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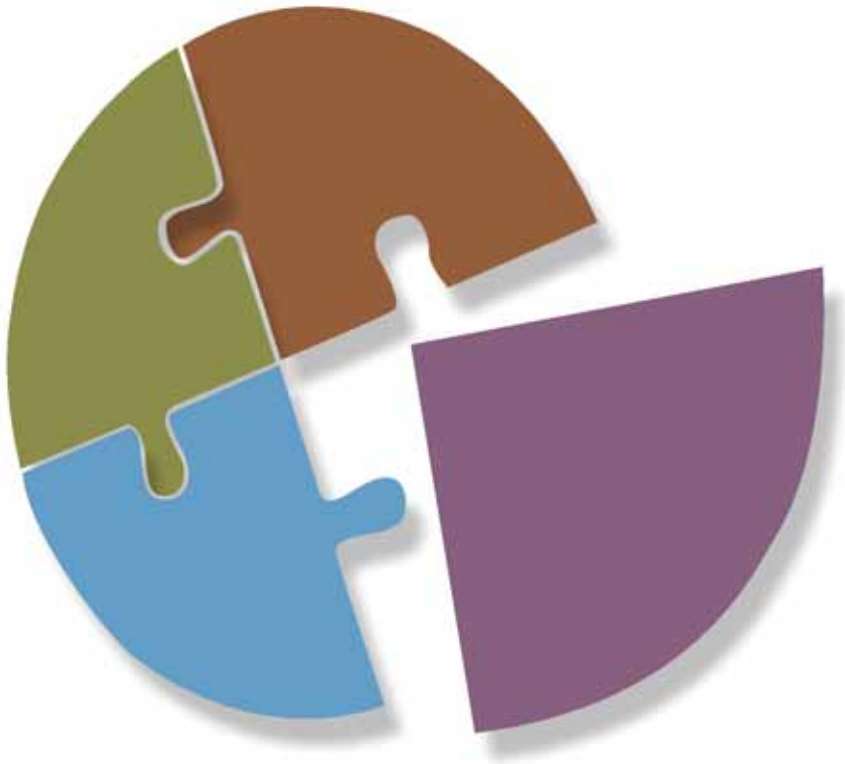

Information Misfit -
Creating Barriers

बीमा विनियामक और विकास प्राधिकरण

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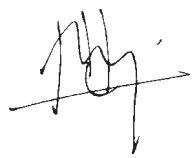
From the Publisher

Insurance is a risk-transfer tool and as such the risk faced by one party is transferred to another, at a price and subject to several conditions. In order that the 'price' at which the risk is transferred by one and accepted by the other, and the conditions with which the transaction takes place are reasonable; it is very essential that the information that supports the entire process of an insurance contract is reliable and truthful. For achieving a near total completion of the process, the proposal forms have been undergoing several changes over a period of time. But unless the two parties involved disclose information pertaining to their side sincerely and without prejudice, it is almost impossible to design a comprehensively analytical questionnaire. For example, in the domain of life insurance, which medical examination can bring out the incidence of a childhood ailment that has underwriting repercussions, unless it has visible manifestations?

On most occasions, information that is provided may suffer from some lacuna but not with deliberate intentions. It is here that the objectivity of designing the proposal form comes into play; as also the role played by the distributor. Insurers should find ways to ensure that the questionnaire is fully explained to the applicant and only then has his consent been obtained. In view of the low literacy levels among a large segment of the population, the use of the vernacular language should be brought into play. The importance of going through the entire proposal form and understanding its contents thoroughly should be explained to the applicant as the underwriting decisions are fully dependent on the information provided.

On the other hand, there is need for insurers to be totally transparent in matters pertaining to the line of business, product specific information etc in general; and the exclusions of coverage, conditional acceptance of the risk etc in particular. The importance of being transparent is more intense in the competitive regime where the proponent can exercise his choice in favour of a specific player. As mentioned time and again, the emphasis on openness is more relevant in a nascent market where the nuances are not well-understood. There is need for the insurers to walk that extra mile in ensuring that the information flow is uninhibited and purposeful.

'Asymmetry of Information in Insurance' is the focus of this issue of the **Journal**. For information to be stored, collated and analyzed effectively; it is essential that there is proper data storage and access in place. 'Data Warehousing / Mining in Insurance' will be the focus of the next issue of the **Journal**.



J. Hari Narayan

INSIDE

ISSUE FOCUS

THINKING CAP

Unadulterated Information
- First and Foremost

For any commercial transaction to be concluded, it is essential that good faith is an inherent component. In the case of insurance, where the risk of one party is transferred to another, it is not mere good faith but utmost good faith or *uberrima fidei* that has to be observed by both the parties. For this to be accomplished, the information that flows between the two parties must be total, veracious and unconditional. The very fact that one party agrees to take over the risk faced by the other makes it obligatory for the parties to ensure that the information provided is absolutely true.

The designing of the questionnaire or the proposal form thus attains a great deal of importance as a tool that elicits information objectively. While it may not be possible to design a questionnaire exhaustively, the emphasis should be on asking the right questions so that there is no dilution of the purpose. Besides, the applicant should also realize the spirit behind which a question is being asked and furnish the replies accordingly. However, to what extent this can be achieved, especially in a nascent domain, is one's guess!

In the Indian insurance domain, it is very common to observe that the proposer claims ignorance about the contents of the proposal form. However, should he not bother to read and understand the queries before signing the declaration which is so vital for the insurance contract? There is certainly a very important role for the distributor in ensuring that the contents of the proposal form are explained to and well understood by the proponent before he or she signs the declaration; and it would certainly be instrumental in reducing claim-related controversies to a large extent.

The question of the insurers being open and transparent has also been raised often. It would be futile to mention that in a country where financial literacy is low, the aim should not be to resort to taking shelter under the garb of jargon. There is added emphasis on being plain and articulate when it comes to terminology.

'Asymmetry of Information in Insurance' is the focus of this issue of the **Journal.** Mr. G.V. Rao sets the trend by saying that there is need for the insurers calling for detailed information and analyzing it properly before taking over the risk. In the next article, Mr. Gnanasundaram Krishnamurthy criticizes the practice of some life insurers obtaining and treating information in a very casual manner which leads to complications at a later stage. 'A great deal of asymmetry of information occurs at the time of insurance selling' says Mr. C.L. Baradhwaj in his article that follows. Mr. K. Nagaraja Rao opines that there is still an obsession for top-line growth among insurers and this tendency leads to a certain extent of information distortion.

There are three articles in the 'Thinking Cap' section. Ms. Nirmala Ayyar brings in an analysis of Retail Distribution Review and its possible applicability for the Indian market. In the next article, Mr. Bikas Chandra Bose throws light on the institution of Insurance Ombudsman and its progress in India. Finally, we have Mr. R.P. Samal discussing about some of the claim-related practices being followed by the public sector insurers, and suggestions for improvement.

The success of insurance business is largely dependent on the quality of data that supports it. 'Data Warehousing and Mining in Insurance' will be the focus of the next issue of the **Journal.**

Mr. C.R. Muralidharan, Member (F &I) demitted office on 3rd November, 2009. As a part of the editorial board, he has been a great source of inspiration and support to the Journal. On my personal behalf and on behalf of the Journal; I wish him a long, happy and peaceful retired life. I also take this opportunity to welcome Dr. R. Kannan to the editorial board; and look forward to his continued support.

U. Jawaharlal

Report Card:LIFE

First Year Premium of Life Insurers for the Period Ended September 2009

Sl No.	Insurer	Premium u/w (Rs. in Crores)			No. of Policies / Schemes			No. of lives covered under Group Schemes		
		September, 09	Up to September, 09	Up to September, 08	September, 09	Up to September, 09	Up to September, 08	September, 09	Up to September, 09	Up to September, 08
1	**Bajaj Allianz**									
	Individual Single Premium	27.74	131.68	166.26	4792	30774	39310			
	Individual Non-Single Premium	232.64	1104.50	1792.59	155359	819941	1159628			
	Group Single Premium	5.77	25.26	1.36	0	6	0	6891	29365	6150
	Group Non-Single Premium	42.50	177.72	56.15	51	349	311	1406466	7271925	2881200
2	**ING Vysya**									
	Individual Single Premium	0.60	3.98	16.38	94	562	1974			
	Individual Non-Single Premium	66.88	293.47	305.31	24233	137520	165839			
	Group Single Premium	0.81	4.50	8.65	0	0	1	168	1235	2565
	Group Non-Single Premium	0.01	0.16	1.69	0	0	66	336	2826	29588
3	**Reliance Life**									
	Individual Single Premium	9.25	54.05	216.28	1582	11026	53335			
	Individual Non-Single Premium	253.85	1077.88	1173.19	151643	890985	710392			
	Group Single Premium	24.75	74.39	67.22	0	2	17	-45	331	23738
	Group Non-Single Premium	13.25	42.21	16.42	45	246	154	31701	515016	324582
4	**SBI Life**									
	Individual Single Premium	40.79	169.29	287.22	7025	30207	45584			
	Individual Non-Single Premium	270.28	1238.11	1086.72	108584	510725	309604			
	Group Single Premium	78.79	137.08	111.80	0	1	1	31819	64834	54999
	Group Non-Single Premium	296.46	846.55	919.53	15	63	56	139711	551698	1917379
5	**Tata AIG**									
	Individual Single Premium	1.44	8.17	24.45	206	1832	5023			
	Individual Non-Single Premium	91.58	430.18	410.87	54844	329572	307477			
	Group Single Premium	1.75	11.92	19.97	0	1	7	3863	18708	63212
	Group Non-Single Premium	28.08	62.87	38.91	3	36	44	7809	81502	117488
6	**HDFC Standard**									
	Individual Single Premium	15.15	64.15	67.28	96004	215058	27072			
	Individual Non-Single Premium	190.35	962.05	1178.41	52722	294301	371976			
	Group Single Premium	19.63	73.16	46.00	24	121	69	82245	211302	118517
	Group Non-Single Premium	2.71	20.99	13.27	2	5	5	718	5518	13387
7	**ICICI Prudential**									
	Individual Single Premium	10.74	61.89	126.86	1114	6825	22696			
	Individual Non-Single Premium	349.97	1697.35	2637.57	154551	805367	1262534			
	Group Single Premium	13.40	79.71	131.31	14	177	147	117366	516629	352661
	Group Non-Single Premium	28.30	289.00	568.58	10	256	290	35151	358791	466662
8	**Birla Sunlife**									
	Individual Single Premium	3.71	21.88	19.10	8096	52275	75406			
	Individual Non-Single Premium	201.76	965.54	1049.77	142819	707728	404098			
	Group Single Premium	-0.08	0.16	8.89	0	0	3	54	638	23237
	Group Non-Single Premium	32.26	108.97	96.55	29	114	88	35885	172464	113291
9	**Aviva**									
	Individual Single Premium	2.56	35.09	9.96	134	4441	1433			
	Individual Non-Single Premium	50.70	249.26	319.95	10432	90843	168802			
	Group Single Premium	0.00	0.00	0.05	0	0	0	0	0	63
	Group Non-Single Premium	6.10	19.59	11.82	24	59	36	162373	922237	469066
10	**Kotak Mahindra Old Mutual**									
	Individual Single Premium	3.38	8.15	12.07	265	944	1417			
	Individual Non-Single Premium	78.32	314.12	541.81	25359	124940	287948			
	Group Single Premium	5.46	19.87	18.38	1	5	4	12680	57487	72442
	Group Non-Single Premium	6.95	37.20	21.61	47	261	185	38157	268028	274456
11	**Max New York**									
	Individual Single Premium	15.55	95.33	125.98	-1703	10960	9210			
	Individual Non-Single Premium	122.14	713.02	790.75	74192	458756	567666			
	Group Single Premium	0.09	0.96	7.13	0	9	10	232	273253	187394
	Group Non-Single Premium	8.01	32.78	13.23	54	381	272	1443869	3847143	254703

12	**Met Life**									
	Individual Single Premium	0.99	3.79	3.17	108	525	1036			
	Individual Non-Single Premium	74.07	339.16	419.39	22855	116618	111857			
	Group Single Premium	2.70	14.99	13.45	0	0	63	1118	7303	170290
	Group Non-Single Premium	4.71	17.70	0.00	9	88	0	40475	171154	0
13	**Sahara Life**									
	Individual Single Premium	3.66	14.85	22.84	1002	4289	5867			
	Individual Non-Single Premium	5.46	27.71	34.71	5095	30260	39234			
	Group Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Group Non-Single Premium	3.04	16.40	0.00	0	1	2	517473	2078826	78
14	**Shriram Life**									
	Individual Single Premium	5.36	34.87	93.48	821	5328	15525			
	Individual Non-Single Premium	28.56	114.95	68.48	10028	60401	34917			
	Group Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Group Non-Single Premium	0.05	0.26	0.24	1	6	2	4203	20732	10755
15	**Bharti Axa Life**									
	Individual Single Premium	0.65	2.63	3.27	1005	3467	759			
	Individual Non-Single Premium	25.35	143.35	111.19	11451	67026	75747			
	Group Single Premium	2.47	11.08	4.06	0	7	1	1056	6842	19691
	Group Non-Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
16	**Future Generali Life**									
	Individual Single Premium	0.48	3.40	0.68	95	588	144			
	Individual Non-Single Premium	32.50	131.63	7.93	25283	110070	11225			
	Group Single Premium	0.00	0.03	0.00	0	0	0	8	119	0
	Group Non-Single Premium	2.40	10.31	6.89	5	49	31	19853	132673	211790
17	**IDBI Fortis Life**									
	Individual Single Premium	7.50	43.59	49.57	934	6599	8005			
	Individual Non-Single Premium	25.88	100.18	62.15	6913	29626	19399			
	Group Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Group Non-Single Premium	0.00	0.03	0.00	0	2	0	2237	15368	0
18	**Canara HSBC OBC Life**									
	Individual Single Premium	0.91	4.82	0.00	41	222	1			
	Individual Non-Single Premium	60.29	271.33	65.81	9745	41064	6266			
	Group Single Premium	0.44	0.92	0.00	0	2	0	308	613	0
	Group Non-Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
19	**Aegon Religare**									
	Individual Single Premium	0.15	0.63	0.08	116	166	12			
	Individual Non-Single Premium	12.07	35.13	3.11	3799	13877	3403			
	Group Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Group Non-Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
20	**DLF Pramerica**									
	Individual Single Premium	0.00	0.03	0.00	0	0	0			
	Individual Non-Single Premium	2.17	9.77	0.05	1384	6469	62			
	Group Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Group Non-Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
21	**Star Union Dai-ichi @**									
	Individual Single Premium	21.70	42.95		2519	5301				
	Individual Non-Single Premium	24.19	67.15		9879	26352				
	Group Single Premium	0.13	3.61		0	4		120	3649	
	Group Non-Single Premium	0.11	0.75		2	4		516	5486	
	Private Total									
	Individual Single Premium	**172.30**	**805.19**	**1244.95**	**124250**	**391389**	**313809**			
	Individual Non-Single Premium	**2199.03**	**10285.83**	**12059.76**	**1061170**	**5672441**	**6018074**			
	Group Single Premium	**156.12**	**457.63**	**438.28**	**39**	**335**	**323**	**257883**	**1192308**	**1094959**
	Group Non-Single Premium	**474.93**	**1683.46**	**1764.90**	**297**	**1920**	**1542**	**3886933**	**16421387**	**7084425**
22	**LIC**									
	Individual Single Premium	2039.34	7879.33	6082.36	454382	1929055	1710712			
	Individual Non-Single Premium	1354.20	7937.37	6900.09	2140429	12135623	10763778			
	Group Single Premium	1609.97	9997.79	6109.03	1414	9729	8563	1711271	9463986	9951789
	Group Non-Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Grand Total									
	Individual Single Premium	**2211.64**	**8684.51**	**7327.31**	**578632**	**2320444**	**2024521**			
	Individual Non-Single Premium	**3553.22**	**18223.20**	**18959.85**	**3201599**	**17808064**	**16781852**			
	Group Single Premium	**1766.09**	**10455.42**	**6547.31**	**1453**	**10064**	**8886**	**1969154**	**10656294**	**11046748**
	Group Non-Single Premium	**474.93**	**1683.46**	**1764.90**	**297**	**1920**	**1542**	**3886933**	**16421387**	**7084425**

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

CIRCULAR

15th September, 2009

Circular No. IRDA/LIFE/CIR/MISC/37/09/2009

To
All CEOs of Life Insurance Companies

Sub: Premium-Awaited Policies

It has been decided to collect information on premium-awaited policies in the manner detailed below:

1. Information pertaining to policies on which premiums are awaited for more than a quarter shall be furnished to the Authority in the formats enclosed herewith.
2. Data of Premiums awaited in the Individual Business of non-single premium type alone shall be included for this purpose.
3. The data shall include both number of policies on which premium is awaited as also the premium amount on these policies.
4. The premiums awaited on the policies sold under Rural and Social Sector Obligations shall be furnished separately in the relevant columns. Individual Business reckoned for the purpose of Rural & Social Sector Obligations only needs to be considered for this purpose.
5. Data for 2008-09 may be furnished separately for linked and non-linked policies with slab-wise break-up of the annual premiums. The data shall be furnished separately for the annualized premium slabs shown in the formats.
6. Beginning with the 1st quarter of 2009-10, life insurers would be required to submit data with linked/non-linked, Premium slab-wise, Mode-wise, Distribution channel-wise break-ups, as shown in the formats.
7. Insurers are required to furnish data for the year 2008-09 not later than 30.9.09. The data for 1st quarter of 2009-10 onwards shall be furnished by the 15th of the month following the subsequent quarter.
8. The detailed process guide and the relevant formats in which data is to be furnished are enclosed herewith.

Sd/-
(G. Prabhakara)
Member (Life)

Process Guide

1. Terms explained:
   - Period Under Consideration (PUC) – The period for which incidence of defaults/persistency is measured. It could be a quarter, half-year, three-quarters or a full-year.
   - Date of Reckoning (DoR) – The last day of the quarter subsequent to the period under consideration (PUC). The defaults position for a PUC shall be verified as at the end of the Date of Reckoning.

   Ex:-

   For PUC – 1.4.09 to 30.6.09, DoR is 30.9.09

   For PUC – 1.7.09 to 30.9.09, DoR is 31.12.09

   For PUC – 1.4.09 to 30.9.09, DoR is 31.12.09

   For PUC – 1.4.09 to 31.3.10, DoR is 30.6.10

   - First Unpaid Premium (FUP) – The next immediate instalment premium due on a policy.

     If the premiums on a policy of Qly mode have been paid, say, upto 9.6.09, the FUP of the policy, which is the next instalment due, is 9.9.09.
2. The total number of policies and premium due during the PUC are to be furnished in columns (ii) & (iii) of the format respectively. The defaults out of such policies are to be furnished in columns (iv) & (v) of the format.
3. The policies which are in default earlier to the PUC shall be excluded from the exercise since the objective of this exercise is to gauge the incidence of fresh defaults during the period under consideration. In other words, only policies whose dues earlier to the PUC have been paid upto date as on the DoR shall be included in the sample.
4. Where the premiums under a policy fall due more than once in the PUC, it should be made sure to count the policy only once while furnishing the number of policies in the formats. However, all the instalment premiums due under a policy during the PUC shall be considered while computing the premiums-awaited.

The manner in which the data is to be compiled for each of the periods as required by the circular is given below:

One-Time Data for full year 2008-09

The data of policies under which premiums are due between 1.4.08 and 31.3.09, but unpaid as on 30.6.09 shall be furnished by the insurers as one-time data.

Process to be followed for extraction of one-time data (for the full year 2008-09)

1. Pick up all individual, non-single premium type policies from the database 'whose premiums due before 1.4.08 have all been paid as on 30.6.09.
2. Out of them, select all policies under which the first unpaid premium, as on 30.6.09, falls between 1.4.08 and 31.3.09. Furnish the number of such policies in column (ii) of the format and the premium total of all such policies in column (iii) of the format, with suitable break-ups.

3. Now, out of the policies noted in column (ii), list out the policies on which premiums are still awaited as on 30.6.09. Furnish the number of premium-awaited policies in column (iv) and the total premium on all the premium-awaited policies in column (v), with suitable break ups as shown in the formats.
4. Similarly pick up all individual, non-single premium type policies belonging to the rural and social sector separately whose premiums due before 1.4.08 have been paid as on – 30.6.09. Repeat the exercise and fill the relevant rows in the formats.

Ongoing Data Collection

1. Commencing from the quarter 1.4.09 – 30.6.09, insurers shall furnish data of premium-awaited policies on a quarterly basis.
2. The quarterly data shall be furnished for each quarter on a stand-alone as well as cumulative basis for the financial year. Thus, while in the 1st quarter of a financial year the data is furnished for the quarter alone, the 2nd quarter data is to be furnished a) for the quarter in isolation, and b) on a cumulative basis for 1st and 2nd quarters together, and so on.

Process to be followed for extraction of data for 1st Quarter of 2009-10

1. The exercise shall taken up after 30.9.09 and the data shall be submitted to the Authority by 15.10.09.
2. Pick up all individual, non-single premium type policies from the database whose premiums due before 1.4.09 have been paid as on 30.9.09.
3. Out of them, select all policies under which premiums are due in the quarter 1.4.09 to 30.6.09.Furnish the number of such policies in column (ii) of the format and the premium total of all such policies in column (iii) of the format.
4. Now, out of the policies noted in column (ii), list out the policies on which premiums are still awaited as on 30.9.09. Furnish the number of premium-awaited policies in column (iv) and the total premium on all the premium-awaited policies in column (v), with suitable break ups as shown in the formats.
5. Similarly pick up all individual, non-single premium type policies belonging to the rural and social sector policies separately whose premiums due before 1.4.09 have been paid as on 30.9.09. Repeat the exercise and fill the relevant rows in the formats.

Process to be followed for extraction of data for 2nd Quarter (stand-alone) of 2009-10

1. The exercise, shall taken up after 31.12.09 and the data shall be submitted to the Authority by 15.1.10.
2. Pick up all individual, non-single premium type policies from the database whose premiums due before 1.7.09 have been paid as on 31.12.09.
3. Out of them, select all policies under which premiums are due in the quarter 1.7.09 to 30.9.09. Furnish the number of such policies in column (ii) of the format and the premium total of all such policies in column (iii) of the format.
4. Now, out of the policies noted in column (ii), list out the policies on which premiums are still awaited as on 31.12.09. Furnish the number of premium-awaited policies in column (iv) and the total premium on all the premium-awaited policies in column (v), with suitable break ups as shown in the formats.
5. Similarly pick up all individual, non-single premium type policies belonging to the rural and social sector policies separately whose premiums due before 1.7.09 have been paid as on 31.12.09. Repeat the exercise and fill the relevant rows in the formats.

Process to be followed for extraction of data for 1st & 2nd Quarters (Cumulative) of 2009-10:

1. The exercise shall be taken up after 31.12.09 and the data shall be submitted to the Authority by 15.1.10.
2. Pick up all individual, non-single premium type policies from the database whose premiums due before 1.4.09 have been paid as on 31.12.09.
3. Out of them, select all policies under which premiums are due in the half-year 1.4.09 to 30.9.09. Furnish the number of such policies in column (ii) of the format and the premium total of all such policies in column (iii) of the format.
4. Now, out of the policies noted in column (ii), list out the policies on which premiums are still awaited as on 31.12.09. Furnish the number of premium-awaited policies in column (iv) and the total premium on all the premium-awaited policies in column (v), with suitable break ups as shown in the formats.
5. Similarly pick up all individual, non-single premium type policies belonging to the rural and social sector policies separately whose premiums due before 1.4.09 have been paid as on 31.12.09. Repeat the exercise and fill the relevant rows in the formats

Process to be followed for extraction of data for 3rd Quarter (stand-alone) of 2009-10

1. The exercise shall be taken up after 31.3.10 and the data shall be submitted to the Authority by 15.4.10.
2. Pick up all individual, non-single premium type policies from the database whose premiums due before 1.10.09 have been paid as on 31.3.10.
3. Out of them, select all policies under which premiums are due in the quarter 1.10.09 – 31.12.09. Furnish the number of such policies in column (ii) of the format and the premium total of all such policies in column (iii) of the format.
4. Now, out of the policies noted in column (ii), list out the policies on which premiums are still awaited as on 31.3.10. Furnish the number of premium-awaited policies in column (iv) and the total premium on all the premium-awaited policies in column (v), with suitable break ups as shown in the formats.
5. Similarly pick up all individual, non-single premium type policies belonging to the rural and social sector policies separately whose premiums due before 1.10.09 have been paid as on 31.3.10. Repeat the exercise and fill the relevant rows in the formats.

Process to be followed for extraction of data for 1st, 2nd & 3rd Quarters (Cumulative) of 2009-10

1. The exercise shall be taken up after 31.3.10 and the data shall be submitted to the Authority by 15.4.10.
2. Pick up all individual, non-single premium type policies from the database whose premiums due before 1.4.09 have been paid as on 31.3.10.
3. Out of them, select all policies under which premiums are due in the three-quarters 1.4.09 to 31.12.09. Furnish the number of such policies in column (ii) of the format and the premium total of all such policies in column (iii) of the format.
4. Now, out of the policies noted in column (ii), list out the policies on which premiums are still awaited as on 31.3.10. Furnish the number of premium-awaited policies in column (iv) and the total premium on all the premium-awaited policies in column (v), with suitable break ups as shown in the formats.
5. Similarly pick up all individual, non-single premium type policies belonging to the rural and social sector policies separately whose premiums due before 1.4.09 have been paid as on 31.3.10. Repeat the exercise and fill the relevant rows in the formats.

Process to be followed for extraction of data for 4th Quarter (stand-alone) of 2009-10

1. The exercise shall be taken up after 30.6.10 and the data shall be submitted to the Authority by 15.7.10.
2. Pick up all individual, non-single premium type policies from the database whose premiums due before 1.1.10 have been paid as on 30.6.10.
3. Out of them, select all policies under which premiums are due in the quarter 1.1.10 – 31.3.10. Furnish the number of such policies in column (ii) of the format and the premium total of all such policies in column (iii) of the format.
4. Now, out of the policies noted in column (ii), list out the policies on which premiums are still awaited as on 30.6.10. Furnish the number of premium-awaited policies in column (iv) and the total premium on all the premium-awaited policies in column (v), with suitable break ups as shown in the formats.
5. Similarly pick up all individual, non-single premium type policies belonging to the rural and social sector policies separately whose premiums due before 1.1.10 have been paid as on 30.6.10. Repeat the exercise and fill the relevant rows in the formats.

Process to be followed for extraction of data for the full year 2009-10

1. The exercise shall be taken up after 30.6.10 and the data shall be submitted to the Authority by 15.7.10.
2. Pick up all individual, non-single premium type policies from the database whose premiums due before 1.4.09 have been paid as on 30.6.10.
3. Out of them, select all policies under which premiums are due in the year 1.4.09 to 31.3.10. Furnish the number of such policies in column (ii) of the format and the premium total of all such policies in column (iii) of the format.
4. Now, out of the policies noted in column (ii), list out the policies on which premiums are still awaited as on 30.6.10. Furnish the number of premium-awaited policies in column (iv) and the total premium on all the premium-awaited policies in column (v), with suitable break ups as shown in the formats.
5. Similarly pick up all individual, non-single premium type policies belonging to the **rural and social sector policies separately** whose premiums due before 1.4.09 have been paid as on 30.6.10. Repeat the exercise and fill the relevant rows in the formats.

NOTICE

October 1, 2009

No: IRDA/AGTS/NOT/BANC/38/10/2009

To
All the Insurance Companies (Life & General)

Re: Notice under Section 110C of the Insurance Act, 1938

The Authority has been receiving number of representations regarding the structure of payments of commission to the banks acting as corporate agents. The issue needs detailed examination to ascertain sustainability of the business through bancassurance channel and its impact on the insurers and the policyholders.

In order to analyze the impact of various payments made to banks on the premiums and Balance Sheets of insurers, IRDA has decided to call for the required information for the period 01.04.2008 to 31.03.2009 and 01.04.2009 to 30.06.2009.

Hence you are directed under Section 110C of Insurance Act, 1938 to provide the information in the annexed format duly certified by the CEO and the CFO of your company before 15.10.2009. Incorrect / incomplete / misleading information, if provided, is punishable under Section 102 of the Insurance Act, 1938.

Sd/-
(J. Hari Narayan)
Chairman

ORDER

8th October 2009 IRDA/ORD/SUR/41/Oct-09

Re: Special dispensation to Insurers under Section 64UM (2) of the Insurance Act, 1938

In exercise of the powers under Section 64UM (2) of the Insurance Act, 1938, the Authority hereby raises the limit of losses required to be surveyed by a licensed surveyor and loss assessor for settlement of claims, from Rs.20,000/- to Rs.50,000/- for the recent floods in the state of Karnataka, Andhra Pradesh, Goa and Maharashtra alone for a period of two months from the date of this order, as a special case. The insurers may utilise the services of in-house surveyors for assessing losses upto Rs.50,000/-. This special dispensation is given to insurers to ensure expeditious disposal of claims and for mitigating hardships to policyholders,

(J. Hari Narayan)
Chairman

CIRCULAR

October 8, 2009 No: IRDA/CHM/CIR/IPO/42/2009

To

Re: Exposure Draft on the Public Disclosures by Insurers

The Insurance Regulatory and Development Authority (IRDA) is entrusted with the regulation, promotion and orderly growth of insurance business in India. Maintaining efficient, fair and stable insurance market is necessary for the growth of the industry as well as for the protection of the policyholders. Public disclosure of risks faced by the insurers is critical for ensuring fair and orderly insurance sector. The disclosures shall be reliable and timely to ensure efficiency of the markets. The markets have to provide necessary feedback to the insurance regulator to ensure safety of the investors as well as the policyholders.

International Association of Insurance Supervisors (IAIS) has recognized that the insurers have an equal if not greater responsibility towards the policyholders than their duty towards the investors. This is because of the fact that when insurers become insolvent, policyholders lose much more money than the investors. Public disclosures on the risks faced by the insurers provide information to the policyholders to make necessary decisions before entering into a contract. In the present context in India, it may not possible for an individual policyholder to have necessary ability and resources to undertake the task of assessing the insurers. However, various stakeholders in the market like agents, brokers, analysts, rating agencies and the media can provide necessary inputs based in the disclosures which will help them in arriving at necessary judgment regarding risks faced by them in entering into a contract with an insurer. Hence the public disclosures become necessary even for the companies which are not listed in any stock exchange.

The IRDA has been bringing out various regulations for fulfilling its mandate of regulating the promoting of insurance market in India. The guidelines on corporate governance is a major development, which will help insurance market to grow in a safe manner. Another important measure, which will strengthen the corporate governance and market discipline, is the standard on public disclosures for the insurance companies. In a few months from now, several companies will be completing the period of 10 years which is the statutory period fixed, after which they may be allowed by the Regulator to go for the Initial Public Offer (IPO). It is essential that the investors are fully aware of the financial performance, company profile, financial position, the risk exposure, the corporate governance and the management of the insurance companies well before the companies go for an IPO. The data shall preferably be available for atleast a period of 4-5 years in order to judge the performance of the companies in a reasonable fashion.

IAIS has brought out the following four papers on the public disclosure by the insurers.

1. Guidance paper on public disclosure by Insurers, January, 2002.
2. Standard on Disclosures recommended by IAIS for Investment risks and performance for insurance and reinsurance – October 2005
3. Standard on disclosures concerning technical risks and performance for life insurance – October 2006
4. Standard on disclosures concerning technical performance and risk for non-life insurers and reinsurers, October, 2004

The Standard on Disclosures recommended by IAIS for Investment risks and performance for insurance and reinsurance are :

- Investment objectives, polices and management
- Asset class segregation, description and profiling
- Performance measurement
- Risk exposure

The Standards on disclosures concerning technical risks and performance for life and non-life insurance prescribes the following requirements for the disclosure:

- Company profile
- Technical Risks
- Technical provisions
- Performance measurement
- Reinsurance risk concentration and risk mitigation

Several jurisdictions have complied with the standards prescribed by IAIS and have detailed disclosure requirements on the basis of above standards. IAIS has also prescribed that disclosures by the electronic means may be encouraged to ensure availability of historical data on a continuous basis to the various stakeholders.

The analysis of disclosure requirements by Monetary Authority of Singapore (MAS) shows that the disclosure requirements both on an annual and quarterly periodicity are more stringent than the standards prescribed by IAIS. The requirements as per the MAS are annexed (Annexure I) to this paper.

CRISIL carried out a study on the disclosure by Insurance companies and the global practices which is annexed at (Annexure II). The study of the Prudential Insurance Company of America and Hartford Fire insurance Company carried out by the CRISIL shows that the annual as well as quarterly disclosure requirements largely comply with IAIS standard and is so comprehensive that the stakeholders will get full understanding of the financial position, performance and risk profile of the companies.

In the above context, IRDA proposes to bring out guidelines for the public disclosure for insurance companies to be with effective from 1st November, 2009. The disclosures proposed are largely inline with the standards prescribed by the IAIS and being followed in other jurisdictions. The disclosure requirement has been kept at the minimum, keeping in view the costs involved in making such disclosures and balancing with the need for transparency in the insurance market.

The formats, the periodicity and mode of publication of disclosures are annexed at (Annexure III).

The disclosures proposed are a subset of the quarterly and annual returns which have already been prescribed by Regulations brought out by IRDA. Where the returns do not cover the disclosure requirement in holistic fashion, additional information disclosures have been prescribed the formats of which, are annexed at (Annexure-IV-A and Annexure-IV-B).

The disclosures proposed can be grouped into:

- Company profile
- Investment profile
- Liability Valuation
- Risk concentration
- Solvency and
- Business statistics

The additional disclosures, which at present are not being submitted to IRDA and being proposed are:

- Sensitivity Analysis
- Related Party Transactions
- Reinsurance risk concentration

The schedules of the Annual Financial Statements which are proposed to be disclosed on quarterly and half-yearly basis are not at present being obtained by IRDA on quarterly basis. However, as the companies are already submitting quarterly financial statements of IRDA, it is presumed that the schedules which feed into the financial statements are readily available for disclosures. It is proposed that the insurers disclose every quarter the data of the same quarter / half year last year and the cumulative figure for the current year.

The stakeholders in the insurance market are requested to offer their remarks on this exposure draft on "Public Disclosures by Insurers" before 25th October, 2009 to the following address:

The Chairman
Insurance Regulatory and Development Authority
3rd Floor, Parisrama Bhavan, Basheer Bagh
HYDERABAD - 500 004
Ph: (040) 2338 1300 (B)
Fax: (040) 6682 3334
Email: chairman@irda.gov.in

Sd/-

(A. Giridhar)
Executive Director (Administration)

Note: *Annexures can be obtained from the website*

PRESS RELEASE

October 12, 2009

Sample Transaction Level Data on Motor and Health Insurance

IRDA has decided to make available samples of transaction level data on Motor and Health insurance on its website to facilitate research on non-life insurance.

IRDA has been collecting transaction level non-life insurance data on Motor and Health from Insurers and Third Party Administrators. The data formats prescribed for data collections are available in the following link. http://www.tac.org.in/format.html.

Motor Data is collected in three structured tables viz:

Motor Table 1.Policy Data – F12A

Motor Table 2.Own Damage Claims – F12B

Motor Table 3 Third Party Claims – F12C

Health Data is collected in three structured tables viz:

Health Table 1.Policy Data – F15A

Health Table 2.Members Data – F15B

Health Table 3.Claims Data – F15C

One lakh records of each of the above tables randomly selected from the data received by IRDA from insurers (totalling to six lakhs records), are placed on the website sampledata for downloading.

In order to maintain the confidentiality and to protect the business interests of the data providers, some of the fields are masked in the data set.

It may be noted that the records are randomly selected and are as received by IRDA. IRDA does not guarantee the accuracy, adequacy or completeness of any information and is not responsible for any errors, omissions in the data.

The data may be used after understanding the concepts, definitions, design and coverage with due appreciation of the limitations thereof. IRDA is not responsible for any decisions / conclusions drawn by anyone based on this sample data. IRDA is not obliged to give any clarification on the sample data.

ORDER

October 15, 2009

No.IRDA/TAC/ORDER/Admn/042/10/2009

Re: Insurance Information Bureau (IIB)

For efficient functioning of the insurance sector companies as well as for the protection of the interests of the policyholders, it is necessary that reliable, timely and accurate data is collected, processed and disseminated by an independent body.

The Insurance Regulatory and Development Authority (IRDA) being the regulator is having necessary access to the data related to insurance business in the country. Hence it becomes the duty of the regulator to ensure that the available data is processed in such a fashion that it is useful for the various market players, researchers, policyholders as well as the common public at such intervals that it will be helpful for real-time decision making.

It is also essential for IRDA to undertake this activity through an advisory body consisting of representatives of the industry, experts in the insurance domain as well as in information technology as the data so produced by such a body will have necessary public confidence.

In view of the above and in order to fulfill the statutory mandate as enunciated in Section 14 (2) (1) (e) of the IRDA Act, 1999, the Authority hereby constitutes Insurance Information Bureau (IIB) with the following membership:

1. Chairman, IRDA	– Chairman
2. Director General (R & D)	– Vice Chairman
3. Executive Director (Admn)	– Member – Convener
4. Secretary General, Life Insurance Council	– Member
5. Secretary General, General Insurance Council	– Member
6. Prof. Arun K Pujari Dean, University of Hyd	– Member
7. Prof. H Krishnamurthy PRO, Indian Inst of Science	– Member
8. Dr. B C Jinaga, Professor, JNTU	– Member
9. One Representative from the life Insurance *(to be nominated by Chairman on annual rotation basis)*	– Member
10. One Representative from the non-life Insurance *(to be nominated by Chairman on annual rotation basis)*	– Member

In exercise of powers conferred on the Authority under section 14 of IRDA Act, 1999 it is ordered that the Bureau be authorized to obtain, process and disseminate the data of insurers as provided in various regulations and the Data Policy annexed to this Order.

- The Bureau will function as the advisory body for IRDA by providing necessary inputs for policy research and development activity.
- The Bureau, in addition will also function as a single point official reference for the entire data requirement on insurance sector.
- All the necessary decisions regarding processing and disseminating of the data will be done as per the policy laid down by the Bureau.
- The staff and officers of the Bureau will be on deputation from IRDA and functional duty allotment will be done by the Bureau.
- The Bureau may delegate any of its regular functions to any officer of the Bureau as found suitable.
- The Bureau shall ensure that the data obtained, processed and disseminated shall not breach business confidentiality and that the dissemination of data is done in such a fashion that the competition in the sector is not affected by asymmetry of information.
- The Bureau shall ensure that the data policy as annexed to this order is strictly implemented in letter and spirit.
- The Bureau is also directed to procure, install and utilize necessary data management systems to ensure confidentiality, precision and the speed necessary for implementing the policy.
- The Bureau may decide upon the necessary policy on pricing of various data products produced by it.
- The accounts department of IRDA shall maintain separate account of revenues and expenses of the Bureau and provide the necessary funds as per the budget prepared by the Bureau and approved by the Chairman, IRDA.
- The rules of business of the Bureau may be decided by the Bureau in its first meeting and amend them subsequently as found necessary.
- The Bureau shall give annual report of its functions to the IRDA by 30th June every year.

Sd/-
(J Hari Narayan)
Chairman

CIRCULAR

October 28, 2009

Ref: IRDA/F&I/CIR/AML/052/10/2009

To
The CEO's of All Insurance Companies

Sub: Guidelines for implementation of Section 51A of Unlawful Activities (Prevention) Amendment Act (UAPA), 2008

1. Financial Action Task Force (FATF) has issued nine special recommendations to combat the financing of terrorism. These special recommendations when combined with the FATF forty recommendations on money laundering set out the basic framework to detect, prevent and suppress the financing of terrorism and terrorist acts. The nine special recommendations require countries to implement fully the 1999 United Nations International Convention for the Suppression of the Financing of Terrorism, particularly the United Nations Security Council Resolution 1373.

2. Legislation in India to deal with the implementation of the United Nations Security Council (UNSC) Resolutions, takes the form of the Unlawful Activities (Prevention) Act (UAPA), 1967. UAPA amended in 2008 now covers various UNSC Resolutions, including UNSC 1267 and UNSC 1373 which require member countries inter alia, to take action against certain terrorists and terrorist organizations; take measures to combat international terrorism; etc. An updated list of individual and entities which are subject to various sanction measures as approved by Security Council Committee established pursuant to UNSC 1267 can be accessed in the United Nations website at http://www.un.org/sc/committees/1267/consolist.shtml.

3. By virtue of Section 51A of UAPA, the Central Government is empowered to freeze, seize or attach funds of and/or prevent entry into or transit through India any individual or entities that are suspected to be engaged in terrorism. To implement the said section an order reference F. No. 17015/10/2002-IS-VI dated 27th August, 2009 has been issued by the Government of India (Copy annexed). The salient aspects of the order with particular reference to Insurance Sector are detailed in the following paras.

4. IRDA would appoint a UAPA Nodal Officer for the purposes of implementation of the said order in the insurance sector and his contact details would be intimated shortly. A consolidated list of all the UAPA Nodal Officers of various agencies governed by the order will be circulated every year and on every change in the list, on receipt of the same from Ministry of Home Affairs.

5. It may be recalled that vide clause 3.1.1 (vi) of the Master

Circular dated 24th November 2008 on AML guidelines, insurers have been advised not to enter into a contract with a customer whose identity matches with any person with known criminal background or with banned entities and those reported to have links with terrorists or terrorist organizations. It is hereby, advised that a list of individuals and entities subject to UN sanction measures under UNSC Resolutions (hereinafter referred to as 'designated individuals / entities') would be circulated to the life and general insurance companies through the respective Councils, on receipt of the same from the Ministry of External Affairs (MEA). This is in addition to the list of banned entities that were circulated to the insurers till date.

6. Accordingly, insurers are advised to maintain an updated list of designated individuals / entities (as indicated in para 5 above) in electronic form and run a check on the given parameters on a regular basis to verify whether designated individuals / entities are holding any insurance policies with the company.

7. **Procedure for freezing of insurance policies of 'designated individuals / entities':**

   In case any matching records are identified, the procedure required to be adopted is as follows:

   1. Insurance companies shall immediately and in any case within 24 hours from the time of identifying a match, inform full particulars of the insurance policies held by such a customer on their books to the Joint Secretary (IS-I), Ministry of Home Affairs, at Fax No.011-23092569 and also convey over telephone on 011-23092736. The particulars apart from being sent by post should necessarily be conveyed on e-mail id: jsis@nic.in.

   2. The insurance companies shall also send a copy of the communication mentioned in 7(a) above to the UAPA Nodal Officer of the State / UT where the account is held, IRDA and FIU-IND.

   3. In case, the match of any of the customers with the particulars of designated individuals / entities is beyond doubt, insurance companies would prevent designated individuals / entities from conducting any transactions, under intimation to the Joint Secretary (IS-I), Ministry of Home Affairs at Fax No. 011-23092569 and also convey over telephone on 011-23092736. The particulars apart from being sent by post should necessarily be conveyed on e-mail id: jsis@nic.in.

   4. The insurance companies shall file a Suspicious Transaction Report (STR) with FIU-IND in respect of the insurance policies covered by paragraph 7(a) above, carried through or attempted, in the prescribed format (as per the Master Circular on Anti Money Laundering Guidelines dated 24th November 2008).

   5. On receipt of the particulars of suspected designated individual / entities IS-I Division of MHA would cause a verification to be conducted by the State Police and / or the Central Agencies so as to ensure that the individuals / entities identified by the insurance companies are the ones listed as designated individuals / entities and the insurance policies, reported by insurance companies are held by the designated individuals / entities.

   6. In case, the results of the verification indicate that the insurance policies are owned by or are held for the benefit of the designated individuals / entities, an order to freeze these insurance policies under section 51A of the UAPA would be issued within 24 hours of such verification and conveyed electronically to the concerned office of insurance company under intimation to IRDA and FIU-IND.

   7. The said order shall take place without prior notice to the designated individuals / entities.

8. Procedure for unfreezing of insurance policies of individuals / entities inadvertently affected by the freezing mechanism, upon verification that the individual / entity is not a designated individual / entity:-

   1. Any individual or entity, if they have evidence to prove that the insurance policies, owned / held by them has been inadvertently frozen, shall move an application giving the requisite evidence, in writing, to the concerned insurance companies.

   2. The insurance companies shall inform and forward a copy of the application together with full details of the insurance policies inadvertently frozen as given by any individual or entity, to the Nodal Officer of IS-I Division of MHA within two working days.

   3. The Joint Secretary (IS-I), MHA, the Nodal Officer for IS-I Division of MHA shall cause such verification as may be required on the basis of the evidence furnished by the individual / entity and if he is satisfied, he shall pass an order, within 15 working days, unfreezing the insurance policies owned / held by such applicant, under intimation to the concerned insurance company. However, if it is not possible for any reason to pass an Order unfreezing the assets within 15 working days, the Nodal Officer of IS-I Division shall inform the applicant.

9. Implementation of requests received from foreign countries under U.N. Security Council Resolution 1373 of 2001

   1. U.N. Security Council Resolution 1373 obligates countries to freeze without delay the funds or other assets of persons who commit, or attempt to commit, terrorist acts or participate in or facilitate the commission of terrorist acts; of entities owned or controlled directly or indirectly by such

persons; and of persons and entities acting on behalf of, or at the direction of such persons and entities, including funds or other assets, derived or generated from property owned or controlled, directly or indirectly, by such persons and associated persons and entities.

2. To give effect to the requests of foreign countries under U.N. Security Council Resolution 1373, the Ministry of External Affairs shall examine the requests made by the foreign countries and forward it electronically, with their comments, to the UAPA Nodal Officer for IS-I Division for freezing of funds or other assets.

3. The UAPA Nodal Officer of IS-I Division of MHA, shall cause the request to be examined, within 5 working days, so as to satisfy itself that on the basis of applicable legal principles, the requested designation is supported by reasonable grounds, or a reasonable basis, to suspect or believe that the proposed designee is a terrorist, one who finances terrorism or a terrorist organization, and upon his satisfaction, request would be electronically forwarded to the Nodal Officer in IRDA. The proposed designee, as mentioned above would be treated as designated individuals / entities.

4. Upon receipt of the requests by these Nodal Officers from the UAPA Nodal Officer of IS-I Division, the list would be forwarded to insurance companies and the procedure as enumerated at paragraphs 6 and 7 above shall be followed.

5. The freezing orders shall take place without prior notice to the designated persons involved.

Communication of Orders under Section 51A of Unlawful Activities (Prevention) Act

10. IRDA would communicate all Orders under section 51A of UAPA relating to insurance policies, to all the insurance companies after receipt of the same from IS-I Division of MHA.

11. This circular is being issued in exercise of powers conferred under section 14 (1) (q) of the Insurance Regulatory and Development Authority Act, 1999.

12. Insurance Companies shall ensure strict compliance with the contents of this circular and the provisions of the UAPA, and the Government order dated 27th August 2009.

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

We welcome consumer experiences.
Tell us about the good and the bad you have gone through and your suggestions.
Your insights are valuable to the industry.
Help us see where we are going.

Send your articles to:
Editor, IRDA Journal, Insurance Regulatory and Development Authority,
Parisrama Bhavanam, III Floor, 5-9-58/B, Basheerbagh, Hyderabad 500 004
or e-mail us at irdajournal@irda.gov.in

Data Warehousing and Mining

Essential Management Tools

'THE QUALITY AND EXTENT OF INFORMATION IS VERY VITAL FOR EMERGING SUCCESSFUL IN THE INSURANCE INDUSTRY. PARTICULARLY, THE NEED FOR A RICH RESOURCE OF DATA WAREHOUSING AND MINING HAS ACQUIRED A HUGE IMPORTANCE IN THE LIBERALIZED ENVIRONMENT' OBSERVES U. JAWAHARLAL.

Information and data have come to occupy a place of prime importance for successful conduct of business. They provide support to management decisions even on vital areas like consolidation, diversification etc apart from providing regular support in more mundane activities. The importance of data may differ in priority for various businesses. Insurance is heavily dependent on the quality and extent of information and data. Hence there is need for creating a rich repository of information and data which will come to great use in the insurers' day to day operations as also their strategic decision making.

The existence of a rich database is very much essential for insurers in such vital areas like product designing, underwriting, pricing etc. With the support of a rich data warehouse and an effective data mining process, insurers can come out with a richer portfolio of products – both by inventing new products and by making improvements in the existing ones; and aim at better market segmentation by identifying the needs of the prospects and designing their product mix.

The importance of underwriting function for an insurer needs no emphasis. In order that the underwriter is enabled to make a good decision, the support provided by an efficient data warehouse and mining is boundless. The importance of having in place a well-maintained and wholesome data warehouse is more emphatic in the liberalized regime where there are multiple players. If an adverse decision pertaining to a particular proponent is updated on a real time basis, the possibility of his taking advantage of several players would be nullified; if supported by a proper access to all the other players. This would be helpful in weeding out unscrupulous elements. It would also help the insurers and underwriters in providing information about the details of other insurance held by the proponents.

Data warehousing will be very helpful to the insurer in the other vital factor of pricing. The process of assessing the risk potential and pricing it equitably is very essential for the long term success of an insurer; and data warehousing and mining will add to the efficiency of the insurers in accomplishing this. The priorities associated with reasonable pricing and market viability need to be supported by a rich resource of data.

The business of insurance necessarily relies on the promises made – on paper, to start with that need to be converted into efficient databases. This presupposes that the data obtained is meaningful and pertinent. Proper consolidation and updation of data obtained should also be taken up from time to time in order to ensure that the data warehouse serves as an efficient management tool. Data quality management is particularly significant in insurance business which is long term in nature. Some of the vital areas for insurers could be Personnel Inventory, Customer Data, Distribution-related data, Policy and Product Administration etc.

'Data Warehousing and Data Mining in Insurance' will be the focus of the next issue of the **Journal**. Let us look forward to a rich collection of expert opinions in the domain.

Cleaner Data –
Better Decisions

in the next issue...

Informational Asymmetry

Non-life Insurance Transactions

G V RAO ASSERTS THAT THE AGE-OLD PRACTICE OF ANALYZING THE PROPOSAL AT THE CLAIM STAGE SHOULD BE REPLACED BY UPFRONT UNDERWRITING THAT IS WHOLESOME, IF SEVERAL OF THE CONTROVERSIES ASSOCIATED WITH THE NON-LIFE INDUSTRY ARE TO BE RESOLVED.

How good are insurers in reducing informational asymmetry in their acceptances of risks offered to them? What underwriting tools are they now employing to better understand the features of the physical risk and the moral hazard of a proponent? Following detariffing, have these tools been upgraded and sharpened?

This article seeks to understand and analyze the current market situation and suggests that insurers need to do a lot more to improve their expertise, underwriting governance and procedural applications now in use.

Understanding asymmetry

The 'popular view' held by the public is that insurers sell their insurance policies to entrepreneurs, as its buyers. Most of the analysis of asymmetry in informational exchange is, therefore, assigned to the buyer of insurance covers. And the incidence of his moral hazard is highlighted on several occasions. In reality the reverse is true in a practical and legal sense.

The insured is selling his risk exposures (offer), and it is the insurer, who is buying them for a price (acceptance). The buyer has right to ask all relevant questions of the seller on the risk exposures, and satisfy himself, before he enters into a contract.

Answers to questions in the proposal form alone are not enough. Any information, which ought to have been made known to an insurer, must have to be disclosed.

Is an insurer doing so now in the de-tariffed regime? In what manner has the process of seeking disclosures from an insured changed? Have the proposal forms, which seek full disclosures, been revised? If not, are insurers really serious about asymmetry in information emanating from the insured segment?

But insurers, of course, are well-protected, since all insurance contracts are based on the principle of utmost good faith; and there is, therefore, a duty of voluntary disclosure cast on the seller of risk exposures. It is the quality and extent of such disclosures that is the subject matter of asymmetry. Insurers end up in the driving seat to decide on the quality and extent of such disclosures made.

Answers to questions in the proposal form alone are not enough. Any information, which ought to have been made known to an insurer, must have to be disclosed. Who is the judge of this: the insurer, of course?

Informational Asymmetry for an insured

The asymmetry for an insured arises from the wording of the policy contract. The policy conditions are all focused on the conduct of an insured, and what an insured should or should not do in the event of a claim. But there are no corresponding obligations mentioned in it for an insurer, except the offer of an indemnity, without reference to time, payment of interest and insurers' wrong decisions on liability etc. Unfortunately, no stakeholder talks about restoring a balance of convenience to both, by changing the policy conditions and ensuring equally binding obligations on the insurers too. There is a presumption of an insurer's good conduct.

Specialization in risk categorization is required to better understand risk exposures and how they are currently managed by an insured.

Risks are Raw materials for insurers

Insurers are the dominant chasers of risk exposures of others in the world. While insured entrepreneurs are eager to shed their hazardous risk exposures to ensure the financial safety of their ventures, the insurers are only too keen to gobble them up. In fact, risk exposures of others are the only raw materials for the insurers to manage and make a margin. That is their reward and their business. Without the world of risk exposures, and more and more of them; they have no reason to exist, as an insurance industry.

The second claim of a non-life insurer is about his professional expertise in superior risk management of the risk exposures of others. An insurance cover, after all, is a risk management product, for the insured, the way it is priced. Insurers' main business pursuit is about prevention of accidents, and minimization of loss potentials, if accidents did occur.

For better understanding the underlying risk factors and pricing them, insurers need informational disclosure from an insured. Hence the usage of structured proposal forms. But with the variety and complexity of risks getting huge, insurers have to dig deep in to their knowledge pool. Specialization in risk categorization is required to better understand risk exposures and how they are currently managed by an insured. The insurers need to help their insured to reduce informational asymmetry to a larger extent than now.

Life Vs Non-life contracts

All life-insurance contracts are completed only after evaluating almost all the risk factors, such as proof of age of the proponent, and his medical condition, which is always examined and confirmed by the medical examiners of the choice of insurers.

In the case of non-life insurance contracts all verification of information disclosed is made only when a claim is reported. Contracts are entered into without any proof of information disclosed. Asymmetry of the informational exchange is scrutinized more severely, when a claim is reported. Such a scrutiny is bound to be eagle-eyed and can be subjective too. Since such a scrutiny is held, after an accident, the insured feel that insurers are always prejudiced, just to deny them a claim, though this may be untrue in most cases.

Use of proposal forms

In the Indian context of a rigid tariff regime that extended over decades till 2007, the proposal forms were regarded only as informational sources for issuing policy documents, and not for evaluation of risk factors or for pricing them. The tariff had given the rates. No risk information of any kind was needed. In fact, many insurers did not even bother to take proposal forms at all. It was just a standardized proposal form, for all kinds of risks written in the portfolio segment. No disclosure of any risk factors was required to be made to price it, based on any underwriting consideration, as the rates were pre-determined.

This business practice of continuing to use the standardized proposal form (or even no proposal form at all) has continued, even after dismantling the tariff regime. Non-life insurers now underwrite risks, based mainly on the erstwhile tariffs; and not by using their expertise for assessing risk factors and pricing risks, as disclosed.

In fact, one can be bold, and say that the underwriters of today have very little knowledge and understanding of risks they accept in their various facets. Insurers have practiced their profession, more as sales persons, using the tariff rating as their underwriter-in-chief.

Asymmetry heightened by insurers' conduct

Insurers have also contributed to encouraging asymmetry by their peculiar underwriting practices. In accepting health insurance proposals, insurers consider 'age' as the only risk factor for quoting rates. But when a claim is reported, the claimant is questioned for non-disclosure of factors that were not essential enough at the acceptance stage, such as 'pre-existing condition'. Information about 'pre-existing' condition should be sought by adding questions in the proposal form, and perhaps even by seeking medical examination, as in the case of overseas medical policies.

The responsibility for uncovering all the relevant risk factors primarily would rest on insurers, and should not be left to the insured alone. In the case of renewal of a

health policy, the insurers do not even ask an insured, if his health condition has changed during the year, and insurers would automatically renew it, if there was no claim reported. Later, if a claim is reported in the year, insurers would ask, why the change in the health condition in the previous year was not reported to them.

Instead of tightening underwriting procedures, and asking for basic health condition reports, prior to accepting the risk, insurers have continued with their past procedures and use 'pre-existing condition' freely to repudiate claims. Insurers must find improved ways and means to determine how to prevent unhealthy persons to be insured, at rates meant for healthy persons. The argument put forth herein is that it is for the insurers to deal with this situation by devising new procedures.

Moral Hazard

The asymmetry of information can arise from two factors: the physical hazard and the moral hazard. Where the risk is inspected by the representative of an insurer, the insured is free from all charges of suppression of information concerning the physical features of the risk.

Information on the moral hazard is a more serious issue, and insurers need to do a lot more to uncover more information on it. The prevalence of the tariffs has led insurers to believe that there was no issue of any moral hazard at all. The tariff rates were fixed on the physical features of a risk; and insurers' were required to sell covers, assuming there was no moral hazard involved.

Such a mindset of insurers continues even now in their underwriting philosophy. The only aspect of moral hazard questioned today is on the claims experience. Aspects such as the quality of industrial relations, the natural inclination of an insured either as law-abiding or as law-breaking, carrying on operations disregarding safety norms, non-observance of prescribed conditions by State and Central authorities all are a pat of evaluation of moral hazard.

The writer pleads that insurers should give more importance to the aspects of moral hazard, in the acceptance of a risk and in its pricing, as it is this moral factor that leads to fraudulent claims, which in many cases are known to be fraudulent, but fail on account of lack of tangible evidence. Unfortunately, insurers' mindset is out of tune to smell a potential fraudster, who wants to help himself to insurance monies due to reckless and dishonest acts.

Insurers must find improved ways and means to determine how to prevent unhealthy persons to be insured, at rates meant for healthy persons.

Final word

Unable to separate the physical and moral hazard aspects, and not having been trained to discover moral hazard at the stage of acceptance; several insurers tend to suspect all insured, with lack of ethics and honesty in their dealings. This is wrong and self-defeating and offensive to their customers. Moral hazard must be probed at the stage of acceptance of the risk, and not at the time of claim, as is done now.

Majority of customers are honest, fair and reasonable. A few dishonest customers, who have slipped through the easy gate of acceptance, should not make a general policy for insurers of suspecting the bonafides of all claimants.

Insurers should devise new strategies of locating and dealing with customers, whose moral hazard might cause problems. On evaluation of physical features, on which they are ill-equipped due to their poor procedural formats, they must upgrade their underwriting tools.

Asymmetry of information is a major issue for insurers. But insurers must accept that their lapses must not only be contractually rectified, but their old mindset of mechanical way of doing business must change to one of reflection, evaluation and a fair process. They should march with the times that are changing and take their customers along with them.

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Symmetry in Information

A Two-Way Process

GNANASUNDARAM KRISHNAMURTHY **EMPHASIZES THAT IN VIEW OF THE LOW AWARENESS LEVELS OF THE GENERAL PUBLIC, INSURERS OUGHT TO KEEP THE POLICYHOLDERS INFORMED OF THE UPDATES ON A REGULAR BASIS IN ORDER THAT THE FLOW OF INFORMATION IS WHOLESOME.**

The statements "Insurance is sold and not bought" and "Insurance is a subject matter of solicitation" are axiomatic expressions which underscore the vital role played by information in this uniquely service-oriented and predominantly welfare but legal business. The contract of insurance requires the proposer to offer himself or his property for insurance and the insurer to accept it. For the contract to be legally valid, the principle of 'consensus *ad idem*' should have been followed. Contracts concluded with or under wrong, incorrect or mistaken impression of the parties result in absence of consensus which can make the contract void. It is well settled in law that the principle of *uberrimae fidei* is applicable both to the insured and the insurer.

The IRDA (Protection of Policyholders' Interests) Regulations 2002 makes a specific mention of the fact that the duty of disclosure of material information applies both to the insurer and the insured in respect of policy and proposal. It is the asymmetry of information, sought for, understood, exchanged and recorded that leads to the undesirable situation of declaring a contract null and void. Symmetry of information flow, therefore, becomes the *sine qua non* in insurance contracts. Responsibility to ensure this symmetry rests heavily on both the parties, viz, the proposer and the insurer, as solicitation is done from both sides.

The duty of disclosure of material information on the part of the proposer commences right from the act of soliciting insurance orally or through the proposal form. Further, judicial pronouncements have made it clear that 'the duty to disclose material facts continues right up to the conclusion of the contract and also implies any material alteration in the character of the risk which may take place between proposal and its acceptance.' (LIC of India vs. Smt. B. Kusuma T. Rai; Reg. F.A. No.1977, H.C. Karnataka).

Again, material facts are not merely those one believes to be material but facts one ought to know are material. In other words, if in the opinion of a prudent person a fact could be deemed to be material, it calls for disclosure.

But when does the duty of disclosure of material fact commence and end for the insurer? While a cursory survey of actualities throws up a good number of situations of breach of *uberrimae fidei* on the part of proposers, comments on the obligations of the insurers under this principle are infrequent.

The principle of *uberrimae fidei* calls for providing insurance benefits to the prospects as per their needs. The code of conduct prescribed by IRDA for the insurance intermediaries requires that they should disseminate information in respect of insurance products offered for sale by the insurers and take into account the needs of the prospects while recommending a specific insurance plan.

It is the asymmetry of information, sought for, understood, exchanged and recorded that leads to the undesirable situation of declaring a contract null and void.

Asymmetry of information arises not only due to the failure to follow principles but also as a result of casual approach while penning down contracts and dealing with contractual obligations in practice.

Opening up of the insurance industry has resulted in dozens of insurers entering the arena, making the insuring public face a plethora of products. No doubt tremendous awareness has been created about the need to take insurance (for whatever reasons), but buying insurance has now become more difficult due to multiplicity of insurers and their products. Plans with identical features are not uncommon in the market. The question before the prospect today, therefore, is whether to first select the product and approach the insurer or to select the insurer first and then go for the product. While IRDA (Protection of Policyholders' Interests) Regulations 2002 enjoins upon the insurers to provide material information on the terms and conditions of a product / policy, flow of information from the insurer to the public also needs to be on the insurer itself to serve the principle well.

The aspiring proposer, while offering to sign up for insurance, is confronted with a volley of questions about his health and habits, age and occupation and family and medical history but information made available to him about the insurer providing the cover is little or none. This is strikingly in contrast with the situation obtaining in respect of the other financial instruments coming up for IPO, FPO, FD and NFO from the companies and mutual funds. While this did not matter much in the pre liberalization era, it assumes great importance in a competitive scenario. In fact, this was one of the points mentioned in the seminar conducted on the 29th July 2009 by the Consumers Association of India at Chennai, in which it was suggested that material information on the insurance company, including its performance in claims, lapses, grievance redressal etc. should be made available to the proposer even at the time of solicitation, along with the proposal form, as is being done in the case of the other financial instruments.

This is not all. If the duty of disclosure makes it obligatory for the policyholder to perform it also during the currency of the policy, on occasions such as renewal and alterations, sauce for the goose should also be sauce for the gander. In fact, it is continuous for the insurer and attaches to the company throughout its existence. This flow of information on material facts and changes thereon, if any, having a bearing on the policyholders' good faith reposed in the insurance company, needs to be ensured at least on an yearly basis through the Annual Reports and Press Releases, if not through individual communications. This will enable policyholders to know where they stand as regards their benefits and services promised *vis-a-vis* the company's performance.

IRDA could come out with a Regulation on Annual Reports of the companies, similar to the one on its own Annual Report. Who else can be the prudent person to decide which information is material for the insurer to disclose and which is not? Data published in the Annual Report of IRDA cannot be a substitute to companies' Annual Reports if the principle of *uberrimae fidei* is to be honoured in toto.

Asymmetry of information arises not only due to the failure to follow principles but also as a result of casual approach while penning down contracts and dealing with contractual obligations in practice. Following certain procedures not mentioned in the prospectus or policy, such as claim investigation, spot survey etc., sending a discharge voucher devoid of explanation for deductions from the claim amount, misselling by mis representation of facts and so on are examples of situations that result in asymmetry of information. IRDA, it is understood, is already seized of the issue of disclosure by the insurers. The obligation of insurers under the principle of *uberrimae fidei* needs to be kept in mind while finalizing the disclosure norms and their dissemination.

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Asymmetry in Life Insurance Selling

Bane of Poor Business Retention

C.L. BARADHWAJ WRITES THAT MOST OF THE PROBLEMS ASSOCIATED WITH ASYMMETRY OF INFORMATION IN LIFE INSURANCE CAN BE SOLVED BY THE AGENTS BEING MORE FORTHRIGHT AT THE TIME OF FINALIZING A DEAL.

Introduction

The word "asymmetry" refers to the absence of correspondence, equivalence or identity amongst constituents of an entity or unit resulting in imbalanced distribution of the elements. Information asymmetry deals with the study of decisions in transactions where one party has more or better information than the other. This creates an imbalance of power in transactions which can sometimes cause the transactions to go awry. In insurance parlance, this includes a situation where the insurer or the proposer possessing limited information about the essential ingredients for entering into a contract of insurance. This article discusses this asymmetry in the area of life insurance selling.

Life insurance companies accept the risk based on the statements and disclosures made in the proposal form.

Information asymmetry for a life insurance company – absence of accurate information about the proposer to assess the risk correctly.

(a)Why should an insurance company need to have accurate facts about the proposer?

Life insurance contracts are contracts of "utmost good faith". The proposer (life to be insured) is expected to reveal the state of his health, personal history, family history, occupation, income etc. in a truthful manner so that the life insurance company is able to fix the premium appropriate to the risk on hand. This disclosure is required to be done in the proposal form designed by the company which is signed by the proposer.

(b)Asymmetry in the process of life insurance selling

While the proposal form is signed by the proposer, it is invariably filled by the agent. In most of the cases, the agent does not take extra care to bring it to the notice of the proposer the nature of the life insurance contracts, the need for truthful disclosure of the facts, especially on the personal health and the consequences of non disclosure of health, even if unintentional. The agent fills the form answering the questions on the status of health in the negative (he ticks "no" to the questions enquiring about illnesses, if any of the proposer) without checking with or informing the customer. In view of the above, the proposer ends up signing the proposal form without even knowing that he is signing on a health declaration.

Life insurance companies accept the risk based on the statements and disclosures made in the proposal form. Where a claim is preferred by the nominee upon the death of the life assured, the company conducts investigation of the claims (usually by an independent professional investigator) who conducts enquiries in the hospitals, clinics where the life assured underwent treatment for the illnesses before the date on which the proposal was signed. Copies of treatment records are produced to conclusively prove the fact that life assured was suffering from illnesses.

On the basis of the above records, life insurance companies repudiate the claims stating that the life assured had failed to disclose the status of health correctly in the proposal form which had impacted the decision to accept the risk (violating the principles of utmost good faith), warranting repudiation of claims. Where

"customer fraud" is proved, insurance company can forfeit the premiums also. Therefore, "knowledge" of the customer about the ailments is also established resulting in forfeiture of the premiums paid by the policyholder.

The result – nominee does not get the intended benefits – the purpose for which life insurance cover was taken – loss to the customer.

Insurance company's reputation is at risk – so is the reputation of the advisor in the market – since the benefit promised is not paid – whatever be the reason.

The irony of the situation is that the customer "did not know" that he needs to disclose and therefore did not disclose about him correctly, but insurance company repudiates the claim on the presumption that life insured had knowledge about the contents of the form before he signed.

We may think that it is the duty of the proposer to read the proposal form before signing it. Further we may also conclude that the proposer should have read Section 45 of Insurance Act which is printed in the declaration part of the proposal form and cannot therefore take advantage of his own ignorance. Even though the declaration contains a sentence confirming that the proposer asserts what is stated is true and correct and that benefits may not get paid if there is any misstatement, how many proposers read and relate it to the importance of proper disclosure on health questions? Does the agent sensitise the proposer about its importance?

Life insurance is not like buying mutual fund where there is a risk of only losing the capital. While it is a widespread knowledge that persons trading in equity markets take the risk, investing public hardly knows the nature of insurance contracts.

How many of us have really understood the import of Section 45? A lengthy section which even legal experts take years to comprehend completely. How do we expect a common man to understand? How many of us have read the housing loan agreement completely and understood the implications before signing it? We end up signing all pages of the book containing the loan agreement without reading it. While you do not end up losing much if you do not read a loan agreement, it is not so in the case of life insurance.

You do not end up losing much if you do not read a loan agreement, it is not so in the case of life insurance.

One may think that keeping in view that the agent acted as the "agent of the insurer" if the agent filled the questions on personal health of the life assured without checking with him, it is the insurance company who should take responsibility and should pay the sum assured.

Well, logically you may be right, though not legally. There are sufficient judicial precedents (Hon'ble Calcutta High Court, Suit No. 1073 of 1956 in the matter of Mrs. Maniluxmi Patel and Another Vs. Hindusthan Co-operative Insurance Society, Ltd. and Another) to confirm that insurance company's agent acts as "agent of the proposer" while filling in the proposal form.

Therefore the poor proposer's family will have to pay for the lack of foresight on the part of the agent on the consequences of not taking "care" while form filling.

The agent is mostly driven by the thought that disclosures of facts of the illnesses of the proposer in the form could result in declinature of the proposal by the insurance company resulting in "loss of commission" to him. But little does he realise that by doing so, he is failing to cover the "risk" under the life insurance policy for which he is receiving the commission.

The problem compounds where the customer is illiterate or does not know English and the vernacular declaration is signed by the agent – a situation of high degree of conflict of interest.

Most of the repudiation of claims happen today due to the above information asymmetry. Had the proposer known about the importance of proper disclosures, he could have even afforded to pay some extra premium and get the claim amount, rather than not disclosing it and let the benefit go.

As per IRDA journal, in the year 2007-08, under individual death claims, the total number of policies repudiated by the life insurance industry was 9,027 and the amount repudiated was Rs.152.66 crores. Under group death claims, the repudiation was in respect of 1,241 lives for Rs.18.30 crores.

What do we do to correct the above information asymmetry?

The need of the hour is creating lot of awareness by the insurance companies at the proposal filling stage amongst their agents, field officers and the investing public. Insurance companies should take special efforts to bring the importance of faithful disclosure to the notice of the customer by any of the following ways:

- any important compliance is best achieved through a process redesign – Highlighting the questions on personal and family health – so as to catch the attention of the proposer – can consider separating the critical questions to a separate sheet like benefit illustration with appropriate disclosures

- need for proper disclosure norms for agents – all insurance companies should mandate that insurance agents need to compulsorily disclose about the nature of insurance contracts to the prospective customers
- customer calling to confirm the health status – at least on a sampling basis
- printing proposal forms in all the major regional languages
- till such time proposals forms are printed in vernacular, agents should not be allowed to sign vernacular declaration – an independent person can do it
- Emphasising the importance of proper disclosure with case studies in the agents' training – clearly highlighting the consequences of non disclosure
- Strict disciplinary action where agent has failed to do his duty – including termination for repeated cases of non disclosures
- Promotion of customer awareness programmes by IRDA highlighting the importance of proper disclosures while buying life insurance.

Asymmetry due to other factors at the point of sale

The other major contributor to the asymmetry at the selling stage is the absence of the correct knowledge about the products, features etc. and mismatch of the expectations of the customer and the benefits and other features which satisfy the customer's requirement.

Life insurance products fulfill customer's need. Therefore, the first step is an understanding what the customer's requirements are and recommending a product which fulfills the need. If this does not happen, it results in an asymmetry between what the agent sells and what the customer's expectations are.

The agent should never be driven by the products which offer him maximum commission. He should recommend products which satisfy the customer's needs. We often come across complaints where the customer required a single premium product, whereas the agent had recommended a regular premium product – the primary driver in the instant case is the commission rate – while for single premium it is 2%, it is around 15% for regular premium products. The result is that the customer cancels the policy or makes it lapse.

Further the other major area of complaints relate to wilful "misrepresentation" by agent to the customer on product features. False guarantees on returns on insurance products, not informing about risks, charges etc. fall under this category.

The mismatch between customer expectations and the product features is the key reason for the asymmetry which results in increased complaints of "misselling".

We often come across complaints where the customer required a single premium product, whereas the agent had recommended a regular premium product.

What can we do to correct the asymmetry related to misselling

Insurance companies may consider prescribing voluntary standards of disclosures by Agents to prospective customers. This shall prescribe what should be disclosed by the agent to the prospective customer on:

- Benefits under the policy
- Terms and conditions, including exclusions like "pre existing illnesses", waiting period clauses etc.
- Should specifically confirm that he has explained the health related questions to the customer and that the proposal form is filled up as told by the customer
- Should confirm that he is satisfied that the policy recommended suits the customer
- Customer call back on a risk based sampling basis to confirm the understanding on risks, charges and guarantees under unit linked products
- Developing "mentor" agents within an insurance company who shall act as guide for other agents for developing "professionalism" in the agency business – they should share the secrets of their success including the need for following ethics and compliance in insurance business
- Insisting on customer service by Agents as a key to the success and promoting ownership of the agency business – there are many LIC agents who maintain policyholder service centres and achieved success through enhanced customer service – clearly promoting the opposite of "disservice"
- Compensation to agents to be driven not only by quantity but also by quality of business the agent brings in – while a fixed basic commission may be given to all agents, flexibility for additional paying additional remuneration only if the complaints ratio is maintained within limits by the agents.
- Promotion of "Rewards & Recognition" program for agents whose quality of business is maintained at a high level.

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Information Distortion

Hidden Practices at Ground Level

K. NAGARAJA RAO OBSERVES THAT THERE ARE CERTAIN PRACTICES THAT ARE FOLLOWED AS A PART OF ROUTINE ALTHOUGH THE POLICYHOLDER IS NOT GIVEN TO KNOW THEM; AND FURTHER STATES THAT THIS ADDS TO THE DETRIMENT OF OBSERVING GOOD PRACTICES.

Old practices die hard. Life insurance is not an exception to this general rule. We find lot many theoretically right concepts bogged down at the bottom level. From canvassing a policy to claim settlement, from sales to service, from theory to practice there lies a hiatus – a hiatus perpetually unbridged for obvious reasons, known to all insurers but no one is prepared to bell the cat and ready to cleanse the Augean stables. In this article, I shall try to highlight certain usual practices in most of the insurance companies which are either against the standard norms or against the good practices which every life insurance company agree at least in theory.

Sales Related Practices

Insurance is an intangible product, a promise that is redeemed at a future date. It is broadly still sold and not bought. The need for insurance does not fit in to any layer of Maslow's hierarchy of needs at least in India, thanks to the presence of huge rural sector constituting nearly 73% of the Indian population. The awareness levels of insurance in its true spirit are still not appreciated. In this environment the canvassing of life insurance starts. 'The one size fits all concept' is perfected by an average agent and we find a common benefit illustration on the desk top of the Agent's PC for all ULIPs with heading of the plan / product changed while canvassing to the customer. The typical canvassing in most of the cases is like – invest Rs.10,000 per year for three years and then you would get a whopping amount in lakhs after a few years. The charts are available at different interest rates ranging from 18% to 36%. The deductions towards administrative charges, mortality charges etc are not normally discounted from the basic premiums before showing the cumulative interest charts to the customers. The element of insurance is pushed to the corner in this type of canvassing.

The major tendency is to sell those products which yield more commission in the first year. It is a general observation in the life insurance industry that the most successful and popular plan is that which promises maximum commission to the agent. The theoretical concept of need based selling is not possible in these types of sales.

Professional rivalries some time tend to make the agents to distort the information leading to surrendering the existing policies. For example, an IC would canvass and get a policy with a SA of Rs.1lakh for a premium of Rs.10,000. A rival agent would tell the customer that he could get Rs.2 lakh sum assured for the same amount of premium and thus implant a seed of suspicion against the first agent. The fact that only multiplier has changed in these two types of sales is never explained. The customer some times, due to lack of awareness, surrenders his first policy in order to take higher sum assured policy. Conceptually this practice is prohibited but conveniently it is practiced to boost up the individual IC's new business performance.

It is a general observation in the life insurance industry that the most successful and popular plan is that which promises maximum commission to the agent.

The customer complaints relating to mis-selling emanate due to the gap between official communication about the product features and the perceived benefits shown to the customers in the sales campaigns.

The proposals are supposed to be filled in by the agents due to complexity of the questionnaire and signatures of customers are taken on the dotted lines. This allows scope for manipulating vital fields like regular premium policy shown as single premium policy, yearly mode shown as half yearly mode etc. This practice has its toll on repeat sales, payment of renewal premium etc apart from leaving a trial of dissatisfaction in the minds of the customers.

Rebates of any nature are prohibited at the time of sale of life insurance policies. Funding a part of first premium or paying a few premiums tend to generate unhealthy competition among agents of the same life insurance company and also among different insurance companies. No mechanism has been so far developed to curtail this practice.

The social and rural obligations prescribed by the IRDA are more of 'obligatory' nature only. No insurance company appears to have definite and exclusive marketing strategy for rural populace. Pitching a few micro insurance plans cannot be a solution. Over and above, majority of the life insurance companies resort to the method of manual marking of rural policies in the system and which are not thoroughly audited by any authority for verifying the veracity.

The practice of spouse doing the business on behalf of his/ her partner still continues and the companies are encouraging, though unofficially, since it is a good business getting proposition. The benami agents are called even to the business meetings for felicitations. This is against professionalism but is practiced conveniently in some life insurance companies.

Funding a part of first premium or paying a few premiums tend to generate unhealthy competition among agents of the same life insurance company and also among different insurance companies.

The focus on premium income by all companies and less focus on number of policies for obvious reasons has its impact on widespread coverage of insurance in the rural hinterland. We have to introspect whether the objective of deregulation and privatization has really been met in our obsession with premium income.

The cases of mis-selling / wrong or misleading moral hazard reports are not pursued to their logical conclusion. The attrition rate in the sales teams are very much high and the teams keep moving to other insurance companies leaving the customers in the lurch. There is no effective data sharing mechanism among life insurance companies to check the details before recruiting the candidates. This lacuna has provided a safety cushion for jumping to different companies at ease. Further all the companies have not perfected systems to take care of the orphan policies.

The Under Writing practices

The under writer assesses the risk based on physical hazards and moral hazards of the subject matter to be insured. Moral hazard report plays an important role to assess the risk for acceptance. The liberalization and privatization of life insurance industry in the present decade unleashed a plethora of changes in the distribution system. The age old agency system is no more a monopoly in the distribution management. The Bank-assurance, the alternate channels, the MLM companies, brokerage firms etc have come to the center stage. The person who signs the MHR perhaps has no knowledge of the customer's health habits and in most of the cases he is miles apart from the customer's place. MHR has become a routine document and the under writer's data to decide is severely restricted. There is no penalty provision if the statements in the MHR are either proved wrong or distorted at any future stage.

The practice of obtaining unfilled printed consent letters with signature along with the proposal is one more irritant which is against the spirit of customer delight. The health extras, occupational extras and other counter offers are written without the knowledge of the customers.

The entry of alternate channels and Bankassurance channel as major source of business have brought in their wake certain peculiar problems for underwriters. The proposals come from long distance and getting a minor requirement also sometimes become a difficulty. The stringent targets set by the companies for completion percentage sometimes force the underwriters and the operational team to resort to unhealthy practices like forged signatures, manufactured documents to achieve the daily TAT and targets.

The Claim settlement practices

The insurance companies have set targets for claim settlements. They are to be settled within certain time from the date of claim intimation. The deadlines are stringent and failure to achieve the targets

will have its toll on operational staff appraisals. The companies have set these deadlines for customer satisfaction and delight. Unless the claimants cooperate in submitting all requirements, viz, death certificate, hospital certificates, employer certificates, FIR, PMR and Inquest reports etc, the operational team find it difficult to settle the claims. But the deadlines set by the companies for settlement hang like the proverbial sword of Damocles. To ensure that claims are settled within the TAT, the operation team resort to unethical practices like issuing all the forms upon receiving the claimant letter and book the liability only on receipt of all forms. The customer is forgotten in this bargain.

In the case of maturities the practice of writing the cheques without requirements and dispatch them on receipt of all requirements are still in vogue in certain life insurance companies. The gap between theory and practice is never bridged.

Direct Customer related practices

The aim of any company / institution is reaching out to its customers, understand their needs and communicate with them in their language. Whether our communications with our customers are really complete, in the sense that are they really being understood in the way they are to be understood, is the big question. Take the following cases:

- The policy bond that is handed over to the customer consists of all relevant and irrelevant details for an individual customer by resorting to pre-printed stationery. For example, a customer has not opted for accident benefit rider in the proposal but still accident benefit provisions are printed in the policy with the remark that these conditions are applicable if the accident benefit rider is opted for by the customer. For Single Premium policies, the details with regard to days of grace, the requirement details in case the policy lapse etc are also printed. What is lacking is we are viewing the customer in the herd without giving individual customer attention and focus. The customer needs to read all the details even though they are not applicable for his policy. Again the bond is printed in English and may not be understood by the bulk of our rural customers.
- The wordings of the policy bonds of some companies are so small that it requires special and exclusive attention to decipher the letters. The purpose of the bond is to explain the contents of contractual obligations. If it cannot be read out, the very purpose of issuing the bond is negated.
- The accounts statement available under the policy is not easily understood by the customers. Sometimes they cannot be explained either by the operations or marketing staff. Frequently the queries related to account statement are referred to head office for clarifications.
- Letters are not addressed to the customers in the language in which they have been addressed to the company. The staff in the offices are not sufficiently trained to draft letters to the customers.
- Usage of insurance jargon in ordinary letters addressed to the customers, viz, FUP (First unpaid premium), admission of claim, DGH (Declaration of Good Health), MHR (Moral Hazard Report) etc. acts as a big constraint in proper communication.
- Keeping huge amounts as policy deposits and proposal deposits; and keeping huge amounts in cheque unclaimed/ written back accounts are some other objectionable practices.

What is lacking is we are viewing the customer in the herd without giving individual customer attention and focus.

Conclusion

The practices of life insurance companies at the ground level in Sales, Operations, New Business, Claims have still wide deviations from the accepted theoretical norms and rules. Sometimes these have led to customer dissatisfaction and wrought the toll on repeat sales. They also led to free look cancellations, untimely surrenders, lapsations etc. These practices are getting progressively minimized with the intervention of IRDA but not completely eliminated at the ground levels. As the scope of this article is not aimed at finding remedies, I leave it for scholarly debate either for reducing or eliminating them in due course of time frame.

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Retail Distribution Review

The Way Forward?

NIRMALA AYYAR ASSERTS THAT THERE IS A HUGE CULTURAL DIVIDE BETWEEN INDIA AND UK; AND DOUBTS WHETHER THE IMPLEMENTATION PROCESS OF RDR CAN BE THE SAME.

A topic that occupies the thoughts of financial product providers, corporate agents as much as that of individual agents nowadays, is the move of the SEBI to abolish entry load on Mutual funds with effect from 1st August 2009. Because, the buck is not likely to stop there. the insurance companies; Life as much as Non-life, the Pension market, Mortgage loan providers and similar setups are all worried over the impact a similar move is likely to have on their business plans. The NPS is already trying to sell its business without the inducement of commission to salesmen. The IRDA has capped charges on fund management. A whole way of life seems to be at stake.

Distributors make money from commissions paid by sellers of products. Distributors offer rebates to consumers. Product providers push sales of their products by using commission as the lever. This has been the sales mechanism that has been driving the financial services market till now. Everybody understood it. Everybody knew that the products sold to the consumer may not really be what he or she really needed, and also that the commission paid and service rendered were two dissociated entities having no relation whatsoever to each other; that the person selling the product knew as little of the market as the buyer, and the product providers knew even less of the buyer or the seller. However, that the mechanism worked is indisputable as witnessed by sales figures published. AUMs have grown like Jack's beanstalk, individual agents have grown rich through commissions, corporates have earned a lot of money. The Government has also benefited by the tax income on such huge earnings. The common man has not protested. So, why the mooted need for change? It may prove to be "a sea change, rich and strange", or it may prove to be like many change management attempts, ending up only changing the labels, putting the same wine in new fancy bottles.

The awakening is possibly an echo of the RDR – the Retail Distribution Review, launched by the Financial Services Authority (UK) in June 2006. The proposals are likely to be finalized by end of October 2009, and implementation is expected to be complete by end of 2012, not through changes in regulation, but only by guidelines issued and through supervision and penalties for non-compliance or violations. Mr Peter Akers has expressed the hope that perhaps India will have time to learn from the experience of UK in the implementation. However, current trends in India seem to belie such hope. It is as if

Product providers push sales of their products by using commission as the lever. This has been the sales mechanism that has been driving the financial services market till now.

India Inc is in a hurry to adapt the RDR proposals and prove their worth. In the context, it may be worthwhile to understand the RDR proposals in some detail, and understand the implications for India.

The major issue is defined as: "Differing rates of commission or other types of incentives offered for sales undermines trust in the investment industry, and create conflicts of interest that could be damaging to the consumer. It is the extent of

incentive (including so-called "soft commissions", paid in non-monetary forms) that drive the sales and not whether the product meets the needs of the consumer. It is proposed to bring an end to the current commission system and let the advisor set his own charges, and collect it directly from the consumer or arrange to get it deducted by the product provider from the payments made by the consumer. The choice is that of the consumer". The new regulation is aimed at letting the consumer decide how much he wants to pay for the service, rather than the product provider deciding how much the consumer should pay to help the provider increase his sales. Succinctly stated, the purpose of the RDR proposals is to:

- Improve consumer confidence in the market for investment by:
  - Removing product provider influence over adviser remuneration
  - Improving clarity of services offered by advisers
  - Setting higher professional standards for all investment advisers
- Improve the distinction between independent and non-independent advice
- Increasing consumer protection through the above measures
- Improving public awareness regarding the nature, cost and scope of advice
- Improving sales through better consumer trust

Any agent, even if he was a school drop out, could sell an endowment policy, and he would have done a service to his client.

As a result of the successful achievement of the above purposes (1) in the long term, the advisers may become more consumer-centric by focusing on price / quality trade off to attract new customers, and, (2) Product providers may also focus on designing better quality products and more efficient distribution channels.

There can be no doubt whatsoever that these highly desirable ideals are what any Government or supervisory body, in India or UK, would like to achieve. It is also quite clear from the mission statement that the problems are the same whether it is India or UK. However, there is a huge cultural divide between the two countries, and the implementation process can hardly be the same. The FSA in the UK is a very active body and has been certifying professional advisers for a long time. The West is also very document oriented, and the public response to such practices has been positive. In India, there has not been much emphasis so far on professional qualification for financial services agencies, though some beginnings have been made. The financial services agency has been used mostly as a means to a supplementary income and those that have made it their full time career and made a success of it are but a small percentage. Therefore, let us look at the pros and cons of the proposals as applied to India, in some detail.

One crucial proposal is to insist on the adviser to disclose to the customer what type of service he is offering, and what it will cost. Towards this end, the advisers are to be classified into Independent advisers and Non-independent advisers. Non- independent Advisers are those who are tied to a single product provider, and are expected to know well all the investment products supplied by that product provider. In other words, their expertise is limited to those products only. This they have to make clear to the customer in advance. They can analyse the client's needs, and recommend the product best suited to his needs from among the products provided by the provider to whom the adviser owes allegiance. But they cannot offer any advice regarding similar products in the market, and how the product they are selling compares with those others.

One cannot but recall the days in LIC when the Endowment policy occupied a pride of place because it is easy to explain to the client that "Live or die, the money is there, for you or for your loved ones". You cannot go wrong either in explaining the benefits or in selling the policy. Any agent, even if he was a school drop out, could sell an endowment policy, and he would have done a service to his client. The situation in India today is very different. There are lots of product providers and each one has a sizable spectrum of product offerings.

The independent adviser is expected to familiarize himself with all the products of all the product providers, know the pros and cons of each, make reliable comparison among same product type from different vendors, and also know substitutable products from other product categories, decide what is best for the client, and offer it. He can take the help, in UK, of the software provided by FSA for such purposes, but should not accept similar software from any product provider supplied as an incentive to sell his product.

The ignorant client will be put to embarrassment to decide how to remunerate the adviser in the absence of required data, and will pay whatever the adviser claims

In India, there are money market magazines carrying out comparative surveys every now and then, but whether they are as comprehensive or as reliable as the FSA expects it to be is a debatable issue. At present there is no mechanism in India to ensure that any adviser – corporate or individual – can attain the level of competency stipulated by the FSA. It is doubtful if such a level can be attained at any time in the future either, considering the number of products that are on the table. One is led to the conclusion, that there can be no adviser, individual or firm, fit to be qualified as independent in the sense defined by the FSA. If they can be depended upon to know well at least all the products of even one vendor, they would certainly qualify for a higher fee or service charge, than those who do not.

But how is the customer to know, if a firm or agent claims he is an independent adviser, and is giving a comparative estimate by showing some data? It is to assume that the customer knows all similar products available in the market, and he is in a position to accept or challenge the comparative data shown by the adviser as comprehensive. Only on such knowledge can the client decide how much to remunerate his adviser. Any client having such knowledge does not really need an adviser. The ignorant client will be put to embarrassment to decide how to remunerate the adviser in the absence of required data, and will pay whatever the adviser claims, which may only slightly be less than what he had been getting by way of a mandate by the product provider (albeit it was the client who paid the commission). As far as the client is concerned, he may neither benefit nor lose more than before. It would be best for the regulator to assume a basic delivery value and mandate the remuneration, with a proviso that if the customer is happy with the service, he may top up the value with another 2% of the basic stipulated.

The FSA proposes an elaborate need assessment sheet that should be prepared by the adviser and to be scrutinized and certified by the product provider, subject to audit by the FSA. This document is to ensure that the adviser has given a fairly dependable analysis of the need of the client and has given unbiased and reliable advice. For a small country (in geographic size) like the UK, the cost of supervision and enforcement of these norms is expected to be around 2 million pounds in one-off costs, and 1.2 million pounds recurring costs per annum. But, for the adviser firms themselves, the cost could be around 430 million pounds one-off and, 40 million pounds annually.

Apart from the need analysis document, the FSA has designed an elaborate Services and Cost Disclosure Document (SCDD), that will have to be shown to the client before processing his case. This document will detail whether the service offered by the adviser is independent or non-independent, the scope of services offered, and the fees to be charged for the service. Only if the client agrees to the terms stipulated in the SCDD, further processing of the client's needs will take place. Apart from the cost aspect, the documentation aspect is what will meet with the greatest resistance in India. Even a basic document like the proposal for life insurance is skimpily prepared and indifferently filled and will not stand scrutiny in a court of law, notwithstanding all regulations to the contrary. The Indian, whether it be the customer or the vendor, has a pathological aversion to documentation. The only professions that seem to delight in documentation are the legal and management consultancies. In the circumstances, there is absolutely no likelihood of an SCDD being filled or filed in India, unless it is a fully pre-printed document requiring only the counter signature of the consumer. As for the need analysis document, since that will have to be certified by the vendor of the product and be available for audit, no regulation or rule may ever be able to ensure that it is implemented.

Talking of the cost aspect, the FSA proposes that the product provider will not be permitted to offer training or provide financial help to acquire professional qualification for individual agents or firms, as an incentive. The FSA itself has raised the doubt whether the individual would be able or willing to spend on acquiring professional qualification. In India, there can be no doubt whatsoever that individuals, unless they are already well established in the field while they are yet young, will not spend any money for acquiring professional qualification. To ensure that there are persons with professional qualification in the field, the only way would be to offer it as a full-

fledged course in colleges, in which case, those with inclination in the field will take up such courses and qualify. However, just as a Ph.D or an MBA is no guarantee of performance in the field, a person acquiring the degree may not be counted upon to deliver in practice. On the other hand, lack of a professional degree has not been a deterrent to many top sellers of financial services, who enjoy the full confidence of their clients. Any system, to be viable, needs to promote both the academician and the pragmatist, to realise the full potential.

If a rule of the law is insisted upon in respect of professional qualification, according to Oxera, the firm that undertook research on behalf of FSA, there could be a 20% drop out from firms among the independent sector, and who may join the non-independent sector. Even in the UK, 75% of advisers would be required to raise the level of their qualification to fall in line with the proposed regime. The percentage projected by Oxera is felt to be too high by the FSA, and though they expect that there may be a rise in the price of products in the short term, the changes are not likely to impact the market structure adversely in the long term, either with regard to quantum of business, or with regard to number of intermediaries operating. However, they do anticipate a switch in the nature of products sold which may take a bias in favour of products with a commission component like pure protection products. Another impact anticipated by Oxera is an unwinding of cross subsidies that could increase cost of advice for smaller sum investors, while large sums investors stand to gain.

It is necessary to disclose that the advice tendered is Basic and Restricted (restricted to products sold by the stakeholder only, and therefore to be remunerated accordingly).

In the ultimate analysis, the FSA has conceded that "without either an explicit or implicit product recommendation there may be insufficient take up of products to make the process commercially viable". The industry is inclined to favour adopting a "simplified advice process" to provide the consumer with a suitable personal recommendation based on an assessment of their needs, noting that this is an important cost-driver for their business models. But the FSA is concerned that such a move may lower the level of professionalism, and undermine the attempts to raise standard of professionalism across the industry. In order to allay the fears of the industry, "on further reflection, and to support the wider stake-holder regime", the FSA has agreed to retain the "Basic Advice Regime". In this process the consumer is asked some pre-scripted questions about their income, savings, and other circumstances to identify the consumer's financial priorities and suitability for a stakeholder product, but a full assessment of their needs is not conducted nor is advice offered on whether a non-stakeholder product may be more suitable. The added condition is that it is necessary to disclose that the advice tendered is Basic and Restricted (restricted to products sold by the stakeholder only, and therefore to be remunerated accordingly). Professionalism qualifications requirements need / will not apply to Basic Advice.

A recent report in the Economic Times describes the scenario one month after the abolition of entry load by SEBI. It reads like a forecast for the future of Financial Services incentives scenario. "Essentially, there are three models by which distributors can charge investors. They can charge a flat amount per investment. Or they can charge a percentage of the invested amount. Or they can charge nothing. All three are being tried, with some variations."

The nothing option works only because fund companies are still paying commission to distributors. They are paying some amount of upfront commissions. Along with that, they will continue to pay the so called trail commission which is mostly around 0.75 per cent per annum of the value of the funds.

Many distributors, including some very large ones appear to have reconciled themselves to this ground zero. My guess is that the free mode will come with some strings attached. The service and advice level is likely to be minimal.

In the circumstances, the move of the PFRDA to fix fee bands ought to be a welcome measure, as it will eliminate the embarrassment for the customer, will do justice to both the customer and the service seller, and will not stand in the way of better qualified people rendering better service from getting willingly paid better by the consumer. It may also help pave the way for creating a professional advisory service through a gradual transformation process.

The author is a Retired Senior Officer, LIC of India. Views expressed are her own.

The Office of Insurance Ombudsman

Role Demystified

BIKAS CHANDRA BOSE WRITES THAT ALTHOUGH THERE IS NOTHING IN A NAME, STILL AN INSTITUTION CREATED TO SERVE THE COMMON MAN PERHAPS DESERVED A NAME, LESS UNCOMMON.

When somebody states that "Insurance Ombudsman is 10 years old now", it is an innocent doublespeak, evidently referring to the institution and not to those who don its mantle. The factual strength of the statement is derived from Redressal of Public Grievance Rules (RPG) of 1998, introducing in law the institution of Insurance Ombudsman, having thus its age now as 10 years (last birthday). It is hence, just a few years younger to its counterpart in Banking (1995). True, that couple of years elapsed in operationalising the law through actual placement of personnel, but it is usual to trace initiation of such institutions from dates of enactment. In that significant sense, the RPG Rules and the institution that it introduced, completed its very first decade marching on to its adolescence.

There seems to be no two opinions that 10 years is not at all a long period, in the life even of an individual, not to speak of an institution. Still a decade is considered as a landmark, imparting a commemorative significance to the references to various aspects that unfolded themselves, in course of time that the institution evolved.

This write-up assumes in that sense a temporal relevance. It neither starts with appraisal of Ombudsman's performance nor ends up with a recommendatory wish list. It is focused to figure out how the RPG Rules and the institution, are taking shape in the eyes of the Judiciary with reference to a few citations. The write-up also touches on contributions made by Judicial interpretation of Rules, making the institution stronger in terms of law and efficacy, as it evolved in the very first decade. There is obviously no claim to comprehensiveness, in view of enormity of materials available on the subject.

In a lighter vein, although there is nothing in a name, still an institution created to serve common man perhaps deserved a name, less uncommon. In fact, it seems that India is still to decide whether 'U' in "Ombudsman" is to be pronounced as "U" in Umbrella or "U" in Union. "Lokpal' is a much more convenient term, but in public perception it seems to get mixed up with "Lokayukt" and its sub-systems, carrying vaguely an ethos of a vigilance outfit, rather than a support system for insuring public at the grassroot level.

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A common approach to ease, the position is to describe Insurance Ombudsman as "Quasi Judicial Forum" for grievance resolution, which is much easier to comprehend by all concerned.

There are, however, a few issues that crop up from such description. First, what is

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Quasi-Judicial? Or, at a more primary level, what is Quasi?

Black's Law Dictionary, puts the meaning of Quasi, as:-

> "Seemingly, but not actually / in some sense / resembling ....."
>
> "It negatives the idea of identity but implies a strong superficial analogy."

On the term Quasi-Judicial, Administrative Procedure Act states:-

> "With the exception of rule-making, any decision by an administrative agency created by law, that has a legal effect, is a quasi-judicial action."

In other words, when an administrative agency, created by legislature, takes decision that carries legal effect, though not arrived at through judicial process – the Agency concerned gets a Quasi Judicial status. To be more complete, orders of a Quasi Judicial Agency carry stipulated judicial effect, provided "there is no abuse of discretion", even though not preceded by compliance to judicial procedure.

In this background, it is worth noting that RPG Rules does not use the term "Quasi Judicial" to connote the status of Insurance Ombudsman in law. Hence it may not be enough in strict reckoning, for the Ombudsman himself or his allied bodies to declare the position as Quasi Judicial. The epithet will be appropriate in law, if Judiciary explicitly assigns the same to Ombudsman. Again, as Quasi Judicial means "resembling Judicial", it is necessary for Judiciary to specify the judicial authority to which Ombudsman resembles.

A search for answer to these two important queries, takes us to a couple of Judgments, brief reference to which is made below:-

First citation is in the matter of Ashok Kumar Dhingra & Others vs. Oriental Insurance Company & Others (AIR 2004 Delhi 161). It was a dispute on non-payment of a Medi-claim. However, the facts of the case are not as important in the present context, as the comments on the status of Insurance Ombudsman contained in the Judgement. The Hon'ble Delhi High Court inter-alia stated (CW 876/2002) that "Insurance Ombudsman is a quasi judicial functionary for the very purpose of speedy settlement of disputes and claims". The Hon'ble Court further observed that "it is the Forum where the Petitioners choose to go for redressal of their grievances. That remedy is adequate and efficacious."

Thus, the Judgement unambiguously described, the Insurance Ombudsman on examination of RPG Rules, as an adequate and efficacious quasi-judicial functionary. It is an interesting example of how the words that remain unspoken in law, get expressed in the process of institutional evolution, by judicial pronouncements.

In respect of the second query, reference is being made to one other citation and here again facts of the case are less relevant than the comments in the Judgement. It is in the matter of Royal Sundaram & Anr. Vs. Smt. L.O. Lepcha & Ors. [W.P. (C) No. 15913-14 of 2006]. Hon'ble Delhi High Court Judgement in the case equated Insurance Ombudsman to an Arbitrator and commented that the Ombudsman as "the Arbitrator, is the sole judge of the quality as well as the quantity of evidence" and "it is for the Arbitrator to interpret the terms of contract." The Hon'ble Court further observed that the Insurance Ombudsman, being in the role of an Arbitrator, is only bound by "the stipulations and prohibitions contained in the Agreement" and that "if the award is made fairly not travelling beyond his jurisdiction", then such "award is not amenable to correction by the Court."

The two citations taken together, fortify Insurance Ombudsman as quasi judicial functionary equivalent in law to an Arbitrator. Such explicit positioning of the institution by Judiciary in the overall legal system of the country, marks a definite improvement on the provisions contained in the governing RPG Rules. This valued judicial recognition, is a gain for both the Rules and the Institution, within its very first decade of introduction.

While judicial pronouncements thus provided strength as noted above, there is at least one area of persistent problem vis-à-vis Commissions and Courts, which

deserves a mention. It is in respect of Complaints / Cases being allowed to be filed against Ombudsman or making Ombudsman, a party. The matter received attention of Insurance Council, but impact of any steps to counter it, did not get reflected in practice. On number of occasions, Ombudsman received notice either as the only opposite party or as 1st party or as one of the necessary parties. The result is misdirection of activities of Ombudsman from resolving disputes to absolving himself.

The inappropriateness of the process is too obvious. There is no provision in RPG Rules for review of Insurance Ombudsman's order by any forum / authority. Whether absence of any such provision is justified, is a debate not relevant in the context of the present paper. First because, the rules are to be followed as they stand, till amended. But more so, because, even if there was such a provision in the RPG rules, the designated authority for review would not have required the Ombudsman, as a quasi judicial functionary, to be made a party in such a review. In other words, what is to be reviewed is the order of a legal functionary and that need not mean impleading the functionary to defend his order either by himself or by a lawyer on his behalf.

The position might have been otherwise at a time when the RPG rules did not specify the quasi judicial status of the Ombudsman. But after the Hon'ble Courts had unambiguously assigned the status, the inappropriateness of impleading the Ombudsman by sending notices against them, becomes all the more apparent. It is true that the Courts had cancelled such notices on pleading through Lawyers and deleted the name of Ombudsman from the list of parties (eg. Hon'ble Gujarat State Commission in its Order dated 22.4.04 on Revision Application No. 8/2004). But that is no consolation when to allow making the Quasi Judicial functionary a necessary party, is an instance of misjoinder *ab initio*.

It is instructive to observe that even Hon'ble Apex Court stood against impleading such functionaries. Although in a different context, but it is relevant to mention the citation in the passing. It was in the matter of Andhra Pradesh SRTC Vs. State Transport Appellate Tribunal & Others (AIR 1998 SC 2621). The Hon'ble Supreme Court in its Judgement dated 11.8.98, inter alia commented to the effect that while making judicial assessment of the order passed by a functionary, designated by law, there is no necessity for him to be made a party in the proceedings.

The Hon'ble Court further observed that there is absence of "any merit in the contention" that if the functionary is not made a party, his orders cannot be judicially reviewed. In the context of this paper, the message is that, even if the order of Insurance Ombudsman is examined by a Court, it is not necessary to implead him as a party.

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As most of such matters come up before District / State Commission, it may be worthwhile for Ombudsman's Office (preferably along with representative of GBIC), on appropriate preparation, to approach the Hon'ble State Commissions, urging upon the Authority not to entertain petitions that make Insurance Ombudsman necessary party. At least a beginning can be made by approaching selected State Commissions and in case, the result is positive, its concerned State Commission may be requested to advise properly the related District Commissions, not entertain petitions making Ombudsman a party.

It is also interesting to observe how Judiciary expressed itself as to what is considered as proper role for Insurance Ombudsman in its functioning and how such position taken by Courts, impinge upon the Ombudsman to undertake sort of a tightrope walking.

In the matter of United India Insurance Company Ltd. Vs. Insurance Ombudsman Chandigarh & Anr. (CWP No. 1129 of 2008) Division Bench of Hon'ble High Court of Punjab & Haryana, inter alia commented:-

> "The Insurance Ombudsman has rightly adopted the approach of a common man which may not necessarily be the strict legal approach. The basic object of such like Agencies is resolution of disputes without getting into niceties of law."

The message is clear that the Ombudsman is to focus on disputes of facts and analysis

Emergence of such grey areas, is common in the evolution of an institution. These are to be approached as challenges of institutional evolution which cannot be without pains.

of facts and not to try to delve in nuances of law and the task is to resolve questions of facts from a common man's point of view.

Hon'ble Delhi High Court commented in the same vein (in the matter of Ashok Kumar Dhingra & Others Vs. Oriental Insurance Company) :

> "…… the settlement of the claim involves examination of disputed questions of facts. ……... these questions are best left to be determined by the Insurance Ombudsman."

But there are other judicial comments that seemingly constrain even the domain of "questions of facts", as the Ombudsman takes up a dispute for resolution. To illustrate, in the Order on Special Leave Application No. 13440 of 2007, the Hon'ble High Court of Gujarat commented inter alia that "Where the disputed questions of facts that has been raised by the Petitioner may require leading of evidence by it to support the case", "the order of the Insurance Ombudsman is without any authority of law."

The above three pronouncements read together give the message:

a) that question of facts (and not question of law) is the domain of Ombudsman.

b) even in a question of fact, if either party may require leading of evidence to support its case, the Ombudsman should relent.

Thus an unwelcome position may be, to avoid the fora by harping on the need to lead evidence, forcing the Ombudsman to get into a tight rope walking – to deal or not to deal with the matter. Seemingly, one gets glimpse of a grey area. Seemingly again, emergence of such grey areas, is common in the evolution of an institution. These are to be approached as challenges of institutional evolution which cannot be without pains.

But if there is emergence of uncomfortable position as in the above instance, there are other instances in which Judicial pronouncements interpreted clause of RPG Rules, contributing necessary clarity that the law as laid down in rules, lacked.

The point gets illustrated with reference to Rule 13 (1), of RPG Rules. The Section inter alia stated that "any person" with grievance against an insurer can lodge a complaint with Insurance Ombudsman. Contention was raised that, when the terms "person" has not been defined either in the Insurance Act or in the RPG Rules, definition of "person", as in the General Clauses Act, Section 3 (42) is to be adopted and consequently, the expression, "any person" takes "incorporated Company as well."

Division Bench of Hon'ble Kerala High Court while allowing WP No. 224/2003 (National Insurance Vs. Indus Motor Company & Anr.), gave its valued interpretation that "any person" in Sec. 13 (1) of RPG Rules, is not to include "incorporated company". The Hon'ble Court observed that its interpretation is only in consonance with the intention of the legislature, "found by reading the statute as a whole", taking into particular account that, the RPG Rules "places emphasis on the words 'individual', 'personal lines', himself or through legal heirs etc." In addition, the Judgement contains a reasoned negation of application of General clauses Act in this regard.

Thus, judicial interpretation refined the RPG Rules, by clearing out ambiguity, significantly impacting the operational area of Insurance Ombudsman. It saved his portfolio dedicated to individual policy holders from invasions of incorporated bodies, who can take their grievance to other available forums.

There are other aspects too and other citations of similar relevance. The few, referred above, demonstrate by way of illustrations as to the way that that institution of Insurance Ombudsman is evolving, drawing contributions from judicial pronouncements. On that count, the first decade ended well raising expectations that, the institution will pass healthy adolescence, with incorporation of further refinements in the years ahead.

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Underwriting Losses

Time to Ponder

R. P. SAMAL MENTIONS THAT A COMPANY'S FINANCIAL HEALTH AND REPUTATION IN THE MARKET DEPEND ON EFFICIENT AND JUDICIOUS SETTLEMENT OF CLAIMS; AND HENCE, SUCH A VITAL ACTIVITY SHOULD NOT BE LEFT ENTIRELY TO THE OUTSOURCED AGENCY.

The underwriting loss of Rs.3566 crores for the year 2008-09 gives a wake up call for the PSU general insurance companies to see the writing on the wall, think and find out solutions with absolute urgency. The speed and severity of the downturn took many people by surprise because it is the highest loss recorded ever. The cat is already out of the bag and the truth is that some of the PSU companies are conducting business with 132% combined ratio, which in common man's language means that while income is Rs.100/-, the expenditure is Rs.132/-. Such results make a very disturbing reading indeed. If we keep losing Rs.3566 crores a year, time will not be far off when we will have nothing left to lose any more. Therefore, our objective should be keen and focussed in matters of reducing combined ratio to an acceptable limit. The prime method to achieve this objective is to feel concerned. Only when we are concerned, we can visualise a solution. Much may not be done in reducing management expenses but more can be done in controlling claim costs which generously contribute to underwriting losses.

Our property claims are managed by surveyors, liability claims by lawyers and health claims by TPA who are not as accountable for their errors of omission and commission as our employees are.

Visiting Claim Sites: a small step but a giant step for better results

Claims are the final products of an insurance company. Any company's financial health and reputation in the market depend on efficient and judicious settlement of claims. Such a vital activity should not be left entirely to the outsourced agency. Our property claims are managed by surveyors, liability claims by lawyers and health claims by TPA who are not as accountable for their errors of omission and commission as our employees are.

In a study conducted among a hundred participants from four PSU companies, it was revealed that leakages in claims are to the tune of 20% by a conservative estimate which means about Rs.3000 crore goes down the drain every year. To tackle this, companies can form the Claims Minimisation Team (CMT) choosing intelligent, dedicated, honest and enthusiastic people to do this most important job. They should, along with the department officials, visit the site of claim; make a conscious effort to take inventory of the loss; follow up for documents and discuss with both the surveyor and the insured; and arrive at the assessment of loss as soon as possible. This has been tested and experimented resulting in an automatic reduction of claim cost by as much as 30%. And this is by a mere visit. More can be achieved by putting in intelligent and sincere application with a view to reducing the life cycle and quantum of claims.

Take for example – A consignment of medicine was despatched from Mumbai to Goa by a truck and was insured with a

private non-life insurer – valued at Rs.50 lakhs. The truck collided with another in Goa and the consignment got damaged. It was the monsoon month of July and thus the insured panicked and intimated to the underwriters in Mumbai. Immediately two officials of the insurer along with the surveyor took the earliest flight to Goa, hired a godown, segregated the good from the damaged in the presence of a drug inspector and the loss was assessed on physical verification then and there for Rs.35,000/- only. The insured accepted the assessment and got most of his consignment saved. This is one of the many examples as to how claims are handled in private sector; and have every reason to be emulated.

The regional heads may be given the primary task of minimising losses and generating profit. With tariff disappearing and market slowly becoming broker driven, they have all the time in the world to visit the site of high value claims to have a look at the extent of damage in its original form rather than depending on the interpreted version of the surveyors. In short, assessment of loss is a vital financial activity and therefore should not be left to the outsourced agencies especially when companies are bleeding profusely.

Diverting Audit Team to Claims: Maximum Utilisation of Human Resources

Audit team is synonymous with a group of extra-ordinarily talented people. But the kind of efforts they are putting in going through volumes of documents and hundreds of activities results in hard labour being lost without producing desired results. A part of the audit manpower may be utilised for claims management. If 60% of manpower in present system of audit doing the dull and routine check up is diverted to form claims management team, there certainly will be a turn around in companies' profit and loss account which at the moment is in the red. If they visit the site of claim, apply their basic intelligence, utilise their experience and participate actively in claims assessment, companies will most certainly regain their lost financial health. These esoteric few thus selected can do wonders if they have a capacity to generate interest, the willingness to know and the necessary conviction for execution of one of the most assured objectives of management – increasing shareholders' value through cutting claims costs.

Surveyors should be appointed by the insurance officials on a case to case basis and must not be picked up by the dealer from the panel.

Auto Tie Up: Let them not take us for a ride

This is another area where companies are bleeding profusely. We release payouts to the dealers to the tune of 40% on premium received and pay claims inflated to the tune of 40% as compared to repair expenses in outside garages. What benefit do the insurance companies get out of it is the million dollar question. If a company receives a premium of Rs.900 crores and pay claims amounting to Rs.1300 crores, it is most non-business like. It is believed that auto-dealers make more money from insurance than from their own business of selling motor vehicles.

Insurers should sign agreements dealer-wise on profit sharing basis keeping management expenses at the back of their mind. Surveyors should be appointed by the insurance officials on a case to case basis and must not be picked up by the dealer from the panel. Reviewing the performance of surveyors constantly is necessary to less utilise the more expensive ones. With such big loss ratios, the insurance company is at a better bargaining position to pull out of the tie up when it feels suffocating. It should always be appreciated that the *raison d'etre* for any modern business organisation is primarily good operating surplus. And it is high time we realised this fundamental economic principle.

TPAs : Let them be partners in Risk Sharing
Implementation of the very TPA system contributes a huge share of loss to insurance companies. Let us pay to the TPAs if they are giving us profit in the portfolio allotted to them and certainly not otherwise. Their fees should only be on profit sharing basis and not to be paid in advance.

Insurance companies have money and men enough to run their in-house TPAs, which will bring down the claim ratio drastically. At least the company will not have to pay TPA fees, which are in crores in addition

to huge load of claims, agent's commissions and broker's fees.

This should be more applicable to specific group mediclaim policies. Agreements with TPAs have to be signed in advance for serving such policies on 'no-profit-no-pay' basis.

Act to replace MACT: A Much needed Amendment

Jeremy Benthom, who was the proponent of utilitarianism once said, law of the land should be made for doing highest good for largest number of people. If this is true, the concept of MACT is untrue and not beneficiary friendly. The settlement ratio of TP claims is much less compared to claims pending and claims filed. There are 12 lakh cases pending pertaining to PSU companies alone amounting to Rs.16,000 crores of public money waiting for decades to be paid to the beneficiaries out of which, more than 99 percent are related to the poor, destitute and helpless.

The claim ratio in T.P is far beyond hundred percent which is a major contributing factor for underwriting losses. In a recent road accident in Goa, 15 NRIs died and in each one of the cases, claims of Rs.10 crores were made towards compensation in MACT, Surat. For a premium of Rs.4,000/- which the concerned vehicle owner had paid, no insurance company will survive if such a huge liability of Rs.150 crores arises in a single accident!

The only way to bring a solution to this huge problem is to make the compensation structured irrespective of person's earning capacity – say Rs.5 lakhs for death of an adult and Rs.2 lakhs for a child below 18. Insurance companies may be empowered to settle such claims directly after getting legal heir certificates and without complicated procedure of going through the court. The rich, which constitute much less than one percent of MACT claims, have enough money for their future and do not have to entirely depend on Third Party Compensation. The poor in turn will get hassle free benefit without paying fat fees to intermediaries like lawyers. Injury cases can be calculated as per Workmen's Compensation Act. This will relieve the insurance company of a backbreaking load of TP claims and will also benefit millions of families with compensation money at a time when they need it most. Under the suggested system, there would be less of manipulation and no filing of bogus claims.

It is a sincere appeal to our lawmakers to take note of this precarious situation and bring about a bill in the parliament authorising insurance companies to pay this simple and rightful compensation directly thereby doing good to the maximum number of countrymen. This will in turn save the lawyers fees on either side because services of learned advocates are not required for such simple matters of claiming and receiving rightful payments. If this is not done, it is most likely that the problem will remain unresolved for next several years.

When the identity of the insured and the vehicle in the accident are known, only the insured may be directed to produce the policy copy or else pay the compensation.

Orphan Claims: Wild Search For the Real Parents

The matter is very simple and solution simpler. When the identity of the insured and the vehicle in the accident are known, only the insured may be directed to produce the policy copy or else pay the compensation. But the matter gets complicated by asking a particular insurance company to prove that they have not issued any such policy covering the vehicle in question only because the said company's name is mentioned in police documents as the insurer. Under such circumstances, we should conduct an investigation on the insured and move an application in the Tribunal to get the policy particulars from the insured failing which the company's name may be appealed for deletion from the list of defendants. In reality we remain indifferent for years until suddenly the judgment copy arrives one day directing us to pay such claims. Then it hits us like a war missile during peacetime.

Eternal vigilance is the price of liberty. It is also the price of being both efficient and effective. Our advocates should be vigilant and we should be more vigilant. We should have a special cell defusing such claims before they reach flash points. More often than not, we land up paying such claims that should have been paid by the vehicle owner for not taking an insurance policy.

Delay is the greatest epidemic that the companies are plagued with. Reputation of the companies is tarnished despite their paying the rightful compensation because they delay it beyond tolerance limit.

And unfortunately such claims are many and make a big dent in our balance sheet and all such uninsured people go scot-free transferring their liability to us. And no lessons learnt for such people in our society.

Cutting Down Layers and reducing delay

Delay is the greatest epidemic that the companies are plagued with. Reputation of the companies is tarnished despite their paying the rightful compensation because they delay it beyond tolerance limit. For a claim of Rs.5 crores, 20 signatories are required from BO / DO / RO / HO. Nobody knows what is inside the file except the insured and the surveyor because those who put their autographs never visit the site of claim to see the original damaged insured property. They rely on assessment of the surveyor, which is only an individual point of view, which may sometimes be outright wrong and sometimes not right enough. If we pay quickly, the mind of the insured will not be corrupted to take advantage of the mishap and inflate his claim. To implement the removal of layers, claim should be handled directly by the office whose financial authority it comes under after initial inspection of the site of loss.

Training: Making it more Down to the Earth

What is needed is more and more practical training through visits to the claim site. No teacher is greater than practical experience. No knowledge can be compared to practical knowledge, which our industry people are having very little scope to acquire. The only people who are trained in the process are the surveyors because they anatomise hundreds of risks by hands-on experience, reading and re-reading the policy condition each time they are allotted a survey job. All other trainings are horizontal but practical training is vertical and utilitarian. More focus should be given on such visits to sites of claims and make the employee participate in the process of claim assessment in detail than making them read reports and sign claim notes.

Mission Possible

If a private insurer of the Indian industry can settle a project claim in Dubai in thirty days why can't his public sector counterpart? Similarly, in the area of claim minimisation; and settlement of health insurance claims, there is a lot that can be achieved. After all, the human resources of the private players are ex-public sector ones. If they can generate sizeable underwriting profit, why can't we. Before this problem snowballs into crisis, let us become pro-active and adopt some of the principles the private operators are implementing for better results. We have the potentiality, we have the time and yes, we can do it.

The author is a General Manager of New India Assurance Co. Ltd. and is currently on deputation to Agriculture Insurance Company of India Limited.

''ನನ್ನ ಕ್ಲೈಮಿನ ಎಲ್ಲಾ ದಸ್ತಾವೇಜುಗಳನ್ನು ಕಳುಹಿಸಿ ಈಗ ಮೂರು ವಾರಗಳಾದುವು .... ನನ್ನ ಹಣವನ್ನು ಅವರು ಬೇಗ ಕಳುಹಿಸಬಹುದೆಂದು ಆಶಿಸುತ್ತೇನೆ.''

''ಹೌದು, ಖಂಡಿತ. ಎಲ್ಲಾ ಕಾಗದ ಪತ್ರಗಳು ಸಮರ್ಪಕವಾಗಿದ್ದರೆ ಅದನ್ನು ಅವರು 30 ದಿನಗಳೊಳಗೆ ಸೆಟಲ್ ಮಾಡಲೇ ಬೇಕು. ಅದು ನಿಯಮ!''

ದ ಇನ್‌ಶೂರೆನ್ಸ್ ರೆಗ್ಯುಲೇಟರಿ ಆ್ಯಂಡ್ ಡೆವಲಪ್‌ಮೆಂಟ್ ಅಥಾರಿಟಿ (IRDA) ಇದು ಭಾರತದಲ್ಲಿರುವ ಇನ್‌ಶೂರೆನ್ಸ್ ಕಂಪನಿಗಳ ಸುಪರ್‌ವೈಸರಿ ಸಂಸ್ಥೆಯಾಗಿದ್ದು ಪಾಲಿಸಿ ಧಾರಕರ ಹಿತವನ್ನು ಸಂರಕ್ಷಿಸುವುದು. ಐ ಆರ್ ಡಿ ಎ ಅವರು ವಿಧಿಸಿರುವ ನಿಯಮಾವಳಿಗಳಲ್ಲಿ ಕೆಲವು ಹೀಗಿವೆ :

- ಸಂಬಂಧಪಟ್ಟ ಎಲ್ಲಾ ದಸ್ತಾವೇಜುಗಳನ್ನು ಸ್ವೀಕರಿಸಿದ 30 ದಿನಗಳೊಳಗೆ ಇನ್‌ಶೂರೆನ್ಸ್ ಕಂಪನಿಯು ಹಣ ಪಾವತಿ ಮಾಡಬೇಕು ಅಥವಾ ವಿವಾದ ವಿದ್ದರೆ ಸಂಬಂಧಿತ ಸಮರ್ಪಕ ಕಾರಣ ನೀಡಬೇಕು.
- ಪ್ರಸ್ತಾವನೆ ಅಂಗೀಕಾರವಾದ 30 ದಿನಗಳ ಒಳಗೆ ವಿಮಾ ಕಂಪನಿಯು ಭಾವೀ ಪಾಲಿಸಿ ಧಾರಕರಿಗೆ ಪ್ರಪೋಸಲ್ ಫಾರಂನ ಒಂದು ಪ್ರತಿಯನ್ನು ಉಚಿತವಾಗಿ ನೀಡಬೇಕು.
- ಪ್ರಪೋಸಲ್ ಕೈಸೇರಿದ 15 ದಿನಗಳೊಳಗೆ ಅದನ್ನು ಪ್ರೊಸೆಸ್ ಮಾಡಬೇಕು ಮತ್ತು ಪಾಲಿಸಿ ಧಾರಕರಿಗೆ ತಿಳಿಸಬೇಕು.
- ಒಂದು ವೇಳೆ, ಎಲ್ಲಾ ದಸ್ತಾವೇಜುಗಳನ್ನು ಸಾದರ ಪಡಿಸಿದ ಬಳಿಕವೂ ಕ್ಲೈಮನ್ನು ಸೆಟಲ್ ಮಾಡುವುದರಲ್ಲಿ ವಿಳಂಭವಾದರೆ ಇನ್‌ಶೂರೆನ್ಸ್ ಕಂಪನಿಯು ಒಂದು ನಿಗಧಿತ ಮೊತ್ತದ ಬಡ್ಡಿ ಕೊಡಬೇಕಾಗುತ್ತದೆ.
- ಜೀವ ವಿಮೆಯ ಪಾಲಿಸಿಧಾರಕರುಗಳಿಗೆ 15 ದಿವಸಗಳ ''ಫ್ರೀ ಲುಕ್ ಪಿರಿಯಡ್'' (ಪಾಲಿಸಿ ಕೈ ಸೇರಿದ ದಿನದಿಂದ) ಹಕ್ಕು ಇದ್ದು ಅವರು ಪಾಲಿಸಿಯನ್ನು ರದ್ದುಗೊಳಿಸಬಹುದು.
- ಪಾಲಿಸಿಧಾರಕರ ಯಾವುದೇ ನಿವೇದನೆಗೆ ಇನ್‌ಶೂರೆನ್ಸ್ ಕಂಪನಿಯು 10 ದಿವಸಗಳೊಳಗೆ ಪ್ರತ್ಯುತ್ತರ ನೀಡಬೇಕು

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• प्रकाशक का संदेश

एक दल द्वारा उठाया गया जोखिम दूसरे दल को जोखिम स्थानांतरित करने के औजार को बीमा कहते हैं जोकि मूल्य विशेष तथा विभिन्न शर्तों पर होता है इसमें इस बात का ध्यान रखा जाता है कि किस मूल्य पर जोखिम स्थानांतरित किया जाता तथा दूसरे द्वारा उसे कैसे स्वीकार किया जाता है। और किन शर्तों पर कारोबार किया जाता है वह उचित हो यह बहुत जरूरी है कि प्रक्रिया के लिए जो पूरी सूचना दी जाती है वह ययोचित तथा सत्य होनी चाहिये। इस प्रक्रिया को पूर्ण रूप से करने के लिए प्रस्ताव पत्र में कई परिवर्तन किये गए हैं जो कुछ समय अवधि में हुआ है। जब तक दोनों दल अपने तरफ की सूचना संजिदा रूप से बिना दुर्भावना के नहीं देंगे तो यह असंभव ही होगा की एक विस्तृत विश्लेषण प्रश्नावली तैयार की जाए। उदाहरणतः जीवन बीमा के क्षेत्र में कौन सी स्वास्थ्य परिक्षा बचपन के समय किसी घटना के मामले बता सकती है जिसके बीमा लेखन में कुछ प्रभाव हो, जब तक की उसको दृष्टिगोचर करते हुए शामिल न किया गया है।

ज्यादातर समय जो सूचना प्रदान की जाती है वह किसी कमी से प्रभावित होती है जोकि जानबुझ कर नहीं की जाती। यहां प्रस्ताव पत्र को बनाने की वस्तुपरकता सामने आती है साथ ही वितरक की भूमिका का भी पता लगता है। बीमाकर्ता को ऐसे तरीके निकालने चाहिये कि प्रश्न पत्र को पूरी तरह व्याखित किया गया है और तभी प्रस्ताव की अनुमति ली गई है। निम्न साक्षरता को ध्यान में रखते हुए जो जनसंख्या के बडे क्षेत्र में है। प्रांतिय भाषाओं का प्रयोग सामने आया है। पूरे प्रस्ताव पत्र पर जाने तथा उसे समझने के लिए उसके तत्वों का प्रस्तावक को समझाना चाहिये क्योंकी बीमा लेखन निर्णय पूरी तरह बतायी गई सूचना के आधार पर लिये जाते हैं।

दूसरी तरफ बीमाकर्ता को व्यवसाय के प्रकार, उत्पाद सम्बन्धित सूचना इत्यादि के मामले में पारदृश्य रूप से कार्य करना चाहिये तथा आवरण में अपवर्जन जोखिम स्वीकार करने की शर्तें विशेष रूप से। प्रतिस्पर्धात्मक स्तर में पारदृश्यता की अधिक आवश्यकता है जहां प्रस्तावकर्ता अपने विकल्पों का प्रयोग कर सकें जो विशेष व्यवसायी के प्रति होती है। जैसा की समय समय पर बताया गया है। शैशव बाजार में खुलेपन की निति को अच्छे से नहीं समझा जाता। बीमाकर्ता के लिए यह आवश्यकता है कि वह अतिरिक्त मील चले यह सुनिश्चित करने के लिए कि सूचना का प्रवाह बिना कंटक के तथा उद्देश्यपूर्ण है।

'बीमा में सूचना की असम्मति' इस अंक के जर्नल के केन्द्र बिन्दू में है। जिस सूचना का भंडारन किया जाना चाहिये, इक्कठा तथा विश्लषण प्रभावशाली ढंग से होना चाहिये। यह आवश्यक है कि उचित आंकडा भंडारण तथा उस पर पहुँच ठीक प्रकार हो। 'बीमा में आंकडा भंडारण तथा खनन' जर्नल के अगले अंक के केन्द्र बिन्दु में होगा।

जे. हरि नारायण
अध्यक्ष

दृष्टि कोण

यद्यपि बीमा के प्रतिभूतिकरण ने वर्तमान वित्तीय उत्पात में कोई भूमिका अदा की हो ऐसा प्रतित नहीं होता की इस पर कोई प्रभाव पडा है।

श्री पीटर ब्रामूलर
अध्यक्ष, आई ए आई एस कार्यकारी समिति

एन ए आई सी के शोधन क्षमता तथा पूंजी मानक ने यह सुनिश्चित किया है कि पॉलिसीधारक के प्रति बाध्यता को पूरा किया जा सके तथा कंपनी स्थिर रहें।

श्री थोमस आर सुलिवन
कैन्टीकट के बीमा कमीशनर

बीमा विनियामक के कार्यों में एक यह है कि बीमा कंपनियाँ हर समय पर्याप्त स्त्रोत रखे जिससे देयता का भुगतान किया जा सके, यदि उन्हें चाहे कल ही आना हो।

श्री जे हरि नारायण
अध्यक्ष, बीमा विनियामक और विकास प्राधिकरण, भारत

यात्रा के लिए मार्ग स्पष्ट है: समय के साथ बैकिंग प्रणाली में पूंजी आवश्यकता को बढाया जाना चाहिये, जबकि द्रव्यता के मानक सखत किये जाने चाहिये।

श्री लार्ड टर्नर
अध्यक्ष, एफ एस ए, यू.के

हमारे विवेकपूर्ण मानक पूंजी पर्याप्तता के इदर्गीद बने हैं। जो प्रभावशाली जोखिम प्रबन्धन तथा अच्छे प्रशासन के लिए है।

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हम यह सुनिश्चित करना चाहते हैं कि हमारी निवेश कंपनियाँ तथा पेंशन प्रदान करने वालों के लिए सता विश्व की सर्वोत्तम परिपाटियों के साथ तथा प्रभावशाली रूप से बारमुडा बाजार के लिए चले

श्री मैथ्यू एल्डरफिल्ड
सीईओ, बारमूडा वित्तीय प्राधिकरण

जीवन बीमा में कालातीत पॉलिसियाँ: कारण और परिणाम

डॉ. सुबोध कुमार और हरीश्चन्द्र रतूड़ी कहतें है कि बीमा व्यवसाय के नियामक के लिए भी यह महत्वपूर्ण विषय है कि जीवन बीमा पॉलिसियाँ कालातीत न हो।

जीवन बीमा पॉलिसी में प्रिमियम अदा करने की तिथियों का उल्लेख रहता है, उन तिथियों को प्रिमियम देय हो जाता है किन्तु प्रिमियम का भुगतान करने के लिए बीमादार को अतिरिक्त अवधि की सुविधा दी जाती है। इसी अतिरिक्त अवधि को 'अनुग्रह दिवस' कहा जाता है यदि अनुग्रह दिवस में बीमादार की मृत्यु हो जाए तब पॉलिसी की रकम में से देय प्रिमियम काटकर शेष रकम दावेदारों को मिल जाती है। वार्षिक, छमाही और तिमाही प्रिमियमों के लिए अनुग्रह दिवस तीस दिनों अथवा एक कलेंडर मास का होता है, मासिक प्रिमियमों के लिए पन्द्रह दिनों को होता है, अनुग्रह दिवस के भीतर ही देय प्रिमियम का भुगतान कर देना चाहिए। जिस दिन अनुग्रह दिवस समाप्त होता हो वह यदि रविवार या सार्वजनिक छुट्टी का दिन हो तब उसके बाद वाले कार्य-दिवस तक प्रिमियम का भुगतान हो सकता है। यदि तब तक भी प्रिमियम अदा न किया जाए जब पॉलिसी कालातीत हो जाती है।

> यदि ऐसी बीमा पॉलिसी जिस पर तीन वर्षों से कम अवधि का ही प्रिमियम दिया गया है कालातीत हो जाए तब उस पॉलिसी के प्रति जीवन बीमा कम्पनी का कोई दायित्व नहीं रहता और बीमादार ने जितना प्रिमियम दिया है वह सब डूब जाता है।

शोध प्रविधि

प्रस्तुत अध्ययन प्राथमिक समंकों पर आधारित है जिसके लिए क्षेत्र में सर्वेक्षण किया गया। समंकों के संकलन के लिए सुनियोजित प्रश्नावली का उपयोग किया गया। प्रश्नावली में निहित प्रश्नों के अतिरिक्त मिली महत्वपूर्ण जानकारी को भी साक्षात्कार पत्र में दर्ज कर लिया गया। प्रथम पॉच सौ फॉर्म यादृच्छिक निदर्शन रीति से बीमा ग्राहकों से भरवाये गये जिनमें निजी बीमा कम्पनियों का प्रतिनिधित्व केवल 25 प्रतिशत तक सीमित रहा। तदन्तर अगले पॉच सौ ग्राहकों के लिए चयनात्मक रीति का आश्रय लिया गया अर्थात् ऐसे व्यक्तियों को चुना गया जिनके पास निजी बीमा कम्पनी की पॉलिसी अनिवार्य रूप से हो। सर्वेक्षण का क्षेत्र उत्तराखण्ड के देहरादून एवं टिहरी गढ़वाल जनपद थे। दोनों जिलों के शहरी, अर्धशहरी और ग्रामीण तीनों क्षेत्रों को सम्मिलित किया गया।

कालातीत पॉलिसी सम्बन्धी शर्तें

यदि बीमादार बीमा पॉलिसी पर देय प्रिमियम की अदायगी अनुग्रह दिवस अवधि के भीतर न करे तब वह पॉलिसी अनुग्रह अवधि समाप्त होते ही कालातीत हो जाती है।

यदि ऐसी बीमा पॉलिसी जिस पर तीन वर्षों से कम अवधि का ही प्रिमियम दिया गया है कालातीत हो जाए तब उस पॉलिसी के प्रति जीवन बीमा कम्पनी का कोई दायित्व नहीं रहता और बीमादार ने जितना प्रिमियम दिया है वह सब डूब जाता है।

किन्तु यदि बीमा पॉलिसी पर तीन वर्षों का पूरा प्रिमियम चुका दिया गया हो और तत्पश्चात् वह कालातीत हो जाये तब 'अहरण नियम' लागू हो जाता है।

कालातीत पॉलिसी के विकल्प

- समर्पण मूल्य
- चुकता पॉलिसी
- दावे की सुविधा
- पुनर्चलन

समर्पण मूल्य - यदि बीमादार अपनी कालातीत पॉलिसी का पुनर्चलन न करना चाहे तब वह उस पॉलिसी का 'समर्पण मूल्य' नकद प्राप्त कर सकता है। 'समर्पण मूल्य' किसी पॉलिसी के नकद वापसी मूल्य को कहते हैं, अर्थात् वह नकद रकम जो

> बीमादार बीमा के लाभ से वंचित हो जाता है। यदि पॉलिसी प्रथम तीन वर्षों के अन्दर ही कालातीत हो गयी तब तो सारे प्रीमियम की ही रकम डूब जाती है।

जीवन बीमा कम्पनी बीमादार द्वारा पॉलिसी का समर्पण करने के बदले में बीमादार को देने को तैयार होती है। पॉलिसी की शर्तों के अनुसार उन्हीं बीमा पॉलिसियों पर समर्पण मूल्य प्राप्त किया जा सकता है जिन पर (1) कम से कम तीन वर्षों का पूरा प्रिमियम दिया जा चुका है, तथा (2) जिनका चुकता मूल्य बोनस छोड़कर 250 रूपए से कम न हो।

चुकता पॉलिसी - ऐसी बीमा पॉलिसी जिस पर तीन वर्ष प्रिमियम चुका दिया हो वह कालातीत होने पर स्वतः चुकता पॉलिसी हो जाती है चुकता पॉलिसी का अर्थ यह है कि भुगतान किए गये प्रिमियम और कुल देय प्रिमियम के अनुपात के आधार पर पॉलिसी का मूल्य घटा दिया जाता है और पॉलिसी घटे हुए मूल्य के लिए बरकरार रहती है।

दावे की सुविधा - बीमा पॉलिसी पर तीन वर्ष का प्रिमियम भुगतान किया जा चुका है तब इस पॉलिसी के कालातीत होने के छः महीने तक पॉलिसी दावों के लिए प्रभावी मानी जाएगी। यदि इस पॉलिसी के कालातीत होने के छः माह के अन्दर बीमादार की मृत्यु हो जाती है तब बीमा कम्पनी बकाया प्रिमियम और ब्याज राशि काटकर बीमा राशि का भुगतान दावेदार को कर देगी। ऐसी बीमा पॉलिसी जिस पर पॉच वर्ष का पूरा प्रिमियम दिया जा चुका है, दावे की सुविधा बारह माह तक उपलब्ध रहेगी। इसी तरह जिस पॉलिसी पर दस वर्ष का प्रिमियम भुगतान किया जा चुका है दावे की सुविधा अट्ठारह मास तक मिलेगी।

पालिसी का पुनर्चलन - पॉलिसी के कालातीत होने के पॉच वर्ष बाद तक पॉलिसी को पुनर्जीवित कराया जा सकता है किन्तु इसके बाद पुनर्चलन नहीं होता है। कालातीत पॉलिसी को पुनर्चलन कराने के लिए बकाया प्रिमियम पर दस प्रतिशत वार्षिक चक्रवृद्धि ब्याज का भुगतान करना पड़ता है। कालातीत होने के छः माह के अन्दर धारक जब चाहे ब्याज सहित प्रिमियम जमा करके पॉलिसी को पुनः चालू करवा सकता है। किन्तु छः माह बीतने के बाद पुनर्चलन के लिए जीवन बीमा कम्पनी के डॉक्टर से अपने व्यय पर स्वास्थ्य परीक्षण कराना होता है। मेडिकल रिपोर्ट से सन्तुष्ट होने के बाद ही बीमा कार्यालय बकाया प्रिमियम ब्याज सहित जमा करने की अनुमति देता है।

पॉलिसी के कालातीत होने का प्रभाव

पॉलिसी कालातीत होने पर प्रतिकूल प्रभाव पड़ता है -

- ग्राहक हित पर
- अभिकर्ता की आय पर
- बीमा व्यवसाय पर
- नियामक संस्था पर

बीमादार बीमा के लाभ से वंचित हो जाता है। यदि पॉलिसी प्रथम तीन वर्षों के अन्दर ही कालातीत हो गयी तब तो सारे प्रिमियम की ही रकम डूब जाती है। तीन वर्षों के उपरान्त कालातीत होने पर 'अहरण नियम' के अन्तर्गत एक अल्प अवधि तक दावों की सुविधा और तुरन्त पॉलिसी के चुकता होने की सुविधा अवश्य मिलती है किन्तु जितनी सुरक्षा गया था उसमें कमी आ जाती है।

बीमा अभिकर्ता की आय पर धक्का पहुँचता है उसे चालू पॉलिसियों पर निश्चित दर से वार्षिक कमीशन मिलता है। पॉलिसीयों के कालातीत होने पर, वह उन पर मिलने वाले कमीशन से वंचित रह जाता है। इसके अतिरिक्त, उसके द्वारा किये गये जीवन बीमा के कारोबार में पॉलिसी के कालातीत होने के कारण कमी आती है जो उसकी कार्यक्षमता के मूल्यांकन के लिए प्रतिकूल परिस्थिति मानी जाती है।

पॉलिसी के कालातीत होने के कारण जीवन बीमा कम्पनी के कुल बीमा कारोबार की धनराशि में कमी आती है, उन पॉलिसीयों पर किया गया समस्त व्यय व्यर्थ हो जाता है और भविष्य की प्रिमियम आय घट जाती है। यह स्थिति व्यवसायिक दृष्टि से प्रतिकूल मनी जाती है। अतः बीमा कम्पनियॉ अपने विकास अधिकारियों और बीमा अभिकर्ताओं को बराबर हिदायत देती रहती हैं कि वे बीमादारों से निरन्तर सम्पर्क बनाये रखें और उन्हें प्रिमियम चुकाने के लिए सचेत रखें। इसके अतिरिक्त कालातीत पॉलिसियों को पुनः चालू कराने के लिए भी प्रोत्साहन दिया जाता है।

बीमा व्यवसाय के नियामक के लिए भी यह महत्वपूर्ण विषय है कि जीवन बीमा पॉलिसियाँ कालातीत न हो क्योंकि बीमा उद्योग के सभी पक्षकारों के हितों पर इसका प्रतिकूल प्रभाव होता है। नियामक संस्था सदैव इस स्थिति के अध्ययन और विश्लेषण के लिए प्रयासरत रहती है कि कालातीत पॉलिसियों का प्रतिशत न बढ़ने पाये। उद्योग के नियमन स्तर पर कालातीत पॉलिसीयों पर नियन्त्रण के लिए उपाय किये जाते हैं।

सर्वेक्षण में सम्मिलित 1000 बीमा ग्राहकों में से 50 लोगों को प्रीमियम जमा करने सम्बन्धी

अनुस्मारक मिला है लेकिन उनको भी नियमित नहीं मिलते हैं। दूसरी ओर यह भी देखने में आया कि शाखा कार्यालय की और से सभी को अनुस्मारक भेजे जाते हैं, यह भी पुष्टि हुई। दोनों तरफ बहुत अन्तर है इसमें कहीं पोस्ट ऑफिस जैसी एजेन्सी की भूमिका हो सकती है क्योंकि अनुस्मारक शाखा कार्यालय द्वारा साधारण डाक से भेजे जाते है, जिसके विषय में कोई प्रमाणिक पूछताछ नहीं हो सकती है। भारतीय जीवन बीमा कम्पनी ने मैट्रो शहरों में ग्राहकों को मोबाइल फोन पर एसएमएस भेजना शुरू कर दिया है लेकिन अभी दूसरे शहरों में यह सुविधा नहीं है जबकि प्राइवेट जीवन बीमा कम्पनी प्रिमियम देय तिथि से एक माह पूर्व नोटिस भेजती है, बार-बार एसएमएस भेजना शुरू कर देती है, फोन करते हैं एवं व्यक्तिगत सम्पर्क करते हैं।

प्रायः जीवन बीमा अभिकर्ता को प्रथम वर्ष कमीशन 30 प्रतिशत मिलता है, अगले वर्ष कम कमीशन यानि 5 प्रतिशत मिलता है जिससे अभिकर्ता पुरानी पॉलिसियों पर ध्यान नहीं देते हैं और पॉलिसी कालातीत हो जाती है।

प्रायः जीवन बीमा अभिकर्ता को प्रथम वर्ष कमीशन 30 प्रतिशत मिलता है, अगले वर्ष कम कमीशन यानि 5 प्रतिशत मिलता है जिससे अभिकर्ता पुरानी पॉलिसियों पर ध्यान नहीं देते हैं और पॉलिसी कालातीत हो जाती है। इसको रोकने के लिए गोवर्धन कमेटी ने अभिकर्ताओं के लिए प्रथम वर्ष में 20 प्रतिशत कमीशन एवं दूसरे वर्ष 15 प्रतिशत कमीशन देने की सिफारिश की है जिससे अभिकर्ता नयी पॉलिसी के साथ-साथ पुरानी पॉलिसियों का भी ध्यान रखेंगे और पॉलिसी कालातीत न हो पाये।

बावा सुमिंदर कौर (2007) द्वारा सम्पादित शोध में उल्लेख किया गया है कि भारतीय जीवन बीमा निगम में औसत प्रभावी जीवन बीमा व्यवसाय की तुलना में शुद्ध कालातीत दर पॉच से छः प्रतिशत के मध्य रही है। वर्ष 1993-94 से 2003-04 की अवधि के लिये किए गये अध्ययन में प्रारम्भ में शुद्ध कालातीत दर 6.3 प्रतिशत थी जोकि अन्त के दो वर्षों में 5.5 प्रतिशत पर स्थिर रही। बीच के वर्षों में यह दर क्रमशः ह्रासमानथी। शुद्ध कालातीत दर की गणना के लिये सकल कालातीत संख्या में से ऐसी पॉलिसियों को घटा दिया जाता है जिनका एक बार कालातीत होने के बाद पुनर्चलन करा लिया गया।

भारतीय उपभोक्ता वर्ग की प्रमुख विशेषता है कि यहाँ निर्धनता और अशिक्षा का पर्याप्त प्रभाव है, साथ ही जागरूकता का स्तर बहुत कम है। उपभोक्ता सशक्तीकरण के लिए सरकार की ओर से प्रयास हुए है। उपभोक्ता संगठनों को भी इस क्षेत्र में सफलता मिली है। उपभोक्ता शिक्षा को स्कूल स्तर पर पाठ्यक्रम में सम्मिलित करने की आवश्यकता है। वस्तुतः प्रत्येक आयु वर्ग के लिए उपभोक्ता सिक्षा का प्रबन्ध अपेक्षित है। प्रिन्ट माध्यम की तुलना में भारतीय प्ररिवेश के लिए दूरदर्शन माध्यम को अधिक उपयुक्त माना जाता है। उपभोक्ता स्वयं उदासीनता छोड़कर अपने अधिकर का उपयोग करने को आगे आयें। (ध्यानी अतुल कुमार 2002)

'वित्तीय सलाहकार और वित्तीय साक्षरता' पर पी.एफ.आर.डी.ए के अध्यक्ष डी. स्वरूप के नेतृत्व में तैयार रिपोर्ट में जीवन बीमा, म्युचअल फण्ड समेत अन्य सभी वित्तीय सेवाओं पर ग्राहकों से कमीशन लेने की मौजूदा परम्परा को समाप्त कर उसके स्थान पर शुल्क आधारित व्यवस्था शुरू करने की सिफारिश की गई है। रिपोर्ट में देश में सरकार के खर्चे से वित्तीय साक्षरता को बढने के लिए राष्ट्रीय कार्यक्रम चलाने की भी बात कही गई है। बगैर वित्तीय साक्षरता के निवेशकों के हितों की सुरक्षा करने के कोई भी उपाय पूरी तरह से सफल नहीं हो सकते।

जीवन बीमा मे पॉलिसियों के कालातीत होने की दर सम्पूर्ण व्यवसाय पर सीधा प्रभाव डालती है, जैसे - बीमा उत्पाद का मूल्य निर्धारण, बीमा दायित्व का आंकलन, दूसरे देशों के साथ तुलना, उद्योग में बेन्चमार्क कालातीत दर, उत्पाद विकास के लिए उपयोगी समंक के रूप में, उपभोक्ता अभिरुचि अध्ययन के लिए, विपणन रणनीति निर्धारण हेतु। शोधकर्ताओं ने अनुशंसा की है कि अनुग्रह दिवस के रूप में सभी बीमा कम्पनियों को एकरूप नियम स्वीकार करना चाहिए, जैसा कि वार्षिक, षड्मासिक और त्रैमासिक भुगतान की पॉलिसियों के लिए पन्द्रह दिन अनुग्रह दिवस। इसी प्रकार कालातीत पॉलिसी की समरूप परिभाषा सभी कम्पनियों को स्वीकार कर लेना चाहिए। उद्योग में सभी कम्पनियों के लिए अनुग्रह दिवस और कालातीत पॉलिसी के समान नियमों की स्वीकार्यता अनिवार्य हो ताकि इरडा को प्राप्त समंक परस्पर तुलना योग्य हो सकें। (कन्णन आर एवं अन्य 2009)

पॉलिसी कालातीत होने के कारण

अभिकर्ता सम्बन्धी

- अभिकर्ता के द्वारा ग्राहकों के साथ धोखाधड़ी करने पर।
- एजेन्ट द्वारा ग्राहक को उनकी आर्थिक स्थिति के अनुरूप पॉलिसी नहीं देने के कारण।
- अभिकर्ता का व्यवहार ग्राहक के प्रति अच्छा न होने के कारण।

- अभिकर्ता को बीमा पॉलिसी और बीमा विषय की सम्यक् जानकारी न होना।
- अभिकर्ता का पूरी तरह प्रशिक्षित न होने के कारण।
- ग्रारक को एजेण्ट द्वारा 'फ्री लुक पीरियड' न बताने के कारण।
- अभिकर्ता अपने कमीशन को महत्व देते हैं और ग्राहक का हित नहीं देखते हैं।
- ग्राहक को अनुपयोगी पॉलिसी देने के कारण।
- ग्राहक को चुकता पॉलिसी के बारे में जानकारी नहीं देने कारण।
- अभिकर्ता के द्वारा ग्राहक को पॉलिसी के गुण एवं दोषों का उल्लेख नहीं करने के कारण।
- ग्राहक को उनकी प्रिमियम देय तिथि पर सूचना न देने के कारण।

अभिकर्ता के लिए सुझाव

- अभिकर्ता को ग्राहक के साथ कपटपूर्ण व्यवहार नहीं करना चाहिए।
- अभिकर्ता को ग्राहक के साथ हमेशा अच्छा व्यवहार रखना चाहिए - पॉलिसी लेते समय भी एवं उसके पश्चात् भी।
- अभिकर्ता को हमेशा ग्राहक को पॉलिसी के बारे में सही जानकारी देने चाहिए जिससे पॉलिसी कालातीत कम होगी।
- अभिकर्ता को ग्राहक को बताना चाहिए कि यदि आप इस पॉलिसी को लेकर सन्तुष्ट नहीं है तो आप इसे 15 दिन के अन्दर बदलकर दूसरी पॉलिसी ले सकते हैं।
- अभिकर्ता को हमेशा ग्राहक के सम्पर्क में रहना चाहिए जिससे वे प्रिमियम देय होने पर ग्राहक को समय पर जानकारी दे सके।
- अभिकर्ता को अपने कमीशन को ही नहीं देखना चाहिए बल्कि ग्राहकों के हित का भी ध्यान रखना चाहिए जिससे उनको उपयोगी पॉलिसी दी जा सके।
- अभिकर्ता द्वारा ग्राहक को जानकारी देने चाहिए कि कम से कम 3 वर्ष तक पॉलिसी चलानी चाहिए। यदि आप 3 वर्ष तक पॉलिसी नहीं चलाते हैं तो आपको नुकसान होगा।
- अभिकर्ता को पॉलिसी कराते समय ग्राहक को पॉलिसी से सम्बन्धित उसके गुण एवं दोषों का उल्लेख करना चाहिए।
- अभिकर्ता को बीमा विषय का पर्याप्त ज्ञान होना चाहिए जिससे वे ग्राहक की आवश्यकताओं की पूर्ति करने वाली बीमा पॉलिसी उन्हें दे सके।
- सभी अभिकर्ताओं को ध्यान रखना चाहिए कि उनके ग्राहकों की पॉलिसी कालातीत न हो पाये क्योंकि पॉलिसी कालातीत होने पर सभी पक्षकार प्रभावित होते हैं। इसलिए अभिकर्ता को बीमा ग्राहक को बीमा के प्रति सचेत करना चाहिए।

सरकारी बीमा कम्पनी को ग्राहकों के मोबाइल नम्बर लेकर प्राइवेट जीवन बीमा कम्पनी की तरह ग्राहक को प्रिमियम देय होने पर एवं त्यौहरो, नववर्ष, जन्मदिन आदि अवसरों पर शुभकामना सन्देश भेजना चाहिए।

बीमा कम्पनी सम्बन्धी

- जीवन बीमा कम्पनी द्वारा विशेषतया भारतीय जीवन बीमा निगम द्वारा प्रिमियम देय होने पर या उससे पूर्व ग्राहक को अनुस्मारक न भेजना।
- गाँव के बीमा ग्राहकों के लिए प्रीमियम जमा करने की सुविधा न होना।
- ग्रामीण इलाकों में जीवन बीमा कम्पनी की शाखा कार्यालय न होने के कारण।
- बीमा कम्पनी के पास ग्राहकों के मोबाइल नम्बर न होने के कारण वे एसएमएस सन्देश आदि नहीं भेज पाते।
- बीमा कम्पनी के द्वारा सूचना भेजने के लिए ई-मेल आदि जैसी आधुनिक तकनीक का प्रयोग न करने पर।
- बीमा ग्राहक को 'फ्री लुक पीरियड' के बारे में जानकारी न देना।
- अभिकर्ताओं को प्रशिक्षित करने के लिए प्रभावी प्रशिक्षण न देने के कारण।
- ग्राहकों में जीवन बीमा जागरूकता न ला पाने के कारण।
- ग्राहक को चुकता पॉलिसी के बारे में जानकारी न देने के कारण।

कालातीत पॉलिसी के लिए ग्राहकों को नोटिस नहीं भेजे जाते अथवा यदि भेजते है तो ग्राहकों तक वह नहीं पहुंचते हैं जिस कारण पॉलिसी का पुनर्चलन नहीं हो पाता है।

बीमा कम्पनी के लिए सुझाव

- जीवन बीमा कम्पनी को समय-समय पर ग्राहकों को प्रिमियम देय होने पर या उससे पूर्व अनुस्मारक भेजना चाहिए जिससे पॉलिसी कालातीत होने से बचेगी।
- बीमा कम्पनी को ग्रामीण क्षेत्रों में अपनी शाखा कार्यालय / प्रिमियम कलेक्शन सेन्टर की सुविधा ग्राहकों को देनी चाहिए जिससे गॉव के लोगों को सुविदा मिलेगी और साथ ही उनकी पॉलिसी कालातीत होने से बचेगी।
- सरकारी बीमा कम्पनी को ग्राहकों के मोबाइल नम्बर लेकर प्राइवेट जीवन बीमा कम्पनी की तरह ग्राहक को प्रिमियम देय होने पर एवं त्यौहरो, नववर्ष, जन्मदिन आदि अवसरों पर शुभकामना सन्देश भेजना चाहिए।

- जीवन बीमा कम्पनी को अपने अभिकर्ताओं को बताना चाहिए कि ग्राहक की आर्थिक स्थिति के अनुरूप एवं जरूरतों को पूरा करने वाली पॉलिसीयाँ दी जाये जिससे पॉलिसी कालातीत कम होगी।
- अभिकर्ताओं को ग्राहक पर अनावश्यक दबाव नहीं बनाना चाहिए, इस बात के लिए भी जीवन बीमा कम्पनी को अभिकर्ताओं को निर्देशित करना चाहिए।
- बीमा कम्पनी को अपने अभिकर्ताओं को निर्देशित करना चाहिए कि ग्राहक से हमेशा व्यवहार अच्छा रखें। कुछ ग्राहकों ने अपने अभिकर्ता के व्यवहार अच्छा न होने के कारण अपनी पॉलिसी बन्द कर दी।
- अभिकर्ता को वास्तविक रूप से प्रशिक्षित किया जाय जिससे वे ग्राहक को अच्छी अर्थात् उनके अनुसार पॉलिसी दें जिससे कालातीत होने की सम्भावना कम रहेगी।
- जीवन बीमा कम्पनी को अभिकर्ताओं पर पूरी तरह नियन्त्रण रखना चाहिए जिससे अभिकर्ता ग्राहक के साथ धोखाधड़ी न कर सकें।

अगर बीमा दाता व्यवसाय परिचालन में अधिक दक्षतापूर्ण और उपभोक्ता के प्रति अधिक जवाबदेह ढ़ग से कार्य करे तब इसका प्रत्यक्ष लाभ बीमा संस्था और बीमाधारक दोनों को एक साथ पहुँचेगा।

ग्राहक सम्बन्धी

- ग्राहक दवारा अपनी आर्थिक स्थिति को न देखते हुए बड़ी पॉलिसी (अधिक प्रिमियम वाली पॉलिसी) लेने के कारण।
- ग्राहक को प्रिमियम देय तिथि याद न रहने के कारण।
- ग्राहक द्वारा अपने अभिकर्ता से बराबर सम्पर्क न रखने के कारण।
- ग्राहक को जीवन बीमा कम्पनियों की प्रिमियम जमा करने की अन्य सुविधाओं जैसे बैंक आदि में जमा करने की जानकारी न होना या उन सुविधाओं का प्रयोग न करना।
- ग्राहक अभिकर्ता के दबाव में एक या दो किस्त जमा करते हैं बाद में प्रिमियम जमा करना छोड़ देते हैं जिसके परिणामस्वरूप पॉलिसी कालातीत हो जाती है।
- जीवन बीमा के महत्व के प्रति कम जागरूकता।

ग्राहक के लिए सुझाव

- ग्राहक को अपनी प्रिमियम देय तिथि को नोट कर एवं मोबाइल फोन पर अलार्म रखना चाहिए जिससे ग्राहक समय पर प्रिमियम जमा करेंगे और उनकी पॉलिसी कालातीत होने से बचेगी।
- ग्राहक को स्वयं भी सावधान रहने और जागरूक होने की जरूरत है। वह बीमा कम्पनियाँ की विविध सुविधाओं की जानकारी लें और उनका उपयोग करें।
- ग्राहक को हमेशा सन्तुष्ट होकर ही पॉलिसी लेनी चाहिए। किसी अभिकर्ता के दबाव में पॉलिसी नहीं लेनी चाहिए। वे जिसे अपने लिए उपयोगी समझे उसी पॉलिसी को उनहें लेना चाहिए।
- ग्राहक को जीवन बीमा के प्रति जागरूक होना चाहिए जिससे पॉलिसी कालातीत कम होंगी।

बीमादाता की समाज में विविध भूमिकायें हैं। बीमा करने और बीमा पॉलिसी चलाने के दौरान बीमा कम्पनी को परामर्शदाता के रूप में भी काम करना होता है। अगर बीमादाता सलाहकार होने के दायित्व को स्पष्ट रूप से स्वीकार करे तो यह सम्पूर्ण उद्योग के लिए लाभप्रद होगा। जीवन बीमा उत्पाद की प्रकृति इस प्रकार की है कि इनमें विपणन से पूर्व ग्राहक के वैयक्तिक विवरण के विश्लेषण की जरूरत है। दूसरी ओर, ये इतनी लम्बी अवधि के अनुबन्ध है कि इनमें ग्राहक और विक्रेता दोनों को संविदा अवधि में विभिन्न परिस्थितियों से गुजरना होता है, चाहे वे पॉलिसी का समर्पण हो, चुकता मूल्य हो अथवा पुनर्चलन। ऐसे प्रत्येक अवसर पर बीमादाता का परामर्श महत्वपूर्ण हो जाता है। बीमा व्यवसाय के लिए कुछ सामाजिक दायित्व भी निर्धारित किए जाते हैं, जैसे भारतीय जीवन बीमा निगम की जीवन निधि का विनियोग समाज हित की योजनाओं में अनिवार्य रूप से किया जाता है। इसी प्रकार, बीमा उद्योग जनहित के लिए दूसरे उपायों में भी सक्रिय सहयोग देता है, जैसे सामान्य बीमा द्वारा हानि निवारण संघ का संचालन करना आदि। सामाजिक कार्यों का अप्रत्यक्ष लाभ बीमा व्यवसाय को अवश्य मिलता है। किन्तु, अगर बीमा दाता व्यवसाय परिचालन में अधिक दक्षतापूर्ण और उपभोक्ता के प्रति अधिक जवाबदेह ढ़ग से कार्य करे तब इसका प्रत्यक्ष लाभ बीमा संस्था और बीमाधारक दोनों को एक साथ पहुँचेगा। ग्रामीण विकास की दृष्टि से भी बीमा कम्पनियों पर अनुशासन लागू किया गया है किन्तु वहाँ भी अगर बीमादाता अपने व्यवसायिक दायित्व को ही सम्पूर्णता के साथ स्वीकार कर ले तब भी व्यापक जनहित और व्यवसाय सम्वर्धन दोनों एक साथ हो सकते हैं। यहाँ व्यवसायिक दायित्व में उपभोक्ता संरक्षण के साथ नैतिक मर्यादायें और व्यवसाय में श्रेष्ठ व्यवहार के बेन्चमार्किंग मानक भी सम्मिलित है।

सन्दर्भ

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परिशिष्टः (01) व्यवसाय संरचना वार ग्राहक वितरण

वेतन भोगी	629
सेवा निवृत्त	16
व्यापार	228
पेशेवर (पण्डित, वकील, ठेकेदार, मैकेनिक आदि)	99
उद्योग	9
अन्य (गृहिणी, छात्र)	19
कुल	1000

परिशिष्टः (02) पॉलिसी वार ग्राहक वितरण

आजीवन बीमा	23
सावधि बीमा	730
मनी बैक	899
यूलिप	819
पेन्शेन प्लान	69
स्वास्थ्य बीमा	54
अन्य (चाइल्ड, विवाह)	52
कुल पॉलिसियॉ	2646

परिशिष्टः (03) कालातीत पॉलिसी के कारण

प्रिमियम दे पाने में असमर्थता	66
प्रिमियम जमा करने की याद न रहना	16
पॉलिसी का अनुपयोगी लगना	10
अभिकर्ता का व्यवहार अच्छा न होना	4
अभिकर्ता द्वरा धोखाधड़ी करने पर	4
अन्य कोई कारण	5
कुल	105

परिशिष्टः (04) पारिभाषिक शब्दावली

अनुस्मारक	Reminder
अनुग्रह दिवस	Grace Period
कालातीत	Lapsed
अहरण नियम	Non-forfeiture regulations
नियामक	Regulator
चुकता पॉलिसी	Paid up policy
समर्पण मूल्य	Surrender value
पुनर्चलन / पुनः प्रवर्तन	Revival
अवशिष्ट	Arrear
यादृच्छिक निदर्शन	Random sampling
दावे की सुविधा	Claim concession

डॉ. सुबोध कुमार - रीडर, वाणिज्य विभाग, हे.न.ब.ग. केन्द्रीय विश्वविद्यालय स्वामी रामतीर्थ परिसर, बादशाहीथौल, टिहरी गढ़वाल, (उत्तराखण्ड)
हरीश्चन्द्र रतूड़ी - शोध छात्र, हे.न.ब.ग. केन्द्रीय विश्वविद्यालय, स्वामी रामतीर्थ परिसर, बादशाहीथौल, टिहरी गढ़वाल (उत्तराखण्ड)

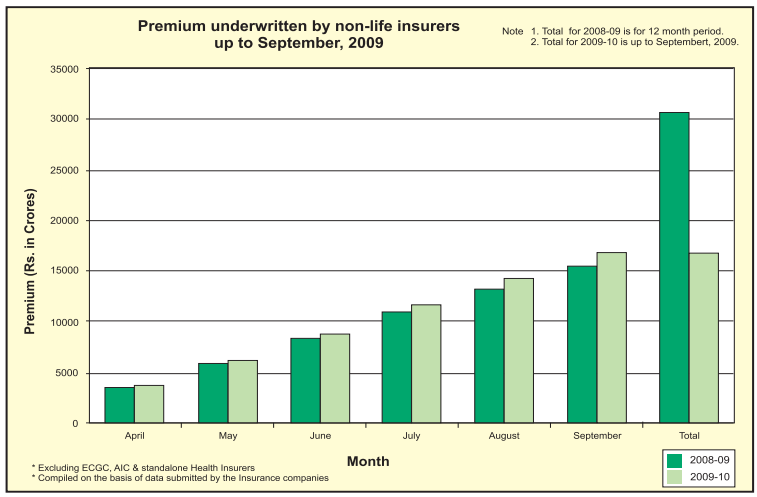
Report Card: General

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

(Rs.in Crore)

INSURER	SEPTEMBER		APRIL-SEPTEMBER		GROWTH OVER THE CORRESPONDING PERIOD OF PREVIOUS YEAR
	2009-10	2008-09*	2009-10	2008-09	
Royal Sundaram	78.31	67.04	438.30	388.99	12.68
Tata-AIG	63.20	59.16	461.16	497.27	-7.26
Reliance General	168.74	146.00	1045.55	986.22	6.02
IFFCO-Tokio	104.05	97.83	748.20	716.02	4.49
ICICI-lombard	236.40	271.45	1611.70	1925.11	-16.28
Bajaj Allianz	177.97	212.78	1217.74	1416.15	-14.01
HDFC ERGO General	59.80	28.08	421.14	143.36	193.77
Cholamandalam	61.29	53.22	415.21	358.33	15.87
Future Generali	22.30	14.17	168.92	71.96	134.73
Universal Sompo	12.75	0.08	67.07	1.14	5806.32
Shriram General	26.15	5.37	137.44	7.17	1817.73
Bharti AXA General	16.35	0.68	96.00	0.70	
Raheja QBE $	0.07	0.00	0.33	0.00	
New India	486.71	446.09	3027.63	2790.07	8.51
National	345.46	346.24	2192.74	2164.66	1.30
United India	393.72	316.94	2463.22	2095.49	17.55
Oriental	350.69	292.86	2307.59	2009.08	14.86
PRIVATE TOTAL	**1027.37**	**955.85**	**6828.77**	**6512.42**	4.86
PUBLIC TOTAL	**1576.58**	**1402.13**	**9991.18**	**9059.30**	10.29
GRAND TOTAL	**2603.95**	**2357.97**	**16819.95**	**15571.72**	8.02
SPECIALISED INSTITUTIONS					
1.Credit Insurance					
ECGC#	63.67	63.97	390.38	347.22	12.43
2.Health Insurance					
Star Health & Allied Insurance	13.93	7.94	433.87	239.19	81.39
Apollo DKV	14.28	3.16	48.91	13.14	272.29
Health Total	**28.21**	**11.10**	**482.78**	**252.33**	91.33
3.Agriculture Insurance					
AIC	289.19	164.74	802.82	383.57	109.30

Note: Compiled on the basis of data submitted by the Insurance companies.
$ Commenced operations in April, 2009.
** Figures revised by insurance companies.*



08 - 11 Nov 2009 Venue: Singapore	**10th Singapore International Reinsurance Conference** By *Singapore Reinsurers' Association*
09 - 11 Nov 2009 Venue: NIA, Pune	**Marketing Strategies (Life)** By *National Insurance Academy*
14 Nov 2009 Venue: New Delhi	**Insurance Summit 'Towards Sustainable Growth'** By *Birla Institute of Management Technology*
21 Nov 2009 Venue: Mumbai	**Seminar on Insurance Perspectives** By *NIA School of Management*
23 - 24 Nov 2009 Venue: NIA, Pune	**Seminar on Information Security Audit** By *National Insurance Academy*
24 - 25 Nov 2009 Venue: Singapore	**Asian Healthcare Conference** By *Asia Insurance Review, Singapore*
07 - 08 Dec 2009 Venue: NIA, Pune	**Seminar on Terrorism Risk Insurance & Management** By *National Insurance Academy*
09 - 10 Dec 2009 Venue: Manama, Bahrain	**3rd Middle East Healthcare Insurance Conference** By *Asia Insurance Review, Singapore*
10 - 12 Dec 2009 Venue: NIA, Pune	**Prevention of Insurance Frauds** By *National Insurance Academy*
24 - 26 Dec 2009 Venue: NIA, Pune	**Programme on Financial Awareness** By *National Insurance Academy*
28 - 30 Dec 2009 Venue: NIA, Pune	**Workshop on Distribution Channel Management** By *National Insurance Academy*

RNI No: APBIL/2002/9589

view point

Although insurance securitisation does not appear to have played a role in the current financial turmoil, it has been affected by it.

Mr. Peter Braumuller
Chair, IAIS Executive Committee

The NAIC's solvency and capital standards have ensured that policyholder commitments are met and companies remain stable.

Mr. Thomas R. Sullivan
Connecticut Insurance Commissioner

One of the jobs of the insurance regulator is to ensure that the insurance companies at all times have sufficient resources to pay off their liabilities, even if they were to come tomorrow.

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

The direction of travel is clear: the overall level of capital required in the banking system must be significantly increased over time, while liquidity standards must be significantly tightened.

Mr. Lord Turner
Chairman, FSA-UK

Our prudential standards are built around capital adequacy, effective risk management and good governance.

Mr. John Trowbridge
Executive Member, Australian Prudential Regulation Authority

We want to be sure our regime for investment firms and pension providers remains in line with best international practice, as well as being effective and practical for the Bermuda market.

Mr. Mathew Elderfield
CEO, Bermuda Monetary Authority