Volume I, No. 8

irda Journal

JULY 2003

बीमा विनियामक और विकास प्राधिकरण

Volume I, No.8
Journal
JULY 2003

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

Editor: K. Nitya Kalyani

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

From the Publisher

I assume office of the Chairman, IRDA, with a great sense of humility and see before me the great strides that this organisation has made in the last few years of its existence. I have inherited an organisation with a firm foundation, known for its independence, transparency and fair play. I also realise that there are vast areas still to be traversed. It shall be my endeavour to build on the enormous goodwill that the organisation enjoys in the industry and the Government. I seek the cooperation and assistance of all members of the organisation and the players in this sector in building upon the sound foundation, an impressive superstructure.

C.S.RAO

Inside

COVER STORY

Marketology

Apparao Machiraju 20

INTRODUCING

Profile of
Mr. C.S. Rao

5

"Quite Satisfied"

R.C. Sharma 3

Things to come...

This edition of **IRDA Journal** comes to you with a welcome and a farewell!

Mr. C. S. Rao took over as Chairman, IRDA, on June 10 on the retirement of Mr. N. Rangachary on June 9. We present you a quick profile as he gets down to his task and wish him well in his responsibility of taking the Authority and the insurance industry to greater heights on the wings of the best of regulatory practices.

The farewell is to Mr. R. C. Sharma, Member (Non-life), IRDA, the general insurance industry veteran who retired on June 20.

Our issue focus this month is Information Technology (IT). In most parts of the world it is difficult to imagine a data, transaction and document intensive service industry like insurance not being powered by IT. But the Indian market, as in many other ways, is in transition in this matter. Our writers, with experience in insurance, technology and the art of selling, have laid before us a menu of what the power of IT in insurance is and what it can be.

In the next issue we will be taking a look at bancassurance, how it has established itself, or otherwise, in the Indian market, and what we can look forward to. The Indian market is vast and served by an incredibly large network of bank branches – one of the most positive outcomes of bank nationalisation – and the latter seems to be just made right for the distribution of insurance products. Let's see what's happening, what is working and what is hindering this process.

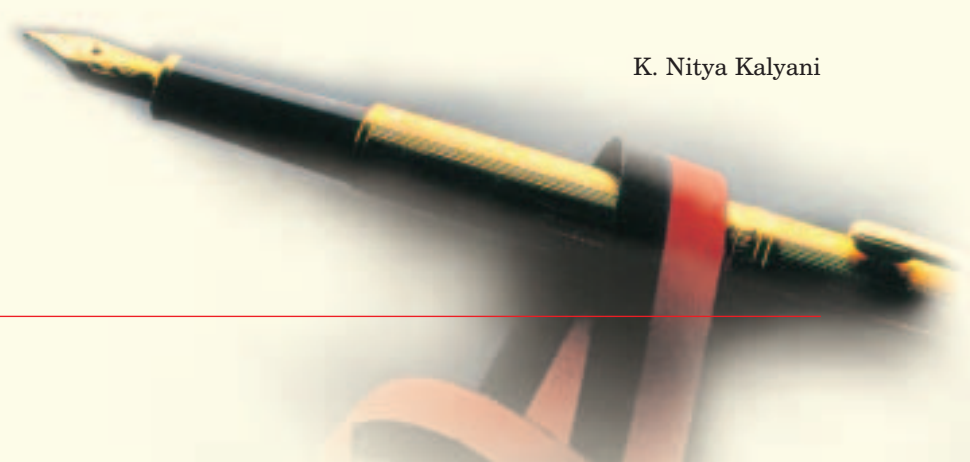
The Journal, more than being the voice of the Authority, has been positioned as a forum for the industry to voice its concerns and opinions and to discuss and debate issues. And a valuable outcome of that is being able to garner and broadcast the reactions and opinions of the consumers and stakeholders on various initiatives of the Authority. A couple of months ago we brought out a special supplement on the Standard Pension Plan suggested by the Shinkar Committee, constituted by the IRDA. Your responses have been coming in, constituting valuable feedback on the product and its purpose.

We bring you in this issue a fairly detailed profile of another initiative being planned by the IRDA. You have been reading news about the need for centralised data collection to support decision-making in Motor and Health insurance. In the section End User is a profile of projects aiming to fill this need and also the data that is proposed to be collected and analysed. What you think of its scope and utility is something that we would like to know. Please write or e-mail us in as much detail as you wish, so that we can publish a variety of suggestions and opinions. If the issues are well debated and understood that will help shape the project suitably.

We hope you enjoy the rest of the Journal as well. There is a critique of the Justice Rangarajan Committee by Mr. K. N. Bhandari and a discussion about what constitutes liability in Motor insurance by Mr. D. Varadarajan.

Mr. G. V. Rao, retired CMD of Oriental, who started analysing non-life business trends for the Journal from the last issue, throws light on what the premium figures reveal at the end of May, 2003. Statistics, as usual, tell the most interesting story and, by turns, bemuse and enthuse us. So it is in this issue as well!

K. Nitya Kalyani



QUITE SATISFIED

"I have had a variety of experience and am quite satisfied," says Mr. R. C. Sharma at the end of his two-year stint as Member (Non-Life), IRDA.

Mr. Sharma, who retired on June 20 on turning 62, joined the general insurance department of the Life Insurance Corporation of India (LIC-GI) in 1964 and retired as General Manager of the Oriental Insurance Company Limited in 2001.

After various operational and technical postings, including stints as acting Chairman and Managing Director of both United India Insurance Company and Oriental, when – he recalls with amusement – he had to sign many documents twice, once as General Manager and then again as current-in-charge, Mr. Sharma moved to 'very interesting, conceptual' work in the IRDA.

That was the time when the new-born authority was writing the regulations and gearing up to register insurance companies and "as a person who knew the ills of the industry, I could contribute in a regulatory manner to plugging those ills," he says.

For, the nationalised general insurance industry, regulation had, until then, been all in the family, since its then holding company, the General Insurance Corporation of India (GIC), was also the regulator. But with a statutory regulator in place things changed much.

One of the larger conceptual changes was the developmental role of the IRDA. "This role has never been forgotten," says Mr. Sharma, and this was one of the interesting challenges – repositioning the role of a regulator as understood by many.

Another important achievement of the IRDA that he recalls proudly as having played a part in, is establishing its position among peers around the world. Considering that during the time the International Association of Insurance Supervisors (IAIS) was being set up, the mid nineties, the IRDA was still faced with being a voluntary body with lengthening efforts to get statutory status, the respect that it has earned has been impressive. How was it done? "It depends on what committee meetings you attend and what you say – if you are technically sound, people will listen."

India was part of important committees looking after emerging markets, reinsurance and evolving accounting standards, due to the effect of the towering personality of Mr. N. Rangachary, the recently retired Chairman of IRDA, he says. "I cashed in on the opportunities and established our presence." India was elected as member of the Executive Council, which is the decision-making body of the IAIS.

"Mr. Rangachary had set the image of IRDA at a high level and I had only added to it," says Mr. Sharma. "I am happy that he saw the potential in me and gave me the role."

On IRDA's priorities in the near term as he sees it, Mr. Sharma counts monitoring and implementation of the regulations. The simplest thing would be to see that the financial disclosures conformed to the requirements in the regulations and to strengthen the fledgling, but fundamentally strong, inspection capabilities within the IRDA.

In the long term we have to strengthen these capabilities. We have standardised formats and methods prescribed by the IAIS that we can use to strengthen core functions, he says.

And what of his retirement? At this point, he is looking forward to spending a relaxed couple of months with his sons in the US. And then it's likely to be consultancy. But for now he is not thinking beyond the upcoming holiday!

Introducing ...

From getting state governments – many of them fiscally chaotic – to accept caps on their borrowings from the Reserve Bank of India (RBI), to overseeing an insurance industry that presents a study of contrasts today. Mr. Chellapilla Satyanarayana Rao may just find that the more things change, the more they remain the same!

But for now, it is reading-up-the-files time for the recently retired Revenue Secretary, Union Finance Ministry, who took over as Chairman, IRDA, on June 10. So, any observations on and plans for the industry will have to wait a bit!

So we talked about his studies (English Literature and Emerson) and his career (mostly finance ministries at the state and the Centre, with a little bit of rural development, irrigation and consumer affairs thrown in).

Talking about the Overdraft Regulation Scheme brings a smile to his face. Getting state governments to go in for a debt swap scheme and replace it with market borrowings, though to their benefit, was not an easy project to sell at all, as he describes it. He found though, that states acted quickly when they realised that it was their own credibility at stake, and started opting for the fiscal reform facility created by the Eleventh Finance Commission, which has both incentives and stiff targets for fiscal deficit reduction.

Another project he is remembered for is the disaster management scheme that he put in place in Andhra Pradesh, and which has become the model for the Centre and for other states as well.

What sparked it off was the major cyclone in Andhra Pradesh in May 1990. Affecting 12 coastal districts, submerging crops and rendering whole drowned villages inaccessible, it reminded him of his experience as Collector of Krishna District in 1977, when a tidal wave wiped out villages and killed about 9,000 people. It took all year for the rehabilitation and reconstruction to get done.

As Andhra Pradesh's Finance Secretary, Mr. Rao set about preparing a project report for the World Bank, which had shown some interest in long term rehabilitation programmes of the affected areas. He co-ordinated the multi-sectoral project sending the project report in just six weeks and completing negotiations with the World Bank in another two months.

An aid of $265 million was sanctioned and the work had to be completed, and funds utilised, in three years. The World Bank wanted to deal with just one nodal officer, and Mr. Rao it was!

"I took advantage of the disaster to look at the long term problems of the affected areas," he says.

The first of these was communications, and the second, agricultural productivity. Because the flood waters washed away roads and inundated fields.

Identifying vulnerable areas, the project quickly mapped alternative state highway routes while National highway roads were repaired. Coastal roads were built or strengthened so that in future emergencies, reaching aid or evacuating people would not suffer.

As for waterlogging of fields, the money went to rebuild and repair the extensive drainage system of the Krishna-Godavari delta which had aged. The locals sacrificed a crop to let this work take place, but were rewarded the very next year when another cyclone left their fields unharmed!

Working with a small team of a few officers experienced in administration, engineering and accounts, Mr. Rao set up a Project Monitoring Unit (PMU) which worked as a facilitator and clearing house identifying schemes and getting them implemented within the framework of World Bank tender and other conditions. The PMU also worked simultaneously submitting accounts to the Union Government and getting reimbursements in record time, and in previously unheard of quanta too!

"In one year $100 million was used and drawn and they told me that even major projects did not draw funds so quickly," he says. This was possible because of the centralised nature of the PMU and also the fact that he remodelled the accounting machinery. He created pay and accounts organisations in each district across departments where all the expenditure accounts would get consolidated and sent directly up to the PMU.

This quickened the work and use of the allotted aid. What's more, the US Dollar, which was at Rs. 16 when the aid was sanctioned moved to Rs. 31 within a year, and Mr. Rao was able to talk the World Bank into expanding the project!

The project was expanded in another unexpected way too! The PMU model was much appreciated, and one such has been set up in the Union Finance Ministry which, in turn, has got all states to do the same for quick completion of projects and complete utilisation of aid.

And he's not a stranger to the markets either! The first public sector unit to be disinvested – Modern Foods – was taken up when Mr. Rao was Additional Secretary and Financial Advisor, Ministry of Food and Consumer Affairs.

"Being the first disinvestment effort we were particular that it should be done quickly and efficiently." And happen it did, fetching the Government Rs. 1,000 for a Rs. 100 share.

Mr. Rao, in a way, has come back home to Hyderabad, and his wife, a law graduate and home-maker, will join him shortly. His recently married elder son is an MBA and is in the US, while his younger son seems to have harked back on his father's English literature days. He's a writer and his first book is being published by Penguin.

Mr. Rao himself remembers little of Emerson he admits, and his main relaxation is Carnatic music, which he enjoys listening to. Specially, Dr. M. Balamuralikrishna and M. S. Subbulakshmi!

Road Map to Detariffing

The IRDA has decided to detariff Motor Own Damage (OD) premiums from April, 2005, following the discussion of the Justice Rangarajan Committee's report on the subject at a meeting of the Chief Executives of general insurance companies at Hyderabad, held on May 6.

Following this, a committee has been set up under the chairmanship of Mr. S. V. Mony, Vice Chairman, AMP Sanmar Assurance Company, to consider the alternatives to free the market from the tariff to allow new products to be introduced and the measures to be taken for it, including the adoption of differential tariffing.

The members of the committee are:

Chairman, GIPSA (representing the public sector)

Mr. Micky Brigg, Managing Director, Royal Sundaram (representing the private sector)

Mr. M.K. Tandon, CMD (Retired), National Insurance Company Ltd, Calcutta

A representative of the Ministry of Surface Transport (MoST)

Mr. Jagdish Khattar, CEO, Maruti Udyog Ltd, or his representative

Mr. D. Varadarajan, Advocate, Legal Advisor to IRDA

Mr. P.K. Swain, AGM, Tariff Advisory Committee (TAC) – Convenor-Secretary

The group has been given a deadline of December 31 to submit its report to the IRDA, after which the report will be published and its implementation taken up after examining the suggestions received.

LICENSED BROKERS

P.S. Manian
Link-K Insurance Broker Co. Pvt. Ltd.
#36, Vinayakakoil Street, Sivananda Colony
Coimbatore-641012 Tamil Nadu
Ph: (0422) 2496878/2496024

R.S. Gupta
Paramount Insurance Brokers Pvt. Ltd.
First Floor, Jeevan Tara Building, Gate No. 3
5 Parliament Street, New Delhi-110001
Ph: (011) 51501152/51501153

Ashok Jain
Jain Insurance Intermediaries Pvt. Ltd.
T-1, Green Park Ext., New Delhi-110016
Ph: (011) 26167775/26197775

Jatin V. Saghavi
Satyan Insurance Services Pvt. Ltd.
404, Vishwanank Apartment, Chakala
Andheri(East), Mumbai-400099
Ph: (022) 28369054/56771005/06/07

B.S. Sujay
Sujay Insurance Services Pvt. Ltd.
"Sujay House", No.4, Uttaradhimutt Road
Shankarapuram, Bangalore-560004
Ph: (080) 6602597/6602598/6602600

S.V.L.N. Sarma
Fouress Insurance Services Pvt. Ltd.
6-3-1100/5, Somajiguda, Hyderabad-500082
Ph: (040) 23414944/23414945

Suresh Balakrishnan
MF Insurance & Reinsurance Services
4B-Jeevan Asha, 60-A.G. Deshmukh Marg
(Peddar Road), Mumbai-400026
Ph: (022) 23891388/23889893

S.S. Prakash
Athena Insurance & Reinsurance Brokers Pvt. Ltd.
112, 'C', Mittal Tower, Vidhan Bhavan Marg
Nariman Point, Mumbai-400 021
Ph: (022) 56301616

Poonam Seth
Authentic Insurance Brokers India Ltd.
C-77, Shyam Apartments, Sarojani Marg
C-Scheme, Jaipur-302001
Ph: (0141) 2364706/2365667

R.J. Pereira
Midtown Insurance Services Pvt. Ltd.
Gammon House, Veer Savarkar Marg
Prabhadevi, Mumbai-400025
Ph: (022) 56614063

Pawan Puri
Peraj Insurance Brokers Pvt. Ltd.
Bombay Life Bldg., 45, Veer Nariman Point
Mumbai-400001
Ph: (022) 22043154/22829129/22845460

Manish Rathi
AR Insurance Brokers Pvt. Ltd.
3rd Floor, J.K. Somani Bldg., British Hotel Lane
Bombay Samachar Marg, Fort, Mumbai-400023
Ph: (022) 56377000

Bhaskar De
Pegasus Insurance Brokers Pvt. Ltd.
218, JK Chambers, Sector 17, Vashi
Navi Mumbai-400705
Ph: (022) 55912385/86

Anil Kumar Sharma
Suraksha Insurance Advisors Pvt. Ltd.
113, Park Street, 7th Floor, Kolkata-700016
Ph: (033) 22298228

"Less often human than not..."

B. Raghavan

The title may baffle the reader and prompt him to think that the writer is a man with ingrained enmity towards Mr. Rangachary, since, in the perception of the reader, Mr. Rangachary possessed and practiced characteristic features acceptable to the whole world. But I would wish to allow the reader the latitude to think for a moment that I am biased against Mr. Rangachary. The reader's anger towards me will covert itself into delight shortly.

I have had the privilege of working with Mr. Rangachary ever since he joined the Authority in August, 1996, as Chairman, till his retirement in June, 2003 – nearly a full seven years – seven years of most pleasant and golden association, seven years of being a witness to the exhibition of an extraordinary erudition, seven years of his service to humanity, seven years of his great assistance to the Government in nation-building, seven years of …….. the list can be enlarged to an unparalleled extent.

When I talk of seven years of Mr. Rangachary's endowments to humanity and the country and the insurance industry, I should not be taken to mean that his service and philanthropic acts are confined to just seven years. No! That is not the case, I emphasise only what he took upon himself during his association with the Authority to which I was a witness.

I am irrefutably sure that his philanthropic and altruistic inclination started not at this birth but got into his system many births ago. I am categorical in this observation because the Bhagavad Gita authoritatively gives plausible reason and reasoning for the extraordinary characteristic features noticed in some rarest human beings – first of these being Mr. Rangachary.

Nobody can confute me in this conclusion of mine as I could come across not even a single occasion when he declined to render any help to anyone, sought at any moment of the day. When I say 'any moment,' I mean it in the strictest sense of the term because I was, on many occasions, present beside him at his house and, even at 11 pm his residential telephone would ring and someone would request his intervention to solve one issue or the other involving official matters.

My illustrious boss would lift the telephone as patiently and amiably as ever – a hallmark of his character – and would answer in the affirmative for rendering the requisite help. The request – even if received at the oddest of hours – would enter the CPU of his brain and the first thing he would do the next day in the office would be to attend to the resolution of that issue. This magnanimity and modesty, noticeable in all his dealings, is unique and unexampled.

This magnanimity and modesty, noticeable in all his dealings, is unique and unexampled.

Having seen him perform exceedingly well, academically, professionally, officially, managerially, and above all, spiritually, and still keep his equanimity and cool on all occasions, I cannot help concluding that Mr. Rangachary has been more often Godly than not. The support for this conclusion is derived from the Bhagavad Gita, Chapter 16.

"Fearlessness, purification of one's existence, cultivation of spiritual knowledge, charity, self-control, performance of sacrifice, study of the Vedas, austerity, simplicity, non-violence, truthfulness, freedom from anger, renunciation, tranquility, aversion to faultfinding, compassion for all living entities, freedom from covetousness, gentleness, modesty, steady determination, vigour, forgiveness, fortitude, cleanliness, and freedom from envy and from the passion for honour – these transcendental qualities, O son of Bharata, belong to Godly men endowed with divine nature."

I have justified the title of this write-up!

I will conclude by quoting from a letter which the greatest biographer of all times, Mr. James Boswell, wrote, dedicating his great work "Life of Dr. Samuel Johnson" (which he wrote by assiduously spending the whole of his life) to Sir Joshua Reynolds. This was written in 1791 and no other piece of writing can be a better description of the characteristic features of Mr. N.Rangachary.

"Your equal and placid temper, your variety of conversation, your true politeness, by which you are so amiable in private society, and that enlarged hospitality which has long made your house a common centre of union for the great, the accomplished, the learned, and the ingenious; all these qualities I can, in perfect confidence of not being accused of flattery, ascribe to you."

– James Boswell

The author is Assistant Director, IRDA.

Most Admired

Arup Chatterjee

Mr. N. Rangachary has been the most admired, respected and revered icon of insurance in India, who has given the seven best years of his life for the cause of development of this sector in India in the new millennium.

His astute leadership in the backdrop of social values both in public and private life has served as a strong anchor in the turbulent sea of changes as the market evolved from monopoly to competition.

The Authority was fortunate to have him as its first Chairman when the foundations were being firmly laid.

According to Thomas Carlyle, the eminent historian of the eighteenth century, "Every institution is the length and shadow of one great person," and the short history of insurance in the liberalised era has become "His Story" which resonates everywhere.

But what has been done is just the beginning, as Rome was not built in a day. And therefore, as the baton passes, we are sure that we are doubly blessed.

Being a keen follower of the gentleman's sport of cricket, he carried the same philosophy to the insurance market place faced with a rocky prologue, by ensuring that the players played with responsibility and regulated themselves, both on and off the field. At the same time his singular contribution lay in initiating efforts to bring insurance awareness – like cricket – to the masses, so that it doesn't remain elitist.

According to Confucius "Leaders are dealers in hope." The change managers and alchemists of insurance with a bias towards optimism and action can learn seven lessons from his master strokes which I had the benefit of witnessing very closely in these seven years of his tenure.

- 'Maestro' style leadership pays. By acting as a conductor of a highly articulate team of gifted individuals, he always led by example and inculcated discipline, commitment, pride and diligence.
- Resources are scarce and need to be utilised optimally. Realising this fact he chose his resources carefully and wisely, displaying a high degree of optimism. This led to the creation of one of the most efficiently run regulatory offices in the world.

Being a keen follower of the gentleman's sport of cricket, he carried the same philosophy to the insurance market place.

- Leadership is character and character is knowing yourself, finding your voice and deploying your talents to achieve your goals. He provided a sense of purpose including elements of passion, vision and meaning in a world of confusion.
- Follow an open house relationship built on trust. According to him 'trust' alone holds any relationship together in the journey with competence, constancy, caring, candour, and congruity.
- Unity in thought and action. He always remained a visionary by remaining high on details, and a copy book follow through ensured he converted himself into a conceptualiser and effective dream maker.
- Be selfless and not selfish. He took up the task of building leaders at every level and consequently it was the task of the leader to develop the leader for generation next.
- Sense of humour. This final ingredient offered ease in relationship with others and reduced distance. It also provided the maturity to take failure in one's stride and to keep a sense of purpose in success.

The author is Deputy Director, IRDA.

Happily Ever After?

S. Bhattacharya

The concept of bancassurance that originated in France is gaining momentum here in India as well. Bancassurance, in its simplest sense, is the distribution of insurance products through the outlets of banks. Gradually, it may take more complex forms depending on several factors including demographic profiles and the economic and legislative environment of the country.

The Gramm Leach Bliley Act of 1999 in the US, followed by the Insurance Regulatory & Development Authority (IRDA) Act, 2000, in India, has provided the stimulus required for the growth of bancassurance in the country. Now, the IRDA (Corporate Agents) Regulation is also in place. Insurance and banking companies are well aware of the numerous benefits which they can derive through bancassurance. This is precisely why they are on tie-up sprees these days. However, the tie-ups are being entered into basically to create an agent-principal relationship.

In the regime of dwindling interest rates, the growth in the interest income of banks has not been very high and in fact has been falling. The total fee-based income of the Indian banking industry in 2001-2002, was around Rs. 9,200 crores. As a percentage of total income, fee-based income from brokerage and commission decreased to 6.1 per cent in 2001-02 from 6.73 per cent in 2000-2001.

Bancassurance could bring in good revenues for banks in the form of commission income through selling of risk products. Let us find out how much revenue the banks would be able to garner from the sales of general insurance products alone.

Roughly estimated, there are about 17 crore bank accounts. If a bank can sell one general insurance policy to each of these account holders over a period of five years, with an average premium of Rs. 3,000 per policy and an average commission of 10 per cent, the banks could earn a total commission of Rs. 5,100 crores. The banks' total cost incurred per Rupee of revenue earned would also come down significantly as they do not have to spend much on infrastructure and facilities. Rather, this would also enable better deployment of surplus manpower, if any.

The greatest advantage of the banks is that they have direct contact with their customers. They can easily package insurance products with car loans or housing loans to their clients. Customers who have developed a loyalty to the bank are even less likely to move if they get add-ons like premium payment facilities and administration of surrender or transfer of policies.

Insurance penetration in India, particularly general insurance, has been abysmally low at below one per cent of the Gross Domestic Product (GDP). This means that there is a vast potential yet to be explored and this is where the wide branch network of public sector banks, particularly in rural areas, would come into play.

Insurance companies would also benefit from marketing through banking channels. Middle income consumers, who constitute a major chunk of the banks' customer base, get little attention from most insurance agents. By capitalising on bank relationships, insurers will be able to recapture much of this under-served market, particularly for their personal line products.

Insurance companies are keen to utilise the wide spread of bank branches and the potential of tapping the large number of customer accounts. Customer database of banks can provide basic information on the customers' spending habits, investment patterns etc.

The market potential in India is immense and the four public sector general insurance companies have the necessary infrastructure to expand the pie. Now, the question is whether non-life insurance products would be able to gain popularity through bancassurance like their counterparts in life insurance. In spite of the roaring success of bancassurance in Europe, while more than 50 per cent of new life-insurance premium is generated through bancassurance, particularly in Belgium, France, Germany and Spain, non-life premium generated would be far less than 10 per cent.

In India, would the scenario be different? Barring Motor and Health, how many products of non-life are readily saleable?

Some insurers may plan to buy shelf space in banks and sell insurance to those who voluntarily purchase it. But to make a breakthrough with a financial product that is not so easily bought over the counter, a trained task force, which will focus on hard-selling risk products, is absolutely essential.

In India, life insurance schemes get exemptions in respect of income-tax but Personal line general insurance products, except Mediclaim premiums, do not. People in India still see insurance behind the screen of savings. Only generating awareness amongst the masses can make protection the primary objective of insuring. Here lies the role of insurance companies and banks who have, over the years, built up customer relationships. They can create insurance awareness so that the voluntary purchase of personal line insurances grows sizeably. However, developing savings linked general insurance products may also be thought of. To promote the cause of insurance, tax incentives may have to be provided for general insurance products.

All said and done, the success of bancassurance would depend on a close relationship between the insurers and banks and the way they draw up strategies suited to their mutual interests and that of the consumers. For this we need to create a database of customer needs, synchronise them with the appropriate insurance packages, simplify procedures both at the level of insurers and banks, and ensure prompt after-sales service coupled with an effective on-line system of getting feedback from branches.

Selling the packaged instruments as combined units of banking and insurance products will also require imparting necessary training to the staff and proper administration of the participating banks and insurers with a result-based data system working to perfection.

A successful implementation of bancassurance can ensure a win-win situation for the banks, the insurers and the consumers.

The author is Assistant Administrative Officer in National Insurance Company. The views expressed here are his own.

Consumer has Recourse

The Insurance Ombudsman system, an alternate system of dispute resolution that helps the customer of an insurance company have his problems sorted out speedily and inexpensively, has been elaborated upon in various earlier issues of **IRDA Journal.**

Here is a letter received from Mr. R. K. Kohli, a Delhi-based Advocate and Legal consultant, about some provisions of the Insurance Ombudsman scheme, and our Legal Department's clarification of the issues.

The Doubt

This has reference to the article "How an Ombudsman Works" by Samiran Bhattacharya (**IRDA Journal**, April 2003, Page 11 and May 2003, Page 34). In particular I draw attention to paragraph three of the middle column where it is stated that the consumer has the liberty to move the consumer forum or civil court in case he is not satisfied with the award of the Ombudsman.

I may point out that the aforesaid proposition made by you may not be sustainable in law as applicable to the Insurance Ombudsman in light of law and procedures currently applicable.

You will no doubt recall that in accordance with procedures prescribed by the Governing Counsel, every complainant is required to sign an arbitration agreement before the complaint is admitted for consideration by the office of the Insurance Ombudsman. The said agreement is signed with specific reference to the Insurance Arbitration and Conciliation Act, 1996. In such a scenario, the award of the Insurance Ombudsman is an arbitral award under the provisions of the Indian Arbitration and Conciliation Act, 1996. No challenge to such an award can be made except on limited grounds enumerated in Section 34 of the aforesaid Act. It is respectfully submitted that a civil court and/ or consumer forum/ commission is not competent to sit in judgement over the award of the Insurance Ombudsman except as laid down in the Arbitration and Conciliation Act, 1996.

> Mr. Kohli says: "A civil court and/ or consumer forum/ commission is not competent to sit in judgement over the award of the Insurance Ombudsman, except as laid down in the Arbitration and Conciliation Act, 1996."

I, therefore, shall request that the position in this regard may be clarified since the subject article appeared in the official journal of the statutory authority, i.e. the IRDA. I may also add that the position suggested in the article may be true in relation to rules governing financial ombudsman services of the UK, but it does not have legal support for functioning of Insurance Ombudsman in India.

It will be of relevance to note that civil courts and the consumer forum/ commission in Delhi do not entertain complaints which have already been adjudicated upon by the Insurance Ombudsman. In the light of the law as prevailing on date I am of the view that the said approach of the civil courts and/ or consumer forums cannot be faulted. Your article therefore created a doubt which should be cleared in the interest of sound professional practices.

I shall be obliged if you will throw some light on the above.

The Clarification

The system of Ombudsman is similar to the system of Lokpal since both are aimed at redressing the grievances relating to various departments/ sectors. The system of Ombudsman has been introduced in different specialised fields with a view to expedite the process of grievance redressal with low expenditure and minimum of annoyances.

In the insurance sector the Ombudsman system was introduced on lines similar to that of Banking Ombudsman. The Central Government in exercise of the powers conferred upon it by Section 114 (1) of the Insurance Act, 1938, framed "The Redressal of Public Grievance Rules 1998," (hereinafter referred to as the rules) which came into effect from the November 11, 1998.

These rules apply to all the insurance companies operating in life and in general insurance business, unless exempted by the Central Government (on fulfillment of the requisite conditions).

The objects of these rules are to resolve all complaints relating to settlement of claims on the part of the insurance company in a cost effective, efficient and impartial manner.

Currently the Insurance Ombudsman under the rules is empowered to deal with only complaints lodged by an individual by whom or on whose behalf an insurance policy has been taken on personal lines – defined to mean an insurance policy taken or given in an individual capacity – and he is empowered to award compensation to the complainant not exceeding Rs. 20 lakhs (including ex gratia and other expenses).

There appears to be some confusion between the Arbitration and Conciliation Act, 1996, and the "The Redressal of the Public Grievance Rules, 1998."

Firstly, there is no act called the "Insurance Arbitration and Conciliation Act,1996," to the best of our knowledge.

Secondly, a complainant who knocks the door of the Ombudsman *does so under the rules* and not under the Arbitration and Conciliation Act, 1996, (hereinafter referred to as the act). Hence the question of applicability of the grounds enumerated in Section 34 of the act does not arise.

The Insurance Ombudsman, under Rule 12 of the rules has been empowered to receive and consider the complaints/ matters enumerated in that rule. Further, the decision of the Ombudsman, as to whether the complaint is fit and proper for being considered by it or not, has been made final by Rule 12(3) of the rules, and Rule 13 specifies the manner in which the complaint has to be made to the Ombudsman.

With reference to Para 3 of the article referred to in the letter above, it is clarified that there are two ways in which a grievance may be dealt with by the Insurance Ombudsman under the present rules.

First, when the complainant and the insurer request the Ombudsman in writing to mediate and settle the complaint. In such a case the Ombudsman makes a recommendation not later than one month from the date of receipt of the complaint and if the complainant accepts the recommendation he will communicate to the Ombudsman his acceptance in writing within 15 days of the receipt of the recommendation. The Ombudsman sends a copy of the recommendation along with the acceptance letter to the insurer, who shall comply with the terms of the recommendations not later than 15 days of the receipt of such recommendation and shall also inform the Ombudsman of its compliance. Where the complaint is not settled by agreement under Rule 15, the Ombudsman shall pass an award which he thinks fair in the facts and circumstances of a claim under Rule 16 of the rules. A copy of the award is sent to the complainant and the insurer.

An individual can approach the Consumer Courts under the Consumer Protection Act, 1986, or file a suit before the civil court under the Civil Procedure Code either directly or when the recommendation or award of the Ombudsman is not acceptable to him.

The complainant shall furnish to the insurer within one month from the date of the receipt of the award, a letter of acceptance that the award is in full and final settlement of his claim.

The insurer shall comply with the award within 15 days of the receipt of the acceptance and also send its compliance to the Ombudsman.

Rule 17 of the rules deal with the consequence of the non-acceptance of the award by the complainant and clearly states that the insurance company may not implement the award if the complainant does not intimate the acceptance of the same.

Readers would thus appreciate that the individual complainant may choose to get his grievance redressed by the Insurance Ombudsman system which is an alternative dispute resolution mechanism evolved with a view to redress grievances efficiently and speedily, since the individual may not be in a position to fight long legal battles against the insurance company.

An individual having a grievance thus continues to have the option to approach the Consumer Courts under the Consumer Protection Act, 1986, or to file a suit before the civil court under the Civil Procedure Code, either directly to get his grievance redressed or when the recommendation or award of the Ombudsman is not acceptable to him.

Know Thyself!

The IRDA has been planning initiatives to rectify the near total lack of data and real time information in two critical areas of insurance and, in fact, in the Indian society, namely health and road accidents.

The need for a Health insurance data warehouse stems from the fact that no reliable data or information is available in India on this subject. Whether individual health history or morbidity patterns across the populace, very little information is collected, analysed and made public.

The plan is to pool data related to incidence of diseases geographically and in terms of socio-economic classes. Also required is a mapping of diagnostic, treatment and drug regimens and their availability and pricing across the country. Using this information, the patterns of morbidity and mortality can be traced, and the market, in terms of insurance pricing and medical facilities, will then adjust itself to the needs as revealed by the analysed data.

The other project has to do with Motor insurance and road and vehicle safety. India, with a relatively small vehicle population leads the world in road fatalities. On the other hand the general insurance industry here has been crying hoarse that its losses in this class of business, which brings in close to 40 per cent of its Rs. 14,000 crores plus premiums, have been destroying gains from other classes of business. At the same time it does not have the data to prove its case conclusively.

The plan of the IRDA is to collect and analyse data on road accidents and Motor insurance from various stakeholders like the general insurance companies, police, road transport authorities, vehicle manufacturers, vehicle financiers, hospitals, courts and so on for use by the very same stakeholders to make our roads a safer place.

There is also a plan to test various vehicles for their overall safety and correlate their performance on the roads with the results of scientific testing.

Here are overviews of the plans and what they envisage. We present them here to get the opinions and comments of readers on their utility and value, and to create a public debate on these projects before the specifics are crystallised.

Please also send us your comments and suggestions on any aspect of the project and issues including the actual data that is proposed to be collected, how to collect it and make use of it. All possible areas of concern, whether they be of the security of the data, confidentiality and privacy, and the sustainability of the project, also need to be debated in public and addressed as we work towards the implementation of these common user facilities.

Write to us at the following address:

The Editor, IRDA Journal, Insurance Regulatory and Development Authority

5-9-58/B, Fateh Maidan Road, Basheer Bagh, Parisrama Bhavanam, Hyderabad - 500 004, or e-mail us at irdajournal@irdaonline.org

Medical Informatics

Current medical practice does not insist on a system of medical record keeping. Perhaps this is because of health *per se* being in the Government's domain and also the limited usage of Health insurance by the masses hitherto.

With the increasing popularity of Health insurance in the country as also diminishing healthcare spending by the Government, the need for organisation of healthcare informatics is of paramount importance as it will have a major impact on the cost and quality of healthcare to be delivered under private Health insurance by exhibiting demonstrable cost savings and efficiency.

The emphasis of the Medical data warehouse, therefore, shall primarily be on collecting and storing centrally, patient information and information on drugs, their prices, treatment regimens, their costs in different geographical areas and in different categories of medical facilities and so on. The data will be stored for retrieval by the patient or his or her doctor anytime and anywhere and the consolidated and analysed data will find multiple uses in medical and sociological research and will help shape medical facilities to suit the morbidity trends that are revealed.

Medical records are required for historical purposes. They are also needed for communication among providers who will use them for anticipating future health problems, recording standard preventive measures, identifying deviations from the expected, as legal record and for forming the basis for clinical research.

Records are kept by doctors, nurses, hospital offices and paramedical staff. The forms of clinical data that can be collected are numerical measurements or narrative text.

The former includes lab data, bedside measurements, diagnostic outputs like electro cardio grams (ECG), X-rays, MRI and ultrasound, discrete data like family history, patient's medical history, current complaint, symptoms and signs, physical examination, and medications. The latter would include doctor's and nurse's notes, discharge summaries and referring letters.

The database will have identifying information like name, age, sex, race, religion and insurance information, the patients' profile including occupation, education, marital status, children, hobbies, worries, moods, sleep patterns and habits, medical history, chief complaints, history of present illness, past medical history, review of systems, family history, medications, physical examination, laboratory data and physiological tests.

Taking care of confidentiality and privacy issues, consolidated data from these records would be used by several parties like healthcare providers, managements of hospitals, insurers, government policymakers, legislators, lawyers, healthcare researchers, clinical investigators, health sciences journalists and editors, patients and their families.

Many institutions would also use consolidated data and research findings that flow from these records. They include public health departments, peer review organisations, quality assurance companies, risk management companies, employers, registries, health data organisations, healthcare technology developers and manufacturers, research centres, medical, nursing and public health schools, and policymakers in the central, state, and local government agencies.

The data can be used by hospitals, for instance, for proof of identity and verification of billing, to ensure continuity of care, describe diseases and causes and support decision-making about diagnoses and prescriptions.

The primary use of the data would be to assess and manage risk, facilitate care via clinical practice besides evolving guidelines to document patient risk factors, assess and document patient expectations and satisfaction, generate care plans, determine preventive advice, remind clinicians, support nursing care and to document services provided. From the patient care management perspective it helps to analyse the document case mix, establish severity of illness, formulate practice guidelines, manage risk, characterise use of services, identify the basis for utilisation review and perform quality assurance.

It also helps to allocate resources, analyse trends and develop forecasts. In terms of procedures it helps billing and reimbursement, submitting insurance claims, adjudicating insurance claims, determining disabilities, managing and reporting costs and performing actuarial analysis.

The secondary uses of the data is in the areas of education, where it helps in documenting professional healthcare experience, preparing conferences and presentations and teaching students. In the area of regulation it serves as evidence in litigation, fostering post-marketing surveillance, assessing compliance with standards, accreditation of professionals and hospitals and comparing healthcare organisations.

In policy formulation and research, it is useful for allocating resources, conducting strategic planning, monitoring public health, developing new products and planning marketing strategy, conducting clinical research, assessing technology, studying patient outcomes and the effectiveness and cost effectiveness of care, identifying populations at risk, developing registries and databases and assessing the cost-effectiveness of record systems.

The data – from multiple sources – will be collected and stored with uniform coding and in standardised formats. This standardisation and coding will make retrieval easy while interpretation and understanding trends will become simpler. It will also make feasible transferability of information among specialties and sites with relevant literature and with other registries and will facilitate e-billing. Patients will be able to access their records at any location while their confidentiality is fully protected.

Road and Vehicle Safety

This project envisages bringing together data from various agencies involved in the management of road accidents or funding the losses thereof.

The Motor insurance business brings in the most premium and accounts for the largest part of claims payouts in the non-life insurance in India. The premiums are dictated by The India Motor Tariff, the credible and socially acceptable revision upwards of which depends on reliable statistics about losses due to motor accidents and claims payouts which will establish the need for it and help estimate the quantum of increases.

Today, the industry has no organised data to base the arguments for its case on.

Also, one class of Motor insurance customer is subsidising the other and premiums are set only by broad criteria like the cubic capacity of the vehicle and the zone in which it is used and are not matched to the actual risk profile of the owner /user which is not mapped in any detail.

There is a dire need for proper data collection and analysis for the general insurance industry in order to establish the profitability and profile of its Motor insurance business.

This activity will acquire greater value if it is done, not on a company to company basis, but on a nationwide basis. It would then become an instrument for loss minimisation which will in the long run bring benefits back to the insurance industry in the form of lower losses and better profitability. This in turn will bring benefits to the consumers of the industry in the form of lower premiums and better products.

India of course, can do with less road accidents, injuries and deaths, and the socio-economic effects of these on individuals and the society.

We, as a society have low loss awareness and poorly developed systems of operations and enforcement for traffic, road and vehicle safety. This is reflected in the fact that India has the highest number of road accident fatalities in the world though our vehicle population is nowhere near the top. In addition, we are very badly equipped for disaster management including even the very basic rescue operations related to road accidents within cities, let alone highways.

We have no information or control over how many of the purchased vehicles are registered (20 per cent is one newspaper estimate) or how many registered vehicles are insured (40 per cent is one insurance industry estimate), though Third Party liability insurance is mandatory under the law. Further questions that emerge are: who owns, runs and operates these vehicles, how to track stolen or lost vehicles, how to identify offenders in accident cases and so on. And we are in an uncomfortable situation where we do not have clear facts on these.

The idea is to collect all this information and make it available to stakeholders, including the public, from a single point after appropriate processing and value addition by way of research, surveys, analyses and recommendations.

The most important stakeholder section – the insurance industry – will get aggregate data and also information mined to the detailed levels they want and need in areas that could form the basis for fine risk profiling of their customers.

These could include health of the driver, financial condition of the owner (pointing to moral hazard), usage patterns of vehicles, accident and claims patterns, trends in garage /surveyor workings.

The project will have vehicle manufacturers as stakeholders as well and so will track spare parts availability, pricing and quality across makes to enable insurers to procure the best and the cheapest parts and service in their process of settling the claim and delivering back to the customer a repaired vehicle.

To sum up, the motor data unit will collect, mine, analyse, warehouse, research and disseminate/ sell/ publish data and information related to motor vehicles, their safety, road safety and accidents in India.

The data that is proposed to be collected will relate to

- **Vehicles:** Their ownership and operation, their insurance and financing information and road accidents
- **Owners:** Age, health and personal profile of the owners, ownership patterns, financial situation, lifestyle, geographical location and the like, likely usage pattern of the vehicle (long trips, teenaged children driving, frequency of usage), maintenance profile
- **Operators:** Licence status, age, health and personal profile, lifestyle (alcoholism)
- **Licensing authority:** Profiles of licence holders
- **Registering authority:** Profiles of vehicle owners
- **Law enforcement**

  Traffic police: Information on road accidents on a real-time basis and follow-up information about the progress of the cases and their conclusion

  Crime police: Information on stolen vehicles
- **Vehicle financiers :** Information on borrowers
- **Vehicle manufacturers:** Database of vehicles manufactured and mapping of their sales geographically. Information on spares and services.
- **Emergency rooms of hospitals:** The kinds and severity of injuries and trauma in different kinds of accidents (head on collision, overturning) and under different circumstances (two-wheeler rider with or without a helmet, seat-belt usage, driving under the influence of alcohol or drugs)
- **Emergency services:** ambulance services, blood banks and so on

This project can also evolve into a clearing house for real-time information on road accidents. Any of the stakeholders can input accident information on a real-time basis and it will be made available to information seekers from among the stakeholders aimed at helping quick rescue of and remedy to the injured and information to the next of kin/ various authorities.

This will benefit various sections of the society in the following ways:

Insurance companies: This data will help them in rate-making, fashioning new and better products due to a better fix on profitability. The real time information will trigger off improvements in other services and activities that will lead to loss minimisation.

Police: The database will help them locate all necessary details regarding a vehicle within seconds when an accident happens or an offence is committed. It will set the police off on their work faster and help them close cases faster and help them bring relief to the victims and inform and pursue other formalities with the next of kin quickly and efficiently as the time and friction for getting basic information is almost completely wiped out.

Road Transport Authorities: There is a gap between vehicles sold and those registered and, given that, the first thing that the RTAs get from this project is a chance to plug revenue losses! They can also track annual tax payments and pursue legal formalities in cases of accidents, abandonment, theft or pollution checking, re-registration and fitness

testing. Networking the entire nation will help them sort out issues relating to migrating vehicles and tax issues involved in those cases.

Hospitals: Real-time information on accidents will help them gear up emergency room facilities. Trends emerging from the data they provide and their aggregation nationwide are likely to pave the way for better equipped and better focused emergency ward infrastructure, staffing and operations fitting local and regional requirement in terms of the number and types of injuries they are likely to keep facing.

Vehicle Financiers: Vehicles involved in accidents, and stolen or supposedly stolen vehicles, are likely to become bad loans for financiers. Reliable and on-time information on these and a higher likelihood of such cases being solved and solved quickly will translate into direct loss minimisation for financiers.

Vehicle Manufacturers: Accident, road safety and vehicle usage and safety information from the analysed data will be inputs for developing and implementing higher safety standards. In the future, product and public liability are going to be areas fraught with high risk for manufacturers of any kind, and specially of vehicles. Management of this risk would require inputs that could be enabled and triggered by the findings of an industry neutral body.

Vehicle owners and insureds: will get better Motor premium rates suited to their risk profile since this project will help their records to be captured accurately and hence arbitrary rates like those relating only to the cubic capacity of the engine can become a thing of the past.

Vehicle safety research and testing

This part of the initiative will work on research projects based on field data pertaining to vehicle safety.

Some of the early priority topics in this area include pedestrian safety, two-wheeler safety, helmet usage and its impact on road safety, mobile phone usage, road design, commercial driver fatigue and alcohol usage, age, seat-belt usage, traffic management and so on.

Some technical facilities would be needed for this work like equipment for testing vehicle safety and design but a lot of desk research would also be included.

Test equipment will enable dual-purpose research to be undertaken that would equally be of interest to consumers. For example, performance testing of vehicle lamps offers benefits to safety research (sufficient power, resistance to premature failure etc.) and also to consumer organisations' publications providing value-for-money buying advice.

Part II of Know your Regulation-Protection of Policyholders' Interest Regulation will be carried in next issue.

Reviewing the Report

K.N. Bhandari

With due respect to the Hon'ble Justice Rangarajan and other respected members of the Committee (the Committee on Detariffing of Own Damage constituted by the IRDA in October, 2002, headed by Justice T. N. C. Rangarajan), I must say that I am rather appalled and disappointed to read the report. It appears to be based on incorrect assumptions and dubious logic. To my mind, its reasoning is misconceived and conclusions are misplaced.

The report has been divided into two parts. The first part deals with some issues pertaining to Third Party (TP) liability. The report, inter alia, has stated that *"the argument that TP liability cannot be unlimited with fixed tariff is sound and that only remedy is to statutorily limit the guarantee provided by the compulsory insurance and leave it to the parties to have separate insurance of unlimited liability at market pricing."*

The aforesaid propositions are based on the hypothesis that existing TP premium rates and TP claims costs are already high in India, and therefore, there is no need to improve the TP premium rates and that we must find ways and means to reduce TP claims by prescribing a statutory limit of liability as in the case of rail and/ or air accidents.

The premises on which these propositions have been based are far from the truth. The truth is that both TP and Own Damage (OD) premium rates in India are among the lowest in the world. Nowhere else in the world are premium rates so abysmally low as in India. The average rate for a comprehensive cover for a four-wheeler, including cover for the so-called unlimited TP liability and OD, works out to approximately 3.5 per cent of the value of the vehicle. This is without taking into account the No Claim Bonus (NCB) which an insured can earn and which can go up to 50 per cent of the gross premium.

Worldwide, the premiums for comprehensive cover of motor cars are at varying rates, six per cent onwards. Only in a few underdeveloped countries where per capita income and vehicle population are rather low, the premium rates are around five per cent of the Insured Value. Why quarantine the TP premium? There is absolutely no case to warrant this.

The other proposition that TP claims costs in India are already high and need to be brought down is also belied by facts. The fact is that the cost of human life lost on account of a road accident in India is also one of the lowest in the world. According to published data, the average cost of all TP claims in India does not exceed Rs. 1 lakh. This includes interest liability for delayed payouts. The average cost per claim as above has been worked out both for injury and disablement and also fatal claims.

> This is rather unique to the legal system in India that unlimited liability provided for in law, becomes limited through a compensation formula laid down by the apex court.

In the absence of hard data, a sample survey has revealed that of all TP claims reported to the insurers, nearly 70 per cent are injury cases where the average per claim cost is less than Rs. 50,000. For fatal cases, the liability per claim provided for, by insurance companies in their books, will not exceed Rs. 4 lakhs, including the component of interest. The reality is that a compensation of Rs. 4 lakhs payable to the dependents of a bread winner who has lost his life in a road accident is grossly inadequate and not high at all. With today's negative rates of return, a family of five can barely survive on the income from an investment of Rs. 4 lakhs.

Thus, there is no case to limit the liability on claims merely because the owners of the vehicle are unwilling to pay higher rates of premium. Why protect the vehicle owners at the cost of road accident victims? Those who own and use vehicles can certainly afford to pay a few hundred rupees more to compensate the unfortunate victims of road accidents.

What is this myth of unlimited liability in the context of published data of the insurers, on which the honourable members of the Committee have dwelt at length?

While TP liability in respect of human life is unlimited in law (in case of property, it is only Rs. 6,000), the fact is that the Supreme Court, through its various judgements, has already limited the liability of the insurers by linking the compensation payable to the income of the deceased combined with a multiplier relevant to his age.

All other considerations, including the prospective income (in an economy where the Rupee constantly and continuously gets devalued on account of inflation), are not factored in computing the compensation payable. And this is rather unique to the legal system in India that unlimited liability provided for, in law, becomes limited through a compensation formula laid down by the apex court.

It would be grossly unfair and inequitable to cite a few cases involving foreigners and non-resident Indians (NRIs) where high awards were given on the basis of high income of the victims to justify a statutory limit on compensation. What is the per capita income of Indians compared to US citizens? What is the average payout excluding interest to victims of road accidents in India? Is it not less than the statutory limit prescribed for victims of railway accidents? What are we then trying to achieve by fixing a statutory limit? Have we seriously considered the financial and legal implications of the proposal? I have reasons to believe that these and many

other vital issues have not been addressed by the report.

Here, I must also draw attention to the provisions of Section 175 of the Motor Vehicles (MV) Act which debars any suit or claim by the victims of road accidents against the insured and/ or insurer except before the MACT. This is a unique feature of our MV Act with perhaps no analogous law anywhere else. The Committee has argued that while in the case of rail and/ or air accidents, the law provides a maximum compensation payable to the claimants, why should the MV Act not have similar provisions.

The laws and regulations relating to compensation payable to victims of rail and air accidents do not debar claimants from seeking remedy under the law of torts, in addition to the fixed amount payable. The protection available to insurers under Section 175, in fact, has helped them to avoid multiple litigation and thus has reduced the cost of claims. I am not sure whether both, the insurers and insured, are willing and ready to forego this protection as this provision cannot coexist with the concept of limited liability under the MV Act.

As regards the Committee's findings and recommendations on OD claims, it is difficult to understand the basis and rationale of various conclusions arrived at. That the OD claims ratio is favourable and, hence, the tariffs must be dismantled is rather strange logic. If so, then why is the Tariff Advisory Committee (TAC) not applying the same logic to the Fire Tariff?

The Indian automobile market is integrating itself with global markets and all new and expensive models of automobiles are flooding Indian roads. Compared to international rates, even OD premium rates are lower in India. The cost of claims in India so far has been low on account of a variety of factors, the most important being that safety norms were sacrificed to save cost of repairs, making repaired vehicles more prone to accidents resulting in higher TP claims. Most of the damaged parts are recycled with total disregard for safety requirements. Patch-up repairing at neighbourhood garages manned by untrained and unqualified 'mistrys' is the order of day.

Instead of reducing OD premiums, insurers should insist on and promote safe repairing practices, instead of unsafe but economical practices. This would ensure compliance with safety norms by the repairers and reduce, if not eliminate, the use of spurious and recycled components in motor vehicles to make them safer on roads.

The argument that each portfolio must stand on its own and there should not be any cross subsidisation between OD and TP portfolios also defies logic. Firstly, cross subsidisation is integral to non-life insurance business as, even with the fullest application of actuarial science, it is impossible to establish an exact co-relation between premium and actual claims. Imbalances between the two are bound to exist and need constant correction. Moreover, in the absence of the cushion of cross-subsidy, no new product can be developed.

Last but not the least, I wish the Committee had enlightened us as to whether the detariffing of OD premiums would result in a reduction of rates or otherwise, more so in the present state of the market which is yet to experience real competition in the Motor business. I have reasons to believe that detariffing may lead to increase in premiums, and if so, the very purpose of detariffing will be lost.

The Committee should have also spelt out its recommendations on detariffing of terms and conditions of Motor policies. Were the omissions deliberate? I must congratulate the Committee for producing this report without the benefit of any data. It is indeed a remarkable feat. It is no fault of the Committee if cynics like me have failed to persuade themselves to agree with it.

The author is retired CMD, The New India Assurance Company Limited.

EDITOR'S NOTE

1. This article makes a mention of the Committee having finalised its report without data. Absence of data, to a large extent, is not the fault of the Committee, but is due to the reluctance of insurers, who apparently have data but do not wish to part with it, despite some insurers being members of the Committee. The Committee has used the data available with the TAC and the transport operators.
2. Comparison of rates of insurance prevalent outside India with Indian rates is an academic exercise which does not take note of underlying circumstances like safety of vehicles, safety of roads, capital costs, repair costs etc.
3. The article does point to one recent development – the presence of a large variety of models of vehicles on the road whose preference seems to be replacement, not repairs.
4. It is only a passing thought that limits to compensation have been fixed with regard to facilities operated by the State and no cap exists in other cases.

The Editorial Board wishes to receive comments on this subject in the background of the appointment of a Committee to work out the road map on detariffing of OD Motor rates (see page 6). The detariffing of rates of this class, we understand, is a precursor to detariffing of other classes of business.

Liable or Not?

D. Varadarajan

For general insurers, especially in the public sector, the Motor portfolio accounts for a considerable percentage of the total business underwritten. Notwithstanding rationalisation and revision of the Motor insurance tariff, insurers are finding it extremely difficult to sustain the ever mounting losses in that portfolio.

This is compounded by the rulings of the judiciary vis-à-vis their liability under Motor insurance policies and the futility of the exclusion clauses as carved out in the policy documents. Any ruling of the apex court (whether good, bad or indifferent – no matter how it is perceived by the parties concerned) becomes the law of the land, requiring due compliance.

In the context of Motor insurance policies, insurers try to avoid their liability by taking refuge under the provisions of the Motor Vehicles Act (MVA) or swimming to the harbour of safety as couched in the exceptions and exclusions in the policy documents. It is not unusual to repudiate a claim, inter alia, on the grounds that the vehicle was driven by a person who was not authorised to drive or, in other words, that the vehicle was driven by a person not possessing a valid driving licence; or on the grounds that the vehicle was transferred to another without due intimation to the insurer. There is yet another basis for refusal, viz., that the insurer is not liable for paying compensation to gratuitous passengers of commercial vehicles.

In this article, the maintainability or otherwise of the first two grounds is discussed based on the latest rulings of the apex court, while the third ground will be discussed in the next issue.

Fake Licences

Recently, the apex court in *United India Insurance Co. Ltd. vs Lehru and Others*, (C.A. No. 1959 of 2003, decided on 28-2-2003), while coming down heavily on the insurer for repudiation of a Third Party claim on the technical ground that the driving licence was fake, held that insurance company was liable to pay the compensation as they had failed to prove that the insured had deliberately committed any breach of any condition. In this case, the apex court after examining the anthology of cases decided by it earlier and reiterating the ratio precedents, has declared and reaffirmed the law in this behalf to the effect that even if the licence was fake, the settled law was that the insurance company had to first pay to the claimants and they could then recover from the owner, if in law they were entitled to do so.

Way back in 1960, the question before the apex court in *British General Insurance Co. Ltd. vs Captain ltbar Singh and Others,* 1960(1) SCR 168, was whether an insurance company can take up defences other than those enumerated in Section 96(2) of the Motor Vehicles Act, 1939. It may be noted that Section 149 of the Motor Vehicles Act, 1988, is identical in all material particulars to Section 96 of the 1939 Act.

It was held that the insurance company got the right to defend or file an appeal only by virtue of statute and therefore the right could only be exercised subject to the restriction laid down by the statute. It was held that an insurance company could only defend itself on grounds enumerated in Section 96(2) of the Motor Vehicles Act, 1939, and on no other ground. The Supreme Court held in that case, on an interpretation of Section 96, including sub-section (6) thereof, that if the insurance company was made to pay something which, under the policy, they were not bound to pay, they can recover from the assured. It has also been held that it was equitable that if a loss has to fall on someone, then it should fall on the insurer, as the insurer is carrying on this business.

In *Skandia Insurance Co. Ltd. vs Kokilaben Chandravadan and Others,* (1987) 2 SCC 654, the question for consideration was whether the insurance company could avoid liability because the accident was caused by the cleaner of the truck who had no licence. The insurance company relied upon Section 96(2)(b)(ii) of the 1939 Act. It may be noted that Section 96(2)(b)(ii) of the 1939 Act is identical to Section 149(2)(a)(ii) of the 1988 Act. The argument of the insurer to avoid liability was turned down for the following reasons:

- On a true interpretation of the relevant clause which interpretation is at peace with the conscience of Section 96, the condition excluding driving by a person not duly licensed is not absolute and the promisor is absolved once it is shown that he has done everything in his power to keep, honour and fulfill the promise and he himself is not guilty of a deliberate breach.
- Even if it is treated as an absolute promise, there is substantial compliance therewith upon an express or implied mandate being given to the licensed driver not to allow the vehicle to be left unattended so that it happens to be driven by an unlicensed driver.
- The exclusion clause has to be 'read down' in order that it is not at war the 'main purpose' of the provisions enacted for the protection of victims of accidents so that the promisor is exculpated when he does everything in his power to keep the promise.

The Court held that Section 96(2)(b)(ii) of the 1939 Act [Section 149(2)(a)(ii) of the 1988 Act] extends immunity to the insurance company if a breach is committed of the condition excluding driving by a named person or persons or by any person who is not fully licensed, or by any person who has been disqualified for holding or obtaining a driving licence during the period of disqualification.

The expression 'breach' is of great significance. The dictionary meaning of 'breach' is 'infringement or violation of a

promise or obligation'. It is therefore abundantly clear that the insurer will have to establish that the insured is guilty of a wilful infringement or violation of a promise that a person who is duly licensed will have to be in charge of the vehicle.

If the insured is not at all at fault and has not done anything he should not have done or is not amiss in any respect how can it be conscientiously posited that he has committed a breach? It is only when the insured himself placed the vehicle in charge of a person who does not hold a driving licence that it can be said that he is 'guilty' of the breach of the promise that the vehicle will be driven by the licensed driver.

It must be established by the insurance company that the breach was on the part of the insured and that it was the insured who was guilty of violating the promise or infringement of the contract. Unless the insured is at fault and is guilty of a breach, the insurer cannot escape from the obligation to indemnify the insured and successfully contend that he is exonerated having regard to the fact that the promiser (the insured) committed a breach of his promise. Not when some mishap occurs by some mischance. When the insured has done everything within his power and has placed the vehicle in charge of a licensed driver, with the express or implied mandate to drive himself it cannot be said that the insured is guilty of any breach. And it is only in case of a breach or a violation of the promise on the part of the insured that the insurer can hide under the umbrella of the exclusion clause. [See also *Sohan Lal Passi vs P. Sesh Reddy and Others*, (1996) 5 SCC 21; *Kashiram Yadav vs Oriental Fire and General Insurance Co*., 1989(4) SCC 128]

In *New India Assurance Co. vs Kamla and Others*, 2001(4) SCC 342,the question was whether by virtue of Section 149(2)(a)(ii) an insurance company could avoid liability if it is proved that the driving licence was fake. This Court considered, in detail, Section 149 of the Motor Vehicles Act, 1988, and held that the insurer has to pay to third parties on account of the fact that a policy of insurance has been issued in respect of the vehicle. It is held that the insurer may be entitled to recover such sum from the insured if the insurer was not otherwise liable to pay such sum to the insured by virtue of the contract of insurance. The question as to whether or not the insured would be protected if he had made all enquiries left open. However, this point has been squarely dealt with in Skandia's and Sohan Lal Passi's case (ibid).

After analysing the aforesaid judicial precedents, the apex court (in United India Insurance Co. Ltd.'s case) reiterated the law and observed that where the owner has satisfied himself that the driver has a licence and is driving competently there would be no breach of Section 149(2)(a)(ii). The insurance company would not then be absolved of liability. If it ultimately turns out that the licence was fake, the insurance company would continue to remain liable unless they prove that the owner /insured was aware of, or had noticed that the licence was fake and still permitted that person to drive. More importantly even in such a case the insurance company would remain liable to the innocent third party, but it may be able to recover from the insured.

> Insurers try to avoid their liability by taking refuge under the provisions of the Motor Vehicles Act (MVA) or in the exceptions and exclusions in the policy documents.

Transferred Vehicles

This question came to be considered once again, very recently, by the apex court in *Rikhi Ram and Another vs Smt. Sukhrania and Others* (CA No. 1578 of 1994, decided on 5-2-2003). Earlier, there was a conflicting view of the High Courts as regards the question whether the insurance policy lapses and consequently the liability of insurer ceases when the insured vehicle was transferred and no intimation as prescribed under the Motor Vehicles Act was given to the insurer.

On an earlier occasion, the apex court in *G. Govindan vs New India Assurance Co. Ltd. & Others.,* 1999(3) SCC 754 has held that since insurance against Third Party liability is compulsory, and once the insurance company had undertaken liability to third party incurred by the persons specified in the policy, the third party's right to recover any amount is not affected by virtue of the provisions of the Act or by any condition in the policy.

Concurring with the aforesaid view, the apex court in Rikhi Ram's case (ibid) gave further reasons that the liability of an insurer does not come to an end even if the owner of the vehicle does not give any intimation of transfer to the insurance company. It observed that that there are two third parties when a vehicle is transferred by the owner to a purchaser. The purchaser is one of the third parties to the contract and other third party is the one for whose benefit the vehicle was insured. So far, the transferee who is the third party in the contract, cannot get any personal benefit under the policy unless there is a compliance of the provisions of the Act. However, so far as a third party injured or victim is concerned, he can enforce liability undertaken by the insurer. Accordingly, it held that, that whenever a vehicle which is covered by the insurance policy is transferred to a transferee, the liability of insurer does not cease so far as the third party /victim is concerned, even if the owner or purchaser does not give any intimation as required under the provisions of the Act.

The author is a delhi-based Advocate and an insurance and corporate laws Counsel. He is a Member of the Insurance Advisory Committee of the IRDA. He has served as a Member of Justice T.N.C. Rangarajan Committee and has been nominated as a Member of the Group constituted by the IRDA under the Chairmanship of Mr. S.V. Mony to suggest the road map for detariffing the OD portion of motor insurance premium. He can be reached at dvarada@hotmail.com.

Marketology!

Apparao Machiraju

Facts are stubborn things. And the fact is that industry marketers experience increasing competition just about every day. What once worked well for so many on the marketing front just doesn't seem to be working that well any more. Prospective buyers of insurance products and services are increasingly becoming targets for information-based communications and sophistication, at times leading even to skepticism.

Time, more than ever, has become an obstacle. In our first changing society, driven by continual technological arrangements, marketing methodologies that attract prospects' interest should be our immediate concern.

The life blood of the insurance business – the intermediaries who represent the companies – don't have the time. They are in the trenches every day. They are so busy attempting to make a living that every second counts. The irony within their situation is that all their actions, which of course must lead to continuing sales, often put them further and further behind in their daily quest to survive and prosper. This is because many of them are simply not equipped to function in the faster, more efficient way that current times demand.

There must be a better, quicker, way for these marketers to serve their clients, prospects, and the insurers they represent. The answer is linked to technology. Technology is something many of them simply don't seem to have the time to keep up with, though they should.

Marketers (agents, brokers etc) can do themselves, their clients, prospects and the insurers they represent, a huge favour by looking into electronic marketing tools like laptop computers and CD-ROM presentations. Insurers should be encouraging this methodology, both for their survival and the survival of their producers. To do otherwise is to invite disaster. These marketing tools can help salespersons shorten the sales process cycle.

What also must be considered is that a growing number of clients and prospects in certain segments of the market place are very up-to-date on the technological front. Many of them use various electronic media. They naturally expect not only their insurance companies but their representatives to be doing the same. If they are not, the odds are great that sooner or later many of those clients will go elsewhere – probably to producers who more accurately reflect their (the client's) tools of technology.

> Technology does not have to be impersonal. The combination of technology and trained manpower could be incredibly powerful. And that is "Marketology."

If the 'medium' is the message, as Canadian communication expert and philosopher, Marshall Macluhan, said, then it is reasonable to conclude that, in similar fashion, the process is the product. In the context of the insurance industry, the distribution experience is what consumer may really value.

It is frequently bandied about that the 'value addition' provided by producers is the advice they give – so much so, insurance intermediaries prefer to call themselves 'advisors'. The 'advice' has literally become a product for sale – the process has become the product.

Driven by e-commerce, a fundamental and far reaching change is taking place in professional selling. The sales person who is emerging may well be known as 'customer evangelist.' Apple computer and other companies employ 'evangelists' as enthusiastic and representatives of the customer's best interests. If we take that concept further, customers will enjoy the benefits of doing business with new types of sales representatives.

Like it or not, the type of selling so vigorously defended is quickly disappearing. At the same time, there is a new opportunity for a different type of selling derived from e-commerce. We call this person a 'customer evangelist,' the enthusiastic, supportive advocate representing the customer's interests.

While the rhetoric of sales meetings have long attempted to foster the belief

that 'we are working for the customers; few customers and even sales people have become true believers. At worst there are those in sales who believe that their best advantage in convincing customers is that they are 'on their side.' While such ploys persist, customers are put off by such transparent and self serving tactics.

To make the best use of information technology (IT) as a resource, we need to adapt new organisational strategies aimed at sensing new economic trends, new business competitors, and new technology modes. It is imperative. Undoubtedly, companies in the financial services industry would have to be operating their business in a cave not to recognise technology as a force that will make or break them in the new millennium.

Technology, admittedly, is one of the most pervasive causes and elements of change, but it does not have to be impersonal. The combination of technology and trained manpower could be incredibly powerful. And that is "Marketology."

Looking Ahead

The new business model for the insurance industry demands a new automation model; primarily customer centric. That is, all processes are designed to satisfy customer needs. The new model should be a decentralised one with more responsibility and power given to the people who are on the frontlines with the customers.

Every intermediary contact is a social event and an ethically challenging situation.

Specially in the matter of life insurance, the public's grasp of the character of the product as primarily an instrument of 'protection,' but with some characteristics of a savings medium, is confused and tinged with suspicion. Its experience with agents, by and large, is ambivalent; their help is desired but their motives are questioned.

It is often commented that life insurance selling is based on unconscionable exploitation of innocents who are beguiled into acting as agents for a while and discarded after they have sold to their in-laws and friends.

Not surprisingly, staunch defenders of the agency distribution system state that technology will never replace personal selling. They view technology as being used by agents in many ways, shapes and forms. Some observers have gone so far as to rename the agent of the future as a 'cyber mediary.'

All the short-term limitations to technology will diminish in time. It may take a decade or more before technology will play a significant role in the actual buying and selling process.

In the next five to ten years, technology is not expected to become a significant direct-response method for buying life insurance.

In India's contextual situation, this view is not surprising, given the fact that the industry in the developed markets also has never been able to realise more than approximately two per cent of premiums or five to 10 per cent policy sales annually from all types of direct response methods. It will not be until technology becomes an integral part of the home that significant shifts in actual buying behaviour will occur.

There is no question that all the short-term limitations to the emergence of technology as a direct response method will diminish in time. But it may take a decade or more before technology will play a significant role in the actual buying and selling process.

Training considerations

The success of technology depends upon a variety of factors.

- Accurate assessment of the needs to be met and whether these needs can be fulfilled by using technology
- Infrastructure development
- Issues of organisational culture related human performance and work patterns
- Scientific selection process of intermediaries at the contact level
- Training strategies

Special attention must be paid to the users of the technology. By focusing on the 'users.' We can learn what technology computers can be actually used for instead of concentrating on what 'they could do.'

The author has had inter disciplinary background in life insurance for four decades in Management, Marketing, Research, Training and Teaching. He has taken to full time teaching and has been the Founder/Director of College of Insurance and Financial Planning (CIFP) established in 1991. currently he is the Director of International Institute for Insurance and Finance (www.iiifindia.com) located on the Osmania University Campus, Hyderabad.

Mapping the Nervous System

Information Technology in Insurance

Anup K. Mathur

Intense competition together with rising business acquisition costs and shrinking operating margins is driving insurers to invest in information technology to increase profitability, reduce costs and target operational efficiency.

The focus of the new companies is on revenue generation, growth through geographical expansion, customer acquisition and a need to capture a sizeable market share in the shortest possible time. Simultaneously, they are grappling with the issues of expansion, innovation and differentiation in products and services, knowledge dissemination and management, target marketing, developing alternate channels, strengthening the existing channels, maintaining underwriting discipline and implementing an effective service delivery model while optimising costs.

Existing companies are experiencing a different set of challenges like retaining profitable customers, improving underwriting and operational profitability, simplifying and automating business processes, optimising distribution channels, creating positive delivery experience, innovating products and reducing costs/expenses.

Technology works as a business enabler, assisting companies in freeing insurance marketing people and producers from cumbersome, time-consuming, paperwork and allowing them to focus on building and maintaining customer relationships and procuring business.

Technology – enabling business

Technology addresses the needs of an insurance enterprise in the rapidly changing market. It is primarily aimed at sustaining distribution effectiveness, helping in acquiring and retaining customers, maintaining underwriting discipline, controlling expenses, managing claims, providing customer service, processing efficiency, connecting business to intermediaries, consumers, service providers and providing flexibility of choice, convenience, and delivery in real time to different entities. Investment in information technology (IT) is strategically targeted towards providing greater value to customers, distributors, producers, partners, intermediaries, third party service providers and employees. Value, that creates real competitive advantages.

IT applications can be broadly classified into two categories – operational and analytical systems. An operational application such as policy administration, financial accounting or claims processing provides support to employees in their everyday business activity and improves their productivity. An analytical application like data mining helps knowledge workers (executives, managers, analysts and actuaries) make faster and better decisions through decision support systems.

Developments in technology

Traditionally, applications written in COBOL were ported on mainframe systems. The PC revolution changed all that as many platforms, operating systems, applications, middleware, and other peripherals appeared, confusing everybody!

> Currently, the processing environment is extremely time-intensive, paper dependent, costly and error prone. Data entry is required in multiple steps and multiple forms.

Developments in technology created a chaotic mix of PC, PC-LAN, minicomputer and mainframe systems, all using different hardware, operating software and applications software.

Insurers elsewhere in the world are using systems that are 25-30 years old and are experiencing issues like integration of legacy and disparate systems with e- commerce applications that are difficult, expensive and time consuming. IT systems and applications in the insurance industry were designed on specific lines of business and gradually developed into parallel systems functioning separately without much interaction between them. Communication between multiple systems and applications required integration. Proprietary software created a dependency on the vendor that designed it.

Insurers are now undertaking re-engineering studies to either refit or redesign their slow, difficult-to-use, archaic, COBOL-coded mainframe systems. Some are even considering outsourcing IT activities. Insurers realise the need to align the technology with the field force with an ultimate aim to acquire, develop, retain the producers, distributors and improve customer satisfaction. Web enablement of insurance applications was a strategic requirement to reduce business acquisition costs, underwriting costs and claim processing costs and to make meaningful use of data.

Further developments saw networked PCs working on LAN (Local Area Networks) and WAN (Wide Area Networks) dominating the financial services landscape largely due to the need of providing capabilities to the field force at the point of sale, reduce multiple data entry and reduce costs. Applications running on these systems perform a wide variety of risk management and insurance functions (risk control and risk financing) with impressive technical capabilities, such as electronic data interchange, expert systems in predicting case reserves, and detailed policy registers using optical character recognition scanning technology.

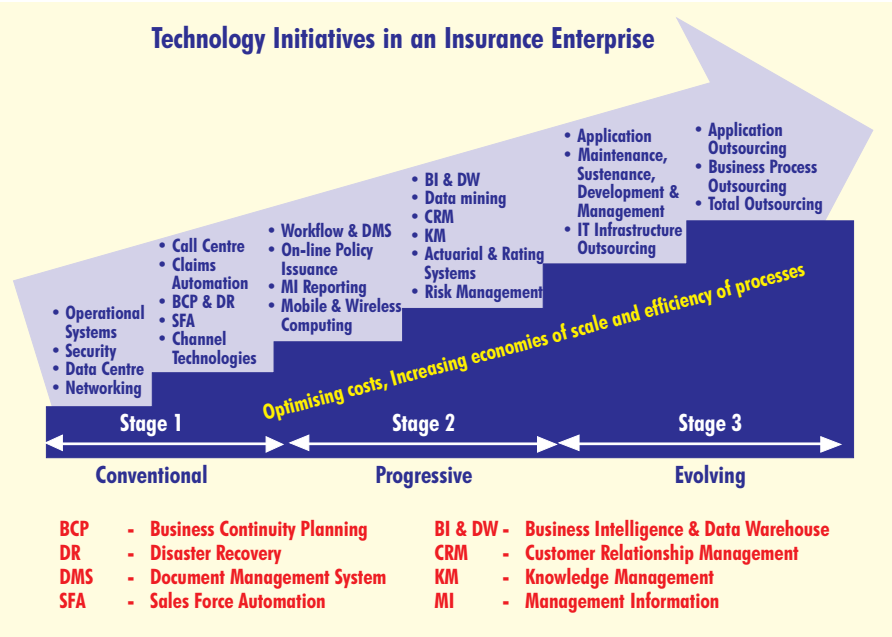
Consequently, companies started using different applications on different technology platforms and different architectures. There was no industry standard interface; no standard application; no standard quote system; no standard proposal system and so on. This led to a need for automated exchange of data between processes. Development of common technology protocol XML (Extensible Markup Language) is now enabling transfer of data and information among various constituents in financial services. XML is a representation of data defined in a standard way that allows disparate systems and databases to communicate and exchange data with each other and with third parties. XML was developed by W3C (World Wide

Web Consortium) and no single vendor owns it. Software majors provide support to XML.

Indian scenario

Investments have been made by each player in new proprietary systems to support the insurance value chain for their operations. Indian insurers are in an advantageous position as they can learn from their counterparts and incorporate suitable changes in the technology and the processes.

Typically, technology implementation is carried out in multiple stages as is evident from the diagram. (See below).



Insurers in the first stage of IT initiatives invest mostly in back office administration systems, i.e., core insurance applications catering to underwriting, policy administration, claims, financial accounting etc. Investment is also made in front-office sales and service technology, primarily to capture a market share and build the brand by enabling faster and simplified customer service. Agents, agencies, brokers, banks, insurers, service providers and other intermediaries want to maintain a unique and effective presence at point-of-sale and service.

Multiple systems are installed to cater to different business requirements. These systems generate information that is complex and needs to be harnessed for making informed decisions achieving operational efficiency. Gradually, an insurance enterprise moves up in hierarchy to outsource various process related activities that support the business and focuses its energies on core business areas in Underwriting, Claims, Reinsurance, Finance and Asset Management.

Currently, the processing environment is extremely time-intensive, paper dependent, costly and error prone. Data entry is required in multiple steps and multiple forms. Paper applications/ proposals are frequently inaccurate, incomplete or illegible. Manual data entry of such applications is time consuming and spawns more errors. Multiple systems generate complex information on different components of the business.

Let us examine how technology impacts various components of the insurance business.

Marketing and Sales

Evolving market dynamics due to convergence of financial services, telecom and the IT industries, distribution of insurance products and services through diverse distribution channels like captive agents, independent brokers, banks, investment dealers, employers, affinity groups, worksite groups, auto dealers, mutual fund dealers and personal advisors such as accountants, lawyers, and tax planners together with growing customer expectations is fuelling the challenges faced by the insurers.

The evolution of non-traditional and hybrid channels of distribution requires companies to constantly upgrade and integrate their applications with other systems. The advent of brokers and multiple intermediaries in India will lead to another issue of time-consuming exercise of sending requests for quotes/ proposals to multiple insurers/ brokers.

IT supports an insurance enterprise in measuring effectiveness of distribution channels, developing front-end capability for collection of error-free and consistent customer data across customer contact points, identifying profitable customers for cross selling, tracking and routing leads, forecasting revenue and disseminating information, thereby increasing efficiency in sales.

Channel Management

The emerging marketing and sales models characterised by proliferation of distribution channels, with multi-disciplinary practices, shortened distribution chain, fee-based advisors, and convergence of financial services, is affecting the relationships of the producers with insurers. Licensing, training, marketing and education events are being integrated into the value chain to support the 360-degree relationship bonds between consumer and agent, agency and insurers, and insurers and advisor and so on. Providing technology support for the emerging value chain is increasing the complexity and costs for each insurer.

Agency management systems, call centres, computer telephony interface, point of sales systems, portals, knowledge management applications, wealth management, remote access and mobile computing support the distribution agencies by providing timely information on products, customers and market. The channels of customer interaction have expanded from face-to-face or phone contact to include automated telephony systems, the web, fax, e-mail, and even wireless devices and voice over internet protocol (VOIP).

However, the response from call centres has not been too encouraging. Consequently, there is a growing need to transform the customer service centres from mere call centres into "virtual contact centres" that handle the myriad needs of the customers from different channels of contact in an integrated fashion.

Internet and e-business

Evolution of web-based applications (anywhere, anytime service and support) has enabled insurers to connect, inform and communicate with agents, partners, customers and end-users. Websites and portals have been designed not only to provide information about products and services but are increasingly becoming a low cost distribution channel. E-business through the Internet enables and supports business by facilitating online quotes, online policy issuance, online bill presentment and payment, claims submission, and providing support to distribution channels by disseminating knowledge and services. However e-business is not just about technology.

It is about new models of commerce, marketing and distribution. The Indian insurance industry is rapidly gearing up to catch up with the rest of the financial services industry to provide secure electronic transactions over the public/ private network to take care of the customers who would prefer to use the electronic delivery system. But, delivering such solutions requires new skills that are relatively scarce.

However, as compared to other financial services like banking or securities, insurance is traded less frequently. An insurance product by its very nature is complex, regulated and invariably, requires to be sold rather than purchased. Insurance is not purchased like FMCG products, fashion apparel or like a credit card that one can procure online. A minimal underwriting process is necessary before a product can be sold. Customers are required to provide essential information enabling an underwriter to assess the risk and price it. The trend towards purchasing policies on-line is slower for complex types of property and casualty, term life, annuities, universal life and home insurance than for others.

An insurance transaction normally happens once in a year as in property and casualty insurance, except in life insurance, where a customer may be required to pay premium at regular intervals. Similarly, an insurance claim does not happen so often as compared to trading/ transfer in stocks or bank deposits. Human interaction is important to achieve customer satisfaction.

It is estimated that insurers in personal lines in the US will decrease their expenses on sales, administration, claims settlement and claims payment by $ 15 billion or about 12 per cent, and in commercial lines by about nine per cent of the total expenditure. It is anticipated that the sales of personal lines covers in retail side of the business like Travel, Accident, Health and Auto, in particular, which are simplified pre-underwritten products, will expand rapidly through on-line distribution. This will reduce distribution costs. Nevertheless, the inherent nature of the insurance transaction compels alignment of technology with human resources. This is inevitable.

The inherent nature of the insurance transaction compels alignment of technology with human resources. This is inevitable.

Mobile-computing and Wireless Field Force

Wireless automation is changing the face of the field force. Emerging wireless devices and applications provide faster, efficient access to information and enables real-time processing. Sales, marketing, technical support, customer service, loss assessors, service providers and other field staff must have anywhere, anytime access to corporate data and applications using any device to compete and win.

The objective is to derive benefits by providing the information to the field force when they actually need it, in real-time. The field force of an insurer must be able to access corporate data and applications, wherever they sell, from any device, at any time. Wireless technologies boost the performance of the field force as they can close the deal in one meeting by presenting to their customers various quotes and illustrations relying upon the up-to-the-minute information. Infrastructure and links among channels need to be built to reduce response times.

Insurance Processing

IT solutions and robust business processes together improve the efficiency of the business processes while maintaining discipline with accuracy, uniformity, consistency and efficiency. Insurers require the core underwriting and claims processes involving documents and records to be low cost, highly efficient, swift, scalable and reliable. The challenge is to streamline the complex and challenging paper-based business processes and reduce bottlenecks. Business processes require support from technology to reduce costs, reduce processing time and conduct business profitably.

Technology-based transaction-centric solutions like work flow and document management, rating/ quoting engines, business rules engine, electronic bill presentment and payment system, exception-based processing, content management, integration with sales force automation, automation of business processes, web enablement and digital signature are poised to optimise insurance processing and change the way the insurance business is transacted.

Similarly, claims processing is supported by technological implementation of automated claims processing using workflow and document management systems right from claim origination, notification to settlement and with an ability to compile information from multiple sources like the customer, service providers, repairers, lawyers etc. The information is linked electronically, allowing rapid processing and provides access to information to different parties.

Straight Through Processing

An important area for the insurers in the present scenario is to integrate front-end systems with back-office systems to crash processing time and increase overall efficiency. Straight through processing or auto-underwriting enhances the ability of an insurer to capitalise on the untapped market segment.

Knowledge Management

Information is critical in today's business environment. The rapidly changing environment in which business is operating, demands access to information. Gaining competitive advantage requires the insurers to accelerate their decision making process enabling them to respond quickly. Key to this accelerated decision-making is in making the right information available, at the right time, to the managers in a simple format.

Actuarial and risk assessment applications and rating solutions can be integrated with the underwriting and claim applications enabling the insurers to collect, collate, compile, analyse the risk-related data and calculate chances of loss and the average likelihood of an event happening.

Business intelligence and data warehousing solutions provide a breadth of information to the decision-makers on practically every aspect of business, enabling analysis on each component of the business. Data mining tools allow organisations to leverage the information contained in their back-end systems to identify key data such as customer profiles, market trends, demographics, behavioural patterns and preferences.

Customer Value Management

Customer profitability, both current and future, is an estimate based on customer profile, lifetime value, wallet share, delivery costs, retention cost and projected life stage changes affecting the insurance relationship with the insurer. Customer profitability analysis is the cornerstone for successful implementation of sales and marketing strategy, product development etc. CRM solutions enable an insurance enterprise to capture information generated by client encounters across all sales and service channels to present a single, unified picture of the customer in all transactions. Mining customer data reveals lifetime value of consumers' needs, enables customer segmentation and generates cross selling opportunities. It caters to the more complex retirement, insurance, care and estate planning needs of the demanding, present day customers.

Relationships with profitable and potentially profitable customers must be continually developed and enhanced in a cost-effective manner. The remaining customers are potential profitable prospects or targets for lower cost sales and service models. Insurance companies need to determine a picture of individual customer profitability, both short-term and long-range channel productivity and profitability. The underlying business challenge is in harnessing the potential of distribution channels in securing customers and fostering loyal lifetime customer relationships with profitable customers by leveraging customer and agency data.

> Insurers elsewhere in the world are using systems that are 25-30 years old and are experiencing issues like integration of legacy and disparate systems with e-commerce applications.

Business Process Outsourcing

While technology is a business enabler, insurers realise that managing IT and other supplementary activities is not their core business operation. An insurance enterprise may not want to spend a lot in building up IT infrastructure, and even more in managing it. The result of this realisation has been the evolution of outsourcing as a business model. The logic: transfer the onus of IT management to companies who know IT. Business process outsourcing is about partnering with an insurance enterprise and taking over of the partner's operations, managing processes, human resources, planning IT, infrastructure and strategising along with the organisation, thereby reducing costs and allowing an insurance enterprise to concentrate on its core business. Increasing costs of ownership and management require availing the benefits of off-loading the business processes to companies specialising in this area.

Challenges

The biggest challenge before a CIO/ CTO seeking higher budgetary allocation for IT investments is to convince the management of the return from such investments. The benefits are not always evident and may not easily translate into a measurable return on investment (ROI) and are not cogently quantifiable in monetary value. Financial constraint contributes to this challenge.

Technical challenges would be in the areas of integration (cost, time, skills), lack of standards in application, architecture and channel conflicts. Integration of core applications with satellite applications, productivity tools, strategic applications, business intelligence software and databases into a single, usable system accessed through standard Internet browsers is crucial.

IT cannot automatically cure business problems. An insurance enterprise needs to emphasise the basics of insurance business, especially marketing, distribution, underwriting, new business processes, risk assessment and claims management, before seeking business benefits and ROI from IT. IT cannot be a panacea for all the ailments. Investment in IT is strategically crucial to support the business strategy and destination of a company.

The author is Consultant-Insurance, Insurance Vertical with Wipro Infotech. The views expressed in this article do not represent the company's views on the subject.

Strengthening the Backbone – IT and Managing Customer Relationships

Rumeer Shah

Information technology (IT) is fundamentally changing insurance today. Exploiting the fact that insurance can be delivered almost seamlessly on-line, innovative marketers are reaching out through the Internet to sell directly to customers and attempting to disintermediate brokers and displace more traditional competitors. Customers are, and will be, the primary force driving e-business strategies of these companies.

The motivation is the deepening of relationships with the customers in order to stay competitive. Cost reduction is another important factor reflecting a growing need to use e-business to streamline internal as well as external business processes.

The four critically important areas where insurance companies will need to integrate IT at all levels are: Point of Sale (Marketing et al), Customer Relationship Management (CRM), Claims Management, and Risk Management Information System (RMIS). In this article I wish to focus on CRM, since it will eventually form a backbone of how the industry shapes in the future.

Act with lightening speed, access the best information available – this sums up the advice, customer service and distribution system vendors are giving insurance companies. The pressure is on to become more customer-centric, to provide anywhere, anytime service and to capture the information generated by these kinds of encounters.

With IT budgets eventually forming a critical part of most insurers' business operations, and with a greater understanding of where e-commerce fits into a business strategy, insurers are in a position to make significant investments in customer service and distribution-related technologies, including call centres, CRM suites, sales-force automation tools, agency and new business systems and integration technologies.

But to go beyond the buzzwords of customer-focus and customised-delivery, insurers will need to invest in technology to help them address several specific challenges, customer service and distribution systems vendors agree. Perhaps most important, companies have to be able to determine a picture of individual customer profitability-both an immediate snapshot as well as what a longer-term association may look like.

> Companies have to be able to determine a picture of individual customer profitability – both an immediate snapshot as well as what a longer-term association may look like.

CRM is based on three core technologies:

- Data mining, or using the information that you have collected in the past.
- Data warehousing, this involves storing information in an integrated database that creates a more complete picture of the customer.
- Predictive modelling, which studies past customer behaviour to determine future offers.

Teaching company personnel to use these three technologies will help insurers to more effectively match customer needs with appropriate products.

For both customer service and distribution purposes, analysing customer profitability is critical. Insurance companies need to know how they are approaching their insureds, and that includes evaluating interactions as well as transactions, whether it involves requesting a quote, making a payment or having a policy issued.

Furthermore, insurers need systems – whether web-based or facilitated through a live sales agent – that facilitate placing information immediately into a customer's hands through whatever channel a consumer wants.

Imagine sitting at a home PC, and being able to have an insurance policy bound within minutes over the Internet, or being able to store policy information electronically and make it available to anyone with the right authorisation who needs it. These processes do take time to evolve and require a lot of computing power. But with modern machines easily available at the disposal of the companies and relatively cheap manpower available to implement and run these systems, ignoring them would be a costly mistake.

Along these lines, insurers will have to build both infrastructure and links among channels to help cut down on response time on claims and other requests, reducing costs in the process.

Since it is generally less expensive to cultivate existing customers than to acquire new ones, it is crucial to view one's current customer base in a new way. It is necessary to discuss the different ways that we value customers. All customers are not created equal – some actually cost money, while others provide a definite profitability.

Customer value analysis –measuring the customer's profitability – provides valuable information as to which customers you want to retain, and how to match resources to customers based on their value, and will eventually distinguish the top insurers from the rest of the pack. Some customers who appear unprofitable on a single product basis may be profitable when two or more products are sold to them.

More insurance companies are becoming aware of this problem and are starting to educate their people about CRM concepts to determine how they can better leverage their data to refine offers and increase profitability. Whilst several Indian companies have, in the initial growth phase, laid an emphasis on customer relationship, it is the continuous credence this operation gets that will eventually determine the market share of these companies. In the end, companies that are able to build more comprehensive profiles of their customers and implement concise marketing programmes to match customer needs with appropriate products are the ones that will survive and thrive.

And all this can effectively and efficiently be accomplished by sensible infusion and use of IT and data integration. Eventually this will reflect in customer loyalty and increased business with lesser direct expenses. It is no secret that renewal business is always cheaper than new business with little additional cost. Effective CRM will help insurance carriers achieve this nirvana.

A word about claims management. Eventually at the end of the day, having sold a large number of policies and more or less having done an effective relationship management, companies are bound to face claims. At this juncture, it is not how fast the company handled the claim that matters, but how efficiently it did it. A client will not mind waiting 24 more hours to receive his claim payment, but will absolutely loathe any inconvenience caused to him in that process. After all, the last thing an insured involved in an accident claim wants, is the recollection of it. Insurance companies can make proper use of IT, in the form of quick claims filing and reporting processes and quick surveying systems, in this critical process.

Finally, even with smoother, faster and more integrated processes, many insurers still will be grappling with questions about how the agent channel operates. But rather than getting bogged down over philosophical questions about disintermediation, savvy firms will find ways to get their agents more involved in efforts to share data about their customers without fear that they're giving up a client in the process. Independent agents and brokers will continue to be protective of their data, but insurance carriers can break down those barriers by sharing their analytics and forecasting with them, showing them which customers are most profitable.

> Customer value analysis – measuring the customer's profitability will eventually distinguish the top insurers from the rest of the pack.

In fact, agency performance, productivity and profitability will be an essential focus of investments in distribution and customer service technologies. This means, measuring not simply the volume, business agents produce, but also the quality of that volume – that is, whether it is business the insurer really wants. This is total integration.

But, while it is relatively easy to describe what total integration could be, getting there is another story, especially with the costs and complexity of implementing distribution/ CRM technologies. That's why many insurers need to be investigating outsourcing to handle data management, claims servicing and other services. At issue is the quality of service customers will receive and whether the third party is using so-called best-of-breed technology.

The author holds an M.S. in Insurance and Risk Management from the College of Insurance, St. John's University, New York. His research interests include investment management of insurance companies as well as multi-channel marketing strategies. He can be contacted at ***rumeershah@netscape.net****.*

The next Issue Focus is on **BANCASSURANCE.**

WANT to write about it?

Send your articles to:

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

प्रकाशक का संदेश

मैं आईआरडीए के अध्यक्ष का पद विनम्र भाव से धारण करता हूं तथा मैं अपने सम्मुख उन किये गये कार्यों को पाता हूं जो इस संगठन द्वारा पिछले कुछ वर्षों में किये गये हैं। मैनें उस संगठन का अध्यक्ष पद ग्रहण किया है जो अपने मजबूत आधार, स्वतंत्रता, पारदर्शिता एवं अच्छे कार्यों के लिये जाना जाता है। मेरी कोशिश रहेगी कि संगठन की इस साख को जो इसने उद्योग एवं सरकार में प्राप्त की है को और भी मजबूती प्रदान की जाये। मैं संगठन के सभी सदस्यों तथा इस कार्यक्षेत्र के अनुभवी लोगों से सहयोग तथा समर्थन की अपेक्षा रखता हूं ताकि संगठन का आधार मजबूत तथा संरचना प्रभावशाली हो।

सी. एस. राव

क्यों

हम बताएं...
गुंचा और गुल में है
फर्क क्या ?
एक बात है कही
दूजी अनकही

“कुछ तो लोग कहेंगे”

जैसा कि अब हम अपने टेलीविजन स्क्रीन पर 24 घंटे देखते हैं, एक अटूट बंधन है जो अमेरिका और इंग्लैंड को जोड़ता है। हमारी 150 वर्ष से बाजार में व्यापक भूमिका को देखते हुये लॉयड एक बाह्य बीमाकर्ता तथा पुनर्बीमा के रूप में देखा जाता है। क्या वास्तव में हमारे साथ ऐसा व्यवहार होना चाहिये ? क्या एक सा व्यवहार सभी पार्टियों की प्रक्रिया को अच्छा नही बनायेगा।

लॉर्ड पीटर लिवेन, चैयरमैन, लॉयड्स ऑफ लंदन

यह बीमाधारक को संरक्षण देने के लिये कदम है। एक जीवन बीमाकर्ता के लिये यह अच्छा होगा कि वह कम या न्यूनतम गारंटी लब्धि प्रदान करे। हम यह विकल्प प्रदान कर रहें हैं।

जापान के प्रधानमंत्री अपने देश की संसद में ऐसे बिल पर जो बीमाकर्ता की गारंटी देने तथा गिरते हुये ब्याज दर पर बीमाधारक को अपनी निवेश पर लब्धियां सुनिश्चित करेगा।

कमीशन के संबंध मे हमने एक बात नोटिस की है वह है असली इनपुट तथा सही दिशा जो अंशधारकों द्वारा दिया जाना था और इसमें बिलकुल संदेह नही है कि खतरे कि घंटी बज रही है... संस्थाओं के लिये यह अवसर है विशेष रूप से निधियों का प्रबंध करने एक प्रकार से तथा दूसरे प्रकार के जिससे वे नेतृत्व कर सकें। छोटे निवेशक... को प्रोत्साहित करना चाहिये अपने कार्यनिष्पादन की समीक्षा करने के लिये तथा कंपनी को चलाने के लिये जिनमें वे निवेश करते हैं और उन्हें चाहिये कि उनके विचार सुने जायें।

एच आई एच रॉयल कमीशनर,
न्यायाधीश नेविली ओवेन

यह जरूरी है कि निवेश जोखिम को निवेशकर्ता पर स्थानांतरित किया जाये क्योंकि निवेश का वातावरण काफी जटिल हो गया है, ब्याज दर गिर रही हैं तथा निवेश के सीमित अवसर उपलब्ध हैं।

श्री एस. बी. माथुर, चेयरमैन,
भारतीय जीवन बीमा निगम

(भारतीय बीमा कंपनियों) को यह समझना चाहिये कि पुर्नस्थापना लाभप्रद नही है, न केवल अपने लिये वरन् ग्राहक के लिये भी।

श्री रिचर्ड एच सूलेगर, अध्यक्ष, मिलियन डॉलर राउंड टेबल (एमआरडीटी) वित्तीय सेवा व्यवसायियों का विश्वव्यापी एसोसियेशन

एलआईसी ने एक योजना पेश की है, जिसके अनुसार वे इस शोधन क्षमता के अनुपात को 31 मार्च 2004 तक पूरा कर लेंगे। यह एक तकनीकी आवश्यकता है, हम एलआईसी की योजना से संतुष्ट हैं।

श्री सी. एस. राव, अध्यक्ष, आईआरडीए, भारतीय जीवन बीमा निगम की 10,000 करोड रूपये की शोधन-क्षमता के संबंध में।

पूर्व अध्यक्ष श्री एन. रंगाचारी से साक्षात्कार

प्र. आज उद्योग की क्या स्थिति है?

उद्योग विकास की राह पर है। जब नयी कंपनियों ने सन् 2000 में बाजार में कदम रखा था तो धीमे विकास की संभावना व्यक्त की जा रही थी क्योंकि उन्हें सार्वजनिक क्षेत्र की कंपनियों से कड़ी प्रतिस्पर्धा करनी थी जो पहले से ही मजबूत है तथा उनपर लोगों को विश्वास है।

जीवन तथा गैर जीवन बीमा के क्षेत्र में निजी कंपनियों ने 2-3 वर्षों में ही लगभग 10 प्रतिशत बाजार की हिस्सेदारी ले ली है, जिसकी उम्मीद पाँच वर्षों में होने की थी। नयी कंपनियों ने अपना कार्य बड़ी ही कुश्लता के साथ किया है तथा अपने इतिहास तथा संबंधों का पूरा पूरा उपयोग किया है।

प्र. लेकिन संचालन का लाभ प्रश्न है और निवेश तथा आय कम है...

संपूर्ण विश्व में अभिलेखा का लाभ बहुत ही कम है। शुद्ध बीमा व्यापार से लाभ सदैव ही चिंता का विषय रहा है, परंतु निवेश के लाभ में गिरावट ने इसे और अधिक पेचीदा कर दिया है। आज बाजार तनावग्रस्त माहौल से गुजर रहा है।

गलत योजनाओं तथा निवेश के कारण आज भारत से बाहर अग्र बीमाकर्ता समस्या का सामना कर रहे हैं।

प्र. आज आप उद्योग को किस तरह की नीति अपनाने को कहेंगे?

सार्वजनिक क्षेत्र के बीमाकर्ता अत्यधिक मजबूत हैं। उनके पास अत्यधिक पूंजी है। उन्हें सिर्फ अपने कार्य को जोखिम प्रबंधन तथा जोखिम मूल्य पर केन्द्रित करना है। ये महत्वपूर्ण चीजें आज लुप्त हैं। निजी क्षेत्र ने ऐसे समय में बाजार में कदम रखा था जब लाभ की परिभाषा बदल रही है।

वहाँ पर बाजारू स्थिति की पहचान होनी चाहिये। विनियामक की भूमिका महत्वपूर्ण हो जाती है तथा उसे देखना होता है कि कहीं कोई खिलाड़ी उदासनी माहौल ना बना ले।

प्र. विनियामक क्या कर सकता है?

ये सभी समस्यायें मूल्य कंट्रोल को मुक्त कर के ही सुलझायी जा सकती है।

प्र. कंपनियाँ खुद इस पर साफ नही है। क्या बाजार तैयार है, या कंपनियाँ तैयार है?

किसी तरह हमें इसके लिये तैयार होना है। प्रतिस्पर्धा तथा टैरिफ साथ साथ नही चल सकते। बाजार को स्वयं ही मूल्य का निर्धारण कर देखना होगा कि वह मूल्य तथा लाभ में कहा ठहरता है तथा उसे यह सभी एक योजना के रूप में करना होगा।

जीवन व्यापार में मूल्य निर्धारण एक मुद्दा रहा है। गारंटी धन वापसी ने उन्हें मुसीबतों में डाल दिया है जिसका परिणाम अब या तो ब्याज दरों में कमी अथवा उत्पाद को वापस लेना है। यदि ब्याज दरें कम होती है तो उन्हें प्रीमियम मूल्य बढ़ाना पड़ सकता है। वे स्वंय को नही चला सकते हैं।

इसका दूसरा उपाय है प्रबंधन खर्च में कटौती। मैनें अधिक कर्मचारियों वाले सार्वजनिक क्षेत्र के यूनिटों तथा कम कर्मचारियों वाले निजी क्षेत्र के यूनिटों में प्रबंधन खर्च की समस्याओं को लेकर एक तरह की लड़ाई देखी है।

प्र. सार्वजनिक क्षेत्र की प्रंबधन खर्च के बारे में कुछ नही कह सकती है क्योंकि उनका 80 प्रतिशत खर्च पक्का है?

मैं तभी खुश हो सकता हूँ जब वह 80 प्रतिशत उनलोगों पर खर्च हो जो व्यापार लाते हैं। परंतु ज्यादातर यह प्रबंधन पर खर्च होता है।

प्र. विनियामक इस बारे में क्या कर सकता है?

पहले बाजार को इसे परखना होगा। यदि खर्चें पक्के हैं तो उत्पादकता को बढ़ाना होगा।

वहाँ अलग मुद्दे भी है जो बाजार की क्षमता तथा बाजार की रचना से जुड़े हैं। यदि चीजें ठीक नही चल रही हैं तो विनियामक को को आगे आकर देखना होगा की कैसे उसे ठीक किया जा सकता है। बहुत जल्द विनियामक को इसमें शामिल होना ही होगा।

प्र. क्या प्रंबधन खर्च तथा ऐसे अन्य मुद्दे कंपनी के आंतरिक नहीं है?

कुछ भी आंतिरक नही है यदि वह उपभोक्ता से संबंधित है तथा वह मूल्य देने के लिये बनाया गया है जो कि जरूरत से ज्यादा बड़ा तथा वारंटी में है।

प्र. क्या चार गैर जीवन बीमा का विलय खर्च को कम करेगा तथा उन्हें बाजार में एक नयी क्षमता देगा?

विलय मूल समस्याओं का समाधान नही है। यहाँ ज्यादा जरूरी है कि संस्था के अंदर ही अच्छी संवाद तथा संचार सुविधा तथा उसके कारक को उजागर करना है। भारतीय जीवन बीमा निगम इसे करने में कामयाब रहा है जबकि गैर जीवन कंपनियाँ न रह सकी। सभी कम्पनियों ने एक मिश्रित संस्कृति को अपनाया है। जो कि 30 वर्ष पुरानी है और आज तक यह एकरूप में नही आयी है।

प्र. उद्योग किस तरह स्वंय को मजबूत कर सकता है?

ज्यादा अच्छी सुविधा। कंपनियाँ अपने आप को बाजार में रख सकती है जब वह बाजार के अनुसार, बाजार की माँग, नये उत्पादों का उत्पादन, उच्च स्तरीय सुविधा तथा इन सब से ऊपर निवेश का तरीका। यदि वो इसे स्वीकार करते हैं तो वो उपभोक्ता पर ज्यादा विश्वास कायम कर सकते हैं।

प्र. आप नयी कंपनियों के लिये कहाँ चुनौती देख रहे हैं?

वे सभी छोटी कंपनियाँ हैं जिन्होनें अपना व्यवसाय 100 करोड़ रूपये की पूँजी से शुरू किया है। उनमें से कुछ ने अपने व्यापार के बढ़ाने के लिये इसे बढ़ाया भी है और वो फल-फूल भी रहे हैं। 6 से 7 वर्षों के पश्चात वे पूर्णतया: विकसित हो जायेंगे। यह सब निर्भर करता है कि व्यापार के लिये वे किस तरह की मानसिकता सावधानी के साथ अपनाते है। क्या वे बाजार में टिके रहेंगे या अपने फंड के साथ किसी अन्य के साथ विलय होगें...

प्र. वहाँ पर पुर्न: बीमा को देश में आने को ज्यादा प्रोत्साहन क्यो नही है?

प्रीमियम दरें देश में एक समान स्वीकार नही है। यह स्थिति पुर्न:बीमाकर्ताओं को खुशी प्रदान नही कर सकती है। ये वे लोग हैं जो जोखिम प्रबंधन स्वंय के लिये करते हैं तथा सीधे व्यापार के लिये कीमतें कम करते हैं। यदि आप बाजार को आगे बढ़ाना चाहते हैं तो सीधे बीमाकर्ताओं को वापस भेजना होगा।

प्र. बीमाकर्ता कहते हैं कि ग्रामीण तथा सामाजिक क्षेत्र में व्यापार करना आसान है, परंतु मूल्य ज्यादा है। किस तरह कोई इस बाजार को बढ़ा सकता है?

कोई भी कंपनी, चाहे नयी या पुरानी ने इसे भुनाने के

लिये अधिक कदम नही उठाये हैं। यदि आप नगर में व्यापार करते हैं तो वह रूपया मांगता है।

बीमा खरीदना प्रीमियम देने की क्षमता पर निर्भर करता है। ग्रामीण क्षेत्र गरीब नही हैं। वहाँ पर भी बड़ी जेबें है जैसा कि एफएमसीजी ने दिखाया है।

हम उन क्षेत्रों में इस बारे में जानकारी तथा शिक्षा देना चाहते हैं। हमने अपना पहले कैम्पैगन को पूरा कर दिया है तथा हम क्षेत्रीय प्रिंट मीडिया पर अपना दूसरा कैम्पैगन शुरू करने जा रहे हैं। प्राधिकरण इन पर खर्च करना चाहता है - ये हमारे विकास का हिस्सा है।

हम उद्योग के प्रति लोगों की आस्था बढ़ायेंगे जिससे दूरियाँ कम होगी।

व्यापार वहाँ है। परंतु पहल स्थापित करनी बाकी है, तथा हमें ऐसे लोगों को तलाशना है जो व्यापार को बढ़ा सके।

कंपनियाँ अब छोटे शहरों में जाने की योजनायें बना रही है जो समस्याओं को संभाल सकती हैं।

सहयोगी संस्थायें ग्रामीण तथा सामाजिक क्षेत्र में व्यापार को बढ़ाने के लिये बीमा क्षेत्र में आ रही हैं। यहाँ पर दो समस्याएँ हैं एक है दो विनियामक तथा दूसरा बीमा अधिनियम जो १०० करोड़ रूपये की पूंजी तथा साख की नियम व शर्तें सामने रखता है। कुछ क्षेत्र ऐसे हैं जहाँ सहयोगी संस्थायें व्यापार ज्यादा अच्छी तरह चला सकती हैं। हम उद्योग को बढ़ाने के लिये उन्हें पूँजी में कुछ रियायत दे सकते हैं तथा विनियामक को नियम व शर्तें भी आसान करनी होगी।

नियमन क्या कहता है...

- बीमाधारकों की सुरक्षा

ग्राहक का हित आईआरडीए का प्रमुख लक्ष्य है। यह एक उद्योग के आधारभूत नियामक के क्षेत्र से बाहर आता प्रतीत होता है परंतु वास्तविकता यह नही है। एक नियामक का मुख्य कार्य उद्योग का नियमन, विकास एवँ संचालन है। उद्योग की स्थापना ग्राहकों के साथ व्यापार करने के लिये एवँ इस प्रकार कुछ लाभ की प्राप्ति के लिये किया जाता है। क्या यह तर्कयक्त कथन नही है कि एक उद्योग का विकास ग्राहक की संतुष्टि, प्रसन्नता और सुरक्षा पर निर्भर करता है? और क्या यह एक नियामक का कार्य नही है कि उद्योग और ग्राहक के मध्य दृढ़ संतुलन स्थापित करें?

इन्ही तथ्यों को ध्यान में रखकर बीमा विनियामक एवँ विकास प्राधिकरण विनियमन 2002 का निर्माण किया गया था।

आईआरडीए के पूर्व अध्यक्ष श्री एन. रंगाचारी कहते है कि हमारे पास उन ग्राहकों की शिकायतों का ढेर लग गया जो बीमाकर्ताओं के उदासीन व्यवहार का सामना कर रहे थे। उन्हें सर्वे रिपोर्ट नही दी जाती थी। उन्हे उन उत्पादों को बेचा जाता था जो उनके लिये उपयोगी नही थे तथा उनके दावों का भी सही तरीके से निपटारा नही किया जाता था।

इस प्रकार का एक मामला जो प्रकाश में आया:-

यह एक विधवा की तरफ से पत्र था जिसके पति की जीवन बीमा पॉलिसी के दावे को नकार दिया गया था। कारण था कि उसके पति ने एक बार मेडिकल छुट्टी ली थी तथा उसका जिक्र आवेदन में नही किया गया था।

आईआरडीए ने मामले को लिया तथा बीमा कंपनी को मामले की जाँच के लिये कहा। यह पाया की मेडिकल छुट्टी एक आकस्मिक छुट्टी थी जो किसी संबंधी को रेल्वे स्टेशन से लाने के लिये ली गयी थी। इस आधार पर कंपनी ने उस विधवा को बीमे की 29000 रूपये की रकम देने से मना कर दिया जिसकी उसे आवश्यकता थी।

इस प्रकार के मामले से आईआरडीए को काफी धक्का लगा जिसका कार्य बीमा क्षेत्र का नियंत्रण है। ऐसा निर्णय लिया गया कि ग्राहकों की सुरक्षा के लिये आवश्यक कदम उठाये जायें तथा ऐसे नियमन निर्धारित किये जायें जो सभी बीमा कंपनियों पर समान रूप से लागू हों। श्री रंगाचारी का कहना है कि बीमा उद्योग में ग्राहकों के विश्वास को बनाये रखने के लिये ऐसा आवश्यक है।

इसमें एक महत्वपूर्ण नियमन - दावे के निपटारे के लिये निर्धारित समय तथा यदि बीमा कंपनी दावे के निपटारे में 30 दिनों से अधिक का समय लेती है तो ग्राहक को उचित मुआवजा दिया जायेगा।

बीमा उत्पादों एवँ खासकर वित्तीय उत्पादों के लिये एक महत्वपूर्ण शिकायत यह है कि ग्राहक को यह पता नही होता है कि वह क्या खरीद रहा है। उसे हमेशा सूचित नही किया जाता है, वह नही जानता की क्या पूछा जाये, तथा प्राय: वह वो उत्पाद खरीद लेता है तो उसे नही चाहिये। कभी - कभी यह उत्पाद की प्रकृति हो सकती है परंतु यह बीमा कंपनी द्वारा उत्पाद की सही सूचना प्रदान करने की कमी भी हो सकती है।

इस प्रकार उत्पाद की बिक्री के समय जब बीमाकर्ता या उसका कोई एजेन्ट किसी ग्राहक से बातचीत कर रहा है तो उसे अपने उत्पाद की संपूर्ण जानकारी अपने ग्राहक को प्रदान करनी चाहिये ताकि ग्राहक यह समझ सके कि कौन सा उत्पाद बेहतर है? तथा यह भी किया जा सकता है कि आवेदन पत्र के अंत में बीमाकर्ता द्वारा यह घोषणा की जायें की उसने अपने ग्राहक को उत्पाद के तथ्य भली-भांति समझा दिये है तथा ग्राहक इससे संतुष्ट है।

नियमन इस बात की गहराई में जाना चाहता है कि ग्राहक से प्रत्येक चरण में बातचीत के दौरान क्या करना चाहिये और क्या नही करनी चाहिये।

बीमा और उसका स्वरूप

एच. एम. जैन

बीमा व्यवसाय सम्पत्ति या जीवन के आर्थिक संरक्षण से सम्बन्धित है। हर सम्पत्ति का चाहे वह मूर्त हो अथवा अदृश्य एक मूल्य होता है। इस सम्पत्ति का सृजन और संचय व्यक्ति के अपने श्रम से होता है। यह प्रक्रिया व्यक्ति की सारी संभावित जीवन अवधि तक चलती है। पर ऐसे अनेक जोखिम हो सकते है, बीमारी या मृत्यु भी। बीमा इन सभी संभावित आपदाओं के विपरीत परिणामों से जूझने का एक माध्यम भी है और एक अस्त्र भी इस तरह बीमा का उद्देश्य या आवश्यकताओं में मृत्यु और वृद्धावस्था के जोखिम के अलावा उसकी सम्पत्ति के मूर्त रूप जैसे, मकान, कार, गोदाम, कारखाने, माल का आयात, निर्यात या आधुनिक व्यवसाय के जटिल रूपों में हानि की, आग, बाढ़ भूकम्प आदि के खतरे भी होते है। इन दोनो प्रकारों के जोखिम से निपटने के लिये जीवन बीमा सम्भावना, जो हों भी सकती है और नहीं भी सकती है और नहीं भी। इस अनिश्चितता से जूझने के लिये बीमा आवश्यक और प्रासंगिक बन जाता है। किसी भी समान समूह के समान खतरे होते हैं इसलिये किसी भी समुदाय या वर्ग के एक से जोखिमों के लिये हानि की स्थिति में भरपाई करने के लिये बीमा संस्थान प्रीमियम के रूप में किश्ते लेते है। यह हानि में हिस्सेदारी की अवधारणा पर होता है।

इस प्रकार हम कह सकते है कि समाज में वे लोग जो एक समान प्रकार के जोखिम का सामना करते है यदि उनके समूह के किसी भी सदस्य को इस जोखिम की वजह से कोई हानि होती है उसकी हानि की पूर्ति वे सब मिलकर करेंगे। सब प्रकार के जोखिमों की पहचान की जा सकती है और उन समूहों को विभाजित कर श्रेणीवद्ध किया जा सकता है। उनसे अधिक या कम योगदान लेकर भागीदार बनाया जा सकता हैं, जिससे एक व्यक्ति के जोखिम को पूरे समूह में बाँटा जा सके। इस प्रकार भिन्न भिन्न रूप में बीमा का यह कार्य है कि जिन लोगों को इस प्रकार के संकटों के लिये भिन्न भिन्न समूहों से मिलकर हानि की पूर्ति करें। यह जोखिम का एक समूह के रूप में वहन है। यही बीमे का मूल सिद्धान्त है कि हानि का बँटवारा कर अनिश्चिता का निश्चितता में रूपान्तरण किया जाये जो हानि की भागीदारी है।

यदि जोखिम समय से पूर्व मृत्यु से सम्बन्धित है तो उससे होने वाली आर्थिक हानि की पूर्ति जीवन बीमा से होती है। यदि आर्थिक हानि शारिरिक अपंगता से होती है तो उसकी क्षतिपूर्ति स्वास्थ्य बीमा से होती है। सामाजिक रूप से स्वास्थय बीमा ऐसी प्रणाली है जिसमें समाज के लोगों के अंशदान से कोष बनता है जिसें अनिश्चित हानियों की पूर्ति करने के काम में लाया जाता है जो असमय मृत्यु या अपंगता से होती है। इस प्रकार यह व्यक्तियों द्वारा सब पर समान रूप से उपस्थित जोखिम अथवा संकट को मिलकर अंशदान करके किसी के एक अथवा अधिक पर आने वाली उसकी आर्थिक हानि की पूर्ति करना है।

संविदा या अनुबन्ध

व्यक्तिगत रूप से जीवन बीमा अथवा स्वास्थ्य बीमा एक प्रकार का संविदा या अनुबंध है जिसमें एक पक्ष बीमाधारी को बीमाकर्ता द्वारा उसे अथवा उसके द्वारा नामित व्यक्ति को एक निश्चित धन उसकी मृत्यु, अपंगता अथवा कोई अन्य विशेष अनुबंधित घटना घटित होने पर देगा और बीमाधारी इस दायित्व को वहन करने को लिये बीमाकर्ता को प्रतिफल के रूप में एक विशेष धनराशि जिसे प्रीमियम कहा जाता है, देगा। प्रत्येक बीमा करने वाला संस्थान जैसे निगम, कम्पनी, न्यास अथवा सहकारी सोसाइटी हानि को वितरित करने का कार्य करते है।

अधिक संख्या के सिद्धान्त का उपयोग कर इस प्रकार बीमा की अवधारणा हानि को लाखों लोगों में बांट देती है और इसलिये जब यह हानि प्रत्येक व्यक्ति के भागों में आती है तो वह नगण्य बन जाती है। जुआ लगने वाला यह हिस्सा एक सुव्यवस्थित व्यापार बन जाता है। इस व्यापार में निहित मूल सिद्धान्त यह है कि यदि हम भिन्न भिन्न श्रेणियों के संकटों को एक समूह में बांट देंगे जिनमे बहुत संख्या में लोग सम्मिलित हों तो हानि की अनिश्चितता समूह में बांट देंगे जिनमे बहुत संख्या में लोग सम्मिलित हो तो हानि की अनिश्चितता समूह की संख्या की वृद्धि के साथ साथ घटती चली जायेगी। जैसे दस लाख व्यक्तियों में एक लाख रूपये की हानि बांटी जाये तो वह एक पैसा प्रति व्यक्ति होगी जो नगण्य राशि है।

दूसरी ओर एक व्यक्ति दूसरे व्यक्ति का स्वयं अकेला ही बीमा करता है तो यह जुआ होगा क्योंकि प्रथम व्यक्ति की मृत्यु होने पर दूसरे व्यक्ति को अकेले ही धन का भुगतान करना होगा। इसी भांति यह एक व्यक्ति का जोखिम कई बीमाकर्ताओं में बांट दिया जाये तो भी प्रत्येक बीमाकर्ता के दायित्व में कमी आ जायेगी। इसी सिद्धान्त पर पुनबीमा-रिइन्शयोरंस का सिद्धान्त आधारित है।

दूसरी बात इस सम्बन्ध में समझने की है कि बीमाकर्ता के पास पिछले वर्षों के मृत्यु के आंकड़े उपलब्ध होने पर और विशेष आयु वर्ग के अनुसार उनका शोध और विश्लेषण करने के पश्चात् भविष्य में होने वाली मृत्यु संख्या की भविष्यवाणी भी की जा सकती हैं।

इसलिए कोई बीमाकर्ता यदि अपने बीमा कराने वालों में इतनी अधिक वृद्धि कर ले तो औसत के नियम को लागू करने पर मृत्यु से होने वाली बीमाराशि सम्बन्धी अनिश्चितता लगभग हो चाती है। कहा जाता है कि मृत्यु से अधिक अनिश्चित संसार में और कुछ नहीं है और जीवन बीमा से अधिक निश्चित और कुछ नहीं है।

बीमा उत्पादों की संरचना

मूलभूत रूप से तमाम प्रकार के बीमा की रचना एक ही प्रकार की होती है क्योंकि उनमें विभिन्न प्रकार के जोखिमों को समूह के रूप में सम्मिलित कर उनका संचालन किया जाता है लेकिन भिन्न - भिन्न जोखिमों का बीमा होने के कारण उनकी प्रकृति

भिन्न - भिन्न होती है। इसी सम्बन्ध में जीवन बीमा और अन्य प्रकार के बीमा में मुख्य अन्तर यह है कि अन्य प्रकार का बीमा करने पर बीमित की जाने वाली सम्भाव्य घटना घट भी करता है और नहीं भी घट सकती और अधिकतर यह सम्भाव्य घटना घटती ही नहीं। लेकिन जीवन बीमा जिस सम्भाव्य घटना अर्थात् मृत्यु हो सकती है एक वर्ष-दो वर्षों तक कई वर्षों में न घटे। लेकिन समय के बीतने के साथ-साथ उसके घटने की सम्भावना बढ़ती ही जाती है और एक दिन निश्चित रूप से घटित हो जाती है क्योंकि जो प्राणी जन्मता है उसकी मृत्यु निश्चित है। इसलिए जीवन बीमा में लम्बी अवधि कर जोखिम लेनी पड़ती है और आजीवन बीमा में पूरे जीवन भर यह जोखिम रहती है। इसके लिए जीवन बीमा में उचित कोष की व्यवस्था आवश्यक है जिससे उन दावों का भुगतान किया जा सके जो किसी एक वर्ष में निश्चत रूप से देय होंगे।

स्वास्थय बीमा यदि वह एक वर्ष की अवधि के लिए कराया जाये तो प्रत्येक बीमाधारी बीमारी के कारण अपंग नहीं होता और मृत्यु की भांति इसमें निश्चितता नहीं है परन्तु यही स्वास्थय बीमा निरंतर चलता रहे और लम्बी अवधि के लिए किया गया हो तो इसमें भी जोखिम की निरंतर वृद्धि होती जाती है और इसके लिए भी एक कोष एकत्रित करना आवश्यक हो जाता है जिससे आयु बढ़ने के साथ-साथ उनमें होने वाले दावों का भुगतान किया जा सके।

विविध प्रकार

जीवन बीमा और स्वास्थ्य बीमा के लिए बीमाकर्ता संस्थान को कोष की स्थापना हेतु कई महत्वपूर्ण बातों को ध्यान में रखना होगा जो जीवन कराते समय एक ही आयु के नहीं होते क्योंकि छोटी आयु वाले लम्बी अवधि तक जीवित रहेंगे और बड़ी आयु वाले छोटी अवधि तक जीवित रहेंगे। इसलिए ज्यों-ज्यों आयु बढ़ती जाती है उसी के अनुसार बीमा कराने के लिए प्रीमियम दर भी बढ़ती जाती है और यदि प्रतिवर्ष नया बीमा कराया जाये तो एक वर्ष के लिए ही करना हो तो प्रतिवर्ष उसी व्यक्ति से अधिक प्रीमियम राशि ली जायेगी। स्वास्थय बीमा के सम्बन्ध में भी यह सच है कि आयु बढ़ने के साथ बीमा होने का अंतराल घटता जाता है और एक बार बीमा होने पर उसके पश्चात् ठीक होने में भी लम्बा समय लगता है तथा रोग से अक्षता की अवधि में वृद्धि होती जाती है। इसी लिए कई प्रकार की पॉलिसियाँ जीवन बीमा और स्वास्थ्य बीमा में होती हैं। जैसे किसी पॉलिसी में तो जीवन भर प्रीमियम देना पड़ता है और बीमाधन मृत्यु पर देय हेता है। किसी पॉलिसी में निश्चित वर्षों के लिए बीमा किया जाता है। और यदि मृत्यु नहीं हुई तो अवधि समाप्त होने पर बीमाधन लौटाना होता है। इन सावधिक बीमा में भी कई विशेष पॉलिसियाँ होती हैं जैसे बीच-बीच में धन मिलने वाली पॉलिसी, थोड़ी अवधि की पॉलिसी, दुगुना जोखिम लेने वाली पॉलिसी, बीमा में कई प्रकार का बीमा होता है कुछ में केवल चुने हुए कुछ रोगों के उपचार हेतु दावा स्वीकार करने का प्रावधान है कुछ अधिक विस्तृत होती है। कुछ में सब प्रकार के रोग तथा अस्पताल में बिना भरती हुए घर पर ही चिकित्सा कराने पर सब को आधार बनाकर किया जाता है। इस विधि से प्रीमियम लेने में लाभ यह है। कि इसमें प्रति वर्ष परिवर्तन नहीं किया जाता, समान रूप से सदा रहने के कारण बीमाधारी को भी सुविधाजनक होता है और बीमाधारी इसको देने के लिये मनोवैज्ञनिक रूप से आदत डाल देता है।

इस समान प्रीमियम लेने की विधि में प्रथम कुछ वर्षो में आगे आने वाले वर्षों का बढ़ने वाला प्रीमियम ले लिया जाता है जिससे बढ़ते वर्षों में बढ़ी जोखिम का भुगतान किया जा सके। प्रथम वर्षों में अधिक एकत्रित प्रीमियम राशि और उस पर मिलने वाला ब्याज उस आयु में प्रीमियम भुगतान में समायोजित कर लिया जाता है जब बहुत अधिक प्रीमियम लेना होता है। यह बीमाधारी का ही धन है और बीमाकर्ता संस्थान इसका न्यासी के रुप में संरक्षक है यह संचित कोष या पालिसी रिजर्व है। इस भांति एक रक्षित कोष का भविष्य में उत्पन्न दावों के भुगतान के लिए संचय करना किसी भी बीमा संस्थान के लिए सुदृढ़ आधार की रचना करता है और जीवन बीमा और स्वास्थ्य बीमा के लिए बीमाधारियों और अभिकर्ताओं में विश्वास पैदा करता है।

(लेखक भारतीय जीवन बीमा अभिकर्ता महासंघ के अध्यक्ष हैं)

जीवन सुरक्षा हेतु शोध

आईआरडीए दो नये संस्थान स्थापित करने जा रहा है जिसमें से एक है सड़क तथा वाहन सुरक्षा टेस्टिंग एवँ रेटिंग के क्षेत्र में तथा दूसरा मोटर बीमा डाटा के क्षेत्र में है।

यह सब USAID के वित्तीय संस्थान पुनर्रचना एवँ विकास कार्यक्रम (FIRE) के द्वारा मौजूदा वाहन बीमा क्षेत्र की कमजोरियों के गहन अध्ययन के पश्चात किया जा रहा है। FIRE कार्यक्रम से आईआर डीए को भी संस्थानों की स्थापना एवँ विभाग के विभिन्न कार्यकलापों के संचालन में मदद मिलने की आशा है।

आईआरडीए के पूर्व अध्यक्ष श्री एन. रंगाचारी ने 6 मई 2003, को हैदराबाद में एक सभा को संबोधित करते हुये कहा कि संस्थान की स्थापना चैन्नै में की जायेगी तथा आईआरडीए इसमें निवेश करेगा। तमिलनाडु सरकार ने चैन्नै के पास ही वाहन सुरक्षा टेस्टिंग सेंटर के निर्माण के लिये 50 एकड़ भूमि प्रदान की है। इस विषय में तमिलनाडु विधानसभा में मई के पहले सप्ताह में घोषणा की जा चुकी है। यह केन्द्र सड़क सुरक्षा शोध संस्थान का एक हिस्सा होगा तथा मोटर डाटा एवँ बीमा शोध संस्थान भी वहाँ स्थापित किया जायेगा।

आईआरडीए का मानना है कि ये दोनों ही शोध के लिये विस्तृत क्षेत्र हैं जो कि बीमा उद्योग को संयुक्त उपभोक्ता सुविधायें प्रदान करेंगे।

सड़क सुरक्षा शोध संस्थान भारत में सड़क सुरक्षा के लिये एक प्रमुख शोध एवँ सूचना केन्द्र के रूप में उभरेगा - यह कहना है उपभोक्ता शोध संघ, ब्रिटेन के श्री क्राइस इवान्स का। इवान्स ब्रिटेन में उपभोक्ता कार्यक्रमों में कार्य कर चुके हैं जो कई वर्षों से वाहन सुरक्षा क्षेत्र में अग्रणी है।

अपनी रिपोर्ट में उन्होनें कहा है कि सड़क सुरक्षा शोध संस्थान महत्वपूर्ण शोध कार्य कर रहा है। ये शोध पुलिस एवँ प्रवर्तन अधिकारियों, चिकित्सालयों एवँ बीमा उद्योग द्वारा प्राप्त किये गये आँकड़ो पर आधारित होगा। इन शोध कार्यों के में सीट-बेल्ट का उपयोग तथा अल्कोहल से जुड़ी दुर्घटनायें शामिल होगी। इन शोध कार्यों के द्वारा बीमाकर्ता, कानून बनाने वाले, वाहन बनाने वाले एवँ आम जनता को काफी लाभ पहुँचेगा। श्री इवान्स के अनुसार - दुर्घटनाओं में कमी होगी, जान-माल की कम हानि होगी एवँ जोखिम घटेगा। उनके अनुसार बीमा उद्योग को इससे सर्वाधिक फायदा होगा क्योंकि दुर्घटनाओं में कमी से दावों में भी कमी होगी।

इस शोध कार्य को प्रारंभ करने का एक प्रमुख कारण यह है कि भारत में लगभग 5 करोड़ वाहन हैं तथा प्रतिवर्ष 85,000 से अधिक लोग सड़क दुर्घटनाओं में मारे जाते हैं जबकि अमेरिका में लगभग 22 करोड़ वाहन है परंतु सड़क दुर्घटनाओं में प्रतिवर्ष मारे जाने वाले लोगों की संख्या सिर्फ 42000 के आस-पास है। अत: भारत में सड़क दुर्घटनाओं का जोखिम अमेरिका के मुकाबले लगभग 10 गुना है।

इन दुर्घटनाओं से न केवल मानव हानि होती है परंतु संपत्ति की भी हानि होती है। सन् 2001-02 में भारत का कुल सकल घरेलू उत्पाद लगभग 1265429 करोड़ रूपये था जबकि इसी वर्ष दुर्घटनाओं में लगभग 25308 करोड़ रूपये की क्षति हुयी है। यह रकम सकल घरेलू उत्पाद की 2 प्रतिशत है।

ऐसा प्रस्तावित है कि सड़क सुरक्षा शोध संस्थान एवँ मोटर डाटा एवँ बीमा शोध संस्थां एक साथ एक ही व्यक्ति के संचालन में कार्य करें। इसमें मोटर डाटा एवँ बीमा शोध संस्थान आंकड़ों को एकत्रित करने का कार्य करेगा जो इसके स्वंय के एवँ सड़क सुरक्षा शोध संस्थान के लिये उपयोगी होगा।

मोटर डाटा एवँ बीमा शोध संस्थान एवँ सूचना केन्द्र भी स्थापित करेगा जहाँ सड़क दुर्घटनाओं के बारे में जानकारी मौजूद रहेगी। इससे पीड़ित बचाव व आपातकालीन सेवा में मदद मिलेगी।

संसदीय राजभाषा समिति द्वारा आईआरडीए का निरीक्षण

17 जून 2003 को संसदीय राजभाषा समिति ने आईआरडीए में राजभाषा की गतिविधियों एवं कार्यों का निरीक्षण किया। इस उप-समिति के उपाध्यक्ष डॉ लक्ष्मीनारायण पाण्डेय, संयोजक श्री नवल किशोर किशोर राय तथा सदस्य श्री बी. वेवकटेश्वरलू, डॉ सी नारायण रेड्डी, श्री एस जगत रक्षकन व श्रीमती सरला माहेश्वरी ने निरीक्षण में भाग लिया।

आईआरडीए की ओर से अध्यक्ष श्री सी. एस. राव, सदस्य श्री आर. सी. शर्मा व श्री पी.ए. बालासुब्रह्मण्यम, कार्यकारी निदेशक प्रबोध चन्दर तथा के सुब्राह्मण्यम के साथ राजभाषा उपनिदेशक संजीव जैन ने भाग लिया।

वित्त मंत्रालय आर्थिक कार्य विभाग की ओर से निदेशक श्री आर. डी. मासीवाल व सहायक निदेशक श्री मोहन चन्द मिश्र भी निरीक्षण के समय उपस्थित थे।

संसदीय समिति ने इसके अतिरिक्त आंध्रा बैंक तथा बीएचईएल में हिन्दी कार्यान्वयन का भी निरीक्षण किया।

Performance Guarantees
A Perspective

Ritesh Kumar

The Indian economy has demonstrated a marked resilience in the last few years in the wake of a global economic downturn spurred by recessionary trends in several developed economies. The notable rise of Indian multinational companies in several sectors like information technology, automobiles and pharmaceuticals has been accompanied by a discernible trend towards recovery in the overall industrial sector.

The recent trends have provided a strong foundation for a broad based industrial development, specially in key infrastructure sectors. There has been a strong impetus for growth in the last few years in telecommunications, roads and urban infrastructure.

Similarly in the road sector, the Government has embarked on the ambitious National Highway Development Project (NHDP) covering 13,500 km with a cost of Rs. 54,000 crores (at 1999 prices).

This comprises the Golden Quadrilateral project (linking the four metros) covering 5,846 km, North-South/ East-West connectivity project of 7,300 km and 400 km of Port connectivity projects. Almost the entire portion of the Golden Quadrilateral project has already been awarded – about 1,300 km have been completed by April, 2003, and the balance is expected to be completed by December, 2004.

Out of the North-South/East-West connectivity project, only about 1,000 km is under implementation and the balance is likely to be awarded over the next two years. It is estimated that this project would be completed by December, 2007. The average cost per km is in the range of Rs. 4 crores to Rs. 6 crores.

The resurgence in industrial/ infrastructure projects will trigger an increased requirement for performance guarantees and bonds for these projects.

Insurance Companies and Sureties

Surety bonds are credit instruments underwritten, based on corporate credit metrics and the terms and conditions of the underlying obligations. Worldwide, surety bonds are favoured by corporate financial managers because of their general off-balance sheet treatment. Surety bonds do not encumber bank borrowing lines of credit and are not usually disclosed in financial statements as contingent liabilities. They have been attractive alternatives to bank letters of credit at a substantial cost discount.

Internationally, multi-line non-life insurance companies as well as mono-line guarantee companies are major providers of surety bonds. The domestic surety market in the US alone accounts for approximately $3.3 billion of annual written premium. Almost $1 billion of this total represents the premium generated from commercial surety risks for corporations on obligations ranging from compliance bonds and license and permit bonds required by public statutes, performance bonds required by the construction contractors and court bonds to any number of financial guarantees. The financial guarantees segment has witnessed turbulent market conditions in the recent past with major losses stemming from the recent string of corporate failures in the US. However, the requirement of sureties in the other segments remains buoyant.

> Because of their higher reserve and capital adequacy requirements, commercial banks' pricing of guarantees is usually more inflexible than that of a comparable insurance company.

In India, prior to nationalisation of the general insurance sector in 1973, insurance companies were underwriting sureties for corporate clients, albeit on a small basis. After nationalisation, there was a general drift of the insurance companies away from this business and, at present, the bulk of the contract guarantees business has come to be dominated by the commercial banks in India.

Performance Guarantees in India

Guarantees are extensively used in the construction sector in India to secure performance or other obligations. They provide the project Sponsor/ Beneficiary with access to the amount guaranteed should there be a breach of contract or performance.

Types of Guarantees

It is usual for a banker to issue guarantees on behalf of his customers on payment of commission. The guarantees usually executed by the banker are:

(i) Bid Bond or Earnest Money Deposit (EMD) Guarantee
(ii) Performance Guarantee
(iii) Advance Payment Guarantee (also known as Mobilisation Advance Guarantee)
(iv) Retention Money Guarantee

I. Bid Bond/EMD Guarantee

When a contractor bids for a construction contract, he usually has to submit a guarantee along with the tender. This type of guarantee is called a bid bond guarantee. A bid bond is an obligation undertaken by a bidder promising that the bidder will, if awarded the contract, furnish the prescribed performance guarantee and enter into the contract agreement within a specified period of time. The guarantee indicates the genuine interest of the contractor towards the tender process. In case of a default by the successful bidder in furnishing the performance guarantee, the project Sponsor/Beneficiary can enforce the guarantee, and the contract is then awarded to the next bidder.

A bid bond ranges in amount from one to five per cent (normally one per cent) of the estimated contract amount, while an EMD guarantee is usually for one to five per cent (normally two per cent) of the contract amount. The tenure of these guarantees is usually in the range of six to 12 months, depending on the tender process.

II. Performance Guarantee

A performance guarantee is essentially a promise by the guarantor to make good the loss to the client in the event of the contractor failing to complete the contract or delaying its completion.

In this type of guarantee, the guarantor does not undertake to perform the obligations undertaken by the contractor on the latter's failure or default, as the performance obligation may be of a highly technical nature. The purpose of obtaining a performance guarantee is to fix the financial or monetary liability upon the guarantor in the event of default or failure in performance of the obligations undertaken by the contractor.

A performance guarantee ranges in amount from 10 to 15 per cent (upto 20 per cent in some cases, depending on the contract agreement) of the contract amount. The tenure of the guarantee usually extends to a period of six to 12 months beyond the completion date of the contract, that is specified in the contract agreement. This defects liability period (or warranty period) varies from project to project and the performance guarantee also covers the successful running/ performance of the project during this period.

III. Advance Payment Guarantee

After the contractor has successfully bid for the project and has furnished a performance guarantee, he is awarded the contract by signing of the contract agreement. In most contracts, the project sponsor usually advances a lumpsum amount, which is typically 10-15 per cent of the contract amount, as an advance payment or mobilisation advance to meet initial contract-related costs which the contractor would be required to pay to third parties.

Therefore, as the project progresses, the contractor is paid the amount of each bill raised by him, less a certain pro rata amount of the mobilisation advance. As a result, by the time the project is 100 per cent complete, the outstanding mobilisation advance amount reduces to nil. Normally, the mobilisation advance is adjusted prior to the retention money payment i.e., out of 95 per cent of the contract payments.

The advance payment guarantee is essentially a promise by the guarantor to pay if the contractor fails to complete the contract, or fails to adhere to the scope of the contract, and thereby causes a loss to the sponsor, to the extent of the outstanding mobilisation advance amount.

As may be readily interpreted from the above, an advance payment guarantee ranges in amount from five to 15 per cent of the contract amount, and progressively reduces to zero over the tenure of the contract. The tenure of the guarantee usually coincides with the completion date of the contract, that is specified in the contract agreement.

IV. Retention Money Guarantee

In some projects, the sponsor retains/ holds back an amount equal to five per cent of every bill raised by the contractor. This sum, called the retention money, finally aggregates to five per cent of the contract amount at the end of the project, and is usually paid in the following manner : 45 to 50 per cent after the completion of the project.

> Sureties present an attractive business opportunity for risk diversification of the business portfolio.

The purpose of the retention money is to ensure the continued interest and commitment of the contractor in the project till its completion. However, in some cases, the sponsor agrees to release a portion of/ the full retention money, provided the contractor furnishes a retention money guarantee.

The tenure of the guarantee usually coincides with the defects liability period/ warranty period stipulated in the contract agreement.

The other guarantees in the construction business are security deposit (which is essentially like a mobilisation advance), suppliers advance guarantee and equipment finance guarantee. The suppliers advance and equipment finance guarantee can be over and above the mobilisation advance guarantee, depending on the size and requirements of the contract.

Current Market Scenario

As mentioned earlier, the performance guarantees business is dominated by commercial banks in India. Traditionally, the guarantees are unconditional and irrevocable in nature. Guarantees are normally issued with recourse to the contractor and further, are usually secured. Guarantee limits are sanctioned as part of the non-fund based working capital limits allotted to the construction companies, and are generally secured by the current assets of the company.

Because of their higher reserve and capital adequacy requirements, commercial banks' pricing of guarantees is usually more inflexible than for a comparable insurance company. Further, from the project sponsor's point of view, the stringent solvency and capital adequacy requirements stipulated by the Insurance Regulatory and Development Authority (IRDA) ensure that a guarantee issued by an insurance company is as safe as that issued by a commercial bank. Insurance companies are thus ideally placed to compete with commercial banks in this business.

As the Indian insurance industry marches steadily towards a fully liberalised regime, sureties present an attractive business opportunity for risk diversification of the business portfolio. The institution of proper credit and technical evaluation methodologies in underwriting will be a critical factor is determining the success of insurance players venturing in this arena. An entry by insurance companies will also serve to deepen and broaden this market in India, making it globally competitive, which will ultimately benefit the construction industry.

The author is Head-Risk and Reinsurance, ICICI Lombard General Insurance Company Limited.

Report Card:GENERAL

Growth slows in May

G.V.Rao

The industry's growth rate has slowed down to 9.7 per cent as at the end of May, 2003, down from the previous spectacular growth rate of 19 per cent in the previous fiscal. In these two months of April and May, the industry has recorded a growth in volume of Rs. 269 crores to register a total premium of Rs. 3,036 crores(Rs. 2,767 crores). The growth rate as at the end of April, of 12 per cent, has slid to 9.7 per cent by the end of May, 2003. It is inexplicable why the growth rate has plummeted from a 19 per cent high to 9.7 per cent in a short span of just two months. What is really happening?

One reason for the slower growth could be that the extraordinary increases in rates obtained last year on very large value risks remained either at the same level or were negotiated downwards resulting in no further increases in volumes.

The other reason could be that there were accounting time-shifts that the threat of increased service tax rate provided, resulting in quite a few renewals being accounted twice last year. Another probable reason for poor growth in business could be the voluntary retirement scheme (VRS) of Development Officers resulting in non-renewals of a few covers. Fierce competitive pressures too could have brought the premium levels down by a notch.

It is interesting to note that out of the increase of Rs. 269 crores in these two months, the private players have garnered an increase of Rs. 198 crores, with a 79 per cent growth rate. The public players have recorded an increase of only Rs. 71 crores with a growth rate of 2.8 per cent.

It is obvious who is setting the agenda for the year 2003-04. Not only is the insurance pie not getting bigger as was expected, but the public players have been driven to the wall to defend their existing accounts.

Since department-wise premium figures are not available yet, it is not possible to analyse what has hit the public players so hard and brought down growth rates so much.

The growth rate for the industry in the month of May, 2003, is 7.6 per cent down from 12 per cent in April, 2003, and, if this is a trend, there is likely to be much tougher competition for business in the remainder of the current year. The month of May has shown that the insurance pie grew by only Rs. 84 crores (it grew by Rs. 185 crores in April, 2003) of which the private players had a share of Rs. 39 crores and the public players Rs. 45 crores. These trends should make the the public sector companies ponder what they must do to regain the initiative to prove their undoubted strengths.

Market shares:

The market share of the private players that was 9.5 per cent at the last fiscal is running now at 14.5 per cent. Their volume growth is Rs. 198 crores as against

Gross Premium Underwritten – May 2003

(Rs. in lakhs)

Insurer	Premium 2003-04		Premium 2002-03		Market share upto May 2003	Growth % Year on Year
	For the month	Upto the month	For the month	Upto the month		
Royal Sundaram	1,744.75	4,833.98	1,189.87	3,051.67	1.56	58.40
Tata AIG	2,131.25	6,686.56	4,129.52	5,234.74	2.16	27.73
Reliance General	1,170.15	3,086.38	997.76	4,323.13	1.00	-28.61
IFFCO-Tokio	3,207.93	8,779.15	1,809.51	4,184.50	2.84	109.80
ICICI Lombard	2,608.44	10,137.21	1,240.45	2,689.05	3.27	276.98
Bajaj Allianz	3,264.41	8,624.26	2,234.96	5,606.10	2.79	53.84
HDFC Chubb	405.34	689.07			0.22	NA
Cholamandalam	994.06	2,048.09			0.66	NA
New India	30,463.00	76,432.00	29,699.00	77,725.00	24.69	-1.66
National	23,663.00	58,269.00	21,709.00	52,224.00	18.82	11.58
United India	26,021.00	62,881.00	24,740.00	61,428.00	20.31	2.37
Oriental	22,984.00	61,187.00	22,490.00	60,286.00	19.76	1.49
ECGC	3,373.20	5,936.21	2,640.21	5,233.76	1.92	13.42
Private Total	**15,526.33**	**44,884.71**	**11,602.07**	**25,089.19**	**14.50**	**78.90**
Public Total	**1,06,504.20**	**2,64,705.21**	**1,01,278.21**	**2,56,896.76**	**85.50**	**3.04**
Grand Total	**1,22,030.53**	**3,09,589.92**	**1,12,880.28**	**2,81,985.95**	**100.00**	**9.79**

the Rs. 71 crores of the public players.

Private players:

ICICI-Lombard now ranks at the top with a premium of over Rs. 101 crores with an accretion of Rs. 74 crores over two months. IFFCO-Tokio ranks second with Rs. 88 crores to be followed by Bajaj-Allianz which was till recently at the top of the heap with Rs. 86 crores. These top three have shown dynamism, rare even in the private sector.

Public players:

National Insurance Company continues its run of success with a growth rate of 11.6 per cent and an accretion of Rs. 60 crores. Oriental with an accretion of Rs. 10 crores and United India with Rs. 15 crores seem to be mere shadows of their former selves. New India has recorded a fall in business of Rs. 13 crores. Do these figures tell a tale for the future? One hopes not. But the growth rate of the four at 2.8 per cent is difficult to accept as befitting big players.

Future prospects:

Business volumes will be hard to garner for all players unless there is a significant drive to create new markets in Personal lines. All players for various reasons seem to be uncommitted to organising this field. What strategies do the public sector players have, better placed as they are, to harness their strengths to chase Personal lines business? Has the VRS. of Development Officers affected them to a great extent? What will happen to them when the VRS for officers is announced?

The future is full of interesting possibilities for the market expansion. Will the market grow? Who are the drivers of growth?

It is as yet unclear how the bottom lines will look like for 2002-03. Poor growth rates, if compounded by lower investment returns, high costs and an unprofitable book of business, can impede growth of business further.

The author is retired CMD, The Oriental Insurance Company Limited.

Rural/Social Sector Performance – 2002-03 (Non-Life Insurers)

(Provisional)

S.No.	Insurer	Year of operations - 2002-03	Total Gross Premium (Rs. lakhs)	Number of policies	Policies in rural areas	Gross Premium in rural areas (Rs. lakhs)	% of rural sector business (GPI)	No. of lives covered in social sector
	PRIVATE SECTOR							
1	Royal Sundaram	III year	18,443.00	3,12,339	45,512	709.18	3.85	10,902
2	Reliance General	III year	18,567.78	28,631	3,029	563.07	3.03	8,797
3	Bajaj Allianz	II year	28,928.49	8,19,190	53,014	1,697.11	5.87	14,053
4	IFFCO-Tokio	III year	21,412.70	1,46,559	450	1,160.71	5.42	8,27,334
5	Tata AIG	III year	23,307.28	2,27,187	42,203	657.62	2.82	8,617
6	ICICI Lombard	II year	21,521.00	98,293	147	475.34	2.21	16,660
7	HDFC Chubb	I year	979.80	18,426				
8	Cholamandalam	I year	1,477.70	27,133	1	1.60	0.11	
	Sub total		**1,34,637.75**	**16,77,758**	**1,44,356**	**5,264.63**	**3.9**	**8,86,363**
	PUBLIC SECTOR							
9	National		2,90,601.00	77,77,494	15,94,197	23,191.00	7.98	16,48,480
10	Oriental		2,78,241.12	79,64,173	4,22,212	9,960.00	3.58	36,19,274
11	New India		3,92,900.00	1,44,61,798	17,83,445	32,679.00	8.32	2,75,39,481
12	United India		2,97,122.00	95,06,487	25,29,057	21,145.00	7.12	32,56,984
13	ECGC	First year of IRDA registration	37,603.00	10,779	NA	NA	NA	NA
	Sub total		**12,96,467.12**	**3,97,20,731**	**63,28,911**	**86,975**	**6.7**	**3,60,64,219**
	Grand Total		**14,31,104.87**	**4,13,98489**	**64,73,267**	**92,239**	**6.4**	**3,69,50,582**

- Private insurers' obligation in the rural sector in I, II and III years is 2, 3 and 5 per cent of gross premium income respectively. The public sector insurers are required to exceed the performance in the previous year, and have done so.
- Private insurers' obligation in the social sector in I, II and III years is 5,000, 7,500 and 10,000 lives respectively. The public insurers are required to exceed the performance in the previous year, and have done so.

Align it with the ICAI!

R. Anand

The Insurance Regulatory and Development Authority (IRDA) issued a circular for non-life insurers dated April 29, 2003, clarifying and elaborating a few more issues relating to preparation of financial statements.

The first real test of transparency and disclosures in accordance with the new generation accounting standards was felt for insurance companies for the year ended March 31, 2002. It can be safely said that almost all the companies fell in line with the compliance of accounting standards read with the requirements of IRDA Regulations.

The insurance industry is saddled with special legal features built into the Insurance Act, 1938 (the Act), read with The Insurance Regulatory and Development Authority (Preparation of Financial Statements and Auditor's Report of Insurance Companies) Regulations, 2000. The salient features of the circular dated April, 29, are as under:

Segment Reporting

It is stated that all non-life insurance companies are required to prepare separate revenue accounts for Fire, Marine and Miscellaneous business. This anyway is required as per the Act. Further, separate schedules are required to be prepared for Marine cargo and Marine-others. In respect of Miscellaneous business, the circular stipulates separate schedules to be furnished for (1) Motor (2) Workmen's Compensation /Employer's liability (3) Public /Product liability (4) Engineering (5) Aviation (6) Personal Accident (7) Health insurance and (8) Others.

The point to note is that the basis of segment reporting as per Accounting Standard 17 is the prerogative of the management. However, for the insurance industry, it is laid down in the regulations. Non-life insurance companies have to necessarily follow the business segments as required by the regulations and the circular mentioned supra.

The circular also requires that segments have to be reported on the basis of business within "and outside India." The crux of the issue in deciding geographical segment is: how does one determine the parameters for geographical segments for non-life insurance? One would go by the premise that the location of the risk decides the geographical segment. More often than not, for all insurance players, the major portion of the business is attributable to India and a negligible portion will relate to risk determined outside India.

Cash Flow Statement

The circular mandates all insurers to furnish cash flow statement as per the Direct Method. There are two methods for the preparation of cash flow statements in Accounting Standard 3. They are:

- the direct method, whereby major classes of gross cash receipts and gross cash payments are disclosed; or
- the indirect method, whereby net profit or loss is adjusted for the effects of transactions of a non-cash nature, any deferrals or accruals of past or future operating cash receipts or payments, and items of income or expense associated with investing or financing cash flows.

It must be noted that the circular requires insurance companies to adopt only the direct method. It is learnt that several insurance companies have represented stating that indirect method is the more convenient method of furnishing cash flow statement. However, the Insurance Act requires in Section 11(1A) the preparation of receipts and payments along with financial statements. It is obvious that receipts and payments accounts is close to the direct method of cash flow statement and the Act, and the circular effectively precludes the adoption of indirect method as an alternate method for preparing cash flow statements.

Investment for stakeholders

All insurers are required to maintain separate investment accounts for the shareholders and the policyholders (separate business segments) and the income/ losses accrued/ capital losses on the investments is to be credited/ debited to the respective Revenue Account/ Profit & Loss Account, as the case may be. However, in case of practical difficulties, the consulting Actuary and the Investment Head can take a view on the subject, and consistently follow the same. The policy on this matter should be spelt out in the Significant Accounting policies.

In non-life insurance business, it is extremely difficult to segregate investment relatable to shareholders' funds and policyholders' funds. There is consequently an urgent need for some basis of allocation to arrive at the appropriate investment income relatable to each of the categories viz., shareholders' funds and policyholders' funds.

Some companies are adopting the technical method representing outstanding claim and unexpired premium reserve as the basis for allocation of funds to represent policyholders' funds, and net worth as the basis to represent shareholders' funds. For example:

	Amount (Rs)
Capital	100
Reserves	10
Net worth	**110**
Outstanding claims	40
Unexpired Premium Reserve	60
Technical funds	**100**
Investments	80
Technical funds	100
Net worth	110
Total funds	**210**

Shareholders' funds : $\frac{110}{210} \times 80$

Policyholders' funds : $\frac{100}{210} \times 80$

While circulars and clarifications at periodical intervals are welcome, it is necessary to ensure that issues on accounting as far as possible synchronise with the requirements of various accounting pronouncements issued by the ICAI. The special features of the Insurance Act and the regulations have to necessarily be taken into account in formulating the rules of accounting for the insurance business. The initial two to three years will be the testing period for implementing the disclosure requirements particularly for the new generation private sector players.

The author is President, Corporate Affairs, Sundaram Finance Ltd. The views expressed here are his own.

Report Card : Life

We present below the business statistics of various life insurance companies from the financial year 2002-03 with regard to their obligations towards the rural markets and the social sector. The norms for are also given below. A similar table for the general insurance industry appears on Page 39. (The monthly new business statistics are being held over due to a change in reporting formats.)

Rural/Social Sector Performance – 2002-03 (Life Insurers)

(Provisional)

S.No.	Insurer	Year of operations 2002-03	New business Premium (Rs. lakhs)	Number of policies (new business)	Policies in rural areas (new business)	% of in rural policies	No. of lives covered in social sector (new business)
	PRIVATE SECTOR						
1	HDFC Standard	III year	13,218.70	1,24,837	15,352	12.30	10,490
2	ICICI Prudential	III year	36,471.00	2,44,434	29,376	12.02	17,964
3	Max New York	III year	6,726.72	77,531	9,345	12.05	15,669
4	OM Kotak	II year	3,532.00	32,767	5,169	15.78	32,499
5	Birla Sun Life (Annualised)	III year	14,957.00	64,758	10,422	16.09	12,033
6	Tata-AIG	II year	5,975.36	91,487	9,137	9.99	11,825
7	SBI Life	II year	7,275.16	17,746	2,700	15.21	37,478
8	ING Vysya	II year	505.47	10,976	3,800	34.62	7,500
9	MetLife.	II year	620.09	11,227	2,916	25.97	851
10	Allianz Bajaj	II year	5,378.39	1,15,964	19,368	16.70	11,111
11	AMP Sanmar	II year	598.17	16,344	1,510	9.24	8,192
12	Aviva	I year	1,261.26	17,023	96	0.56	2,370
	Sub total		**96,519.32**	**8,25,094**	**1,09,191**	**13.43**	**1,67,982**
	PUBLIC SECTOR						
1	LIC		11,34,301.97	2,45,45,580	45,46,148	18.52	7,61,752
	Grand Total		**12,30,821.29**	**2,53,70,674**	**46,55,339**	**18.35**	**9,29,734**

- Private insurers are required to underwrite 7, 9 and Twelve per cent of the policies in the rural sector direct policies in the I, II and III years of their operations. LIC is required to underwrite rural business not less than that underwritten in the financial year 2001-02, and has done so.
- Private insurers are required to underwrite 5,000, 7,500 and 10,000 lives in the social sector in the I, II and III years of their operations. LIC, is required to insure lives are not less than that underwritten in the financial year 2001-02, and has done so.

More jobs will be offshored to India

UK-based banks and insurance companies may shift as many as 2,00,000 clerical, processing and administrative jobs to India during the next five years to cut costs, say UK newspapers.

Adecco SA, the world's largest provider of temporary workers, has forecast 1,00,000 UK call centre jobs will be moved to India by the end of 2008.

Barclays Plc, UK's third-biggest lender, said that it cut about 150 UK jobs at its business banking and credit card businesses and contracted the work to companies in India.

It follows similar moves by HSBC Holdings Plc, Lloyds TSB Group Plc and Prudential Plc.

Faced with slowing revenue growth and greater competition, some companies are turning to India with its lower paid, English-speaking workforce.

While Britain is shipping thousands of jobs to India, it is far from the biggest exporter of service industry employment. According to Nasscom, the Indian trade body representing software and service companies, America accounts for 75 per cent of business.

The Deloitte report urges FIs to quickly get abreast of the move offshore. It cites the example of Citigroup, whose rise to become the world's most profitable company has coincided with its move to offshore processing hubs.

GIC to open office in London

National reinsurer General Insurance Corporation of India (GIC) is set to open a full-fledged office in London by March 2004.

Mr. P. B. Ramanujam, Managing Director, GIC, is reported saying that Munich Re's plans to come to India mean GIC losing some of its business. This kind of development makes it imperative for the GIC to expand beyond India, he added.

KenIndia Assurance, a joint venture between LICand GIC is expected to set-up TanzIndia in Tanzania in the next two months. GIC is looking at opening branches in overseas markets such as South East Asia, the Middle East and Africa.

GIC has subsidiary offices in Singapore and Kenya and representative offices in London and Russia.

AICI seeks 50% subsidy on agri-insurance premiums

The newly incorporated public sector, Agriculture Insurance Company of India (AICI), has asked the Union Government to maintain the 50 per cent subsidy on premiums to be paid for policies taken under National Agricultural Insurance Scheme (NAIS).

The Government has been reducing the level of subsidy on premiums by 10 per cent per year since the first year of the scheme when it was 50 per cent (to be shared equally by the Centre and the respective state governments) and this has come down to 20 per cent this year, Mr. Suparas Bhandari, chairman-cum-managing director of AICI is reported to have stated.

This is so that the company may raise premium rates to expand its coverage of farmers. The crop insurance scheme covers farmers facing crop failure due to natural calamities in every state except Rajasthan, Punjab and Haryana, where the governments are yet to agree on implementing the scheme.

FUTURES TRADING STARTS

India kicked off trading in bond and treasury bill futures in mid-June and deals for at least Rs. 1.45 billion were done on the first day on the National Stock Exchange (NSE).

The futures market is expected to reveal the market's view of where the interest rates are headed, apart from hedging the interest rate risk.

A futures contract is an agreement in which a buyer or a seller agrees to respectively take delivery of or deliver a specified amount of an asset at a specific price on a designated date.

It thus protects the holder against future price movements, and in the case of an interest rate futures contract, movements in interest rates.

The exchange acts as a counter-party to all trades, thus reducing the risk of default.

"Interest rate derivatives will provide market protection to institutions like provident funds, insurance companies, banks and corporates, which have long term liabilities that tend to be susceptible to interest rate volatility," said Finance Minister Jaswant Singh, who launched the trade in New Delhi.

To start with, banks can use futures only to hedge the interest rate risk on their government bond portfolios, but primary dealers can also trade.

The Reserve Bank of India will at a later stage consider allowing banks to use the product to hedge other items on their balance sheets and to trade if they have adequate capital and their risk management systems are in place.

Cognizant gets LOMA Award

Cognizant Technology Solutions Corporation, one of the leading providers of information technology (IT) services has been given the LOMA Excellence in Education Award, a leading insurance industry accolade. Insurance is one of Cognizant's key industry concentrations.

"We were the first major offshore company to organise by vertical industry, and we are continually improving the value we can provide to our customers," Mr. Kumar Mahadeva, Chairman and CEO of Cognizant, has been quoted saying.

LOMA is an international association through which more than 1,250 insurance and financial services companies from over 60 countries engage in research and educational activities to improve company operations. Members are involved in life and health insurance, managed care, annuities, pensions, banking, bancassurance, securities, and other financial services areas.

Technically aggressive insurers are beginning to consider outsourcing as a key strategic initiative and are identifying business opportunities that may result from outsourcing, an insurance industry research analyst for Gartner was quoted saying. "Offshore outsourcing plays a major role in insurance carrier's sourcing strategies as a means to control costs, respond to tactical constraints and support competitive differentiation."

i-flex eyes insurance

i-flex Solutions, which is a leading IT products provider for the banking industry, now plans to extend its flagship brand, Flexcube, to cover the insurance sector.

The company has put in place a small team and has begun to gain the required domain expertise. It has also initiated dialogues with insurance companies and mutual funds.

Commenting on the recruitment pattern for the insurance sector, Mr. Deepak Ghaisas, CEO and CFO, India operations, i-flex, is quoted saying that from the total i-flex staff, about 20 per cent are bankers and the same trend may be applied while recruiting the staff for the insurance sector.

He indicated that the software used in most of the insurance companies in India was not centralised. In addition, the companies being cost-conscious, implement software accordingly. The product from i-flex on the other hand is a premium product, he said.

Deloitte to check LIC's health

The Life Insurance Corporation of India (LIC), has engaged the services of Deloitte Touche Tohmatsu India Pvt Ltd to do a performance audit.

The purpose was to identify for the finance ministry, the implications of guarantees given to the LIC and also to assess the corporation's assets-liability matching at different points in time.

The ministry has also asked the General Insurance Corporation of India (GIC) to undertake a similar financial health check, especially in light of the demerger of its four subsidiaries.

The report on LIC is expected by mid-July.

Deloitte will identify the changes we should bring about in our investment strategy and methodology, LIC Chairman, Mr. S. B. Mathur, was quoted saying.

The report is also expected to ascertain whether the way decisions were taken was structurally adequate or needed to be changed, he added.

Sun and Oracle target insurance

The Indian subsidiaries of Sun Microsystems and Oracle have entered into a strategic alliance to offer low-cost computing in the Indian market. One of their focus industries is insurance, apart from banking, financial services and telecom.

The two information technology (IT) majors have been jointly marketing their products and applications in the high-end enterprise segment, and now they are entering the low and medium segment, dominated currently by the NT and Unix servers.

As part of their global strategy to expand the base of open source code and Linux operating system, Sun and Oracle will provide solutions to reduce the cost of ownership by about 70 per cent and ensure an early return on investment.

Currently, the NT server market in India is about $70 million, while the Unix server market is estimated to be about $80 million.

Sun Microsystems India Managing Director Mr. Bhaskar Pramanik was quoted saying that pricing their products and services in the range of $2000-4000 would target those customers looking for alternative offerings in the sub-$10,000 price tag adding that the open standard architecture of our products will bring scalability and reliability to low-cost servers running mission critical applications and that his company intended to simplify access to technology and support for developers by sharing information and services.

Since information and communication technologies are being increasingly used by the services sector, banking and finance and insurance have emerged as leading customers for IT.

According to independent surveys, the Indian banking and financial services and insurance sectors have been growing at a steady rate generating a business of $34 billion and $17 billion respectively.

"With tech spending by these sectors constituting 2-3 per cent of their turnover, the low-cost computing market offers enough opportunities to grow our market share exponentially," Mr. Shekhar Dasgupta, Oracle India Managing Director, is quoted saying.

Global Warming is here already

Experts from the Harvard Medical School and Swiss Re briefed members of the US Congress on what they see as the current effects of global warming, indicating that it is no longer "a hypothetical concern for future generations," but is causing problems right now.

Dr. Paul R. Epstein, M.D., Associate Director, Center for Health and the Global Environment at Harvard Medical School and Mr. Christopher T. Walker, Swiss Re's Managing Director, Greenhouse Gas Risk Solutions, Financial Services Business Group, told U.S. House and Senate members that global warming already is a front-burner issue in the public health and financial sectors (particularly the insurance industry). They cited new "outbreaks" of health problems, including asthma and West Nile Virus, and a palpable danger of added insurance risks and costs as indicating that climate-change issues must be addressed now.

Concerns about climate change are often mistakenly placed into the distant future, Dr. Epstein explained, but as the rate of climate change increases, so do the biological responses and costs associated with warming and unstable weather. The influence of intensifying droughts on the spread of West Nile Virus in the U.S. and the impacts of rising carbon dioxide levels on allergies and asthma demonstrate that global warming has come into our backyards.

Today, climate change as a financial issue is very much underestimated from the point of view of the insurance and reinsurance industry's potentially rising costs and risks. Mr. Walker stated, adding that "carbon is becoming a tradable commodity, allowing companies to hedge their risks, profit from emissions assets and turn this new discipline into a competitive advantage."

"So, in addition to potential liabilities for corporations from greenhouse gas emissions reductions, there also are business opportunities where the financial industry and, in particular the insurance industry, can be the prime mover of emissions reduction activities. The reality here is simple: insurance and reinsurance companies have the potential to become prime catalysts for the development of renewables, emission reduction and energy-efficient technologies for two reasons: such steps will reduce risks and open up new and lucrative lines of business activity."

Negative outlook for reinsurers yet

Global rating agency Standard & Poor's has indicated a negative outlook for reinsurers for the sixth year in a row. "Continued rate increases in the global reinsurance market have failed to stem the downward pressure on ratings and market outlook remains negative for the sixth successive year," it said in a recent report. There may, therefore, be more rating downgrades than upgrades over the short-to-medium term, it cautioned.

"Despite further price increases during the January, 2003, renewal season, the market continues to suffer from a diminished quality of capital, reduced financial flexibility (defined as the ability to source capital, relative to requirements), prior-year liabilities, the overhang of reinsurance recoverables, and the likelihood that many companies' operating performance will fall short of expectations," an S & P credit analyst said.

The report, entitled "Global reinsurance 2003 mid-year outlook: Negative outlook masks divergent fortunes," states that pressure on ratings continues despite the hard market conditions.

A number of reinsurers have been finding it difficult to take advantage of the situation "to rebuild and restructure their capital bases and put in place foundations to reduce future loss volatility."

S & P cited the "ease of entry for new players and increased competition in the market" as limiting the "ability of existing players.

Lloyd's and EU

Lloyd's Chairman, Lord Peter Levene, has said that now is the time for Lloyd's to take whatever steps are necessary to make sure that the London market shares in the expansion of the European Union.

"Lloyd's must be at the centre of Europe," he said, adding that for 50 years the British insurance industry has hesitated over Europe to its detriment and "now is the time for Lloyd's to be open, creative and willing to take bold decisions."

Levene pointed out that the European market is in the process of being transformed, both from the inside with more risks moving into the private sector, and from the outside with increased exposures to and rising claims from natural catastrophes – conditions that have created capitalisation and capacity problems for many in the industry. He also observed that, although "the wall that divided Europe has now been removed, barriers still exist, even if they cannot be seen, such as linguistic and cultural barriers. Our objective is to remove those barriers."

By 2004, he said, the EU will consist of 25 nations. "I can't begin to imagine what a GDP of $30 trillion actually feels like, but it means that Europe will soon represent the world's largest commercial market – and its power can only grow." He stressed that underwriting performance and the flexibility to respond to the new and complex and creative discipline is vital to the success of the European insurance industry.

"Today's changing business culture, evolving investor attitudes, social and political trends, governance trends and technological changes, all require creative risk solutions. Our approach must be flexible enough to handle all the challenges that emerge, and we must be innovative enough to be able to anticipate and respond to these demands," he concluded.

A.M. Best Affirms Cologne Re 'A++' (Superior) Rating

A.M. Best Co. announced that it has affirmed the financial strength rating of 'A++' (Superior) of Koelnische Rueckversicherungs-AG (Cologne Re) and its core subsidiaries, with a stable outlook. The affirmation was part of an overall reaffirmation of the 'A++' ratings of Berkshire Hathaway's General Re Group, which Best announced separately.

"The rating action reflects Cologne Re's status as a core subsidiary of its ultimate parent company, General Reinsurance Corporation (General Re), its superior capitalisation and excellent business profile," said Best. "An offsetting factor is Cologne Re's recent deteriorated underwriting performance."

Best noted that "Cologne Re is responsible for writing the majority of the property/ casualty business outside North America and the life and health business worldwide. Cologne Re is fully integrated into General Re Group and benefits from explicit reinsurance support through a subsidiary of Berkshire Hathaway, the ultimate parent company of General Re. In addition, General Re has recently announced its intention to acquire the remaining shares of Cologne Re from AXA Versicherung in Germany after which General Re will own 88.5 per cent of Cologne Re."

It also indicated that "Cologne Re's risk-adjusted capitalisation is superior, based on A.M. Best's capital model. Although overall capital levels have declined in the last two years due to adverse development in its underwriting reserves, Cologne Re will maintain its superior risk-adjusted capitalisation due to the explicit reinsurance support provided by its parent."

The company has an "excellent business profile," said Best, ranking among the top five in the European non-life reinsurance market, and as the third-largest player worldwide in the life reinsurance market. The rating agency noted, however, that "gross premiums declined by approximately 10 per cent to EUR 4.1 billion ($ 4.8 billion) in 2002, following the company's ongoing review of its reinsurance portfolio." Best said it "expects a further decrease in premiums in 2003 as Cologne Re continues its restrictive underwriting strategy.

It also noted that "Cologne Re has recorded overall after-tax losses in two consecutive years. Results for 2002 will be negatively impacted by losses from natural catastrophes such as floods in Central Europe, adverse reserve development from prior accident years and some equity write-downs due to unfavourable development of the capital markets in 2002."

Best expects at least some of the adverse effects to be offset by the improving profitability figures in the Property and Casualty business generally. It sees a combined ratio of approximately 103 per cent in 2003. It also said, "Consolidated technical results in life and health are improving despite the negative effect of lower investment income and the strengthening of reserves for the North American business placed in run-off," and it expects the company to return to profitability in 2003.

In conclusion, Best indicated that it "expects Cologne Re to significantly contribute to General Re's consolidated earnings in 2003." It warned that a "failure to do so could put pressure on Cologne Re's core status."

Japan to let insurers cut guaranteed yields

A Japanese parliamentary committee approved a bill in June that would allow life insurers to cut guaranteed payouts to policyholders, a move aimed at preventing problems in the sector from affecting the whole financial system.

With stock prices weak, interest rates at near zero and policy cancellations running high, politicians have argued, insurers should be partially relieved of payouts promised to customers a decade ago, when returns were much higher. The idea has run into opposition, but supporters argue that a collapse of a big insurer could result in massive liquidation of assets that would churn the markets.

Approval by the lower house fiscal and financial committee paves the way for the bill to be passed through parliament, to take effect in July. The bill, drafted by the financial services agency, would give life insurers the option of taking action if there was a risk of them being unable to continue insurance business.

Major life insurers have said they have no plans to cut promised yields and credit rating agencies have said they would consider such a move tantamount to default.

The draft also set a floor for a yield cut at three per cent and added a measure that could temporarily freeze policyholders' rights to cancel contracts once an insurance firm applies for a yield cut. Many guaranteed yields are now five or six per cent.

Analysts have said a cut in yields could also damage the insurer's standing with customers and further damage their business.

Farewell at FICCI

Outgoing Chairman, IRDA, Mr. N. Rangachary, was felicitated by FICCI at a session held in New Delhi on May 26.

L to R: Mr. P. Murari, Mr. Y. K. Modi, Mr. N. Rangachary, retired Chairman, IRDA, Mr. Ashvin Parekh, Managing Director, Deloitte Touche Tohmatsu, Mr. H. O. Sonig, retired Member (Life), IRDA, Mr. Harbhajan Singh, retired Member, IRDA and Mr. Fali Poncha, Managing Director, International Insurance and Reinsurance Services Ltd.

At the CII

Mr. Sunil Mehta, Country Head and CEO – India, AIG, shares a laugh with Mr. N. Rangachary at the Confederation of Indian Industry's felicitation for the retiring Chairman, IRDA, held on May 26.

The Institute Bids Goodbye

Mr. N. Rangachary and Mr. R. Bupathy, President, Institute of Chartered Accountants of India (ICAI), at a round table on 'Insurance, the Happening Sector' organised at Hyderabad on June 6.

Send us a write-up!

Event?

Send us a picture!

Mr. N. Rangachary, Chairman, IRDA, receives the ISO 9001: 2000 certificate from Mr. Srihari Kotela, Director, American Quality Assessors (India) Pvt. Ltd. Also in the picture is Mr. Suresh Mathur, Deputy Director, IRDA.

The Quality Stamp!

The IRDA has implemented Quality Management System in line with the Standards laid down by International Organization for Standardization, based in Geneva. ISO 9000:2000 articulates for the first time eight Quality Management Principles which are, customer focus, leadership, involvement of people, process approach, system approach to management, continual improvement, factual approach to decision-making and mutually beneficial supplier-relationship.

The IRDA has prepared Quality Manual and Quality System Procedures taking into consideration the ISO 9001:2000 requirements and the existing systems being implemented. Once these systems were implemented, American Quality Assessors (India) Pvt. Ltd., which is functioning in India under the offices of AQA International LLC, US, has carried out Conformity Assessment. The assessment has been successfully completed and ISO 9001:2000 certificate was awarded to IRDA for the scope of "Regulating and Developing Insurance Business in India."

Leaving Office...

Mr. Prabodh Chander, Executive Director, IRDA, and Mr. K. Subrahmanyam, Executive Director (Actuary), IRDA, flank Mr. N. Rangachary, Chairman, IRDA, as he leaves his office on June 9, his last day in office.

Dear Editor

Compensating Agents

The article "Right Sizing the Prize" by Apparao Machiraju (**IRDA Journal,** May 2003, Page 22) is very thought-provoking. This article discusses a very important and pertinent issue that is encountered in the sales and marketing division of any organisation.

The author rightly brings to light the current trend of compensating sales agents heavily for attracting new customers. High incentives baited to attract new clientele ignoring the old database has almost become a norm. This philosophy when transferred to the insurance industry, translates into a conclusion that a product like life or general insurance needs selling and is not a necessity, which, in fact, is.

With this selling attitude every insurance agent runs amuck in the market trying to amass new customers with his sales pitch each time, knowing well that the end result is monetarily very lucrative.

With this 'sales mantra' would his organisation flourish in the long run? In his quest for seeking a new customer base each time, hasn't he forgotten his old sincere customers? The principle of heavy compensation in the first year is definitely worth reflecting upon.

However, in contrast, when a salary-based approach to sales is made, the prognosis of the sales and the incentive is not as motivational for the individual to sell the product.

Today, the consumer is aware of all the gimmicks an organisation will try to sell. The cognisant consumer is more concerned with the quality of the product that he receives for the value of his money. Bearing this viewpoint in mind, every organisation has to evaluate if its financial infrastructure can cope with a first year heavy compensation and can withstand it over a long period of time. What may be a good sales strategy for one kind of infrastructure may not necessarily apply for another.

Most certainly, the author has made a very keen observation and presented it to the readers in a very unbiased way.

Ms. Anjali B. Gharpure
Librarian,
The Actuarial Society of India

Objection

The article "Report Card : General" (**IRDA Journal,** June 2003, Page 38) has caught our interest for reading and putting forward our observations.

We focus our reservation to your observation that the slice of seven per cent in Motor insurance by the private companies is a wise move.

This is prejudice and a lop-sided opinion formed by you in favour of the private companies. While their strategy to restrict Motor insurance is seen as a "wise move," the same strategy if followed by the public sector units tantamounts to bossism and high handedness, and such acts are reprimanded by the Authority concerned in the strongest terms.

As such we request you to voice not only for the cause of the private companies but also speak for the PSBs.

General Secretary
The New India Assurance Officers' Association, North Eastern Region

The analysis of the non-life premium figures for April 2003, by Mr. G. V. Rao, makes observations on the business strategies of different sectors of the industry as revealed by their performance.

The obligatory nature of Third Party liability (TP) insurance under the law applies equally to all insurers, whether in the private or public sector, and the IRDA has always held that legal position.

Claims Made Easy!

Many thanks for including my name in the mailing list of your esteemed insurance journal, one of the best...

The article "Handling a Difficult Claimant" by Mr. C.P. Udayachandran (**IRDA Journal,** June 2003, Page 18) provides a practical need and an approach to be adopted by insurers and surveyors in handling of claims.

The line 'A difficult person can be killed with kindness' is to be kept in mind always and says it all. Author had presented and described the article in a very effective manner.

The surveyors and claim departments of the insurance companies can learn and gain a lot from this article.

I also want to bid my hearty farewell to Mr. N. Rangachary, Chairman, IRDA, on his retirement. Men of his genius, calibre and thoughtfulness are rarely to be found. He was, and is a true leader and hero of the Indian insurance sector for his pioneering works and efforts.

Also, I want to welcome the new Chairman of IRDA, Mr. C.S. Rao, and wish that IRDA will reach new heights under his able leadership and try to look at and resolve problems being faced by surveyors in small towns.

I hope that growing IT in insurance industry in india will help all the persons in insurance industry and can benefit the surveyors a lot if they can properly use the Internet, e-mail, digital cameras, scanners, chatting and so on.

Yogendra Prakash Gilra
Hony. Secy., IISA, Garhwal Unit,
Uttranchal

As we now see on our TV screens 24 hours a day, there is an unbreakable bond which links the United States and the United Kingdom. Despite our integral role in this market throughout the past 150 years, Lloyd's is treated as an alien insurer and reinsurer. Is this really how we deserved to be treated? Wouldn't equal treatment improve the process for all parties?

Lord Peter Levene, Chairman, Lloyd's of London

It is a move to protect policyholders. Is it better for a life insurer to go under or to lower guaranteed yields? We are offering that option.

Japanese Prime Minister Junichiro Koizumi about the bill to be presented in that country's Parliament to allow life insurers to cut guaranteed payouts to policyholders following falling investment returns.

One of the things I noticed during the commission was the lack of any real input and any real direction being given by the shareholders, and there is no doubt that the warning bells were chiming... There is an opportunity obviously for institutions and especially for managed funds of one sort or another to take a lead. Small investors ...should be encouraged to undertake analysis of the performance and governance of the companies in which they invest and they should make their views known.

The HIH Royal Commissioner,
Justice Neville Owen

It is necessary to pass on investment risks to investors as the investment climate has become tough with falling interest rates and limited avenues of investment.

Mr. S. B. Mathur, Chairman,
Life Insurance Corporation of India

LIC has submitted a plan of action envisaging that they will meet the solvency margin by March 31, 2004. It is a technical requirement. We are satisfied with LIC's plan.

Mr. C. S. Rao, Chairman, IRDA, about Life Insurance Corporation of India's (LIC) needing to make provisions for meeting the solvency margin.

(Indian insurance companies) must begin to see that replacement is not profitable not only for them but for clients as well.

Mr. Richard H. Sullenger, President of the Million Dollar Round Table (MDRT), the global association for financial services professionals.

RNI No: APBIL/2002/9589

Events

July 7-12, 2003
Venue: Pune
Trainers Training Programme (Life)

July 7-12, 2003
Venue: Pune
Management of Petrochemical Risks (Non-Life)

July 8-9, 2003
2nd Conference on Catastrophes Insurance in Asia Seeking Real Solutions to CAT Exposures in Asia Taiwan

July 13-16, 2003
Venue: New York
39th Annual International Insurance Society Conference

July 24-26, 2003
Venue: Singapore
Singapore Insurance Institute Conference
Towards Professional Excellence

August 4-9, 2003
Venue: Pune
Retail Insurance (Non-Life)

August 4-9, 2003
Venue: Pune
Data Warehousing and Data Mining(Life)

August 11-16, 2003
Venue: Pune
Pension & Group Insurance Business(Life)

August 18-19, 2003
Venue: Mumbai
4th Conference on Bancassurance & Alternative Distribution Channels: Choosing the Right Bancassurance Business Model

August 18-23, 2003
Venue: Pune
Relational Database Management Systems (Non-Life)

August 21 – 22, 2003
Venue: Banaglore
5th Asia Pacific Conference & Exhibition on IT & e-applications in Insurance: IT & e-applications to Boost Business & Efficiency – Getting Beyond the Hype & Mantras to Exploit the Right Technologies Best Suited to your Business

August 25-30, 2003
Venue: Pune
Comprehensive Technical Programme in Life Insurance