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Grievance handling in Insurance Industry

– For better customer relationship and good governance

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From the Publisher

Grievance Handling in Insurance Industry

"How you think about your customers influences how you respond to them"

-- Marilyn Suttle

Any industry which is not responsive to the interests of its customers cannot succeed and insurance industry is no exception to this principle. To know what the interests of their customers are - one need to put themselves in the shoes of its customers and listen to them carefully. Just understanding and getting feedback from customers is not enough; the industry need to be prompt, careful and dedicated in its efforts to serve its customers.

In insurance, the interests of policyholders are supreme. All decisions of Regulator – be it Regulations, circulars, guidelines, orders all revolve around protection of those interests. Insurance being a service-oriented industry, dealing with policyholder grievances is a critical function of any insurer/ insurance intermediary. The Insurance Ombudsmen System that implements the Redressal of Public Grievances Rules, 1998, the Protection of Policyholders Regulations, the Guidelines on Grievance Redressal and the Integrated Grievance Management System of the IRDAI are all intended to put in place a robust mechanism of expeditious grievance redressal. Each insurer/ insurance intermediary too have their own Grievance Redressal systems in place. All these put together have though succeeded to a large extent in satisfactory settlement of grievances, the timelines need to be strictly adhered to so that the policyholder is not made to wait beyond the prescribed timelines.

The Draft Indian Financial Code also proposes setting up of a Financial Redress Agency as a single Grievance Redressal Platform encompassing all financial services, work on which is underway in the Government.

The Articles published in the current issue have covered several issues relating to handling of grievances in insurance industry. Keeping in view the importance of Agriculture in our country, **Crop Insurance** will be the focus of next issue of the Journal.

T.S. Vijayan

ISSUE FOCUS

A take off from Curtain Raiser

Grievance handling in Insurance Industry

In Good old days, kings in monarchy form of governance used to hold open Durbar/ Court to listen to grievances of their subjects which was marked by instant Decisions. In fact they were looked upon as Dispenser of Justice. These indirect informal ways of handling Complaints gave way to Rules & Regulations in Modern times. With Constitutional Democratic Governments in place where Citizens welfare took Centre Stage, Grievance Handling took also a definite shape with an objective for prompt redressal of complaints by Service Providers . Insurance Industry In general has been continuously updating Grievance handling Machineries from time to time towards settlement of various Complaints of Policyholders/ Stakeholders. Use of Information Technology & latest Mobile Technology have ensured qualitative & quantitative changes as far as Complaints handling machinery with Insurers & Regulator is concerned. However no amount of technology can replace the personal attention to the aggrieved policy holder, sensitivity and prompt responsiveness in customer relationship management which form the soul of grievance handling. This also requires sentitilization at all levels of the organisation towards customer, not just frontline staff.

With Growing volume of business & increasing penetration of insurance in our country, IRDAI has been playing a significant role in grievance handling by Insurers & other Stakeholders in the Industry. It is hoped that all these will evolve to "Citizen's Charter" on the part of insurers towards Good Governance in time to come.

B.K. Sahu
Consultant, Communication

ISSUE FOCUS

A Conceptual Framework for Integrated Approach towards Grievance Handling in Insurance Services

- Girijesh Pathak

Abstract:

Grievance handling in Insurance Service is such a function that requires an integrated approach covering the entire life cycle of grievance; starting from reasons of grievance generation to satisfactory closure of them and also recycling back the experience to various functions to minimize the reasons of grievance generation.

Grievance can happen due to any reason. It may be due to lack of awareness at the customer level or may be due to wrong information at any stage of service to the customer or may be some genuine issue related to service process or may be anything else. But, if the grievance handling system works on the grievance when it gets generated and closes the matter when the grievance gets closed, then such system is badly incomplete.

This article walks through grievance life cycle and various functions related to Insurance service and prepares a conceptual framework that can be helpful in meeting aspirations of the customers from Insurance Industry. Thus, leading to minimized grievances and an effective grievance handling.

Grievance Life Cycle:

Grievance has a life cycle. That is why it is necessary to have an integrated approach towards grievance handling rather than just completing some process of grievance settlement. The life cycle of grievance starts the moment a service provider intends to provide services to service seekers by pull or push. Seeds of grievance can get sown at the very initial stage of understanding the insurance needs and designing various insurance products or services. Understanding customers' expectations and making them fully aware so that service starts with full understanding is a big challenge. There can be miss-selling. Important information can be hidden. Certain terms can be miss-explained or miss-interpreted. There can be some hidden agenda at the customers level as well as insurers level. Ensuring that the terms, conditions, expectations and procedures have been thoroughly understood by both the parties require proper provisioning for these in the system. These are some of the stages in the pre-contract phase of the grievance life cycle.

Insurance service is a contract that is valid for a time period as per the terms and conditions of the contract. There is no issue as long as both the parties keep meeting their obligations. One can default here either because of some misinformation or misunderstanding or intentionally. There can be lack or delay in service that can be mostly related to providing information or documents. Use of technology with proper control and triggers is very helpful in preventing such incidences.

Insurance contract is to cover certain risks and if the risk gets

materialized, claim has to be paid as per the contract terms and conditions. Very large number of grievances happen because of difference in understanding between insured and insurers about the cause of loss, whether the cause is among the covered risks, extent of loss, validity of contract etc. during claim handling. All these are again, related to providing information in complete way at various stages before and during the contract.

Hence the Pre-grievance phase is mostly related to understanding the requirements and providing information in transparent way. Lack of these lead to uneasiness and dissatisfaction. This worsens to grievance if left unattended.

Once, grievance happens, it enters in the phase of grievance settlement. There has to be a friendly system for grievance intimation, communication, feedback and grievance escalation. There can be benchmarks and set timelines for each of the steps in the grievance handling phase. Once again, keeping customers informed and having time bound steps in grievance handling and escalation can significantly ease the intensity of grievance.

Closing the grievance after its settlement offers an opportunity to the Insurance service providers to capture some important inputs for their functions like product design, requirement understanding, customers insurance awareness etc.. For example, there are some common reasons for rejection of health insurance claims. Many rejections due to such common reasons lead to grievance because either the customer is not aware or he has set a wrong expectation. Each grievance settlement provides important inputs about the information that need to be made available to customers and also the mode and frequency of these information. May be that displaying top reasons of claim denial in health insurance at hospitals, in various forms and some public places can lead to better grievance management. Hence, closure of grievance can have two parts. One is the formal closure from customers and all other related agencies. And other may be related to identifying the inputs from this experience for various functions of Insurance service.

Thus, grievance life cycle starts with the initial activities like understanding insurance needs, risk involved, product design, customers awareness etc.. Then moves into selling the product, having insurance service contract, providing the services, information management and so many operational activities. If, grievance takes place, it needs to be settled and then it gets recycled into the initial activities like understanding insurance needs, risk involved, product design, customer awareness etc..

Conceptual Framework of Insurance Functions:

Diagram 1, below presents a conceptual framework of various functions related to Insurance service. These functions are being shown as module here to get a feeling of designing an integrated system.

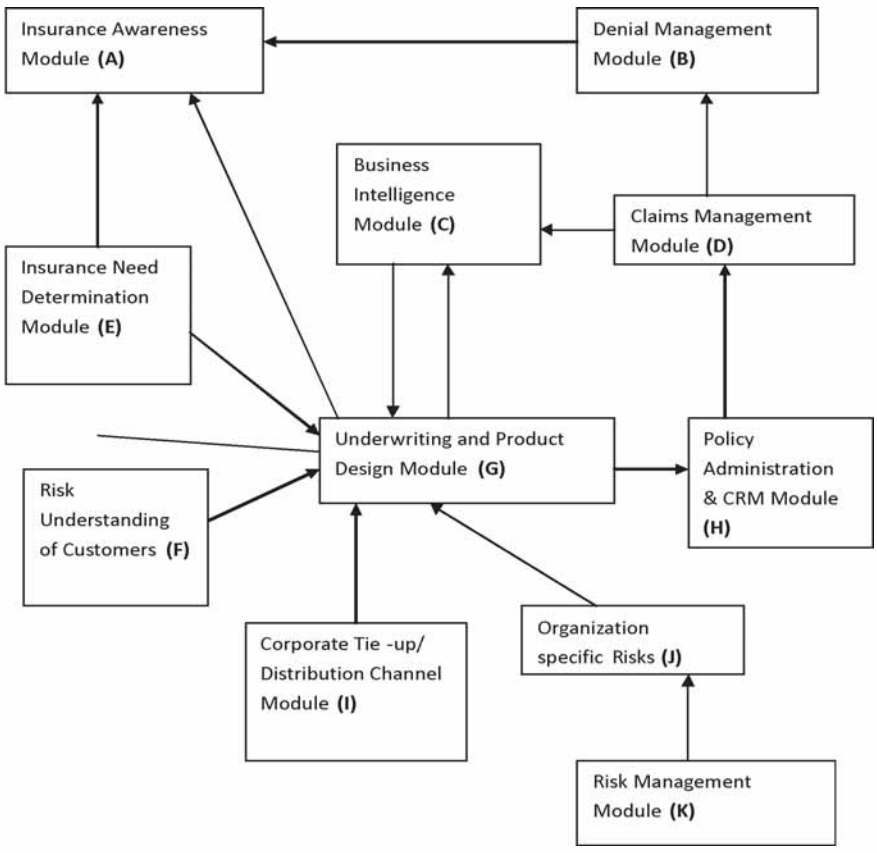
At the centre, it is Underwriting and Product Design module. It is getting inputs from modules like – Risk Understanding of Customers, Insurance Need Determination Module, Corporate Tie-up/ Distribution Channel Module, Organization Specific Risks and Business Intelligence Module. The advantage of this framework is that it emphasizes on risk understanding of customers, insurance need determination and organization specific risks; and also suggests taking advantage of Business Intelligence techniques in Underwriting and Product Design. This module provides input to other modules like – Policy Administration and CRM Module, Insurance Need Determination Module and Insurance Awareness Module.

There are two modules at the top of this framework – Insurance Awareness Module and Denial Management Module. Insurance Awareness Module gets inputs from Denial Management Module, Underwriting and Product Design Module and Insurance Need Determination Module. This

provides focus on making customers aware about Insurance products, claim denial system and Insurance needs. This works at the root level of the grievance management system. Denial Management Module gets inputs from the Claim Management Module and including its outputs in insurance awareness can help immensely in setting the customers' aspirations right.

This framework also indicates that there may be some generic Risk Management Module; but when it comes to underwriting and product design, the organization/ customer specific risks needs to be seriously included. Hence there can be a module to manage and analyze data related to Organization Specific Risks. Also, modern Business Intelligence techniques are helpful in finding hidden valuable patterns from the data and making use of them. It can also analyze unstructured data like opinions and sentiments expressed by customers in various media. Hence, Business Intelligence Module plays an important role.

Diagram 1: Conceptual Framework of Various Functions Related to Insurance Service



Summary:

Thus, grievance has a life cycle and it is useful to recycle the experience of grievance settlement into various functions of insurance service to have an effective grievance management system.

Grievance management should not be treated as a separate isolated function; rather it needs to be integrated with other core functions of insurance service. Providing proper importance to risk understanding of customers, denial management, insurance awareness, insurance need determination and organization specific risks is necessary to have integrated grievance management system. Use of Business Intelligence techniques can help in building a proactive and intelligent system.

Girijesh Pathak, *Associate Professor, National Insurance Academy, Pune, India*

ISSUE FOCUS

Grievance Redressal Mechanism: Balancing Fairness and Efficiency

- Jagendra Kumar

Insurance is a contract of utmost good faith. All the contracting parties have to observe good faith throughout the period of contract. But most of the time there is bad faith. Bad faith insurance means that an insurance company has illegally denied or delayed paying a valid claim. Doing so can have consequences for policyholder and his property or loved one. Insurers have a duty to act in good faith toward their policyholders; failure to do so can be considered bad faith insurance. If this happens, the policyholder may file a lawsuit against the insurance company. In cases where the insurance company's conduct is beyond unreasonable, punitive damages may be awarded. Complaint redressal by insurance companies is set to get a lot speedier. In a bid to strengthen the consumer grievance mechanism, the Insurance Regulatory and Development Authority of India (IRDAI) has set up an automated complaint tracking system with insurance companies — life and non-life. The IRDAI is responsible for addressing complaints filed by policyholders. Complaints against Life and Non-life insurers are handled separately. This cell plays a facilitative role by taking up complaints with the respective insurers. Insurance regulations stipulate the turnaround times (TAT) for various services that an insurance company has to render the consumer. These are part of the IRDA (Protection of Policyholders' Interests Regulations), 2002. Insurance companies are also required to have an effective grievance redressal mechanism and the Regulator has created the guidelines for that too. The redress of consumer grievances is a pre-requisite for ensuring long-term customer loyalty and profitability for any business concern. In service companies, handling of customer complaints is all the more necessary. In fact, consumer grievance redress by companies is an effective way of self-regulation, which is beneficial for not only the consumer but also the company and the government. Policyholders who have complaints against insurers first approach the Grievance/Customer Complaints Cell of the concerned insurer. If they do not receive a response from insurer(s) within a reasonable period of time or are dissatisfied with the response of the company, they use to approach the Grievance Cell of the IRDAI.

THE REDRESSAL PROCEDURE:

Managing grievances or complaints is one of the top priorities among all private and public sector insurance companies these days; in fact it is the 'key' to the growth of insurance business in today's fast moving and competitive market. Today, the regulatory body is concerned about customer rights and fair trade. Customer centric organizations today look for a robust complaints tracking system to ensure superior customer care support and service to their esteemed customers. Inside the organization, internal employee force, complaint redressal process

Life Insurance Companies

Service	Maximum Turn Around Time
General	
Processing of Proposal and Communication of decisions including requirements/issue of Policy/ Cancellations	15 Days
Obtaining copy of the Proposal	30 Days
Post Policy issue service requests concerning mistakes/Refund of proposal deposit and also Non-Claim related service requests	10 Days
Life Insurance	
Surrender value/Annuity/Pension processing	10 Days
Maturity claim/Survival benefit/Penal interest not paid	15 Days
Raising claim requirements after lodging the Claim	15 Days
Death Claim settlement without Investigation requirement	30 Days
Death Claim settlement/Repudiation with Investigation requirement	6 Months
Grievances	
Acknowledging a Grievance	3 Days
Resolving a Grievance	15 Days

General Insurance Companies

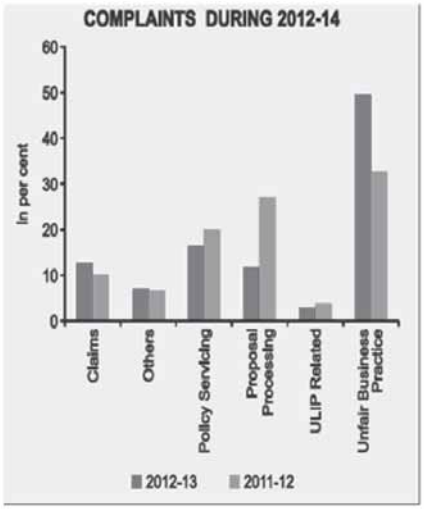
Service	Maximum Turn Around Time
General	
Processing of Proposal and Communication of decisions including requirements/issue of Policy/ Cancellations	15 Days
Obtaining copy of the Proposal	30 Days
Post Policy issue service requests concerning mistakes/Refund of proposal deposit and also Non-Claim related service requests	10 Days
General Insurance	
Survey report submission	30 Days
Insurer seeking addendum report	15 Days
Offer of Settlement/Rejection of Claim after receiving first/addendum survey report	30 Days
Grievances	
Acknowledging a Grievance	3 Days
Resolving a Grievance	15 Days

& policies and automation tool together are responsible for successful functioning of the customer care function. Some companies develop their own custom built systems, which take lot of resources and months to develop. Some go for readymade CRM tools, but such systems are rigid enough to meet: organizational needs, adherence to compliances, process flow specific requirements and flexibility. Custom changes are again time and resource consuming, and add more rigidity to future change management. Also, overheads and maintenance costs on such systems increases exponentially over a period. IRDAI's regulations stipulate the Turnaround Times (TAT) for various services that an insurance company has to render to you, the consumer. These are part of the IRDAI Protection of Policyholders' Interests (PPHI) Regulations 2002. Insurance companies are also required to have an effective Grievance Redressal Mechanism and IRDAI has created the guidelines for that too. Here are the TATs for an insurance company to deal with various types of complaints:

INREGRATED GRIEVANCE MANAGEMENT SYSTEM:

The regulator has set up robust grievance management and redressal mechanisms to service and protect interests of end customers. Seeing exponential growth in the Insurance domain, the IRDAI recently developed their Integrated Grievance Management System. Apart from creating a central repository of industry-wide insurance grievance data, IGMS is a grievance redress monitoring tool for IRDAI. Policyholders who have grievances should register their complaints with the Grievance Redress Channel of the Insurance Company first. If policyholders are not able to access the insurance company directly for any reason, IGMS provides a gateway to register complaints with insurance companies. IGMS is a comprehensive solution which not only has the ability to provide a centralised and online access to the policyholder but complete access and control to IRDAI for monitoring market conduct issues of which policyholder grievances are the main indicators. IGMS has the ability to classify different complaint types based on pre-defined rules. The system has the ability to assign, store and track unique complaint IDs. It also sends intimations to various stakeholders as required, within the workflow. The system has defined target Turnaround Times (TATs) and measures the actual TATs on all complaints. IGMS sets up alerts for pending tasks nearing the laid down Turnaround Time. The system automatically triggers activities at the appropriate time through rule based workflows. A complaint registered through IGMS will flow to the insurer's system as well as the

CLASSIFICATION OF LIFE



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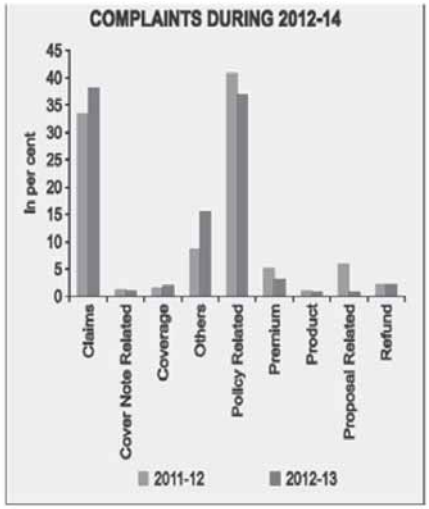


IRDAI repository. Updating of status will be mirrored in the IRDAI system. IGMS enables generation of reports on all criteria like ageing, status, nature of complaint and any other parameter that is defined. Thus IGMS provides a standard platform to all insurers to resolve policyholder grievances and provides IRDAI with a tool to monitor the effectiveness of the grievance redress system of insurers.

JURISDICTION OF OMBUDSMAN:

There is another aspect of the system as well. If the company ignores the consumer's dissatisfaction and grievance, he/ she would approach the relevant government agency and regulatory body to seek redress of his/ her grievance e.g. Insurance Ombudsman. If the insured is unhappy with the company's response, he can approach the insurance ombudsman 30 days after he first lodged the complaint with the insurer. It is a quasi-judicial body which deals with cases up to a value of Rs 20 lakh and has the power to award compensation to aggrieved policyholders. The ombudsman primarily comes into the picture for complaints that involve monetary compensation. There are 17 ombudsmen appointed across the country allotting them different locations as their areas of jurisdiction. The ombudsman may hold sitting at various places within their area of jurisdiction to speed up disposal of complaints. Ombudsman's power is restricted to insurance contracts of value not exceeding Rs. 20 lakh. The Insurance Ombudsman scheme was created to deal with consumer complaints, or public grievances as they are called. The Insurance Ombudsman scheme was created by Government of India for individual policyholders to have their complaints settled out of the courts system in a cost-effective, efficient and impartial way. Your complaint to the Ombudsman can be about:

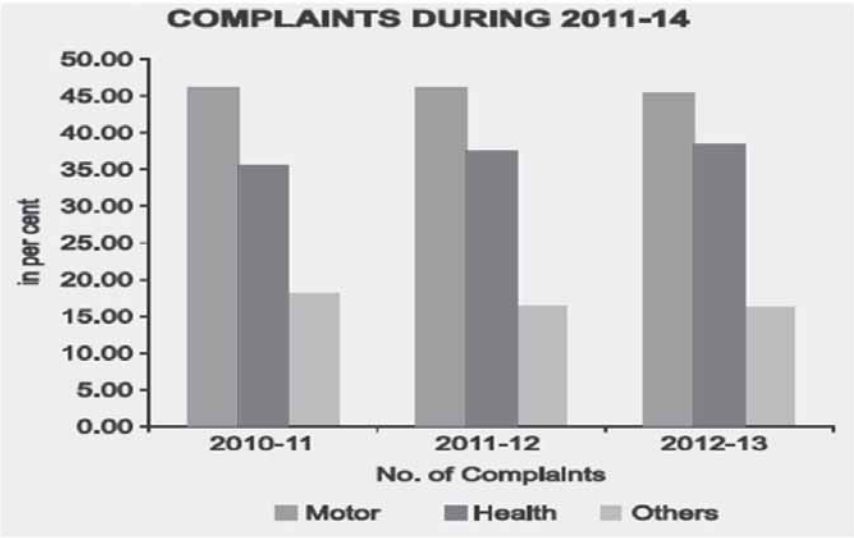
- Any partial or total repudiation of claims by an insurer
- Any dispute about premium paid or payable in terms of the policy
- Any dispute on the legal construction of the policies as far as it relates to claims
- Delay in settlement of claims
- Non-issue of any insurance document to you after you pay your premium

If a settlement by recommendation does not work, the Ombudsman will pass an award within 3 months of receiving the complaint and which will be

- A speaking award with the detailed reasoning
- Binding on the insurance company but
- Not binding on the policyholder

The Ombudsman can also award an ex-gratia payment. Policyholder has to accept the award in writing and the insurance company has to be informed of it within 30 days and the Insurance Company has to comply with the award in 15 days after that. In case the claimant is not satisfied with decision of Ombudsmen, appeal can be filed at the appropriate judicial forum like civil courts.

CLASS-WISE NON-LIFE



CONSUMER PROTECTION COURTS:

If A Policyholder is not satisfied with the recommendation/solution of the ombudsman, he can approach other venues like consumer forums and courts of law for redressal of grievances. The Consumer Protection Act, 1986 was passed "to provide for better protection of the interest of consumers and to make provision for the establishment of consumer councils and other authorities for the settlement of consumer's disputes. The Act has been amended by the Consumer Protection (Amendment) Act, 2002. "Consumer dispute" means a dispute where the person against whom a complaint has been made, denies and disputes the allegations contained in the complaint. Consumer disputes redressal agencies" are established in each district and state and at national level. All the three agencies have powers of a civil court.

I. District Forum: The forum has jurisdiction to entertain complaints, where value of the goods or services and the compensation claimed is up to Rs.20 lakhs. The District Forum is empowered to send its order/ decree for execution to appropriate civil court.

II State Commission: This redressal authority has original, appellate and supervisory jurisdiction. It entertains appeals from the District Forum. It also has original jurisdiction to entertain complaints where the value of goods/service and compensation, if any claimed exceeds Rs. 20 lakhs but does not exceed Rs. 100 lakhs. Other powers and authority are similar to those of the District Forum.

III. National Commission: The final authority established under the Act is the National Commission. It has original, appellate as well as supervisory jurisdiction. It can hear the appeals from the order passed by the State Commission and in its original jurisdiction it will entertain disputes, where goods/services and the compensation claimed exceeds Rs.100 lakhs. It has supervisory jurisdiction over State Commission

Consumer courts are the last resort for a policyholder. Approaching the consumer forum is the simplest, fastest and most economical remedy. The entire process is governed by the IRDAI Protection of Policyholders' Interests (PPHI) Regulations 2002. As part of this, the regulator had issued detailed guidelines specifying turnaround times in July 2010. The insurer is required to send a written acknowledgement to the complainant within three working days, mentioning the name and designation of the officer in charge of resolving the grievance, in addition to details of the redress process. The maximum turnaround time for resolving complaints is two weeks. If the complaint is rejected within two weeks, the insurer has to give reasons for the same and guide the policyholder on subsequent recourse options. Some consumer activists complain that the ombudsman framework has not turned out to be as helpful as it was expected to be. This procedure is good in theory and looks attractive on paper, but is not effective. Most often, the grievance cell ignores the complaint, or acts like a postman, forwarding the grievance to the insurance office and communicating the same response to the insured, The first point of contact for a policyholder should always be the insurer.

The Consumer Affairs Department of IRDAI facilitates resolution of

policyholder grievances by insurers and takes several initiatives towards consumer education in insurance. Grievance Redressal Guidelines of IRDAI mandate that all insurers should have a Board approved grievance redressal policy, designate a Grievance Redressal Officer at the senior management level at the Head Office/Corporate Office/Principal Office and a Grievance Redressal Officer at every other office and constitute a policyholder protection committee as per the corporate governance guidelines for receiving and analyzing reports relating to grievances. The guidelines mandate each insurer to put in place automated systems for online registration and tracking of complaints as well as systems of receiving grievances by call or emails and integrate these systems with IRDAI. Further, the guidelines contain timelines for various activities relating to grievances like acknowledgement, redressal, closure etc. IRDAI facilitates resolution through review/re-examination by taking up the matter with the insurance companies. However, the Regulator does not investigate into or adjudicate upon each complaint received or escalated to IRDAI. With competition getting fiercer every other day, customer service is becoming a key focus of differentiation for insurers. And hence, leading insurers are adopting strategies to transform their business models from being product and channel-centric to being more customer-centric balancing fairness and efficiency.

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JAGENDRA KUMAR, Ex. CEO, Pearl Insurance Brokers, 71/143, "Ramashram.", Paramhans Marg, Mansarovar, JAIPUR-302020

Curtain Raiser For January 2016 Issue With Focus

Crop Insurance assumes importance in view of Falling Agricultural Income & Failure of Crop in recent years in our country. Inspite of tremendous progress in other sectors of economy, Majority of India's Population are still dependent on "This Great Culture , that is Agriculture". With failure of monsoon & losses due to other natural disasters, Farmers are facing undue hardship- Insurance against such growing risks brings great relief for Farmers & their Families. In this background recent attempt by Central Government to revamp crop insurance is in right direction- "Pradhanmantri Fasal Bima Yojana" has just been announced.

Keeping in view the tremendous importance of such insurance for boosting the productivity & may bring required Innovations, Focus for January, 2016 Issue of the Journal will be **"Crop Insurance"**

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ISSUE FOCUS

If dissatisfied, Tell us If satisfed, Tell others

- R. Venugopal

Like any other service industry, Life Insurance too has to deal with the complaints of its customers. The policyholder has his/her expectations, services to be rendered and remedies for his/her problems. The Insurer has the duty and the responsibility to give proper answers to the queries of his clients, not only in a satisfactory manner but also in an expeditious way. Especially as life insurance policies are long term contracts ranging from 5 to 25/30 years, there are ample chances of complaints arising from the customers. Initially it is a simple **request** letter from the policyholder to the insurer for a particular service say a loan on the policy or a revival or a surrender. If no reply comes from the insurance company within 15/20 days, the request becomes a **complaint** and this is sent to a Senior Officer of the insurance company, referring to the earlier letter. If no response or a satisfactory reply does not come to the client within a month's time, this complaint metamorphoses into a **grievance**. **Thus every letter of the customer does not turn into a complaint or a grievance automatically- this process takes time. Hence it is the duty of the insurer to nip it in the bud so that there is no scope for grievances to arise.**

The First Level

All Insurance companies provide in their websites a host of information to get your complaints resolved like the phone numbers of their branches, locations and the e-mail addresses. There is also one particular officer designated as the Grievance Redressal Officer in each Office to be approached in case the regular customer service department's response does not satisfy the customer.

The Insurer is supposed to maintain records of all the complaints received and the details of their disposal. The company should also have a specified time frame within which the complaint has to be resolved, apart from the initial acknowledgment to be sent to the customer within three days of the receipt of the complaint. After this, within 10/15 days-depending upon the nature of the complaint, it has to be resolved and a letter of final resolution has to be sent to the customer.

IRDAI's Benchmarks

IRDAI has given the following benchmarks for resolving the queries and complaints of policyholders as per the nature of the complaint in the life insurance sector:

10 days:

- Policy bond not received.
- Wrong policy bond issued.
- Surrender value not paid.
- Product differs from what was disclosed or requested.
- Term of the policy different or altered without consent.

- Malpractices or unfair business practices.
- Hidden charges not explained.
- Free look refund not paid.

15 days:

- Maturity claim not paid.
- Pension installments not paid.
- Requirement in respect of death claim not raised by insurer.

30 days:

- Death claim not paid.
- **Policyholder Protection Guidelines, 2002, IRDA**
- IRDAI has also prescribed time limits for attending to the different services to be rendered to the customers in the above Guidelines as detailed below:

10 days:

A. Recording change of address.

B. Noting a new nomination or change of nomination under a policy.

C. Noting an assignment on the policy.

D. Providing information on the current status of a policy indicating matters such as accrued bonus, surrender value and entitlement to a loan.

E. Processing papers and disbursal of a loan on security of policy.

F. Issuance of duplicate policy.

G. Issuance of an endorsement under the policy; noting a change of interest or sum assured or perils insured, financial interest of a bank and other interests and

H. guidance on the procedure for registering a claim and early settlement thereof.

Time limit for Policy Maturity Claims:

15 days within receipt of all papers from the customer by the insurer.

Time limit for Death Claims under life insurance policies:

30 days within the intimation of the death of the policyholder received by the insurer.

All requirements to be informed to the claimant in the case of the death claim within 15 days from the date of the receipt of the intimation in one lot and not in piecemeal.

In the matter of early claims-death claims arising within 2/3 years of the date of commencement of the policy-a time limit of 60 days is given. If any claim investigation is involved, this time limit is extended to a maximum of six months from the date of intimation received by the insurer.

IRDAI has allowed a **Free Look Period** of 15 days from the date of receipt of the policy document to return the policy and claim refund of the premium paid from the insurance company, if the customer is not satisfied with the terms & conditions of the policy or the policy received is at variance with what has been sold by the agent. This is a great **Revolutionary step** taken by the IRDAI available only in our country.

The Non-compliance

Any failure to stick to the deadlines by the insurer will make them liable to penalties.

If the insurance company decides to reject the complaint, it has to give a reason along with information on further redressal avenues that the complainant can pursue. Before the complainant proceed with taking up the complaint further, he/she has to inform the insurance company of his/her dissatisfaction of the resolution of the complaint.

If the customer does not respond within eight weeks of the receipt of insurer's response despite being dissatisfied with it, the company will assume that the complaint has been resolved.

The Second Level

If the Redressal officer was not of much help, then the customer can approach either IRDAI's Grievance Redressal Cell or the Insurance Ombudsman of the area of the complainant.

A Portal- www.igms.irda.gov.in permits policyholders to lodge complaints on line. These are forwarded to the insurance companies concerned. Customers too can track the status of their complaints. The customer has to register himself/herself on the portal to file and later track the complaint. IGMS stands for the Integrated Grievance Management System of the IRDAI.

However, the first stop for redressal has to be the insurance company of the policyholder. He/she can register the complaint through a branch office of the insurer by a letter or mail or phone or website. If no response comes within a reasonable time, he/she can approach the insurance company's grievance redressal officer.

Insurers are needed to acknowledge the customer's complaint in writing within 3 working days of its receipt. The grievance redressal norms also require the company to specify the period by when it is likely to be resolved. If a solution is given within 3 days, the client will be intimated. If not, the insurer has 2 weeks' time to send a final letter of resolution.

The next step is take the grievance to the Regulator through the IGMS, IRDAI Grievance Redressal Cell or the Insurance Ombudsman offices. Most of the complaints are now integrated on the IGMS Platform as it is for monitoring complaints and for analyzing the patterns. Claims under Rs 20 lacs in personal accident, health and life insurance policies are directed by the IRDAI to the Insurance Ombudsman.

The Insurance Ombudsman

The office of the Insurance Ombudsman is authorized to mediate and if necessary award compensation to policyholders/ claimants involving insurance contracts with a value of up to Rs.20 lacs.

IRDAI appoints the Insurance Ombudsman in major States of India-there are 12 such persons mostly in the State Capitals-these people are mostly drawn from the retired Senior Directors/Managing Directors of Public Sector Insurance companies, Judiciary and the Bureaucracy.

Ombudsman is someone who investigates complaints made by people against the insurance company. He is an independent official who examines and analyses the cause of the complaint and gives his decision which is normally binding on the insurer. The customer is free to appeal to a Civil Court if he/she is not satisfied with the decision of the Insurance Ombudsman.

The Insurance Ombudsman is a quasi-judicial Authority-he does not permit any advocate or counsel on behalf of the customer-he listens to the complainant and the Insurance official directly in his chamber and then dictates his verdict.

The Ombudsman has to satisfy himself that the complainant has exhausted all the internal avenues available to him/her internally within the insurance company like the Grivance Redressal Officer/ the Review Committee etc before knocking at the doors of the Ombudsman.

The Ombudsman gives his recommendation normally within a month of the receipt of the Grievance.

After receiving his recommendation, the complainant has to send a written communication indicating acceptance of the settlement within 15 days.

The Insurance Company has to comply with the Ombudsman's order within 3 months.

The nature of the complaints that are normally heard by the Ombudsman is as per following:

1. Rejection-whether partial or total-of claims.
2. Disputes about premiums.
3. Policy wordings in case the dispute relates to claims.
4. Delay in settlement in claims.
5. Non-issuance of insurance document after collecting the premium.

IRDAI's Grievance Redressal Cell

Unlike the Insurance Ombudsman, this Cell does not have authority to pass orders. However the complaints received here are taken up with the Insurers concerned.

Apart from the other complaints given in this article, the complaints regarding the conduct of the Insurance Agents/Advisors are also received here.

There is a toll-free number-155255-for contacting this Cell and follow-up can be done and the status can be tracked at complaints@irda.gov.in

Civil and Consumer Courts

The Consumer Protection Act 1986 is to safeguard the interests of the consumer and this Act applies to all goods and services except for goods for re-sale or for commercial purpose and services rendered free

of charge and under a contract for personal service.

The provisions of the Act are compensatory in nature and it covers Public, Private, Joint and the Cooperative Sectors.

This Act was primarily enacted to protect consumers from below-standard goods and deficient services offered by unscrupulous traders and service providers.

This Act covers insurance services too.

There are Consumer Forums at the District level, State level and at the National level.

Consumer can appeal to the State Forum if he/she is not satisfied with the verdict of the District Forum and to the National Forum if he/she is not satisfied with the verdict of the State Forum.

The customer can approach the Supreme Court if he/she is not satisfied with the verdict of the National Forum.

The President of the Forum permits an advocate to argue the consumer's case unlike the Insurance Ombudsman.

Apart from these Forums, there are Civil Courts available for grievance redressal.

The Insurance Ombudsman will not take up a case if it is already pending either in the Consumer Forum or in any Civil Court.

LIC's Grievance Redressal Mechanism

LIC of India, the Market Leader, has an excellent Grievance Redressal Mechanism in place. Since a majority of the grievances pertain to LIC in view of its huge size as well as a humungous number of policies procured by it every year, it is only pertinent that its grievance redressal mechanism is discussed here so as to be of benefit to a vast majority of the policyholders and the general public.

Every Monday is declared as the Grievance Redressal Day in the sense between 2.30 to 4.30 pm and a customer can simply walk in to any LIC Office and meet the Designated Officer with out any prior appointment and present his grievance.

The following are the Designated Officers for this purpose at different offices:

- Branch Manager at the branch office
- Manager-Customers Relations Management-CRM- at the Divisional Office level
- Regional Manager-CRM at the Zonal office and
- Executive Director-CRM at the Central office, Mumbai.

Each complaint is registered and followed up vigorously and settled with in 15 days of its receipt.

In the matter of repudiation of death claims, there is a claims review committee at the Divisional, Zonal and Central office levels

Important functionaries like the Marketing Manager at the Divisional office, Regional Manager-Marketing at the Zonal office and Executive Director-Marketing at the Central Office are the Chairmen of these committees so that the representations received from the claimants are properly examined and disposed off.

At the Zonal and Central office claims review committees, even outsiders like the Retired Judicial Members are also taken in as Members in order to ensure fairness and impartiality.

LIC ranks as one of the lowest in the matter of pending complaints at the end of every financial year in the entire life insurance industry.

The Role of the Regulator

- IRDAI has to make more efforts to bring a lot of awareness among the insurance customers as well as the general public regarding the customers' grievance redressal procedures now available, although the Regulator is already undertaking various measures and campaigns in this direction through short films, advertisements in both English and the vernacular media.
- The limit of Rs 20 lacs fixed for cases to be dealt with by the Insurance Ombudsman was mandated before more than a decade- it has to be increased to at least Rs 50 lacs, if not more.

- Since the Health Insurance grievances form 60% of the complaints being handled by the Insurance Ombudsman, there is a crying need for appointing a separate Ombudsman only for the Health Insurance cases, at least for the 4 Metros and for Hyderabad & Bengaluru. This will facilitate faster disposal of complaints and also bring about more cheer among the clients.
- A few figures of the policyholders' complaints during 2014-15 pertaining to a few leading life insurance companies:
- LIC of India- 81614.
- ICICI Pru Life Insurance company- 11796.
- SBI Life Insurance company- 12273.
- HDFC Life Insurance company- 31957.
- Max Life Insurance company- 16546.
- Bajaj Alliance Life Insurance company- 19946.

The Role of the Customers

Now the time has come for the public to take up their issues themselves instead of depending upon the Government or the Regulator.

The IRDAI has done its part in setting up the grievance redressal mechanisms in place and it is for the customer to utilize them.

The customer has to be alert and he/she must see that he/she is served well and in time.

He/she must be Delivered On Time and every time- DOT on DOT.

The Turn Around Time- TAT- is also to be maintained by the Insurer.

Clause 11 of the Policyholder's Protection Guidelines 2002 puts the onus on the customer too to inform the IRDAI, if he/she comes across any malpractice either by the insurer or his intermediary, instead of turning a blind eye to it, thinking that it has not affected himself/ herself. Each customer has to be a Whistle Blower.

Out of the total complaints of 374620 in the entire insurance industry during 2013-14, 56% pertain to mis-selling by agents and the non-receipt of policy documents from the insurers. This shows that the customers have to remain watchful and follow the dictum of **'Caveat Emptor' meaning 'Buyer Beware'.**

It is only in the customer's hands that he/she is heard and heard effectively.

In the words of Horstmann, " there is a strong & positive relationship between the customer satisfaction and loyalty. A satisfied customer is six times more likely to repurchase a product and share his experience with five or six other people".

The insurer should have the following maxim to all their customers in their offices:

- **IF YOU ARE DISSATISFIED WITH OUR SERVICES, PLEASE TELL US.**
- **IF YOU ARE SATISFIED, PLEASE TELL OTHERS.**

The insurer must cultivate the habit of listening to the customers regularly- this can be done by having Customer Meets and special meetings with important policyholders and opinion- makers in the town. Let the insurer hear not only praises and compliments but also learn to lend an ear to the complaints as well. As a matter of fact, a dissatisfied customer teaches more lessons to the insurance company than a thousand satisfied customers.

R.Venugopal is a Retired Executive Director LIC of India.

ISSUE FOCUS

Handling Customer Complaints in Insurance: Issue of major concern

- Dr.Ashish Barua

WHAT IS A COMPLAINT?

A complaint is generally defined as: "Any expression depicting dissatisfaction by a customer or likely customer about the service delivery system by the company or its agents, and/or about the company or about the industry policy." The Customer Complaints Handling Procedure is such a way specifically designed to make it sure, that complaint is handle with efficient way, fairly manner and effective result oriented perception. The Insurance company must ensure that the procedures are:

- Easy - to find out and well publicised perfectly;
- Simple - to understand and use;
- Efficient – setting out when you can expect a reasonable and effective response from us;
- Fair – ensuring each complaint is investigated fully and fairly;
- Respectful – respecting and maintaining your desire for total confidentiality;
- Effective – addressing all the points you raise and providing an efficient and effective response and appropriate redress system;
- Monitored – regularly monitored and audited to ensure it is effective and to allow improvements to be made;
- Reported – furnishing information to management so services can be improved; and
- Consistent – with the standards set out in

At some point of business, everyone has to deal with a dissatisfied customer. Dissatisfied customers are the greatest source of strength for a successful company. Those insurance companies which are today at the pinnacle of success, are those who handled and realized that their dissatisfied insurance customer are the greatest source of their strength for the anticipated future success. The major challenge is to handle the situation in such a fashion that leaves the customer thinking what a great insurance company, and left behind an everlasting good and positive impression on the minds of

customer. If one is lucky, one can even encourage them or her to serve as a passionate advocate for your brand.

It is quite surprising that many insurance customers don't even bother to complain. They simply go away and buy from your insurance competitors. Research suggests that up to 80 percent of insurance customers who go away were, in fact, satisfied with the original insurance company's performance. Obviously, insurance customer satisfaction is not enough in today's business world. Businesses now a days need to positively delighted customers if they want to earn their loyalty. Delighted means much more than mere satisfaction. Some extra care and features, which leaves behind everlasting impression in the minds of the customers and they go for repeat purchase.

It must be realized by the insurance companies that it canbe a counter-intuitive move, but it depends on a business owner's ability to effectively deal with insurance customer complaints provides a ample opportunity to turn a dissatisfied insurance customers into the active promoters of the insurance business.

WHY YOU NEED TO LISTEN TO INSURANCE CUSTOMER COMPLAINTS

There are various reasons why you should listen to, and respond to your insurance customers complaints; the following are some of the most important one :

Development

The important reason why you should listen to insurance customer complaint is very simple. If someone is complaining to you , that means the chances are there is a problem in your existing insurance products or insurance service that is really causing it.Patiently listening to complaints allows you to find out what the problems issues are with your insurance business, and how to solve them. Customers satisfied may cost money; you may need to spend extra money on that, but you will normally regain much more than this over time by retaining the customer who are the brand ambassador of your insurance product.

Fixing a problem once will help you keep the insurance customer who made the insurance complaint, but fixing it permanently will help keep all insurance customers satisfied, and maybe even help to bring in some new insurance customers.

Loyalty

Research shows that customers who really complain, and have a problem solved are generally much more loyal than those who are simply happy with the insurance business. If you can fix a insurance complaint quickly, it shows not only that your insurance business respects the insurance customer and wishes to provide a good reasonable service; but also that you can be relied upon, even when things go wrong. It can provide a insurance customer with a sense of security in your insurance business, making them much less likely to go to your insurance competitors.

Lost Customers

There is a choice left with the dissatisfied customers; Let them complain, and try to solve their problems by them; or watch them go to your insurance competitors domain. Although there are few proven figures, most experts believe that you are up to 10 times more likely to keep a complaining insurance customer (whose problem you try to solve) than you are one who says nothing to them.

Always remember that it costs up to five times as much to win a new insurance customer than to keep an old one, even if keeping a dissatisfied customer costs you now, in the long run, it will almost certainly save you money. If a insurance customer complains, it gives you a chance to make them satisfied with your insurance business again, and for this reason, you should encourage dissatisfied insurance customers to complain.

Employees

If a complaint is the result of a mistake by an insurance employee, a complaint will always help you to know where problems lie and rectify it effectively. Minor insurance problems can be fixed by reminding insurance employees of certain information or processes, major problems can be looked at over a period of time, with the aim of long term improvements. In repeated cases of employee fault, you should consider giving verbal warnings.

Front line insurance employees can often face the insurance complaints caused by other insurance employee's mistakes, but attempting to solve all problems revealed by complaints will help to keep your insurance customers happy. Matters can also be helped if you give employees enough training and empowerment to deal with insurance complaints and problems quickly,

HOW TO HANDLE INSURANCE CUSTOMER COMPLAINTS

Handling insurance customer complaint is a big challenge. Effective handling is the secret of success in the progress of the company. The truth is that no matter how hard you try, things are bound to go wrong once in a while automatically. No matter the reason for the complaint, the important thing is to try and please the insurance customer and send them home knowing that, yes there was a problem and we are really worried about that, but it is not typical of your establishment. Let them realize that you, the owner, value their comments and their business. How you handle insurance customer complaints will determine if the customer comes back to your office again or not. Here are some tips to help you field your next complaint and send your insurance customer home with a big smile.

Listen To Insurance Customer- Listen to what the insurance customer has to say to you. Even if you can't solve the insurance problem, you still need to listen them effectively. For example, perhaps a insurance customer is displeased because there is waiting line of complainant. Well, there isn't much you can do about it, except let them vent.

Effective Body Language- Effective body language is the secret of success. The way you stand in front of insurance customer and look at a insurance customer can speak more than words. Maintain perfect eye contact balance and don't cross your arms over your chest anyway, if you are feeling defensive. Avoid the urge to roll your eyes anyway, if you are feeling somewhat exasperated. Instead, nod and smile a little, no matter how irritated you may feel. This shows how you value their opinion and their business.

Apologize- Remember always that insurance customer who was so upset over the long waiting line? Offer a pleasant apology to them. "I understand that you are not happy about the wait, sir, but we are working as fast as possible we will solve your problem at the earliest. We really appreciate your patience and willingness to wait for us." You demonstrate that you completely understand insurance customer's frustration and are working diligently on a solution.

Freebies- If a insurance customer has problem that could have been prevented. Like in insurance, delay in claims settlement process, Lack of proper response from insurance man after selling the policy., and many many other such issues may come as a complaint in insurance. This type of problem could be anticipated well in advance and can be solved well in advance by proper planning and management and infact anticipation.

Occasionally you will have a truly angry insurance customer (perhaps justified, perhaps not) who declares "I'm never coming back!" Well, if that is the case there probably isn't any freebies you can offer to change the mind of insurance customer. Calmly assure the insurance customer that you understand their frustration, and offer an pleasant apology (again) out rightly and let them know if they change their mind you would love to see them again.

By sending them off on a courteous note, there is a very good chance, once their anger has cooled, they will come to your insurance business premises again and again.

Important Rules For Handling Insurance Customer Grievances

Customer centric approach is the important focus of all modern management thinking and strategic business practice. Keep your insurance customers happy always and your policy sales will continue to soar high - neglect them or take them for granted and your bottom line will suffer greatly accordingly. To respond to the querry of an insurance customer who has several legitimate complaints you must keep these seven rules firmly in mind always.

Rule One:

Listening is art of influencing the customer perception. It creates deep understanding & deep sympathy. This will diffuse any anger and will always demonstrate your sincere concern. Tell the insurance customer something such as "I am sorry you have been inconvenienced. Tell me what happened exactly so that I can help you". It is important to show a very sincere interest and sincere willingness to help them. The insurance customer's first impression of you is always in gaining co-operation. First impression is the last impression.

Rule Two:

Always make it sure No matter what or who caused the problem, never, ever blame or make excuses anyway at all . Instead, take full responsibility yourself and take the first initiative to do whatever you can to solve the insurance customer problem as quickly as possible.

Rule Three:

Record carefully all statement what the customer tells you. Whenever you hear an important point say "let me make sure I understand; you were promised delivery the insurance policy on the 10th and you did not receive the policy until the 1st of the following month. Is that correct?"Let me check.

Rule Four:

Find out what the customer actually perceive and wants. Do they want some different insurance product which is not in your knowledge? The insurance customer is complaining because he/she has a problem and wants it solve the problem as quickly as possible. Find out what their problem is so you can work towards solving it and not towards a solution they do not want at all

Rule Five:

Propose an insurance problems solution and gain the insurance customer's immediate support. When the insurance customer tells you what he or she wants the solution is usually obvious. State your solution in a very positive and effective manner.

Rule Six:

If the insurance customer does not like your suggested solution, ask what they would like to consider a fair alternative solution for this . Never let a insurance customer lose face and dejected. If you cannot meet their request, say so, but never say that they are wrong, and never get into an argument with an insurance customer. It is important to be considerate of the insurance customer's feelings and to be courteous always. Sometimes the insurance customer knows full well that there is nothing you can do for them. All the insurance customer really wants is someone to hear and respect his or her point of view, and you can always give them that. This is key for success.

Rule Seven:

Follow up within a few days to ensure that the insurance customer is completely and fully satisfied. This last tip should ensure that the relationship bond is strengthened forever and you may well gain additional insurance business for your concern. Do remember that, a insurance customer's loyalty is only as strong as the success of their last contact with you.

THE KEY TO HANDLING CUSTOMER COMPLAINTS

Handling insurance customer complaints is an art which has to

be mastered thoroughly, It may have more to do with establishing your good reputation for excellent insurance satisfaction than all the designer frames you can find and all the technology you can install. Even if you satisfy 99% of your insurance clients, that means that two or three patients leave unsatisfied every week from the average sized practice. Can you live with 150 people in your community talking negatively about your insurance business? I don't think so. In this hyper-competitive insurance industry, we cannot let even one slip out the door with less than a big stellar experience. Any reputed insurance company would say, "Our strongest competition is our own reputation build over the year."

Deliver Unforgettable Customer Service

Insurance companies must recruit many dynamic positive and go getter sales people, whom one interaction with the customer remains in their mind most pleasant and unforgettable for the entire lifetime. This kind of service is only possible, when HR people in our insurance companies are themselves highly cautious and dynamic and loyal to their company to which they belong. They must recruit such people who are an asset for the company not an liability.

Empower Your Employees

Accept that you do have daily and recurring insurance customer challenges and create a protocol for how to handle them immediately and effectively. Follow it even if the insurance customer is 30 minutes late for a confirmed appointment. No one leaves disgruntled atany cost. Empower and train your insurance employees with a system so that everyone is capable of addressing and resolving a insurance complaint as soon as it arises...or even before. You want every team member to look for opportunities to be a hero. The best way to regain lost patients is to never lose them in the first place at all . Psychologically insurance employees must be trained so that they can face any kind of unpleasant situation unexpectedly with easy tact and emerge winner at the end. Insurance Industry needs employees who are winner always, means who think winning only. Positively tuned people are an asset for the insurance industry

Role-playing is the best training to prepare for worst-case scenarios and frequently cited objections. Role-playing also corrects the false impression that most people believe they have great insurance customer service skills and are able to handle almost any situation easily. Of course, it is unpleasant at times to do what seems uncomfortable and let the customer get away with something, but hopefully those times are few. Happy insurance customers are an investment in the future of your business, and that is something you just can't buy. You have to work very seriously for handling the customer grievances.

Finding Out Customers Expectations

Finding out what customers expect from insurance business is essential to providing service quality. The following description present some useful methods to find out what customers really expect from our services.

Using Complaints Strategically

Though listening to insurance complaints is rarely sufficient to understand insurance customers' expectations, insurance complaints can become part of a larger process of staying in touch with insurance customers and can make big success story. In particular, they can provide important information about the failures or breakdowns in the service system. If compiled, analyzed, and fed back to insurance employees who can correct the problems, insurance complaints can become an inexpensive and continuous source of adjustment for the service process. To truly understand insurance customers' needs, companies can encourage

and facilitate insurance customers' feedback about problems.

Researching what customers want in similar industries

It is very important for every insurance company to understand, what customers expects and anticipating from other insurance companies for the similar insurance product sold by them. For example Hospital patients and customers of hotels, for example, expect many of the same features when using these two services. Besides expert medical care, patients in hospitals expect comfortable rooms, courteous staff, and food that taste good—the same features salient to hotel customers. Same is the case with insurance companies.

Conducting key-client studies

Conducting key-client studies is indispensable, and infect helps a lot to a insurance company in establishing it business base and it can augment it further business prospect. This is the most powerful medium of enhancing insurance business prospect. Thus in-depth research studies can also be appropriate for end customers when key clients, who are larger or more important than others, can be identified. Law firms, for example, could focus on clients involved in major cases, banks could study their top depositors or borrowers, and airlines could research key corporate clients, insurance company's can focus on segment were they get more business.

Creating customer panels

Creating an insurance customer panels is very a strategic move for speedy success. Its importance must be realized by all the insurance company in the contemporary business world. This panel must comprises loyal insurance customer who are the brand ambassador for the insurance company and can prove an effective mouth organ for promoting the insurance company's product in every nooks and corners of the business segment

Tracking satisfaction with individual transactions is an asset

A research trend gaining in popularity in service businesses world over involves transaction-based insurance customer surveys and tracking satisfaction level. In this method, insurance customers are surveyed immediately after a particular insurance transaction about their work satisfaction with the contact personnel with whom they have interacted. Express customer-service representatives handle billing problems, they mail insurance customers surveys that measure insurance employees' courtesy and competence, and the insurance customers' overall satisfaction.

This type of research is simple, fresh, and provides the management with current information about interactions with the insurance customers. Further, the research allows management to associate service-quality performance with individual contact personnel so that high performance can be rewarded and low performance corrected. It also serves as an incentive for employees to provide better service because they understand how and when they are being evaluated.

Engaging in comprehensive customer-expectation studies

Engaging in comprehensive customer-expectation studies is an asset forthe insurance companies. The insurance company must develop a comprehensive program of measuring the expectations of all its insurance customers, including both external and internal (employee) customers. Using companywide employee surveys, focus group interviews will helping a big way.

Here are some insurance customer-oriented tips:

Listen carefully the customer has to say, and let them finish. Don't get defensive any time. The insurance customer is not attacking you personally; he or she has a genuine problem and is may be upset. Repeat back with genuine concern, what you are hearing to show that you have listened to him with care and patience.

Ask questions in a sincere and deep caring and concerned manner.

Better the more information you can get from the insurance customer, the better you will understand his or her personal perspective.

Best advice is put yourself in their shoes.

As a insurance business owner, your goal should be to solve the problem, not argue at any cost. The insurance customer needs to feel like you're on his or her side and that you personally empathize with the present situation.

Apologize sincerely without blaming.

When a customer senses that you are really sincerely sorry, it usually helps to diffuse the situation. Don't blame another at any cost any person or department. Just say, "I'm sorry about that."

Ask the customer personal opinion, "What would be an acceptable solution he is expecting?"

Whether or not the insurance customer knows what a good solution would be, I 'think it is better to propose some solutions to alleviate his or her sufferings. Become a partner with the insurancxe customer in solving the problem.

Solve the problem as early is possible, or find someone who can solve it— quickly!

Research indicates that insurance customers prefer the person they are speaking with to instantly solve their problem. When complaints are moved up the chain of command, they become more and more expensive to handle and only add to the customer's frustration.

There is no way one can avoid customer complaints, regardless of your industry. However, by employing these preventive steps and taking the proper time to review the issue with the insurance customer, you can turn challenges into something very constructive.

Conclusion

The common old saying is, "Everybody makes mistakes, but how you are able to handle them makes for either happy customers or no business." How do you handle any conflicts with your insurance customers? Just start by taking inventory of instances where things didn't go well for you at all . Nobody likes poor service in insurance, which is why it's important that you take every possible step to avoid insurance customer complaints at any cost . But when there are insurance complaints, how can you make your insurance customer complaint procedure work well? Start by avoiding these mistakes:

Mistake No. 1: Not having a well structured customer complaint procedure is a serious risk for insurance business. Whenever there is a insurance customer complaint, don't put your insurance company's reputation down — and your chance of getting good referrals — in great jeopardy by not having a complete written procedure which has been used to train your insurance customer service people. Think of it as risk management process . Make sure that everyone knows what you expect your insurance customer service to do to resolve insurance complaints, even with the most difficult insurance customers. The process will make it less likely that insurance customers will be totally unhappy. Kindly and competently explaining the process to even a difficult insurance customer means that there will be a good chance of a successful resolution. The insurance customer will know their responsibilities as well yours.

Mistake No. 2:. If you have a very few insurance customer service agents means that many complaints may not get a full fair hearing from your side and may not be resolved quickly. Unresolved insurance customer complaints mean no referrals and worse, negative word of mouth publicity ! Insurance Customer service is your insurance policy to keep customers happy so they will give you more referrals. Would you go without liability insurance or business interruption insurance? Then why would you forget to have insurance customer happiness insurance?

Mistake No. 3: Don't Lose personal touch with how your insurance customer service functions at all . Take the time to examine your insurance company correspondence files and service department records. This will reveal the current insurance customer attitude toward your organization. Complaints will probably highlight principal problem areas. In fact, if you analyze those records regularly, you may find that some of the insurance complaints you're receiving are actually doing your firm a big favour, pointing out areas that need constant improvement immediately.

Mistake No. 4: Don't neglect your insurance customer service people at any way. If they know well that you care about them very seriously and how they treat insurance customers, they can become your biggest source of further referrals. Consider what would happen if a insurance customer service person successfully resolves a problem, asks a now-happy insurance customer for a referral and gets rewarded for each insurance referral they get.

Mistake No. 5: Establish an insurance customer complaint procedure of checking back with the insurance customer 30 or 60 days after a complaint, asking how the insurance customer felt the service was provided to them , and if you can be of further assistance to them. That's not just fixing the problem, that's making sure the relationship stays fixed forever.

Mistake No. 6: Don't take short cuts at any cost . If you have a written procedure to deal with insurance customer complaints, stick with it. Insurance customers will get used to the fact that you have an organized way of approach and give them a fair chance to state their own case also .

Mistake No. 7: Don't Let any complaints linger at length. You will be surprised by how fast and courteous kind attention can defuse most of the very serious complaints before they become major problems for your business. All insurance customer who is complaining wants to know is that someone cares for him and that you should respond as close to fast as possible. Even if you had a big problem, speedy resolution always means that your insurance company spent a few minutes solving that insurance customer's problems. But since you are quick to respond, he or she will actually want to talk up your operation and your ability to stand behind your insurance product or service.

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ISSUE FOCUS

IRDAI and Grievance Redressal in Insurance Sector

- Dr. G. Mallikarjun

I. INSURANCE AND INFORMATION ASSYMETRY

Insurance is a complex financial product about which understanding of members of public is relatively lower in comparison to other financial products like savings or investment products. In simple terms insurance is a financial product aimed at covering risk. Depending on the nature of risk, insurance is broadly categorized as life insurance – if it covers risk of death or survival; health insurance – if it covers risk of ill-health and treatment thereof; and general insurance – if it relates to risks other than life (though health insurance has been made a separate line of business for the purpose of registration of insurance companies, it still is a part of general insurance).

Members of public are generally not aware of the need for insurance, the benefits of insurance and the products of insurance that are appropriate for their need. Further, the general feeling is that insurance is forcibly sold, the terms and conditions are complex and the fine print cannot be understood; and the agents selling products make money out of selling insurance but never explain the features fully. Insurance is being taken largely for tax saving purposes (eg. pension policies), where it is statutorily required (eg. motor third party) or mandated as a part of terms governing credit arrangements (eg. home or fire insurance with loan) or just to help agents in the family. With the introduction of ULIPs, the promise of high returns became the main enticement for people buying insurance. Decreasing quality of health and increasing cost of treatment has led to health insurance being seriously considered for purchase by many. However, the primary reservations people had about insurance still persist. The knowledge asymmetry between the insurance consumer and the insurance company or its agent/ intermediary continues in spite of the multi-pronged efforts taken by the regulator and the insurers for promoting insurance awareness. The absence of knowledge of the recourses to get the grievances resolved also makes people resign to the fate of poor service by the insurers or their agents, which adds up to the negative image about the sector.

In order to ensure that the insurance sector grows and provides services to the consumers, while it is imperative to promote insurance awareness, emphasis should equally be placed on providing an effective, efficient and speedy grievance redressal framework for addressing, redressing, settling and adjudicating upon grievances and making people aware of the same.

II. REGULATORY FRAMEWORK FOR GRIEVANCE REDRESSAL

Insurance Regulatory and Development Authority of India (IRDAI), as the regulator of the insurance sector, has issued regulations and guidelines relating to the grievance redressal mechanism to be put in place by all insurers; a corporate governance structure to monitor the nature, volume and disposal of grievances; and a disclosure regime to make public aware of not only the business and financial performance but also grievance related performance.

(1) Insurance Regulatory and Development Act, 1999 (IRDA Act, 1999)

The preamble of IRDA Act, 1999 states that it is "An Act to provide for the establishment of an Authority to protect the interests of holders of insurance policies, to regulate, promote and ensure orderly growth of the insurance industry...".

According to Section 14 (2) (b) of the IRDA Act, IRDA's powers and functions includes "protection of interests of policyholders in matters concerning assigning of policy, nomination by policyholders, insurable interest, settlement of insurance claim, surrender value of policy, and other terms and conditions of contract of insurance."

Section 114A (2) (zc) of the Act empowers IRDAI to make regulations on "matters relating to redressal of grievances of policyholders to protect their interest and to regulate, promote and ensure orderly growth of insurance industry".

Therefore, IRDAI, set up under 3 of the Act, has been statutorily entrusted with the power, function and duty of protecting the interests of policyholders and to regulate, promote and ensure orderly growth of insurance industry and framing of regulations relating to redressal of grievances of policyholders.

(2) IRDA (Protection of Policyholders' Interests) Regulations, 2002

Regulation 5 of **IRDA (Protection of Policyholders' Interests) Regulations, 2002** deals with Grievance Redressal procedure for insurance companies. The Regulation reads as follows:

Regulation 5. Grievance redressal procedure

"Every insurer shall have in place proper procedures and effective mechanism to address complaints and grievances of policyholders efficiently and with speed and the same along-with the information in respect of Insurance Ombudsman shall be communicated to the policyholder along-with the policy document and as maybe found necessary."

(3) Guidelines for Grievance Redressal for Insurance Companies

In furtherance of regulation 5 of the above Regulations, exercising powers under Section 14 of IRDA Act, 1999, IRDAI issued **Guidelines for Grievance Redressal for Insurance Companies** on 27.7.2010 which contains the entire process of receipt, handling, redressal and closure of grievances by insurers including using of electronic and call centre platforms for receipt of complaints.

Grievance / Complaint has been specifically defined in Para 1 of the Guidelines which reads as follows:

"A 'Grievance or Complaint' is defined as any communication that expresses dissatisfaction about an action or lack of action about the standard of service / deficiency of service of an insurance company and/or any intermediary or asks for remedial action."

The grievance or complaint is distinctly separate from an inquiry or a request. While all complaints or grievances have to be registered, the same is not necessary for inquiries and requests.

The key aspects of these guidelines in relation to system of handling of grievances by insurers in brief are as follows:

- Every insurer should have Board approved Grievance Redressal Policy to be submitted to IRDAI
- Every Insurer should designate an officer of Senior Management level (CEO / Compliance Officer) as Grievance Officer. Every Office other than Head Office/ Corporate/Principal Office should have a nominated officer for grievance redressal
- Grievance Redressal System / Procedure –

o Receiving, Registering and disposing in each office

- Insurer should provide an acknowledgement of complaint in 3 working days. It should contain name and designation of officer dealing with the complaint, details of grievance redressal procedure and time taken for resolution of disputes.
- A separate acknowledgement is not necessary where the complaint is resolved in 3 days
- A complaint should be resolved within 2 weeks of receipt of the complaint. The insurer should resolve the complaint and send a final letter of resolution
- In case of partial redressal or rejection of complaint, the insurer should send a written response with reasons and inform how the complaint can be pursued.
- The complainant should also be informed that the complaint will be treated as closed if no reply is received in 8 weeks after receipt of response

o Every office to have a system of grievance registration and disposal

o Proper closure of grievances - Closure can be in following ways

- the company has acceded to the request of the complainant fully.
- where the complainant has indicated in writing , acceptance of the response of the insurer.
- where the complainant has not responded to the insurer within 8 weeks of the company's written response.
- where the Grievance Redressal Officer has certified that the company has discharged its contractual, statutory and regulatory obligations and therefore closes the complaint

o Where the complaint is not resolved and the matter falls with the purview of Insurance Ombudsmen, the complainant should be advised to take up the matter with Insurance Ombudsmen giving details of the Ombudsman.

- Classification of complaints should be done as specified by IRDAI
- Minimum software requirements for computerized system are specified by IRDAI and the same should be implemented
- Insurers to have Systems

o to receive and deal with calls / voice/emails relating to grievances and

o to enable and facilitate interfacing with IRDAI's system of handling calls and emails

- Every insurer should ensure that a Policyholder Protection Committee as mandated by corporate governance guidelines is in place, it is receiving and analyzing reports and is carrying out monitoring activities as mandated in the guidelines.

(4) Policyholder Protection Committee

Corporate Governance guidelines for insurers mandate that every insurer should have a Policyholder Protection Committee. This requirement is a clear indication that IRDAI places significant emphasis on the protection of policyholder's interests and on the adoption of sound and healthy

market conduct practices by insurers. In order to address various compliance issues relating to protection of policyholders' interests and keeping the policyholders well informed of and educated about insurance products and complaint-handling procedures, each insurer has been directed to set up a Policyholder Protection Committee which shall directly report to the Board.

The Committee should put in place systems to ensure that policyholders have access to redressal mechanisms and establish policies and procedures, for the creation of a dedicated unit to deal with customer complaints and resolve disputes expeditiously.

The responsibilities of the Policyholder Protection Committee include:

- Putting in place proper procedures and effective mechanism to address complaints and grievances of policyholders including misselling by intermediaries.
- Ensuring compliance with the statutory requirements as laid down in the regulatory framework.
- Reviewing the mechanism at periodic intervals.
- Ensuring adequacy of disclosure of "material information" to the policyholders. These disclosures shall, for the present, comply with the requirements laid down by the Authority both at the point of sale and at periodic intervals.
- Reviewing the status of complaints at periodic intervals to the policyholders.
- Providing the details of grievances at periodic intervals in such formats as may be prescribed by IRDAI.
- Providing details of insurance ombudsmen to the policyholders

The policyholder protection committee and its monitoring of grievances provides the framework for the insurer not only to examine the effectiveness of grievance redressal mechanism but also to identify the major kinds of grievances and systemic deficiencies leading to grievances so that they can be rectified for better customer service and consumer protection.

(5) Public Disclosures

Insurers have been mandated to make disclosures of the grievance disposal related information in a quarterly manner in the formats L-41 for Life insurers and NL-41 in case of non-life insurers. In order to make the analysis of data relating to grievances more meaningful in comparison to total number of policies and total number of claims, this information has also been added in the formats of L-41 and NL 41.

The Statements contains information about

- Complaints

o Opening balance as at beginning of the quarter

o Additions during the quarter

o Complaints resolved / settled during the quarter classified as

- Fully accepted
- Partial accepted and
- Rejected

o Complaints pending at the end of the quarter

o Total complaints registered upto the quarter during the financial year (cumulative total)

The complaints are classified into following categories in case of life complaints

o Death claims

o Policy servicing

o Proposal processing

o Survival claims

o ULIP related

o Unfair Business Practices

o Others

The complaints are classified into following categories in case of non-life complaints

o Proposal related

o Claim

o Policy related

o Premium

- Refund
- Coverage
- Cover note related
- Product
- Others

- Business paramaters vis-à-vis complaints
  - Total no. of policies during previous year and current year
  - Total number of claims during previous year and current year
  - Total no. of policy complaints to 10000 policies (current year)
  - Total no. of claim complaints to 10000 policies (current year)
- Duration-wise pending status giving a break up of complaints made by customers and complaints made by intermediaries

The information provides to the members of public a clear idea about the performance of the insurer in relation to grievances and claims so that it can serve as a parameter for choosing the insurer for purchasing an insurance product.

III. IRDAI AND GRIEVANCE REDRESSAL

Apart from issuing regulations / guidelines for insurers to put in place a grievance redressal system, IRDAI does not have the power to adjudicate upon disputes between an insurer and a policyholder under the provisions of the IRDA Act. However, in order to enable that the grievances referred to it are forwarded to the insurer for resolution and ensuring that they are handled properly and promptly, IRDA has provided alternate channels of raising grievances and accessing the database of grievances for ascertaining the status of resolution. For the purpose of MIS on grievances, IRDAI has also put in place a Grievance Mechanism. Consumer Affairs Department of IRDAI handles the area of customer grievances as well as devising the policy on grievance redressal for insurers. Brief details of the grievance redressal channels provided by IRDAI are as follows:

IRDAI provides alternate channels for taking up complaints with insurers. A complaint can be registered with IRDAI through any of the following modes

- Calling Toll Free Number **155255** (i.e. IRDAI Grievance Call Centre) or **1800 425 4732** – Launched in 2010, the call centre serves as a toll free, 12 hours X 6 days service platform, from 8 AM to 8 PM, Monday to Saturday offering services in Hindi, English and other major Indian languages. The call centre is serving as an inexpensive, expeditious and simple method of registering complaints, ascertaining their status and escalating them to IRDAI.
- Sending an e-mail to **complaints@irda.gov.in**
- Registering a complaint on Integrated Grievance Management System at www.igms.irda.gov.in
- Sending the complaint through letter / courier to IRDAI at Consumer Affairs Department, Insurance Regulatory and Development Authority, 3-5-817/ 818, United India Towers, 9th Floor, Hyderguda, Basheerbagh, Hyderabad – 500 029
- Sending the complaint by Fax to 040-66789768

In case a complaint is not resolved within 15 days or not resolved to the satisfaction of the complainant, the complaint can be escalated to IRDAI for taking up with the insurer for resolution or re-examination.

The most important initiative taken by IRDAI in the grievance redressal is putting in place the Integrated Grievance Management System (IGMS), an industry-wide technological solution for handling grievances.

Integrated Grievance Management System (IGMS) was launched by IRDAI in April 2011. IGMS is a comprehensive solution which not only has the ability to provide a centralized and online access to the insurance consumer but also provides for complete access and control to IRDAI for monitoring

market conduct issues based on customer grievances. IGMS has the ability to classify different complaint types based on pre-defined rules. The system has the ability to assign, store and track unique complaint IDs. It also sends intimations to various stakeholders as required, within the workflow. IGMS provides a gateway to register complaints with insurance companies and track their status. A complaint registered through IGMS will flow to the insurance company's system as well as the IRDAI repository. Thus, IGMS provides a standard platform to all insurance companies to resolve insurance consumer grievances and provides IRDAI with a tool to monitor the effectiveness of the grievance redress system of insurance companies. Updating of status will be mirrored in the IRDAI system. Therefore, apart from creating a central repository of industry-wide insurance grievance data, IGMS is a grievance redress monitoring tool for IRDAI. The reports, insurer-wise and industry-wise, are being published annually by IRDAI in the Consumer Affairs Booklet and in the Annual Report.

Thus, IRDAI plays a facilitative role by taking up the complaint with the insurance companies for their resolution and responding to the complaint.

The role of IRDAI in grievance redressal can be summarized as follows:

- Facilitates registration of complaints against insurers and ascertaining status
- Facilitates resolution of complaints by insurers
- Monitors timeliness of disposal
- Takes up complaints on a sample basis for off-site supervision
- Uses MIS based on complaints for monitoring market conduct and regulatory compliance

IRDAI does not investigate into or adjudicate upon insurance consumer grievances but only facilitates resolution of grievances by insurers.

IV. RECOURSES FOR UNRESOLVED GRIEVANCES

In case a consumer is not satisfied with the resolution provided by the insurer or if insurer fails to resolve the grievance, for a decision in the matter, the insurance consumer can take any of the following recourses:

- **Approaching Insurance Ombudsman** for conciliation and adjudication of grievances under Redressal of Public Grievances Rules, 1998 if complaint is on personal lines of insurance and on certain grounds of complaints
- **Filing complaint with appropriate Consumer Forum** based on the pecuniary jurisdiction for adjudication under Consumer Protection Act, 1986
- **Taking up for Arbitration** as per terms of policy – generally available for partial repudiation of general insurance claims only
- **Approaching appropriate Courts** - Insurance grievances are largely disputes in contract. The remedy for any breach of contract terms lies with civil court. Where the grievance involves fraud, forgery, coercion, etc., the matter can be taken up before criminal court.

V. INSURANCE OMBUDSMAN SYSTEM AND ROLE OF IRDAI

With an objective of providing a forum for resolving disputes and complaints from the aggrieved insured public or their legal heirs against insurance companies, the Government of India, in exercise of powers conferred on it under Section 114(1) of Insurance Act, 1938, framed **"Redressal of Public Grievances Rules, 1998"** (RPG Rules), which came into force with effect from 11 November 1998. These Rules aim at resolving complaints relating to settlement of disputes of proposers or policyholders with insurance companies on personal lines of insurance, in a cost effective, efficient and impartial manner. These Rules apply to all the insurance companies operating in general Insurance business and life insurance business, in public and private sectors. To implement the above Rules, the Institution of Insurance Ombudsman has been

established which has been functioning since 1998. There are 17 offices of Insurance Ombudsman at present.

(1) Grounds of complaint before Insurance Ombudsmen

Complaints on any of the following 5 grounds can be made in respect of personal lines of insurance

- Any partial or total repudiation of claims by an insurance company
- Any dispute about premium paid or payable in terms of the policy
- Any dispute on the legal construction of the policies as far as it relates to claims
- Delay in settlement of claims
- Non-issue of any insurance document to after payment of premium

(2) Requirements for lodging a complaint before Ombudsman

- A complaint in writing should have been made to the Insurance Company and the same should have been rejected or not satisfactorily replied to or not responded to within 30 days of its receipt.
- The complaint should be lodged within 1 year of rejection or receipt of reply or non-response after 30 days of making complaint.
- The complaint should be by an individual on 'Personal Lines' of insurance
- The complaint should be in writing duly signed by the complainant or through legal heirs and should state clearly the name and address of the complainant, the name of the branch or office of the insurance company against which the complaint is made, the fact giving rise to complaint supported by documents, if any, relied on by the complainant, the nature and extent of the loss caused to the complainant and the relief sought from the Ombudsman
- The complaint should be made to the Ombudsman having jurisdiction over the location of office or branch of the insurance company against which the complaint is made.
- The complaint should be on one of the grounds of complaint that can be handled by the Insurance Ombudsman.
- The subject matter of the complaint is not currently before a Court/Consumer Forum/ Arbitrator or disposed of earlier by a Court/Consumer Forum/ Arbitrator.
- The total relief sought is not exceeding Rs.20 lakhs.

(3) General Procedure adopted by Insurance Ombudsman

The Ombudsman takes up a complaint for settlement through mediation if both the complaint and insurance company, by mutual agreement, request for the same in writing. In such a case, the Ombudsman, within one month of receipt of complaint, will make a recommendation which he thinks fair based on the circumstances of the case. The recommendation is sent to complainant and insurance company. If the complainant accepts the recommendation in full and final settlement of his grievance within 15 days, the same is communicated to the insurance company. The insurance company should comply with the recommendation immediately or within 15 days and inform compliance to the Ombudsman.

If a settlement by recommendation does not work, the Ombudsman will dispose the complaint by passing a speaking Award within 3 months from receipt of complaint. The award, with reasons indicating the amount awarded and ex gratia, if any, will be communicated to complainant and insurance company. The complainant must convey his acceptance of the Award in full and final settlement of his grievance to the insurance company within one month. In case he does not do so, the insurance company may not implement the Award. If the award is accepted by the

complainant, the insurance company should comply with the same within 15 days of receipt of letter of acceptance and submit compliance to the Ombudsman.

There is no provision for appeal against the order of the Insurance Ombudsman under the RPG Rules, 1998. However, in case a complainant is not satisfied with the decision of the Insurance Ombudsman, he can choose not to accept the decision of the Ombudsman. He can take up the matter before Consumer Forum or any other appropriate Court.

In case an insurer is not satisfied with the decision of the Ombudsman, though there is no provision for appeal by insurer, the constitutional remedy of taking up the matter before High Court under Article 226 of the Constitution of India is available where there is an apparent error in the decision of the Insurance Ombudsman.

(4)IRDAI's Role in relation to Insurance Ombudsmen

From the RPG Rules, the role of IRDAI insofar as Ombudsmen are concerned, is as follows:

- Chairman of IRDAI is the Chairman of Committee for empanelling of Ombudsmen - The Ombudsman is appointed by the Governing Body of Insurance Council. The Ombudsman is selected from a panel prepared by the Committee consisting of Chairman, IRDAI, two representatives of Insurance Council - one each from Life Insurance and General Insurance business and one representative of Central Government. (Rule 6)
- IRDAI is entrusted the task of examining report of enquiry of misconduct by an Ombudsman and recommending action to be taken to Governing body - An Ombudsman can be removed from service for gross misconduct committed by him during his term of office. Governing Body will appoint a person to conduct an enquiry on misconduct of Ombudsman. All enquiries on misconduct are sent to IRDAI. IRDAI will take a decision on the proposed action to be taken against the Ombudsman. On IRDAI's recommendation, if Governing Body is of the opinion that the Ombudsman is guilty of misconduct, it will terminate his services. (Rule 8)
- IRDAI has to organize meetings of Advisory Committee to review the performance of Ombudsman - An Advisory Committee consisting of not more than five eminent persons should be notified by Central Government to assist IRDAI to review the performance of Ombudsman from time to time. IRDAI should decide about the time, venue and quorum of the meeting. (Rule 19)
- IRDAI can make proposals to Government for amending RPG Rules for improving the functioning of Ombudsman - IRDAI may, after discussing with governing body, make recommendations to Government for effecting improvements in functioning of Ombudsman. In the light of these recommendations, Government may carry out amendments to the rules. (Rule 19)

(5)Monitoring and review of Ombudsman by IRDAI

The Advisory Committee, as contemplated under Rule 19 of the RPG Rules as formal mechanism to review the performance of Ombudsmen, has not been notified by Central Government. In the absence of this, there is no formal arrangement for monitoring and review of Ombudsmen. However, Insurance Ombudsmen forward a copy of the report containing general review of activities of the Office of the Ombudsman which is required to be submitted to Central Government as per Rule 20 of RPG Rules, 1998. The Report contains a review of quality of services rendered by insurer and suggestions for improving the same. A consolidated report of all Ombudsmen is forwarded to IRDAI by Governing Body of General Insurance Council (GBIC). The feasibility of implementation of suggestions for improving the services by insurers is examined by IRDAI.

Another forum where IRDAI interacts with the Insurance Ombudsmen is the Annual Seminar on Policyholders' protection and welfare held by Consumer Affairs Department.

Though not in a structured or periodic manner, workshops of Ombudsmen conducted by IRDAI or GBIC provide an opportunity for IRDAI officials to interact with Ombudsmen and discuss measures to improve the insurance ombudsmen system and regulatory system based on observations of ombudsmen during the course of handling grievances. The feedback obtained and suggestions on improving the Ombudsman system are forwarded to Department of Financial Services for consideration. Administrative and operational issues are taken up with GBIC for necessary action. The feedback on regulations and the constraints / difficulties faced by ombudsmen are also discussed with the Insurance Ombudsmen. Systemic issues leading to grievances and Regulatory issues, including suggestions for fine-tuning regulation to strengthen policyholder protection, are forwarded to the concerned regulatory departments for examination, consideration and suitable action. However, the system remains largely unstructured and not formal.

(1) IRDAI and Complaints against Ombudsmen

IRDAI (and GBIC) receive complaints relating to Ombudsmen. The kind of complaints and general action taken in relation to these at IRDAI is as follows:

- Complaint of non-implementation of decisions - They are treated as complaints and taken up with insurers for compliance advising the complainants that IRDAI is not an enforcing authority or appellate authority of insurance ombudsmen.
- Complaints expressing dissatisfaction with the decisions of the Insurance Ombudsman - The complainants are advised that IRDAI is not the Appellate Authority for examining the decisions of Ombudsman and they may take up the matter with any other legal forum. The letters are forwarded to GBIC for examination and taking up with the Ombudsmen
- Complaints against the Ombudsman - These are sent to the Governing Body of Insurance Council for examination.
- Complaint relating to interpretation of RPG Rules by Insurance Ombudsman - These are sent to the Department of Financial Services (Insurance Division), Ministry of Finance examination and necessary directions.

(2) Information received by IRDAI from Insurance Ombudsmen

The information received from Insurance Ombudsmen and their periodicity is as follows:

- Report of activities of Ombudsman - Annual (from Individual Ombudsmen and consolidated report from GBIC)
- Return on complaints handled by Insurance Ombudsmen - Quarterly (from GBIC)

IRDAI publishes the information about handling of complaints by insurance ombudsmen in its Annual Report and in the Annual Consumer Affairs Booklet.

(3) Significant differences between Insurance Ombudsman and Banking Ombudsman

The Banking Ombudsman Scheme has been in force from 1997 and it was issued as a direction of Reserve Bank of India under Section 35A of the Banking Regulation Act. The Insurance Ombudsman system has been in force from 1998 and it is operating as per the RPG Rules, 1998 issued by Central Government under Section 114 of Insurance Act, 1938. Unlike Banking Ombudsman Scheme, Insurance Ombudsman system is not administered or staffed by the IRDAI, the Insurance Sector Regulator, but administered by the Governing Body

of Insurance Council and the staff from public sector life and general insurance companies. The insurance ombudsmen are not officers of IRDAI but retired public servants, civil servants, judges or senior insurance executives. The pecuniary jurisdiction is Rs. 20 lakhs for insurance ombudsman as against Rs. 10 lakhs for banking counterpart. There is no appellate authority to insurance ombudsman to whom an appeal can be made if an insurance consumer or an insurer is not satisfied with the decision of the insurance ombudsman. A failure to comply with award by banking ombudsmen is treated as a violation of Section 35A of the BR Act and RBI monitors compliance of Awards of ombudsmen. There is no enforcement mechanism for awards of insurance ombudsmen leading to delayed compliance even after award is issued. There is no formal mechanism of monitoring implementation of awards of insurance ombudsmen, much less from IRDAI's side. Further, there is no periodic and formal mechanism of IRDAI examining the functioning of ombudsmen and their decisions from the perspective of monitoring timeliness of disposal of complaints by ombudsmen or examining the complaints and decisions of ombudsmen from market conduct angle. Any change in the Scheme of Banking Ombudsmen can be taken by RBI and RBI has revised the scheme twice in 2002 and 2006 and made several amendments to the Scheme for increasing the effectiveness of the Scheme. Amendments to RPG Rules have to be carried out by Central Government with IRDAI's role being limited to being advisory at the most. This is one of the reasons why there has been virtually no change in the Insurance Ombudsman system though it is almost as old as Banking Ombudsman system.

The effectiveness of Insurance Ombudsmen system is largely limited to handling claim related complaints of personal lines of insurance with IRDAI having limited role in improving the effectiveness of ombudsmen system or in factoring the grievance information and decisions of insurance ombudsmen in assessing market conduct and for fine tuning the regulatory framework. Since IRDAI is the regulator entrusted with the responsibility of ensuring policy holder protection along with an orderly growth of the insurance market, entrusting IRDAI with the responsibility of administering the insurance ombudsman system on the lines of banking ombudsman, can put the reins of grievance redressal firmly in IRDAI's hands so that the grievances can be effectively handled and they can be used for market conduct assessment to provide valuable inputs for regulatory action or for regulatory changes.

VI. CONSUMER EDUCATION

The nature of grievances in relation to insurance can arise at any stage of the policy. The stage of insurance and the major areas of grievances are as follows –

- the **policy issuance stage** - mis-selling by selling unsuitable products or resorting to unfair business practices for selling products, non-receipt of policy or medical card, rejecting free-look cancellation or
- the **policy servicing stage** - non-renewal, lapsation, non-payment or delayed payment of survival benefits, problems in assignment, nomination and change of address etc. or
- the **claim stage** - non-payment or delayed payment, partial or complete repudiation of claim.

Awareness of products, benefits, terms and conditions, regulations and role of IRDAI, the timelines for providing services, the recourses available for resolution can help the proposer/policyholders in handling issues at the above stages. IRDAI has provided a lot of education material in the form of handbooks, comics, videos, etc. and placed them on its Consumer Education website www.policyholder.gov.in. The content has also been placed in youtube and facebook. Insurers are also having consumer education material. In spite of these efforts the issues remain.

The nature of grievances at various stages indicated supra, makes it clear that lack of awareness is preventing exercise of choice in selecting the most suitable insurance products leading to excessive reliance on agent or intermediary or blind faith in whatever is claimed at the point of sale. Lack of understanding of the terms and conditions governing the product benefits and exceptions leave the feeling of being cheated when the terms are quoted by the insurer at the time of point of reckoning – i.e. at claim stage. Absence of knowledge of the free look option, IRDAI's regulatory role and the timelines for delivery of services as specified by regulations leads to the grievances being addressed to several agencies like insurer, IRDAI, DFS, PMO etc. The fact that a decision is not communicated adds up to the helplessness experienced by the policyholders / claimants. A combined result of all this is hesitation, bordering to aversion, in buying insurance products.

The benefits provided by insurance, especially in covering risk, cannot be overemphasised. The narrative of cheating by mis-selling of life policies, ever increasing premium for health insurance and refusal to have payment of claim on time in case of general insurance has not been effectively countered by the innumerable success stories of insurance coming to the help of families faced with untimely death of bread winner, monetary succour provided by health insurance cover and the relief provided by general insurance policies during fire, floods, cyclones, etc. However, it can safely be said that information asymmetry is the single most important roadblock hindering insurance from expanding in spite of the dire need for adequate insurance. Therefore, financial education can alleviate the concerns and build trust so as to promote insurance habit so that the sector is able to realize the immense potential for growth and expansion given the low levels of insurance penetration and density.

VII. CONCLUSION

An effective Grievance Redressal System can serve the purpose of providing the much needed confidence in the insurance consumer so that he is assured that even if he has a problem in availing of the insurance service, the grievance is resolved in an effective manner by the insurer or settled through conciliation or by adjudication in a simple, easy, inexpensive and expeditious manner through the insurance ombudsman.

Putting IRDAI at the forefront of grievance policy, grievance systems, management information system, consumer education and ombudsman system for mediation and adjudication of grievances can help enhance the effectiveness of insurance sector's grievance redressal. This in turn can be a positive reinforcement for greater insurance consumer protection thereby giving the fillip for greater insurance inclusion.

Disclaimer: The opinions expressed in this article are solely that of the author and do not express the views of IRDA of India

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प्रकाशक का संदेश

बीमा उद्योग में शिकायत प्रबंध

''आप अपने ग्राहकों के बारे में जो सोचते हैं वह उनके प्रति आपकी प्रतिक्रिया को प्रभावित करता है''

- मैरिलीन सटल

कोई भी उद्योग जो अपने ग्राहकों के हितों के प्रति उत्तरदायी नहीं है, सफल नहीं हो सकता और बीमा उद्योग इस सिद्धांत का अपवाद नहीं है। यह जानने के लिए कि अपने ग्राहकों के हित क्या हैं, किसी के लिए भी अपने ग्राहकों की परिस्थिति में स्वयं को रखने और उनकी बात सावधानीपूर्वक सुनने की आवश्यकता है। केवल ग्राहकों को समझना और उनसे प्रतिसूचना प्राप्त करना पर्याप्त नहीं है; उद्योग को तत्पर, सतर्क और अपने ग्राहकों की सेवा करने के लिए अपने प्रयासों में समर्पित रहने की आवश्यकता है।

बीमा में पॉलिसीधारकों के हित सर्वोपरि हैं। विनियमनकर्ता के सभी निर्णय - चाहे वे विनियम हों, परिपत्र, दिशानिर्देश या आदेश... सबके सब उन हितों के संरक्षण के चारों ओर परिभ्रमण करते हैं। बीमा उद्योग एक सेवा-उन्मुख उद्योग होने के कारण पॉलिसीधारकों की शिकायतों को सँभालना किसी भी बीमाकर्ता/बीमा मध्यवर्ती के लिए एक महत्वपूर्ण कार्य है। बीमा लोकपाल प्रणाली जो सार्वजनिक शिकायत निवारण नियम, 1998 को लागू करती है, पॉलिसीधारक संरक्षण विनियम, शिकायत निवारण संबंधी दिशानिर्देश और आईआरडीएआई की समन्वित शिकायत प्रबंध प्रणाली... इन सबका उद्देश्य एक सुदृढ़ त्वरित शिकायत निवारण व्यवस्था उपलब्ध कराना है। प्रत्येक बीमाकर्ता/बीमा मध्यवर्ती के पास भी उनकी अपनी-अपनी शिकायत निवारण प्रणाली है। ये सब मिलकर यद्यपि एक बड़ी सीमा तक शिकायतों का संतोषजनक निपटान करने में सफल हुए हैं, फिर भी समय-सीमाओं का कड़ाई से पालन किया जाना चाहिए ताकि पॉलिसीधारक को निर्धारित समय-सीमाओं से अधिक प्रतीक्षा न करनी पड़े।

भारतीय वित्तीय संहिता के प्रारूप में भी एक वित्तीय सुधार एजेंसी की स्थापना का प्रस्ताव किया गया है जो सभी वित्तीय सेवाओं को सम्मिलित करेगी, जिसके संबंध में कार्य सरकार के स्तर पर प्रगति पर है।

प्रस्तुत अंक में प्रकाशित आलेखों के अंतर्गत बीमा उद्योग में शिकायतों पर कार्रवाई से संबंधित कई विषय समाविष्ट किये गये हैं। हमारे देश में कृषि के महत्व को ध्यान में रखते हुए जर्नल के अगले अंक का केन्द्रबिन्दु **फ़सल बीमा** होगा।

टी.एस. विजयन

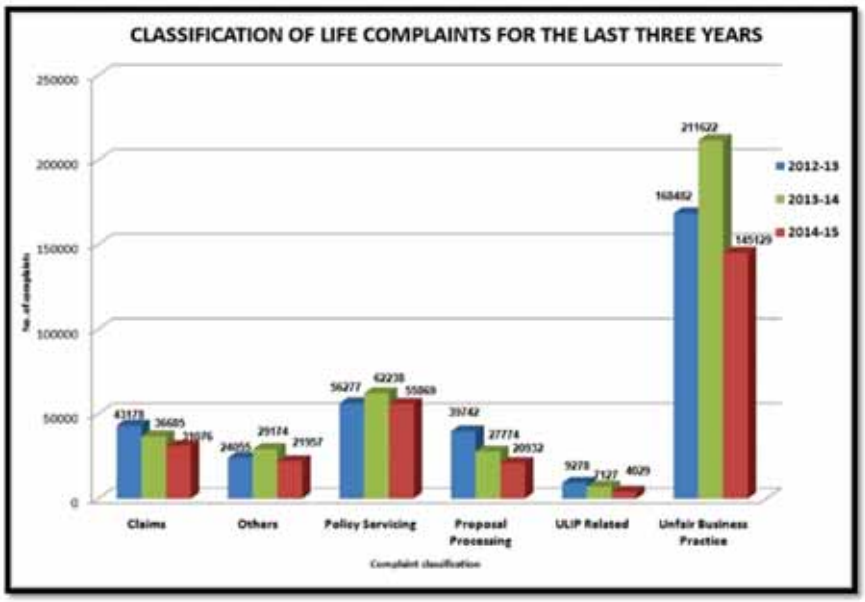
टी.एस. विजयन
अध्यक्ष

जीवन बीमा उद्योग में शिकायत निवारण

- डॉ. अजय कुमार मिश्रा

जीवन बीमा शिकायत: जीवन बीमा व्यवसाय में ग्राहक को सर्वोपरी माना गया है और समस्त नीति और निर्देशन ग्राहकों के हितों को ध्यान में रखकर लिये जाते है। प्रत्यक्ष और अप्रत्यक्ष रुप से बीमा कम्पनिया, बीमा मध्यस्थ, और भारतीय बीमा विनियामक और विकास प्राधिकरण का संयुक्त प्रयास रहता है की एक भी ग्राहक का हित प्रभावित न हो। इसके लिये समय-समय पर बीमा कम्पनियाँ जागरूकता अभियान चलाकर लोगों में बीमा सम्बन्धी जानकारी को प्रदान करती रहती है जिससे बीमा सम्बन्धी किसी भी शिकायत को पूर्व में ही रोका जा सकें। इसके अतिरिक्त भारतीय बीमा विनियामक और विकास प्राधिकरण भारतीय व्यावसायिक परिवेश को ध्यान में रखते हुए आम जनता को जागरूक करता रहा है साथ ही किसी भी शिकायत के सम्बन्ध में उचित कार्यवाही का भी अधिकार, पूर्व निर्धारित माध्यमों के द्वारा प्रदान करता है । समस्त बीमा कम्पनियों को भारतीय बीमा विनियामक और विकास प्राधिकरण के समस्त नीति और निर्देशन को कानूनन मानना अनिवार्य है। इसी विषय पर यदि शिकायतों के बारें में विवेचना की जाय तो ज्ञात होता है की किसी भी शिकायत की वजह में जितना योगदान बीमाकर्ता, बीमा मध्यस्थ का होता है उससे कही अधिक लापरवाही ग्राहकों की होती है। जीवन बीमा ग्राहकों का एक बड़ा वर्ग बीमा लेते समय तटस्थ रूप में समस्त पहलुओं को नहीं समझना चाहता और न ही अपनी आवश्यकता के अनुरुप बीमा लेते समय आँकलन करता है और कागजी कार्यवाही तक सीमित रहकर बीमा में निवेश करता है नतीजतन जब किसी सेवा या अपेक्षा में बीमा कम्पनी खरी नहीं उतरती है तो दोष बीमा कम्पनी या फिर बीमा मध्यस्थ का मान कर ग्राहक

चित्र संख्या-1



शिकायतों पर कार्रवाई - सुनिश्चित करें

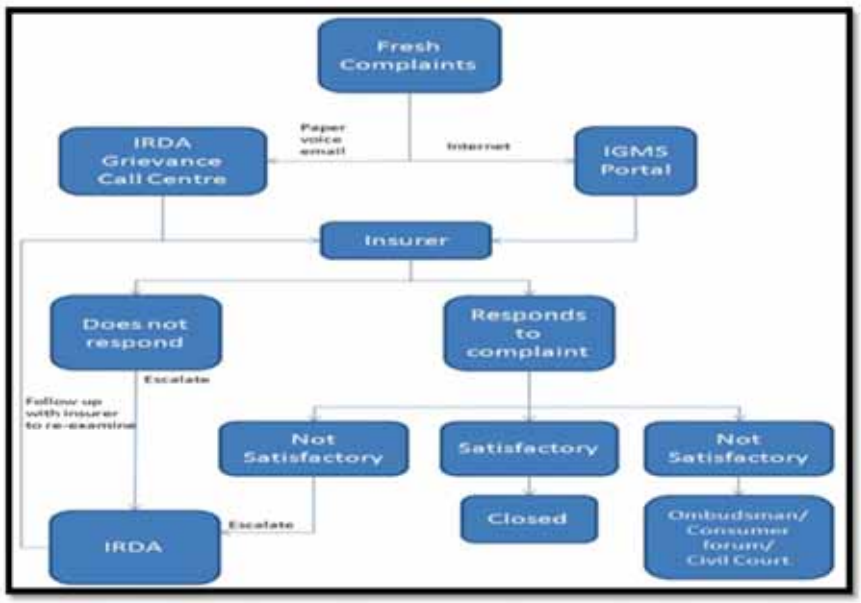
शिकायती कार्यवाही प्रारम्भ करता है। हालाँकि यह शत प्रतिशत सत्य नहीं है कुछ ग्राहक ऐसे भी है जो जागरुक होकर बीमा पॉलिसी लेते है। यहाँ पूर्व के तीन वित्तीय वर्षों में प्राप्त समस्त बीमा सम्बन्धी शिकायतों का वर्गीकरण समझना अनिवार्य है जो की चित्र संख्या-1 में प्रदर्शित है।

यदि उपरोक्त विवरण का मुल्यांकन करें तो ज्ञात होता है की सबसे अधिक बीमा सम्बन्धी शिकायत पिछले तीन वर्षों में अनुचित व्यावसायिक कार्य की वजह से है दुसरे स्थान पर बीमा सेवा सम्बन्धी शिकायतें है, तीसरें क्रम में दावा सम्बन्धी शिकायतें चौथे स्थान पर प्रस्ताव पत्र सम्बन्धी पाचवें स्थान पर अन्य बीमा सम्बन्धी शिकायतों एवं सबसे कम शिकायत छठे क्रम में यूलिप से सम्बंधित है। यहाँ ध्यान देने वाली बात यह है की कभी यूलिप सम्बन्धी शिकायतों का अम्बार सा होता था और क्रम में प्रथम होती थी। निसंदेह यहाँ भारतीय बीमा विनियामक और विकास प्राधिकरण की तारीफ करनी होगी जिसने अपने नियम निर्देशों में आवश्यक सुधार करके यूलिप सम्बंधित समस्याओं का लगभग समापन कर दिया है और आज लोगों में बीमा सम्बन्धी किसी अन्य उत्पाद की अपेक्षा यूलिप उत्पाद के बारें में ग्राहकों को अधिक जानकारी ज्ञात है।

बीमा सम्बन्धी शिकयतों के कारण: जीवन बीमा के निजीकरण के पश्चात् बीमा क्षेत्र ने अलग-अलग तरह की शिकायतों का सामना किया है और वर्तमान में भी कर रहा है। इसे समाप्त तो नहीं किया जा सकता परन्तु व्यापक स्तर पर कभी लायी जा सकती है और कमी लाने के लिए यह अत्यंत आवश्यक है की ग्राहकों में जागरुकता लायी जाए। ग्राहकों का बीमा के बारे में जानकारी का आभाव होना, बीमा मध्यस्थों पर नव-व्यावसायिक लक्ष्य प्राप्ति का दबाव होना, बीमा मध्यस्थों में किसी एक पॉलिसी का विक्रय इस लिए करना की उसमें पारिश्रमिक आय अधिक है, आवश्यकता आधारित विक्रय न करना, आम जनता द्वारा बीमा को मृत्यु के पश्चात प्राप्त होने वाला धन माना जाना अदि मूलभूत समस्तयाएं है जो बीमा कम्पनी के उत्पाद और ग्राहकों की अपेक्षा में अंतर पैदा कर देती है जिसकी पूर्ति न होने पर ग्राहक शिकायत का रास्ता अपनाता है और न्याय की उम्मीद करता है। कई बार यह भी देखने में आता है की पॉलिसी धारक बीमा सम्बन्धी सेवा जिसे प्राप्त करने का उसका अधिकार है वह भी नही प्राप्त करता और वह शिकायत के जरिये आवश्यक सेवा प्राप्त करना चाहता है। समस्त तरह की शिकायतों का यदि बारीकी से अध्ययन किया जाय तो कुल शिकायतों में से एक बड़ा हिस्सा शिकायतों का सिर्फ इसलिए है की बीमा उत्पाद को बीमा विक्रय प्रतिनिधि, ग्राहकों को पारदर्शिता के साथ उत्पाद के लाभों को स्पष्ट नहीं कर पाते है। नतीजतन अनुचित व्यावसायिक विक्रय का जन्म होता है जो आगे चलकर शिकायतों का रूप ले लेता है। यहाँ पुन: एक बात पर नये सिरे से सोचने की जरुरत आज के बीमा व्यावसायिक परिवेश में है की आवश्यकता आधारित विक्रय को जन मानस में प्रचारित किया जाय जिससे शिकायतों में कभी लायी जा सकती है।

बीमा सम्बन्धी शिकायत प्रक्रिया? भारतीय बीमा विनियामक और विकास प्राधिकरण ने ग्राहकों के हितों को संरक्षित करने के लिए शिकायतों के निस्तरण हेतु अलग-अलग फोरम बनाये है जिनकी जिम्मेदारी है की तय समय सीमा में उस शिकायत का निवारण करें। प्रत्येक जीवन बीमा शाखा कार्यालय पर शिकायत निवारण अधिकारी होते है वहां पर शिकायत लिखित दर्ज कराजी जा सकती है, और ऐसी समस्त शिकायतों का निस्तारण 15 दिनों में करना अनिवार्य होता है और यदि ऐसा नहीं होता या प्रदान किया गया समाधान संतोषजनक नहीं है तो भारतीय बीमा विनियामक और विकास प्राधिकरण के शिकायत निवारण सेल के टोल फ्री सम्बर 155255 (या) 1800 4254 732 या complaints@irda.gov.in पर शिकायत भेजी जा सकती है या www.igms.irda.gov.in वेबसाईट पर अपनी शिकायत ऑन-लाइन दर्ज करायी जा सकती है और ऑन-लाइन शिकायत स्थिति से अवगत हुआ जा सकता है इसके अलावा सीधे तौर पर प्राधिकरण को पत्र प्रेषित किया जा सकता है या फिर शिकायत फैक्स के माध्यम से भी भेजा जा सकता है। शिकायत पर उचित कार्यवाही प्राधिकरण तय सीमा में अवश्य सुनिश्चित करता है। समस्त बीमा कम्पनीयों को शिकायत प्राप्त होने पर तीन दिनों के अंदर शिकायत प्राप्ति की सूचना शिकायतकर्ता को देनी होगी एवं 15 दिनों के अंतर उक्त शिकायत का समाधान भी। प्रत्येक बीमा कम्पनी को बोर्ड सदस्यों से संस्तुत शिकायत निस्तरण पॉलिसी बनायी और व्यवहार में लानी अनिवार्य है और उसका निस्तारण भी

चित्र संख्या-2



चित्र स्रोत: http://www.policyholder.gov.in/

करना अनिवार्य है। यदि उक्त माध्यमों से भी शिकायतों का स्तिारण नहीं होता है या प्राप्त निस्तारण असंतोषजनक है तो ग्राहक बीमा लोकपाल या फिर सिविल कोर्ट का सहारा ले सकता है। शिकायत करने की प्रक्रिया को चित्र संख्या-2 के माध्यम से समझा जा सकता है।

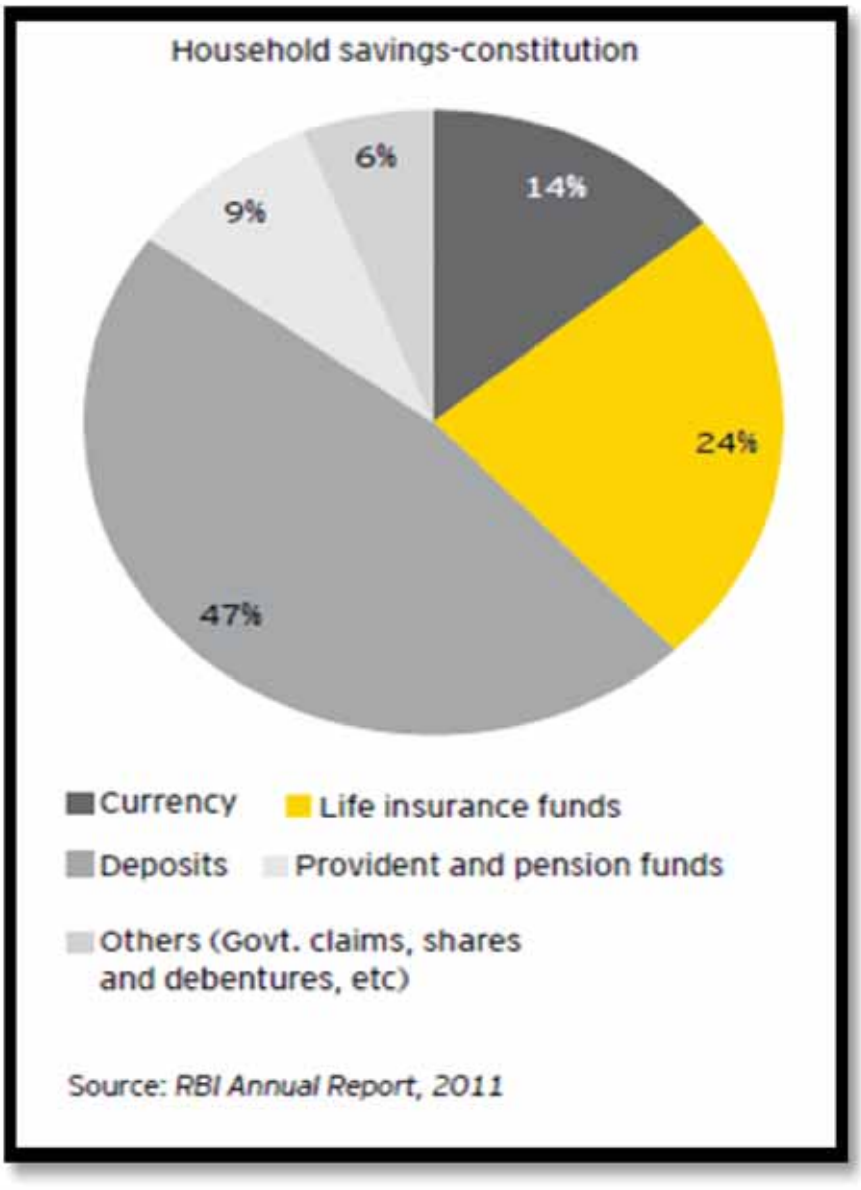
निष्कर्ष: प्रभावशाली ढांचागत परिवर्तन करने के बावजूद दुनिया के कई ऐसे व्यावसायिक क्षेत्र है जहाँ से शिकायतों को पूर्ण रुप से समाप्त आज तक नहीं किया जा सकता है परन्तु संतोष का विषय है की शिकायतों की संख्या न के बराबर है। जीवन बीमा क्षेत्र से भी शिकायतों का समापन तो नहीं किया जा सकता बल्कि व्यापक स्तर पर कभी अवश्य लायी जा सकती है इसके लिये यह अत्यंत आवश्यक है की वर्तमान में चल रहे प्रयासों के अलावा जीवन बीमा सम्बन्धी जानकारी को नई पीढ़ी के पाठ्यक्रम में शामिल किया जाय जिससे एक समय पश्चात् बीमा के सम्बन्ध में देश के कोने कोने में लोग शिक्षित हो और बीमा व्यवसाय में शिकायत की संख्या न के बराबार रह पायें। साथ ही आज के व्यावसायिक परिवेश में यह अत्यंत आवश्यक है की आवश्यकता आधारित विक्रय को प्राथमिकता दी जाय। कोई भी प्रस्ताव पत्र बीमा कम्पनी के पास आये तो उसके बीमांकन के पहले यह टेलेफोन के माध्यम से अवश्य पुष्टि की जाय की आवश्यकता आधारित विक्रय हुआ है की नहीं। हालाँकि कुछ कम्पनियां ऐसा कर रही है पर शिकायतों में कमी लाने के लिए प्राधिकरण द्वारा निर्देशित हो की समस्त बीमा कम्पनियां अनिवार्य रूप से ऐसा करें। आवश्यकता आधारित विक्रय की पुष्टि करने के लिए विशेषज्ञों की टीम हो जिसमें भारतीय बीमा संस्थान से प्राप्त विशेष योग्यता वाले व्यक्ति टीम में अनिवार्य रुप से हो।

डॉ. अजय कुमार मिश्रा, विचार लेखक के व्यक्तिगत है।

भारतीय बीमा उद्योग और ग्राहक परिवाद (ग्रीवांस)

- डॉ. अमित सिन्हा, डॉ. पवन कुमार मिश्रा

किसी भी उद्योग में ग्राहक व्यवसाय की धुरी होता है, और इस सन्दर्भ में बीमा व्यवसाय विशेषत: जीवन बीमा व्यवसाय भी अछूता नहीं है। पिछले दशक में हुई जीवन बीमा व्यवसाय की वृद्धि का एक महत्वपूर्ण पहलू रहा है, करोड़ो नयी पालिसी के विक्रय ने करोड़ों ग्राहक भी जोड़े है और ये शहरी और ग्रामीण दोनों क्षेत्रों में उत्साहजनक रुप से बढ़े है। नए ग्राहक जोकि ऑनलाइन जीवन बीमा खरीद रहे है साथ ही ग्रामीण क्षेत्रों में जीवन बीमा के तरफ बढ़ते हुए रुझान से जुड़ते नए ग्रामीण ग्राहक। रिजर्व बैंक की एक रिपोर्ट के अनुसार जीवन बीमा ने घरेलू जमा के विकल्प के रुप में 24 प्रतिशत हिस्सेदारी बना ली है और यह प्रतिशत आने वाले दिनों में जीवन बीमा के व्यवसाय ले साथ साथ बढ़ता ही जाना है।



ये बढ़ते हुए ग्राहक जहाँ व्यवसाय के लिए एक सफलता है, इन ग्राहकों को संतुष्ट रखना हर कंपनी के लिए एक चुनौती भी है। इरडा की पहल से हर बीमा कंपनी को ग्राहकों के हित के लिए निर्देशित कर एक कंपनी बोर्ड द्वारा स्वीकृत ग्राहक परिवार पोलिसी बना कर ग्राहकों को समुचित

रुप से सूचित करना भी आवश्यक किया गया है। आज जहाँ ग्राहक 24 घंटे सेवा चाहता है, कंपनी को भी ग्राहक के ईश्वर स्वरुप रुप के मंत्र को ध्यान रखते हुए एक स्ट्रेटजी के तहत ग्राहक से हर संपर्क के स्तर पर ग्राहक की सुविधा का ध्यान रखना आवश्यक हो चला है। ग्राहक को पॉलिसी फार्म भरने से लेकर कर दावा भुगतान लेने के बाद भी किसी भी स्तर पर किसी भी दशा में कंपनी द्वारा दी गयी किसी भी सुविधा अथवा आश्वासन के सन्दर्भ में अपनी असंतुष्टि को दर्ज करने का अधिकार है।

आज का प्रगतिशील ग्राहक व्यक्तिगत संपर्क, पत्र आदि पुराने विकल्पों से आगे बढ़ कर ईमेल, टोल फ्री नंबर, मोबाईल द्वारा सन्देश सुविधा आदि का प्रयोग कर रहे है और कंपनी को प्रत्येक सूचना को परिवार के रुप में दर्ज करना आवश्यक है। एक निश्चित अवधि, तीन दिनों, के अन्दर इस सन्दर्भ में ग्राहक से संपर्क कर परिवार का प्राथमिक निस्तारण आवश्यक है। इरडा ने ग्राहकों को स्वंत्रता देते हुए अपनी वेबसाइट और अपनी टोल फ्री नंबर पर भी परिवार दर्ज करने की सुविधा दी है, साथ इरडा ने हर कंपनी हेतु यह डाटा रखना आवश्यक किया है कि ग्राहक की हर शिकायत अथवा सूचना जो किसी भी माध्यम से - ईमेल, टोल फ्री नंबर, मोबाईल द्वारा सन्देश सुविधा, व्यक्तिगत संपर्क, पत्र आदि से प्राप्त हुई हो उसको एक समयबद्ध तरीके से एक विशिष्ट अधिकारी द्वारा निष्पादित किया जाये तथा इस डाटा को समयबद्ध अंतराल पर इरडा को उपलब्ध करने साथ ही कंपनी वेबसाइट पर भी प्रदर्शित करना आवश्यक किया गया। कई कंपनी अपने ग्राहक संतुष्टि के आकड़ों में ग्राहक परिवादों को शत प्रतिशत अथवा इसके निकटतम प्रदर्शित करते है।

कई बार यह आकड़े रिकाडों में तो सही होते है परन्तु ग्राहक परिवाद संतुष्टि की वास्तविक सच्चाई से अलग होते है। कई परिस्थियों में ग्राहक आपनी समस्या को ही नहीं बता पाता है और न ही बीमा सलाहकार और कंपनी अन्य माध्यमों से खुद अपनी ओर से ग्राहक संतुष्टि और परिवाद हेतु विशिष्ट प्रयास करती है। आकड़ों के लिए तो पूरा विभाग और कस्टमर केयर कार्य करता ही है। आज आवश्यकता है, ग्राहक से सवांद के नए रास्ते ढूँढने की और ग्राहक को उसकी आवश्यकता के अनुसार बीमा विक्रय की परन्तु व्यवसाय बढ़ने की होड़ में ग्राहक पीछे रह जाता है। सेल्स टीम अक्सर अपने व्यवसाय वृद्धि और कमीशन आय हेतु अपने हित आगे रख लेते है। कंपनी को एक स्ट्रेटेजी के तहत परिवाद निस्तारण को क्रियान्वित करना होगा और ग्राहक परिवाद के समस्त संभावनाओं के लिए न केवल सेल्स टीम अपितु समस्त कर्मचारिगण को ग्राहक संतुष्टि के लिए कार्य करना होगा। ग्राहक संतुष्टि केवल कस्टम केयर अथवा सेल्स टीम ही ही जिम्मेदारी नही है, अंडरराइटिंग टी का सदस्स, पॉलिसी डिस्पैच सेक्शन का कर्मचारी, कार्यालय के चपरासी और गार्ड तक के स्तर के कर्मचारी भी ग्राहक संतुष्टि के लिए सामानरु से महत्वपूर्ण कड़ी है। ग्राहक परिवाद का शत प्रतिशत निवारण किसी भी कंपनी के लिए ग्राहक संतुष्टि का सम्पूर्ण मानक नहीं हो सकता, आवश्यकता है कुल जारी की गयी पॉलिसी के सापेक्ष दर्ज ग्राहक सूचना/ इनपुट जो परिवाद हो भी सकता है और नहीं भी। परिवाद एक भावनाओं का प्रस्तुतिकरण है अत: हर कंपनी को इसका निस्तारण भावात्मक रुप से ग्राहक से जुड़ने के प्रतेयक स्तर पर करने हेतु प्रयास करना चाहितए ना की आकड़ों में ग्राहक संतुष्टि के उच्च प्रतिशत को दर्शने की लिए प्रयासरत होना चाहिए। बीमा व्यवसाय की सफलता ग्राहक संतुष्टि के बिना नहीं हो सकती इसलिए यह नितांत आवश्यकता है की शिकायतों में कभी लायी जाय।

डॉ. अमित सिन्हा, डॉ. पवन कुमार मिश्रा, विचार लेखक के व्यक्तिगत है।

पॉलिसीधारक नियुक्त कर सकते है स्वतंत्र सर्वेक्षक

- भावना दहिया

अश्विन त्रिवेदी को एक गंभीर कार दुर्घटना का सामना करना पड़ा और बीमा कंपनी ने एक सर्वेक्षक इस दुर्घटना का मुआयना करने को भेजा। मुआयने के बाद सर्वेक्षक का कहना था कि अश्विन को 75 फीसदी वाहन बीमा मिलना चाहिए। अश्विन सर्वेक्षक के इस फैसले के बाद बेहत संतुष्ट हुए। लेकिन बीमा कंपनी बहुत खुश नही थी। इसके बाद कंपनी ने एक दूसरे सर्वेक्षक को भेजा और उसने इस बीमा को कम करके 60 फीसदी कर दिया। उसके बाद तीसरे सर्वेक्षक ने इसे कम करके 40 फीसदी कर दिया और बीमा कंपनी इसका भुगतान करने के लिए तैयार थी। इसमें कोई आश्चर्य की बात नहीं है कि अलग-अलग सर्वेक्षकों के आने से त्रिवेदी थोड़े परेशान हो गए। उनका कहना है, 'मेरा बोनट पूरी तरह से बर्बाद हो गया। उसके बाद भी बीमा कंपनी भुगतान नही करना चाहती।'

बीमा नियामक और विकास प्राधिकरण के अनुसार अगर गोई कंपनी के सर्वेक्षक के मुआयने से संतुष्ट नहीं है तो वे स्वतंत्र सर्वेक्षक को नियुक्त कर सकते है। लेकिन यहां भी बहुत बाधाएं है। उद्योग के अधिकांश लोगों को इस बाद की जानकारी नही है। वास्तव में कई एजेंट भी इस बाद को नही जानते । एक बीमा एजेंट का कहना है, 'हम यही जानते हैं कि केवल बीमा कंपनी ही सर्वेक्षक नियुक्त कर सकती है। हमें इस बाद की जानकारी नही है कि बीमा के लिए दावा करने वाला व्यक्ति भी स्वतंत्र सर्वेक्षक नियुक्त कर सकता है।

सर्वेक्षक - एक स्वतंत्र प्रोफेशन:

सर्वेक्षक स्वतंत्र प्रोफेशनल होते है जिन्हें बीमा कंपनियां किसी नुकसान या दुर्घटना का मूल्यांकन करने के लिए रखती है। जब वाहन दुर्घटना, आग, चोरी या किसी और दुर्घटना के लिए कोई दावा किया जाता है तो वे अपना विचार रखते है।

बीमा का क्लेम करने के लिये जब आप अपने इसन सभी दस्तावेजों को अपनी बीमा कंपनी के सुपुर्द कर देते है। तो कंपनी एक सर्वेयर यानी की सर्वेक्षक को आपके केस के लिये नियुक्त करती है। जो कि आपके वाहन, दुर्घटना और अन्य बातों की जांच करता है। आपकी कार तभी रिपेयर होगी जब सर्वेयर उसकी जांच कर चुका होगा। जब कोई पॉलिसी धारक बीमा कंपनी के सामने दावा करता है तो एक सर्वेक्षक को नुकसान का मूल्याकंन करने के लिए नियुक्त किया जाता है। बीमा कंपनी दावे का निपटान सर्वेक्षक के द्वारा जमा किए गए रिपोर्ट के आधार पर करती है। अगर बीमा कंपनियां सर्वेक्षक के दिए गए रिपोर्ट से संतुष्ट नहीं है तो वे इसे नजरअंदाज करती है।

सर्वेक्षक का विकल्प:

सर्वेक्षक स्वतंत्र माने जाते है लेकिन कई बार बीमा कंपनियां उन पर अपना नियंत्रण रखती है। जब स्वतंत्र सर्वेक्षकों की नियुक्ति की जाती है तो कंपनियों के पास यह विकल्प होता है कि वे सर्वेक्षकों को तब तक दुबारा नियुक्त करती रहती है जब तक वे अपना मनचाहा रिपोर्ट नहीं पा लेती । दावेदार के पास सर्वेक्षक रखने का विकल्प

भी होता है। बीमाकर्ता यह चाहते है कि उनके विश्वस्त लोग ही कोई फैसला करें। नियामक ने बीमा कंपनी और दावेदार दोनों को सर्वेक्षक रखने का प्रावधान किया है लेकिन ज्यादातर कंपनियां दावेदार द्वारा नियुक्त किए गए सर्वेक्षक के मूल्याकंन को स्वीकार नहीं करती है।

आंशिक नुकसान के समले में ज्यादातर कंपनियां दावा किए गए रकम का 40-50 फीसदी की मंजूरी देती है जबकि पूरे नुकसान के दावे का निपटान दावा किए गए रकम के 75 फीसदी तक ही हो पाता है। एक सर्वेक्षक के अनुसार, 'जो रिपोर्ट इससे ज्यादा बीमा की बात कहती है उनको तवाजो नहीं मिलती है। दूसरी ओर बीमा उद्योग का कहना है कि ज्यादा सर्वेक्षक होने से चींजें बेहद जटिल हो जाती है। दावे के निपटान की प्रक्रिया थोड़ी जटिल होगी अगर कंपनी और ग्राहक एक-एक सर्वेक्षक नियुक्त करते है। दावेदार को कंपनी को यह सूचना देनी चाहिए कि वह सर्वेक्षक सें संतुष्ट नहीं तो कंपनी दूसरे सर्वेक्षक को नियुक्ति कर सकती है।

अलग-अलग सर्वेक्षकों के मूल्यांकन:

अलग-अलग सर्वेक्षकों के मूल्यांकन के बाद भी अगर दावेदार संतुष्ट नहीं है तो उसे बीमा कंपनी के शिकायत निपटान विभाग से संसपर्क करना चाहिए। अगर कंपनी यह कहती है कि ग्राहक का दावा पॉलिसी के नियमों के अनुरूप नही है तो दावेदार कंज्यूमर कोर्ट में संपर्क कर सकते है। लेकिन उसके बाद भी अगर दावे का निपटान नहीं होता है तो मध्यस्थों से संपर्क किया जा सकता है।

बीमा पॉलिसीयों के विभिन्न प्रकार के तहत दावों के मामले में, आंशिक रूप से क्षतिग्रस्त सामना या एक बार का कबाड़ या कोई मशीनरी या कोई अन्य संपत्ति का निपटान कुल हानि के आधार पर किया जाता है जिसे ''साल्वेज'' कहता हैं। पूरी राशि के लिए दावा निपटान के बाद अवशिष्ट बीमा कंपनी की संपत्ति हो जाता है। आमतौर पर साल्वेज निपटारे का काम बीमा कंपनी द्वारा सर्वेक्षक को सौंपा जाता है जो कि नुकसान का आंकलन करता है, वह साल्वेज निपटारे के लिए प्रक्रिया पालन के अधीन होता है। साल्वेज निपटारे के माध्यस मे प्राप्त होने वाली राशि बीमा कंपनी द्वारा उनके द्वारा चुकता किए गए घाटे की भरपाई में प्रयुक्त की जाती है।

सर्वेक्षक की रिपोर्ट के बाद सहमति:

सर्वोच्च न्यायालय ने राष्ट्रीय उपभोक्ता आयोग के एक फैसले के खिलाफ ओरिएंटल इंश्योरेंस कंपनी द्वारा दायर की गई अपील खारिज कर दी। आयोग ने बीमा कंपनी से ओजमा शिपिंग कंपनी के स्वामित्व वाले एक पोत के लापता होने के कारण 21 लाख रुपये की बीमा राशि चुकाए जाने को कहा था। मामला यह था कि जब ओजमा का एक जहाज केरल के तट पर डूब गया तो उसने बीमा राशि की मांग की, लेकिन बीमा कंपनी ने आयोग के समक्ष यह दलील दी कि हालांकि उसने सर्वेक्षक की रिपोर्ट के बाद 21 लाख रुपये दिए जाने पर सहमति जता दी थी, लेकिन यह जहाज पॉलिसी लिए जाने के बाद काफी पुराना हो चुका था और इसका मूल्य काफी कम रह गया था।

राष्ट्रीय आयोग ने इस याचिका को खारिझ कर दिया। इसके बाद बीमा कंपनी सर्वोच्च न्यायालय में चली गई जिसने इसकी अपील को खारिज कर दिया। न्यायालय के फैसले में कहा गया, 'असली और वास्तविक दावों में बीमा कंपनियों को भुगतान से बचने का रवैया नहीं अपनाना चाहिए। यह रवैया उनकी साख और विश्वासनीयता पर गंभीर सवाल उठाता है। ऐसे हरेक मामले में सर्वोच्च न्यायालय से संपर्क किए जाने की प्रवृत्ति भी समाप्त किए जाने की जरुरत है।

सर्वेक्षक की रिपोर्ट:

राष्ट्रीय उपभोग्ता आयोग ने बजाज आलियांज इंश्योरेंस लिमिटेड की अपील को खारिज कर दिया और आदेश कि बीमा कंपनी अनाज व्यापारी मैसर्स गोंडामल हरदयाल मल को मुआवजा दे जिनका माल तूफान और भारती बारिश की वजह से क्षतिग्रस्त हो गया था।

जब व्यापारी ने इस मुआवजे का दावा किया था तो बीमा कंपनी ने तर्क दिया था कि सर्वेक्षक की रिपोर्ट के मुताबिक यह नुकसान गोदाम की छत से पानी के बहाव की वजह से नहीं हुआ था बल्कि पानी गोदाम की छत के सुराग से घुसा था। इसलिए यह जोखिम पॉलिसी, जो सिर्फ बाढ़ और जल प्लावन को कवर करती है, की शर्तों के दायरे में शामिल नही था। इस तर्क को ठुकाराते हुए उपभोक्ता आयोग ने जोर देकर कहा कि पुराने फैसलों और ऑख्सफोर्ड कनसाइज डिक्शनरी के मुताबिक 'फ्लड' का मतलब 'पानी का बहाव' है और इसलिए यह जोखिम इस पॉलिसी के दायरे में आता है।

अन्य सर्वेक्षक की नियुक्त:

राष्ट्रीय उपभोक्ता अदालत ने यूनाइटेड इंडिया इंश्योरेंस कंपनी लिमिटेड को मुबंई स्थित एक जौहारी को 28.49 लाख रुपये का भुगतान करने का निर्देश दिया ताकि 12 साल पहले उनके दुकान से 6.8 किलोग्राम सोने के आभूषण की चोरी से हुए नुकसान की भारपाई हो सके। राष्ट्रीय उपभोक्ता विवाद निवारण आयोग (एनसीडीआरसी) ने भुगतान का निर्देश देते हुए कहा कि यूनाइटेड इंडिया इंश्योरेंस कंपनी लिमिटेड नामक बीमा कंपनी द्वारा मुंबई के आभूषण व्यापारी चंपकलाल हसंराज शाह के दावे को खारिज किया जाना न्यायोचित नहीं था, खासतौर से जब सर्वेक्षक ने नुकसान का आकलन किया था। पीठ ने यूनाइटेड इंडिया इंश्योरेंस कंपनी लिमिटेड को यह भी बताया कि अगर वह सर्वेक्षक के निष्कर्ष संतुष्ट नही थी तो उसे दावे को खारिज करने से पहले एक अन्य सर्वेक्षक को नियुक्त करना चाहिए था।

राष्ट्रीय उपभोक्ता अदालत का फैसला 2003 में दायर की गई शाह की याचिका पर आया जिसमें कि आरोप लगाया गया था कि बीमा कंपनी ने मनमाने ढंग से उसके दावे को इस आधार पर खारिज कर दिया कि सोने के आभूषणों को 'सेंधमार रोधक' तिजोरी में नहीं रखा गया था जबकि वह 1995 से हर साल बिना किसी समस्या के अपनी पॉलिसी का नवीकरण करा रहा था।

सर्वेक्षक का फैसला अंतिम नहीं:

सर्वोच्च न्यायालय ने राष्ट्रीय उपभोक्ता आयोग के फैसले को चुनौती देने वाली न्यू इंडिया एश्योरेंस कंपनी की अपील खारिज कर दी और कहा कि बीमा कंपनी के सर्वेक्षक का आकलन बाध्यकारी नहीं है। मामला यह था कि आलू से भरा एक ट्रक टिहरी गढ़वाल में एक खड्ड में गिर गया था। हालांकि इस ट्रक की मरम्मत के लिए 1.5 लाख रुपये का दावा किया गया था, लेकिन बीमा कंपनी के सर्वेक्षक ने इसके लिए अनुमानित खर्च सिर्फ 63,000 रुपये तय किया। जब इसे आयोग में चुनौती दी गई तो सर्वेक्षक के आकलन को खारिज कर दिया गया।

सर्वोच्च न्यायालय ने भी इंश्योरेंस ऐक्ट की धारा एस 64-यूएम(2) के आधार पर आयोग के फैसले को बरकरार रखा और कहा, 'हालांकि'बीमा कंपनी द्वारा 20,000 रुपये या इससे अधिक के दावे के निपटान के लिए नुकसान का आकलन मान्यताप्राप्त सर्वेक्षक द्वारा किया जाना पहली जरुरत है, लेकिन सर्वेक्षक की रिपोर्ट अंतिम और निर्णायक नहीं है। सर्वेक्षक की रिपोर्ट दावे के निपटान पर आधारित हो सकती है, लेकिन निश्चित तौर पर ऐसी रिपोर्ट न तो बीमा कंपनी और न ही बीमित व्यक्ति पर बाध्यकारी है।

इंश्योरेंस कंपनी को देना होगा मुआवजा:

जिला उपभोक्ता फोरम ने एक दुकान में आग लगने पर बीमा कराने के बाद भी क्लेम की राशि न दिए जाने पर इंश्योरेंस कंपनी को 4 लाख रुपये कंपनसेशन के तौर पर और 55 सौ रुपये हर्जाने के रुप में देने के आदेश दिए है। बता दें कि तिगांव रोड बल्लभगढ़ में बंसल गारमेंट्स के संचालक रामेश्वर दयाल ने 3 अगस्त 2007 को अपने वकील के मार्फत जिला उपभोक्ता फोरम में याचिका दायर कर बताया कि उन्होंने एक प्राइवेट इंश्योरेंस कंपनी से 31 मई 2006 से लेकर 31 मई 2007 तक 16 लाख रुपये का इंश्योरेंस कराया था।

22 अक्टूबर 2006 को उनकी दुकान में आग लग गई। इसमें करीब 13 लाख रुपये का नुकसान हुआ। आग में माले के कागजात सहित अन्य कागजात जल गए। आग लगने की जानकारी मिलने पर इंश्यारेंस कंपनी का सर्वेयर आया और उसने दुकान में जले माल का बिल मांगा। बिल न होने के कारण इंश्योरेंस कंपनी ने दावा राशि देने से इनकार कर दिया। इसी मामले की सुनवाई के दौरान जिला उपभोक्ता फोरम ने इंश्योरेंस कंपनी ने कंपनी को मुआवजे की राशि सारा खर्चा देने के आदेश दिए है।

मुआवजा देने का आदेश:

जहांगीपुरी स्थित औद्योगिक क्षेत्र में हरीश गुप्ता नामक शख्स ने प्रिंटिंग प्लांट लगाया था। उन्होंने न्यू इंडिया इंश्योरेंस कंपनी से प्लांट में लगी मशीनों, फर्नीचर और स्टॉक आदि को मिलाकर करीब 73 लाख रुपये का इंश्योरेंस कराया था। कुछ समय बाद प्लांट में भयानक आग लगा गई। आग से प्लांट में लगी महंगी मशीनों, फर्नीचर और स्टॉक का काफी नुकसान हुआ। इसके बाद हरीश ने इंश्योरेंस कंपनी से क्लेम मांगा। कंपनी ने आग से हुए नुकसान का अनुमान

लगाने के लिए सर्वेयर नियुक्त कर दिया। सर्वेयर ने अपनी रिपोर्ट में कहा कि फैक्ट्री में आग लगने के कारण फैक्ट्री मालिक का लाखों रुपये का नुकसान हुआ है सर्वेयर की रिपोर्ट के बाद इंश्योरेंस कपनी ने उन्हें 9.27 लाख रुपये लेकर समझौता करने के लिए कहा। फैक्ट्री मालिक को यह रकम बहुत कम लगी। लिहाजा उन्होंने कंपनी के साथ समझौता करने से साफ मना कर दिया। फैक्ट्री मालिक का कहना था कि आग लगने से उनकी ऑफसेट प्रिंटिंग मशीन बिल्कुल बेकार हो गई। यह मशीन उन्होंने 20 लाख रुपये में खरीदी थी। कंपनी के सर्वेयर ने इस मशीन की कीमत मात्र 6 लाख रुपये आंकी है। कंपनी ने उन्हें 5.45 लाख रुपये का भुगतान भी कर दिया। गुप्ता ने इंश्योरेंस कंपनी से 18 पर्सेंट ब्याज के साथ 13.94 लाख रुपये आर मांगे, लेकिन कंपनी ने उनकी बात अनसुनी कर दी।

उन्होंने परेशान होकर कंस्यूमर फोरम मे केस दायर किया । फोरम ने दोनों पक्षों को नोटिस जारी किया। कंपनी ने अपना लिखित जवाब फोरम में दाखिल कर दिया। उन्होंने उपभोक्ता की दलीलों को सिरे से नकार दिया। सेंट्रल डिस्ट्रिक्ट कंस्यूमर फोरम ने उपभोक्ता के हक में फैसला सुनाते हुए इंश्योरेंस कंपनी को 13 लाख 94 हजार रुपये का भुआवजा देने का आदेश दिया। फोरम ने उपभोक्ता को हुई मानसिक परेशानी के लिए 20 हजार और मुकदमा लड़ने पर हुए खर्च के रुप में 10 हजार रुपये अलग से कंपनी भुगतान करने का आदेश दिया आग लगने से हुए नुकसान की क्षतिपूर्ति करने के लिए कंस्यूमर फोरम ने इंश्योरेंस कंपनी को फैक्ट्री मालिक को 13 लाख 94 हजार रुपये का मुआवजा देना का आदेश दिया है। कंपनी को मुआवजे की यह राशि 9 पर्सेंट ब्याज के साथ देनी होगी

उपभोक्ताओं के जायज दावों को खारिज करने की बीमा कंपनियों की प्रवृत्ति से अप्रसन्न जिला उपभोक्ता अदालत ने पांच बीमा कंपनियों को विभिन्न शिकायतों पर उनके पांच उपभोक्ताओं को 15 हजार से 60 हजार रुपये तक के दावे का भुगतान करने को कहा है। जिला उपभोक्ता अदालत ने कहा कि बीमा अब बहुत लाभप्रद कारोबार बन गया है। बीमा कंपनियां अपने उत्पादों का आक्रामक ढंग से विपणन कर रही है और किसी भी घटना या संभावित अदालत ने उपभोक्ताओं की शिकायतों से जुड़े छह विभिन्न मामालों का फैसला सुनाते हुए कहा कि जब दावों का भुगतान करने की बात आती है तो एक प्रवृत्ति है कि किसी न किसी बहाने से उसे खारिज कर दिया जाए। अदालत ने रिलायंस जनरल इंश्योरेंस कंपनी लिमिटेड को आदेश दिया कि वह कार चोरी दावे के मामले में दिल्ली निवासी ए.के. दत्त को मुआवजे के रुप में 6.6 लाख रुपये का भुगतान करे। इसमें छह लाख रुपये का दावा औरबीमा कंपनी द्वारा दावे को खारिज किए जाने से उपभोक्ता को हुए मानसिक एवं शारीरिक पीड़ा की भरपाई के लिए 60 हजार रुपये शामिल है। अदालत ने इसी तरह कई अन्य मामलों में भी विभिन्न बीमा कंपनियों को उपभोक्ताओं को विभिन्न राशि क्षतिपूर्ति के रुप में देने का आदेश दिया।

बीमा कंपनियों की हर बीमित से ऐसा व्यवहार करने की अपेक्षा होती है मानों वह बीमित नहीं है हानि की रेकथाम व बढ़ने से बचाने के लिए सभी सावधानियाँ बरतें। बीमा कंपनी को सूचित करें जिससे नुकसान का निरीक्षण का मौका दिया जाए। फायर ब्रिगेड को सूचित करें जो आज बुझाने में मदद करेगी। आग बुझाते समय पानी के कारण अन्य बीमित संपत्ति के हुए नुकसान की भरपाई बीमा कंपनी द्वारा की जाएगी। सर्वेक्षक को निरीक्षण करने और हानि का आंकलन करने में सहयोग दें। यदि सर्वेक्षक के आगमन में देरी होने की संभावना है, तो, तस्वीरें लें/और सुरक्षा की एक जगह पर अप्रभावित संपत्ति पहुँचा दें। अपने दावे के समर्थन में पूरा दावा प्रपत्र और दस्तावेजों को बीमा कंपनी को दें। क्षतिपूर्ति के सिद्धांत का उद्देश्य बीमित को उसकी समान जगह रखना है जो कुछ घटने से पहले उसके कब्जे में थी। बीमित प्रत्येक पॉलिसी के तहत नुकसान की पूरी राशि के लिए दावा नहीं कर सकता है। बीमा कंपनी केवल वास्तविक नुकसान की सीमा तक बीमित को क्षतिपूर्ति करेगी जो कि अवमूल्यन, पॉलिसी अधिशेष आदि के अधीन होगा और हानि में से लाभ कमाने की अनुमति नहीं देती। मुआवजा तब देय होगा जबकि कवर की गई हानि या नुकसान होता है, यह आँकलन भी मान्यताप्राप्त सर्वेक्षक द्वारा इस आधार पर किया जाएगा कि क्या संपत्ति का बीमा पर्याप्त रुप किया गया है अथवा नहीं। यदि बीमित राशि अत्याधिक है, तो इसका बीमा पर्याप्त रुप किया गया है अथवा नहीं। यदि बीमित राशि अत्यधिक है, तो इसका तात्पर्य अनावश्यक प्रीमियम की अति-अदायगी होगा, अगर बीमित राशि अपर्याप्त है तो केवल बाजार मूल्य के अनुपात में राशि प्राप्त होगी। बीमा कंपनियों दावे की सूचना

के 48 घंटों के भीतर सर्वेक्षक/निरीक्षक की नियुक्ति कर रही है। अवकाश/सप्ताह के अंत में और कार्यालय के घंटों के बाद सर्वेक्षक की नियुक्ति के लिए सहायता/अन्य किसी प्रकार के मार्गदर्शन के लिए कंपनी के टोल-फ्री हैल्पलाईन नंबर ग्राहकों को उपलब्ध करवा रही है। बीमा सर्वेयर योग्य पेशेवर है और नुकसान के आकलन के लिए है। उसका काम वास्तविक नुकसान का आकलन और झूठे दावों द्वारा बीमा कंपनियों को घाटे से बचाने और दूसरी ओर बीमा जो वास्तविक हानि के समय मदद करने के लिए है, के उददेशय की पालना करना है। बीमा का मूल्यांकन करता है। मैकेनिकल इंजीनियरिंग में एक पृष्ठभूमि के साथ एक सर्वेक्षक एक औद्योगिक दुर्घटना के मामले में वास्तविक हानि का मूल्यांकन करता है। सर्वेक्षक बस सर्वेक्षण नहीं करता - वह जांच करता है, मूल्यांकन करता है, हानि का मूल्याकंन - समायोजन करता है, दायित्व निर्धारित करता है, बातचीत करना है और अंत में रिपोर्ट देता है। वह बीमा कंपनियाँ आरै बीमित के बीच एक विशिष्ट लिंक है। वह बीमा कंपनियों के घाटे को न्यूनतम करने और झूठी, अतिशयोक्तिपूर्ण दावों से बचाने में मदद करता है।

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भावना दहिया, सी-301, ऐम्बीयेंसएन्स अपार्ट्मेंण्ट्स, ग्राम नाथुपुर, जिला: गुडगाँव, गुडगाँव-122 001. एन.सी.आर

Snapshot of Life Insurance Industry as at 30.10.2015

The Life Insurance Sector procured Rs. 66997.80 crore First Year Premium with a growth of 21.11% as at the end of 31st October, 2015. LIC procured Rs 47109.24 Cr with a growth of 18.82% where as Private Sector procured Rs 19888.55 Cr posting a growth of 26.90%. Private sector experienced a growth in both Individual NB and Group NB where as LIC shown a growth in Group NB and decline in Individual NB.

The number of individual policies has shown a growth of 7.33% by public sector and 9.04% by private sector and a overall growth of 7.73% at the industry level. The number of lives covered under Group policies has shown a growth by 54.45% at the industry level.

ULIP business has shown a growth of 60.34% up to the period ended 31st October, 2015 compared to the corresponding previous period. The Life Insurance Industry has procured Linked Premium of Rs.8691.85 crore as at 31st October, 2015 as against Rs. 5420.59 crore for the same corresponding period of previous year. This entire growth may be attributed to the Private Sector (growth of 60.07%) while LICI has a growth of 2385.93% with Rs. 15.91 crore against the Rs. 0.64 crore business in the previous year corresponding period.

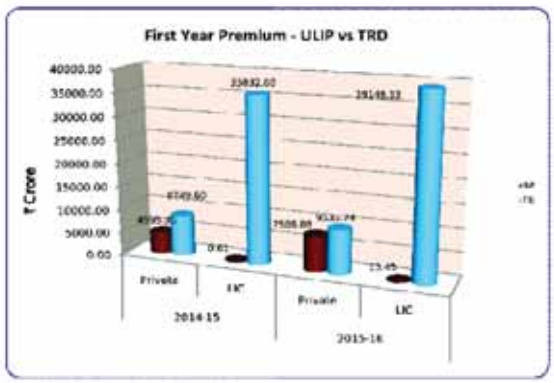
The share of Pension (32.29%), Annuity (7.43%) and Health (0.15%) segments has shown growth where as Life (60.13%) segment has shown a decline when compared to last year's performance. The individual pension business shows a decline both in terms of number of policies and premium. Group Pension premium has a growth of 24.05% for private sector and 50.69% for LICI. However, the share of individual pension premium out of the total pension premium remains at just around 2.3%.

The number of individual agents* in life insurance sector stood at 20,33,959 with a net reduction of 33,877 (1.6%) for the period. There is a net addition of 31,114 (3.4%) agents in private sector which has ended up with a total of 9,35,346 agents while there is a net reduction of 64,991 (5.6%) in case of LIC which closed the month of October 2015 with a total of 10,98,613 individual agents.

(* Source data is from Life Council's MIS for the month of October, 2015)

Analysis of ULIP business:

The Life Insurance Industry has procured Linked Premium of Rs.8691.85 crore as at 31st October, 2015 as against Rs.5420.59 crore for the same corresponding period of previous year. It shows an increase of 60.34%.



LIC's Premium is Rs.15.91 crore (PY Rs.0.64 crore), an increase of 2385.93%.

Private players have collected linked Premium of Rs.8675.94 crore (PY Rs.5419.95 crore), an increase of 60.07%.

Analysis of Traditional Business:

The Life Insurance Industry has procured Non-Linked Premium of Rs.58305.95 crore as at 31st October, 2015 as against Rs.49899.72 crore for the same corresponding period of previous year. It shows a growth of 16.85%.

LIC's Premium is Rs.47093.33 crore (PY Rs. 39646.73 crore), a growth of 18.78%.

Private players have collected Non-linked Premium of Rs.11212.61 crore (PY Rs.10252.99 crore), an increase of 9.35%.

Compiled by Life Dept., IRDAI

Report Card : General

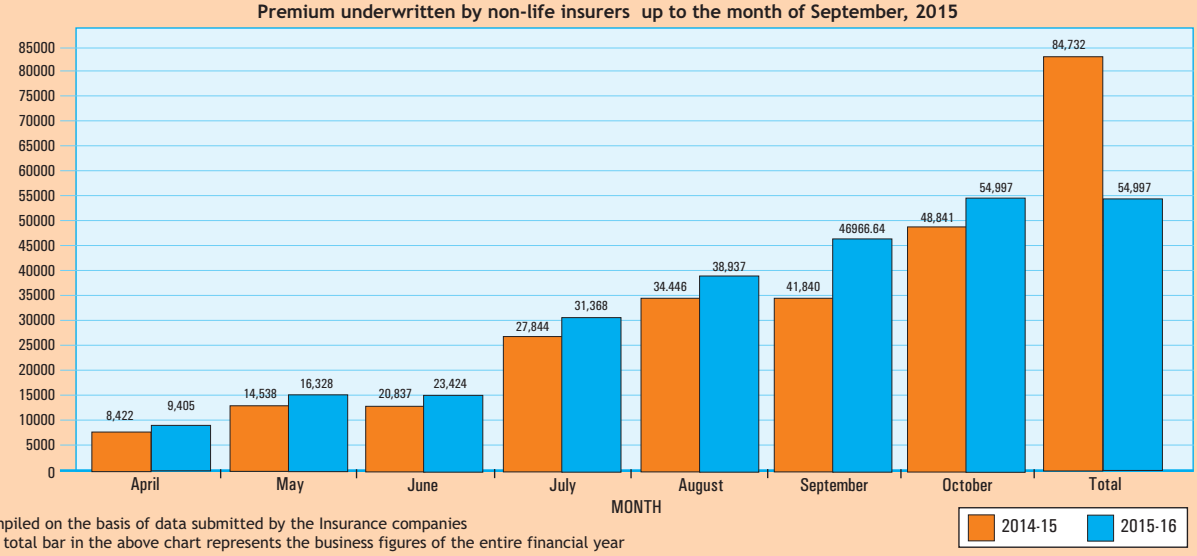
Gross Premium underwritten for and up to the month of October, 2015

(₹ in Crores) (%)

INSURER	OCTOBER		APRIL-OCTOBER		GROWTH OVER THE CORRESPONDENCE PREVIOUS YEAR
	2015-16	2014-15*	2015-16	2014-15*	
Royal Sundaram	150.50	136.12	937.59	907.75	3.29
Tata-AIG	234.97	203.56	1,806.48	1,532.72	17.86
Reliance General	228.62	228.26	1,716.41	1,644.82	4.35
IFFCO-Tokio	282.38	251.12	2,086.99	1,877.33	11.17
ICICI-lombard	743.83	625.33	4,740.95	3,990.94	18.79
Bajaj Allianz	488.41	446.83	3,264.37	3,062.91	6.58
HDFC ERGO General	293.28	248.28	1,886.20	1,880.44	0.31
Cholamandalam	202.69	137.72	1,290.19	1,110.10	16.22
Future Generali	130.80	113.46	888.03	826.20	7.48
Universal Sompo	68.30	45.49	462.31	359.65	28.54
Shriram General	139.68	119.09	930.87	829.59	12.21
Bharti AXA General	129.05	139.51	780.19	888.66	-12.21
Raheja QBE	1.98	1.72	15.04	12.91	16.55
SBI General	159.41	115.04	1,016.46	777.66	30.71
L&T General	43.26	34.15	242.58	174.25	39.21
Magma HDI	37.99	44.28	226.42	253.80	-10.79
Liberty	33.82	25.83	238.88	149.68	59.59
Star Health & Allied Insurance	144.64	104.26	967.96	723.98	33.70
Apollo MUNICH	71.74	46.54	437.81	328.26	33.38
Max BUPA	38.99	26.86	250.68	186.09	34.71
Religare	39.15	16.91	269.59	122.34	120.36
Cigna TTK	9.52	1.19	48.56	4.86	898.53
New India	1,165.60	1,039.46	8,690.57	7,606.44	14.25
National	1,015.72	919.06	6,863.12	6,350.49	8.07
United India	973.43	867.08	7011.03	6318.29	10.96
Oriental	672.62	603.40	4859.29	4406.88	10.27
ECGC	124.93	109.95	718.39	720.36	-0.27
AIC	403.51	350.97	2,350.28	1,793.58	31.04
PRIVATE TOTAL	**3,673.00**	**3,111.55**	**24,504.56**	**21,644.95**	**13.21**
PUBLIC TOTAL	**4,355.81**	**3,889.93**	**30,492.69**	**27,196.04**	**12.12**
GRAND TOTAL	**8,028.81**	**7,001.47**	**54,997.25**	**48,840.99**	**12.60**

Note: Compiled on the basis of data submitted by the Insurance companies
** Figures revised by insurance companies*

Premium underwritten by non-life insurers up to the month of September, 2015



* Compiled on the basis of data submitted by the Insurance companies
The total bar in the above chart represents the business figures of the entire financial year

PUBLIC NOTICE

IRDAI CAUTIONS PUBLIC AGAINST SPURIOUS CALLS AND FICTITIOUS OFFERS

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

- Claiming to be representatives of IRDAI and offering insurance policies of different insurance companies with various benefits.
- Claiming that IRDAI is distributing bonus to insurance policyholders out of the funds invested by insurance companies with IRDAI.
- Claiming that the policyholder would receive bonuses being distributed by IRDAI if they purchase an insurance policy and wait for a few months after which the bonus would be released by IRDAI.
- Advising customers to subscribe to fresh policy after surrender of the existing policy and wait for a few months after which the fresh policy would be entitled for additional enhanced returns/ benefits.
- Informing that 'Survival Benefit or Maturity Proceeds or Bonus' is due under their existing policy and investing in a new insurance policy is mandatory to receive the amounts which are due.
- Advising public to invest in insurance policies to avail gifts, promotional offers, interest free loans, or setting up of Telecom towers or other such offers.

The general public is hereby informed that IRDAI is a regulatory body established by an Act of Parliament, i.e. the Insurance Regulatory and Development Authority Act 1999, to protect the interests of the policyholders, to regulate, promote and ensure orderly growth of the insurance industry and for matters connected therewith or incidental thereto. Further, IRDAI informs the members of public that:

- IRDAI does not involve directly or through any representative in sale of any kind of insurance or financial products.
- IRDAI does not invest the premium received by insurance companies.
- IRDAI does not announce any bonus for policyholders or insurers.
- Any person making any kind of transaction with such individuals/agents will be doing the same at his own risk.

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

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

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Bima Bemisaal

BEWARE OF FAKE TELEPHONE CALLS

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

I.R.D.A of India:

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

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

A public awareness initiative by

भारतीय बीमा विनियामक और विकास प्राधिकरण

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