोज अपने आप हो रही है। उद्योग के साथ समूचे देश के लिये एन्टी मनी लॉड्रिंग (एएमएल) विरोधी प्रावधान महत्वपूर्ण है।

बीमा सहित वित्तीय सेवाओं में कार्यरत कंपनियों के लिये बीमा सुविधा के जरिये धन के अवैध लेन-देन की रोकथाम के लिये समाधानपूर्ण मानकों की स्थापना करना और उन्हें सुनिश्चित करना जिम्मेदारी से भरा कार्य है।

प्रत्येक बीमाकर्ता के लिये भी अपने संस्थान के सभी स्तरों पर जागरूकता लाने के लिये आवश्यक कदम उठाना महत्वपूर्ण है। साथ ही एमएल जैसी गतिविधियों को रोकने के लिये कंपनी की समूची प्रक्रिया में अपने कर्मचारियों के साथ ही बाहरी क्षेत्र में कार्यरत लोगों को भी निर्धारित मानकों की अमलावरी के लिये प्रोत्साहित किया जाना चाहिये। यदि कोई बीमा व्यवहार इस तरह की अवैध गतिविधि के लिये उपयोग में लाये जाने का मामला समय रहते सामने नही आया तो कंपनी की प्रतिष्ठा पर आँच आने के साथ ही उसके गंभीर वित्तीय संकट में भी फँसने की प्रबल संभावना रहती है। विचारणीय कार्य हमेशा अंतर्राष्ट्रीय एजेंसियों या आईएआईएस के जरिये गठित किया जाना चाहिये। सरकार ने इस बारे में विधान पहले ही जारी किया है, और आईआरडीए ने भी इस क्षेत्र के बारे में दिशा निर्देश जारी किये हैं।

बीमा कंपनियाँ एवँ कर्मचारी विशेष रूप से वरिष्ठ प्रबंधन तथा निदेशकों को बीमा क्षेत्र के संवेदनशील क्षेत्रों के बारे में सजग रहना आवश्यक है। साथ ही स्थान एवँ अमलावरी के प्रति भी बारीकी से नजर रखने के अलावा सुरक्षा के आवश्यक उपाय करना भी अनिवार्य है। इसमें कोई दो राय नही है कि अतिरिक्त काम एवँ खर्च एवँ दिशा-निर्देशों और जोखिम प्रबंधन की अमलावरी के प्रति लापरवाही का खामियाजा निश्चित ही अधिक होगा।

लेखक जीवन बीमा परिषद के महासचिव हैं।

Report Card: GENERAL

G. V. Rao

27.5 percent - An unprecedented business growth in May 2006!

The non-life industry has recorded, in May 2006, an unprecedented monthly growth rate of 27.5 percent. This number has broken all the previous records for the monthly growth rates. The monthly performance in May 2006 has also pushed up the cumulative growth rate of the market up to May 2006 to 21.67 percent, yet another landmark in the business progress of the non-life industry.

What has caused this surge in the growth rate in May 2006? The impressive performance of the new players, aided by an improved performance by the established players is the answer. The new players have pushed up their market share to 35 percent, up from the previously held 27 percent till the end of the fiscal 2005/06. They have held the market share of 35 percent consistently in each of the months, April and May 2006.

Like it performed in April 2006, ICICI Lombard has maintained the dominance of the market in May 2006 as well, with a contribution of about 33 percent to the total market accretion of Rs.435 crore. It has added Rs.128 crore in April to the market accretion of Rs.384 crore; in May 2006, ICICI Lombard has added Rs.141 crore to the market accretion of Rs.435 crore. This has pushed up its market share from 8.2 percent to 12.5 percent. Its monthly

GROSS PREMIUM UNDERWRITTEN FOR AND UP TO THE MONTH OF MAY 2006

(Rs.in lakhs)

INSURER	PREMIUM 2006-07		PREMIUM 2005-06		GROWTH OVER CORRESPONDING PERIOD OF PREVIOUS YEAR
	FOR THE MONTH	UP TO THE MONTH	FOR THE MONTH	UP TO THE MONTH	
Royal Sundaram	4694.81	11202.17	3205.63	8280.00	35.29
Tata-AIG	6271.85	17098.73	5089.09	12812.31	33.46
Reliance General	3987.51	11014.03	1014.26	4062.52	171.11
IFFCO-Tokio	11964.86	24107.11	6923.64	16574.09	45.45
ICICI-lombard	25901.41	58951.95	11798.50	32016.14	84.13
Bajaj Allianz	14265.46	32529.48	9862.61	22854.73	42.33
HDFC CHUBB	1478.81	3068.36	1147.03	2543.32	20.64
Cholamandalam	2640.04	5866.85	2177.46	5745.68	2.11
New India	37624.00	97622.00	33100.00	84617.00	15.37
National	29691.00	66205.00	27828.00	64071.00	3.33
United India	31237.00	70954.00	28025.00	66081.00	7.37
Oriental	31784.00	73108.00	27846.00	68051.00	7.43
PRIVATE TOTAL	71204.76	163838.67	41218.21	104888.79	56.20
PUBLIC TOTAL	130336.00	307889.00	116799.00	282820.00	8.86
GRAND TOTAL	201540.76	471727.67	158017.21	387708.79	21.67
SPECIALISED INSTITUTION:					
ECGC	3538.69	7669.87	3903.56	8717.15	-12.01
Star Health & Allied Insurance*	3.81	3.81			

*** Commenced operations on 18th May, 2006**

premium in May 2006 was Rs.259 crore, nearly 83 percent of the monthly premium of United India of Rs.312 crore; and 81.5 percent of Oriental of Rs.318 crore. Is this new player, ICICI Lombard, closing in faster than expected on the established players?

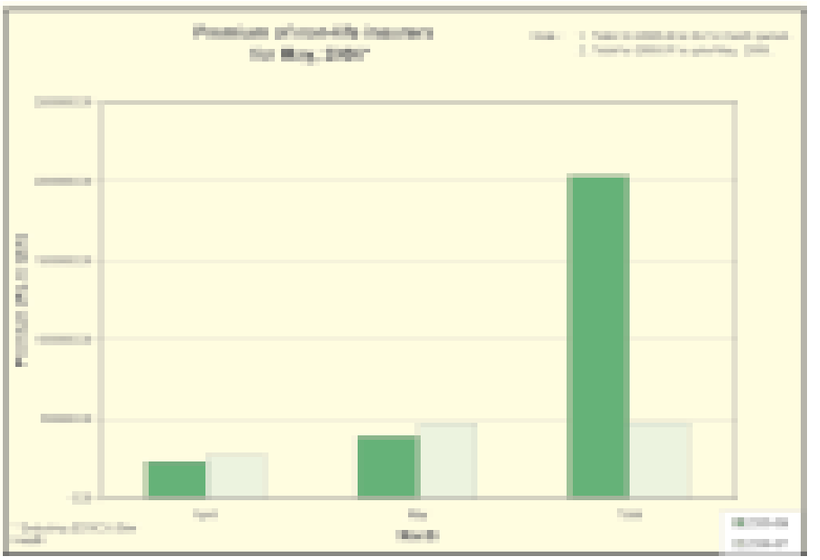
Performance in May 2006:

The non-life industry grew in May 2006 by Rs.435 crore (27.5 percent). The new players grew by Rs.300 crore and the established players by Rs.135 crore. ICICI Lombard has added Rs.141 crore to the total accretion of Rs.435 crore; followed by IFFCO Tokio with Rs.51 crore and New India by Rs.45 crore. The disparity in the accretion rates among these top three players is indicative perhaps of the struggles and the strategies adopted to gain prominence at the market place. The wide variation in the accretion rates cannot be explained otherwise.

Reliance is the latest new player that has suddenly veered into the fast track growth channel. In April 2006 they have added Rs.40 crore to their monthly premium; in May they have added yet an additional Rs.30 crore, taking their cumulative growth rate to the top rank of the table. The premium of Reliance has zoomed up in two months by Rs.70 crore from a cumulative Rs.40 crore held earlier. The fast track channel suddenly seems to be getting crowded.

The established players have indeed done better in May 2006 compared to their previous performance standards. Their cumulative growth rate has gone up to 11.5 percent in May 2006 from the previous month's 5.6 percent growth rate. While they are improving their growth rates by very impressive margins, the market seems to be surging even faster, due to the more competitive efforts by the new players. It is now beginning to look like a race, wherein the level playing field is getting evened out faster than expected.

National Insurance has at last emerged into the green channel of growth in May 2006. The rigors and compulsions of the previous year have hopefully served its particular needs of pruning the quality of business accepted. The established players, having reached out for faster growth in May, one does hope that this trend will accelerate in the future months, making the Indian insurance market more vibrant and attractive for the fence-sitters from abroad to plunge in. For the



consumer, a higher growth rate signifies that insurance density and penetration levels are going up and up. Industry is serving a wider market.

Performance up to May 2006:

A growth rate of 21.67 percent as at the end of May 2006, from the previously held 16.55 percent as at April 2006 is a superb performance, considering the level of improvement in the growth rate. The accretion in market premium is Rs.840 crore; the new players having chipped in with Rs.590 crore and the established players with Rs.250 crore.

Among the top five accretion earners up to May 2006 are: ICICI Lombard that dominates this growth with an accretion of Rs.270 crore; New India, the next ranked insurer contributing an accretion of Rs.130 crore; Bajaj Allianz which has added Rs.97 crore; IFFCO Tokio with an accretion of Rs.75 crore; and Reliance with Rs.70 crore.

ICICI Lombard with Rs.590 crore, Bajaj Allianz with Rs.325 crore and IFFCO Tokio with Rs.241 crore are clearly ahead among the new players. Tata AIG with Rs.171 crore is the fourth ranked new player. Reliance is catching up to move ahead of Royal Sundaram to emerge as the fifth ranked one. There seems to exist a fierce race for business growth judging that the market premium levels are zooming up.

Market shares:

The new players have raised their market share to about 35 percent up from 27 percent last year. They are holding on to this number steadily. The established players have given up about 7.5 percent of the market share. Oriental and United India have lost 2 percent each. National has lost 2.5 percent and New India a little more than 1 percent.

ICICI Lombard has improved its market share from 8.2 percent to 12.5 percent - the biggest beneficiary of the change in the market share. Bajaj Allianz has gained 1 percent and IFFCO Tokio 0.7 percent.

ECGC seems to have hit a bad patch on the growth front. Star Health has made its debut with about Rs.4 lakh in May 2006.

Final word:

The market buoyancy now being witnessed is indeed a piece of welcome news. Both the new players and the established players seem to have hit the groove of the brisk growth path. That is another plus. That the new players have done well in the liberalized environment and quite a few of them have begun to make profits is another good augury. The Indian market has grown to be very vibrant in 2006/07 and that is the cumulative contribution of all the players in the game.

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

CHALLENGING RISKS FOR EVENT INSURERS

Fresh challenges are confronting insurers, who undertake financial risks of sports and other events. With major events such as cricket tournaments taking place throughout the year, despite bad weather; providing cover for the success of such events has become a different 'ball game' for the insurers, it is reported.

Apart from the forecasts of inclement weather, insurers are now also taking a look at such details as the quality of protective covers at the grounds, efficiency of drainage systems, seepage of the soil etc. which actually matter for the probability of the game taking off. For example, in a scenario of overnight rain, a ground deployed with better equipment may not find it difficult to see the game starting on time the next day whereas even with a lesser rainfall, play may have to be called off on account of poor drainage system and the likelihood of inundation of the playing arena in another case.

As against the insurance companies traditionally looking at factors like weather, political risks, terrorism risk etc., insurers are now additionally sensitive to the ground conditions, likely timing of the rainfall, readiness to face nature's vagaries etc. The premiums are likely to be higher in case of grounds with poorer facilities as in many Indian venues, it is reported.

COVER FOR UNSUCCESSFUL STERILISATION SURGERIES

Several reports of sterilization surgeries conducted at various welfare centers across the country being unsuccessful are nothing new; and in order to face such an eventuality, the health and family welfare ministry has purchased an insurance policy for Rs.9 crore, as per reports. It aims to compensate the victims of failed sterilization surgeries.

Under the scheme, a compensation of Rupees One lakh would be payable in case of death of a married person, although there is no assurance of any payment for maintenance of the child who is born in spite of the protective surgery. In a significant verdict last year, the country's highest court directed the states and the centre to frame a suitable compensatory package for monetary relief to victims of failed surgeries, as the sterilization methods are not absolutely fool-proof, reports say.

OPTION FOR HEALTH INSURANCE COVER FOR GOVT. EMPLOYEES

Serving employees of the Government of India; and retired civil servants will be shortly given the option of obtaining health insurance cover from private sector insurance companies, as per reports. This is under a scheme that the government is rolling out for such of those employees who are not covered by the Central Government Health Scheme (CGHS).

The scheme is likely to cover around three million central government employees and retired persons. The entire scheme is expected to be to the tune of around Rs.600 crore, for which the public sector companies as well as the private insurers, are in the race. The scheme is likely to be finalized in the next couple of months, it is reported.

GOOD RESPONSE FOR MEMBERSHIP OF INSTITUTE

The IRDA and the Indian Institute of Insurance Surveyors and Loss Assessors (the 'Institute') had invited applications for membership of the Institute. The response has been very good and the authority has received around five thousand applications for membership of the Institute. The processing of the applications is on and as soon as it is over, the list containing the exact number and other details would be hosted on the website of IRDA for the information of all concerned, followed by forwarding individual communication to the applicants.

AGENTS' TRAINING INSTITUTE

In consideration of the comments and suggestions received by the Authority in response to the existing on-line training institute guidelines notice dated 24th May, 2005, it has been decided by the Authority to issue the following addendum to the existing guidelines:

- Opening of more than one Login (multiple Login) on the same computer as well as Login by same user ID/ password on different machines at the same time is not permissible.
- The Training Institutes must have only one domain to launch the IRDA accredited online training for Life and General Insurance. Use of more than one domain is not permissible.

All the existing accredited on-line training institutes have been advised to comply with the above additional requirements latest by 15th September, 2006; and have been cautioned that non-compliance would entail withdrawal of accreditation.

WORKING GROUP TO EXAMINE INVESTMENT REGULATIONS

The IRDA (Investment) Regulations 2000 were, after notification, subsequently modified partially in the year 2004. The KPN Committee on amendments to Insurance Act, 1938 has also recommended a re-look at the statutory provisions on the pattern of investments prescribed for insurers and has suggested amendments that would provide flexibility to the Authority in the manner of regulation on investments of insurance companies. With the expansion of the financial sector and introduction of new financial instruments, a need was felt for considering requests for investment in such instruments and derivatives and for developing appropriate regulatory framework.

IRDA has therefore decided to form a Working Group to examine the existing investment regulations and to review comprehensively the current statutory prescriptions and pattern of investments for insurance companies; and to suggest changes considered necessary in the light of experience gained, developments in financial markets and the genuine constraints faced by insurance companies. Further, the group will look into the structure of the prescribed returns and suggest modifications as may be considered necessary. The working group would be chaired by Mr. C.R. Muralidharan, Member, IRDA; and will comprise of executives drawn from various insurance companies as its members.

CODE OF CONDUCT FOR AGENTS ON THE CARDS

The Life Insurance Council is coming out with a Code of Conduct for the agents in the life insurance industry, it is reported. Once the code comes into operation, agents will have to be careful with their market practices with regard to interpretation of clauses, coercing a prospect into buying a product or while criticizing a rival insurance company. The Council was assisted by the CEOs of insurance companies in finalizing the code.

The Council is also setting up a committee of professionals to deal with complaints between different insurance companies, other than third party complaints. The purpose of the Code of Conduct for agents is to serve as a deterrent against unhealthy practices sometimes adopted by rival insurance companies; and it would also deal with specific guidelines on agent training and customer service.

Among other things, focus would be on product literature which should be devoid of making false promises regarding guaranteed returns or bonuses and also preclude any hidden charges. The code also envisages specific guidelines for ULIP business and insists on specialized training for agents undertaking ULIP sales. The entire system is aimed at increasing the awareness levels in the industry and to rule out any negative propaganda by the agents, it is reported.

INSURANCE REGULATORS SEEK HELP

The insurance regulators in the US are seeking help from the Congress in finding ways to help states, insurers and homeowners to be better equipped in dealing with catastrophes like Hurricane Katrina, as per reports. A resolution was adopted by the National Association of Insurance Commissioners (NAIC) proposing a Federal Natural Catastrophe Preparedness Commission.

The association is demanding the panel to consider the creation of a national catastrophe fund which would act as a backstop to private insurance companies so that they are encouraged to continue to remain in business. The resolution is an aftermath of the huge property insurance losses to the tune of nearly US $60 billion last year. There is forecast of a turbulent hurricane season this year as well; and alarmed by the severe hurricane losses, insurance companies are hesitant to renew several thousands of homeowners' policies in the coastal areas of Florida, Texas, New York etc.

The premiums, naturally, have undergone a steep rise; and some companies are excluding the coverage of earthquake related losses in order to cut down on catastrophe losses. The Head of NAIC, Mr. Alessandro Iuppa is reported to have said that no place in the country is totally immune to natural disaster; and that a federally coordinated program is the best way to tackle the threats from hurricanes, earthquakes and floods.

In light of the strict reservation that insurers are exercising in renewal of the contracts, the state-run insurance company in Florida is expected to become the state's biggest property insurer. The private insurers are required to pay more for their reinsurance covers, which is also adding to the overall costs. The NAIC, reportedly, wants the proposed commission to consider issues such as incentives for states to adopt stronger building codes that would make them more resistant; incentives for property owners to retrofit existing homes and buildings to make them stronger etc.

MAJOR HURRICANE SEASON IN THE OFFING

Close on the heels of the last year's major hurricanes; another active season is on the cards for the US Atlantic basin, as per reports. A forecast team of the Colorado State University maintained its earlier predictions of the severe storms. A total of seventeen storms are likely of which at least nine are predicted to become hurricanes. Within these nine, five may be touching severe intensity, as per their predictions.

There were a total of 27 storms last season, with the tropical cyclone activity of around 275% of the annual average. For 2006, the estimates are that there will be 195%, (i.e. almost twice) of the average season. Prof. William Gray of the university is reported to have commented that if the atmosphere and the ocean behave as they have done in the past, an active season is imminent; although it could not be taken to mean that it would produce storms with as much destruction as the ones witnessed last year.

The active period of Atlantic major hurricane activity is likely to continue for the next two decades almost, although it is unlikely that the impending season or the subsequent ones would have as many major landfall events, reports say.

SIGNIFICANT RISE IN M&A ACTIVITY IN 2005

The Mergers & Acquisitions activity took an upward surge during the year 2005, recording the highest incidence in the last five years, as per reports. It may be indicative of further acceleration of the activity during the coming years, as the study puts it. The continuing increase was spurred by a number of factors - like solid profitability, strong stock performance etc. The advantages of scale also added to the rise.

The M & A transactions went up to 324 during the year 2005, totally amounting to a whopping US $51 billion, thereby far exceeding the 2004 figures. Property and Casualty domain recorded a strong performance in public offerings, including secondary offerings, reportedly.

REQUEST FOR DROPPING MALACCA STRAIT FROM WAR LIST

There is an urge to drop Malacca Strait from the Lloyd's list of war-risk areas, in view of piracy attacks having come down sharply, as per reports. Considering the recent figures of the incidence of piracy and other such activities, there is no justification to its continuance in the list, as per Noel Choong, Head of International Maritime Bureau (IMB). The drop in such incidents has been the result of active patrolling by Malayasia, Singapore and Indonesia, it is reported.

A Joint War Committee of Lloyd's Market Association has earlier added a list of several areas, which were prone to threats to security in shipping activities. This resulted in insurers increasing premiums in view of the higher risks. Despite being one of the busiest waterways, Malacca strait has not reported any major armed robbery during this period, prompting the urge to delist it, as per reports.

PRIVATE HEALTH INSURERS OF GERMANY WEAN AWAY FROM COALITION

The private health insurers of Germany are not inclined to join a proposed communal fund to pay the future health bill, it is reported; while their participation is being looked up to as very crucial for the successful reform of the country's healthcare system.

The proposed Healthcare reform that tests the success skills of the coalition government on domestic policy promises has become a contentious issue in the country. The private health insurers who are presently serving about eight million people belonging mainly to upper strata of the society feel that the health fund would deal a death blow to their business interests; and hence their reservation, as per reports.

FURTHER RISE IN CAR CRASH DEATH RATE FOR SENIORS

The number of deaths of senior citizens in car accidents is likely to go up in the years to come, reportedly. Even as per the present statistics, this segment of the population is second only to that of young people (below age 24). A study undertaken by a university professor indicates that the higher number of accidents is on account of this group being more susceptible to accidents.

The study also reveals that the woman to man ratio is also likely to go up steeply as the age progresses; and as women tend to be more frail, it would make them more vulnerable. Some of the interesting findings of the study included the following:

- Senior citizens dying in car accidents are more likely to die of chest injuries.
- In the younger group, head injuries are likely to cause the deaths.
- Frailty or pre-existing conditions played a significant role in the fatal accidents in the older group.
- Injuries or fatalities in car accidents in the older group are higher despite such precautions as driving at a lower speed; wearing a seat belt etc.

The study recommended to the government and the industry officials that these points should be borne in mind while designing the dynamics of the cars, possibly leading to creation of better crash avoidance systems, it is reported.

"The Third meeting of South Asian Insurance Regulatory Forum (SAIRF) was held in Kathmandu, Nepal in April 2005."

Photograph shows Mr. C.S. Rao, Chairman, IRDA and Mr. Madhav P. Upadhyay, Chairman, Insurance Authority of Nepal engrossed in serious deliberations at the meeting.

Exchange of mementos between the two Chairmen as a goodwill gesture.

"The Fourth meeting of SAIRF was held in Thimpu, Bhutan in April 2006."

Photograph shows Mr. C.S. Rao, Chairman, IRDA in a discussion at the meeting.

Delegates of various SAIRF countries.

Events

16-19 July 2006
Venue: Chicago - IIS Annual Seminar
By International Insurance Society,
New York

17-19 July 2006
Venue: Pune
Underwriting in Detariff Regime
By NIA Pune

24-26 July 2006
Venue: Pune
Workshop on Reinsurance
By NIA Pune

27-29 July 2006
Venue: Pune
Financial Risk and Insurance Derivatives
By NIA Pune

30 Jul-02 Aug 2006
Venue: Meiji University, Tokyo
APRIA Conference
By Asia-Pacific Risk & Insurance Association,
Singapore

03-05 Aug 2006
Venue: Pune
Program on Marketing Strategies
By NIA Pune

07-12 Aug 2006
Venue: Pune
HRD for Line Managers
By NIA Pune

17-19 Aug 2006
Venue: Pune
Ethical Values in Human Capital
By NIA Pune

24-25 Aug 2006
Venue: : Mumbai
Life Insurance Summit in Asia
By Asia Insurance Review, Singapore

24-26 Aug 2006
Venue: Pune
Alternate Grievance Redressal Mechanism
By NIA Pune

28-29 Aug 2006
Venue: Mumbai
Bancassurance & Alternative
Distribution Channels
By Asia Insurance Review, Singapore

"The higher costs of providing insurance could be attributed to various forms of insurance fraud, including identity theft and the perpetration of criminal syndicates with insider networks."

- Mr Bassel Hindawi,
Director General for the Insurance Commission of Jordan

"Whether the taxpayers live in Chicago, Illinois or Pierre, South Dakota--we are all going to be paying for many years for the rebuilding of the Gulf region…and unfortunately given the lack of any comprehensive national approach to this problem, we all could be paying the bill for this year's hurricanes too."

- Michael McRaith, Illinois' insurance regulator

"The better consumers understand their health insurance options, as well as their share of the costs for premiums, co-pays and deductibles; the better they'll be able to plan for health related expenses."

- Alessandro A. Iuppa,
President, National Association of Insurance Commissioners (NAIC).

"It is not that the regulator wants more powers. The Insurance Act (in India) is a 1938 legislation. Some of the clauses have become redundant and some have to be updated to meet the current reality."

- C.S. Rao, Chairman,
Insurance Regulatory and Development Authority (IRDA).

"Regulators can play an active role by encouraging the supply of catastrophe insurance capacity in the market, promoting an effective distribution network for catastrophe insurance and improve transparency, clarity and certainty of catastrophe insurance."

- Richard Yuen, Office of the Commissioner of Insurance, Hong Kong.

"It is unfair to compare the health program with other insurance polices that cover accidental and death compensations as their rates are calculated on a different basis."

- Chu Tung-kuang,
Convener of the Department of Health, Taiwan.

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