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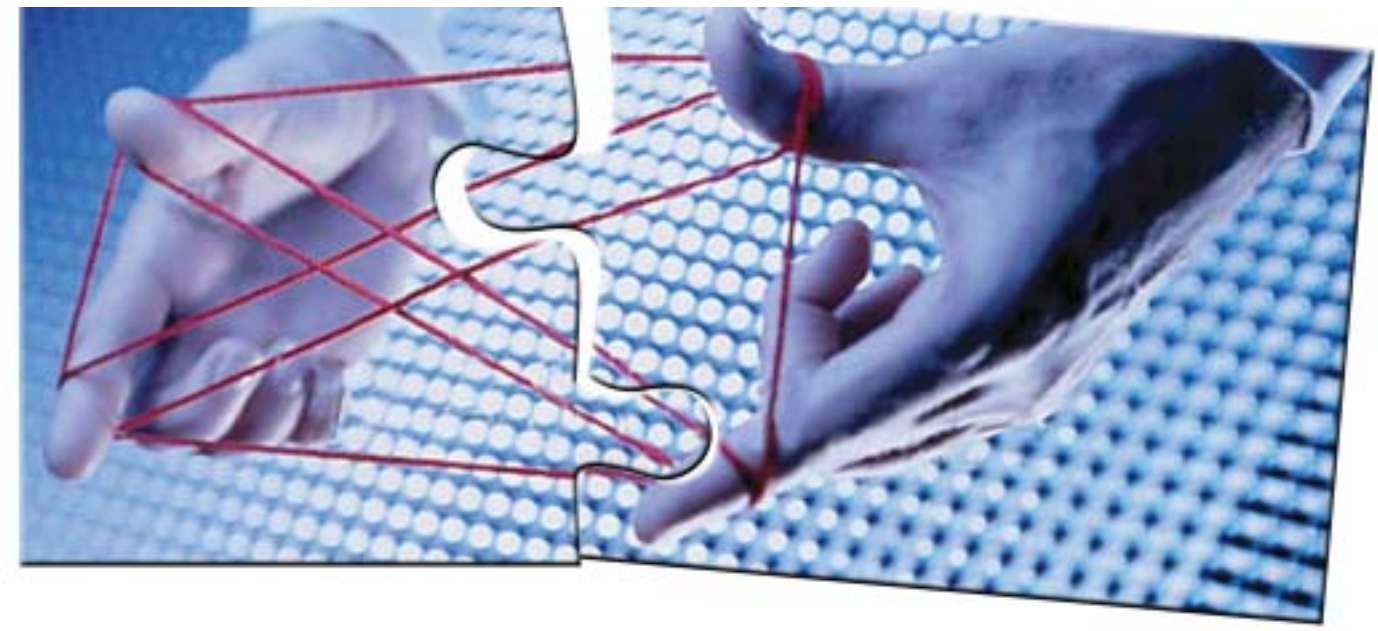

Making Insurance Contracts Simpler

बीमा विनियामक और विकास प्राधिकरण

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From the Publisher

It is very essential to draft the policy conditions and clauses in an insurance contract explicitly and in as simple a manner as is possible. While the basic structure of a policy bond, which is the evidence of the contract, is uniform; insurers make use of certain clauses and endorsements specifically to suit the requirements of the insured. It is vital for the insurers to strike a balance between the requirements of the insured and the possibility of covering the risk at an affordable cost. This is achieved through differential pricing and/or appropriate exclusion clauses.

Insurers make use of a detailed questionnaire or the proposal form through which they elicit information about the risk to be accepted. It goes without saying that the information provided by the prospects should be wholesome and accurate; and insurers generally rely on the statements of the insured. Insurers, on their part, should appreciate that there is need for being explicit while drafting the policy conditions; and this need is more pronounced in evolving markets. Care should be taken to ensure that there is total transparency in framing the clauses; and also that they are totally devoid of ambiguities. The process should start while drafting the proposal form itself so that the information gathered is useful in making an objective assessment of the risk. The importance of clauses and their interpretation in an insurance contract is the focus of this issue of the Journal.

The devastation that is caused by a catastrophe knows no bounds; and in spite of all the scientific and technological developments, nature's fury inflicts immeasurable losses on humanity. While the incidence of a catastrophe itself cannot be avoided, care can be taken to ensure that the losses are minimized to a great extent. Disaster management and preparedness form the focus of the next issue of the Journal.

C.S. Rao

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It is said, insurance contracts are synallagmatic in nature; that is, they impose reciprocal obligations on the parties to the contract. This being so, it is very essential that the policy bond, which is the evidence of the contract; enumerates all the details of the contract. Insurance documents have been said to be steeped in jargon and rhetoric, historically. But considering the changing times, and the need for simplicity and openness; there must be urgent transformation towards drafting more explicit clauses. Who would not prefer a forthright 'Put off the candle' to a bombastic 'De-capitulate the summit of the nocturnal luminosity'?

In order that the reciprocity of obligations is accomplished, it is very essential that both the parties understand their role very clearly. The proposal form is so designed that it elicits all the information required for making an objective assessment of the risk at the disposal of the insurer. It naturally presupposes that the information furnished by the proposer is factual; and to this extent, the proposer signs a declaration that is very critical, at the end of the proposal form. However, filling up of the proposal form continues to be a perennial bone of contention; and it is argued in several cases that the applicant cannot be held liable because the inputs were given by the distributor. In a nascent market, such problems are bound to occur unless the insurers take extra effort to explain the nuances.

The Clause of Indisputability, or Section 45 in the Indian life insurance parlance, is very crucial in the matter of deciding the role of responsibility. In light of its importance, both the parties to the contract have to play their role in a wholesome and truthful manner. Above all, the insurers should realize that despite the importance of the declaration, there is need for being additionally cautious; and educating their distributors accordingly would go a long way in solving the complications. While putting additional clauses and/or conditions, it should be ensured that their importance is clearly understood by the policyholders.

'Interpretation of clauses and the reciprocal obligations of the parties to the contract' is the focus of this issue of the **Journal**. Mr. V. Ramakrishna, in his article 'Plain English in Insurance' highlights the importance of explicit clauses in the contract and takes a critical view of how contractual wordings have evolved over a period of time. In the next article titled 'Contract Certainty and the Insurance Market', Mr. Arup Chatterjee talks about the contractual terms being the key to contract certainty. Mr. K.L. Naik emphasizes the importance of self-regulation in reinsurance contracts; and the role of arbitration in case of disputes.

The various clauses of a life insurance policy are explained threadbare, with emphasis on their background by Mr. G. Prabhakara, in his article 'Life Insurance Contracts'. Mr. G.V. Rao talks about the role of a surveyor in non-life insurance claims settlement in his article 'Contractual Obligation in Insurance Contracts'. In the next article titled 'Understanding the Insurance Policy', Ms. Yegnapriya Bharath throws light on the need for the insurers to encourage the policyholders to read the policy conditions. In the follow-through section, Ms. Laxmi talks about the importance of a common pool of data in her article 'Claims Data Pool'.

Catastrophes, both natural as well as man-made, leave behind a trail of destruction in the form of loss of human lives and economic losses. While disasters cannot be averted, the financial losses can be taken care of by proactive management. Financial management of catastrophes forms the focus of the next issue of the **Journal**.

U. Jawaharlal

Report Card:LIFE

January, 2007 - Industry records 131.94% growth over January, 2006

Individual premium

The life insurance industry underwrote Individual Single Premium of Rs.17920.14 crore (P.Y. Rs.7367.68 crore) for the period ended January, 2007 of which the private insurers garnered Rs.1953.68 crore (P.Y Rs.1390.72 crore) and LIC garnered Rs.15966.46 crore (P.Y. Rs.5976.96 crore). The Individual Non-Single Premium underwritten during April-January, 2007 was Rs.26903.61 crore (P.Y. Rs.12326.31 crore) of which the private insurers underwrote Rs.9018.76 crore (P.Y. Rs.4396.08 crore) and LIC Rs.17884.85 crore (P.Y. Rs.7930.23 crore)

Group premium

The industry underwrote Group Single Premium of Rs.7871.89 crore (P.Y. Rs.3019.75 crore) covering 11667122 lives, out of which the private insurers covered 677843 lives underwriting Rs.602.49 crore (P.Y. Rs.280.57 crore) and LIC covered 10989279 lives underwriting Rs.7269.40 crore (P.Y. Rs.2739.18 crore). During the corresponding previous year private insurers covered 641517 lives and LIC 9422584 lives. The Group Non-Single Premium underwritten during April-January, 2007 was Rs.784.75 crore (P.Y. Rs. 343.73 crore) which was underwritten entirely by the private insurers, covering 3300836 lives (P.Y. 2049854).

Segment-wise segregation

A further segregation of the premium underwritten during the period indicates that Life, Annuity, Pension and Health contributed Rs.35519.61 crore (66.46%), Rs.1125.63 crore (2.11%), Rs.16780.29 crore (31.40%) and Rs.18.25 crore (0.03%) respectively. In respect of LIC, the break up of life, annuity and pension categories was Rs.24851.63 crore (60.44%), Rs.962.68 crore (2.34%) and Rs.15306.41 crore (37.22%) respectively. In case of the private insurers, Rs.10667.98 crore (86.57%), Rs.162.95 crore (1.32%), Rs.1473.88 crore (11.96%) and Rs.18.25 crore (0.15%) respectively was underwritten in the four segments.

Unit linked and conventional premium

Analysis of the statistics in terms of linked and non-linked premium indicates that 49.38% (Rs. 26391.14 crore) of the business was underwritten in the non-linked category; and 50.62% (Rs. 27052.63 crore) in the linked category. While private insurers' total business comprised of 86.64% of linked premium and 13.36% of conventional premium; composition of LIC's business has 39.82% share of linked premium and 60.18% of non-linked premium. During the corresponding period of the previous year, linked and non-linked premium indicates that 55.29% (Rs. 12734.47 crore) of the business was underwritten in the non-linked category, and 44.71% (Rs. 10298.96 crore) in the linked category. In case of LIC, the linked and non-linked premium was 31.36% and 68.64% respectively; while for the private insurers taken together it stood at 79.51% and 20.49% respectively.

First Year Premium of Life Insurers for the Period Ended January 2007

Sl No.	Insurer	Premium u/w (Rs. In Lakhs)			No. of Policies / Schemes			No. of lives covered under Group		
		Jan, 07	Up to Jan, 07	Up to Jan, 06	Jan, 07	Up to Jan, 07	Up to Jan, 06	Jan, 07	Up to Jan, 07	Up to Jan, 06
1	**Bajaj Allianz**									
	Individual Single Premium	79.06	878.28	1006.12	19574	98245	84881			
	Individual Non-Single Premium	283.29	1649.25	657.16	194422	1040702	366333			
	Group Single Premium	0.42	4.19	2.02	0	1	1	290	1792	655
	Group Non-Single Premium	2.59	17.32	15.23	21	180	130	91386	619681	276746
2	**ING Vysya**									
	Individual Single Premium	0.70	21.61	6.93	58	1575	824			
	Individual Non-Single Premium	27.09	284.29	149.71	11596	145957	82963			
	Group Single Premium	0.00	2.31	8.44	0	0	0	0	517	2267
	Group Non-Single Premium	0.44	5.91	8.98	0	40	58	493	12499	24009
3	**Reliance Life**									
	Individual Single Premium	6.74	81.90	99.05	1298	13283	14686			
	Individual Non-Single Premium	55.36	379.25	29.56	31616	239299	32924			
	Group Single Premium	2.13	11.57	1.05	6	21	0	898	14384	0
	Group Non-Single Premium	0.89	7.98	5.48	12	133	80	17127	153415	113308
4	**SBI Life**									
	Individual Single Premium	39.66	326.24	61.73	6680	49114	9270			
	Individual Non-Single Premium	116.78	689.56	122.30	41554	291868	145151			
	Group Single Premium	23.63	170.48	168.16	0	2	2	12970	102560	164322
	Group Non-Single Premium	19.04	203.55	75.34	6	274	1544	78807	868207	594061
5	**Tata AIG**									
	Individual Single Premium	2.06	14.19	4.42	270	1578	0			
	Individual Non-Single Premium	38.68	395.49	296.35	29679	310998	232166			
	Group Single Premium	4.37	42.38	18.92	1	7	2	22321	224631	123892
	Group Non-Single Premium	7.25	36.33	48.76	4	66	221	17626	193986	363370

6	**HDFC Standard**									
	Individual Single Premium	10.19	98.33	86.87	11437	89746	76478			
	Individual Non-Single Premium	135.76	881.42	537.28	37863	243454	179935			
	Group Single Premium	17.83	117.29	39.43	11	82	82	15592	148563	110365
	Group Non-Single Premium	4.92	56.59	22.01	5	27	18	9350	48537	14154
7	**ICICI Prudential**									
	Individual Single Premium	51.76	305.22	65.84	7684	45847	29289			
	Individual Non-Single Premium	381.68	2658.04	1430.30	195603	1302401	549110			
	Group Single Premium	84.35	235.30	31.91	11	134	103	14211	124584	221460
	Group Non-Single Premium	46.92	315.93	132.86	24	257	108	67393	311566	100363
8	**Birla Sunlife**									
	Individual Single Premium	4.86	28.21	16.90	12840	51346	52870			
	Individual Non-Single Premium	53.76	471.22	371.09	34618	203900	121854			
	Group Single Premium	0.16	6.55	7.70	0	0	0	93	3731	5227
	Group Non-Single Premium	8.79	73.81	18.81	8	125	34	2334	50463	7306
9	**Aviva**									
	Individual Single Premium	3.53	25.04	7.26	530	2748	2342			
	Individual Non-Single Premium	54.68	473.14	248.81	26575	212680	105757			
	Group Single Premium	0.28	2.74	1.08	0	1	0	217	1547	688
	Group Non-Single Premium	1.26	19.81	1.95	15	63	14	31117	270255	154756
10	**Kotak Mahindra Old Mutual**									
	Individual Single Premium	4.06	28.32	19.25	330	3034	2735			
	Individual Non-Single Premium	44.18	314.34	147.66	16345	99513	59254			
	Group Single Premium	2.00	9.67	1.85	0	9	2	12874	55534	11912
	Group Non-Single Premium	2.93	28.75	6.50	26	147	73	54672	239281	93535
11	**Max New York**									
	Individual Single Premium	8.56	69.07	1.42	512	5015	211			
	Individual Non-Single Premium	48.66	570.99	315.04	30111	411318	326811			
	Group Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Group Non-Single Premium	0.06	4.05	1.04	14	57	80	6447	58060	32955
12	**Met Life**									
	Individual Single Premium	0.86	5.39	4.62	144	1154	1069			
	Individual Non-Single Premium	39.47	191.49	87.21	11324	74318	72294			
	Group Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Group Non-Single Premium	1.50	13.78	6.76	6	184	156	36516	371695	275291
13	**Sahara Life**									
	Individual Single Premium	2.87	12.97	10.30	775	3412	2602			
	Individual Non-Single Premium	2.32	7.00	3.60	4453	15980	14891			
	Group Single Premium	0.00	0.00	0.01	0	0	10	0	0	729
	Group Non-Single Premium	0.00	0.94	0.00	1	3	0	60	103191	0
14	**Shriram Life**									
	Individual Single Premium	2.90	58.92		673	12703				
	Individual Non-Single Premium	2.40	50.43		1878	49372				
	Group Single Premium	0.00	0.00		0	0		0	0	
	Group Non-Single Premium	0.00	0.00		0	0		0	0	
15	**Bharti Axa Life**									
	Individual Single Premium	0.00	0.00		0	0				
	Individual Non-Single Premium	0.95	2.85		734	2023				
	Group Single Premium	0.00	0.00		0	0		0	0	
	Group Non-Single Premium	0.00	0.00		0	0		0	0	
	Private Total									
	Individual Single Premium	217.81	1953.68	1390.72	62805	378800	277257			
	Individual Non-Single Premium	1285.08	9018.76	4396.08	668371	4643783	2289443			
	Group Single Premium	135.17	602.49	280.57	29	257	202	79466	677843	641517
	Group Non-Single Premium	96.60	784.75	343.73	142	1556	2516	413328	3300836	2049854
16	**LIC**									
	Individual Single Premium	756.00	15966.46	5976.96	556043	4837523	1596868			
	Individual Non-Single Premium	1178.10	17884.85	7930.23	2624502	15755078	16652234			
	Group Single Premium	932.82	7269.40	2739.18	1792	15365	12457	1075767	10989279	9422584
	Group Non-Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Grand Total									
	Individual Single Premium	973.81	17920.14	7367.68	618848	5216323	1874125			
	Individual Non-Single Premium	2463.18	26903.61	12326.31	3292873	20398861	18941677			
	Group Single Premium	1067.99	7871.89	3019.75	1821	15622	12659	1155233	11667122	10064101
	Group Non-Single Premium	96.60	784.75	343.73	142	1556	2516	413328	3300836	2049854

Note: 1. Cumulative premium upto 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

Catastrophe Risks and Insurance

'WHEN A CATASTROPHE STRIKES, IT FOLLOWS NO RHYME OR REASON FOR THE DEVASTATION IT CAUSES. THUS IT CALLS FOR GREATER ALERTNESS BY THE INSURERS AND REINSURERS' WRITES **U. JAWAHARLAL.**

Not very long ago, a natural catastrophe used to be heard of infrequently and thus disaster management used to be in manageable proportions. More recent trends indicate that if there has been anything certain with regard to their occurrence, it is the alarming frequency. The reasons assigned are many - like the global warming, emission of gases occurring all over the globe and such similar phenomena. Whatever the reasons, the bottom line is that disaster management has become a huge challenge. As an aftermath of a catastrophe, nature leaves behind a trail of devastation - in the form of economic losses, loss of human lives etc. While nature's fury cannot be controlled altogether, the financial management of such catastrophic disasters can certainly be within the ambit of human ability, if tackled properly.

One of the most effective ways of tackling such a disaster is to transfer the risk to an insurer, although it comes at a premium. It is quite a challenge for insurers also to design suitable products; and as regards the terms of acceptance, pricing the risks, net retentions etc. Historically, the impact of some of these catastrophes has been devastating in a few cases but because of the infrequent occurrence, they did not really question the success of the catastrophe insurers. But the challenge is ever-increasing; and testing the best skills of underwriters. Several actuaries feel that the regular models that are applicable in the cases of other lines of insurance may not be very effective when it comes to severe natural catastrophes.

Yet another intriguing aspect that usually comes to surface in the aftermath of such catastrophes is the total amount of economic losses; and the insured losses. In more developed parts of the world, most of the losses are covered sufficiently by insurance; and as such the economic losses are made good. This goes a long way in ameliorating the distressed, their emotional losses notwithstanding. However, in several developing economies, insurance is still not used as a strong tool for mitigation of such disasters. For example: The Tsunami that hit several coasts of South East Asian countries a couple of years ago left behind a trail of destruction and wreaked havoc in several littoral regions, leading to huge losses of assets and human lives. Similarly, Hurricane Katrina that occurred a few months later devastated several regions around the Gulf of Mexico. On a comparative note, the Tsunami affected a greater geographical area and also killed more people than the Hurricane Katrina did. But when it comes to the insured losses, the bill on account of the hurricane was far in excess of all the losses reported in all the countries put together, in the case of the Tsunami. Some of the reasons attributed for such an imbalance are the economic value of the assets, poor loss minimization methods etc. But above all, the fact that most of the assets and the individuals themselves were either under insured or not insured at all is the main reason. This emphasizes the need for spreading insurance awareness among these vulnerable sections.

Apart from the natural catastrophes, terrorism has been raising its ugly head in more recent times at alarming intervals. As against the earlier notion that only a few regions are vulnerable to such attacks, sporadic events in Mumbai to Madrid have shown that no place is additionally safe. This once again underlines the need for gearing up against the losses that can be caused by these senseless bouts of terrorist attacks.

Disaster management and preparedness for the eventualities forms the focus of the next issue of the Journal. The subject is ever very topical and universal in nature; we will be publishing articles commenting upon the very sensitive issue.

Guarding against Catastrophe

in the next issue...

CIRCULAR

31st January, 2007 CIRCULAR NO: 048/IRDA/ACTL/FUP/VER 3.0/JAN 2007

Re: File and use procedure life insurance products

1. This has reference to the File and Use Circular No: IRDA/ACTL/FUP/VER 2.0/DEC 2001/ dated: 12th December 2001, and also CIRCULAR NO: IRDA/ACTL/FUP/VER 2.0/DEC 2003/ dated 18th December 2003; which the insurers are required to comply with, before launching the product in the market. [The F & U Circular is specific and a detailed instruction is also provided under each item of the F & U Application.]

2. As per existing procedure, after filing of the products, insurers may use the product if they do not hear anything from the Authority (IRDA) within 30 days from the date of receipt of application at the Authority.

   In view of the difficulties experienced by the insurers, it has been decided to reduce the waiting period to 15 days with respect to the filings of the following products: (This means that if insurers do not hear from the Authority within fifteen days from the date of receipt of application for the under noted product filings at the Authority, insurers can offer sale of such products.)

   a. All individual non-linked products (both participating and non-participating), where the products shall be simple Endowment assurance or Whole Life assurance or Money Back assurance or Term Assurance or all types of Immediate Annuities

   b. In case of non-linked participating products, as mentioned in (a) above this 15 days waiting period is applicable only for products with reversionary bonus.

   c. All modifications in respect of products which fall under sub-para (a) and (b).

   d. In respect of products other than those referred in Para (2) above, the existing practice in regard to the waiting period of 30 days would continue.

3. In addition to the conditions mentioned Para (2), the following requirements should also be satisfied for availing the above relaxation.

   3.1 The product shall have a minimum policy term of 5 years.

   3.2 An additional certificate from CEO and the Appointed Actuary as enclosed in Annexure-I (required for all the products filed with the Authority for clearance).

   3.3 A check list signed by the CEO and the Appointed Actuary as enclosed in Annexure-II (required for all the products filed with the Authority for clearance).

   3.4 The product should not be attached with riders other than Accident Benefit and Permanent Disability; (this condition would apply to sub-clause (a) of Para 2. above);

   3.5 The product features should offer, in case of lapses, a revival period of at least 2 years;

   3.6 The product should not be modified in any regard for at least six months from the date of filing with the Authority;

   3.7 Premium rates with the facility of premium calculator should be made available at the insurer's website;

   3.8 The product should be subject to the Authority's Circular NO.01/IRDA/Actl/MC/2006-07 dated 12th July, 2006;

   3.9 After launch of the product in the market, soft copy of the scanned file and use documents should be furnished to the Authority, immediately;

It is also proposed now to acknowledge electronically the receipt of the product at authority's office. This date is the date of receipt of the product filing.

R. Kannan
Member (Actuary)

ANNEXURE: I

A certificate signed by the Appointed Actuary and countersigned by the CEO stating that

(1) Name of the insurer:

(2) Name of the product:
   a)there are no contradictions/deviations between the policy bond and what is indicated in the File & Use Application Form;
   b)there are no contradictions/deviations between the policy bond and sales literature;
   c)the proposal form contains the particulars, which are in conformity with the provisions of Section 41 & 45 of the Insurance Act, 1938 and also that the proposal form does not give any right to the insurer to share the information contained in the proposal form with any other third party other than re-insurer.

Signature of the CEO
Signature of the AA
Date:

ANNEXURE: II

Name of the Insurer:
Name of the Product:
Check List for submitting the File and Use Application to the Authority:

S. No	Description	Page numbers and item numbers where it is stated in F & U Application	Remarks, if any	Sales literature	Policy document
1	Eligibility criteria				
2	Benefits		Death, Maturity Surrender etc		
3	Options available to PH				
4	Bonus availability and bonus philosophy				
5	Riders attached				
6	Premium paying modes and modal factors				
7	Exclusions				
8	Grace Period				
9	Revival				
10	Nomination				
11	Any discounts offered like SA related				
12	Any other relevant issue				

Signature of the CEO
Date:

Signature of the AA

CIRCULAR

31st January, 2007

CIRCULAR NO: 47: IRDA/ACTL/FUP/VER 4.0/JAN 2007/

Re: File and use procedure life insurance products - Unique Identification Number (ID)

1. This has reference to the File and Use Circular No: IRDA/ACTL/FUP/VER 2.0/DEC 2001/ dated: 12th December 2001, and also CIRCULAR NO: IRDA/ACTL/FUP/VER 2.0/DEC 2003/ dated 18th December 2003; which the insurers are required to comply with, before launching the product in the market.

2. In this process, it has been decided that every life insurance product, whether individual or group, and every rider, should be identified with a unique number; and this number has to be quoted in all relevant documents furnished to the policyholders, other users (public, distribution channels) and also in the statutory returns filed with the IRDA.

3. This unique number will have ten characters/digits as follows:-

Insurer's Registration Number allotted by IRDA C1	Nature of product/Rider: L/N/A/B/C C2	Serial number of the product/rider allotted by IRDA C3	Version C4	Number C5
1 2 3	4	5 6 7	8	9 10

Notes:

C1: 1-3: numeric to indicate the registration number of Insurer allotted by the IRDA to identify the name of insurer in 3 digits;

C2: 4 is an alphabet to indicate the nature of product/rider: L would indicate linked product; N a non-linked product; A: Rider (linked); B: Rider (non-linked) and C: Rider (for both linked as well as non-linked;

C3: 5 to 7 : numeric value to indicate that the product is the nth product of insurer-this is a running serial number to be assigned by IRDA (starting from 001);

C4: 8 : alphabet -V - to indicate the Version. This is same for all products/riders;

C5: 9 -10: numeric value to indicate the number of times the product is modified-this is a running serial number starting from 01 for new product, for instance, 02 would indicate Version 02 of the product available for marketing from the date the modification is cleared; the older version could indicate that they are no longer in the market from the date of the latest modification.

For instance, 107L050V02 would indicate that this is 50th product, which is linked and modified twice, of an an insurer with registration number 107 given by the IRDA. 4. IRDA would publish in its website www.irdaindia.org the details of products cleared by the Authority, for public information, as below:-

S No	Name of Insurer	IRDA Product/ Rider Number	Brand Name of Product/ Rider	Offer to public from	Offer to from public ended
(1)	(2)	(3)	(4)	(5)	(6)

Notes:

Col (1) would indicate the running serial number of products / riders;

Col (2) is the name of insurer registered with IRDA;

Col (3) is the IRDA Product/rider number allotted by the IRDA;

Col (4) is the brand name of the product/rider corresponding to the IRDA Product/Rider Number;

Col (5) would reflect the date from which the insurer is allowed to offer the product/rider under col (3) for sale in the market;

Col (6) would reflect the date from which the insurer stopped sale of the product/rider or modified the product/rider under col (3) with prior clearance from the IRDA.

Col (2) would provide hyper-link to the insurer's website for public use.

5. All life insurers are hereby requested to obtain the IRDA Product/Rider Number for all existing products/riders which are being offered for sale in the market. In this regard, insurers are requested to furnish the details in the format mentioned in para 3 above for all the existing products (except col (3)) for allotment of IRDA Product/Rider number within 15 days from the date of receipt of this circular. However, where an existing product has been modified from the date of first clearance, the insurer shall indicate the last two digits of the unique number in col (3) which will be verified by the Authority at the time of allotting the said number i.e. the insurer shall indicate the number of times the product was modified from the date of first clearance.
6. For all the new products the Authority shall allot this number at the time of clearance of the product/rider.
7. The above procedure comes into force since 1st April, 2007.

R. Kannan
Member (Actuary)

SUSPENSION ORDER

19th February, 2007

Re: Suspension of Broking License Code No. 128/03 & License No. 170
M/S. MF Insurance & Reinsurance Services

A complaint was received against MF Insurance & Reinsurance Services from President, Reliance General Insurance Company Limited vide their letter dated 7 th April, 2005 alleging gross irregularities with regard to placement of 60% of risk of Jeweler's Block Insurance issued to M/s M. Suresh & Co.

The IRDA vide its letter no. 128/ broke - MF/ 2005 dated 30.9.2005 appointed Ms Suvira Das as the Inspecting Officer to investigate the case. The Inspecting Officer in her report dated 17.1.2006 had observed that:

1. the broker failed to provide a true and complete copy of reinsurance placement slip to the insurance company
2. the broker failed to provide a true copy of the placement slip signed by the leading reinsurer until after expiry of the policy
3. the broker failed to follow up the cover note by a formal signed reinsurance policy document within one month of receipt of reinsurance premium which was received by the broker on 24.9.2004
4. the broker did not keep the insurance company informed of the placement of the cover nor did they inform the insurance company of the changes in reinsurer, a fact known to the broker through their co-broker, Hughes & Partners.

Following this the IRDA vide its notice dated 10 th May, 2006 decided to conduct an Enquiry into the matter and appointed Ms M.G. Meenakshi as the Enquiry Officer. The Enquiry Officer has submitted her Interim Report dated 2 nd January, 2007 , wherein she has given her finding that:

1. MF Re have violated provisions of 2a, 2b, 2i, 3e, 4c, 5a, 5c 5d and 9b of the Code of Conduct Schedule III of the IRDA (Insurance Brokers) Regulations, 2002; and
2. There are contra indications on the basic issue of there being a valid reinsurance cover placed by MF Re for the Risk of M/s. M. Suresh & Co. sought to be reinsured by Reliance General Insurance Co. Ltd.

The Enquiry Officer has further commented on the following aspects, which came to light during scrutiny of the records produced during the enquiry proceedings:

During the enquiry the invoices raised by Hughes and Partners Limited on MF Insurance and Reinsurance Services for the combined remittance made by HDFC Bank in respect of 9 risks amounting to Rs. 1.43 crs were examined. It was observed that out of 9 risks 8 risks were reinsured with Condor Insurance. In case of M Suresh & Co, MF Insurance and Reinsurance Services stated that the risk was placed with Condor Insurance. However, on being asked to furnish documentary proof for the transfer of premium from corresponding broker a/c to Condor a/c and also the signed copy of the cover note issued by Condor Insurance issued for the period 2004-05, MF Insurance and Reinsurance Services could not produce the same. On cross verification from other insurers whether they had accepted Condor Insurance as the Reinsurer, it was found the Reinsurer to whom the premium has been remitted and those whose names are given in the slip issued by MF Insurance & Reinsurance services are different.

In light of the above findings, the Authority is of the view:

" that the Broker had violated Regulation 21 read with Schedule III - Code of Conduct of the IRDA's (Insurance Brokers) Regulations, 2002.

" that the Broker committed serious irregularities against the cedants by giving wrong names of the reinsurers.

" that the insurance company may have been put in financial jeopardy had a claim arisen under the policies, since the reinsurers so named in the reinsurance slip issued by the broker were not on risk.

Therefore, pending further enquiry, in exercise of powers granted to it under Regulation 35 of the IRDA's (Insurance Brokers) Regulations, 2002, the Authority has suspended the license of the broker vide its order dt. 9 th February, 2007 .

K.K. Srinivasan
Member

CIRCULAR

February 20, 2007 Circular No. 054/IRDA/F & A/FEB-07

Re: Unit Linked Disclosure Norms

To
CEOs of
All Life Insurance Companies

This is further to our letter no. 37/2/F&A/Circulars/146/JAN/2006-07 dtd 4 th January 2007 under the cover of which the Authority had circulated the draft of the guidelines for disclosure in respect of unit linked business which are to form part of the annual accounts of the insurance companies with effect from financial year 2006-07. The draft guidelines were circulated seeking comments of insurers.

The Authority has since examined the feedback received from the insurance companies. The format of reporting under the IRDA (Preparation of Financial Statements and Auditor's report of Insurance Companies) Regulations, 2002 has been modified to ensure transparency and consistency in the disclosures across the industry.

As indicated earlier, the revised formats include the following:

1. Segregation of the Unit Linked Revenue A/c into two components, viz., (i) Non -Unit Funds and (ii) Unit Fund (which form Addendum to the Form A-RA);
2. Format of reporting of the Segregated funds - Revenue A/c, Balance Sheet and the underlying Schedules;
3. Additional disclosures to form part of the Annual Report.

In view of the queries raised by the insurers as to the manner of reporting further clarifications are being issued:

1. The Investment portion of premium shall be disclosed in the Unit segment and the non-investment portion in the non-unit segment;
2. Income on investment shall be disclosed under unit and non unit portion in consonance with (1) above;
3. Fees and charges shall be shown as "Income" in the non-unit segment and as "Expenses" in the unit segment.
4. All operating expenses and Commission shall be disclosed in non-unit segment
5. Claims arising from cancellation of units alone shall be shown against linked segment and other items like mortality, morbidity and value of guaranteed benefits shall be disclosed under non-unit segment

The above proposals are intended to further improve the quality of disclosures on ULIPs and are exclusively based upon the information already available and/or used for aggregation/compilation of the figures for the annual financial statements. The Authority therefore considers that the adoption of the revised formats do not pose any serious operational difficulty. It has therefore been decided that the insurers should comply with the above modifications w.e.f. the financial year ending March, 2007after effecting the necessary systems modifications.

Yours faithfully
(**C.S. Rao**)

CIRCULAR

February 21, 2007 Circular No. 055/IRDA/F & A /FEB-07

Sub: Applicability of revised AS 15

To
All the Insurers/Reinsurer

The Council of the Institute of Chartered Accountants of India (ICAI) at its 265 th Meeting held on February 3-4, 2007, decided to defer the date of applicability of Accounting Standard (AS) 15, Employee Benefits (revised 2005), issued by the ICAI. As per the decision the AS would come into effect in respect of accounting periods commencing on or after December 7, 2006 (instead of April, 2006, as stated in the said Standard) and is mandatory in nature from that date.

In respect of insurance companies, since the accounting period commencing on or after December 7, 2006 is financial year 2007-08, the revised AS 15 is effective for them, from the financial year commencing from 1 st April 2007.

(**C.S. Rao**)
Chairman

CIRCULAR

2nd March 2007 Circular No. 057/IRDA/AML/MAR-07

Sub: Guidelines on Anti-Money Laundering Programme for Insurers

To
All the Life Insurers

Guidelines on Anti-Money Laundering Programme for Insurers

Please refer to "Guidelines on Anti-Money Laundering Programme" which became effective from 1 st August 2006, wherein collection of photograph on all new insurance contracts was made mandatory.

We have received representation from the Life insurance companies and Life Insurance Council that the compliance with the requirement is proving difficult apart from adding to the costs, especially in case of low value products. The matter has been examined by the Authority in the specific context of hardships in complying with this KYC requirement by small value policyholders with possible implication for the spread of insurance into rural and low-income domains, especially the micro insurance sector. The Authority, has since decided to provide exemption upto a total Annual Premiumof Rs.10000/-on all the life insurance policies held by a singleindividual from the requirement of recent photograph and proof of residence.

We also advise that the suggestion of the insurers to obtaining of a photo identity card (of an official entity) with the photo in-lieu of a recent photograph has been examined, but it has not been possible to accede to.

Insurers are advised to take note of the above modifications and ensure compliance with the framework in entirety.

Yours faithfully,

(**C. R. Muralidharan**)
Member

PRESS NOTE

2nd March 2007 Circular No. 057/IRDA/AML/MAR-07

Sub: Misleading Sales literature on Unit Linked Product

It has come to the notice of the Authority that some of the Development Officers and Agents of Life Insurance Corporation of India are promoting their Unit linked Insurance Product 'Money Plus' claiming to offer astronomical returns and guaranteed benefits at the end of specific periods. Some of the leaflets assure a maturity value of Rs 3.38 crores at the end of 20 years on an annual investment of Rs 1 lakh over a period of three years. projecting a growth of 25% per annum.

Similar claims have also been made by agents of a few other insurers.

The authority would like to clarify that such projections are misleading, inflated and also do not have the approval of the IRDA. As per the guidelines of the Life Insurance Council, the Insurers are required to project their returns at a rate ranging between 6% and 10% only. The insurers are also expected to state that even these returns are not guaranteed. It may also be noted that the returns under the Unit Linked Products are dependent on the performance of the chosen fund, which is in turn affected by the performance of the stock markets.

While the Authority has already taken up the matter with the concerned insurers, it cautions members of the public not to get carried away by such unapproved sales presentations being circulated in the market. They may take an informed decision while purchasing a policy, on the basis of proper disclosures by the licensed representatives of the Insurer.

(**C.S. Rao**)
Chairman

Plain English in Insurance

Need of the Hour

V. RAMAKRISHNA ASSERTS THAT THERE IS A COMPELLING REASON FOR INSURERS TO ADOPT A "POSITIVE CLAIMS ATTITUDE" TOWARD POLICY INTERPRETATION, THAT IS, TO FOCUS ON LOOKING FOR WAYS TO COVER A CLAIM RATHER THAN FOR WAYS TO EXCLUDE IT.

Introduction

"XYZ General Insurance Company Limited ("the Company"), having received a proposal and the premium from the Proposer named in the schedule referred to hereinbelow, and the said Proposal and Declaration together with any statement, report or other document leading to the issue of this Policy and referred to therein having been accepted and agreed to by the Company and the Proposer as the basis of this contract do, by this Policy agree, in consideration of and subject to the due receipt of the subsequent premiums, as set out in the schedule with all its Parts, and further, subject to the terms and conditions contained in this Policy, as set out in the Schedule with all its Parts that on proof to the satisfaction of the Company of the compensation having become payable as set out in Part 1 of the Schedule to the title of the said person or persons claiming payment or upon the happening of an event upon which one or more benefits become payable under this Policy, the Sum insured/appropriate benefit will be paid by the Company."

If you have fully understood the above paragraph in the first reading, chances are you are a seasoned insurance veteran. It is an extract - known as the "preamble" - from an Insurance policy of an Indian general insurance company. One wonders how many people actually read and understand the preamble, leave alone the entire policy document which is normally more than ten pages.

For various reasons, traditionally insurance policies have always been difficult to understand and read almost like legal documents. An insurance product is intangible by nature - the only tangible component is the policy document, which is difficult to comprehend. A consumer about to sign a proposal or purchase an insurance policy for her Householders insurance should not have to pay a lawyer to explain what the legalese in the relevant documents means.

World over, insurance contracts remain a question of concern as regards the language used.

Why is it that when insurance is a contract between two parties, one of them (the insured) has no say in the wordings? Would the number of disputes come down if plain language was used in all contracts?

History of Insurance policy wordings

The earliest authenticated insurance contract (i.e. that which displays the characteristics of insurance), is a marine insurance contract on a ship "The Santa Clara" dated 1347 in Genoa. The policy is in the Italian language and appears in the form a maritime loan to avoid the church prohibition against usury.

The earliest insurers were merchants underwriting risks for fellow merchants, on a part time basis. The contract of insurance was not created as a result of judicial or legislative innovation, but by the merchants themselves as a result

One wonders how many people actually read and understand the preamble, leave alone the entire policy document which is normally more than ten pages.

of commercial expediency and need (Necessity being the mother of invention).

Very few reported cases exist, or legal principles were established by the judiciary on the Continent, until Lord Mansfield C.J. took office in the Highest Court in England. During his tenure in office a large number of cases and principles were established by the eminent judge, many of which today exist unaltered (examples of which would be that insurances contracts are contracts of good faith, the duty of disclosure, the effect of misrepresentation and non-disclosure on the insurance contract, the effect of fraud on the insurance contract, warranties, etc , to name a few).

However, policy wordings have to a large extent, remained unaltered and follow the example of the Lloyds policy wordings which had been created more than 200 years ago. This is particularly evident in the field of marine insurance. Personal lines insurance policy wordings however have been greatly improved and simplified in recent times.

The Legal Position

It is a generally accepted rule of contract law that a party to a contract is imputed full knowledge of the contract provisions. In written contracts in general, an individual will be bound by the terms whether they were read and understood or not. Although an insured can be held to have knowledge of the provisions of the insurance contract even though he or she may not have read it, the courts have traditionally been reluctant to hold insureds responsible for the same, as they recognize the highly technical nature of insurance; and the fact that insurance policy language is not easily understood by the average insured. There is therefore a tendency on the part of the courts to balance what they perceive as the unequal bargaining positions of insureds and insurers by giving the insured the benefit of the doubt.

In written contracts in general, an individual will be bound by the terms whether they were read and understood or not.

An insurance policy is a "contract of adhesion", which means that any doubt or ambiguity in a policy provision will be resolved against the party that drafted it. Since the insurer drafted the policy, any question concerning its meaning will ordinarily be decided against the insurer and in favor of the insured. Courts have essentially adopted this position. The rationale behind this principle is that since the insurer chose the policy language, it can be assumed that the insurer has sought to limit its scope. Fairness dictates that any doubt as to the meaning of the language used should be resolved in favor of the insured. To do otherwise, and employ a narrow and technical construction, would result in an injustice. As a result, there is a compelling reason for insurers to adopt a "positive claims attitude" toward policy interpretation, that is, to focus on looking for ways to cover a claim rather than for ways to exclude it.

What is Plain English?

Plain English is language that is clear, direct and straightforward.

- Clear straightforward expression, using only as many words as are necessary - using language that avoids obscurity, inflated vocabulary and convoluted sentence construction.
- It is not baby talk, nor is it a simplified version of the English language. It is written with the reader in mind and with the right tone of voice that is clear and concise.
- It doesn't mean reducing the length or changing the meaning of your message.
- It's not about banning new words, killing off long words or promoting completely perfect grammar. Nor is it about letting grammar slip.
- It is not an amateur's method of communication. Most forward-looking senior managers always write in plain English.

And finally, it is not as easy as we would like to think.

Examples of Complex Clauses

Readability experts recommend that the average length of sentences should be 20 or fewer words. Longer sentences risk providing too much information and often fail to organize that information in a clear, accurate and effective manner.

Take for instance a Re-instatement clause (174 words) picked up from an insurance policy today. It is too long, contains superfluous information, arranges its relative and subordinate clauses poorly (they intrude between the subjects and their verbs), and presents ideas in a way that is not logically organized.

"If the Company at its option, reinstate or replace the property damaged or destroyed, or any part thereof, instead of paying the amount of the loss or

damage, or joint with any other Company or Insurer(s) in so doing the Company shall not be bound to reinstate exactly or completely but only as circumstances permit and in reasonably sufficient manner, and in no case shall the Company be bound to expend more in reinstatement than it would have cost to reinstate such property as it was at the time of the occurrence of such loss or damage nor more than the sum insured by the Company thereon. If the Company so elect to reinstate or replace any property the insured shall at his own expense furnish the Company with such plans, specification, measurements, quantities and such other particulars as the Company may require, and no acts done, or caused to be done, by the Company with a view to reinstatement or replacement shall be deemed an election by the company to reinstate or replace.

A suggested revision (89 words) follows:

"If the Company decides to settle the claim by reinstating or replacing the damaged property entirely or partly, it need not necessarily reinstate exactly but may do so to the best of what the circumstances permit. This is to be done in a reasonable time frame and restricted to the cost of reinstating at the time of loss subject to adequacy of the sum insured. Cost of any kind of betterment and also including the cost of plans, specifications, measurements, quantities etc is to be borne by the insured.

In a similar vein, consider the following clause in a property insurance policy:

"We will not disclaim coverage under this policy if you fail to disclose all hazards as of the inception date of the policy, providing such failure is not intentional."

This sentence pattern can be improved as follows:

"If your failure to disclose all hazards is not intentional, then we will not disclaim coverage under this policy."

Plain English is any message, written with the reader in mind, which gets its meaning across clearly and concisely so the reader can take the appropriate action.

What is happening - World / India

Over the last two decades, a 'culture of clarity' has been gaining ground with many insurers around the English-speaking world. In several countries including US and UK, campaigns towards making insurance policies in Plain English have become a movement. In these countries apart from insurance companies other companies like government departments, banks and local councils have come to realize that clear communication is actually a good idea. Instead of writing to impress or confuse, they are now writing to inform and explain. They are using plain English to do this. It is heartening to note that in several states of the United States, the need to shift to plain English has gained momentum. Almost all insurance policies in Michigan are now written in plain English, or at least score fairly well on the readability tests. Furthermore, they have been written in plain English for the last five to ten years. But

Consider these examples:

- In 1977, Royal Insurance Company, Canada unveiled its "simple English" Select Homeshield Policy for home insurance. Sales increased 38%, from $58 million to $79 million in the same year.
- Since the early 1970's, Bank of Nova Scotia has been redesigning forms and writing contracts in plain legal English. So far, it has never had a court case because of plain language.

In India, to a large extent with IRDA's intervention and the opening up of the industry, several insurers have been working towards simplifying the policy wordings to make them more reader-friendly. Highlighting difficult/ technical words and providing definitions for them has been one significant improvement in rendering the policy more understandable.

Conclusion

In spite of the above, even today, if you ask the general public, they will still cite insurance policies as prime examples of legalese. Why? Because insurance policies used to be written in legalese, and people simply gave up trying to read the policies. There is a strong case for all the industry players to devote more attention to propagating Plain English in insurance policy wordings.

With the consumers interest gaining momentum across the world the day is not far off when the insurance policies will be in plain English and this would hopefully result in the spread of insurance awareness.

Over the last two decades, a 'culture of clarity' has been gaining ground with many insurers around the English-speaking world.

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

Contract Certainty and the Insurance Market

Lessons for Learning

'THERE HAVE BEEN MYRIAD DISPUTES AS TO THE PRECISE MEANING AND EFFECT OF CONTRACTUAL RIGHTS AND OBLIGATIONS WHICH HAVE PROVED TO BE LONGSTANDING, WIDESPREAD, RECURRENT AND EXPENSIVE' ARGUES **ARUP CHATTERJEE.**

Contract certainty means different things to different people. From the broker's perspective it means delivering to the client, complete, correct and final contract documentation before or, at the very least, at the point of inception. For the client it means knowing exactly what has been paid for, from the moment the policy comes into force. From the underwriter's perspective it means knowing what they have committed to, so that they can calculate the level of capital they need to assign to any given risk. All stakeholders will be concerned that the exact coverage is known and agreed.

The lack of contract certainty has proved a longstanding and problematic topic for the (re)insurance industry. It has led to a "deal now, detail later" culture, which essentially refers to the fact that a large number of insurance contracts are not finalised at the point of their inception. While the issue is prevalent in London, it is not necessarily unique to this market as some firms believe. It applies to all firms who undertake general insurance business and particularly those conducting business with commercial and wholesale customers. All firms in this sector will need to demonstrate that they have proportionate systems and controls in place to support a working environment that is contract certain.

Collectively, if the stakeholders fail on the delivery of contract certainty, several profound problems can arise. Arguably, however, the most significant problem associated with the lack of contract certainty is the fact that the client or insurer cannot be certain what claim amount is going to be paid, possibly leading to litigation and delay. There have been myriad disputes as to the precise meaning and effect of contractual rights and obligations which have proved to be longstanding, widespread, recurrent and expensive. This aspect is fundamental to the value of insurance itself, as essentially the industry only exists on the basis of paying valid claims in a full and timely manner. Without certainty of contract, the value of the insurance proposition is greatly reduced. Indeed, it has been said that there is something absurd about an industry that deals in protecting against risk, yet creates risk through its own processes.

Although, contract disputes are not the exclusive preserve of the worldwide insurance/reinsurance industry; nevertheless, the ability to avoid, manage or resolve disputes at an early stage, and on a reasonable commercial basis, has been undermined by the all-too-frequent failings or non-existence of documentation.

The documentation of contractual terms is the key to contract certainty. There are three inextricably linked elements to such documentation:

- agreed terms and underlying information (and the right to access such information) are reduced to writing and are permanently recorded and readily accessible;

Indeed, it has been said that there is something absurd about an industry that deals in protecting against risk, yet creates risk through its own processes.

- any given term is expressed in such a way that its meaning is fully comprehensible on a reasonable, objective basis;
- any and all of the terms make sense when read together or as a whole.

There have been a number of recent cases arising from the absence of one or more of the above elements. The 9/11 World Trade Centre losses were an important catalyst, providing a high-profile example of a dispute arising from the lack of contract certainty at inception. Much comment has been made on the discrepancies in documentation in the World Trade Centre dispute of whether there were one or two losses. These cases illustrate how assumptions and incomplete information are no substitute for contract certainty, which is an essential component in managing functions which are fundamental to an insurer's core business: the acceptance, evaluation and management of the exposure to risk. Judges all over the world have complained that similar cases increasingly take up a disproportionate amount of time and cost.

Contract certainty is an issue which affects existing agreements as well as new agreements, whether for inward or outward business. There are three basic considerations:

- *the benefits of contract certainty as a means of reducing dispute resolution costs* - although insurers cannot expect to avoid contract disputes completely, contract certainty will help reduce the costs of disputes, and to refine and enhance the operation of insurers' core business;
- *the steps needed to achieve contract certainty* - these will depend on individual circumstances, but insurers' action to achieve certainty in respect of existing agreements will be influenced by the following factors:
  - the nature or status of the counterparty or business line (for instance, with respect to personal lines, the Insurance Ombudsman can rule on certain issues of fairness with respect to insurance obtained by consumers; the measure of contract certainty in this context would be the clarity of the contractual terms and their degree of fairness to consumers),
  - the amount of cover at issue on a risk in respect of which documentation is missing or the contractual terms are unclear,
  - the length of delay affecting such terms,
  - the reasons (if known) for any such delay,
  - the identity and location of those responsible for providing documentation,
  - whether any terms give rise to issues requiring legal or regulatory advice;
- *the effect of failing to achieve contract certainty* - aside from the obvious drain of arbitration or litigation; London Market participants, and the individuals responsible for their management, are likely to feel the force of the insurance supervisor's powers if the requisite progress is not made.

One of the initial - and most important - steps taken by the various UK insurance industry stakeholders charged with delivering the FSA's requirements on contract certainty involved agreeing an industry-wide definition of the term. It is:

Contract certainty is achieved by the complete and final agreement of all terms (including signed lines) between the insured and insurers before inception.

- the full wording must be agreed before any insurer formally commits to the contract;
- an appropriate evidence of cover is to be issued within 30 days of inception.
- in addition, to help the UK industry comply with this definition, several other documents have subsequently been issued, including a Contract Certainty Code of Practice, Contract Certainty Checklist and additional guidelines on such topics as measurement, late placements, signed lines and exceptions.

Although the FSA, UK recognises that there are initial investment costs associated with finding a solution to contract certainty, they ultimately believe that these will be outweighed by the long-term benefits.

There are numerous examples of the good practice which the FSA expects: *paragraph 7.1.30G of the Integrated Prudential Sourcebook ("PRU")* sets out the steps an insurer should take in controlling its exposure to risk, such as the regular review and revision of, including legal advice on, its policy documentation; in respect of reinsurance, *PRU paragraph 7.1.34G states that insurers should, amongst other things, "ensure … all terms, conditions and warranties are unambiguous and understood" with "adequate legal checking procedures" for draft agreements.*

Although the FSA, UK recognises that there are initial investment costs associated with finding a solution to contract certainty, they ultimately believe that these will be outweighed by the long-term benefits. Making the necessary improvements, however, should over time be offset by a reduction in costs arising from the benefits of contract certainty. These should include reduced legal fees and other costs arising out of claims disputes; which is not to say that such disputes will be

eliminated - of course they won't - but it should be clear that the costs borne by the market as a result of a lack of contract certainty are currently significant.

Just as costs are bound to be affected in the short term by the market moving towards greater contract certainty, so we would expect behaviour to change in respect of some working processes. Indeed, whilst some people may have focussed on the technological underpinnings, or a lack thereof; in the London market, the real change that needs to take place is in the behaviour of all parties in the insurance chain.

Behavioural change should start with the policyholder. In wholesale markets where many, if not most, buyers of insurance are relatively sophisticated it should be normal practice for the buyer to demand a wording to review before giving the broker the instruction to bind cover. Clearly this will be more onerous where the risk is new to the market than at any subsequent renewal, as in the latter case the assured may only need to ascertain whether or not the details of cover are as expiring. It is, however, important that buyers are robust in ensuring that they chase their agents for timely production of wordings.

If buyers place greater pressure on their agents to get a wording in place prior to inception then this will have to result in changes in the way that brokers manage the placement process and should mean that renewal discussions with insurers will start earlier. It should, however, also result in a reduced risk to the broker of errors and omissions and reduce the amount of time firms spend dealing with contentious claims where a wording has not been finalized. For brokers, though, the benefits of contract certainty should not just be felt in their E&O premiums. It should be about providing a better service to clients and, as such, putting them a step ahead of overseas competition.

What behavioural changes are needed from the risk carriers? In the past there has been a sense in which, for most risks, the underwriter sits back and waits for the wording to come to him - sometimes more in hope than expectation. There might be an occasional whip round the market with a list of outstanding wordings from each broker, but by and large it has been a fairly passive process unless the wording itself was the subject of a serious negotiation prior to placement.

If the market solution that has made much progress so far comes to fruition, then one would expect underwriters to have a much more proactive role in the process of achieving contract certainty - not just by monitoring and chasing more aggressively, but by getting more involved more often in detailed wordings negotiations, and, where necessary, by being prepared to say "no" to brokers who persistently fail to produce wordings on time.

Contract certainty is not a prescriptive set of rules imposed by the regulator, but a series of guiding principles that have emerged initially from the market itself. Some of the solutions already implemented by the UK insurance industry include:

- base wordings (model or "as expiring") to be used wherever possible as a basis for negotiation of bespoke clauses
- checks and associated measurements to be carried out before inception wherever possible
- changes to the insurance contract after inception are now always to be processed as endorsements
- a move to introduce new technology, in order to move away from an inefficient paper-based process.

Obviously there may be delays in the first instance as a result of people getting used to new procedures. There should not, however, be any need for these procedures to be implemented in an overly-bureaucratic manner provided that brokers and underwriters cooperate sensibly - indeed this already happens to a large extent in classes where bespoke wordings are the norm.

The FSA has indicated that uncertainty as to the terms of risks accepted or ceded undermines the proper conduct of insurance business has ramifications for its mandate to maintain confidence and prevent financial crime in, and promote understanding of, the UK insurance market. Ultimately, it is believed that these improvements will result in the UK insurance industry gaining significant competitive advantage. Although there is still no doubt that price remains one of the most important factors in today's global competitive insurance industry, there is now, a growing sense that a reasonably-priced insurance policy accompanied with certainty of contract is valued by an increasingly large number of clients. Many of those involved in this reform process suggest that overseas buyers and brokers may be attracted to this location, as they will see their own risks reduced by placing business in markets where details of the deal are agreed at inception, not months afterwards.

Interestingly, achievements to date have already given the FSA the confidence to tout the benefits of contract certainty to insurance regulators and insurance industry representative organisations around the world.

Although there is still no doubt that price remains one of the most important factors in today's global competitive insurance industry, there is now, a growing sense that a reasonably-priced insurance policy accompanied with certainty of contract is valued by an increasingly large number of clients.

The author is Principal Administrator, International Association of Insurance Supervisors, Basel, Switzerland.

Reinsurance Agreements

Legal and Contractual Aspects

'REINSURANCE IS A SELF-REGULATED PROFESSION, OPEN TO REFORMS AND REVISIONS OF PRACTICES; TO MEET CHALLENGES OF CHANGING TIMES' ASSERTS **K.L. NAIK.**

Introduction

Reinsurance consciousness both on the part of the Reinsured and of the responding Reinsurer is to be instinctive, intuitive and innovative. There is no special law of reinsurance. The special rules governing insurance contracts are applicable to reinsurance. In many markets of Latin America and Asia, the insurance business is nationalised. Still there is no special law of reinsurance, even after liberalisation and globalisation.

Reinsurance is a self-regulated profession, open to reforms and revisions of practices; to meet challenges of changing times. In an interview with the Chief Executive of Mercantile & General, Mr. Julius Neave, Patricia Binns writes about self-regulation in reinsurance in following words:

> "A critical point in understanding Neave's philosophy, however, is his strong support of self-regulation. Progress through reform, rather than stopping free enterprise, is a key tenet behind his approach to reinsurance. He is a fervent believer that no government of any political flavour will idly stand by while a reinsurer collapses, bringing the market to disrepute. A reaction like this could leave original policy holders with a big loss in their hands. Only when self-regulation is an impossibility, do expose yourself to government interference".

Mr. Neave believes that self-regulation is at its best when there is much more co-ordinated and co-operative attitude of all reinsurers towards reform for progress.

Reinsurance policies and reinsurance contracts

Prof. R.L. Carter writes "Reinsurance Treaties and Reinsurance Policies are not synonymous; reinsurance treaties are contracts 'for' insurance and reinsurance policies or cessions are contracts 'of' insurance".

Facultative reinsurance is not for creation of capacity but it is for risks already underwritten, where limits are beyond the capacity of the insurer. It is a contract of insurance by way of a reinsurance policy for current single risk.

Under Reinsurance Treaty method, the reinsurance contract is for creation of capacity for future portfolio of risks to be underwritten and declared therein.

Again, under Quota Share treaty and Excess of Loss treaty the risks accepted by the ceding office of insurer are automatically reinsured according to the terms of the treaty. But under Surplus treaties, a risk is reinsured once it crosses the retained limit of liability. Thus under Surplus treaties the reinsured has to declare a risk by an entry on bordereau.

Open covers or Automatic Facultative covers or Facultative obligatory covers are agreements to make future reinsurance where the reinsured has got an option to declare a risk but, once declared, the reinsurer has to accept it as an obligation under the contract. Thus such reinsurance is 'Facultative' for reinsured but 'Obligatory' for the reinsurer.

Facultative reinsurance is not for creation of capacity but it is for risks already underwritten, where limits are beyond the capacity of the insurer. It is a contract of insurance by way of a reinsurance policy for current single risk.

A reinsurance policy is issued under Facultative reinsurance and such a policy contains detailed description of the risk, its location, its period of coverage, perils covered, exclusions if any, territorial scope, premium rate, limits of liability, reinsurance commission etc. Such policy is for each individual risk reinsured. Generally, there is a convention of not providing profit commission on such reinsurances. Premium and losses are accounted separately as provided therein.

A reinsurance treaty is an agreement for twelve months between the reinsured on one part and the reinsurer on the other whereby the reinsured agrees to cede and the reinsurer agrees to accept the reinsurance business, pursuant to the provisions.

Treaty reinsurance is a contract for future reinsurance. It is offered before its inception and main terms of the treaty are specified on a SLIP. The prospective reinsurer goes through the slip and decides his acceptance. After its acceptance, the reinsurer signs one copy of the slip and returns it to the reinsured. Such signed slip is called a Binder, when a broker is given an order for placement of a treaty. When he completes his order he issues a Cover Note to the reinsured giving list of participating reinsurers along with slip terms of the treaty. The reinsured then issues full contract wording called Treaty Document or Treaty Wording to each reinsurer. There should not be any discrepancy between the slip terms and the terms in the contract. Any such discrepancy is to be cleared off before executing the Treaty Document.

In the event of any discrepancy between the slip and the treaty document discovered subsequent to signing, in strict legal sense, document supercedes the slip.

Issuance of reinsurance contract

According to Prof. R.L. Carter, a reinsurance contract is based on the following facts for its validity:

- The parties have capacity to contract.
- There is an intention to create a legal relationship.
- There has been an offer and an acceptance.
- Consideration has passed.

In Great Britain, a purely oral contract of reinsurance would be valid except in Life and Marine insurances. The Life Insurance Act of 1774 and the Marine Insurance Act of 1905 provide for issuance of a policy. But it is not clear as to what extent this provision is applicable to reinsurance.

In France, the law of 13 July 1930 requires non-marine insurance contracts to be made in writing but it is specifically stated that this does not apply to reinsurance and as such, oral contracts of reinsurance do not offend against the statute.

According to Kenneth R. Thomson (in his book 'Reinsurance'), in America as "a general rule, a contract of reinsurance is not regarded as a promise to pay the debt of another and accordingly does not need to be in writing".

But in practice, it is generally put into writing for clearer definitions of terms and conditions.

Often reinsurance involves international relationship established either directly or through an intermediary and it is very much essential to put reinsurance contracts into writing to avoid any misunderstanding about any technical or legal aspects.

Is reinsurance a triangual relationship among original insured, the reinsured and the reinsurer?

Insurance is a contract between the insurer and the original insured. Reinsurance is a contract between the reinsured (the insurer) and the reinsurer.

Therefore, the original insured is not a party to the contract of reinsurance. Now, if insurer goes into liquidation can the original insured sue the reinsurer for recovery of loss under the policy?

This question involves the protection of the rights of the reinsured's policy-holders. In America, a special provision is made in the reinsurance contracts to safeguard the interests of the reinsured's policyholders, that is the original insured. A specific clause called 'loss assumption clause' is incorporated in the body of the reinsurance contract whereby the original insured can recover his loss on the policy from the

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reinsurers, if the reinsured goes into liquidation.

In the English law the validity of "Cut-Through Clause" is extremely ambiguous. This is explained by J.S. Butler in his article "Cut-through clauses are not short-cut" in November 1972 issue of 'Reinsurance' magazine. There are many 'ifs' and 'buts' in the body of the clause, thereby making its implementation difficult. Some reinsurers nickname it as 'Cut-throat clause'. But if they have to pay their share of indemnified loss, can they recover premiums due from reinsured who has gone into liquidation? No they cannot recover premiums from insureds. There are legal tangles and it is difficult to generalise corollaries of such a clause.

London market has adopted cut-through clauses in Saudi Arabian reinsurance treaties. "Swiss Re" have their own cut-through clauses different from the wording of London market.

Can a reinsured recover claims from reinsurers before paying the same to his insured?

The basic point involved here is whether reinsurance is a contract of indemnity against payment of loss or a contract of indemnity against liability? If it is taken as a contract of indemnity against liability, the reinsurers have to pay losses irrespective of the payment by the reinsured.

In some wording of American reinsurance contracts, a clause is worded differently:

"The reinsurer's proportionate share of loss... shall be paid to the reinsured upon the proof of the payment of such items, by the reinsured. The terms 'Ultimate Net Loss' shall be understood to mean... the sum actually paid in cash in settlement of losses".

Thus the payment of loss by the reinsured is a pre-condition of payment of the loss by the reinsurer.

In ex parte Norwood case, there was a specific wording in reinsurance contract which read 'Loss, if any, payable at the same time pro-rate with insured'. The judge Blodgett said thus:

"Now it is to my mind absurd to say, if a loss occurs on one of those reinsured policies, that the company primarily liable is to have its claim against the reinsuring company limited by its ability to meet its obligations to its original policyholders. The very object of making the polity of reinsurance was to place the company in funds with which to make its policyholders whole, and that is defeated if the construction which is insisted upon by assignee is a true one.

I am of the opinion that the 'Republic' is liable on these policies to the extent of the adjusted losses, even if the 'Lorillard' had not been paid a cent".

In 1997 Fagan Syndicate was in financial difficulty. Charter Re as Leader had agreed to pay all claims as 'Pay as Paid' basis.

Fagan Sydicate was not in a financial position to pay the claim to the insured and requested Reinsurers to pay. Charter Re rejected the request.

Fagan Syndicate lost the case in lower courts but the House of Lords ruled that basic function of reinsurance is to strengthen solvency of the reinsured. They therefore ordered Charter Re to pay the claim to Fagan Syndicate to enable them to pay the claim to the insured.

Conflicts of laws in international contracts of reinsurance

Reinsurance is arranged for global spread of risks. Therefore, it is usual that companies to a reinsurance contract are domiciled in different countries with different sets of laws and the risks are situated in altogether a different country. In the event of disputes which system of law should apply particularly when there is a conflict of laws?

According to Prof. R.L. Carter, the answer to this question may be found within the contract in the Arbitration Clause. But in absence of any reference to a legal system, it is necessary to turn to the principles of private international law to determine which system of law shall govern the contract.

English courts have established a number of principles for determining which system of law should apply according to the presumed intentions of parties. When it is decided that the law of a particular foreign country should apply the English courts will apply that law and take help of experts on the foreign law.

In USA, every state has got its own different legal system. Foreign reinsurers should get themselves 'authorised' in America to do reinsurance trading. Unauthorised reinsurers are supposed to open escrow accounts or open Letter of Credit (LC) for each and every loss even if the loss is outstanding. Nationalised markets have no free trade facilities and reinsurers domiciled in such markets cannon get authorisation in USA. Unauthorised reinsurers have also to pay Federal Tax of 1% which may be revised from time to time. There are even restrictions on authorised foreign

reinsurers in making any fronting arrangement to pass on business to unauthorised reinsurers.

According to New York Regulation: 98, with effect from 1 October 1982 the original insured must get full information about all parties to a reinsurance transaction. It requires the intermediaries to name and to report the financial conditions of the involved unauthorised insurers. Other states of USA may likewise frame similar laws.

Recourse to arbitration

Majority of the disputes arising out of interpretation of reinsurance Contract Wording are settled outside the courts by Arbitration.

In practice, the Arbitration clauses are universally included in reinsurance contracts. They are agreed means of settling disputes. The British courts have recognised validity of Arbitration clauses. The courts have held that no action shall be brought to the courts until the dispute has been submitted to arbitration and an award has been made.

However, an English court will not uphold an arbitration clause which seeks to remove its jurisdiction altogether. Again, when a question of fraud by either party arises, the court may order that arbitration clause shall have no effect. Court decision supercedes arbitration awards.

Conventions are to be followed as unwritten laws. Arbitration, if general, must abide by some fixed and recognised system of law. If an arbitration clause is worded as under, it invalidates the whole contract on the ground that parties did not want to have legal effect.

> "The arbitrator or umpire, as the case may be, shall interpret this treaty as an honourable engagement rather than as a mere legal obligation. The arbitrators and umpires are relieved from all judicial formalities and may abstain from following the strict rules of law".

Courts may set aside the arbitration award on following grounds:-

- If arbitration award is procured by corruption, fraud or undue means.
- If there was evident partiality or corruption in the arbitrators.
- If rights of any party are prejudiced by misconduct of arbitrators in their proceedings.
- If the arbitrators exceeded their powers or imperfectly executed them.

In 1975, the Institute of London Underwriters has proposed a standard arbitration clause after consultation with the ROA and Lloyd's Insurance Brokers' Association.

Facultative reinsurance policies

As mentioned earlier, a reinsurance policy is essentially different from a reinsurance contract. A reinsurance policy is in respect of risk which is already written and the reinsurance is required for limits in excess of net retention limits and other reinsurance capacities. It is not obligatory for the reinsured to effect facultative reinsurances and the reinsurers have option open to accept or reject a risk.

Facultative reinsurances are of two types, viz., Pro-rata or Contributing Facultative Reinsurance and Facultative Excess of Loss Reinsurance. Reinsurance policies are contracts for risks already written and not for future risks to be written.

Reinsurance treaty contracts

A reinsurance treaty is a contract for reinsurances. A set of terms and conditions for a given class of business is provided and the reinsurance capacity is created for the reinsured to underwrite any risk which will be written in future. As opposed to facultative reinsurance it is meant to create capacity and it gives a reinsurance facility to cede risks after retentions. All future writing of risks has got an automatic, simultaneous and continuous reinsurance cover.

Reinsurance treaties are placed before the inception of the treaty year on the basis of a slip which summarises 'main' terms and conditions of the treaty arrangement. Generally, it contains name of the company, type of treaty, class of business, perils covered, territorial scope, retention, limits of reinsurance cession, commission percentage, profit commission formula and percentage, portfolio provision or reserve provision, if any with interest (less tax) on reserves, cash loss limits, frequency of accounts rendering and underwriting information with mention of specific exclusions

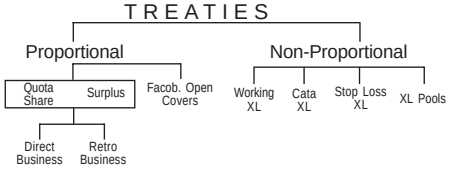
A reinsurance policy is in respect of risk which is already written and the reinsurance is required for limits in excess of net retention limits and other reinsurance capacities.

Reinsurance is a long term relationship based on Mutual Trust. A suspicious Reinsured and a non-cooperative Reinsurer make all relationships fragile.

essential for the reinsurer's acceptance. Once the treaty is placed on the basis of the slip, the broker prepares a cover note with names and shares of reinsurers. Such cover note serves the basis of reinsurance agreement and later on treaty wording is prepared. The treaty wording is to be corrected if there is any error in the main terms as compared to the slip.

If the slip is wrong and wording is correct, the ceding company must give satisfactory explanation and obtain agreement of the leader to be followed by other reinsurers.

Treaty wordings have a number of variations in form and structure but standardised London market clauses are common in use. American market treaties contain American market standard clauses. Every market has its own peculiar provisions of law and the wordings may vary. Again, wordings will vary according to type of treaties as shown in the following chart:-



Again, from class to class there will be variation of clauses in treaty wordings. Therefore, the best way, according to me, is to generalise common pattern of treaty wording and then add special clauses peculiar to the type of treaty or particular class of business.

The Reinsurance Officers Association has made valuable contribution to standardise Treaty Wording in late seventies and eighties. With computerisation and standardization, Treaty Clauses are drafted and are available in a CD.

After WTC attack losses, leading global reinsurers like Munich Re / Swiss Re have drafted Terrorism Exclusion Clauses, Political Risks Exclusion Clauses and introduced Treaty Slip formats with attached main clauses to avoid any misgiving. Such Treaty Slips are standardised by them and run into 100 pages instead of earlier slips of 3 or 4 pages.

Some legal conventions

Follow The Fortune Clause means Reinsurers follow Legal and Technical Fortune of the Reinsured in respect of claims settlements.

Reinsurers do not follow Ex-gratia payment of claims.

Claims Co-Operation Clauses provide that Reinsured must seek Reinsurer's advices before entering into litigation in respect of a disputed claim.

Claims payable by Reinsurers **can be more than TSI** to the extent of legal expenses, court awards, punitive damages etc.

Proportional Treaty Contract Clauses

- Time Clause
- Territorial Scope Clause
- Covered Perils Clause
- Exclusion Clause
- Operative Clause
- Premium Clause
- Commission Clause
- Claims Settlement Clause
- Borderaux Clause
- Accounts Clause
- Profit Commission Clause
- Inspection of Records Clause
- Errors, Omissions and Alteration Clause
- Portfolio Adjustment Clause
- Reserves Clause
- Cash Loss Clause
- Arbitration Clause
- Intermediary Clause
- Insolvency Clause
- Currency Conversion Clause
- Cut-Through Clause
- Special Termination Clause like Sun-Set Clause

Changes by way of addendum

XL TREATIES: Some clauses in addition to common clauses between Proportional Treaties and XL Treaties.

- Definition of Loss Occurrence
- Ultimate Net Loss Clause
- Net Retained Lines Clause
- Definition of GNPI Clause
- Reinstatement Clause
- Extended Expiration Clauses
- Notification of Claims and Loss Settlement Clauses

Conclusion

Reinsurance is a long term relationship based on Mutual Trust. A suspicious Reinsured and a non-cooperative Reinsurer make all relationships fragile.

The author is Chief Executive Officer, J.B. Boda Reinsurance Brokers Pvt. Ltd.

Life Insurance Contracts

Significance of Policy Conditions and Privileges

'IT IS WORTHWHILE THAT A SERIOUS ATTEMPT IS MADE AT THE EARLIEST TO REDUCE THE COMPLEXITIES OF THE POLICY BOND WITH A JUDICIAL STANDARDISATION WHICH PROVIDES MUCH NEEDED SOLUTION WITHOUT COMPROMISING THE COMPETITIVE SPIRIT OF THE MARKET' WRITES **G. PRABHAKARA.**

Life insurance policy is a document which expresses the contract between the insurer and the insured. Most of the insurance companies have standard forms of policies with standardized policy conditions in respect of various plans of assurance offered by them. The policy document, to be enforceable by law, is to be signed by the competent authority and duly stamped according to the Indian Stamp Act.

The preamble of the policy states that the proposal and declaration signed by the party form the basis of contract. The form contains a schedule which gives all essential particulars of the policy like name, address, plan of insurance, premium, amount of insurance, etc. On the back of the policy, the standardized terms and conditions applicable to all persons insuring under a particular plan are printed. Any special conditions imposed are indicated by endorsement.

Some of the most common and important conditions and privileges which form a part of the policy document, and their significance, are narrated below:

Days of grace

Days of grace or grace period is the 'extra time' given to the policyholder for payment of instalment premium after the due date, during which the policy remains in force. It is normally provided for a period of a fortnight to a month. Grace period is meant to be a convenience to the policyholders, some of whom may not be able to pay the premiums on time due to certain preoccupations etc.

Revival of Policies

A lapsed policy can be brought back to life through revival, as if it is a fresh contract, subject to certain restrictions with regard to the period of lapse etc. The policyholder may however be required to submit a fresh set of medical and other requirements/declarations at the time of revival. For the purpose of a claim too, the policy may be treated as new and Sec.45 of the Insurance Act, 1938 be applied.

Surrender and Paid up Value

Sec.113 of the Insurance Act provides for accrual of certain benefits to policyholders even if they are unable to keep their policies in full force by payment of further premiums. If premiums for at least three consecutive years have been paid, there shall be a guaranteed surrender value. If the policy is not surrendered, it shall subsist as a paid up policy for reduced sum. The policy conditions usually provide for a more liberal surrender value and paid up value than those secured by the statutory provisions.

Policy Loans

Policy loan is a ready source of borrowing to a policyholder, in a financial contingency. It is paid by insurers against the surrender value accrued to a policy. Policy loans lend liquidity to contracts which are otherwise 'frozen' during the term of the policy. From the insurers' point of view, they add to the marketability of the insurance products while also being an avenue for secure investments.

The preamble of the policy states that the proposal and declaration signed by the party form the basis of contract.

Non-Forfeiture Regulations

While grace period is meant to be a convenience, non-forfeiture regulations provide succour to policyholders who are unable to pay premiums due to temporary financial difficulties. Non-forfeiture regulations allow additional time of, say, six months or a year for payment of premiums on a policy, even as the risk under the policy continues to be covered. Insurers offer this privilege after the policy has been in force for a few years and is not offered on term assurance and some of the 'high risk cover' policies.

Riders: It is possible to tag-along coverage of additional risks to the basic life product on payment of additional premiums, subject to certain conditions and restrictions. Such add-ons like accident riders, critical illness riders, premium waiver riders in case of minor life policies etc are quite popular and more such riders are coming into vogue.

Riders are complex by nature and are often not properly/fully understood by the parties concerned. This causes complaints and legal disputes at the time of claims and calls for defining and interpreting the coverages and exclusions sharply.

The most popular and perhaps the most ancient of all the riders is the accident benefit rider which provides for payment of additional sum assured in the event of death or permanent disability by accident.

Suicide Clause

As per Indian law suicide is not a crime, but attempt to suicide is a crime unlike in English law where suicide is a crime. Hence, contracts of insurance that agree to pay the sum assured even in the event of the death of life assured due to suicide are not against public policy. But, to avoid a possible moral hazard and adverse selection, insurance companies do place a restrictive clause by not covering death as a result of suicide up to one year from the date of commencement of policy or date of issuing of policy whichever is later. However, provided a due notice is received, life insurers protect the bonafide interests of the third parties who are having an interest in the life of the life assured. While the former dissuades the life assured to be not magnetic of the benefits of life assurance by committing suicide, the later protects the financial interests of third parties as life insurance policies are also used as tools of collateral security.

Pregnancy Clauses

On life insurance policies issued during the pregnancy of a female proponent, life insurers apply this clause to exclude coverage of pregnancy/child birth related deaths. However, with the advancement of medical technology, the relevance of these clauses is gradually reducing. But, life insurers may apply these clauses to those female lives who reside away from medical facilities that are potentially prone to risks of pregnancy/child birth related deaths. If data pertaining to pregnancy risk in a particular region is not available, insurers may apply these clauses to the female lives of the region.

Specific clauses on female lives

Certain classes on female lives such as females in the age group of 20-35 who have no earned income are susceptible to moral hazard. To avoid this risk, insurance companies do impose these clauses excluding coverage of accidental death in other than public places.

Occupation related clauses

To exclude the risks that are closely related to the occupation (like that of a pilot whose occupation is prone to aviation risks) of the life assured, insurance companies do levy these clauses excluding the risk coverage owing to the death of the life assured during the course of employment. Ex: Aviation clause, divers' clause.

Lien Clause

In respect of certain types of high risk life insurance policies where insurers have a lower level of comfort due to the adverse disclosures made in application for life insurance and where insurance coverage cannot be denied based on such disclosures, life insurance companies do impose lien clause which could either limit the liability of the insurer during a specified period (like 50% of sum assured during first year, 75% in the second year and 100% from the third year onwards); or defer the coverage for a specified period (like no life cover during first year of the policy).

Life insurers also reserve the right to impose a clause during the term of the policy through a clause based on the future occupation that a minor life may engage in. Under the current clause, insurers require the minor life to notify them in the event of minor life engaging in hazardous occupations. On receipt of information from the life assured on his reaching the majority or on his joining the services of hazardous occupations, life insurers may apply such occupational clauses as deemed necessary. Hence, policies issued to minor lives will be subject to these clauses.

While grace period is meant to be a convenience, non-forfeiture regulations provide succour to policyholders who are unable to pay premiums due to temporary financial difficulties.

The advent of unit linked insurance policies has created new issues with regard to policy conditions and privileges of the policyholder apart from issues on disclosures.

IRDA (Protection of Policyholders' Interests) Regulations, 2002

Reg.6 of the IRDA (PPI), 2002 exclusively deals with matters to be stated in a life insurance policy and includes important items such as:

- Name of the plan and whether it is participating in profits or not.
- Benefits payable and contingencies upon which these are payable
- Details of the riders attaching to the main policy
- The premiums payable, periodicity, grace period, implication of discontinuing the payment of an instalment of premium and provisions of a guaranteed surrender value.
- Age at entry and admission status, policy requirements for surrender, non-forfeiture and revival of lapsed policies.
- Exclusions, both in respect of main policy and riders
- Provisions for nomination, assignment and policy loans and statement about rate of interest on policy loans.
- Special clauses such as suicide clause, first pregnancy clause etc.
- Address of the insurer.
- Documents normally required to be submitted by a claimant in support of a claim.
- Reg. 6(2) refers to the 15 days period available to the policyholder to review the terms and conditions and where he disagrees to the same, to return the policy.

Unit Linked Insurance Policies

The advent of unit linked insurance policies has created new issues with regard to policy conditions and privileges of the policyholder apart from issues on disclosures. To overcome these issues, IRDA came out with its guidelines in Dec 2005 which mandate, among others, that the following be mentioned prominently on a policy bond:

- The minimum and maximum percentage of the investments in different types (like equities, debt etc)
- The definition of all applicable charges, method of appropriation of these charges and the quantum of charges that are levied
- The maximum limit up to which the insurer reserves the right to increase the charges subject to prior clearance of the Authority
- On top of the policy document, wherever applicable, the statement 'In this policy, the investment risk in investment portfolio is borne by the policyholder'.

At present as many as sixteen life insurance companies are operating in India and each one is issuing policy formats with different variations. As there is no uniformity, it is difficult for the market as well as policyholders to comprehend and make reasonable comparisons of terms and conditions, privileges and benefits offered by different insurers. Hence, it is worthwhile that a serious attempt is made at the earliest to reduce the complexities of the policy bond with a judicial standardisation which provides much needed solution without compromising the competitive spirit of the market.

The developments in technological front enabled financial sector to move from paper based documentation to digitalisation of documentation. The trend which was initiated in securities market has revolutionised the services and reduced the transaction costs to individual investors. The pace of services has also improved with the time. Digitalisation of documents along with the availability of techno-driven banking services like ECS (Electronic Clearing Services) enabled financial sector to settle financial transactions on a real time basis, thus increasing the expectations of investing public for a similar service in other spheres of financial sectors like '*insurance*'.

Drawing a cue from the success stories of these sectors there is a growing demand from various sections of society that insurance companies shall also usher in digitalisation of policy documents, thus converting them to a dematerialized (*demat*) form. However, unlike other financial transactions, in the case of insurance contracts, they are either annual contracts as in the case of general insurance or long term contracts as in the case of life insurance contracts. Further, there is not much movement in these contracts, except at the time of renewal or final payments. Hence, there is a need to probe in detail before the industry decides to go in for dematerialisation of insurance policies.

The author is Member (Life), Insurance Regulatory and Development Authority. The views expressed in the article are purely his personal views.

Contractual Obligation in Insurance Contracts

Importance of Fulfilling

'THE INSURED-CLAIMANT IS REQUIRED TO PROVIDE PROOFS AND INFORMATION THAT THE INSURER MAY SEEK TOUCHING ON THE LIABILITY OF THE CLAIM OR THE AMOUNT OF LIABILITY' AVERS **G V RAO**.

Liability to pay a claim goes to the root of the policy contract on performance, rendering the very performance of the contract outside its contractual scope; and hence such issues of liability are to be determined by courts.

This article seeks to discuss the interpretation of two specified conditions of the contractual obligations of an Insurer in the policy contract that he issues to an insured. One of these conditions refers to the duties and responsibilities of an insured-claimant, which he has to fulfill, to obtain an indemnity for a loss or damage he incurs. And the other condition deals with the interpretation of the condition of Arbitration and its applicability, should there be a difference on the quantum of claim amount to be paid. Liability to pay a claim goes to the root of the policy contract on performance, rendering the very performance of the contract outside its contractual scope; and hence such issues of liability are to be determined by courts.

The following discussion outlines the general interpretations put in on these two conditions by insurers, often frustrating the efforts an insured-claimant to obtain an indemnity due to him in the normal course. It argues that such approaches are contrary to both the law and the spirit of the current regulations guiding the market conduct of insurers. It suggests that the Regulator should intervene and clarify on the two issues raised for the sake of smoother functioning of the insurance system. More importantly, as the Insurers have a Council of their own, it should take a stand that is satisfactory to both the parties to the policy contract.

Is a survey of a loss necessary?

The policy conditions, as currently written, do not stipulate the appointment of a Loss Assessor as necessary to evaluate the quantum of loss or the liability of an insurer under the policy. An insured claimant is only required to give notice of the occurrence of the happening of any loss to him and then deliver to the insurer the items of property damaged and the amount of loss, at the time of the loss, without any element of profit being included in the list.

In addition, the insured-claimant is required to provide proofs and information that the insurer may seek touching on the liability of the claim or the amount of liability. The truth of the statements made is subject to a declaration on oath or in any legal form that the insurer may seek. Compliance with these requirements is a condition precedent to any payment of the claim by the insurer. There is no reference in the policy document for the appointment of an independent surveyor under the contract to assess the loss quantum or to determine its liability to pay. This policy condition is on lines of what is written in most insurance contracts all over international markets.

Duties & responsibilities of loss assessors

In the Indian market, the role of a loss assessor has a statutory backing. The insurers are legally bound to appoint loss assessors for claims whose value exceeds Rs.20,000. The legal obligation, requiring a claim, whose value is beyond Rs.20,000 to be surveyed by an approved and licensed surveyor, is the creation of the section 64 UM of the Insurance Act, 1938. The subtle distinction between the policy contracts, as issued in India and the above compulsive legal provision should be noted. The IRDA has further issued regulations for the surveyors that are licensed and approved by it in relation to their business conduct, duties and job responsibilities under regulation 13 applicable to their licensing.

The loss assessors' duties include: "examining, inquiring, investigating, verifying and checking upon the causes and the circumstances of the loss..." ... "Advising the insurer about loss minimization, loss control and safety measures" ..." Assessing liability under the contract of insurance" ... " Taking expert opinion wherever required".

Insurers in India must ask themselves the question, whether the loss assessor they have appointed is performing all the above functions expected of him. Any duplication of the allotted duties and responsibilities to be discharged by the loss assessor under these regulations, if entrusted to any other unlicensed parties by the insurers, such an action certainly would smack of vindictiveness against the insured; and also display distrust in the abilities and expertise of the loss assessor appointed by them. In addition, it amounts to a breach of laid down regulations that should be observed by the loss assessors and the insurers, both in spirit and in law.

Investigators

Why do the insurers appoint independent investigators-in many claim cases-- without the knowledge and consent of the loss assessor, when his duties specifically include investigation into the causes and circumstances of the loss and enabling him to seek an expert's opinion in the course of discharge of his professional responsibilities? Perhaps the insurers want to rule out fraudulent claims being foisted upon them; hence the appointment of the investigator.

But before appointing an investigator, the insurers must have necessary grounds or serious suspicions to suspect frauds on the part of the insured. Is not the loss assessor the right person to detect suspected frauds to commission investigations on his own? If the appointment of an investigator is necessary, for whatever reason, the insurer can direct the loss assessor to appoint one and include such findings in his report.

Getting an independent report from the investigator would amount to under-cutting the role of the loss assessor. And the insurer having an independent investigative report, which has insufficient evidence of criminal conduct on the part of the insured, would make it doubly difficult for the insurer to decide on which way to go. Frauds need evidence 'beyond reasonable doubt' and failure to prove fraud would invite charges of libel being brought against insurers. Often, the courts regard the final police report and the fire brigade report as proof for or against frauds on the part of insured. The investigative report does not serve the conclusive purpose for which it is intended.

Adopting the next best course as inaction on the claim that is generally followed or repudiating the claim on minor technical grounds is not a good business practice. There has to be a better procedure than inaction or frivolous repudiation.

Availing of such two independent reports that may throw up irreconcilable conclusions would, therefore, place the insurers themselves in a difficult situation to make a final decision. An investigator is not licensed and his report is not officially recognized by the IRDA, as a report to be relied upon to decide on the fate of the claim. Simply put, such actions amount to breach of regulations of licensing surveyors and protection of policyholders.

This argument is highlighted to enable both the insurers and the IRDA to understand how the insured-claimants are often subjected to extra-contractual obligations, not binding on

Frauds need evidence 'beyond reasonable doubt' and failure to prove fraud would invite charges of libel being brought against insurers.

There has to be an element of ethics and transparency in deciding on these issues of liability, for the issue not to be used as a bargain chip on the quantum.

them, and in breach of the regulations enacted towards a reasonable settlement of the claim. Why then are such processes continued to be indulged in by insurers? Would they do something that would bring some relief to the insured-claimants?

The surveyors' duties can be redefined and the investigator may be brought under regulations, if the insurers so desire (but not desirable), through regulatory intervention, for the professional conduct of investigators and loss assessors. It would also imply that the loss assessor is meant only for quantification of the loss amount and not for determining the liability issue. The current claim process that is irregular needs to be reviewed in the interest of both the parties to the contract viz. the insurer and the insured. A regulatory intervention is necessary to give this contentious issue finality.

Arbitration condition

The condition of arbitration usually incorporated in policies issued in India takes into account two elements: "If any dispute or difference shall arise as to the quantum to be paid under this policy ***(liability being otherwise admitted)*** such difference shall independently of all other questions be referred to the decision of a single arbitrator….".

The condition goes on to say ***"It is clearly understood that no difference shall be referable to arbitration…if the company has disputed or not accepted liability under or in respect of the policy"***. The making of an award is a condition precedent to any right of further action.

The English policy condition on arbitration states: "If any difference arises as to the amount to be paid under this policy (liability being otherwise admitted), such difference shall be referred to an arbitrator to be appointed by the parties in accordance with statutory provisions. Where any difference is by this condition to be referred to arbitration, the making of an award shall be a condition precedent to any right of action against the insurer". The difference between the two conditions on the second element is noteworthy. The second portion of the Indian condition quoted does not find a place in the English policy. That difference has to be noted.

Two points arise for discussion: Would any insurer admit liability in writing at any point of time in the course of processing a claim? Even if the loss assessor, as required, gives a report that liability to pay does exist, the assessor's report is never made available to the insured-claimant, despite a regulatory direction to him by the IRDA.

Either the IRDA direction has to be amended to make it obligatory for the insurer (not the surveyor) to make the report available to the insured or a new regulation has to be enacted making it obligatory for an insurer to decide on the liability within three months of occurrence of a loss, whether he admits liability for the claim or not. Failure to do so, without reaching agreement with the insured, should attract penal action.

The second point to discuss: 'liability being otherwise admitted'? For some reason the Indian arbitration condition stipulates, "…***if the company has disputed or not accepted liability***", no difference shall be referable to arbitration. Does it not mean that the insurer should have declined or disputed liability or rejected liability in writing to make any arbitration procedure by an insured inapplicable? Would these phrases overrule the phrase "(liability being otherwise admitted)" or do they provide greater clarity as to when an arbitration procedure could be resorted?

The insurer would tend to argue and conclude that if he did not decline or repudiate liability for the claim in writing, the insured must conclude that the insurer's mere inaction to do anything on the claim is conclusive enough that he has either disputed or repudiated the claim.

As such the claim is not arbitrable by the insured.

On the contrary, the insured can contend that not having the claim disputed or repudiated by the insurer in writing, he has impliedly accepted liability to pay it. In one instance, an insurer took the stand that liability to pay a claim, whose quantum fell within the excess amount under the policy amounted to no liability existing for the insurer under the policy contract itself. As such the difference between the two was not arbitrable.

Since these contentions are legal issues, it is for the IRDA to ensure that the policy wordings do not lead to ambiguity to the detriment of the insured. There has to be an element of ethics and transparency in deciding on these issues of liability, for the issue not to be used as a bargain chip on the quantum. With Boards of PSU insurers disassociating themselves from claims settlement decisions, the insured need a shield to protect their interests. Insured want a fair and credible process.

Insurers should perhaps be compelled

A claim occurrence deals with their reputational risks, and provides them an opportunity to add value to the product coverage bought by an insured to reinforce the benefits of insurance to him.

by the IRDA either to accept liability or reject it, with grounds to be enumerated therefor, within a reasonable time frame; while quantification of loss amount would take more time of the loss assessor, the aspects of liability need not wait endlessly to tire out an insured-claimant. Liability and quantum of loss need to be differentiated in dealing with claims from the point of view of time frames. This is not an unreasonable stand.

Summing up

1. The role of the investigator that is an extra-regulatory creation of insurers needs to be dealt with by the IRDA. It should be up to the loss assessor to decide to appoint an investigator, at his discretion. There should be one independent authority to make a recommendation on a claim but not two, who often differ, to the disadvantage of the insured.

   The insurers do have rights to appoint another loss assessor, whose report can be made available to the insured, as per the regulations, and whose professional expertise can be questioned in a court of law if necessary; but it is not possible to bring in the investigator to the witness box, as his report is never made available to the insured nor offered as proof to deny liability. Vague assertions by insurers do not make reasoned and credible arguments on the issue of liability. The game has to be fair on both sides.

2. The insurers could certainly settle claims faster, if they addressed the liability issue first, leaving the issue of quantification of loss to take its own time. The insured should know that any delay is due to his not having provided adequate information to the insurer. But in respect of deciding on the issue of liability, the onus is clearly on the insurers alone. But to deal with this issue in a mutually satisfactory way requires regulatory intervention.

This article has not touched on other interpretative issues, due to constraints of outlining the article's scope. But insurers must realize that a claim occurrence is an important aspect of contractual performance. A claim occurrence deals with their reputational risks, and provides them an opportunity to add value to the product coverage bought by an insured to reinforce the benefits of insurance to him. It is also a challenge to insurers to build a valued customer relationship of long-term. At any other point of time, but for a claim occurrence, it is just a passive relationship between the two that is untested by any challenge.

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Understanding the Insurance Policy

Emphasis on Openness

'INSURERS ARE BEGINNING TO GET A BETTER FEEL OF WHAT THE CUSTOMER WANTS AS THEY GET PREPARED TO COMPETE IN A COMPLETELY DE-TARIFFED SCENARIO' WRITES **YAGNAPRIYA BHARATH.**

Although the process of de-tariffing of the Indian non-life insurance industry commenced more than a decade ago, beginning with Marine Cargo Insurance followed more recently by Marine Hull Insurance and talk about de-tariffing the rest of the tariff portfolios has been in the air for some time; it is only from September, 2005 when the IRDA laid out the roadmap to de-tariffing of 70% of the non-life insurance business that de-tariffing began to be seriously reckoned with.

After the roadmap to de-tariffing was laid down, insurers began to take stock of their businesses, philosophies and strategies keeping de-tariffing in view. Since the IRDA contemplated carrying out the process of de-tariffing in a phased manner beginning with the rates, to be later followed by the terms and conditions; the industry's attention currently has been focused more on rating and underwriting. Terms and conditions of Fire, Engineering, Motor and Workmen's Compensation policies shall continue as per the erstwhile tariff for some time (1st April, 2008, as of now unless the IRDA announces a change in the schedule).

Two months of business in the new scenario (with effect from 1st January, 2007) and insurers are gaining experience on what it is like to be functioning in an increasingly competitive environment. With no variation in terms and conditions, today, competition is all about rates and efficiency of service. But it is not going to be very long before insurers compete on what the products under these portfolios have to offer. Insurers are beginning to get a better feel of what the customer wants as they get prepared to compete in a completely de-tariffed scenario. While the industry waits in anticipation and is perhaps getting itself ready working on the terms and conditions of the various products, the customer needs to be educated about the next phase of the process of detariffing. It is the collective responsibility of all those concerned - the industry, the intermediaries and the Regulator, to create awareness amongst insurance customers, existing and potential; that policies offered under one product type would differ from one company to another. It is important that a customer understands the wordings of the insurance contract he has entered into or is seeking to enter into.

Contracts of insurance being evidenced in the form of policies, and policies usually including a good deal of close printing; it would be worthwhile to run through what a policy would contain. Whatever the type of insurance, policy forms have many common features. A policy consists of five main parts, the **preamble or recital clause**, the **operative clause**, the **attestation clause**, the **policy conditions** and **the schedule**.

The preamble clause recites the fact that there are two parties to the contract, the insurer and the insured, and that the insured has made a proposal to insure.

The operative clause explains the circumstances in which the insurance operates.

With no variation in terms and conditions, today, competition is all about rates and efficiency of service. But it is not going to be very long before insurers compete on what the products under these portfolios have to offer.

The attestation clause is the form of words that confirm that the insurers have authenticated the policy by signature.

While understanding the operative clause is key to a customer, it must be borne in mind that even if no policy conditions were printed, the law would imply certain conditions; for example, that the insured has an insurable interest in the subject-matter.

The operative clause is the meat of the policy. It sets out the perils insured against, and the exceptions to the insurance. While the insuring agreements state what is covered; the exclusions take coverage away from the insuring agreements. The operative clause should be given a detailed reading by the policyholder. If he or she has any doubt as to the coverage or exclusions, it must be got clarified. Further, the customer should look for deductibles and understand their impact on the coverage.

A policy will also include definitions of the various terms used. An insurance policy would list out the conditions of the contract - precedent to liability as well as after occurrence of a claim. It would contain conditions inserted for the benefit of the insured to explain his legal obligations, such as the duty to give subrogation rights to the insurers, etc.

The policyholder should make it a point to read and understand the conditions relating to renewal and cancellation of the policy and their implications. Conditions relating to underinsurance, double insurance etc need to be understood as well. Every policy would contain a clause providing for arbitration. The geographical jurisdiction of the cover, as well as legal jurisdiction should disputes arise, are also spelt out. A well-drafted policy would contain details of grievance redress channels and brief procedures relating to them.

Next, a detailed look at the policy schedule is important as it groups together important details special to the particular policy, such as the policy number, the name and address of the insured, a description of the subject-matter of insurance, the amount of the premium, the sum insured, and the duration of the insurance.

It is also necessary to pay attention to endorsements. Endorsements are terms peculiar to the particular insurance granted by the policy to which they are attached. It is natural therefore that, as they are particular, they should override the more general provisions in the policy itself.

It is often suggested that policies might be simpler and more shortly worded than they are. All businesses are apt to fall into the use of jargon. But in defence of insurers, it should be pointed out that they have to draft policies to provide for all kinds of future contingencies. Policyholders and prospects would, however, find comfort in the fact that the law generally protects the insured. If the policy proves to have been ambiguously phrased, the adjudicator would place on the policy, the interpretation that is most favourable to the insured. This is in accordance with the general principle whereby documents prepared by one party to a contract are construed by the law in the sense most favourable to the other party, in order to prevent any possibility of unfair dealing.

In conclusion, when a new policy is issued, insurers must advise the insured to read it in order to make sure that the cover granted conforms to his or her wishes. As for the insured, in his own interest, the time to raise any queries is before, rather than after, a claim arises.

If the policy proves to have been ambiguously phrased, the adjudicator would place on the policy, the interpretation that is most favourable to the insured.

The author is Officer on Special Duty (Non-Life), Insurance Regulatory and Development Authority. The views expressed in the article are her own.

Towards Simpler Contract Wordings ...

'THE USAGE OF PLAIN LANGUAGE WILL PROTECT CONSUMERS FROM MAKING CONTRACTS THAT THEY DO NOT UNDERSTAND' SAYS **SANJEEV KUMAR JAIN.**

Many consumer contracts are written, arranged and designed in a way that makes them hard for consumers to understand. Competition would be aided if these contracts were easier to understand. The usage of plain language will protect consumers from making contracts that they do not understand. It will help consumers to know better, their rights and duties under those contracts.

The tendency to acquire authority, power, and credibility by some people condition them to use more formal, complex language from academic. Plain language has a decidedly democratic character with implications for democracy. Using personal pronouns and the active voice in writing make the things simpler. All democratic governments and institutions talk about the importance of plain language but in practice, no one wishes to loose the authority and power.

We need to reposition plain language in the eyes of decision-makers in businesses. In law firms, we need to show those decision-makers that with plain language, their organization's documents can satisfy and delight everyone who reads those documents. That is so whether the reader is a client, a staff member, a regulator, a judge, an investor, a litigant, or someone reading the law.

To help those decision-makers determine whether the style of their organization's documents is helping or hindering their organization, we should encourage them to measure those documents against their organization's brand values. All of that should help deliver the economic and social benefits of clear communication-because the long-term solutions to the problems of poor communication to some extent lie in organizations competing on the basis of the plainness of their documents. An organization needs to treat the voice of its brand as seriously as it treats its visual identity, its customer service.

Test of readability

(a) General rule - All consumer contracts shall be written, organized and designed so that they are easy to read and understand.

(b) Language guidelines

- The contract should use short words, sentences and paragraphs.
- The contract should use active verbs.
- The contract should not use technical legal terms, other than commonly understood legal terms, such as "mortgage," "warranty" and "security interest."
- The contract should not use Latin and foreign words or any other word whenever its use requires reliance upon an obsolete meaning.
- If the contract defines words, the words should be defined by using commonly understood meanings.
- When the contract refers to the parties to the contract, the reference should use personal pronouns, the actual or shortened names of the parties, the terms 'seller' and 'buyer'; or the terms 'lender' and 'borrower'.
- The contract should not use sentences that contain more than one condition.
- The contract should not use cross references, except cross references that briefly and clearly describe the substances of the item to which reference is made.
- The contract should not use sentences with double negatives or exceptions to exceptions.

To play on the plain language front is an attempt to show that plain language is no longer a movement. Instead, it has evolved to become a product, a business, an industry, or a professional service.

The author is Deputy Director (Official Language), Insurance Regulatory and Development Authority. The views expressed are purely personal.

The contract should not use cross references, except cross references that briefly and clearly describe the substances of the item to which reference is made.

Claims Data Pool

The Initiative Must Begin

'A HUMBLE BEGINNING COULD BE MADE BY INITIALLY COLLATING AND ORGANIZING CLAIMS DATA ON MOTOR AND HEALTH POLICIES' FEELS **LAKSHMI.** SHE FURTHER ADDS THAT SUBSEQUENTLY, THIS COULD BE EXTENDED TO CLAIMS IN ALL DEPARTMENTS WHERE DATA WOULD BE AVAILABLE ON EASY SEARCH.

The 'claims data pool' will be in right earnest the answer for such a mechanism. This database in addition to putting fraudulent claims to rest would also ensure speedy settlement of claims.

The article titled 'CRM Paradigm' in the January issue of this Journal triggered in me the desire to pen this article on the practical necessity of a foolproof mechanism to process and settle only genuine claims. This mechanism will help in weeding out false and duplicate claims, which bleed the general insurance companies of their hard earned profits. The 'claims data pool' will be in right earnest the answer for such a mechanism. This database in addition to putting fraudulent claims to rest would also ensure speedy settlement of claims. With de-tariff having become a reality and the insurers cutting throats of their competitors for underwriting business, insurers cannot permit claims of false and spurious nature to choke them further.

I vehemently support the views expressed in the article 'CRM Paradigm' particularly the observation that in India we do not have any strict mechanism to deal with erring clients.

As an insurance professional, I have many a times felt the impending necessity for a closer coordination among the general insurance companies. I would like to share a few of my experiences which would, I am sure, ignite in you the essential need for this beneficial interaction between the general insurers. I had been earlier with a private insurer as a Regional Claims Head. As the claims head, I always told myself that I should look at every claim with the intention of settling it in full with justice to the claimants. I always looked at my claims note with empathy. However certain instances did try to shake this view.

An insured had lodged a hospitalization claim under a Mediclaim policy. He did not produce original bills of the hospital and was requesting me to accept the photocopies for settlement of a claim. My discreet enquiries revealed that the claimant had met with a road accident and had lodged a motor third party claim against the erring party. When confronted with my revelation, he admitted that he was claiming at both the places. He did not submit the original bills to me because he wanted them for contesting the TP case. I advised the insured to produce the originals for verification which I agreed to return after affixing a seal on the documents with details of claim settled and quantum thereby enabling him to claim difference amount if any also. He refused and insisted that we accept the photocopy of the bills.

In another instance of a third party case, I found that the opponent party's vehicle was insured with another company and it had already assessed the loss and the claim was due for settlement, whilst a claim for the entire repair amount was lodged in the third party MVC also. We insurers have by

experience observed that courts take a very sympathetic view of the claimant's position upon repudiation of a claim even if there has been a misrepresentation or a non-disclosure in the proposal. It would be easier for the advocates of the insurance companies to prove in such cases that there had been a clear intention on the part of the claimant to cheat the insurance company. I have practically observed several instances of two companies settling a claim on the same stolen vehicle; motor claims settled as total loss/salvage loss being repaired and again insured elsewhere after sale without revealing the claim experience; and similar such instances to list a few.

An interesting experience I underwent as an underwriter during my service will give enough food for thought for a wide interactive database available among the general insurers. A client had approached us for a marine insurance policy. The client was in the business of importing seeds and crushing them to extract oil, which was widely used for cosmetic purposes. The client wanted a marine all risk policy for his imports with an extended cover for storage in open whilst the seeds were stored in the yard. The client's business proposal appeared extremely impressive. However, on a query to any existing insurances, the client remarked that he earlier had policies with other insurance companies but was unhappy with his experience. The client insisted that we make a prior inspection of his facilities and working modalities and that we issue a certificate indicating that we have understood the working of his plant well and that we were satisfied by the same. We sought time from the client to understand his business better. Here again, interaction between the insurers helped. It was revealed that the client had made one claim with each of the insurance companies against decreased extraction of oil from the seeds.

The nature of the claim made it unique. The insurers were at a loss of information because the client's business was one of its kind in India; and he having no competitors, it was not possible for them to verify the correctness of the oil extracting methodology used by him. The client had made a claim stating that the nuts were kept in open and were damaged by the weather conditions and he was therefore unable to extract good quality oil from the seeds. On further enquires it was revealed that globally there were only 3-4 players in this business and that each one had its own mechanism of extraction, which they kept confidential to avoid competition. There was no possible manner by which anyone could assess a loss of low quality output reported, as there are no standards or yardsticks available even to verify this statement. Though this does not make the risk uninsurable, a reasonable study would be required on pricing of the risk based on past claim experience. But how does one obtain accurate claim data? This is where the data bank of claims would help.

How easy would it be if there were to be an online database on motor claims where it would be possible to get history of claims pertaining to a vehicle by just keying the registration number!

Until the de-tariff regime came into force, insurance companies have been sharing only limited information on Motor OD claims merely because there has been a provision for the same under the motor tariff regime. After the de-tariff of the motor sector, even such exchange of information may not take place.

How easy would it be if there were to be an online database on motor claims where it would be possible to get history of claims pertaining to a vehicle by just keying the registration number! All basic information including the date, quantum and the nature of loss, the information on the insurance company where the claim was launched, the amount for which the claim settled - these basic inputs of information should be available on this online data pool. Access to this site should be restricted to insurance companies who would have valid login identity and password. The insurers would then be able to seek detailed information (if required) on such claimants from the respective insurance companies. It should be made mandatory for the insurers to submit information of such claims on a monthly basis to this organized database.

Where do we start?

A humble beginning could be made by initially collating and organizing claims data on motor and health policies. Subsequently, this could be extended to claims in all departments where data would be available on easy search.

The issues involved

Basically, there are three issues that need to be addressed for setting up of a common claim data pool.

- Clients should be agreeable to their information being shared amongst other insurance companies. Every insurer will have to take a declaration in the proposal form that information

on claims would be shared amongst other insurers and that the insured shall not have any objection for the same. This will be made a part of the declaration available in the proposal form. Insurers should not encourage acceptance of risk of such clients refusing to agree to this declaration.

- The insurers should have an open mind to share the basic information of claims with all other insurers. Having understood the necessity of such sharing of information as detailed in the earlier part of this article, I am sure that insurers will sink their inhibitions and come forward with information, which would make the database fool proof. The database would require information on claims only and not information on all policies.
- With about 12 general insurance companies (and many more to come), one stand-alone health insurer and two specialized agencies like ECGC and Agricultural Insurance Corporation; the task of collecting data would be a major initiative. A specialized agency authorized by the general insurance council will be able to collate, pool and organize such data within a span of 3-4 months. Subsequently the data need to be updated online on a monthly basis.
- One day it would a vital tool for underwriting.

As explained earlier, the de-tariff scenario has set the cat among the pigeons and every insurer is vying for a share of the pie. It is now that the insurers should stand united in certain areas - particularly claims. This would ensure that dishonest clients do not take undue advantage of the competition prevailing amongst the insurance companies and obtain cover - suppressing information. I am of the firm opinion that a bad risk should not be priced low even by oversight, which can be detrimental to the economic health of the insurance company.

Truly, the initiative must begin - Don't you feel it should?

The author is Senior Product Manager - SME (Small and Medium Enterprises) segment at Cholamandalam MS General Insurance Co. Ltd., H.O., Chennai.

प्रकाशक का संदेश

यह आवश्यक है कि बीमा पॉलिसी संविदा में शर्तें एवँ धारायें जहाँ तक संभव हो सरल तथा प्रभावशाली ढंग से तैयार की जानी चाहिये। पॉलिसी दस्तावेज का मूल ढाँचा जो संविदा के लिये साक्ष्य होता है बीमाकर्ता द्वारा इसकी एकरूपता बीमाकृत के लिये इसकी कुछ धाराओं और पृष्ठांकन को विशेष रूप से उपयोगी बनाता है। बीमाकर्ता के लिये यह महत्वपूर्ण होता है कि वह एक संतुलन बीमाकृत की आवश्यकताओं तथा जोखिम को आवरण की संभावना के मध्य रखे जो वहन करने योग्य लागत पर हो। इसको अभेदय दरों तथा अथवा उचित अपवर्जन धाराओं द्वारा प्राप्त किया जा सकता है।

बीमाकर्ता एक विस्तृत प्रभावशाली का प्रयोग करते हैं अथवा एक प्रस्ताव पत्र जिसमें वे जोखिम से संबंधित सूचनायें प्राप्त करते हैं। यह कहना उचित होगा कि भावी द्वारा प्रदान की गई सूचना संपूर्ण तथा ठीक होनी चाहिये। आमतौर से बीमाकर्ता बीमाकृत के बयान पर विश्वास करता है। बीमाकर्ता अपने आप में इस बात की प्रशंसा करेंगें की पॉलिसी की धाराओं को बनाते समय उन्हें प्रभावशाली होना चाहिये और बनते हुये बाजारों में यह अधिक महत्वपूर्ण हो जाता है। इसका ध्यान रखना चाहिये कि धारायें बनाने में पूर्ण पार्दशिता रखी जाये तथा वह अस्पष्टता विहिन होनी चाहिये। प्रक्रिया प्रस्ताव पत्र तैयार करते समय ही प्रारंभ होनी चाहिये। यह सुनिश्चित किया जा सके कि इकठ्ठा की गई सूचना जोखिम के मूल्यांकन के लिये उपयोगी है। धाराओं का महत्व तथा उनकी बीमा संविदा में व्याख्या जर्नल के इस अंक मे केंद्र बिन्दु में है।

किसी आपदा के कारण क्षति की कोई सीमा नही है। इतनी वैज्ञानिक तथा तकनीकी विकास के चलते, प्रकृति मानवता पर अमूल्यांकित क्षति डालती है। वैसे आपदा को दूर नही रखा जा सकता है कि बड़े स्तर पर हानि को कम किया जाये। आपदा प्रबंधन तथा उसकी तैयारी जर्नल के अगले अंक का केंद्र बिन्दु होगा।

सी. एस. राव

सी. एस. राव
अध्यक्ष

"दृष्टि कोण"

संयुक्त संरचना के विकास करने के लिए नया दस्तावेज बीमाकर्ता की शोधन क्षमता के मूल्यांकन तथा आई ए आई एस के लिए एक प्रारंभिक कदम इस विषय पर मानक तथा मार्गदिशाएँ विकसित करने के लिए है।

श्री टोम कार्प

तकनिकी कमेटी के अध्यक्ष, आई ए आई एस के संयुक्त संरचना को बीमा शोधन क्षमता के मूल्यांकन के लिए।

बडी संख्या में गैर मुसलमानों के इस्लामिक बीमा लेने कारण तथा ज्यादा नये बीमाकर्ता के बाजार में प्रवेश करने के कारण इस वर्ष बीमा बाजार का बडा हिस्सा उधर जायेगा।

श्री नासिर यासीन

कार्यकारी सचिव मलेशिया टेकफुल एसोसिएशन

वित्त मंत्रालय विनियमों को जारी करने का प्रयास टैरिफ युद्ध समाप्त करने के लिए आम बीमा में कर रही है। सरकार की योजना है उद्योग की सांख्य एकत्र करके मोटर वाले वाहनों के लिए शुद्ध जोफिम की गणन की जाए।

श्री इसह रचमातार्वता

वित्त मंत्री, ब्योरोजीफ आफ इंडोनेषिया बीमा

स्थानीय बीमा जो अभी कित नहीं होगा विदेशी खिलाडियों के आने के बाद जब एशिया में मुक्त व्यवसाय प्रारंभ होगा तो एशिएन फ्री ट्रेड समझैता लागू होगा।

श्री जोस क्युशिया

अध्यक्ष फिलिपाइन्स अमेरिकन लाइफ तथा आम बीमा

क्षेत्र में वित्तीय सेवाएँ सबसे तेजी से विकसित हो रही हैं। इनके लिए निरंतर बीमा तथा पुर्णबीमा क्षेत्र के सहयोग की आवश्यकता है। इस वृद्धि को बनाये रखने के लिए यह महत्त्वपूर्ण है कि वित्तीय सेवा फर्म पयप्ति रूप से जोफिक का प्रबन्धन कर सके।

महामहीन ओमर बीन सुलिमन

दुबई इंटरनेशनल फइनान्शियल सेंटर के गवर्नर (डी आई एफ सी)

बीमा उदारिकरण विनियमों से यह अपेक्षा है कि वह अधिशेष रेखा बीमा बाजार के प्रभाव को सुधारेंगे तथा संपत्ति दायित्त्व बीमा को ग्राहक को आसानी से उपलब्ध करवायेगा।

श्री रिचर्ड बोयुहन

कार्यकारी निदेशक नैशनल एसोशियेशन सर्प्लस लाइन आफिस युए में पुर्णबीमा अधिनियम 2007 पर बात करते हुए।

परीक्षण परख बीमा

परीक्षण यर्थात् की आवश्यकता

परीक्षण परख बीमा मूलतः एक विधि दायित्व बीमा है जो बीमाकृत को वित्तिय आवरण प्रदान करता है- प्रायोजक संगठन व अनुसंधान संगठन इत्यादि- विधि दायित्व जो पैदा हो परीक्षण परख करने से ऐसा लिखते हैं -

दाटला के एम एस राजू

प्रस्तावना

भारत विभिन्न क्षेत्रों में विश्व का बाह्यकार्य का गंतव्य स्थान बन गया है। चाहे वह आईटी व आईटीईएस, ऑटोमोबाईल, इंजीनियरिंग समान, संविदा हो। नई संधि इस बड़े वाहन में परीक्षण परख उद्योग है। विश्वव्यापी ड्रग कंपनियों तथा परीक्षण परख संगठनों की आवाज तथा डब्लयूटीओ के दबाव के कारण भारत सरकार ने जूंन 2005 में ड्रग तथा कॉस्मेटिक नियमों में परिवर्तन किये। इन परिवर्तनों से पहले एक अपेक्षा स्तर पर आधारित थी, जिसमें परीक्षण परखें की जा सकती थी और वह थी यदि कोई भूमंडलीय कंपनी भारत में स्तर 2 अध्ययन करना चाहती है तो स्तर 3 पहले से ही विश्व के किसी देश में पूरा कर लिया गया हो। नये नियम के सामने आने से विदेशी ड्रग कंपनियाँ तथा अन्य को अन्य स्थानों के समान ही यहाँ परीक्षण परख करने की भारत में अनुमति प्रदान की गयी।

अवसर

देश में परीक्षण परख उद्योग को तीव्रता प्रदान करने के लिये इन विनियमनों से बड़ी अपेक्षाएँ हैं। परीक्षण कारक जो उद्योग के विकास को प्रभावित करते हैं उन्हें अधोलिखित में सारांश किया जा सकता है -

यूएस तथा अन्य पश्चिमी देशों में सख्त विनियमन होने के कारण ड्रग का प्रशिक्षण दिनों दिन अधिक रूप से अलाभकारी होता जा रहा है। विस्तृत सुरक्षा तथा क्षतिपूर्ति आवश्यकताओं तथा छोटी जनसंख्या के चलते। यह प्रक्रिया परीक्षण विषय को अधिक धीमी तथा खर्चीली बना देती है। यह कारक अर्थव्यवस्था विश्वव्यापी ड्रग तथा फार्मासुटिकल कंपनियों की गतिविधियों को लागत समविष्ट करते हुए आर एंड डी को कठिन बनाती है। परिणामस्वरूप बहुत सी अनुसंधान आधारित कंपनियाँ अपने परीक्षण परख गतिविधियों को विकासशील देशों जैसे चीन, इंडोनेशिया, थाईलैंड तथा भारत में बाह्य रूप से स्थापित करना चाहती हैं। विश्वव्यापी परीक्षण परख उद्योग अनुमानतः10 बिलियन यूएस डॉलर आंका गया है जो भारत में मात्र 30 मिलियन यूएस डॉलर ही है। यह अंतराल अगले कुछ वर्षों में भारत के अनुकूल कारकों को देखते हुये प्रतिपादक वृद्धि की संभावना रखता है।

बड़ी संख्या में मरीजों की जनसंख्या, चिकित्सा विविधता उन्नत तथा विकासशील अस्पताल तथा परीक्षण परख सुविधा, अच्छी प्रकार प्रशिक्षित अंग्रेजी बोलने वाले चिकित्सक तथा सहायता देने वाले पेशेवर स्थापित जैनरिक ड्रग उत्पाद, विकसित सांख्यिकी तथा बुनियादी सुविधायें आदि। भारत एक आकर्षक अवसर विभिन्न प्रकार की ड्रग को विकसित करने तथा परीक्षण परख के लिये रखता है। परीक्षण परख के लिये ए टी कैनरी द्वारा बनाये गये इंडेक्स में पाँच मुख्य क्षेत्रों को शामिल किया गया है। मरीज की उपलब्धता, लागत, कार्य कुशलता, संबंधित अनुभव, विनियामक शर्तें तथा राष्ट्रीय मूलभूत सुविधायें इसमें चीन, भारत तथा रूस को सबसे आकर्षक देशों की श्रेणी में रखता है।

परीक्षण परख को समझना

परीक्षण परख अथवा परीक्षण अनुसंधान मानव स्वंयसेवकों पर एक अध्ययन करती है जो विशेष चिकित्सा प्रश्नों/प्रश्न के उत्तर देता है। परीक्षण परख तीव्रतम तथा सुरक्षित ढंग है जो चिकित्सा मानव पर कार्य करती है तथा कुछ ढंग जिससे उनकी हैल्थ अच्छी होती है। मध्यवर्ती परख यह सुनिश्चित करता है कि प्रायोगिक इलाज अथवा नये प्रकार की चिकित्सा नियंत्रित वातावरण में सुरक्षित तथा प्रभावशाली है। 'परीक्षण परख' से हैल्थ कारक संबोधित होते हैं जो प्राकृतिक परिवेश में बड़ी संख्या में लोगों के लिये है।

परीक्षण परख उपचार परख भी हो सकते हैं जो परीक्षण उपचार करते हैं, ड्रग के नये सम्मिलित स्वरूप अथवा शल्य चिकित्सा के लिये नये ढंग व रेडियेशन थैरेपी इत्यादि अथवा निवारक परख जो रोग को रोकने का अच्छा ढंग है जिन्हें कभी कोई रोग नहीं हुआ उन्हें रोग होने से रोकना अथवा परीक्षण परख जो की जाती है अच्छे परीक्षण के लिये। अनुवीक्षण परख सबसे अच्छा ढंग है। हैल्थ स्थिति अथवा जीवन की गुणात्मक

मरीज की उपलब्धता, लागत, कार्य कुशलता, संबंधित अनुभव, विनियमक शर्तें तथा राष्ट्रीय मूलभूत सुविधायें इसमें चीन, भारत तथा रूस को सबसे आकर्षक देशों की श्रेणी में रखता है।

तथा आंबन परख को जानने के लिय जिससे सहजता को इन लोगों के लिये सुनिश्चित किया जा सके जो गहन रोग से पीड़ित है। परीक्षण परख स्तरों में किये जाते हैं। प्रत्येक स्तर पर अलग प्रयोजन होता है तथा वह मदद करता है विभिन्न प्रश्नों का उत्तर देने के लिये।

स्तर 1 के प्रशिक्षण के लिये अनुसंधानकर्ता अपनी ड्रग का छोटे समूह पर प्रथम बार प्रशिक्षण सुरक्षा जानने के लिये करता है। सुरक्षित खुराक तथा सहदुष्प्रभाव इत्यादि को जानने के लिये स्तर 2 में प्रौद्योगिक ड्रग अथवा इलाज को अपेक्षाकृत बड़े समूह को दिया जाता है इसके प्रभाव तथा सुरक्षा देखने के लिये। स्तर 3 में ड्रग को बड़े समूह को दिया जाता है इसके प्रभाव तथा सहदुष्प्रावों को सुनिश्चित करने के लिये तथा उसके मिलने वाले इलाज से तुलना होती है तथा सुरक्षा की जाँच होती है।

स्तर 4 के प्रशिक्षण भी होते हैं जो विपण्णन को बाद के अध्ययन के अनुसार अतिरिक्त सूचना प्राप्त करने के लिये होते हैं जिसके ड्रग को जोखिम, लाभ तथा इष्टतम उपयोग शामिल है।

परीक्षण परख दायित्व

पिछले कुछ समय में परीक्षण परख उद्योग पर मुकदमेबाजी बढ़ गयी है। इसमें आरोप इतने बड़े हैं कि रिपोर्ट तथा विवरण झूठे होते हैं तथा अध्ययन के लिये धनराशि लेने के लिये गलत सूचना, सहमति पत्र, विनियमों की अवहना, आचार नीति का उल्लंघन, हितों में संघर्ष शामिल हैं।

अधिकांश मामलों में परीक्षण परख जाँच-पड़ताल तथा अनुसंधान संस्थाओं का जो इसमें शामिल होते हैं लक्ष्य बनाया जाता है। कंपनी जो ऐसे परीक्षण प्रायोजित करती है वह भी मुकदमेबाजी के जोखिम के दायरे में आती है। विशेषरूप से प्रकटन ठीक प्रकार नहीं करना। हितों में संघर्ष, अच्छी परीक्षण परख का अतिक्रमण आदि। प्रायोजित कंपनी को जोखिम प्रबंधन के लिये प्रभावशाली कदम उठाने चाहिये उन्हें यह सुनिश्चित करना चाहिये कि जो परीक्षण परख वे कर रहें है वह हितों में संघर्ष को रक्षित करती है।

जब तक विश्व मेडिकल एसोशिएशन हैल्सिंकी प्रोटोकॉल तथा अंतरराष्ट्रीय अच्छी परीक्षण प्रणालियों को विनियामक मानकों के साथ लागू नहीं किया जाता प्रायोजक तथा अनुसंधानकर्ता बड़े जोखिम में होंगे। जबकि परीक्षण परख बीमा कुछ दायित्वों के विरूद्ध संरक्षण प्रदान करता है। कंपनियाँ जिन पर पर्याप्त जोखिम प्रबंध नहीं है वह ऐसे बीमा लेने में कठिनाई का अनुभव कर सकते हैं अथवा कम क्षतिपूर्ति के लिये अधिक बीमा शुल्क देना होगा।

परीक्षण परख बीमा

परीक्षण परख बीमा एक वैधानिक देयता है जो बीमाकर्ता को वित्तीय सुरक्षा प्रदान करती है - प्रायोजक संगठन अनुसंधान इत्यादि - वैधानिक दायित्व जो परीक्षण परख के परिणामस्वरूप आता है। वस्तुगत की मृत्यु अथवा क्षति के कारण दायित्व उत्पन्न हो सकता है तथा संपत्ति को क्षति कम रखवाली अपर्याप्त तथा गलत प्रकटन, हितों में संघर्ष, दावाकर्ता अनुसंधान विषय / स्वंय सेवक मृत्यु के विषय पर निर्भर करते हैं। बच्चों के अभिभावक, प्रायोजक संस्थायें तथा अनुसंधान एक दूसरे पर सरकार तथा विनियामक इत्यादि।

परीक्षण परख बीमा एक विशेष विषय है तथा बीमा कंपनी के विशेष बीमा लेखक ही इस प्रकार के बीमा का लेखन करने के लिये अभिनियुक्त हो सकते हैं। बीमालेखक इस प्रकार के बीमा व्यवसाय के लिये प्रणालीबद्ध ढंग से आगे बढ़ सकते हैं। बीमालेखकों के दृष्टिकोण से पॉलिसी चाहने वालों को मदद मिलती है उस सूचना की माँग करने के लिये जो एक बीमालेखक चाहता है तथा शेष बीमा आवश्यकता जो अनुसंधान संस्थाओं तथा प्रायोजकों के लिये है।

जोखिम मूल्यांकन

सभी बीमा के अनुसार इसमें भी बीमालेखक के लिये सूचना महत्वपूर्ण है। बीमालेखक नाजुक सूचना का मूल्यांकन करना चाहेंगे। इससे पहले कि वह इस प्रस्ताव पर कोई निर्णय ले। एक सूचना जो बीमा लेखक नाजुक तथा संबंधित समझता है, उसमें परख के उद्देश्य तथा कारण शामिल हो सकते हैं। प्रायोजक का परिपेक्ष तथा अनुभव तथा जाँच करना (यदि प्रायोजक से अलग हो) साथ ही अनुसंधान जो परख को करने के लिये उत्तरदायी है। परख प्रयोगशाला / तकनीकी संस्था का विवरण जो इस परख में शामिल हो। उत्पाद जाँच-पड़ताल, जिन्हें गैर परीक्षण अध्ययन से लिया गया है। जिनकी भावी रूप से परीक्षण सार्थकता है जनसंख्या जिसका अध्ययन किया जाना है।

साहित्य तथा सांख्यिकी जो परख के लिए संदर्भित है तथा अहरीत मानदंड, इलाज जो किया जाना है, उत्पाद का नाम, खुराक अनुसूची प्रशासन का रुट / मॉडल, अनुवर्ती कार्यवाही की अवधि मैडिकेशन अनुमत: इलाज (शामिल है बचाव इलाज) और अनुमत: इलाज अनुमति का प्रकार तथा प्रभाव। मरीज के अनुमति संबंधित सूचना तथा दस्तावेज, वित्तीय संविदा दस्तावेज प्रायोजक तथा अनुसंधान कर्ता के मध्य इत्यादि।

यह सूचना बीमालेखक को मदद करेगी, जोखिम की विवेचना करेगी तथा बीमा आवश्यकताओं को पर्याप्तता प्रदान करेगी प्रायोजक तथा अनुसंधान कर्ता के लिए। अधिकांश सूचना अनुसंधान प्रोटोकोल में उपलब्ध रहती है आचार नीति समिति के प्रस्तुतीकरण, सूचना सहमति, दस्तावेज तथा संविदा / समझौता इत्यादि। कई मामलों में अनुसंधान प्रोटोकोल उपलब्ध करवाता का बीमा आवश्यकता के अनुरूप न्यूनतम क्षतिपूर्ति। बीमालेखक को यह सभी सूचना किसी निर्णय पर पहुँचने से पहले ही उपलब्ध करवा देनी चाहिए।

परीक्षण परख बीमा पॉलिसी

परीक्षण परख बीमा पॉलिसी सामान्यत: दावा आधारित होती है। इन दिनों बाजार में घटना आधारित पॉलिसीयाँ उपलब्ध नहीं है। बीमा पॉलिसी विशेष परीक्षण परख के लिए की जा सकती है (एकल परख पॉलिसी) अथवा विभिन्न परख पॉलिसी होल्डर को एक ही पॉलिसी में आवरण प्रदान किया जा सकता है (विविध परख पॉलिसी)।

- बीमाकर्ता के अनुरोध पर सभी अथवा अधोलिखित इकाईयों को पॉलिसी में शामिल किया जा सकता है।
- निदेशक, साझेदार बीमाकर्ता के रूप में भूमिका प्रदान करते हुए।
- बीमाकर्ता के कर्मचारी जिसमें मेडिकल कार्मिक शामिल हैं।
- सह ठेकेदार, डॉक्टर, परामर्शदाता, फिजिशियन, अस्पताल तथा अनुसंधान संगठन अथवा नर्स जो अपने कार्य का निष्पादन परीक्षण परख के लिए करते हैं।

कंपनियाँ जिन पर पर्याप्त जोखिम प्रबंध नहीं है वह ऐसे बीमा लेने में कठिनाई का अनुभव कर सकते हैं अथवा कम क्षतिपूर्ति के लिये अधिक बीमा शुल्क देना होगा।

• आचार समिति अथवा इसके सदस्य जिन्होंने परख के संबंध में पॉलिसी आवरण को सुरक्षा प्रदान की है।

बीमा आवरण

पॉलिसी यह ऑफर करती है कि बीमीत अवधि में परीक्षण परख जो बीमाकर्ता की तरफ से किये जाते हैं इस परख विषय में मृत्यु, शारीरिक चोट अथवा हैल्थ को हानि शामिल हैं। कुछ पॉलिसीयाँ मैटिरियल हानि को भी आवरण प्रदान करती है जिनका संबंध परीक्षण परख से होता है। आवरण में शामिल डाटा संरक्षण के लिए परीक्षण परख।

संविदा की अवधि में बीमा आवरण परीक्षण परख जो भारत में किए गए हों सामिल हैं। प्रादेशिक सीमा को विशिष्ट अनुरोध पर बढ़ाया जा सकता है। आवरण को परख के बाद की अवधि के लिए भी बढ़ाया जा सकता है।

कुछ देशों में आवरण (वैद्यानिक आवश्यकता) आवश्यक है, संविदा समाप्त होने को 60 माह बाद तक भी (परख के बाद का बीमा)

पॉलिसी बीमाकृत अथवा दावे वालों के विरुद्द क्षतिपूर्ति का प्रावधान रखती है, लागत फीस तथा खर्च इत्यादि भी शामिल हैं। फिर भी अधिकतम दायित्व इस पॉलिसी के अन्तर्गत सीमित है जो क्षतिपूर्ति बीमाकत ने पॉलिसी के लिए ली हो। इसमें आवश्यक कटौतियों जिसका निर्वहन बीमाकृत को करना होगा।

आवरण में अपवर्जन

- अधोलिखित प्रकृति को परख के लिए बीमाकर्ता दावे का भुगतान नहीं करते।
- वर्तमान हैल्थ में बिखराव जो परख न करने की स्थिति में भी संभव था।
- जाँच - पडताल के अन्तर्गत दिए गए दिशा निर्देश में जान बुझकर हानि पहुँचाना।

जुर्माना, दंडात्मक क्षतिपूर्ति खर्च

- बीमाकर्ता द्वारा सूचीबद्द किए गए सार, सूत्र अथवा प्रस्तुति के कारण हानि।
- ऐसी हानि जो कुछ मात्रा में विपरीत क्रम जो परीक्षण परख में आपेक्षित हैं, आज के मेडिकल ज्ञान के अनुसार।
- आपेक्षित प्रायोजन के अनुसार कार्य संपादन परीक्षण परख में न हो पाने के कारण।

बीमा में दावे शामिल नहीं हैं जो उत्पन्न होते हैं:-

- युद्ध, रेडियेशन, रेडियोधर्मिता, संदूषण इत्यादि से
- हैपेटाइटिस तथा एड्स से
- प्रस्तावित वैद्यानिक विनियमन की अनुपूर्ति न करने पर
- जानबूझ कर, दावों की रोकथाम के लिए कार्यवाही न करना।
- संविदा पर नियुक्त को हानि जो बीमाकर्ता अथवा ठेकेदार या सहठेकेदार के साथ हो।

बीमाकर्ता के लिखित भरोसे के बिना किसी भी पक्ष से कोई समझौता, क्षतिपूर्ति, वचन दावे के संबंध में नहीं किया जाना चाहिए।

बीमाकर्ता के दायित्व

वैद्यानिक, आधिकारिक, विधि विनियमों का अनुपालन

परीक्षण परख की सूचना के लिए वैद्यानिक रुप से आवश्यकता

जहाँ बीमाकर्ता तृतीय पक्ष की नियुक्ति परीक्षण परख के लिए करता है वह सुनिश्चित करे की तृतीय पक्ष इन दायित्वों को पुरा करता है।

यदि कोई घटना घटित होती है जो बीमा को प्रभावित करती है। बिना देरी के इसकी सूचना बीमाकर्ता को दी जानी चाहिए। किसी मृत्यु की जल्द सूचना दी जानी चाहिए जिससे वह पोस्टमार्टम के उपाय कर सके।

बीमा कंपनी को तथ्यों को जानने तथा हानि को कम करने में मदद करे।

यह सुनिश्चित करे कि परीक्षण परख के लिए ठीक प्रकार के रिकॉर्ड रखे जाए और यह इस प्रकार हो कि रिकॉर्ड के द्वारा वह स्थिति पुनः बनायी जा सके जिसके कारण दुर्घटना घटित हुई।

बीमाकर्ता के लिखित भरोसे के बिना किसी भी पक्ष से कोई समझौता, क्षतिपूर्ति, वचन दावे के संबंध में नहीं किया जाना चाहिए।

बाध्यता को भंग करना

यदि बीमाकर्ता तृतीय पक्ष की नियुक्ति परीक्षण परख के लिए करता है अथवा परख का विषय बाध्यता का उल्लंघन करता है, यह साधारण नहीं है कि बीमा संविदा समाप्त हो जाए जब तक की यह साबित किया जाए कि परिस्थितियाँ में यह दुर्घटना थी तथा यदि सभी शर्तों को पुरा भी किया जाता तब भी दुर्घटना घटित हो सकती थी।

कुछ अधिकार क्षेत्र बाध्यता को भंग करते हैं जो बीमाकर्ता पर लगाई गई है अथवा तृतीय पक्ष को परीक्षण परख के लिए नियुक्त करने पर तथा परीक्षण परख के कारण केवल श्रोतों पर बीमाकृत का अधिकार हो जाता है। ऐसे मामलों में परख विषय को यह अधिकार होता है कि वह सीधे बीमा कंपनी पर दावा करे तथा बीमा कंपनी बीमाकृत का पुनः भुगतान कर सके।

भारत की स्थिति परीक्षण परख उद्योग में काफी अच्छी है। यह प्रस्तुत करता है एक अवसर बीमाकर्ता को बीमा के नवीनतम उत्पाद परीक्षण परख जोखिम के क्षेत्र में। इसकी कुंजी इसकी प्रक्रिया की संपूर्ण समझ में है। राष्ट्रीय तथा अंतर्राष्ट्रीय विधान, विधि, विनियमन तथा परंपराएँ इत्यादि। कैमिकल मैडिकल तथा बायो मैडिकल तकनीक. उन्नत विश्वव्यापी परिपाटिया। कुल मिला कर सफल बीमालेखन कल उचित प्रश्न पुछने में छिपी है और हम अच्छे प्रश्न पुछ सकते हैं यदि हमें अच्छा ज्ञान हो। ज्ञान केवल सूचना नहीं। ठीक ज्ञान से भरे होने पर बीमालेखक अर्थपूर्ण परिचर्चा कर सकते हैं, परीक्षण परख के बारे में। उद्योग को नवीनतम उच्पाद उतारने हैं तथा मानव हेल्थ को क्रियात्मक होकर प्रोत्साहन देना है तथा भारत तथा विश्व का भला सोचना है।

लेखक - प्रबंध निदेशक तथा सीईओ, निविस्टा रिस्क मैनेजमैंट सर्विस प्राईवेट लिमिटेड, हैदराबाद

भारतीय निगमित क्षेत्र में आईपीओ संभावित अरक्षितता तथा सुरक्षा आवश्यकता

साझे दावेदार जानना चाहते हैं कि उनकी धनराशि को किस प्रकार निवेश किया गया है तथा वह अधिक ज्ञानवान तथा माँग करने वाले हो रहे हैं - बी साई रजनी। वह आगे कहती है कि विशेष बीमा संरक्षण प्रतिभूतियों को जारी करने तथा सुविधाकर्ता आने वाले दिनों में आवश्यक हो जाएगी।

वर्ष 2006-07 में आईपीओ से शुद्ध 34,000 करोड़ रुपये रहने की संभावना है। निगमित कंपनियाँ आईपीओ के माध्यम से 34,000 करोड़ रुपये की उगाही प्राथमिक बाजार इस वित्तीय वर्ष में करेगी। अप्रैल-नवम्बर 2006 में आईपीओ से जुटाई गई पूँजी 14,189 करोड़ 37 आईपीओ के जरिये थी जो 2004-06 वित्तीय वर्ष में 79 आईपीओ की धनराशि 10,936 की तुलना में थी। (आभार - फाइनेंसियल एक्सप्रेस, 6 जनवरी 07)

जबकि निगमित कंपनियाँ भारत में बड़े स्तर पर आईपीओ ला रही है, ऊपर बताए गए आंकड़े प्रदर्शित करते हैं सेवी की कंपनियाँ तथा उनके निर्देशकों के प्रति बाजार परिचालकों, ब्रोकर, वित्तीय तथा डिपॉजिटरी में भाग लेने वालों की संख्या में वृद्धि हो रही है।

पहले सेबी ने पाया कि 2003 से 2005 के बीच 24 मुख्य परिचालकों ने 21 आईपीओ के मुख्य भाग को 58,938 बेनामी एकाउंट खोल कर प्राप्त कर लिया। नवम्बर 2006 में सेबी द्वारा लाए गए आदेश के अनुसार मध्यवर्तियों से 1.16 बिलियन रुपये देने को कहा गया जो बताता है कि नजर रखने वाला अधिक सावधान हो गया है। बाजार के ऊँचे होने पर धोखा धड़ी की संभावना के समय। यह धोखा डी एण्ड औ. के इस दावे को देश की दो डिपोजिटरी संस्थाओं के लिए ले जाता है। आबंटन में हेराफेरी कोर्ट के लिए पहले अनदेखा किया गया उनके द्वारा जो इन संबंधित संस्थाओं के प्रबंधक स्थिति रखते थे।

इन परिस्थितियों में यह महत्वपूर्ण है कि इन संस्थाओं द्वारा जोखिम अरक्षिता तथा इनके प्रतिनिधि इसे प्रभावशाली ढंग से नियंत्रित कर सके।

एक निगमित इकाई जब पूँजी बाजार से पूँजी उगाही निवेश कर्ताओं को निमंत्रण देकर तथा विवरणिका का प्रकाशन करके तथा गैर सूचीबद्द प्रतिभूति की बिक्री करते हुए वह विनियामक, नये शेयर धारक, ग्राहक, प्रतिस्पर्धा वालों के निरीक्षण में आ जाती है।

इकाई के निदेशक तथा अधिकारी इकाई स्वयं, शेयर धारक अथवा परामर्शदाता इकाई स्वयं लीड प्रबंधक प्रायोजक आदि लागु हो भावी दायित्व को देखते हैं जो सार्वजनिक रुप से अश पूँजी जारी करने के परिणामस्वरुप होती है। यह दायित्व गलत सूचना, गलत विवरण, भ्रामक प्रकटीकरण, झूठे राजस्व तथा गलत लेखा परिपाटियाँ अनुमान तथा आगे के विवरण के कारण हो सकती है।

विवरणिका जारी करने से भावी दायित्व काफी बड़े हो सकते हैं। सेबी अधिनियम 1992 की धारा 14 एच बी के अनुसार जमाकर्ता तथा डिपोजिटरी भागीदार अपने कर्तव्य के निर्वाहन में चूक जाते हैं। सेबी 10 मिलियन रुपये तक दंड लगा सकती है। पिछले कुछ समय में बहुत से मामले (कुछ को नीचे बताया गया है) सामने आए हैं। जिनमें सेबी ने दंडात्मक कार्यवाही की है। इन स्थितियों ने भावी दावा पीओएसआई (पब्लिक ऑफरिंग ऑफ सिक्यूरिटी इंश्योरेंस) पॉलिसी के अंतर्गत किया है।

जनवरी 2007 - निशान कॉपर दिसंबर 2006 में एक आईपीओ के लिए बड़ी विवरणिका के साथ बाजार में गए। ट्रेडिंग के प्रथम दिवस 29 दिसंबर 2006 को 6.41 मिलियन अंशों को पहले निर्गमन के रुप में जारी किया गया, प्रथम दिन 130 मिलियन शेयरों की ट्रेडिंग रिकॉर्ड की गई। सेबी ने निरीक्षण प्रारंभ किया तथा निशान कॉपर के शेयर का भुगतान रोकने के लिए कहा। अपनी अंतरिम रिपोर्ट में सेबी ने लगभग 40 इकाइयों के भुगतान तथा शेयर स्थानांतरण पर प्रतिबंध लगा दिया।

दिसंबर 2006 - दिसंबर 2006 में सेबी ने गैमन इंडिया पर पूँजी बाजार में आने के लिए एक वर्ष का प्रतिबंध लगा दिया। सेबी ने गैमन इंडिया तथा उसके प्रोत्साहकों को वर्ष 2001 में राइट्स निर्गमन में कंपनी के फंड गलत ढंग से प्रयोग करने का दोषी पाया तथा वह वैद्यानिक घोषणाएँ करने का दोषी पाया।

सेबी 10 मिलियन रुपये तक दंड लगा सकती है। पिछले कुछ समय में बहुत से मामले (कुछ को नीचे बताया गया है) सामने आए हैं।

अनिमिताओं में शामिल है विनियामक द्वारा प्रस्तावित स्थानों से अलग पर टर्मिनल देना। ग्राहक के दस्तावेजों को ठीक प्रकार न रखना तथा बीएससी तथा एनएससी के खातों में विविधता न रखना।

नवम्बर 2006 - नवम्बर 2006 में वैल्थ सी लिमिटेड से कहा गया कि वह डनलप इंडिया तथा फैलकॉन टायर में 20 प्रतिशत हिस्सेदारी के लिए खुली बोली लगाए तथा शेयर धारकों को जून 2006 के मध्य की अवधि शेयर लेने की अवधि के बीच शेयर धारकों को 10 प्रतिशत की दर से ब्याज का भुगतान करे। इसके लिए कोई सार्वजनिक घोषणा नहीं की गई (अप्रत्यक्ष अधिगृहण)।

अगस्त 2006 - सेबी ने हालकोम इंडिया प्राइवेट लिमिटेड पर 250 मिलियन का दंड लगाया, क्योंकि उन्होंने एवरेस्ट इंडस्ट्रीज लिमिटेड के लिए खुला प्रस्ताव नहीं दिया। यह कंपनी एसोसिएटेट सीमेंट कंपनी (एसीसी) की अनु कंपनी है। होलकोम ने एसीसी के 34.71 प्रतिशत अंश अधिगृहित किया था तथा 76.01 अंश ईआईएल के लिए अप्रत्यक्ष अधिग्रहण था।

प्रतिभूतियों के लिए बीमा की आवश्यकता कभी भी इतनी अधिक नहीं थी। अंशों के सार्वजनिक निर्गमन अथवा पीओएसआई नीति के किए बीमा आवरण गलत कार्य के लिए आवरण है तथा इनके निदेशकों को विवरण के लिए आवरण है तथा इनके निदेशकों को विवरण के कारण जो करना पड़ता है। आवरण में शामिल होता है बीमालेखन के दावे अथवा प्रायोजक के कारण निदेशकों को व्यक्तिगत रुप से दी गई वारंटियां तथा क्षतिपूर्ति जो प्रायोजक तथा बीमा लेखक द्वारा दी जाती है।

पीओएसआई पॉलिसी की विशेषताएँ

- दावा बनाने का फॉर्म
- प्रतिवाद करने का वाक्यांश
- एकल प्रीमियम पर उसे 6 वर्ष की खरीद
- यह (आईपीओ) प्रारंभिक प्रस्ताव को आवरण दे सकती है तथा द्वितीय प्रस्ताव को भी निजी रख रखाव में संरक्षण दिया जा सकता है।
- आवरण का क्षेत्र (नीचे बताए गए आवरण केवल सांकेतिक हैं, वास्तविक शर्तें एक से दूसरे बीमा लेखक पर बदलती है)
  - रक्षा लागत तथा दायित्व की सीमा के अंतर्गत खर्चे
  - कुछ बीमा लेखक विवरित प्रचार को रोकने के लिए अथवा कम करने के लिए शेयर की दरों में 10 प्रतिशत अथवा अधिक की गिरावट के लिए प्रावधान रखते हैं।
  - वैद्यानिक देयता जो संगठन के निदेशकों तथा अधिकारियों के प्रबंधकीय कार्य के परिणामस्वरुप पैदा होती है, डब्ल्यू. आर. टी. सार्वजनिक निर्गमन। पॉलिसी में दंपति एस्टेट तथा विधि प्रतिनिधि जो निदेशकों तथा अधिकारियों के ही शामिल हैं।
  - संगठन की वैद्यानिक दायित्व स्वयं में जो सौदे बाजी के बाद पैदा होती है, प्रस्ताव के संबंध में निर्णय तथा बातचीत से पैदा होती है।
  - दंडिक तथा छूट की क्षति के लिए आवरण
  - कपट अनन्यत: वंचित नहीं करता, निरीह बीमाकर्ता को रक्षा लागत आवरण से
  - बीमाकर्ता व्यक्ति की परिभाषा को बढ़ाया गया है जिसमें प्राकृतिक व्यक्ति तथा कंपनी का परिवार जो अपने अंश को सार्वजनिक प्रस्ताव से बेची है।

अपवर्जन

- दंड तथा जुर्माना
- व्यक्ति लाभ के लिए कपटपूर्ण कार्य
- अपनी ही प्रतिभूतियों को खरीदने के लिए संगठन द्वारा भुगतान जो पर्याप्त नहीं है अथवा ज्यादा हैं, जिसके कारण दावा उत्पन्न होता है।

निर्गमन के लिए जारी धनराशि से साधारण कम राशि के आवरण की आवश्यकता होती है और कई बार अधिक की भी यह 240 से 500 मिलियन के मध्य होता है और कई बार अधिक भी। यदि जोखिम यूएस सिक्यूरिटी अधिनियम के अनुसार हो तो ऊँची सीमाएँ प्रस्तावित की जाती है।

पीओएसआई पॉलिसी तथा डीवओ पॉलिसी में यह है कि जोखिम का सम्बोधन उनके द्वारा ही किया जाता है। एक डीवओ पॉलिसी को इस प्रकार नहीं बनाया जाता की वह विवरणिका तथा सूची प्रक्रिया के कारण उत्पन्न जोखिम को आवरण प्रदान करे। पारंपरिक रुप से वे आवरण नहीं प्रदान करते कंपनी के विरुद्द दावों का। विवरणिका पॉलिसी लम्बे समय की होती है तथा डीवओ पॉलिसी वार्षिक पॉलिसी होती है। प्रीमियम को बढ़ाया जा सकता है तथा विवरणिका को जोखिम को नवीनीकरण के समय वापस लिया जा सकता है डीवओ पॉलिसी में यदि भावी विवरणिका दावे का ज्ञान हो। अब तक दृष्टि जोखिम पर थी, किसी संगठन के कर्मचारियों तथा निदेशकों के लिए। पंजीकरण तथा ट्रांसफर एजेंट भी बड़ा जोखिम रखते हैं जिनका संबंध इक्वीटी अंश / बॉंड तथा प्राथमिक संगठनों द्वारा जारी करने से है। पिछले दिनें ऐसे मामलों में शामिल है:-

- दिसम्बर 2006 - सेबी ने कोटक सिक्युरिटी पर 1 मिलियन रूपये का दंड लगाया आवश्यकता के अनुसार मार्जिन का प्रबंधन न करने पर तथा अन्य अनियमिताएँ जो 2001-2003 की अवधि में की गयी। अनिमिताओं में शामिल है विनियामक द्वारा प्रस्तावित स्थानों से अलग पर टर्मिनल देना। ग्राहक के दस्तावेजों को ठीक प्रकार न रखना तथा बीएससी तथा एनएससी के खातों में विविधता न रखना।
- दिसम्बर 2006 - सेबी ने एचएसबीसी निवेश सेवा (नीदरलैंड) एनवी, एक विदेशी संस्थागत निवेशक को एक मिलियन का जुर्माना किया कारण था सहभागी नोट (पीएन) को जारी करने की जानकारी न देना।

रजिस्ट्रार तथा ट्रांसफर एजेन्ट के लिये बीमा पॉलिसी निम्नलिखित जोखिमों को आवरण प्रदान करती है।

- अनिरक्षण में प्रतिभूति की हानि अथवा अंतरण में जोखिम जैसे सैंधमारी आद इत्यादि
- प्रत्यक्ष वित्तिय हानि किसी कर्मचारी की बेइमानी के कारण उत्पन्न। इसमें भी शामिल है विधि दायित्व तृतीय पक्ष को जो बेइमानी के कारण उत्पन्न हुआ
- जालसाजी के कारण उत्पन्न वित्तिय हानि
- वैधैनिक दायित्व जो आवश्यक हानि जो किसी

गलती के कारण प्रत्यक्ष रूप से हो मूल अथवा व्यक्तिगत कर्तव्य का विश्वासघात

- इलेक्ट्रॉनिक डाटा के क्षतिग्रस्त होने से प्रत्यक्ष वित्तिय हानि दुर्भावनापूर्ण कारण अथवा आग / सेंधमारी / हड़ताल के कारण
- भुगतान / निधि की सुपुर्दगी इलेक्ट्रॉनिक डाटा के कपटपूर्ण अंतकरण के कारण जो सीधा बीमाकर्ता के कंप्यूटर पर भरा गया हो।

बीमा आवरण का क्षेत्र विविधता रखता है। एक बीमा लेखक से दूसरे बीमा लेखक के मध्य बीमा कंपनी कई बार इस जोखिम को नियंत्रित करने के लिये एक वारंटी रखती है जो है 10,000 रूपये से अधिक के खर्चो को दो प्राधिकृत हस्ताक्षरकर्ता हस्ताक्षरित करेंगे और यह पहले से मुद्रित स्टेशनरी पर नही होगा अथवा कार्यालय तथा कार्यालय परिसर से बाहर जाने वाले दस्तावेंजों के लिये एक फाइल संचालन रजिस्टर रखेंगे।

दंड, जुर्माना जो प्रतिपूर्ति क्षति के कारण उत्पन्न होता है सामान्यतः अपवर्जन में होता है। यह पॉलिसी आईपीओ विशेष के लिये हो सकती है वह है पॉलिसी जो ली गई रजिस्ट्रार के द्वारा एकल आईपीओ अथवा वार्षिक आधार पर।

संक्षेप में पीओएसआई आवरण कंपनी के गलत कार्यो तथा उसके निदेशकों के द्वारा जारी विवरणिका को आवरित करता है। यदि कंपनी या उसके निदेशक गलत सूचना उपलब्ध करवातें है। विवरणिका में अथवा रोड शो में अंश धारक वैधानिक मुकदमा कर सकते हैं। विवरणिका दायित्व में विधि लागत जो विभिन्न दिवानी तथा फौजदारी अदालत में की जाये। आईपीओ का बीमा आईपीओ से संबंधित दायित्व के लिये डीवओ कार्यक्रम के लिये सीमावृत निर्धारित करता है।

रजिस्ट्रार तथा ट्रासफर एजेंट के लिये बनायी गई पॉलिसी सार्वजनिक प्रस्ताव के लिये इकाई की सेवाओं को सुरक्षा प्रदान करती है। जोखिम का क्षेत्र निधि के स्थानांतरण जो अभिरक्षा में शेयर की हानि अथवा गलत आबंटन के कारण उत्पन्न होता है तथा परिणामस्वरूप इन इकाईयों द्वारा अंकित किये गये जोखिम बड़े हैं।

निवेशक तथा विश्लेषक हमेशा कंपनी के विवरणों की समीक्षा करता है तथा पूँजी को शेयर बाजार में सूचीबद्ध करवाते हैं और रूकते नही है जब लेन देन समाप्त हो जाये। हक धारक यह जानना चाहते है कितनी अच्छी तरह से उनकी धन राशि को निवेश किया गया है तथा अधिक ज्ञान वाले और माँग वाले हो रहे हैं। इसलिये विशेष बीमा सुरक्षा बीमाकर्ता की प्रतिभूतियों तथा उनको सुविधा प्रदान करने वालों के लिये आज के समय में एक आवश्यकता बन गयी है।

विवरणिका में अथवा रोड शो में अंश धारक वैधानिक मुकदमा कर सकते हैं। विवरणिका दायित्व में विधि लागत जो विभिन्न दिवानी तथा फौजदारी अदालत में की जाये।

लेखक- शाखा प्रमुख- कोलकता होवडन इंश्युरेंस ब्रोकर इंडिया प्रा. लि.। उन तक पहुँचा जा सकता है ***sai.ranjani@howdenindia.com*** *द्वारा। यहाँ प्रस्तुत विचार उनके पूर्ण रूप से अपने व्यक्तिगत है।*

Report Card: General

G V Rao

January 2007 growth rate surges to 25.6 per cent

Insurers surpass market expectations

There have been eager and keen expectations of how the non-life insurance market would behave in January 2007, the first month since the rating regime was freed. Those that expected the premiums to fall or the growth rate to slide downwards, due to pressures of competitive bidding for rates, are in for a pleasant surprise. The premium growth rate of 25.6 percent in January 2007 is a significant improvement over the growth rate in December 2006 that was 19.7 percent.

Have insurers brought in more people into the insurance net? Has competitive bidding on rates led to more uninsured customers joining the bandwagon of insurance or did the hitherto under-insured decide to update their insurance values or has the increase in Motor TP premium rates given the growth a big boost? It would only be known when portfolio premiums are available. For now, it is a happy situation.

The new players that many thought would shrivel in their growth rates have continued unabated in their growth phenomenon in the free rating regime, in January 2007, as though there was no interruption in their previous growth curve. They have achieved a growth rate of 71 percent in January 2007 (as against 65 percent in December 2006). The established players too have kept up their growth rates at 8.8 percent (as against 4 percent in December).

Whatever the reasons for this excellent growth rate, the Insurance Regulatory & Development Authority must be quite pleased with the market behaviour, at least in the first month, since it took

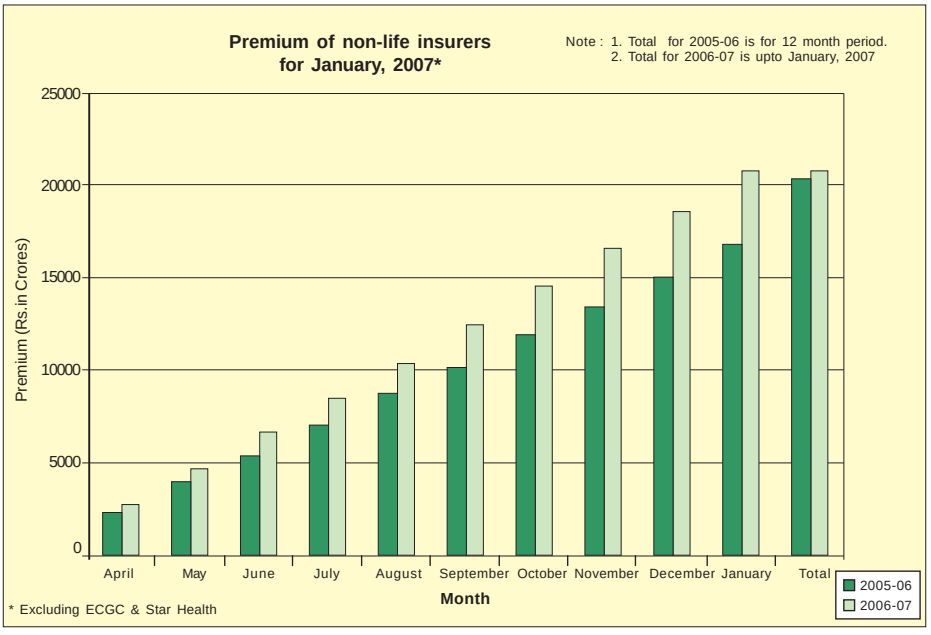
GROSS PREMIUM UNDERWRITTEN FOR AND UP TO THE MONTH OF JANUARY, 2007

(Rs.in Crores)

INSURER	PREMIUM 2006-07		PREMIUM 2005-06		GROWTH OVER THE CORRESPONDING PERIOD OF PREVIOUS YEAR
	FOR THE MONTH	UP TO THE MONTH	FOR THE MONTH	UP TO THE MONTH	
Royal Sundaram	56.31	494.13	46.68	373.26	32.38
Tata-AIG	66.62	636.27	53.03	490.24	29.79
Reliance General	101.12	712.26	18.62	130.05	447.67
IFFCO-Tokio	102.12	995.88	80.95	711.15	40.04
ICICI-lombard	275.03	2601.56	132.30	1354.64	92.05
Bajaj Allianz	166.77	1474.27	106.98	1070.30	37.74
HDFC CHUBB	14.28	156.21	17.21	160.08	-2.42
Cholamandalam	29.05	258.65	17.84	194.26	33.14
New India	422.40	4132.94	414.66	3832.74	7.83
National	362.25	3108.45	304.86	2914.73	6.65
United India	273.04	2901.81	251.47	2608.51	11.24
Oriental	333.10	3302.74	306.54	2931.22	12.67
PRIVATE TOTAL	811.30	7329.23	473.61	4483.98	63.45
PUBLIC TOTAL	1390.79	13445.94	1277.53	12287.20	9.43
GRAND TOTAL	2202.09	20775.18	1751.14	16771.18	23.87
SPECIALISED INSTITUTIONS					
ECGC	49.37	492.78	49.21	466.35	5.67
Star Health & Allied Insurance	1.20	15.68	0.00	0.00	

Note: Compiled on the basis of data submitted by the Insurance Companies

the uncertain plunge, into a free rating regime. It is to be hoped that the next couple of months would maintain this level of market discipline in growth rates. Insurers would also get an opportunity to represent to the Reinsurers that the Indian non-life market continues to be vibrant and it is growing as well as in the past, if not even more vibrantly.



Performance in January 2007

The new players have completed Rs.811 crore recording an accretion of Rs.377 crore and a growth rate of 71 percent despite all efforts at competitive bidding. The top players have continued their march in accretion levels and ICICI-Lombard leads the market with an accretion of Rs.143 crore with Reliance ranking next with Rs.82 crore accretion. Bajaj has recorded an accretion of Rs.60 crore. Cumulatively the accretion of new players is Rs.337 crore, ensuring a market share of 37 percent in the month of January 2007. As against a market share of 35.3 percent in the monthly December 2006 premium, they have achieved a market share of 36.8 percent in the monthly January 2007 premium. The performance of the new players in this free rate regime in January 2007 is a pleasant surprise indeed.

Among the established players, National Insurance has recorded Rs.57 crore accretion followed by Oriental with Rs.26 crore. UIIC ranks next with Rs.22 crore accretion. They have cumulatively achieved an accretion of Rs.112 crore. New India, the largest insurer, has turned in an accretion of Rs.7 crore only. But they have done far better in January 2007 than in December 2006 (Rs.50 crore).

Who then is the biggest beneficiary of the free rating regime in January 2007? It seems to be the non-life market itself, with an impressive growth rate of 25.6 percent and an accretion of about Rs.450 crore. Would this trend repeat in February 2007 is the eager expectation of almost everyone.

Performance up to January 2007

The market has completed a premium income of Rs.20,773 crore recording an accretion of Rs.4002 crore at a growth rate of 23.87 percent. At the end of December 2006, the growth rate was 23.7 percent. The new players have maintained the same growth rate of 63 percent; the established players too have maintained the growth rate of 9.5 percent. None has yielded ground in their market growth rates, despite the freeing of rates.

The contribution of the new players to the overall market growth of Rs.4002 crore was 71 percent at the end of January 2007, the same percentage as at the end of December 2006. Their market share stands at 35.3 percent while it was 35 percent at the end of December 2006.

Among the new players, ICICI-Lombard continues to dominate the market with an accretion of Rs.1246 crore, followed by Reliance with Rs.582 crore and Bajaj with Rs.404 crore. Among the established players, Oriental leads with an accretion of Rs.371 crore followed by New India with Rs.300 crore.

So, who are the winners of the free rating regime in the first month of its operation between the two sets of players? The position does not seem to have changed between the two; but for the market it has been a shot in the arm at least as the month of January 2007 indicates. But it is too soon to see any emerging trends.

Prospects

It is not easy to make predictions for the future. The systems and procedures in the new rating system have yet to be put in place for reporting numbers particularly by the established players. The spirit of competition in its fierceness is likely to intensify than diminish. Initial hesitancy to let rating strings loose would take more time to inspire enough confidence among the players. Now that all the players have their numbers with them, the marketing strategies might change. But the indications are sufficient enough to deal with any misapprehensions of Reinsurers that premium would go down in a free rating regime. Quite the contrary; it has surged beyond expectations. This should assist the market as a whole.

Comments may be sent to:
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The first conference on Financial Management of Large-Scale Catastrophes was held at Hyderabad, India, on 26th and 27th February, 2007 under the auspices of Organization for Economic Co-operation and Development (OECD) International Network. The conference was aimed at providing an international multistakeholder forum for the exchange of information and experiences on the financial mitigation and compensation of large-scale disasters. The conference was sponsored by Government of Japan and General Insurance Corporation of India (GIC); and it was co-hosted by GIC and IRDA.

Photograph shows General N.C.Vij, PVSM,UYSM,AVSM (Retd.), Vice-Chairman, National Disaster Management Authority, India, lighting the lamp to mark the inauguration of the Conference. Looking on are (L to R) Mr. C.R. Muralidharan, Member (Finance) IRDA; Mr. C.S.Rao, Chairman, IRDA; and Mr. Andre Laboul, Head, OECD Financial Affairs Division.

Mr. C.S. Rao, Chairman, IRDA greeting General N.C.Vij, PVSM, UYSM, AVSM (Retd.) with a bouquet of flowers.

A section of the delegates that attended the conference.

The 9th Global Conference of Actuaries, jointly hosted by the Actuarial Society of India (ASI) and the International Actuarial Association (IAA) was held in Hotel Taj President, Mumbai on 12th -13th February 2007. The conference was aimed at providing a forum for interaction at a global level amongst actuaries and other financial experts on financial and risk management subjects related to insurance and financial services industries.

Seen in the photograph are (L to R): Dr. R. Kannan, President, Actuarial Society of India and Member (Actuary), IRDA; Ms. Hillevi Mannonen, President, International Actuarial Association; Mr. Stewart Ritchie, President, Faculty of Actuaries; and Mr. G.N. Agarwal, Vice-President, Actuarial Society of India.

Dr. R. Kannan felicitating Mr. Rakesh Mohan, Deputy Governor, Reserve Bank of India; with a bouquet of flowers.

18 - 21 Mar 2007 Venue: Shanghai	International Underwriting Conference By *LOMA*
19 - 24 Mar 2007 Venue: Pune	Actuarial Practices in Life Insurance By *NIA Pune*
25 - 27 Mar 2007 Venue: Beirut	Regional Pension and Social Insurance Conference By *Muhanna Foundation*
26 - 27 Mar 2007 Venue: Singapore	Takaful Conference By *Asia Insurance Review, Singapore*
9 - 10 Apr 2007 Venue: Dubai	UAE - The World Takaful Conference By *Middle East Global Advisors (MEGA)*
11 - 12 Apr 2007 Venue: Kuala Lumpur	1st Asian Conference on Personal Lines Insurance By *Asia Insurance Review, Singapore*
13 - 15 Apr 2007 Venue: Taiwan	9th APLIC Congress By *Insurance and Finance Practitioners Association of Taiwan*
16 - 21 Apr 2007 Venue: Pune	Trainers' Training Programme By *NIA Pune*
23 - 24 Apr 2007 Venue: Jakarta	8th Asian Conference on Bancassurance & Alternative Distribution Channels By *Asia Insurance Review, Singapore*
23 - 28 Apr 2007 Venue: Pune	Creative Thinking and Decision Making By *NIA Pune*

RNI No: APBIL/2002/9589

view point

The new document is fundamental in developing a common structure for the assessment of insurer solvency and an important stepping stone for the IAIS in developing its standards and guidance on this topic.

Mr Tom Karp
Chair of the Technical Committee
– while releasing the IAIS common structure for the assessment of insurer solvency.

With an increasing number of non-Muslims taking up Islamic insurance and more new insurers entering the market, Takaful will take a much larger portion of the country's insurance market this year.

Mr Nasser Yassin
Executive Secretary of the Malaysian Takaful Association.

The Ministry of Finance is contemplating issuing regulation in a bid to end the tariff war in the general insurance business. The government planned to collect industry data to calculate the pure risk of motorised vehicles.

Mr Isa Rachmatarwata
the Finance Ministry's Bureau Chief of Insurance, Indonesia.

Local insurers who do not consolidate now will find it tough to compete with foreign players once free trade in Asia is implemented through the Asian Free Trade Agreement.

Mr Jose Cuisia
President of the Philippine American Life and General Insurance.

Financial services is the fastest growing industry in the region, whose continued growth requires the support of the insurance and reinsurance sector. In the midst of this period of sustained growth, it is especially important that financial services firms are able to adequately manage risk.

His Excellency Omar Bin Sulaiman
Governor of the Dubai International Financial Centre (DIFC).
- while talking about the importance of cross-border supervision.

It is a needed piece of insurance reform legislation that will improve efficiency of the surplus lines insurance market and make property/liability insurance more readily available to consumers.

Mr Richard Bouhan
Executive Director of the National Association of Surplus Lines Offices.
- talking about Non-admitted and Reinsurance Reform Act of *2007, US.*